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Cargo seeks to present materials that are innovative, challenging, and sometimes experimental. As a journal publishing texts in Czech, Slovak, and English, Cargo aims to reach scholars whose fieldwork and topics are close to geographical area of Central and East Europe.

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(Re)Producing Medical Anthropology in Central and Eastern Europe

Ema Hrešanová, Edit Szénássy

Medical anthropology today is one of the most dynamic and vibrant fields within the anthropological enterprise, contributing extensively both to the enhancement of anthropological theory and to a better understanding of crucial social processes in the contemporary world.¹ Yet, in the region of Central and Eastern Europe (CEE) this anthropological sub-discipline seems to be substantially underdeveloped and in some countries even completely missing. This special issue entitled *(Re)producing medical anthropology in Central and Eastern Europe* responds to such unbalanced development and reflects the problematic position of medical anthropology in the production of local anthropological knowledge. Our aims are threefold. Emphasising its focus on CEE, the issue first provides an overview of the state of the art in the individual countries of the region. Second, it highlights the rich theoretical potential that this dynamic sub-field of anthropological inquiry holds for local anthropologists who usually pursue different topics. And third, we seek to encourage the further development of medical anthropology in the region.

In short, our desire is to bring diverse regional voices into conversation with one another. In spite of considerable regional differences, shared experiences of socialist models of healthcare, as well as the impending diversification of services in a neoliberal healthcare market, provide a common platform across CEE countries. The ways these transitions get translated in a post-socialist context and are felt by patients reveal new power dynamics and call for further ethnographic research of emerging changes.

The idea for arranging this special issue was born at the conference, “*Health in transition: (Bio)Medicine as culture in post-socialist Europe*,” held in Prague in 2011, organized by Edit Szénássy, one of the co-editors of this issue. The conference pro-

1 Acknowledgements: Ema Hrešanová would like to thank the Czech Science Foundation for the financial support (GAČR P404/11/P089) which made her work on this issue possible, and to the Fulbright Commission in the Czech Republic, whose fellowship in 2008 – 2009 allowed her to build social and intellectual resources that she made rich use of while working on this issue.

vided a space for discussions among researchers from the region, as well as with their Western colleagues. In a similar fashion, we originally conceptualized this issue as a space for intellectual exchange among both local and Western medical anthropologists and researchers investigating health-related issues, while hoping to provide an inspiration to all. Informed by debates on power disparities in producing international scholarly knowledge, we worked hard to ensure a well-balanced representation of authors from within, as well as from outside the geographical area. However, contrary to our initial intentions and despite our intensive encouragement of local researchers to be part of this project, the vast majority of articles are written by non-CEE anthropologists of an Anglo-American background who are all women. In this context, the issue's geographical specificity awakes interest for yet another reason, because it successfully counters a trend in which non-Western based, small journals have difficulties 'attracting' contributors based outside the journal's geographical scope.

This issue is structured around four main articles built on original empirical research, an essay that elaborates the key concept of biological citizenship, and around ten shorter contributions summarizing the state of the art of medical anthropology in individual countries of the CEE region. The idea that sparked the initiative to collect state-specific reviews was the simple fact that, to our knowledge, very limited information is available on the questions of who, where and how medical anthropological research is done, and indeed if it is done at all, in the countries of CEE. A publication by Elisabeth Hsu and Doreen Montag (2005) stands out as one of the few overviews of institutions in Europe which are involved in teaching and doctoral research in medical anthropology. Particular contributions in the 'state-of-the-art' section review research conducted both by home investigators and foreign scholars. These texts together show that in most countries of the region medical anthropology is, indeed, a rather marginal field. We want to point out that this also has important implications for the potential of the discipline to participate in on-going societal debates and policy formations in the region, and weakens the potential to advocate for the rights of those who are disadvantaged and bear the consequences of increasingly severe health disparities.

Medical anthropology reflects the development of socio-cultural anthropology; in most countries of the region it evolved from a particular type of ethnomedicine or folk medicine. While in countries such as Slovakia, critical reflection on medical care and treatment is almost entirely missing in both local scholarship as well as that produced abroad, in the Ukraine Western researchers have significantly contributed to establishing this field. In other countries, such as Latvia, Hungary or Romania, medical schools and research centres play a key role, whereas in the Czech Republic, Poland and Slovenia medical anthropology is mostly present through interdisciplinary courses and research projects.

The collection of empirically based articles touches diverse issues, among which the theme of reproduction dominates. This not only corresponds to our own research interests, but also reflects a prevalence of this subject in this subdiscipline (see, e.g., Inhorn 2006). The opening article is based on research among American couples seeking reproductive treatment in the Czech Republic, one of the top destinations for assisted reproductive services worldwide. Amy Speier's writing gives a glimpse into the relatively new phenomenon of transnational reproductive travel (also referred to as cross border reproductive care or CBRS, or reductively as reproductive tourism). Through ethnographic interviews, Speier explores the contradicting discourses that surround CBRS from the perspective not only of those who opt for these treatments (patients/clients), but also of those who shape clients' decisions to undergo treatment in the Czech Republic (brokers/clinics).

Jennifer Carroll provides an analysis of how the work of public health professionals is shaped by - and is at the same time shaping - the discourses surrounding evidence-based medicine (EBM) in the HIV-prevention field of the Ukraine. The article reflects on the various players involved in creating and recreating the relevance of EBM, including high profile inter-governmental organizations positioned on the funding side, and small local non-governmental organizations placed on the receiving side of the spectrum. With one of the highest HIV rates in Europe in an extremely resource-dependent health care system, the production of evidence becomes a claim for legitimacy, personal agency and a politics of "deservingness" in the Ukraine.

Polina Aronson's article illustrates that post-socialist healthcare beliefs do not constitute a homogeneous ensemble. Through interviews with migrants from the former USSR living in Germany, Aronson demonstrates a fluid relationship between alimentation, migration experience and the conceptualization of health. She argues that the *Homo Sovieticus*, the compliant, inert soviet person disinterested in their own health, is as imagined as it is unrepresentative of the real-life health dilemmas and food choices of Russian-German and Russian-Jewish migrants, the majority of whom exhibit substantial effort in adopting to what they understand as 'civilized' German patterns of consuming healthy food. The study illustrates what effects the transition to capitalism has on migrants' perception of eating right and being healthy in a 'land of the plenty'.

The last article written by Jennifer Speirs, a British medical anthropologist, gets back to the issue of reproductive medicine. The study focuses on the issue of anonymous semen donation as a medical procedure crucial for the treatment of infertility, but which also, however, creates new forms of family and kinship, thus extending the realm of medicine into processes of family formation. While building on ethnographic research in the UK, the study goes several steps further and provides a description of the European aspects of donor insemination and a compari-

son of the UK and Czech contexts, thus generating a set of new research questions for both of these fields.

The next essay written by Ana Andrejic provokes new reflections on a more theoretical level. Building on insights from the Serbian context, the author re-examines Rose and Novas' concept of biological citizenship and the distinctions they make between its Western and post-socialist forms.

In addition to book reviews, an interview with Susanna Trnka and conference and research reports related to the subject, this special issue also includes a section on teaching medical anthropology. The section consists of two complementary reflections on one of the study programmes in medical anthropology in Great Britain. First, Karolina Dobrovská portrays her impressions and experience with courses she took as part of the medical anthropology curriculum during her studies at Durham University, Great Britain. In the second contribution, Andrew Russell - one of the co-founders of this programme - provides further details relevant from the lecturer's perspective.

We firmly believe that these texts and the issue as a whole manifest the potential of medical anthropology to make relevant conceptual, empirical and methodological contributions to studying the interwovenness of culture and the politics of illness and health in the CEE region. We cordially thank the dozens of contributors and anonymous reviewers whose work is reflected in the upcoming pages. Despite a number of structural, institutional and technical obstacles that complicated the emergence of this issue, including the geographical distance separating co-editors across continents,² we sincerely believe that the result is an interesting read which will meet all expectations, intensified even more by long waiting. It is our wish that this collection will stimulate more scholars to veer in this direction.

REFERENCES

- Hsu, E. and D. Montag, 2005. *Medical Anthropology in Europe. Teaching and Doctoral Research*. Wantage: Sean Kingston Publishing.
- Inhorn, M., 2006. Defining women's health. A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly*, 20 (3), pp. 345-369.

² The journal runs on a voluntary basis, with no remuneration paid to authors, reviewers or editors.

Stati / Articles

- Amy Speier: "IVF Holiday": Contradictions of Patient Care Abroad. 7
- Jennifer J. Carroll: *Evidence Based Medicine and the Construction of Moral Agency in Ukraine* 25
- Polina Aronson: *The Salad of Ideas: Beliefs about Health and Food among Immigrants from the Former USSR in Germany* 51
- Jennifer Speirs: *Anonymous Semen Donation: Medical Treatment or Medical Kinship?* 73

Esej / Essay

- Ana Andrejic: *Reconsidering the Distinction between Western and Post-socialist Biological Citizenship: Reflections on Developments in Reproductive Medicine in Serbia* 91

Medical Anthropology in Central and Eastern Europe: State of the Art

- Sabina Stan, Valentin-Veron Toma: *Medical Anthropology in Romania – Medical Anthropology on Romania?* 118
- Maryna Y. Bazylevych: *Medical Anthropology in Ukraine. The State of the Field* 124
- Aleksandra Bartoszek, Danuta Penkala-Gawęcka: *Medical Anthropology in Poland* 128
- Aivita Putniņa, Zane Linde-Ozola: *Review on the Development of Medical Anthropology in Latvia* 136
- Ekaterina Borozdina: *Medical Anthropology in Russia* 143
- Zorica Ivanović: *Developing and Establishing Medical Anthropology in Serbia* 148
- Katerina Vidner Ferkov: *Medical Anthropology in Slovenia* 158
- Tatiana Bužeková: *Ethnological Research in Slovakia in Relation to Medical Anthropology* 163

Ema Hrešanová: *Medical Anthropology and Related Qualitative Research in the Czech Republic* 166

Anna Susánszky, Imre Lázár: *An Outline of the Situation of the Subject of Medical Anthropology in Hungary* 173

Rozhovor / Interview

Understanding Care, Pain and Responsibilization - Making Sense of Policy and Practice. An Interview with Susanna Trnka (Edit Szenassy) 179

Výuka antropologie / Teaching Anthropology

Karolína Dobrovská: *Teaching Medical Anthropology in Durham: An Experience of a Czech Student* 189

Andrew Russel: *Teaching Medical Anthropology at Durham University. A Lecturer's Perspective* 193

Zprávy z konferencí / Conference Report

Elizabeth King: *Health in Transition: Annual Conference on Health and Healthcare in the Post-Socialist World. June 7-8, 2012, Bucharest, Romania* ... 195

Zprávy z výzkumu / Research Report

Iva Šmídová: *Research Project Report "A Sociological Analysis of Current Reproductive Medicine in the Czech Republic"* 199

Recenze / Book reviews

Radka Dudová: *Interupce v České republice: zápas o ženská těla* (Jaroslava Hasmanová Marhánková) 203

Agita Luse, Imre Lázár, eds.: *Cosmologies of Suffering: Post-Communist Transformation, Sacral Communication, and Healing* (Maria Vivod) 208

“IVF Holiday”: Contradictions of Patient Care Abroad

Amy Speier

Abstract: This paper considers North American patient contradictory experiences in traveling to the Czech Republic for assisted reproduction. Feminist scholars have discussed how reproductive technologies involve contradictions for patients. Although they offer women new opportunities, they also constrain women via medicalization. Most perniciously, these “hope technologies” (Franklin 1997) compel women to keep seeking more treatment. I argue that the global terrain of reproductive travel only exacerbates the contradictions of these “global assemblages” (Ong and Collier 2005) – the movement of reproductive technologies around the world – for patients.

The contradiction of medical holiday more broadly construed involves even further complications as women try to embody positive thinking by taking a holiday. However, it is clear that there are decisive breaks in the vacation couples experience, when the reality of infertility treatment and clinic visits interrupt their European vacation. In addition, the high cost of the trip pressures women to have a successful treatment. They internalize the lay-medical admonitions that they must not be stressed when undergoing treatment, and claim they try to be “zen”, a metaphor for New Age ideology and positive thinking, about the treatment. Inevitably, the experience of infertility treatment abroad is empowering for North Americans whereby patients feel agency as consumers within a neoliberal framework of healthcare, yet also disempowering when patients embrace an etiology of self-managed patient-care.

Key words: IVF Holiday, contradiction, reproductive travel, positive thinking

Introduction

Reproductive travel has grown as one of the main forms of medical travel due to the high cost of treatment, as in the United States (Spar 2006; Thompson 2005); strict regulatory laws, as in Italy (Zanini 2011); or a lack of access to biomedical technologies in some countries (Pennings 2002).¹ The Czech Republic has become an important destination site for the reproductive travel of North American

1 This work was supported by the National Science Foundation Project #0961316. I want to thank Edit Szénássy and Ema Hrešanová for inviting me to contribute to this special journal issue. I especially want to thank the Czech IVF specialists, coordinators and doctors, American brokers and patient travelers who have shared their stories with me.

and European patients, largely thanks to the entrepreneurial efforts of two internet-based brokers. These brokers self-refer as “IVF Coordinators.” North American women suffering infertility, yet unable to afford treatment in the United States, seek information by going online, where they land upon the sites of support or broker websites. The Czech Republic is a popular medical tourism destination for Americans and Westerners not only for reproductive care, but for cosmetic surgery as well. In addition, it is a popular spa destination, offering balneological and hydrotherapeutic treatment for various chronic ailments (Speier 2011a).

The Czech Republic is one of the top five destinations for reproductive travel, which is also prominent in Spain, Russia, India and the United States. Destination sites of fertility travel have evolved through a combination of sophisticated medical infrastructure and expertise, particular regulatory frameworks, and lower wage structures which allow reproductive technologies to be performed at competitive lower costs than in other countries. Cultural familiarity, regulatory boundaries and the availability of services such as sex selection or commercial ova donation are important (Blyth and Farrand 2005). Also, patient tourists travelling to the Czech Republic are seeking “white” babies from Czech egg or sperm donors (see also Kahn 2000:132, Nahman 2008). North Americans are particularly interested in egg donation.

Largely due to reproductive travel, the Czech Republic has witnessed a boom in the field of assisted reproduction, and has seen the growth of thirty-one, mostly private clinics scattered across the nation, some nestled in border towns near Austria and Germany, most situated in urban centers, and others in university towns with easy access to student donors². Czech clinical websites advertise in English, German, Italian and Russian, stressing the ready availability of student ova donors with only a three-month waiting period. The Czech reproductive medical field is profiting from its lower price structure and liberal legislation. In June 2006, the Czech Republic passed Legislative Act No. 227/2006 Col. which governs sperm and oocyte donation. Under this legislation, donation is legal but must be voluntary, gratuitous and anonymous. Donors are recruited largely through local universities, via posters plastered around the university, or public announcements on the radio or in magazines.

This paper considers North American patient contradictory experiences in traveling to the Czech Republic for assisted reproduction. Feminist scholars have discussed how reproductive technologies involve contradictions for patients. Although they offer women new opportunities, they also constrain women via medicalization. Most perniciously, these “hope technologies” (Franklin 1997) compel women to keep seeking more treatment. I argue that the global terrain of reproductive travel only exacerbates the contradictions of these “global assemblages” –

the movement of reproductive technologies across the globe – as they are experienced by reproductive travelers (Ong and Collier 2005).

The contradiction of a medical holiday more broadly construed involves even further complications when women try to embody positive thinking by taking a holiday. However, it is clear that there are decisive breaks in the vacation couples’ experience, when the reality of infertility treatment and clinic visits interrupt their European vacation. The high cost of the trip pressures women to have a successful treatment. They internalize the lay-medical admonitions that they must not be stressed when undergoing treatment, and claim they try to be “zen” about the treatment. The terminology used by Maureen, a reproductive traveler from Los Angeles, evokes a metaphor from New Age ideology and positive thinking in North America. Inevitably, the experience of infertility treatment abroad is empowering for North Americans whereby patients feel agency as consumers within a neoliberal framework of healthcare, yet also disempowering when patients embrace an etiology of self-managed patient-care.

After a brief discussion of methodology, this article addresses the feminist contradictions embedded in reproductive technologies. This paper elaborates upon the contradictions embedded within global reproductive travel, considering the levels at which patients enact agency. North American patient travelers leave their everyday life of work and stress in their pursuit of in-vitro fertilization and a European holiday. Czech clinic coordinators encourage Americans to embrace an ideal of positive thinking, thereby perpetuating a moral economy of reproductive health. In this sense, the “compulsion” to try is extended globally. Inevitably, patients experience ambiguity amidst the many choices about their “IVF holiday”.

Methods

Anthropologists Inhorn (2004), Speier and Whittaker (2010) have discussed the difficulty of gaining access to infertile couples, especially those who travel abroad seeking services. The anthropologist must rely on the clinic as well as IVF brokers to meet patients. The two brokers that work with Czech clinics and North American couples – referred to as “IVF Holiday” and “IVF Choices” – provided me with initial contacts with their Czech employees, clinical coordinators, doctors and sites of patient accommodation in the Czech Republic. Both IVF Holiday and IVF Choices sent out a survey I created to past clients who had already traveled to the Czech Republic, and the survey garnered thirty respondents. Many of these respondents agreed to a follow-up interview. Finally, the brokers put me in contact with patients who were in the Czech Republic while I was there.

This research is based on a multi-sited ethnographic project conducted in North America and the Czech Republic over the past four years. During the summers of 2008 and 2010, I met and interviewed individuals in two separate coor-

2 <http://www.stopneplodnosti.cz/kde-vam-pomohou>

dinator companies for reproductive travel to the Czech Republic. Each coordinator company, owned by Czech women who married American men, works with a different clinic in eastern Czech Republic. IVF Choices is based in Atlanta, Georgia. The owner, Petra, works with a clinic in Brno, Czech Republic, and she has two coordinators based in the United States and two in the Czech Republic. She has a contract with the clinic so that the clinic works exclusively with her. IVF Holiday is based in Ohio, and works with a clinic in Zlín. However, its relationship with the clinic is a bit more strained. The clinic began taking clients directly in 2009, when it hired a clinic-based English speaking coordinator.

During the summers of 2010 and 2011, I traveled to the Czech Republic. I spent a total of three months in Zlín and one month in Brno. In both cities, I conducted participant observation at the fertility clinic, and spoke with North Americans I met at the clinic or *penzion* – guest house – in Zlín. Patients vouched for my credibility on one particular website geared toward North American patients traveling to Zlín, at which point I was able to meet many other patients. This paper is based on 30 surveys and 52 interviews that have been conducted with patients, brokers, coordinators, and reproductive specialists. This research is not complete, since the third phase will be conducted during the summer of 2012, when I will travel to North American households and follow up the life histories of patients I met in the Czech Republic. Pseudonyms have been used for all informants – patients, coordinators, brokers and doctors.

A “compulsion” to keep trying

Feminist scholars have noted the power inherent in biomedical reproductive medicine (Martin 2001; Rapp 2000; Davis-Floyd 2003). Many anthropologists have considered the ways in which medicalization is disempowering to women (Martin 1989; Turiel 1998). For example, Sandelowski (1991) has written of how women feel “compelled to try” reproductive technologies. On the other hand, Sundby (2002) has revealed the empowering nature of reproductive technologies as they are resources, often distributed unevenly, offering some women the chance to conceive. Feminist theory has often failed to consider the actual experiences of women suffering infertility (Sandelowski 1990), and the issue of “choice” with fertility needs to be explored (Turiel 1998). Michal Nahman (2008) has considered the selling of one’s eggs as a question of choice and women’s rights over their body. In this vein, others have noted the feminist contradictions involved in the medicalization of treatment for infertility. Given the cross border nature of reproductive travel, the contradictions that already infuse the experience of infertility are exacerbated.

When patients are quoted \$10,000 to \$40,000 (the minimum price is for women using their own eggs) for in-vitro fertilization in the United States, with no

guarantee of success, they feel as if a road-block has interrupted their “journey” of infertility (Speier 2011b). Often, patients turn to the Internet to seek further options. Patients feel that their stress is eased with the information and new choices they stumble upon when they first hear of reproductive travel. It gives them a sense of control. Here, the hope of reproductive technologies proffered abroad is empowering for patients who see it as removing the road-block. The Czech Republic offers treatment for IVF at around \$3000 and for an egg donor cycle the cost is \$4000, costing North Americans around \$10,000 with travel.

The preliminary survey distributed to previous reproductive travelers asked patients about reproductive care they received in the United States, their assessment of that care, the ways in which they found out about reproductive travel, and their assessment of their treatment in the Czech Republic. Most respondents were unsatisfied with the “care” and high costs of treatment in North America, and often diametrically opposed their experiences in the Czech Republic from their previous treatments. Czech doctors and clinical staff are portrayed as truly caring by North American patients.

Ironically, unlike other forms of medical travel, travel for assisted reproduction is usually not a ‘one off’ procedure, but rather a commitment to a range of tests and procedures across the course of a ‘cycle.’ For this reason, IVF treatment appears an unlikely candidate as a procedure for medical travel because of the time and multiple steps involved. For a woman, a ‘cycle’ in IVF takes place across approximately 21 to 28 days. It involves suppressing a woman’s normal menstrual cycle, inducing ovulation, usually involving daily injections of pituitary hormones to produce a number of eggs, ‘oocyte retrieval’ (the ‘harvesting’ of those eggs using an ultrasonically guided needle), their fertilization by sperm, growth ‘in vitro’ in the laboratory across a number of days, selection and further testing in the case of PGD, further hormonal stimulation for some women to induce the production of endometrial lining, and transferring (usually two) resulting embryos directly into the uterus. Two weeks later, testing (which may occur back in the home country) reveals whether implantation of the embryo has been successful. Men have less physical involvement. This is so even when male infertility requires procedures such as ICSI (intracytoplasmic sperm injection), involving testing and sperm collection through masturbation or a surgical procedure. Alternately, a man may have his sperm collected in his home country and couriered overseas for use.

While some tests and procedures may be undertaken in their home countries before travelling overseas, minimally, a woman undergoing IVF must stay in the Czech Republic for 2-3 weeks. Women are usually able to find a doctor or clinic in North America who will help her complete initial tests and obtain medications. However, if she chooses to complete all of her preparation and testing for a cycle in the destination clinic, she may need to stay for up to three months. Paradoxically,

couples with more complex fertility issues who must use egg donors may need to spend less time in the destination clinic.

Reproductive travelers see themselves as consumers, and they can choose among various inter-related resources as they make travel plans to the Czech Republic (Becker 2000). Metzl and Kirkland's *Against Health* (2010) reveals the ways in which the medical industrial complex, in seeking patients to consume particular products in their endless search for “health,” creates a framework whereby patients are consumers. Furthermore, the various ways patients act as consumers is often framed in terms of “moral responsibility” over one's health, and the extent to which they consume is reflected in moral judgments against the individual.

When health care is situated in a neoliberal framework, individuals often assume (moral) responsibility for their health. In addition, positive thinking is a pervasive ideology of social control (Ehrenreich 2009). Positive thinking implies that what you think will manifest itself in the world. You change the world with your thoughts, exert a force. When women experience infertility, they are often told that if they relax, they will get pregnant. Petra, owner of IVF Choices, claimed that some people are so stressed, they simply cannot ever get pregnant. Dr. R of the Zlín clinic estimated 30–40 percent of infertility cases as mental. What is problematic is that women self-blame and become caught within a vicious cycle of worry, stress, and trying to relax. Once they land upon the option to take an IVF vacation, the pressure to relax grows stronger.

In remembering her own infertility journey, Petra remembers that once she and her husband had decided to have children, they wanted it to happen immediately. When it did not, she said she became “obsessed” with it. In the United States, there is the element of having to add fertility treatment to the everyday stress women already experience. Petra spoke of how stressful treatment is in the United States, because women typically maintain their work schedules when undergoing treatment. Hence, they must juggle the stress of their everyday lives with the clinic's spontaneous requests for women to come in to too-frequent blood work. Petra remembers the stress of having to leave her job at a moment's notice. Daniel also remembered when he and Maureen had begun trying to conceive, and how the timing and introducing stress into the equation was a “nightmare”. Furthermore, the stigma associated with infertility added another element of stress. Many women with whom I spoke did not share their troubles or issues with friends and family. Hence, the burden of secrecy added to the weight of the work involved in undergoing treatment in the United States. Julie, who did not share her infertility struggle with friends, said that it was stressful hiding doing treatment at home, sneaking off to the clinic. The struggle of infertility and experience with fertility treatments at home are understood as work. Zoe remembered asking herself why she had to work so hard in seeking options online. Jenny claims, “If they want children, they have to do the work.”

Despite the very real stress of infertility, the etiology of infertility is explained by the power of the mind. Infertility patients often blame themselves on two fronts, as they assume moral responsibility for their health care and succumb to the ideology of positive thinking. They think they may not be healthy enough or that they have not been thinking positively. Since it is the woman's body that is the focus of reproductive technologies, women tend to blame themselves for their inability to get pregnant. They feel guilt, shame and sadness, often claiming that they feel “broken.” They point to other friends of theirs, who may be overweight or eat poorly, and wonder how they can get pregnant - making direct correlations between “health” and fertility. For example, Valerie, after having experienced four miscarriages, said with exasperation, “I have a friend who is 42, overweight, eats like crap and she got pregnant, damn it. I'm healthier than her, why can't I get pregnant?” Linda also spoke of her relative health status, hinting that since she was a moral (healthy) person, she should get pregnant.

As mentioned, women feel compelled to try the newest reproductive technologies, seeking out other ways to have a family. This compulsion is often framed in moral terms, as a form of social control that pressures women at the same time that it empowers them. Angela, coming from Chicago remembered how she had stopped trying to find affordable options of IVF. She mentioned a friend who “didn't want her to give up” trying to have a baby. While some may see this as supportive encouragement, one could also see it as a form of pressure on Angela, to never stop trying for a child. In addition, as Jenny wrote me from California, after she had miscarried from her third attempt, “We live at a time when things are changing in so many ways on all levels so it's hard to know where you should stand on things. It was so much easier for our parents!” The rapid changes in the field of assisted reproduction may, in fact, confuse women and pull them in multiple directions.

Contradictions of IVF holidays

There has been considerable debate as to the proper label for those patients traveling abroad for care. Some have argued that the term “reproductive tourist” connotes excess pleasure and is inappropriate (Pennings 2005; Inhorn and Birenbaum-Carmeli 2008). Some have argued that we should label these lower and lower-middle class patients “reproductive exiles” since they are forced to seek treatment outside of their home countries (Matorras 2005; Inhorn and Patrizio 2009). Although most would assume that only the affluent can afford to travel abroad for care, Elaine Sobo and others claim, “medical travelers seeking biomedical treatment overseas may be disproportionately representative of the working poor” (Sobo, et al. 2011: 133). What I began to realize is the Americans traveling to the Czech Republic are Caucasian and lower class. If they are not lower class, they have

exhausted their funds for treatment in North America. When I interviewed the head doctor from Reprofit, Dr. M, he said “Of course they are”, adding, “the pure, typical American, they don’t know where Europe is.” One patient self-referred as “Joe Schmoe, not Celine Dion”.³ The average age of informants was 40, with ages ranging from 27 to 53. However, most patients traveling to the Czech Republic are well versed in the world of assisted reproduction, knowing all the medications and the process of treatment, having already experienced at least an intra-uterine insemination (IUI), if not a cycle of in-vitro fertilization (IVF), in the United States. The majority had experience travelling abroad. However, I did meet two couples who had never been abroad prior to their trip to the Czech Republic.

The majority of patients who “do the research” (Speier 2011) online are women, since they often seek support from others on infertility boards and chats – often a source of empowering information. One must remember, not only do women find the vast wealth of information on the internet expands their options, it also leads them to assume a much more active role as a patient, whereby they have increased responsibility over their health care. Leah was thoughtful about the high degree of “self-management” involved in reproductive travel.

At the most basic level, as women “do the research” online, their self-management begins with information gathering about treatment options abroad. While most women I spoke with talked of feeling “comfort” with finding information online, as Zoe did, there is a hidden, underlying level of increased patient responsibility. She said while there is a “world of information out there,” she also had feelings of wondering why this was so much “work.” Then, she quickly reframed the situation. A bit self-righteously, she said women simply have to be “proactive” about their health care. This reframing spins the “work” of infertility onto women as heroic risk takers on “quests for therapy” (Janzen 1978). The majority of reproductive travelers spoke of themselves as active researchers and admonished other women to be proactive about their treatment and “do the research, whether or not they are going to the US or abroad,” as Faith proclaimed. Again, this imperative implicitly judges the women who do the work as morally superior to those who remain uninformed.

As most people know, traveling abroad involves a lot of preparation and “work” (Graburn 2010). Linda and Michael admitted that planning the trip was “stressful.” It is clear that the coordinator companies called “IVF Holidays” or “IVF Choices” frame reproductive travel as a vacation and pose as travel agents. They claim to offer patients not only a more affordable, but also a less stressful IVF treatment. One website reads: “How does shopping, sightseeing, spa treatments, massages, history and quality time alone, or with your close friends/family sound?” Multiple patient testimonials on broker websites claim they had a real vacation while getting

treatment: “We took full advantage of the vacation aspect of this trip and this truly made the medical experiences...less stressful.”

Some couples seem to be spokesmen for IVF brokers, but only after having a successful cycle in the Czech Republic. Deborah said, “If it didn’t work, we got a wonderful vacation.” Tracy kept saying, “For \$11,000 we had a European vacation, made the best of friends, and came home with two babies. That is the best part.” Maria also repeatedly said that it was a “worry free” vacation and that it was much less stressful than in the States. It is no wonder that Hana of IVF Holiday used Maria as a constant referral for people wanting more information about the trip.

Broker websites are adorned with patient testimonials that attest to the fact that they had a European vacation while they were in the Czech Republic. Since in-vitro fertilization does not have a hundred percent success rate, brokers sell a vacation. In this way, patients do not feel that they are wasting their money. One testimonial writes: “When we had failed cycles in the States (we had many, many failures here) we felt like our money just went to waste. It just evaporated. Even if we didn’t get pregnant on our first try in the Czech Republic, our money gave us a great vacation and memories” (retrieved June 23, 2010). Even if a trip and treatment to the Czech Republic costs \$10,000, patients rationalize spending the money in the Czech Republic as also offering them holiday memories.

Brokers like IVF Holiday and IVF Choices market their services as easing couples’ travel abroad, and, in fact they do a lot of the “work” associated with travel and treatment, taking on the stress many couples may face in arranging accommodation and clinic appointments. Lauren and John appreciated the “door to door service” IVF Holiday provided from the airport to their *penzion*, since it added an element of relaxation. The *penzion* has been slowly expanding its services to cater to its North American guests, which include renting cars, serving dinner in addition to breakfast, and providing rides to the clinic. IVF Choices owner Petra claimed that her business sought to offer a “low stress” alternative, with various options based on cost. At the same time, she often said she wanted to help her clients be independent. We confront another contradiction whereby patients are paying for someone to do a lot of the “work,” yet Petra is also encouraging them to be independent, to proactively assume responsibility for their treatment. The rhetoric of a neoliberal patient care model imbues Petra’s words, whereby she “liberates” the patient consumer with choices, while at the same time she reifies their responsibility for their health care.

I would argue that the most insidious contradiction of reproductive travel builds on a common idealistic etiology of infertility. Often women hear from friends, doctors, and the media that if they simply relax, then they will get pregnant. IVF brokers are building on this assumption in promising a vacation. In addition, they are selling a way for couples, who have been told they need to relax, a way to relax. One testimonial claims, “I know being so relaxed and calm helped us get pregnant with twins on our first trip!” (from IVF Alt retrieved June 23, 2010).

3 Joe Schmoe is a colloquial term that refers to the “average” American.

Treatment in the Czech Republic is characterized by patients as less stressful than treatment in the United States, since patients only visit the Czech clinic two or three times (see also Hudson and Culley 2011). Linda claimed her treatment was less stressful, and Kate said during their travels, there were times when they were not thinking about their fertility treatment. When she had been in the United States, it had been “fertility, fertility, fertility,” which affects how you go through a cycle emotionally. In addition to the freedom from the daily stresses of life in North America, couples often enjoyed the quality time they had together. Of course, couples also enjoy being off work, since it is a rarity in the United States to have three weeks off. Couples often diametrically opposed their “normal busy” lives to the quiet, relaxing town of Zlín. Faith said that she enjoyed the family time she had during the trip. In some cases, as with Zoe and Alison, parents, sisters or other family members would join the couple or woman as an additional level of support. Furthermore, a general notion of romance, history and intrigue imbue European travels for North Americans.

Couples who may not have traveled before found comfort in the presence of other North Americans. A true sense of camaraderie of sharing the experience of reproductive travel, as researchers, risk takers, and sufferers of infertility is often cited as one of the high points of many peoples’ experiences. One testimonial writes, “We had three other couples undergoing IVF, and sharing the same experiences and nervousness. In a matter of a very few days we became friends - and probably friends for life.” Maureen had told me that one reason they had chosen to come to the Czech Republic was the “comfort of more people coming here.” Maureen wrote on her blog for the day of the transfer: “Tomorrow’s the big day so we are going to try to be zen about it and relax. It’s good to have met other people here going through the same thing. It makes you feel less alone.” Notice the fact that she feels the pressure to relax – a conundrum indeed. Julie felt comfort in sharing with others in Zlín, especially since she didn’t talk about her infertility at home. One woman said, “I love being away and not having to work, it is really nice not having to deal with daily pressures.” Another husband also said, “The whole cycle thing is going to be tough, so why not go somewhere where one doesn’t have all the everyday stress?”

In my research, there were large variations in the touristic elements of patient experiences. However, their experiences were always fraught with contradiction. The extent to which couples or women enjoyed a European vacation depended largely on their socioeconomic status. Analytically, I have divided my informants into three main groups: those who embody the typical tourist (20 % of respondents), those who visit local Czech sites and take time to relax (50% of respondents), and those who have put all of their savings into treatment and do not “tour” (30% of respondents).

Those who embody the typical tourist are the ones who spend the majority of their time exploring, renting cars or jumping trains and heading to nearby Vien-

na, Prague or Budapest. As one couple said, “We’re traveling and we’re tourists, because we’re seeing the sights. I want to learn more about each place, and I love taking photographs and seeing new things.” We will see, however, that the reality of infertility still intrudes upon these holidays.

Some couples may not have the financial resources to travel so extensively, yet they still head to nearby attractions such as the zoo or castles, which are in abundance. However, they would never have chosen the Czech Republic as a tourist destination. Those who see local sights and spend time relaxing, but find themselves in the Czech Republic have said, “The bonus is the tourism, but would I have specifically chosen the Czech Republic? No. If the focus is the reproductive aspect, I can’t really call myself a reproductive tourist.” And finally, there are couples who are either uncomfortable travelling or without the means to travel more than they already have. They coop themselves up in their rooms, skyping with friends and watching endless videos. Those who have put all their savings into traveling for IVF stay in their hotel rooms the entire time: “We’re not really touring a whole lot, we’re trying to kill time more than anything. We’re not doing a whole lot with our time.”

People vary in the extent to which they travel while in the Czech Republic, given their financial means as well as their level of comfort in European travel. Ten percent of my respondents had never traveled abroad, while the majority had traveled, though never to the Czech Republic. North Americans often approach their travels as a diversion from the fact that they are undergoing treatment, exploring a country they knew relatively little about until their visit. Zoe said that she and her husband traveled to make it a balanced experience, not all about expensive reproductive treatments. You want to go where you can get away from the clinic. Not mentally, she admitted, but physically. She said while couples are sightseeing, they are experiencing something new, which somewhat takes their mind off their treatment. Since it is emotionally taxing to go through treatment, sightseeing takes your mind off of it. However, even for couples traveling around Europe to the fullest extent, the fact or purpose of their trip is rarely far from their minds.

In addition to traveling, patients pampered themselves. Claudia had sought out massages and acupuncture while in the Czech Republic, as did Kate and Maureen. Zoe said she had found a masseuse while in the Czech Republic, since she wanted to deal with the “stress knots on her neck and back.” Coordinators want people to feel like they are tourists, and go as far as to link patient success rate to those who truly treat their trip as a vacation. There is a moral economy at work, whereby social understandings of infertility becomes paramount as an ethical framework is constructed around who deserves to get pregnant. Diana, a Czech coordinator in Brno, claimed that “those who take it easy, don’t do massage or acupuncture, they are the 99% [who] get pregnant.” How ironic! Women are trying to relax through acupuncture and massage, yet are still blamed for being too high strung.

Brokers casually claim that it is the couples who truly relax, who treat their trip as a vacation – embarking upon short trips around Europe and allowing others to coordinate their treatment and accommodation, who are the ones who have a successful treatment. Hana, of IVF Holidays, divided her clients into two main groups: those who go with the flow, and the ones who have to control everything. She also characterized the blogs women belong to as being full of “crazy women” who freak each other out and give advice. Embedded in these two statements is a ridicule of the women undergoing the stress of infertility, as well as the insidiousness of telling women to simply relax and go with the flow. Forty percent of my respondents successfully became pregnant after their cycles in the Czech Republic, although I did not divide women into such categories.

Vacation interrupted by “Stirrups at the End”

Those couples who use IVF brokers do feel they are receiving a service that encourages them to treat their time like a vacation. Julie, from South Carolina, said that the trip would have been too stressful without a coordinator. Her husband joked that when they arrived at the airport, they met this man who did not speak English and handed them a cell phone with someone speaking English telling them to get into his car and that he would take them on a three hour ride to their destination. He joked that this guy could have killed them. This comedic memory brackets the extent to which their vacation is punctuated by stress. In fact, we can consider reproductive patients as “risk takers” who are arranging their services online with a brand new kind of broker. There is an undeniable element of stress simply in contracting with an IVF coordinator – as Amber joked, “I said a little prayer that it wouldn’t crash my computer and I clicked.”

In speaking to a doctor in Atlanta, I asked if it is more relaxing for couples to go abroad, and he bluntly replied, “Silly. You’re in a country that uses a Cyrillic alphabet and you don’t know how to get on the damn bus. You know that’s bull, that’s just bull.” Hana, owner of IVF Holiday did admit that most couples find Czech culture “strange”, in areas such as food, limited hours of shops, and certain clinical practices. While Czech does not have a Cyrillic alphabet, it is difficult to get around for most patients. Alida and Allan, a couple from Texas, said it had been “overwhelming” to travel to the Czech Republic. Daniel did not care for the fact that they had to fly halfway around the world for treatment. Maureen and Daniel, and Allison, had had a terrible time with trains and figuring out schedules and directions. Thus, while patients try to embrace their trip as something relaxing, it is punctuated by stressful preparation and moments of trial and error.

April and Larry had taken full advantage of going out and exploring, visiting nearby Austria, Poland and Slovakia. They had rented a car from the owners of the *penzion*, and spent most of the time exploring. They admitted that it would be nice

to not have issues, to not have to see a doctor, to truly be on vacation. They admitted that having the distractions during treatment was nice. Larry had wondered before they left if they would really be able to just get away, and they had. That is, before they had their second appointment. When they came back to Zlín for their egg retrieval, they talked about how they had a “reality check” when they heard about the number of eggs retrieved. Women are often sedated for the egg retrieval, and may experience cramping or discomfort afterwards. An average number of eight to fifteen eggs may be retrieved, and so women often compare their own numbers to these “norms”. April and Larry only had six, whereby other women had announced that they had had numbers around 18. Hearing only six was a disappointment and felt like an immediate setback to them.

The announcement of numbers of eggs retrieved and fertilized was often followed by feelings of exultation or dejection. Another couple was upset about their three-day transfer, since it was general knowledge that a five-day cultivation period optimizes chances for pregnancy. Jessica had been really disappointed when she had only three embryos, since most couples talk about freezing embryos for possible future visits – “banking” or “saving” for future trips. Couples inevitably felt sad if they did not have this possibility. Hence, it is usually on the egg retrieval appointment or the day of transfer when couples are awakened back to the reality of their situation.

Angela and Chris said 95% of their trip had been smooth, but they did have traumatic stress points with trains and planes. Angela and Chris felt like teenagers backpacking through Europe, and they had not had two weeks off in forever. Yet at the same time, she felt that the process was very stressful. Chris said, “Zlín is an interlude to a really nice trip.” Zlín was not thought of as part of the vacation, it was a stopping place, a break, a waiting station. It was the “stirrups” at the end of a European vacation, stirrups evoking a gynecological visit for North Americans. She said even with an adoption going through at the same time, she still felt a lot of pressure. Women spoke of feeling pressure for the treatment to be successful, as Amber and Angela and Chris had. As Maureen wrote me from her second trip to Zlín, “Thanks for the good wishes, I am terrified, hopeful and excited all rolled into one big ball of tired nerves.” I often witnessed women “stressed” or a ball of “nerves” on the day of the transfer. They would sometimes lash out at their husbands.

A petite Floridian, Kate had large amounts of nervous energy the morning before her transfer, she could barely eat her breakfast and was tearing up as we took a walk outside to try to calm her nerves. Alison, a teacher from Minneapolis, tried to comfort her by saying that the transfer was really easy. However, when it was her day of transfer, Alison was also very nervous. She had asked the clinic to do several tests to “put her mind at ease.” Alison admitted that she could “depress the hell out of myself,” if she thought about her infertility for too long. Women often ate pineapple before and after their transfer, an old wives’ tale circulating among

Czech hosts and American guests claiming it helped create a comfortable atmosphere for the embryos. And finally, Zoe said that by the day of the transfer, they were “utterly freaked out.”

Czech clinic promotes ultimate contradiction: self-managed attitudes

Just as patients often contrasted the stress of treatment in North America with the relaxed Czech treatment, so they also felt more empowered in their clinical encounters. Having already assumed a proactive role with respect to their health, women felt they had voices and could make demands, whereas they repeatedly felt like they were treated as a number in the United States. Faith said that she had wanted “control” over treatment options, whereas she had not had any in the United States. Women appreciated that they had some say in their treatment, whereas we must remember that they have become consumers rather than patients in the context of Cross Border Reproductive Care.

An example of the contradictory nature of reproductive travel – whereby patients have considerable agency as consumers, a more empowered voice in the clinic encounter, and thus they also face the stress of making decisions about their treatment – is in the question of how many embryos to transfer. Faith said, in making her decision:

“So, I had done a lot of research prior to either IVF cycle. I knew the dangers. I know the dangers of transferring too many. I know it’s a gamble. I made an educated decision myself. This was not some crazy person. I was having to factor in all of our circumstances: the fact that this was our only trip, the fact that freezing one embryo and coming back for that one embryo is not cost effective. If we had the money to come back and do another fresh cycle and freeze any from that, and then do another frozen cycle, I would have made that choice - to freeze one embryo. But I didn’t want to just transfer two and freeze two, because I didn’t want to lower the odds for this trip.”

Faith is putting her body under pressure, in transferring more embryos than the embryologist recommended, weighing future trips or the cost-benefits of each, her body becomes the stage for her contradictory experience. Czech insurance covers up to four cycles of in-vitro fertilization for Czech women under the age of 35, as long as only one embryo is transferred. Hence, there is a large difference in the level of “choice” North American patients can make about the number of embryos to transfer, that choice being directly tied to their status as consumers.

IVF is not a “sure bet,” and Eva-Marie Knoll (2001: 120) has discussed the prevalence of gambling metaphors in the realm of reproductive technologies. Dr. S., a reproductive specialist from Atlanta said, “I say to them, this is getting to the

point where I don’t see where we can do anything different that’s going to make a difference. You might get lucky, but there’s been a lot of trying to get lucky. I don’t want this to be like the guy who’s already lost ten thousand dollars at gaming tables in Vegas, who thinks that if he just plays one more hand, he’ll get it all back. Actually, that analogy is very powerful.” There is a lot of discussion of money and different cost-benefit analyses couples undertake when they are weighing the cost of travel and treatment in the Czech Republic compared to the United States. The fact that couples can travel to the Czech Republic three times for the price of one cycle in the United States is the most often cited reason for traveling abroad for treatment. As Tracy said about IVF with donor egg cost of \$50,000 in California: “It’s a hell of a lot of money and you don’t know whether it’s going to work.”

Patients seem to self-monitor their attitudes as they go through treatment. Daniel and Maureen, a couple together since college, talked of consciously trying to treat their trip “like a vacation...except when we were at the clinic.” Daniel said that he could get anxious and Maureen could “spiral.” She had suffered depression in the past, claiming that she was “broken.” They made great efforts to not think about the process. He said he hoped that in a “karmic” world, of a long time of trying, that they would have a successful cycle. He said, “I believe in the power of positive thinking; you can make it happen.” Unfortunately, they have been unsuccessful twice already, and still feel compelled to try again in the spring. The clinic has profitably embraced this idea of positive thinking and hard work that pervades the lives of American patients. Lenka, the clinic’s main coordinator, and wife of one of the doctors, told Daniel: “The only people who don’t get pregnant are those who stop trying.” Daniel found this statement to be empowering, whereas I consider it aggressive self-promotion and marketing. The risks of ovarian cancer, ectopic pregnancy, multiple births and ovarian hyper-stimulation, not to mention the psychological and emotional stress associated with in-vitro fertilization are inevitably downplayed in this statement.

I remember April talking about how she had brought relaxing meditation music with her to the clinic on the day of the transfer, trying to instill relaxation and positive thinking. Couples often talked about trying to be positive, including Linda and Michael, Tracy, Claudia and Ben. Doug talked about how he was “thinking positive.” In other words, even if couples claimed to know that they had no control over the outcome, they would speak in terms of “fate,” as Maureen said, “If it is meant to be,” it will happen. Similarly, Jenny said that if her cycle did not work, she would take it as a “sign.” Yet, she still traveled back to the Czech Republic for a fourth attempt after her miscarriage last fall, selectively ignoring the “signs.” At another level, in addition to patients embracing the self-blame inherent in prescriptions to relax and think positively, those who are positive thinkers are deemed better people. Positive thinking connotes the worthy individual, especially one who would make a good parent. For example, Cindy self-referred as a “positive

person,” signifying her moral worth to become a mother who would stay at home to raise her child.

Claudia, a nurse from Seattle, had traveled to the Czech Republic a total of three times for IVF. She talked about how she remained “healthy” and how she was a positive thinker, and remembered back to a previous trip with another woman who was very negative about the whole thing, but had gotten pregnant. She spoke of this as a cause for wonder. She had done acupuncture and massages to decrease her stress, and often wrote in her journal. In talking about her most recent transfer in the summer of 2011, she had noticed the doctor was different than the one who had done her egg retrieval, and it had struck her. Yet, she did not want to say anything, for fear of “putting negative energy into the room.” One sees that even as empowered as they are as consumers in the Czech clinic, there are times when patients silence themselves, under the new age directive of the power of the mind.

Conclusion

Returning to the previous moment for Faith, who was weighing her choices for embryo transfer, she decided against heeding the embryologist’s advice to transfer only one or two embryos:

“I knew the risk, I knew that it was a gamble, but I also knew how my body responded. I was terrified of never being able to do this again, because I watched my husband work hard for this money for months. I mean basically from as soon as we got home from her [daughter’s] cycle, he was setting money aside again, for the next time. I already felt terrible that my body had responded so poorly, and I kept thinking what could I have done or changed?”

It is the woman’s body that is the site of struggle, where women are the risk takers in this global endeavor of CBRC. All of the contradictions embedded in reproductive technologies abroad become embroiled and enmeshed.

Feminists have shown the contradictions inherent in assisted reproductive medicine, and I argue that these contradictions become more complex when situated within a global, neoliberal stage of health care. My research with North American, heterosexual couples as reproductive travelers in the Czech Republic reveals a wide range of contradictions inherent in the “global assemblage” of reproductive travel (Ong and Collier 2005). North American patient travelers angry about the high costs of fertility treatment in the United States, see it as a big business (Spar 2006). While many find the high costs prohibitive, they find “hope” in their ability to travel. Yet, we must caution patients about the extent to which they will experience a true IVF vacation.

REFERENCES

- Becker, G., 2000. *Elusive Embryo: How Women and Men Approach NRTs*. Berkeley: University of California Press.
- Blyth, E. and Farrand, A., 2005. Reproductive Tourism: a Price Worth Paying for Reproductive Autonomy? *Critical Social Policy*, 25 (1), pp. 91-114.
- Davis-Floyd, R., 2003. *Birth as an American Rite of Passage*, 2nd edition. Berkeley: UC Press.
- Ehrenreich, B., 2009. *Bright-sided: How the Relentless Promotion of Positive Thinking has Undermined America*. New York: Metropolitan Books.
- Franklin, S., 1997. *Embodied Progress: A Cultural Account of Assisted Conception*. New York: Routledge.
- Graburn, N., 2010. Secular Ritual: A General Theory of Tourism. In Gmelch, S. B., ed. 2010. *Tourists and Tourism: A Reader*, 2nd ed. Long Grove: Waveland Press, Inc.
- Hudson, N. and Culley, L., 2011, Assisted Reproductive Travel: UK Patient Trajectories. *Reproductive BioMedicine Online*, 23, pp. 573-581.
- Inhorn, M. C., 2004. Privacy, privatization, and the politics of patronage: ethnographic challenges to penetrating the secret world of Middle Eastern, hospital-based in vitro fertilization. *Social Science & Medicine*, 59, pp. 2095-2108.
- Inhorn, M. C., and Birenbaum-Carmeli, D., 2008. Assisted Reproductive Technologies and Culture Change. *Annual Review of Anthropology*, 37, pp. 177-196.
- Inhorn, M. C. and Patrizio, P., 2009. Rethinking Reproductive ‘Tourism’ as Reproductive ‘Exile’. *Fertility and Sterility*, 92 (3), pp. 904-906.
- Janzen, J. M., 1978. *The Quest for Therapy: Medical Pluralism in Lower Zaire*. Berkeley: University of California Press.
- Kahn, S., 2000. *Reproducing Jews: A Cultural Account of Assisted Conception in Israel*. Duke University Press.
- Knoll, E., 2001. *Reproduktionsmedizinische Imaginationen. Überlegungen zum österreichischen IVF-Diskurs aus ethnologisch-feministischer Perspektive*, University of Vienna: unpublished master’s thesis.
- Martin, E., 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Revised Edition. Boston: Beacon Press.
- Matorras, R., 2005. Reproductive Exile versus reproductive tourism. *Human Reproduction*, 20 (12), p. 3571.
- Metzl, J. and Kirkland, A. eds, 2010. *Against Health: How Health Became the New Morality*. New York: New York University Press.
- Nahman, M., 2008. Nodes of Desire: Romanian Egg Sellers, ‘Dignity’ and Feminist Alliances in Transnational Ova Exchanges. *European Journal of Women’s Studies*, 15 (2), pp. 65-82.
- Pennings, G., 2005. Reply to Reproductive exile versus reproductive tourism. *Human Reproduction*, 20 (12), pp. 3571-3572.
- Pennings, G., 2002. Reproductive Tourism as Moral Pluralism in motion. *Journal of Medical Ethics*, 28 (6), p. 337.

- Rapp, R., 2000. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.
- Sandelowski, M., 1991. Compelled to try: the never enough quality of conceptive technology. *Medical Anthropology Quarterly*, 5 (1), pp. 29-47.
- Sandelowski, M., 1990. Fault Lines: Infertility and Imperiled Sisterhood. *Feminist Studies*, 16 (1), pp. 33-51.
- Sobo, E., et al., 2011. Selling Medical Travel to US Patient-Consumers: the Cultural Appeal of Website Marketing Appeal. *Anthropology and Medicine*, 18 (1), pp. 119-136.
- Spar, D. L., 2006. *The Baby Business: How Money, Science, and Politics Drive the Commerce of Conception*. Boston: Harvard Business School Press.
- Speier, A., 2011a. Health Tourism in a Czech Health Spa. *Anthropology and Medicine*, 18 (1), pp.125-136.
- Speier, A., 2011b. Brokers, Consumers, and the Internet: How North American Consumers Navigate their Infertility Journeys. *Reproductive Biomedicine Online*, 23 (5), pp. 592-599.
- Speier, A. and Whittaker, A., 2010. 'Cycling Overseas': Care, Commodification, and Stratification in Cross-Border Reproductive Travel. *Medical Anthropology*, 29 (4), pp. 363-383.
- Sundby, J., 2002. Infertility and Health Care in Countries with Less Resources: Case Studies from Sub-Saharan Africa, in *Infertility around the Globe: New Thinking on Childlessness, Gender and Reproductive Technologies*. Van Balen and Inhorn, eds. pp. 247-260. Berkeley: University of California Press.
- Thompson, C., 2005. *Making Parents: The Ontological Choreography of Reproductive Technology*. Boston: MIT Press.
- Turiel, J. S., 1998. *Beyond Second Opinions: Making Choices about Fertility Treatment*. Berkeley: University of California Press.
- Zanini, G., 2011. Regulating Assisted Procreation: The Italian Case. *Reproductive Biomedicine Online*, 23 (5), pp. 565-572.

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Evidence Based Medicine and the Construction of Moral Agency in Ukraine

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Abstract: This article explores the ways public health professionals working in Ukraine's HIV-prevention sphere have adopted practices and ideologies of evidence-based medicine (EBM). Public health research concerning HIV in Ukraine remains piecemeal, owing to financial and practical limitations in this region. Despite this, public health professionals remain beholden to international donors (such as USAID and The Global Fund) to adopt EBM as a fundamental standard of practice in internationally funded programs. Through ethnographic evidence collected via interviews and participant observation among various public health professionals in Ukraine, this article outlines two major features of EBM as a discourse in this context. First, many public health professionals in Ukraine frame the validity and reliability of statistical data, the 'evidence' of EBM, not just practically or quantitatively, but also discursively and symbolically, creating or denying evidentiary crises in the production of statistical data according to their own values and purposes. Second, the production of evidence has become an act of tangible social and political value, as much as it is of 'scientific' and practical value. By producing evidence, public health professionals are not only developing the tools to improve their public health efforts, but they are also presenting themselves as morally appropriate and deserving. Through these actions, Ukrainian public health professionals seek legitimacy in the eyes of powerful international actors and claim new forms of morally charged agency within a public health structure that renders them financially and logistically constrained.

Key words: evidence-based medicine, global health, international development, production of knowledge, drug addiction, Ukraine

«Если не было статистики, мы бы даже не подозревали о том, как хорошо мы работаем.»

Служебный Роман (реж. Э. А. Рязанов, 1978)

"If there were no statistics, we would not even have any idea of how well we work."

Office Romance (dir. E. A. Ryazanov, 1978)

Introduction

Evidence based medicine (EBM) has become a central ideological concept in the practice of medicine in the last two decades.¹ The Cochrane Collaboration, which has been referred to as “the best single resource for methodologic research and for developing the science of meta-epidemiology” (Grimshaw 2004), hails EBM as a “long overdue and dramatic evolution” in modern healthcare, one in which clinical expertise and patient values are informed by scientifically rigorous external evidence (The Cochrane Collaboration 2012). EBM has also been adopted as the “gold standard” of medical decision-making by the WHO (World Health Organization 2012) and adopted as a major component of the work of The Global Fund to Fight Tuberculosis, HIV, and Malaria (The Global Fund 2012). Perhaps the most frequently cited definition of EBM states that it is “the conscientious, explicit, and conscious use of current best evidence in making decisions about the care of individual patients” (Sackett, et al. 1996: 71). In other words, EBM is motivated by the goal of letting external, scientifically rigorous, medical evidence take precedence in making both policy and clinical decisions.

In this article, I explore how public health professionals in Ukraine’s HIV-prevention sphere have adopted the practices and ideologies of EBM. The current state of epidemiological and prevention research on HIV in Ukraine (the evidentiary backbone of truly evidence-based public health practice) is improving, but remains limited in a number of strategically significant ways. Despite this, public health professionals remain beholden to international donors (such as USAID and The Global Fund) to adopt EBM as a fundamental standard of practice in the programs they fund. Through ethnographic evidence, collected via interviews and participant observation among the people managing Ukraine’s HIV-prevention efforts, I aim to demonstrate how these public health professionals are shaping EBM as a *discourse*, motivated in large part by the logistical and practical realities in Ukraine that hinder EBM as a *practice*.

The practice of EBM in Ukraine is, first and foremost, defined by the need to interpret and manage the reliability of external evidence (statistics, epidemiological data, etc.). I do not simply mean the quality of data must be evaluated—this

is true of *any* quantitative data source or analysis. Rather, I argue that the validity of evidence is something that is “discursively managed” (Carr 2011: 68) by professionals in Ukraine’s HIV-prevention sphere. Evidence abounds that the ease with which objective knowledge can be manipulated for moral, personal, or political ends (and the frequency with which it is manipulated) was well known to the average citizen of Soviet and post-Soviet regions (Field 1953; Verdery 1999; Petryna 2002; Ninetto 2005; Rivkin-Fish 2005; Patino 2008; Phillips 2008). Similarly, my informants revealed themselves to be poignantly aware of how flexible and manipulable statistics can be. Every epidemiological record, survey, or artifact was viewed, at the very least, as requiring some sort of qualification or interpretation in order to be read clearly. Thus, I make the claim that, in Ukraine, the meaning and the gravity of statistical evidence can be shaped by persons familiar with tactics of data manipulation and knowledgeable in the language of EBM in order to meet their own desired ends, whatever they may be.

Additionally, EBM’s imperative that Ukrainian public health professionals measure outcomes, keep records, and produce evidence with which to support evidence-based practices has gained traction as an end in and of itself. While there is still most certainly a clear and rational purpose to the production of evidence, evidence, itself, has become a commodity. It is often seen as a necessary ‘work product,’ a by-product of a properly functioning entity following the tenets of EBM. By maintaining these practices, public health professionals position themselves as authoritative experts in their field, claiming significant political currency both within Ukraine and in the eyes of the international entities who control the financial weight of Ukraine’s public health interventions. In this way, Ukrainian public health professionals are able to claim agency by strategically situating themselves as “socially and morally appropriate persons” (Zigon 2008: 90) within the larger structure of public health entities and international organizations guided by the ideology of EBM. This can be interpreted as a discursive strategy that Carr (2011: 153) has called “anticipatory interpellation,” the act of adopting an established social role and imploring powerful others to address you as such.

Much of this analysis has been inspired by works presented at the first Health in Transition Conference, hosted by Charles University in Prague in June, 2011. The anthropological research presented at this conference focused in large part on the heteroglossic systems of meaning in biomedical cultures present in Central and Eastern Europe. For many decades, medical anthropologists have characterized biomedicine as a productive cultural system—or a collection of productive cultural systems—that generates knowledge and subjectivities within its quasi-hegemonic discourses (c.f. Navarro 1975; Frankenberg 1980; Lupton 1995; Rhodes 1996; Bourgois 2000). According to scholarship that emerged from the Prague conference, concepts such as health, illness, diagnosis, treatment, medical authority, and

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medical knowledge are not cultural or scientific monoliths but, instead, have proven to be negotiable, re-definable, and co-optable. Anthropological scholarship on post-Soviet Europe has long delighted in focusing on societies 'in transition', on the simultaneous reordering of culture and restructuring of society that is deemed unique to this part of the world (cf. Verdery 1996; Humphrey 2002; Dunn 2004; Lindquist 2006; Patino 2008). Work presented at the conference began to diverge from this trend by highlighting ways in which the dominance of western biomedicine contributes to meaning-making in the face of new global forces and to the *re-rendering of medical paradigms* in order to provide coherency and agency that complements pre-existing social forms and structures—rather than the other way around.

The argument I make here hinges on a particular kind of quandary: namely, the co-occurrence of powerful, homogenizing global forces and tenacious local paradigms that contradict those global forces. I argue that Ukrainian public health professionals are treating EBM in a locally meaningful way as part of their strategy for integrating themselves into those global systems. For many Eastern European public health organizations, the adoption of Western scientific and biomedical approaches to public health, a realm in which EBM dominates, is seen as an integral step in becoming 'part of the international community.' It can also provide meaning, agency, and coherency in the midst of Ukraine's current political and economic troubles in ways that are both social and scientific, both medical and moral. Indeed, this work of generating coherency and re-valuing the discourse of EBM is at the very heart of the politics of HIV-prevention in Ukraine.

Current state of evidence on HIV and drug use in Ukraine

In Ukraine, the spread of HIV poses particularly significant threats to public health. It also significantly overlaps with a second epidemic: injection drug use (International HIV/AIDS Alliance in Ukraine 2011a). An astonishingly high rate of HIV-infection has been detected among IV drug users in Ukraine (national estimates from 2009 indicate a 22.9% HIV-prevalence among IDUs; Ministry of Health of Ukraine 2010). Even more daunting is the growing body of evidence that the HIV and TB epidemics in Ukraine are rapidly merging (Drobniewski, et al. 2005; van der Werf, et al. 2005; van der Werf, et al. 2006; Zignol, et al. 2008). The best surveillance and standardized testing for HIV occurs among pregnant women receiving antenatal care. It is assumed that the HIV-prevalence in this population (varying between 0.55% and 0.47% from 2007 to 2011) reflects the prevalence in the general population (UNAIDS 2012a). Unfortunately, this number is affected by the fact that the populations most at risk for HIV (injection drug users and commercial sex workers) are the least likely to receive anti-natal care (Open Society Institute 2009).

Most scientific research on the HIV and injection drug use epidemics has been carried out in the Eastern, Southern, and Central regions of Ukraine, limited primarily to the towns of Kyiv, Donetsk, Dnipropetrovsk, Odesa, and Mykolaiv (Booth, et al. 2004; van der Werf, et al. 2005; Booth, et al. 2006; Booth, et al. 2007; Booth, et al. 2009; Chintalova-Dallas, et al. 2009; Mimiaga, et al. 2010; Robbins, et al. 2010; Booth, et al. 2011). The vast majority of this literature (Booth, et al. 2004; Booth, et al. 2006; Booth, et al. 2007; Booth, et al. 2009; Booth, et al. 2011) is based on research collected only in Odesa, Kyiv, and Donetsk between 2004 and 2006. These efforts have generated information that is necessary to know, but is not encouraging. For instance, HIV prevalence among drug injecting populations appears to vary greatly, but has still been measured at above 20% in each of these 3 regions (Booth, et al. 2006). Female drug users are reportedly at greater risk of becoming infected with HIV than their male counterparts, but are more likely to know their status (Booth, et al. 2007). We also know that injection drug use and sexually transmitted diseases (including HIV) are significant problems among street youth in Odesa (Robbins, et al. 2010).

Even in light of these important contributions, significant gaps in research remain. To begin with, conventional wisdom among local and international experts is tending towards the conclusion that cases of HIV are severely under-reported across Ukraine. Exemplary of this opinion is a report of Ukraine's UNAIDS priorities for the period from 2007 to 2010, which states:

"Only a small proportion of the people living with HIV infection in Ukraine know their HIV status. From the beginning of the epidemic to the end of 2006, over 100,000 people in Ukraine had been registered with HIV infection. These include over 72,000 people under clinical observation in the network of 27 regional AIDS centers throughout the country. In comparison with the estimated number of people living with HIV, this indicates that less than 20%, or only one in five people who are infected with HIV in Ukraine are currently aware of their HIV status and accessing medical care." (Joint United Nations Team on AIDS in Ukraine 2007)

Furthermore, very little research has been conducted in the western regions of the country, since it was long believed that the HIV epidemic was primarily concentrated elsewhere. However, there is a growing consensus, supported by preliminary research on voluntary HIV testing, that the incidences of HIV and IV drug use have been severely under-reported in these regions, in particular (Seydal and Burruano 2006). According to the most recent UNAIDS Country Report for Ukraine:

"The number of officially registered HIV infection cases reflects the number of carried out tests for antibodies to HIV and the structure of testing in the regions. In regions with limited access to testing, especially for people from most

at risk populations, the registered number of HIV cases may be significantly underestimated. (e.g., Zakarpattia region, Ivano-Frankivsk region, Volyn region, Zaporizhzhia region and Donetsk region).” (UNAIDS 2012a)

The state of medical and epidemiological data on HIV in Ukraine is steadily improving, but truly evidence-based public health efforts remain necessarily hindered by these gaps in our knowledge. We know a lot about some aspects of this epidemic, but very little about others, which occasionally leaves public health professionals and policy makers with only their experience and intuition to guide HIV-prevention efforts across the country.

In this context, I am seeking to better understand how bodies of knowledge about the HIV epidemic (and public health interventions designed to fight it) are being produced, as well as how that knowledge is engaged for decision-making, for social ends, and for other symbolic purposes. The primary aim of this article is to begin this task by viewing the discourses of EBM that have taken shape in the NGO-driven world of HIV-prevention in Ukraine through a critical, ethnographic lens.

Evidence based medicine in cultural context

The term “evidence based medicine” entered into medical discourse in 1992 (Tonelli 2001: 1435). Enthusiasm for this approach to medical decision-making has propelled EBM to a place of prominence. It is both an epistemological project focused on defining and developing systems of medical knowledge and medical evidence, as well as a mode of clinical practice that grounds treatment and diagnostic decisions for individual patients in knowledge produced by large, clinical studies (Tonelli 1998: 1235). Put more simply,

“[t]he general approach of EBM is to formulate a clear, clinical question in relation to an individual patient, search the literature for relevant evidence related to that question, critically evaluate that evidence, and then implement the findings. A clear pathway from the patient to the evidence and back to the patient is described” (Tonelli 1998: 1236).

This pathway is structured by well established and widely accepted hierarchies of evidence, which privilege forms of knowledge generated from large, randomized studies over experiential, intuitive, and otherwise un-systematic forms of knowledge gained by medical practitioners through the course of their work.

Strategies of harm reduction among IV drug users predate the emergence of EBM in medical discourse, but have become reliant on those standards of evidence for much of their defense against opposition to harm reduction on political or moral grounds. Harm reduction practices, as we now know them, emerged in

Amsterdam in the early 1980s, as the Municipal Health Service sought an alternative solution to drug use other than criminalization. The approach developed was given the moniker “The Helping System,” which consisted of four different phases: “(1) contact, (2) harm reduction, (3) drug-free treatment, and (4) resocialization” (Bruning et al. 1988: 60). The concept of harm reduction, as it was conceived in this early context, was based on the assumption that

“most addicts are caught in a pattern of drug use—cleaning up and relapsing finally resulting in either death or a stable, drug-free life. Harm reduction seems the second best aim if it is not (yet) to “cure” the addicts. In this way, the addicts are helped through a difficult phase in their lives, while it is hoped that one day they may overcome their addiction either through treatment or natural recovery” (Bruning, et al. 1988: 61).

As needle sharing was perceived as one of the primary mechanisms of harm, the benefit of steps taken to reduce that specific behavior appeared self-evident, and specific behavior changes became the primary goal of harm reduction efforts (Wood, et al. 2006). This first took the form of syringe exchange, which sought to reduce the need to re-use needles by providing access to new ones. Later, opiate substitution therapy was adopted as a mechanism to avoid needle use all together (Brette 1991). Recently, harm reduction activists in British Columbia have pioneered the supervised injection facility (SIF), where IV drug users can inject in a sterile environment under medical supervision (Vancouver Coastal Health 2012). Though the creation of these programs was largely based on intuition of what interventions would have an impact on infectious disease among the IV drug using population, statistical evidence of the efficacy of harm reduction efforts (cf. Martin, et al. 1990; Wood, et al. 2006) have bolstered the legitimacy of these programs, and the adoption of EBM as a guiding paradigm has allowed harm reduction advocates to defend these programs through “clear-cut, evidence-based policy” (Paradis 2008: 445).

Ukrainian HIV-prevention and harm reduction NGOs and international health and development organizations have been obliged to engage with the language and the ideology of EBM, especially during the months that they spent drafting Ukraine’s application for The Global Fund’s 10th round of HIV-prevention funding. In its own words, The Global Fund “supports *evidence-based* interventions that aim to ensure access to HIV prevention, treatment, care and support for most-at-risk populations” (The Global Fund 2010; emphasis added). At the center of The Global Fund’s public health philosophy is the mantra “know your epidemic,” which has been popularized by the upsurge in attention paid to the need for epidemiologically rigorous evidence-based medicine and public health practice (UNAIDS 2012b). Due to their financial dependence on international donors—and on The Global Fund in particular—Ukrainian NGOs must present evi-

dence-based responses to the HIV and drug use epidemics that are “tailor[ed] and justif[ied]...within the context of the epidemiological situation and the needs of the people at risk” (The Global Fund 2010) in order to gain the monetary and political support they need.

A Global Fund Round 1 grant of over 90 million US dollars had been supporting the existence of harm reduction and HIV prevention efforts in Ukraine since 2002. In fact, this entire field of public health and disease prevention still relies on this channel of funding, specifically, in order to stay financially viable. As one HIV-prevention coordinator in Kyiv described the situation in 2010, “Everything comes down to that [Round 10] application. If something goes wrong, and that funding stream [from The Global Fund] disappears, then [the total sum of HIV prevention efforts in Ukraine] could all shut down tomorrow.” By the time The Global Fund was accepting applications for its 10th round of funding, the money from the Round 1 grant was running dry, and Ukrainian NGOs desperately needed to coordinate their efforts in order to show that their programming was effective, reliable, and adaptable to the constantly fluctuating political and epidemiological realities of Ukraine.

This need to coordinate and create coherency between clinical realities, epidemiological data, cultural values, and political ideologies (i.e. multiple elements other than simply ‘evidence’) in order to successfully articulate a particular public health problem and its proposed solutions is neither uniquely Ukrainian nor uniquely Post-Soviet. Physician Mark Tonelli, one of the most outspoken critics of EBM in US medical practice, has argued that the clinical logic of EBM is rooted in the cultural values of modern science and based upon a hierarchy of evidence that is “neither ‘evidence-based’ nor scientific in any sense of the word” (Tonelli 2001: 1437). He implies that this hierarchy is maintained by philosophical and cultural values rather than some scientific evaluation of the quality of different forms of evidence, whatever that might be.

While Tonelli illustrates that the coordination of multiple kinds of knowledge is a central part of clinical diagnosis and treatment, Cambrosio et al. (2006) suggest that the coordination of collectively produced medical and scientific knowledge has become an integral and inextricable element of current biomedical practice, in general. They describe the production of medical knowledge not only as a collective effort to produce information, coordinated across multiple sites (clinics, hospitals, labs, etc.), but also as a recursive process that incorporates the ideologies of standardization into decision-making and justifies that ideology with the standardized knowledge it produces.

What counts, in other words, is not whether or not the results produced by a particular laboratory are true, in some absolute sense, but whether or not they are compatible (within conventionally determined statistical limits) with results produced by other laboratories (Cambrosio, et al. 2006: 192).

The consequences this observation holds for actors in the fields of medicine and public health are profound, though not necessarily surprising. Ethnographic research (Berg and Mol 1998; Gardner, et al. 2011; Mol 2002) has detailed the ways in which clinical decision-making consists of the effortful coordination of multiple (and highly variable) types of evidence, systems of knowledge, and lived realities. The scale of EBM’s most preferred source of medical evidence and knowledge (i.e. meta-analyses of large clinical trials) is matched by the scale of coordination that must be managed by clinicians, scientists, public health organizations, and policy makers as they frame their work as coherent and effective within the ideological realm of EBM.

The philosophies that framed the Soviet medical system were fundamentally incompatible with an evidence-based approach in a number of ways. The role of medicine was framed by Marxist and Leninist philosophies that attributed disease to social causes. Early communist leaders believed that inequality bred by capitalist conditions led to illness among the workers, and that the Bolshevik revolution, by bringing an end to capitalist exploitation, would also bring an end to the disease and illness that it engendered (Field 1967). For this reason, public health and medical care were seen as the responsibility of the state and offered at no cost (no official cost) to the entire population (Field 1967). However, this also meant the role of physicians was directly tied to the quality of labor and the production capacity of the population. The role of the physician became defined not simply by the need to treat the ill, but also by the need to keep labor losses at a minimum. It thus became the de facto job of clinicians to curb malingering and to validate illness (and the reprieve from work that it granted) among his or her patients (Field 1953). The state guarded against malingering by setting quotas for the illness certificates that physicians were able to distribute. The accepted norms for illness in any given population were determined by the central administration, and physicians risked fines or other sanctions if they violated these norms (Field 1953). Thus, the expectations for population health and the resultant medical practices in the Soviet medical system were not supported by a different kind of evidence than that employed by EBM; rather, they were pre-determined by central administration according to goals set for labor and production.

Recent socio-cultural research on the adoption and implementation of EBM in the Post-Soviet sphere has focused on EBM as a *political discourse* rather than a scientific or medical paradigm. Anna Geltzer argues that the language of EBM has been adopted by some Russian doctors as “a discourse of power, both in the sense of being the dominant discourse of a group that is vested with tremendous symbolic power (the western medical profession) and in the sense that it is a discourse that confers power on those who use it effectively (the Russian advocates of EBM)” (Geltzer 2009: 527). She argues that EBM is also “a medium through which the Russian medical profession is attempting to redefine itself and its relationship

to the rest of the world” (Geltzer 2009: 527). These discursive moves are particularly significant when considered in light of Soviet standards of medical practice and the mechanisms by which they were set. The act of utilizing or promoting EBM as a legitimate paradigm constitutes a radical departure from the logic that governed medical practices and standards during Soviet rule.

Western medical and public health elites, in particular The Global Fund and the U.S. Agency for International Development (USAID), often use the language and logic of EBM as an allegedly value-neutral and rationalistic language for critiquing medical practices abroad (Geltzer 2009: 530). Owing to the reputation of Soviet science as a sphere “in which politics and ideology only interfere with, rather than produce or construct, scientific knowledge” (Ninetto 2006: 448), western experts often use EBM as a baseline for comparing the efficacy of public health practices in the post-Soviet sphere. It is also used as an appeal to a higher authority of knowledge that discredits local forms of knowledge about public health and health care practices. What Geltzer observes among Russian physicians, then, can be interpreted as a strategic engagement with the discourse of EBM designed to position physicians and their practices as legitimate, effective, and deserving in the eyes of foreign experts and international agencies that fund health services abroad.

Methods

The arguments made here are based upon three phases of ethnographic work in Ukraine, which took place during the spring of 2007, the summer of 2010, and the fall of 2012. This research was conducted in Kyiv, the capital of Ukraine, as well as five other regions: Cherkassy, Crimea, Kherson, Lviv, and Odesa. I have been able to observe public health efforts in a variety of venues, including the national headquarters of Ukrainian coordinating organizations, regional offices of international funds and institutes, narcology clinics, rehabilitation clinics, mobile and stationary needle exchanges, numerous community centers, buprenorphine dispensaries, and the headquarters of many grassroots harm reduction agencies. I have also observed trainings led by international public health experts for Ukrainians who work directly with people living with or at risk of HIV and gatherings of representatives from numerous Ukrainian and international organizations in preparation for Ukraine’s single country application to The Global Fund. I have been able to gain access to a wide variety of individuals working in this sphere: from high-level officials in international organizations that coordinate global HIV-prevention efforts to under-paid staff at local NGOs that provide services to small, rural communities. Learning from the diverse experiences of these public health professionals has allowed me to develop a fuller, richer picture of drug use and drug user services in Ukraine.

Over the course of my research, I have conducted over thirty open-ended interviews with public health professionals who work in a variety of roles. These interviews have been transcribed and coded for thematic content. Patterns in discourses of best practice, the production of epidemiological knowledge, and evidence-based programming quickly emerged from this analysis. I have anchored my accounts of these patterns to a collection of recorded events and interview excerpts. By re-telling the stories of these moments in my research, I aim to convey not only the ideological work undertaken by public health professionals as they frame their work in evidence-based discourses, but also to reveal some of the ways in which these personalities interacted with those frames and moved in and out of them fluidly through the course of our conversations.

To protect the privacy of my informants, I have used pseudonyms in place of the names of individuals and organizations throughout this paper. This research was approved by the Human Subject Division at the University of Washington in Seattle, Washington, USA.

Skepticism and distrust in health statistics and promotion

Katherine Verdery has aptly described socio-cultural responses to the collapse of the Soviet Union as the “reordering of people’s entire meaningful worlds...including morality, social relations, and basic meanings” (1999: 35). She has further argued that a critical exploration of the new social realities (and here, medical realities) in the Post-Soviet sphere “requires a theoretically grounded understanding of the system that has crumbled and an ethnographic sensitivity to the particulars of what is emerging from its ruins” (1996: 10). Following her insight, it seems necessary to consider not only current discourses of EBM, but also the historical legacies that have made the social and political character of scientific knowledge much more tangible in contemporary Ukraine.

Amy Ninetto, who has conducted ethnographic work among scientific communities in Russia, discusses this Soviet legacy, noting that

“...even as Western science recognizes its transformation into what Latour (1998) has called ‘the culture of research’ — an enterprise whose authority can no longer rest on a denial of its multiple contextualizations — Russian science is faulted for having yet to become properly Mertonian: inadequately disinterested, skeptical, open, and universalistic” (Ninetto 2005: 488).

In other words, all scientific discourse is embedded in the social structures and political schemas that surround it, but in Russia (and, I would argue, in other Post-Soviet places, especially Ukraine) this fact that science can be swayed by politics is no secret. It is part of the most basic cultural logic.

On top of the risk of politically motivated data manipulation, Ukrainian public health professionals also face a significant specter of data that is unreliable due to

poor collection techniques, poor research design, and even data falsification. The director of a Kyiv-based institute specializing in public health research emphasized the extent of this problem, saying, “We analyzed recently a report from [a local group of researchers]. The sample claimed to represent only IV drug users, but when we talked to people in the field, we realized that they had mostly recruited alcoholics...[Confirming the reliability of data] is important, because sometimes we analyze fantasy. We conduct advanced analyses, use sophisticated techniques, but it’s just air. Not reality, just numbers.”

The discursive force of both of these uncertainties can be seen in the scenes below. Data is questioned for where it comes from as well as for what it may indicate. In each of these four vignettes, an evidentiary failure of some kind is evoked. Through narrative devices and appeals to personal knowledge or expertise, each individual manages the interpretation of data, keeps its meaning in question, and uses that uncertainty as a pivot with which they position themselves within the larger context of Ukraine’s HIV-prevention efforts.

Zaidesh na kavu?

Various public awareness campaigns promoting safer sex practices and other HIV-prevention strategies have appeared in Kyiv in recent years. During the summer of 2010, one poster, in particular, graced nearly every single advertising kiosk that lined the escalators in the Kyiv metro. The poster, designed by the German group GTZ as part of their campaign “*Не Дай CHІДу Шанс*” (*Ne Dai SNIDu Shans*, Eng: Don’t give AIDS a chance), featured a sepia-toned photograph of a young woman sipping a cola and smiling flirtatiously at a young, male companion. A speech bubble, which extends above the young woman’s mouth, reads “*Зайдеи на кау?*” (*Zaidesh na kavu?* Eng: Would you like to go for coffee?). At the bottom of the image, a caption has been printed in large, red block letters: “*Секс = Презерватив*” (*Seks = Preservativ*, Eng: Sex = condom). If you look closely at the image, you will see that the woman’s speech bubble is in the shape of an unrolled condom.

Those who spoke with me about this ad were consistently dismissive of its message as well as its intentions. Sasha, who worked as an officer in the Ukrainian army, interpreted the aesthetics of the image as a cheap ploy to invoke positive visions of Soviet social life. He felt that foreign agencies often tried to exploit such nostalgia for the imaginary in their marketing towards young people, but that they always ended up executing this plan naively and with little effect.

“It’s stupid,” he said. “I don’t think anybody pays attention to this. Besides, I think it is just a scam.”

“A scam?” I asked. “What do you mean?”

“You know, they get some grant from somebody to do this HIV work, and then they just put up some posters. Anybody can put up posters. It costs nothing, but it

looks like they are doing *something*. Then they just pocket the rest of the cash from the grant for themselves. That’s how these things usually happen.”

“Yea?”

“Usually.”

“And what about that phrase, ‘*zaidesh na kavu*.’ I’ve never heard that. Is that a common idiom? Do people say that?”

Sasha looked at me, amused. “No. No one says that.”

Lena

Lena is a program manager for a large NGO that coordinates public health interventions and manages large sums of money from Global Fund grants. From her agency’s main offices in Kyiv, she explained the nature of her work and the tools her NGO uses to scientifically assess the social and epidemiological situation among high-risk individuals (i.e. injection drug users and sex workers) throughout the country.

She mentioned she had recently been involved in a program that promoted naloxone for overdose prevention. She said she and the other project leaders had many problems getting a naloxone program up and running, because people are very scared of drugs. She claimed that many Ukrainians believe only a special doctor like a narcologist should be prescribing something like naloxone, when in reality any doctor is perfectly capable of prescribing or administering it.

She said overdosing is a serious problem in Ukraine. She also expressed frustration over the lack of available information on the human health consequences and mortality resulting from overdose, as there are no national statistics on this cause of death. Overdose cases, she said, get ‘hidden.’ They are generally categorized as instances of heart failure or of poisoning, and, in Ukrainian death records, there is no distinction made between how or with what a person was ‘poisoned.’ Lena’s naloxone program could have been aided by supporting evidence about the number of overdoses that actually occur, but current policies which categorize these deaths as indistinguishable from other accidental poisonings renders drug overdoses invisible to scientific and epidemiological technologies, essentially erasing this cause of death from the public record.

I asked Lena how significant she believed the risk of overdose to be in typical Ukrainian drug users. “In all practicality,” she replied, “we just don’t know.”

Sveta

Sveta is a program officer at a large NGO in Kyiv that coordinates HIV-prevention grants across a network of smaller organizations throughout Ukraine. Her job is to help monitor the programs at nine different NGOs in various parts of the country.

I asked if there were different needs or problems or approaches between male and female clients. Sveta said there aren't many female clients. When I asked her why this was, she suggested that fewer female clients exist because fewer injection drug users, in general, are female. She pointed out that drugs cost money, and a man can get a job more easily than a woman, especially if neither has any education. She clarified, though, that young drug users who start using stimulants in the club scene are probably more evenly split between men and women. For the most part, though, female injection drug users are a rarity.

Sveta openly offered the fact that there is research available indicating that male and female injection drug users exist in equal numbers. She quickly rejected these empirical findings, though, doing so in large part because these statistics don't agree with her own experiences.

"That just isn't the real picture," she said. "Female users are much more stigmatized, and if they even get drugs at all, it's from their husbands."

Death by cucumber

"The problem here is that we have people who settle into methadone treatment." Ivan, the director of a narcological dispensary in Crimea, pulled the bag of leaves out of his tea and pensively dangled it over his cup for a moment before lobbing it into a nearby trashcan. "They don't want to quit taking drugs. They say 'this program is alright,' and they just stay there."

"That's interesting," I replied, "One of the indicators that is often discussed in the US is the percentage of methadone patients who finish the program, who successfully decrease their dosage and step off methadone completely."

"Are those statistics used to measure the success of the program?" Ivan asked. "Sometimes."

"Well, there are lots of statistics that you can use to make this program look like a failure." As though aware of the irony in the act, Ivan paused to smile and wave hello to a energetic, upbeat methadone patient who had popped his head into the office to say 'good morning' and snatch a cookie from the doctor's stash of pastries. Ivan continued, "And not just social outcomes either. It could be the percentage of patients with HIV, the percentage of patients with TB, the percentage who have started treatment for other diseases since they entered this program..."

"You know, we have this one well-known statistic," interrupted Pavel, the assistant head of the dispensary. "Lots of people here like green cucumbers, especially in the summer when they are really fresh. Everybody eats them. We could say that nearly 80% of the people in Ukraine eat green cucumbers on any given day in the summer, including the people who die. So that's where we get this statistic, that 80% of people who die in the summer die from eating cucumbers!"

Ivan and Pavel smiled at each other and erupted into laughter.

Each of these scenes reveals a moment in which the speakers engage with discourses of evidence, negotiating the meaning of the reality that such evidence is meant to indicate. Sasha displayed his deep-seated skepticism of public health messaging. His criticism is based upon his understanding that specific results and indicators can be cherry-picked and selectively emphasized to indicate politically desirable outcomes. He suspected that the public awareness campaign was designed to produce desirable *outcome indicators*, not to produce desirable *outcomes*, per se. In a similar move, Ivan and Pavel creatively demonstrated the ease with which statistics can be used to make any claim at all. They also not so subtly insinuated that evidence of their own program's failure is likely just as fabricated as the statistics in Pavel's anecdote about cucumbers.

Lena spoke of the impossibility of gaining necessary epidemiological knowledge, since record-keeping practices, even when carried out according to Ukraine's current standards, frequently undermine public health goals. On the one hand, she makes the very legitimate point that more research on overdose and the efficacy of naloxone in Ukraine is needed. This fact is not in question. However, her statements also reveal a deeper, more symbolic interaction with statistical evidence of overdose. Lena spoke of the importance of the naloxone program before acknowledging that the morbidity and mortality statistics that could justify this program simply do not exist. While Lena rightly points out the need for more external evidence, she also indicates the need to gain this evidence in order to support (and thus qualify as "evidence-based") a program that has already been deemed valuable and worthy by other measures.

Sveta revealed her distrust in existing statistics by rejecting it as useless or flawed when it did not reflect the relationships she expected. It should be noted that numerous research projects conducted both before and after this interview was taken (cf. Booth, et al., 2009; International HIV/AIDS Alliance in Ukraine 2010; 2011b; 2012), recruited nearly three-times as many male IV drug users as female IV drug users through respondent-driven sampling techniques (in which new research subjects are found through recommendations made by previous research subjects). One of the major drawbacks of respondent-driven sampling is the impossibility of assuring how well the recruited sample represents the general population under investigation (Black 1999), and this is a legitimate factor to consider in current estimates of the drug using population. Regardless, Sveta does not critique the methods or procedures of the research she dismisses. Rather, her rejection is based upon her understanding of the social mechanisms of female drug use. The merit of a particular statistical measure, in this conversational moment, rested not upon the methodological rigor of that measurement, but rather on the

degree to which the statistic coordinated with her own understanding of the social mechanisms of drug use.

What's in a number? The value of producing evidence

Ukraine's HIV-prevention programs must conduct a great deal of accounting, as required by international financiers such as USAID and The Global Fund. Strict tallies must be kept of how many people came in to the clinic, how many needles were distributed, how many condoms were taken, how many people were referred to HIV testing, and so on. I once had the opportunity to ask a staff member at a major foundation in Kyiv whether the records kept by each of their partner agencies need to be repackaged before they are sent back to their donor for accounting. Her eyes widened and she said, "oh yes." They had to hire a full-time staff member to deal with this issue of reporting for their 190,000 annual clients.

Owing to this imperative, Ukrainian public health professionals have become adept at speaking the language of their international benefactors—i.e. the language of EBM. Adopting EBM as a gold standard allows HIV-prevention organizations to make claims of legitimacy, rationality, and authority both in the local political sphere and on the national stage by successfully producing 'evidence' through their own accounting and data collection activities. Recently, when I suggested the importance of maintaining this legitimacy to the manager of a methadone project in Odesa, he paused for a moment and then laughed. "Yes, this is true," he said. "We Ukrainians are very good at writing reports, at making our work *visible*, you know?"

In the scenes below, the effort public health professionals put into making their work 'visible,' in this sense, becomes apparent.

Oksana

During our interview in her office in Kyiv, Oksana described the programming philosophies of her organization. "We go to our partner organizations and talk to them about what they need," She explained. "Once we collect this information, we reformulate those needs into a formal working plan to submit for a grant proposal. There are only two organizations in Ukraine that do this sort of work; we are one of them."

According to Oksana, her organization conducts behavioral surveys of their target population every two years in an attempt to track changes in high-risk behaviors. These projects consist mostly of cross-sectional surveys. She said it is sometimes hard to analyze their data collectively, because they are "not very good with their instruments," and the survey tool changes (sometimes significantly) from year to year. But they still do it, and this, she said, was what really mattered most. She said they ask survey participants about what they know about HIV, if they

have a partner, who that partner is, what they do, and so on. Of particular importance, Oksana said, is her organization's ability to identify new 'subgroups' within high-risk population with these surveys.

I asked Oksana to clarify which organizations conduct this kind of large-scale behavioral research. She replied that, once in a while, everyone is doing this kind of research. Programs have to evaluate what they do, to some degree. However, she was clear to make a distinction between the scale of what her agency is doing and what other organizations do, indicating that the surveys are big, reaching up to 1500 participants. "We are trying to gain some sort of information to build up our programs, some kind of evidence from the field."

Andriy

Andriy also works for a large, Ukrainian NGO. He holds a title similar to Lena's, but he understands his contributions to be more associated with the business end of things, not the provision of services. As we chatted in his office in Kyiv, he emphasized the empirical sophistication of his agency's work and the rational soundness of his own business practices. The following is an excerpt from the interview transcript:

Andriy: Most of our work in here is actually getting the best expertise we can get from around the world in our area of interest. I mean, responding to HIV in the most at-risk populations. And we're trying to get as much as we can. We have The Global Fund support, which helps a lot in terms of funds, and also we have a monitoring team here, which does a lot of, well, they have like regular studies and surveys and so on. Like sentinel surveillance and quite scientific stuff, using respondent driven sampling and going deep into the population... Then we look for different evidence around the globe, trying to model some response programs and then pilot them and then have them scale up... We also do a lot of organizational development, financial management, because it's a lot of money, and of course some organizations need more, you know, training to be able to report on what they are doing, and so on. It was a quite simple task when we were just starting. Now it's more complex. We have like sophisticated software, which every organization uses, so they can track clients' numbers, cards—how much was distributed and so on.

JC: Yea, I had heard about this database before. Why is it so important to track the kind of materials that goes to each individual client?

Andriy: It's more like a kind of liability issue, I think. The Global Fund requires us to follow the money and look where it's being spent. Is it going to the program or not? So there's a lot of program monitoring that's connected to this issue. Also there's the financial monitoring which is separate. Like audits—we have an audit which tracks all the spending accounts and books, but as far as programmatic monitoring, we just want to make sure that we are reaching the clients, that there is coverage, and that we know that they are receiving what we are procuring...

Yulia

Yulia is a local project manager who works for an international NGO. At the time of our interview, she had just ended her participation in a pilot program designed to promote HIV testing and awareness through pharmacies. The intervention involved providing pharmacists with basic training on how to identify and counsel high-risk individuals who come into their pharmacy. Does this person look like a drug user? Do the symptoms being described sound like an STD? If so, the pharmacist was meant to give a referral card to the customer that provided further information on how and where to be tested. They also printed HIV-awareness and testing information on plastic bags that were used to pack pharmacy purchases at the counter, thus spreading information about HIV-testing into the household of every customer who came in to the pharmacy. Yulia was very enthusiastic about the outcomes.

"The results of our intervention were 20%!" she proudly exclaimed. In the seconds immediately following this statement, I held my breath, waiting for Yulia to let me in on the rest of the story (20% of what, exactly?), but she didn't stop to clarify before proceeding with her account. "Who knows if this is a good or bad result," she continued, "but it was so wonderful to have real numbers to report and to receive the feedback from our colleagues."

All the money that was given to the program was used to purchase 500,000 material items to distribute: the 400,000 bags and 100,000 other pieces of literature for a total of twenty-two pharmacies. Many of the pharmacists told her that they would be happy to start up the project again when funding comes back to print more materials.

"Funds are needed," she said. "If someone gets information, this is valuable, but certainly it costs money."

An interesting trait of EBM is revealed in these scenes: namely, evidence is serving two different purposes in the Ukrainian context. On their surface, all three vignettes show a dedicated and conscientious public health professional doing what he or she can in order to manage the logistical realities of running an HIV-prevention program and the evidentiary crises that arise. At the same time, we can also see each individual making certain claims about the value of their program—claims based upon the successful framing of evidence they have produced as 'high quality' or otherwise significant within a positivist medical discourse (EBM) that values reliable, accurate evidence above all else.

Oksana's complaint about the variability of her organization's survey instruments is well founded. Without a consistent tool, the utility of the data, of the external evidence they collect, will suffer, and their ability to enact higher standards of EBM will be compromised. The existence of these difficulties, however, did not prevent her from reporting—with pride—that the surveys reach nearly 1500 respondents year after year. She claims her organization is unique in that it builds

its programs based on "evidence...from the field." This evidence might not be ideal, but having hard numbers to report, regardless of their flaws, is a desirable end in and of itself. As Oksana herself pointed out, they conduct their surveys anyway, and that is what matters the most.

Andriy emphasized need to produce accounting records for their donors. The practical necessity of this sort of record keeping is obvious, and Andriy is correct in his assertion that taking such accounts, when done properly, can help improve the work of his organization. However, he also acknowledged the need to produce various accounting records and reports due to their liabilities (fiscal and practical) to The Global Fund, as a way to, in the words of the program manager from Odesa, "make their work visible." Andriy framed these activities as authoritative and methodologically rigorous by commenting that his organization's monitoring activities include, "sentinel surveillance and *quite scientific stuff*, using respondent driven sampling and going deep into the population" [emphasis mine]. While his organization is most certainly doing its best to operate in-line with EBM as a standard of public health practice, Andriy is careful to see that the political and symbolic benefits of those practices are conferred on his employer as well.

Similarly, Sveta anchors the importance of evidence, a potential index of the efficacy of her program, to these political and symbolic ramifications *entirely*. The legitimacy she believes her project has gained in the eyes of other public health professionals (and, most likely, the international groups that funded the program) was so significant that, in her enthusiastic description of that legitimacy, she failed to even clarify *how* that evidence reflects upon the program's efficacy or success. Her account reveals that statistical evidence is more than just a necessary work product of a legitimate public health enterprise. They are also the foundation of her NGO's claims that it is a deserving entity worthy of international funding. Quite a lot, then, is riding on her ability to project evidentiary rigor in an ontologically uncertain territory.

Evidence and morality in post-soviet place

The ethnographic vignettes above support the argument that public health professionals are establishing identities and claiming certain forms of agency by engaging with EBM as a discourse in Ukrainian HIV-prevention efforts. Recall the assertion of Cambrosio et al., cited in the introduction, that the most important factor in determining the objectivity of a particular scientific research project is not "[truth] in some absolute sense, but whether or not [the results] are compatible (within conventionally determined statistical limits) with results produced by other laboratories" (Cambrosio, et al. 2006: 192). The public health professionals interviewed here are producing coordination, in this sense. Some accuse sets of data of being incompatible with standards for creating sound scientific data (as in

the cases of Lena, Ivan, and Sergey) or with their own personal experience (as in the cases of Sasha and Sveta). Others highlight the value of producing data for the sake of presenting the practices of their organization as legitimate (as in the cases of Oksana and Andriy) or for the sake of gaining approval and resources from powerful actors (as in the case of Sveta). These individuals are asserting their own political and moral evaluations of prevention programs and research projects. In so doing, they are positioning themselves as capable, aware and morally upright actors. They present themselves as fluent in local forms of the manipulation and fallibility of evidence. They present themselves as capable of rescuing efforts at evidence-based public health practices that might fall victim to those fallibilities. They present themselves as authoritative actors within the sphere of public health, thanks to their ability to produce evidence about their own practices and frame that evidence as reliable and sound.

Jarrett Zigon has argued that *agency* is the ability to negotiate one's position within social structures, to make oneself into someone who fits in local structure, into a "socially and morally appropriate person" (2008: 90). It is precisely this kind of self-positioning between multiple structures—between local and international discourses of EBM—that we see public health workers in Ukraine working to accomplish. In this way, EBM both as practice and as discourse provides Ukrainian public health professionals with an opportunity to claim personal agency and embolden their sense of control in an uncertain political and economic environment.

The work of Bruno Latour is frequently used to problematize interactions between so-called 'universal' scientific knowledge (in this context, the standardized premises and practices of EBM) and local knowledge (public health professionals' ability to interpret and manage the meaning of evidence and evidence-based practice). According to Latour, scientific knowledge is created through abstractions, by measurements that place distance between a concrete reality and scientific discourses about that reality (Latour 1999). This knowledge, then, claims the ability to operate at a certain distance from the world, to travel far without sacrificing its relevance and applicability (Latour 1987). Similarly, Clark and Murdoch have argued that this characteristic allows scientific discourses to reshape localities into more convenient forms: "Herein lies the success of science and the basis of its universal claims. It remakes the world in its own image" (Clark and Murdoch 1997: 41).

EBM, as a system of standardized practices, constitutes a method of knowledge-production similar to that described by Latour (1999). Indeed, the central tenets of EBM hold that the most valuable sources of evidence are those that are the most generalizable and maintain the greatest level of abstraction: randomized trials and meta-analyses of randomized trials (Tonelli 2001: 192). However, the state of affairs in Ukraine's HIV-prevention sphere does not mirror that predicted by Clark and Murdoch, in which scientific (or here, evidence-based) ideas and dis-

courses carve through local knowledge like an iceberg, remaking the world in its image. Instead, it seems like something of the opposite is going on. Ukrainian public health workers are adapting EBM as a discourse for their own political purposes. *They* are the ones working towards a correspondence between local and universal standards of evidence. Doing so allows them to successfully engage in the practice of "anticipatory interpellation" (Carr 2011: 153). They are able to take on a particular social role (that of the deserving expert) and to "speak effectively from these designated locales, in politically efficacious ways" (Carr 2011: 154).

In a recent presentation on the epistemological challenges of EBM, Brian Dolan observed, "Saying that one uses evidence to make decisions gives the impression that the decision is itself calculated. But this hides much that is implicit in the act of deliberation" (Dolan 2007). Dolan claims that the interpretation of evidence is much more entangled with culturally informed moral heuristics than the philosophies of EBM would have us believe. In fact, he asserts that the very process of translating between data or evidence and a so-called evidence-based decision is a moral one, and that data and decisions are constructed in constellation with one another—each one capable of bending to fit the other (Dolan 2007). His conclusions point to questions of culturally defined values and moralities that underpin how EBM is able to work 'on the ground' in different cultural settings. What elements of morality will be filtered in or out of evidence-based decision making as EBM, the 'gold standard' of public health practice gets re-interpreted by local social structures and systems of meaning? How will the pre-conceived moral heuristics and 'black-boxed' cultural logics unique to new cultural contexts alter this relationship and the policy it produces?

This article has suggested that the political and financial context of HIV-prevention in Ukraine brings the symbolic and value-laden character of EBM into clearer focus. Public health professionals are using EBM to expand and improve the national response to Ukraine's HIV epidemic in significant ways. They are also using EBM as a discursive tool for framing their identity and behaviors within the larger institutional structure of HIV-prevention as well as claiming new forms of agency, gained through acts of "anticipatory interpellation" (Carr 2011: 153). These social discourses do not get in the way of EBM or evidence-based practices in Ukraine. Rather, EBM as a social discourse is mutually constituted with EBM as a set of scientific or bio-medical practices. While there may be some success in standardizing EBM as a form of medical practice across large parts of the globe, the shape and character of EBM as a social discourse will vary according to the cultural values and logics of the given social context in which it is adopted.

In the Ukrainian context, this social discourse is deeply influenced not only by what local actors feel they have to gain by entering the world of EBM, such as prestige and professional authority, but also by what they feel they have to lose: the funding stream that supports not only their professional positions and the or-

ganizations that employ them, but also the majority of HIV-prevention efforts, as well. For, as a program manager in Kyiv observed, “If something goes wrong, and that funding stream disappears, then this could all shut down tomorrow.” Small wonder, then, that discourses of EBM have become so value-laden in this environment.

REFERENCES

- Berg, M., and Mol, A., eds. 1998. *Differences in Medicine: Unraveling practices, techniques and bodies*. Durham: Duke University Press.
- Black, T. R., 1999. *Doing Quantitative Research in the Social Sciences: An integrated approach to research design, measurement, and statistics*. Thousand Oaks, CA: SAGE Publications, Inc.
- Booth, R. E., Kwiatkowski, C. F., Mikulich-Gilbertson, S. K., Brewster, J. T., Salomonsen-Sautel, S., Corsi, K. F. and Sinitsyna, L., 2006. Predictors of HIV sero-status among drug injectors at three Ukraine sites. *AIDS*, 20 (17), pp.2217-2223.
- Booth, R. E., Lehman, W. E., Brewster, J. T., Sinitsyna, L. and Dvoryak, S., 2007. Gender differences in sex risk behaviors among Ukraine injection drug users. *Journal of Acquired Immune Deficiency Syndromes*, 46 (1), pp. 112-117.
- Booth, R. E., Lehman, W. E. K., Dvoryak, S., Brewster, J. T. and Sinitsyna, L., 2009. Interventions with injection drug users in Ukraine. *Addiction*, 104 (11), pp. 1864-1873.
- Booth, R. E., Lehman, W. E. K., Latkin, C. A., Dvoryak, S., Brewster, J. T., Royer, M. S. and Sinitsyna, L., 2011. Individual and network interventions with injection drug users in 5 Ukraine cities. *American Journal of Public Health*, 101 (2), pp. 336-343.
- Booth, R. E., Mikulich-Gilbertson, S. K., Brewster, J. T., Salomonsen-Sautel, S. and Semerik, O., 2004. Predictors of self-reported HIV infection among drug injectors in Ukraine. *Journal of Acquired Immune Deficiency Syndromes*, 35 (1), pp. 82-88.
- Bourgois, P., 2000. Disciplining addictions. *Culture, Medicine and Psychiatry*, 24, pp. 165-195.
- Brette, R. P., 1991. HIV and harm reduction for injection drug users. *AIDS*, 5 (2), pp. 125-136.
- Bruning, E. C., van Brussel, G. H. A. and van Santen, G., 1988. Amsterdam's drug policy and its implications for controlling needle sharing. In: R. J. Battjes and R. W. Pickens, eds. *Needle Sharing among Intravenous Drug Users: National and international perspectives*. NIDA Research Monograph 80. Rockville, MD: U.S. Department of Health and Human Services. Available at: <<http://archives.drugabuse.gov/pdf/monographs/80.pdf>>. [Accessed 25 November 2012].
- Cambrosio, A., Keating, P., Schlich, T. and Weisz, G., 2006. Regulatory objectivity and the generation and management of evidence in medicine. *Social Science and Medicine*, 63, pp. 189-199.
- Chintalova-Dallas, C., Case, P., Kitsenko, N. and Lazzarini, Z. R., 2009. Boltushka: A home-made amphetamine-type stimulant and HIV risk in Odessa, Ukraine. *International Journal of Drug Policy*, 20 (4), pp. 347-351.
- Clark, J. and Murdock, J., 1997. Local knowledge and the precarious extension of scientific networks: A reflection on three case studies. *Sociologia Ruralis*, 37 (1), pp.38-60.
- Drobniewski, F., Nikolayevsky, V., Asmolov, A., Bazhora, Y. and Servetsky, S., 2005. Increasing trends in HIV and TB rates in Odessa and the Ukraine. *International Journal of STD & AIDS*, 16 (5), pp. 374-378.
- Dolan, B., 2007. The art of evidence. [online] University of California at San Francisco. Available at: <http://escholarship.org/uc/item/4963v0m4.pdf>. [Accessed 25 March 2012.]
- Dunn, E. C., 2004. *Privatizing Poland*. Ithaca, NY: Cornell University Press.
- Field, M. G., 1953. Some problems of Soviet medical practice: A sociological approach. *New England Journal of Medicine*, 248 (22), pp. 919-926.
- Field, M. G., 1967. *Soviet socialized medicine: An introduction*. New York: The Free Press.
- Gardener, J., Dew, K., Stubbe, M., Dowell, T. and Macdonald, L., 2011. Patchwork diagnoses: The production of coherence, uncertainty, and manageable bodies. *Social Science and Medicine*, 73, pp. 843-850.
- Geltzer, A., 2009. When the standards aren't standard: Evidence-based medicine in the Russian context. *Social Science and Medicine*, 68, pp. 526-532.
- Grimshaw, J., 2004. So what has the Cochrane Collaboration ever done for us? A report card on the first 10 years. *Canadian medical association journal*, 171 (7). [online] Available at: <<http://www.cmaj.ca/content/171/7/747.full>> [Accessed 21 October 2012].
- Humphrey, C., 2002. *The unmaking of Soviet life: Everyday economies after socialism*. Ithaca, NY: Cornell University Press.
- International HIV/AIDS Alliance in Ukraine, 2010. Моніторинг поведінки та поширності ВІЛ-інфекції серед споживачів ін'єкційних наркотиків як компонент епінагляду за ВІЛ другого покоління. Аналітичний звіт за результатами дослідження 2009 року. [online] Available at: <<http://www.aidsalliance.org.ua/ru/library/our/monitoring/pdf/sin09.pdf>> [Accessed 19 October 2012].
- International HIV/AIDS Alliance in Ukraine, 2011a. *Summary Report of ICF "International HIV/AIDS Alliance in Ukraine" on progress in implementing "Support for HIV/AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine" programme supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (For the First Six Months of 2011)*. [online] Available at: <http://www.aidsalliance.org.ua/ru/news/pdf/2011-report/EN_15AUG_Alliance_Narrative_Report_201.pdf>. [Accessed 10 October 2011].
- International HIV/AIDS Alliance in Ukraine, 2011b. Моніторинг поведінки та поширності ВІЛ-інфекції серед споживачів ін'єкційних наркотиків як компонент епінагляду за ВІЛ другого покоління. Аналітичний звіт за результатами дослідження 2010 року. [online] Available at: <http://www.aidsalliance.org.ua/ru/library/our/monitoring/pdf/rep_idu_eng10.pdf> [Accessed 19 October 2012].
- International HIV/AIDS Alliance in Ukraine, 2012. Моніторинг поведінки та поширності ВІЛ-інфекції серед споживачів ін'єкційних наркотиків як компонент епінагляду за ВІЛ другого покоління. Аналітичний звіт за результатами дослідження 2011 року. [online] Available at: <<http://www.aidsalliance.org.ua/ru/library/our/2012/me/idu2011.pdf>> [Accessed 19 October 2012].
- Joint United Nations Teams on AIDS in Ukraine, 2007. *Joint United Nations programme of support on AIDS: Ukraine 2007-2010*. Kyiv.

- Latour, B., 1987. *Science in Action: How to follow scientists and engineers through society*. Cambridge: Harvard University Press.
- Latour, B., 1999. *Pandora's Hope: Essays on the reality of science studies*. Cambridge: Harvard University Press.
- Lindquist, G., 2006. *Conjuring Hope: Healing and magic in contemporary Russia*. New York: Berghahn Books.
- Lupton, D., 1995. *The Imperative of Health: Public health and the regulated body*. London: Sage.
- Lupton, D., 2003. *Medicine as Culture*. London: Sage.
- Martin, G. S., Serpelloni, G., Galvan, U., Rizzetto, A. and Gomma, M., 1990. Behavioral change in injecting drug users: Evaluation of an HIV/AIDS education programme. *AIDS Care: Psychological and socio-medical aspects of AIDS/HIV*, 2 (3), pp. 275-279.
- Mimiaga, M. J., Safren, S. A., Dvoryak, S., Reisner, S. L., Needle, R. and Woody, G., 2010. "We fear the police, and the police fear us": Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine. *Aids Care: Psychological and socio-medical aspects of AIDS/HIV*, 22 (11), pp. 1305-1313.
- Ministry of Health of Ukraine (Міністерство охорони здоров'я України), 2009. *ВІЛ-інфекція в Україні*. Інформаційний бюлетень № 31, виходить з 1991 р. [online] Available at: <<http://www.network.org.ua/assets/books/Bulletin/Bulletin-31.doc>> [Accessed 13 March 2011].
- Ministry of Health of Ukraine, 2010. *National report on the progress towards the UNGASS declaration of commitment on HIV/AIDS (Reporting period: January 2008-December 2009)*. [online] Available at: <http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/ukraine_2010_country_progress_report_en.pdf> [Accessed 10 October 2011].
- Mol, A., 2002. *The Body Multiple*. Durham, NC: Duke University Press.
- Murney, M., 2009. *Mores of Addiction: Alcohol, femininity, and social transformations in western Ukraine*. Doctoral Dissertation. University of Toronto.
- Navarro, V., 1975. *Medicine Under Capitalism*. New York: Prodist.
- Ninetto, A., 2005. "An island of socialism in a capitalist country": Postsocialist Russian science and the culture of the state. *Ethnos*, 70 (4), pp. 443-46.
- Open Society Institute, 2009. *Women, Harm Reduction, and HIV: Key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine*. New York: Open Society Institute. [online] Available at: <http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/wmhardred20091001> [Accessed 3 August 2010].
- Paradis, G., 2008. Harm reduction: Keeping the public's health in Sight/Réduction des méfaits : La santé du public en dépend. *Canadian Journal of Public Health*, 99 (6), pp. 445-445.
- Patino, J. 2008. *Consumption and social change in a post-soviet middle class*. Stanford, CA: Stanford University Press.
- Petryna, A., 2002. *Life exposed: Biological citizens after Chernobyl*. Princeton, NJ: Princeton University Press.
- Phillips, S., 2008. *Women's Social Activism in the New Ukraine*. Bloomington: Indiana University Press.
- Rhodes, L. A., 1996. Studying biomedicine as a cultural system. In: Sargent, C. F. and Thomas M. J., eds., *Medical anthropology: Contemporary theory and method*. Westport, CN: Praeger. Pp. 165-180.
- Rivkin-Fish, M., 2005. *Women's Health in Post-Soviet Russia*. Bloomington: Indiana University Press.
- Robbins, C. L., Zapata, L., Kissin, D. M., Shevchenko, N., Yorick, R., Skipalska, H., Finnerty, E., Ornstein, T., Marchbanks, P. A., Jamieson, D. J. and Hillis, S. D., 2010. Multicity HIV seroprevalence in street youth, Ukraine. *International Journal of STD & AIDS*, 21 (7), pp. 489-496.
- Sackett, D. L., Rosenberg, W. M. C., Gray, J. A. M., Haynes, R. B., and Richardson W. S., 1996. Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312, pp. 71-72.
- Seydel, J. and Burruano, L., 2006. The spread of HIV/AIDS in Ukraine. *Gesundheitswesen*, 68 (8-9), pp. 571-574.
- The Cochrane Collaboration. 2012. *Evidence Based Healthcare and Systematic Reviews*. [online] Available at: <<http://www.cochrane.org/about-us/evidence-based-health-care>>. [Accessed 20 October 2012].
- The Global Fund, 2010. *Ukraine: Country grant portfolio*. [online] Available at: <<http://portfolio.theglobalfund.org/Grant/Index/UKR-102-G04-H-00>>. [Accessed 5 August 2010].
- The Global Fund, 2012. *Monitoring and evaluation*. [online] Available at: <<http://www.theglobalfund.org/en/activities/monitoringevaluation/>> [Accessed 20 October 2012].
- Tonelli, M. R., 1998. The philosophical limits of evidence-based medicine. *Academic Medicine*, 73 (12), pp. 1234-1240.
- Tonelli, M. R., 2001. The limits of evidence based medicine. *Respiratory Care*, 46 (12), pp. 1435-1440.
- Wood E., Tyndall, M. W., Montaner, J. S. and Kerr, T., 2006. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. *Canadian Medical Association Journal*, 175 (11), pp. 1399-404.
- World Health Organization, 2012 *Evidence based medicine related resources*. [online] Available at: <http://apps.who.int/rhl/education/Education_EBM/en/index.html>. [Accessed 20 October 2012].
- van der Werf, M. J., Yegorova, O. B., Chechulin, Y., Hasker, E., Veen, J. and Turchenko, L. V., 2005. HIV testing practices of TB patients after introduction of a new testing policy in Kiev City, Ukraine. *International Journal of Tuberculosis and Lung Disease*, 9 (7), pp. 733-739.
- van der Werf, M. J., Yegorova, O. B., Chentsova, N., Chechulin, Y., Hasker, E., Petrenko, V. I., Veen, J. and Turchenko, L. V., 2006. Tuberculosis-HIV Co-infection in Kiev City, Ukraine. *Emerging Infectious Diseases*, 12 (5), pp. 766-768.
- Verdery, K., 1996. *What Was Socialism and What Comes Next?* Princeton: Princeton University Press.

- Verdery, K., 1999. *The Political Lives of Dead Bodies: Reburial and postsocialist change*. New York: Columbia University Press.
- UNAIDS, 2007. *Eastern Europe and Central Asia: AIDS epidemic update - regional summary*. Statistical Report. Geneva. [online] Available at: <data.unaids.org/pub/Report/2008/jc1529_epibriefs_eeurope_casia_en.pdf> [Accessed 16 January 2009].
- UNAIDS, 2012a. *Ukraine harmonized AIDS response progress report: Reporting period: January 2010-December 2011*. Kyiv. [online] Available at: <[http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce-UA_Narrative_Report\[1\].pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce-UA_Narrative_Report[1].pdf)> [Accessed 15 October 2012].
- UNAIDS, 2012b. *Know your epidemic (epidemiology)*. [online] Available at <<http://www.unaids.org/en/dataanalysis/knowyourepidemic/>> [Accessed 15 October 2012].
- Vancouver Coastal Health, 2012. *Insight – a supervised injection site*. [online] Available at: ,<http://supervisedinjection.vch.ca/>> [Accessed 25 November 2012].
- Zignol, M., Dubrovina, I., Miskinis, K., Lyepshina, S., Yann, Y., Hoffmann, H., Zaleskis, R., and Nunn, P., 2008. Drug-resistant tuberculosis and HIV in Ukraine: A threatening convergence of two epidemics? *International journal of tuberculosis and lung disease*, 12 (7), pp. 756-762.
- Zigon, J., 2008. *Morality: An anthropological perspective*. New York: Berg Publishers.

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The Salad of Ideas: Beliefs about Health and Food among Immigrants from the Former USSR in Germany

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Abstract: This article will discuss ways in which migrants from the former USSR in Germany conceptualise the relationship between food, migration experience and health. The objective of this paper is to demonstrate heterogeneity of post-socialist health beliefs and to argue against over-generalisations about health-related passivity as an integral characteristic of Homo Sovieticus. Instead, by comparing conceptualisations of health across groups of migrants distinct in their socio-economic and cultural origins, I will demonstrate that people socialised in different strata of Soviet society develop diverse strategies of navigating the capitalist consumer market and its abundant food supply. Better qualified individuals socialised in urban settings share highly proactive health beliefs and reflectively adapt to nutritional practices of their receiving country. In contrast, less educated people from agricultural backgrounds regard dietary choices as pre-determined by external circumstances and mostly rely on the cooking traditions in which they were socialised. The discussion presented in this paper sets out to contribute to understanding of post-socialist health cultures as structured along the lines of socio-economic and cultural differentiation, rather than as products of socialist ideology alone.

Key words: nutritional choices, migrant health, health beliefs, post-Soviet health

Introduction

Studying migrants from the former USSR provides a new angle on the transformation of socialist health cultures, in particular, on how people's ideas about health change through exposure to globalised discourse and developed capitalist markets. Existing research conducted in three major receiving countries, – USA (Aroian 2004), Israel (Remennick 1999, 2001, 2003) and Germany (Korenblum, et al. 2010; Kyobutungi, et al. 2006; Dreißig 2005; Ronellenfitsch, et al. 2006; Ronellenfitsch and Razum 2004; Wittig, et al. 2004), – has been mostly focussed so far on various aspects of healthcare utilisation and illness patterns among former Soviet citizens. It demonstrates that economic disadvantage and cultural boundaries often prevent people from entering local healthcare systems – similar to other groups of immigrants across the globe (Nazroo 2001; Smaje 1996; Borde 2003; Ahmad 1993). At the same time, some authors suggest that passivity and fatalism

resulting from socialisation in the former USSR aggravate ex-Soviet migrants' inability to overcome the structural disadvantages they face (Remennick 1999, 2003; Aroian 2004; Kirsch 2005; Wittig, et al. 2004; Korenblum, et al. 2010). This paper will, in contrast, demonstrate that beliefs about health as a product of external circumstances are only typical for individuals whose social mobility was severely limited throughout their lifetime, while others approach their health pro-actively. By engaging with the nutritional habits of immigrants from the former Soviet Union in Germany, I am setting out to shift the focus of research from the management of illness episodes to socially, economically and culturally conditioned everyday practises of sustaining health.

The objective of this article is to demonstrate that migrants' beliefs about nutrition and dietary practices are conditioned by socio-economic mobility throughout their lifetimes, by distinct cultural identities, generational differences and exposure to globalised discourses on health. This objective will be met by comparing early Jewish migrants of the 1970s wave, Jewish Kontingentflüchtlinge and Russian German Spätaussiedler, three major groups of former Soviet citizens residing in Germany, which are highly distinct in terms of their socio-economic and cultural backgrounds. In the opening section of this paper I will reflect on the migrants' own conceptualisations of shortages they experienced in Soviet times and the new opportunities they could enjoy upon migration. Thus, I will address common-sense interpretations of structural conditions determining nutritional choices. In the next two sections of the paper, I will address the differences that migrants face in managing the new plenty they encounter in Germany. I will demonstrate that Jewish migrants, most of whom are highly educated and have an urban background, regard nutritional choices as individual responsibility and conceptualize them as part of one's *kultur'nost* or "being cultured". As I will discuss in the final section of this paper, throughout the migratory process *kul'turnost* acquires the meaning of self-"westernisation": a concept which will be addressed in the migrants' own terms. In contrast to the nutritional practices of Jewish migrants, families of Russian German migrants with a lower-class, non-urban background are characterised by a reliance on cooking methods known for generations and the implementation of only familiar ingredients. In these households, where collectivisation and war famines make up a significant part of family history, individual choices on nutrition are often regarded as pre-determined and inflexible. Rather than adapting to a "western" diet, Russian-German interview participants seek means of food production similar to what they relied on in the Soviet agricultural setting from which they come.

Existing research and theoretical background

The health beliefs of former citizens of the USSR came under increasing attention in the 1990s (Cockerham 1997, 1999, 2000; Biloukha 2001; Steptoe 2001;

Rose 2000, 2003; Pietilä 2007, 2008), being theorised as the driving force behind the mortality and morbidity crisis observed by demographers and epidemiologists (Shkolnikov, et al. 1998a, 1998b, 2001). In that respect, works by William Cockerham (Cockerham 1997, 1999, 2000; Cockerham, et al., 2002) pointing out the paternalism of the socialist state and the fatalism of the Soviet people with respect to their health have become increasingly influential. Cockerham claims that "Soviet-style socialism had the potential to induce passivity on the part of many individuals toward health promotion" (Cockerham, et al. 2002: 43). He suggests that the Soviet totalitarian state has created a *Homo Sovieticus* (Cockerham's spelling - P.A.), who, with respect to his or her health is likely to adopt "negative" lifestyles characterised by alcoholism, excessive smoking, non-utilisation of healthcare services and other health-endangering behaviours. The deterioration of health in post-Soviet society is, therefore, explained by the inability of *Homo Sovieticus* to adapt to a capitalist economy and embrace liberal values, in particular, the value of individual responsibility for health.

Cockerham's *Homo Sovieticus* approach indicates important structural problems related to attitudes to health, such as a lack of health education and a tendency to compensate for a permanent lack of resources by increased utilisation of medical care. Food shortages as determinants of nutritional choices are also discussed in the existing literature as a significant structural limitation determining "passive" nutritional beliefs in the former socialist bloc (Biloukha and Utermohlen 2001; Steptoe and Wardle 2001; Thiel and Heinemann 1996). At the same time, Cockerham's approach has been criticised in the existing literature for its tendency to over-generalise the effects of planned economy and collectivist ideology on health beliefs in favour of other factors, in particular, socio-economic inequality and cultural variations within the former Soviet society. Research by Nina Rusinova, Julie Brown and Ludmila Panova demonstrates clearly that in Russia, similarly to other countries, "passive" health beliefs are a function of low socio-economic status and lack of social capital, whereas populations with a higher socio-economic status share a pro-active approach to health (Rusinova and Brown 2003; Brown and Rusinova 1997, 1999; Panova and Rusinova, 2005). Michele Rivkin-Fish (2005) also demonstrates that women with higher education and access to empowered social networks employed a variety of complex strategies to receive the best prenatal healthcare, while less educated women relied on "chance" access to the state healthcare system. At the same time, studies by Temkina (2008) and Pietilä and Rytönen (2008) suggest significant gender variations in health beliefs, with women being generally more pro-active and men tending to believe that "health is not a man's domain".

Whereas the *Homo Sovieticus* model has been criticised in research on post-communist Russia, it has remained fairly unchallenged in studies on migrants from the former USSR abroad. The few existing German studies tend to refer to

“socialist” culture as a static and homogenous phenomenon. Korenblum (2010) and Wittig (Wittig, et al. 2004) attribute migrants’ difficulties using the German healthcare system mostly to the effects of socialisation in the Soviet medical system. A “different culture” as an explanation of healthcare utilisation also appears in studies by Schnepf (2002), Beyer (2001) and Dreißig (2005). Studying migrants from the former USSR in the context of hospital care, Dreißig suggests that they are unable to make autonomous decisions about treatment that is expected of them by the German healthcare system. Schnepf and Beyer indicate low levels of nursing care utilisation by elderly Russian Germans and attribute it to a reliance on informal family care related to “traditional culture”: a finding which captures the important role of kin ties in Russian-German families, but fails to address the effects of socio-economic mobility.

Applied in the context of migration, the concept of *Homo Sovieticus* equally neglects socio-economic differentiation and effects of exposure to globalised discourses of health and transnational health cultures, whereby migrants are depicted as individuals confined to the unchanging “socialist” culture of their native countries. This paper, in contrast, sets out to capture the socio-economic and cultural heterogeneity of post-socialist health beliefs, in particular, beliefs about food. By examining migrants from the former USSR who came to Germany, I will discuss how exposure to capitalist Western discourses of health impact on the health beliefs of individuals socialised in various strata of former Soviet society.

In this paper, I will refrain from imposing pre-developed categories on migrants’ beliefs about healthy food. Instead, I will identify and analyse inductively derived categories, so as to treat nutrition beliefs as elements of common-sense knowledge shaped by medical discourses on health, socio-economic differentiation and cultural identities (Nettleton 2006; Blaxter 1990; Cornwell 1984).

The focus on beliefs about food in favour of other health beliefs can be explained by their primary significance to most people. The relationship between health, food and identity has been widely reflected upon in the existing literature (Caplan 1997; Lupton 2005; Fischler 1988; Minz 1996; Minz and Du Bois 2002). Given that nutrition is necessary to sustain life itself, food is central to the health beliefs of people across all cultures and socio-economic groups; in addition, producing and consuming food constitute practices of care and connectedness (Holloway and Kneafsey 2004). At the same time, as Caplan suggests, ideas about what needs to be considered healthy food (or food, altogether) are highly contextual:

“Food is never ‘just food’ and its significance can never be purely nutritional. Furthermore, it is intimately bound up with social relations, including those of power, of inclusion and exclusion, as well as with cultural ideas of classification (including the food and non-food, the edible and the inedible), the human body and the meaning of health” (Caplan 1997: 3).

In this paper I will study narratives about healthy and unhealthy food as encodings of identity boundaries and functions of social class. I will demonstrate that the migratory process from the former USSR to Germany is interpreted by all migrants as a transition to “the world of plenty”. The responses to new opportunities and challenges of this world, however, vary significantly across groups of migrants. In particular, I will engage with three core concepts structuring migrants’ nutrition narratives along lines of socio-economic and cultural differentiation: *kul’turnost* or “being cultured”, *takaya zhizn* or “life itself”, and “westernisation”.

Methods

The exploratory objective of this research implies reliance on the inductive and constructivist approach associated with qualitative methodology (Bryman 2008). The benefits of qualitative research for studying the relationship between migrants’ identities, their socio-economic mobility and their health beliefs are outlined by Smaje:

“Ethnographic techniques can illuminate important questions such as the social meanings imputed to health in different populations and the nature of participation in family and community networks which help promote health and welfare” (Smaje 1996: 165-166).

The material analysed in this paper was gathered by means of semi-structured interviews conducted in Berlin between September 2009 and April 2011 (N=24)¹. Most interviews were conducted in Russian, with one exception when the interviewees requested to be spoken to in German. Taking into consideration the intricate relationship between collective and individual health beliefs developing in a family (e.g., see Cornwell 1984), fieldwork was carried out with households, rather than single informants. Research participants were asked to give their definition of a healthy person, to talk about what they thought made them healthy or ill and were prompted to discuss episodes of illness which they experienced in recent times or which they considered significant. Although the research questions did not focus on nutrition specifically, the relationship between food and health has proven to be of primary significance for all research participants.

The research sample included three major groups of immigrants from the former USSR to Germany, highly distinct in terms of socio-economic and cultural origin: the Russian German *Spätaussiedler* and Jewish *Kontingentflüchtlinge* who arrived to Germany in the 1990s, as well as early Jewish migrants of

1 This article is based on the material gathered in qualitative sociological research conducted for a PhD thesis titled ‘Health Beliefs and Help-Seeking Practices of Migrants from the Former USSR in Germany’ and defended by the author in the University of Warwick in 2012.

the 1970s. Russian-German migrants had been extremely limited in their social mobility throughout the Soviet era and suffered greatly from socio-economic and ethnic discrimination. First, Russian-German farmers sustained great human and economic losses due to the collectivisation policies and the famines of the 1930s. Second, with the onset of the Great Patriotic War (1941-1945), Russian-Germans were declared to be “enemies of the Soviet people” and were subjected to forced deportations from the Volga region, where they had traditionally settled, into labour camps and settlements in Siberia and Central Asia. Limited in their socio-economic and geographic mobility and deprived of the right to practise their culture, Russian-Germans remained severely disadvantaged in the post-war years, as well. As a result of continuous discrimination, the majority of Spätaussiedler migrants are trained in manual occupations or belonged to clerical professions. In contrast, early Jewish migrants in the 1970s and the later wave of 1990s Kontingentflüchtlinge mostly come from large urban centers in the Western part of the former USSR and tend to have high educational and professional qualifications: according to a survey conducted in Germany in the 1990s, 71% of Jewish Kontingentflüchtlinge had a university degree, with an overwhelming majority having worked in skilled or highly skilled white-collar jobs before migration (about 20% had held managerial positions) (Schoeps, et al. 1996: 42). No similar surveys have been conducted with the members of the earliest Jewish migration wave, however, some studies conducted in the former USSR suggest that at the time of migration (early 1970s) most of these people were well-educated and had an urban background (Gitelman 1997). While collecting and disseminating the material, I particularly focussed on establishing the native health vocabulary, a principle integral to qualitative sociology (Byrne 2012), and to the constructivist approach to health (Charmaz 1990)². All interviews conducted in the course of this project were analysed with the help of NVIVO 8. I started coding by looking for definitions of health and illness, and at a later stage was able to establish three central concepts of kul'turnost, “westernisation” and *takaya zhizn* (“that is how life is”, “life itself”), which will be consistently addressed in this article.

Transition to the World of Plenty

In spite of the internal differences across groups of migrants from the former USSR, none of the people I interviewed questioned the positive effects of migration on their nutritional choices. Only one male Jewish interviewee, who arrived

2 In my translation I was not following the principle of literal translation. Instead, I relied on the technique of “creative translation” which does not seek to translate each word by the most direct equivalent, but rather attempts to convey the meaning of the whole phrase, which existing research considers a suitable solution for sociological work that aims at being “readable” (Overing 1987; Temple 1997).

to Germany as a small child in the 1970s, did not conceptualise the difference between ‘here’ and ‘there’, most likely because he had no distinct memories of food shopping in his country of origin. Even though some people criticised the quality of particular types of groceries, as I will discuss below, everyone I spoke to addressed the positive quantitative change. People cited the supply of groceries in German stores as significantly larger in scope as compared to the USSR and its successor states. Upon migration, people who had previously dealt with permanent shortages of foodstuffs and developed complex strategies for overcoming them, received access to groceries they previously had never seen, tried or even heard of. To people interviewed for this research, migration to Germany means, first and foremost, the removal of structural disadvantages and an increase in individual empowerment. Diner (2001) observes similar conceptualisations of America in interviews with Eastern European Jews who moved there in the course of the 20th century:

“They had felt entitled to eat well before migration, but the realities of scarcity made this impossible. In America satisfaction lay within their means, and they challenged anyone who stood in their way” (Diner 2001: 180).

For example, Julia, a 51-year old Jewish Kontingentflüchtline, says:

“Of course, life itself was different in Moldova. Half of the stuff you can buy here, we did not even know about.”

In this short excerpt Julia addresses food in the context of the changes that migration brought to their lives in general. German food is a component of “life itself” – or, in Russian, *takaya zhizn*. “Life itself” refers to the theorisation of circumstances which seem to be objectively affecting one’s health. Changes in food supply are conceptualised as a component of *takaya zhizn* by most migrants interviewed in this research: in their interpretation, the sheer availability of groceries lies beyond individual agency. Migration to Germany meant the overall improvement of “life itself” and opened up new opportunities and new dietary choices, whereby migrants talk about the possibility of buying food they previously considered “luxury” or “festive” on an everyday basis. For example, 81-year old, Tamara (a Jewish Kontingentflüchtlinge), who was interviewed in her kitchen, insisted that I try her salad. “When we lived in Moscow, we could not even imagine having a ripe, fresh tomato in winter”, says Tamara as she fills our plates to the rim. Her words and her hospitality suggest than even after having spent almost twenty years in Germany, she does not take the everyday abundance of groceries in German shops as self-evident. In contrast, she consciously celebrates her ability to consume.

The contrast between “here” and “there” is particularly pronounced in interviews with Russian-Germans from rural regions – individuals who have been especially disadvantaged throughout their lives. 79 year-old Kristine (Russian-

German Spätaussiedler), who survived the famines of collectivisation and war, remembers her childhood:

“Oh, my dear child, you don’t want to know what we went through. War, war is the worst, famine, we had nothing to eat. I had to gather grass in the fields to feed my younger siblings, and we were lucky if we could kill a squirrel every once in a while.”

In the course of the interview, Kristine speaks of the continuous food shortages she had to endure later in life and the difficulties of having to make ends meet in peaceful times. Having moved to Germany, Kristine, finally, became free of all her worries about food:

“We are very satisfied with our life. We can afford anything we want, even with our pensions. In the supermarket I can choose between this sort of cheese or the other, and if I don’t find it in this shop, I will go to a different one.”

For Kristine and other people her age, coming to Germany means a kind of compensation for previous losses: in the course of the interview she and other elderly Russian-Germans repeatedly express their gratitude to Germany for “accepting” them and for “not neglecting them” in their old age – in comparison to Russia or other sending countries of the former USSR which are described as places where old people inevitably die in poverty. The difference between life before and after migration is so acute that even mundane daily practices such as shopping for everyday food (Kristine mentions cheese), are not self-evident: in the interviews they are addressed and discussed as individual, important themes.

Only two people who came from very privileged backgrounds (as compared to other interviewees) questioned the effect of structural limitations on individual choices, and suggested that with enough effort, one could maintain a healthy diet in the USSR as well. One of them, Sonya (39, Jewish early migrant), whose father was a very famous TV presenter and who grew up in Moscow, says:

“I cannot understand it when people talk about being unable to buy fruit or vegetables during the Soviet era. In Moscow there were these frozen goods supermarkets, and you could buy anything there, all year around. And you could always buy herbs from babushkas (elderly female street vendors, - P.A.). Besides, there are always seasonal vegetables. It does not have to be complicated. In autumn my mother would buy mushrooms, in summer young potatoes. No one forced people to eat noodles every day.”

Sonya’s friend Misha (55, Jewish early migrant) also argued in the interview that his grandmother made “salads every day, while all these fat Soviet people could not get it and thought she was like a cow eating hay”. These two cases are a telling exception to other interviews, as Misha and Sonya are the only people who claimed

that their families had never experienced any shortages. Although Misha and Sonya come from the best supplied parts of the former USSR – Sonja is a Muscovite and Misha grew up in a big city in the Baltics where food shortages were less pronounced than in the other regions – neither of them reflects on access to food which their families had due to their status and place of residence. Instead, Sonya and Misha both attribute diets maintained in their families to smart individual decisions of adult female family members. They suggest that others were simply not savvy enough to pick the right food and, as I will demonstrate in the last section of this paper, attribute it to the “socialist” or “Soviet” approach to health. However, in criticising these “socialist” beliefs Misha refers to *takaya zhizn*, thus unconsciously addressing structural determinants of food choices:

“Life itself was harder, of course. And beliefs and values were more primitive, more simple because of that. But mainly, people were cut off from some very important Truth, that Western Truth we live with now.”

The word Misha uses for “truth” in the excerpt is somewhat old-fashioned, mostly employed in poetic or religious contexts: *istina*. This word means “enlightenment”, “insight”, the ultimate truth (which is the reason I capitalise the word in translation). By using it, Misha suggests the importance of what he believes to be a “western” lifestyle, and places it high above other ways of living. Besides, Misha categorises people who have been socialised in the USSR as altogether “different”, imprinted by socialist ideology – and unfamiliar with Truth.

Germany is thus clearly conceptualised as an antithesis to the limited, scarce Soviet past, and migration means a profound change in the structural circumstances of food supply on the one hand and in individual behaviour on the other. However, the new plenty does not only cause migrants to celebrate their lives every day by consuming food that previously was out of their reach, it also conditions new choices with respect to nutrition, choices meant to maintain a healthy diet. In the next two sections of this paper I will demonstrate how different groups of migrants elaborate their own strategies in navigating the new world of plenty: whereas better-educated, socially mobile groups stress the importance of innovation through “westernising” oneself, less privileged ones adhere to tradition.

Making our own sausage: Russian-Germans

Although elderly Russian-Germans constitute a group of interviewees who strongly stress the positive effect of migration particularly on their access to food, they are also the ones who question the quality of some types of food sold in German supermarkets. In particular, vegetables, meat and poultry are referred to as “unnatural”, “full of chemicals”, “plastic” and “unhealthy”. To a great extent this conceptualisation results from former peasants’ confrontation with the urban means

of food production. Although all elderly Russian-Germans described missing growing their own food, only one couple had been able to secure a garden plot in the vicinity of Berlin and plant their own vegetables. Albert (72) says:

“We made sure we got a garden plot very soon after we came here. So we can have our own potatoes, for example. I think what they sell here in the stores is totally unnatural. And it tastes so much better when you grow it yourself!”

In this account of growing one's own, similar to accounts of other interviewees, the health properties of food are attributed to personal control over the production cycle: in contrast to grocery stores where one does not know “where the food comes from” and “what was put in it”, self-grown food is produced with one's “own hands” and with the “soul”. The health effects of growing one's own food are, however, addressed in an ambiguous way. On the one hand, Albert complains about back pain from working on his plot and taking care of the crops, and other research participants also speak of their health as being destroyed by years of hard work in the field. On the other hand, planting and gathering his own potatoes gives Albert a feeling of satisfaction, in fact, it re-creates the feeling of connectedness to his own past and identity. In contrast, those interviewees who had no garden plots spoke of missing “digging in the soil”, as they put it. Working in the field as a whole family – and later consuming the fruits of their own labour as a family, too – is a production cycle that used to structure Albert's life as well as the lives of other Russian Germans, and great importance is attributed to restoring this cycle in their receiving country. Some interview participants spoke of visiting relatives in rural areas, gathering crops together and making preserves which were distributed among all family members: Heinrich (81) and Kristine (79) went to visit a nephew in southern Germany, and Albert and Nina (both 72) regularly travel back to Russia. Hard work and family ties are concepts which strongly determine knowledge about healthy food, whereby great effort is put into preparing one's own meals “from scratch” at home and sharing them with others. Kristine says:

“The sausage in the shop, who knows what they put in there. We do not buy it. To make a good, healthy sausage, I buy a good piece of meat and make the mince myself. The mince in the supermarket is too fatty, it is not good. And then, I make my own sausage, it is much better in quality, much healthier.”

By making her own sausage, Kristine establishes her competence, her knowledge of what is good for her family. In fact, this is the only competence her husband trusts: 81-year-old Heinrich says he could not eat anything in a German hospital, when he was taken there with a heart attack. He summarises his refusal in a brief “I can't. I only eat what my wife makes”. Kristine comments:

“He only eats what I cook. What comes from the family. He will never eat anything that is made by a stranger.”

In these families, shopping for food and cooking is mostly done by women: one of the interviewees claimed that her husband does not even know how to warm up a plate in the microwave, so she must always be home at his meal times. Even in families with broken family relationships, the production and consumption of food in accordance with generation and gender roles remain important practices. For example, two elderly Russian-German women I interviewed complained about violent treatment by their adult sons. Still, as we were talking, both of them were cooking meals for them, explaining it by the men's “inability to take care of themselves”. In one instance, the son of one woman showed up earlier than expected and was severely drunk. In my presence, he abused his mother verbally and threatened to hit her. Although the old woman cursed her son in response, she still set the table for him and poured him a plate of borscht (traditional Russian beet-root soup, usually based on meat broth). Offering food and consuming food was a practice untouched by other negative transformations in this family.

Unlike in the case of younger Russian-Germans and most Jewish migrants (as will be discussed further), elderly Russian-Germans conceptualise health in functional terms: being healthy means being able to carry on with one's daily workload, and the causes of illness are outside one's reach. It is “life as it is”, with its poverty, hard work and hereditary illness which determines one's condition. In this model of health, individual effort is unnecessary and superficial. Hence, elderly Russian-Germans did not talk about trying to change their own diets or the diet of their family members in accordance with their transforming health needs. Instead, food choices were regarded as prescribed: great importance was attributed to cooking food in accordance with familiar recipes and using familiar ingredients. Most elderly Russian-German women I spoke to shopped in the large Russian supermarket selling groceries typical of the former USSR, such as tvorog (curd), a variety of pickles, cereals and sweets. The supermarket is located in the middle of a Berlin neighbourhood densely populated by Russian-Germans and is within short distance from most people's homes.

Severely disadvantaged throughout their lifetimes, limited in their social mobility and used to relying on family as the only protective mechanism in a world hostile to them, elderly Russian-Germans appear to maintain the same nutritional habits they acquired in their sending countries. Production, distribution and consumption of food are structured along the lines of traditional generation and gender roles and are an integral part of “life itself” or “taking life how it is” – they are pre-determined by life-long experience of “surviving” rather than “living”.

At the same time, a few Russian-Germans I interviewed actively re-conceptualise the nutritional traditions determined by “life itself”. The differences between the traditionalist and innovative households are structured along socio-economic and generational lines: younger people and people with educated or urban backgrounds are the ones who question nutritional choices based on tradition. For Ma-

rina (46) and Ludmila (48), two women with higher education coming from poor, rural regions of Kazakhstan and Russia, growing their own food is simply a subsidiary strategy, a practice of food production that cannot substitute for a healthier choice. They do not identify themselves with agricultural labour the way the older and less educated generation of Russian-Germans does. Ludmila says:

“For example, I spoke with my father on the phone recently. And he says, well, we worked in the greenhouse, got our tomatoes, very nice tomatoes this year! And then, I think, right, that means they will not see a single fresh tomato till next summer. People have much, much lower expectations. They are only used to surviving.”

Irina (27) suggests:

“All these babushkas selling their potatoes along the roads in Kazakhstan – no thanks. Who knows where these vegetables were grown and how much radiation or acid rain they have absorbed?”

Irina is confronting what she considers to be an uncivilised Russian-German tradition, attributing it to babushkas, old uneducated females in rural Kazakhstan. She conceptualises her refusal to consume self-grown food by making references to environmental pollution and thus establishes herself as an informed individualistic consumer, rather than a member of a community united by agricultural tradition.

Larissa (65) and Mikhail (71), a couple from a large Ukrainian city, mostly adhere to tradition when it comes to cooking and distributing food. All the cooking is done by Larissa, and most meals are based on traditional Russian cuisine, with lunch always being a three-course affair. However, even though Larissa carries on cooking borscht, schi (cabbage soup), kasha (buckwheat) and pork roasts, she claims she has altogether ceased shopping in the Russian supermarket:

“Last year I went there to buy a bottle of champagne. It was for the New Year’s fest, so it was important that it was good. But when we opened it, what do you think was in there? Cheap soda! Soda! That’s it, I said then. Enough of these Russian quirks. We are Germans, and we will shop like Germans. I only go to normal supermarkets now.”

The incident of being cheated over an integral component of the most festive meal of the year makes Larissa re-think her identity altogether. When it comes to consumer practices, she is willing to transform herself fully into a “German”: she believes that this change of behaviour may guarantee her better security in food choices. Conscious adaptation of eating habits identified as “German” or “Western” accompanied by a desire to depart from habits identified as “Russian” or “Soviet” are major themes in interviews with people with a similar or higher social status

than Larissa. Unlike Larissa, however, these people – most of whom are highly educated urban Jews – do not simply cease shopping in Russian supermarkets. Instead, they set out to overhaul their diet in general. If they were to be invited to a lunch in Larissa’s house and offered a *kotleta s kartoshkoi* (cutlet with fried potatoes), they would, probably, consider her a person stuck in a “backward” socialist past. In the next section I will discuss how a “westernisation” of diet encodes the identity boundaries and status aspirations of the most upwardly socially mobile migrants.

Kul’turnost, “westernisation” and eating salad

As we sit in a restaurant not far from Misha’s workplace (Misha is a 55-year old Jewish man who came to Germany in the early 1970s, who continuously claimed throughout the interview that healthy nutrition choices are determined by individual will only), my voice recorder on the table, Misha critically investigates a garlic baguette which arrives as a starter and takes a piece after what seems to be a minute’s hesitation: “I usually don’t eat stuff like that!”. I ask him why, and he continues, passionately:

“I watch out for what is healthy. One should not be like an animal, like all those uncivilized [dikie] Soviet people who have no idea about their health.”

Throughout the rest of the interview, Misha characterises people remaining in his motherland and other migrants as “Soviet” people and attributes to them all sorts of behaviours he considers unhealthy: unbalanced nutrition, alcoholism, smoking, abuse of antibiotics and violence. Misha believes it is their culture, or, rather the lack of it, which makes them into unhealthy people:

“They get ill quicker, fall to pieces, eat trash. Our guys drink far too much alcohol which destroys them. And women do the same. Those are the kind of bad habits they have. They do not know how to eat well, they do not exercise as young people, then they start deteriorating and by fifty years old, in fact, they are ready to die.”

As the quotes above suggest, Misha describes his former countrymen with little compassion and attributes their poor health to their individual choices. Structural limitations do not exist for Misha, instead, he believes that it is one’s own responsibility to circumvent the difficulties and make the right decisions. Later in the interview, he claims that his family was able to develop autonomy from the socialist reality already prior to migration to the “world of plenty”:

“Of course, in the USSR books about alternative healing or healthy nutrition were hard to get. But the intelligentsia had their ways. My former mother-in-law had a whole library, books would be copied, photographed, I don’t know

what! (...) If you want to learn something, you will, it is a matter of desire, of your kul'turnost."

This account contains another key concept that better educated urban migrants use to address health – that is, the concept of kul'turnost or "being cultured". On the one hand, this interview excerpt states the major function of kultur'nost as a proactive pursuit and implementation of knowledge about health, against all odds. On the other hand, it clearly treats kul'turnost as a characteristic of a particular social class: the intelligentsia. Indeed, Vera Dunham argues that kultur'nost is a highly important class-differentiating notion coined by socialist culture and adopted by middle-class urban populations as a key concept of their identity (Dunham 1990). Recently, Michele Rivkin-Fish (2005) had analyzed the meaning of kul'turnost in her research of post-Soviet discourses of health. Rivkin-Fish demonstrates that kul'turnost is a native category implemented by Russians themselves in their definitions of pro-active healthy behaviors. At the same time, she suggests that kul'turnost also encodes identity boundaries and class differentiation:

"Despite (...) positive associations, kul'turnost also has been used to signify class, race and cultural difference, serving as a weapon of power and exclusion" (Rivkin-Fish 2005: 12).

Indeed, implying a clearly individualistic approach to health, the kul'turnost narrative with respect to nutrition is most pronounced among better educated, urban Jewish migrants and among younger Russian Germans who treat health as an important marker of achieved status, a token of upward social mobility. The German "world of plenty" supplies them with the necessary food to act upon their beliefs on health. This transformation does not occur immediately, as the interview with 27-year-old, Russian-German Irina may illustrate:

"Of course, first, when we came, we probably behaved like some wild people, as if we came from a starvation zone [s golodnogo ostrova]. I remember how mad I was about all these pizzas and cokes, all that stuff. (...) But then you start thinking, what is good for you? I do not even touch that stuff anymore."

Irina suggests that simply being admitted to Germany does not mean an automatic change in individual behaviour: it is one's personal achievement and merit to maintain a healthy diet and to change old habits. These achievements become an issue in the binary opposition between the past and the present, whereby "socialist", "wild" habits are opposed to the healthy, "civilised" West. When describing the nutritional practices he considers typical for the ex-Soviet migrant community in Germany, Misha, the early Jewish migrant, says:

"There are people here who moved, like, thirty years ago, but they still live like in the Soviet Union. They eat all this heavy food, you know, meat and borscht

every day, and drink vodka, and nothing changes for them. They are like dinosaurs."

By using derogatory comparisons, such as "dinosaurs" and by stressing the incompetence of "Soviet" people, Misha, as well as other interviewees, make it clear that self-"westernisation" is a status marker. Adapting to the nutritional practices of the West is a part of kul'turnost, of the pursuit for individual control over health. This conflation of "westernisation" and upward social mobility is likely to be related to modes of socialisation in the former USSR and with inequalities involved in the consumption and reproduction of globalised health discourses. First the Iron Curtain and then the unsteady economic transition of the 1990s had strong selective effects on who could communicate with contacts abroad and how. The "westernisation" of nutritional habits among Soviet Jews was determined by a variety of socio-economic and cultural factors. Already prior to the Bolshevik Revolution of 1917, Diner suggests (Diner 2001: 149) that "Eastern European Jewish life fostered culinary cosmopolitanism", whereby Jews "adapted local food and adopted it to their laws" (Diner 2001: 148). Due to the centrifugal movement of Jews throughout Eastern Europe and the pre-Revolutionary Pale of Settlement, Soviet Jewish cuisine was a melting pot of many traditions, embracing Romanian, Polish, German, Ukrainian and Baltic influences. Due to forced secularisation, however, the centuries-long tradition of kashrut (Jewish dietary law) had, however, been almost fully abandoned in most Jewish households and the influences of other cuisines were increasingly adopted. Even during the Iron Curtain era, Jews remained a globalised group. This is due in part to the fact that the professional occupations of many urban Jews often permitted them at least some travelling, even if only within the Warsaw block. In addition, from the 1970s onwards Jews grew increasingly involved in chain migration to Israel and the West, so that even those who remained home often managed to maintain at least loose contact with friends and relatives abroad. At the same time, because in Eastern Europe access to products of the capitalist West – material and non-material alike – was severely limited on ideological grounds, the desire to imitate Western consumerist standards was interpreted as status aspiration and political revolt (Bren and Neuburger 2012). Hence, "westernisation" of nutrition was a token of adherence to non-Soviet, if not openly anti-Soviet values and, at the same time, a marker of status aspirations. To urban, in particular, Jewish, intelligentsia, immigration to Germany is the final and most important step on the way to self-"westernisation". Changing one's nutritional practices is meant to symbolise and encode the transformation into a "Westerner". Tamara (81, Kontingent-flüchtlinge) says:

"I do not put chicken in the salad any longer. That was our Soviet habit, when there was nothing to eat, and the purpose of every meal was to simply stuff our-

selves. Now we are older, we have to take care of cholesterol, and I mostly use fresh vegetables.“

The main motivation of the nutritional change that Tamara mentions is her understanding of the family's changing health needs. By swapping chicken for greens, Tamara consciously innovates her diet. At the same time, she suggests that it was immigration to Germany which made the implementation of such change possible in the first place. The “Soviet” past is associated with unreflexive consumption determined by external circumstances, whereas life in the West fosters choice and liberty, opportunities one must seize in order to become healthier. The increase in fresh vegetable intake that Tamara mentions is, in fact, a key theme in how migrants operationalize “westernisation”: in their own terms, they speak of “eating more salad” or, in Russian, “est salat”.

In Russia and the former Soviet republics, salad is usually a mix of different vegetables, dressed with mayonnaise, creme fraiche or oil. Some kinds of salads popular in the former USSR include meat or cheese, such as the famous “Russian salad”, where potatoes are mixed with veal, sweet corn, peas, boiled carrots, and whatever else a Soviet housewife could manage to buy in a grocery store, and often, mayonnaise. Several interviewees among those who stress *kul'turnost* have spoken of “eating a lot more salad” since their arrival to Germany, meaning, however, not the latter type of salad, but a mix of fresh vegetables. In fact, Russian salad (which is called “Olivier” in the former USSR, as it is attributed to a French cook of Count Stroganov) has become a symbol of Soviet nutrition: in the interviews migrants mention it when casting their new, Western habits against the old Soviet ones. Irina says:

“I do not make all these Soviet salads, this Olivier, God forbid! Just a bit of fresh vegetables with oil, that is it.“

Although “salad” was mentioned by everyone who spoke of changing their eating habits, the new practice was approached in quantitative, rather than qualitative terms: interviewees mostly spoke of a mean increase in vegetable intake, rather than about the nutritional qualities of these vegetables. By highlighting the sheer quantities of “salad” they eat, migrants, in fact, stress their ability to consume food previously unavailable to the majority of the Soviet population. Misha says:

“I eat very little meat, almost no meat at all. Mostly fish, and a lot of fresh vegetables. Lots of salad! The way I eat, only very rich people in Russia can afford. Not because the groceries are so expensive, but because they pay a cook, who thinks for them and knows what's good for them.“

The exception to quantity over quality trend are migrants who buy bio - or organic - groceries. The German organic food market is the biggest in Europe (Baker, et al. 2004), and existing market research suggests that preference for organic

food is characteristic of a German social stratum referred to in public discourse as *Bildungsbourgeoisie*, the educated upper middle-class; Faltins (2010: 50) demonstrates that education and income are the strongest predictors for organic food preferences in Germany, with size of household, gender or age playing a less decisive role in food choices. Organic consumerism is a practice embedded in the general context of social, political and environmental engagement typical of educated Germans (Baker, et al. 2004). In migrant households, consuming organic food acquires a very different meaning. Bio shopping is primarily a consumerist practice employed, on a practical level, strictly for improving one's individual health, and, on a social level, to maintain identity boundaries and signify social mobility. A fragment from an interview with Natasha (41, early Jewish migrant) illustrates the ambition to distinguish herself from other migrants:

“You will never meet our people in a bio-shop. They are ignorant. They just do not understand, I think. (They go) across the road, to a supermarket. I peek in the baskets sometimes, you know, out of pure interest: *kolbasa* [sausage] of all sorts, that is it. No bio-food. (...) Germans are a lot more civilized. It is understandable, they are very rich, it is a generation thing. (...) So, they are a lot more used to taking care of themselves. Before buying something in the shop, they will think twice, do I really need it? Will it do me good?“

Natasha is attributing preference for *kolbasa*, - sausage, - to a Soviet lifestyle as opposed to the “civilized” German habit of “taking care of themselves”. In this context, it is important to bear in mind that *kolbasa* is a concept used in Russia not only to describe a particular meat product, but also as a derogatory word for all things material and mundane. At some instances, members of the earliest, 1970s Jewish migration wave to Germany referred to later migrants as “sausage emigration” (*kolbasnaya emigratsia*), that is, composed of people motivated by economic considerations only and attracted to Germany by the abundance of “sausage”. In this excerpt, Natasha in fact stigmatises other migrants as both greedy for material pleasures and passive at the same time. The “German” shopping for organic food is almost literally opposed to shopping for *kolbasa* (it occurs “on the other side of the street”).

Shopping for organic food, however, does not always mean full trust in organic brands. In fact, a few interviewees questioned the quality of organic food. Instead, with a degree of self-humour, they continued shopping and hoping that they were still contributing to their health. For example, an interview with Julia and Joseph (51 and 55, *Kontingentfuchtlinge*) demonstrates the internal conflict migrants feel when investing in expensive organic products, hoping they are healthier:

Joseph: I think the whole bio thing is just a spoof, just to make money. It is all poured from the same bucket, and then some different stickers are attached. It is all done to make you pay more.

P: So, you do not shop for bio?

Julia: I do!

Joseph: Yes, my wife does. She believes in this nonsense, well, I cannot stop her.

P: Why do you prefer bio?

Julia: Because with these brands you can at least hope there will be less chemicals, that they will be fresh. And I just see where rich Germans go. I can't shop like them, all bio, including meat, but at least some vegetables. They are not enemies to themselves, right? If they buy there it does them good, so, it will do us good, too!

Julia mimics "rich" German practices, because she believes they are healthier than the ones she knows from her sending country. She feels the pressure to be like a German woman in order to maintain a healthy lifestyle. The health qualities of food are not attributed to ingredients or production methods, instead, they are directly associated with the status of consumers. For Julia, Natasha, Misha and other "Westernised" interviewees, "rich" and "healthy" are co-dependent concepts; they shop for organic food not because – or not only because – of their environmental awareness, like "local" Germans do, but because of their status aspirations.

Conclusions

This article was about ways in which migrants from the former USSR in Germany conceptualise the relationship between food, migration experience and health. This paper sought to provide a new angle on the transformation of socialist health cultures, in particular, on how people's ideas about health change through exposure to globalised discourse and developed capitalist markets. The material discussed in this paper contributes to research which demonstrates that the desire to control, understand and choose what to put on one's plate is universal to people from all socio-economic and cultural backgrounds. It is differences in what is considered to be good or healthy food that are so vital to an understanding of social order and cultural differentiation.

Although the effects of migration on nutritional possibilities are equally recognised by all interviewed migrants as beneficial, the individual choices people make are conditioned by socio-economic mobility throughout their lifetimes, distinct cultural identities, generational differences and exposure to globalised discourses of health. Elderly Russian-Germans with low levels of education and with an agricultural background conceptualise health as a result of external circumstances, and their individual food choices are determined by tradition, family ties and a life-long experience of poverty. In contrast, better educated and younger Russian-Germans speak of health in more pro-active terms and set out to change their diet, using the new opportunities the German "world of plenty" offers them. The

most pro-active approach to health and nutrition choices is observed among the highly educated Jewish migrants from urban areas of the former USSR. These individuals regard health as a marker of achieved status and conceptualise it as an integral part of one's kul'turnost, or being cultured. In the context of the migratory process, kul'turnost acquires the meaning of "westernisation", and an adaptation to eating habits attributed to the "civilised" West becomes a key theme in individual nutritional behaviour.

The findings presented in this paper contribute to our understanding of the heterogeneity of post-socialist attitudes to health and of the effects the transition to capitalism has on individual behaviours. This paper suggests that migrants' ideas about healthy nutrition should not be only regarded as products of Soviet paternalism and fatalism, as some literatures cited in this paper suggest and as some of the people interviewed in this research claim. Instead, the discussion in this article should contribute to our understanding of "passivity" as a function of social status, and not a specific characteristic of Homo Sovieticus.

REFERENCES

- Aroian, K., Khatutsky, G., Tran, T. and A. Balsam, 2004. Health and Social Service Utilisation Among Elderly Immigrants from the Former Soviet Union. *Journal of Nursing Scholarship*, 33 (3), pp. 265-271.
- Ahmad, W. ed., 1993. *'Race' and Health in Contemporary Britain*. Milton Keynes: Open University Press.
- Baker, S., Thompson, K.E., Engelken, J. and K. Huntley, 2004. Mapping the values driving organic food choice: Germany vs the UK. *European Journal of Marketing*, 38 (8), pp. 995-1012.
- Beyer, M., 2001. Altersbilder und das Verständnis von Gesundheit im Alter aus der Sicht älterer russlanddeutscher Spätaussiedler [Ideas about old age and beliefs about health in old age among elderly Russian German Spätaussiedler]. In: A. Zielke-Nadkarni and Schnepf, W. (Hrsgb.), 2001. *Pflege im kulturellen Kontext*. Berlin: Huber, pp. 69-70.
- Biloukha, O. and V. Utermohlen, 2001. Healthy eating in Ukraine: attitudes, barriers and information sources. *Public Health Nutrition*, 4 (2), pp. 207-215.
- Blaxter, M., 1990. *Health and Lifestyles*. London, Routledge.
- Borde, T., 2003. Sind Migrantinnen gut versorgt? Handlungsbedarf und strukturelle Lösungsansätze [Are the needs of migrant women adequately met? Prospects for policy interventions and structural solutions]. AKF Tagung „Lust auf Dialog“. Berlin.
- Bren, P. and M. Neuburger, 2012. *Communism Unwrapped: Consumption in Cold War Eastern Europe*. New York: Oxford University Press.
- Brown, J. and N. Rusinova, 1997. Russian medical care in the 1990s: A user's perspective. *Social Science and Medicine*, 45 (8), pp. 1265-1276.

- Brown, J. and N. Rusinova, 1999. Socialnie neravenstva i zdorovie [Social Inequalities and Health]. Zhurnal sociologii i socialnoi antropologii, 2. Available at: <http://hq.soc.pu.ru/publications/jssa/1999/1/9rusin.html>. [Accessed 9 December 2012.]
- Bryman, A., 2008. *Social Research Methods* (Third edition). Oxford: Oxford University Press.
- Byrne, B., 2004. Qualitative interviewing. In: Seale, C., ed. 2004. *Researching Society and Culture*. London: SAGE, pp. 179-192.
- Caplan, P., 1997. *Food, Health and Identity*. London: Routledge.
- Charmaz, K., 1990. Discovering' chronic illness: Using grounded theory. *Social Science and Medicine*, 30 (11), pp. 1161-1172.
- Cockerham, W. C., 1997. The Social Determinants of the Decline of Life Expectancy in Russia and Eastern Europe: A Lifestyle Explanation. *Journal of Health and Social Behavior*, 38 (2), pp. 117-130.
- Cockerham, W. C., 1999. *Health and social change in Russia and Eastern Europe*. London: Routledge.
- Cockerham, W. C., 2000. Health lifestyles in Russia. *Social Science and Medicine*, 51 (9), pp. 1313-1324.
- Cockerham, W. C., Snead, C. and DeWaal, F., 2002. Health Lifestyles in Russia and Socialist Heritage. *Journal of Health and Social Behavior*, 43 (1), pp. 42-55.
- Cornwell, J., 1984. *Hard Earned Lives*. London: Tavistock.
- Diner, H. R., 2001. *Hungering for America: Italian, Irish and Jewish foodways in the age of migration*. Cambridge MA: Harvard University Press.
- Dreißig, V., 2005. *Interkulturelle Kommunikation im Krankenhaus. Eine Studie zur Interaktion zwischen Klinikpersonal und Patienten mit Migrationshintergrund* [Intercultural communication in the hospital. A study of interaction between hospital staff and patients with Migrant background]. Bielefeld: Transkript.
- Dunham, V., 1990. *In Stalin's Time: Middleclass Values in Soviet Fiction*. Duke University Press.
- Faltins, R., 2010. *Bio-Lebensmittel in Deutschland: Kaufbarrieren und Vermarktung* [Organic Groceries in Germany. Consumer Barriers and Marketing Strategies]. Hamburg: Diplomica.
- Fischler, C., 1988. Food, self and identity. *Social Science Information*, 27 (2), pp. 275-292.
- Gitelman, Z., 1997. From a northern country: Russian and Soviet Jewish immigration to America and Israel in historical perspective. In: Lewin-Epstein, N., Roi, Y. and P. Ritterband, eds. 1997. *Russian Jews on Three Continents : migration and resettlement*. London: Frank Cass, pp. 21-41.
- Holloway, L. and M. Kneafsey, 2004. *Geographies of rural cultures and societies*, Aldershot: Ashgate.
- Korenblum, W., Bornstein, S. and S. Fischer, 2010. Erkrankungen bei Migranten - Jüdische Kontingentflüchtlinge und deutsche Spätaussiedler aus der ehemaligen Sowjetunion [Illness patterns in Jewish Kontingentflüchtlinge and German Spätaussiedler from the former Soviet Union]. *Diabetes aktuell*, 8, pp. 38-43.
- Kyobutungi, C., Ronellenfitch, U., Razum, O. and H. Becher, 2006. Mortality from external causes among ethnic German immigrants from former Soviet Union countries, in Germany. *European Journal of Public Health*, 16 (4), pp. 376-382.
- Lupton, D. A., 2005. Lay discourses and beliefs related to food risks: an Australian perspective. *Sociology of Health and Illness*, 27 (4), pp. 448-467.
- Mintz, S., 1996. *Tasting Food, Tasting Freedom: Excursions in Eating, Culture and the Past*. Boston, MA: Beacon Press.
- Mintz, S. and C. Du Bois, 2002. The Anthropology of Food and Eating. *Annual Review of Anthropology*, 31, pp. 99-119.
- Nazroo, J.Y., 2001. *Ethnicity, Class and Health*. London: Policy Studies Institute.
- Nettleton, S., 2006. *The Sociology of Health and Illness*. Cambridge: Polity.
- Overing, J., 1987. Translation as a creative process: The power of the name. In: Holy, L. ed., 1987. *Comparative anthropology*. Oxford: Basil Blackwell, pp. 70-87.
- Panova, L. and N. Rusinova, 2005. Neravenstva v dostupe k pervichnoi medicinskoj pomošči [Inequalities in access to primary medical care]. *Sociologičeskie issledovanija*, 6, pp. 127-136.
- Pietilä, I. and M. Rytönen, 2008. 'Health is a not a man's domain'. Lay accounts on gender difference in life-expectancy in Russia. *Sociology of Health and Illness*, 30 (7), pp. 1070-1085.
- Remennick, L., 1999. Preventive behavior among recent immigrants: Russian-speaking women and cancer screening in Israel. *Social Science and Medicine*, 48 (11), pp. 1669-1684.
- Remennick, L., 2001. "All my life is one big nursing home": Russian immigrant women in Israel speak about double caregiver stress. *Women's Studies International Forum*, 24 (6), pp. 685-700.
- Remennick, L., 2003. "I Have No Time for Potential Troubles": Russian Immigrant Women and Breast Cancer Screening in Israel. *Journal of Immigrant Health*, 5 (4), pp. 153-163.
- Rivkin-Fish, M., 2005. *Women's Health in post-Soviet Russia: the politics of intervention*. Bloomington: Indiana University Press.
- Ronellenfitch, U., Kyobutungi, C., Becher, H. and O. Razum, 2006. All-cause and Cardiovascular mortality among ethnic German immigrants from the Former Soviet Union: a cohort study. *BMC Public Health*, 6 (16), pp. 376-382.
- Ronellenfitch, U. and O. Razum, 2004. Deteriorating health satisfaction among immigrants from Eastern Europe to Germany. *International Journal for Equity in Health*, 3 (1), p. 4.
- Rose, R., 2000. How much does social capital add to individual health? A survey study of Russians. *Social Science and Medicine*, 51 (9), pp. 1421-1435.
- Rose, R., 2003. Social Shocks, Social Confidence and Health. In: Twigg, J. and K. Schecter, eds., 2003. *Social Capital and Social Cohesion in Post-Soviet Russia*. New York: M. E. Sharp.
- Rusinova, N. and J. Brown, 2003. Social Inequality and Strategies for Getting Medical Care in Post-Soviet Russia. *Health*, 7 (1), pp. 51-71.
- Shkolnikov, V., Cornia, G., Leon, D. and F. Meslé, 1998. Causes of the Russian mortality crisis: Evidence and interpretations. *World Development*, 26 (11), pp. 1995-2011.

- Shkolnikov, V., Leon, D., Adamets, S., Andreev, E. and Deev, A., 1998. Educational level and adult mortality in Russia: An analysis of routine data 1979 to 1994. *Social Science and Medicine*, 47 (3), pp. 357-369.
- Schnepf, W., 2002. *Familiale Sorge in der Gruppe der russlanddeutschen Spätaussiedler* [Family Care Among Russian German Spätaussiedler], Berlin: Huber.
- Schoeps, J. H., Jasper, W. and B. Vogt, 1996. *Russische Juden in Deutschland: Integration und Selbstbehauptung in einem fremden Land* [Russian Jews. Integration and self-Identification in a foreign country], Beltz Athenäum.
- Smaje, C., 1996. The ethnic patterning of health: new directions for theory and research. *Sociology of Health and Illness*, 18 (2), pp. 139-171.
- Steptoe, A. and J. Wardle, 2001. Health behaviour, risk awareness and emotional well-being in students from Eastern Europe and Western Europe. *Social Science and Medicine*, 53 (12), pp. 1621-1630.
- Temkina, A., 2008. Patients in Contemporary Russian Reproductive Health Care Institutions: Strategies of Establishing Trust. *Democratizatsiya*, 16, pp. 14-22.
- Temple, B., 1997. Watch your tongue: issues in translation and cross-cultural research. *Sociology*, 31, pp. 607-618.
- Thiel, C. and L. Heinemann, 1996. Nutritional behaviour differences in Germany. *Reviews on Environmental Health*, 11 (1-2), pp. 35-40.
- Wittig, U., Merbach, M., Siefen, R.G. and E. Brähler, 2004. Beschwerden und Inanspruchnahme des Gesundheitswesens von Spätaussiedlern bei Einreise nach Deutschland [Complaints and health care system utilisation of ethnic German migrants from the former Soviet Union to Germany and their families]. *Gesundheitswesen*, 66, pp. 85-92.

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Anonymous Semen Donation: Medical Treatment or Medical Kinship?

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Abstract: Opinion in European countries has been divided over whether people conceived with donated gametes (semen, eggs and embryos) should be able to obtain identifying information about their genetic (donor) parents. Despite the increasing number of countries whose laws now permit access to such information, many in the infertility treatment business remain opposed to or anxious about this change of legislation. Based on ethnographic fieldwork on social aspects of anonymous semen donation, including unstructured interviews with doctors in the UK who had donated between the late 1960s and early 1980s and with doctors currently in clinical practice in several European countries, I show in this article how although anonymous semen donation is used to circumvent childlessness caused by male infertility, it is also a way for doctors to wield influence in the domain of kinship and family formation.

Keywords: semen donation, donor anonymity, kinship, family formation

Introduction

The use of donated human semen to avoid childlessness caused by male infertility has become widespread in European countries in the period since donor insemination was developed in the late 1930s.¹ In some countries, the infertility specialists who pioneered and developed the practice insisted that the identity of the donor must be kept from the donor offspring and their parents. In other countries, anonymity was mandated by law. Since the 1980s, an increasing number of countries have passed laws or regulations to prohibit donor anonymity, and to provide for donor conceived people, as adults, to obtain identifying information about their donor (Blyth 2009). Often these legal changes have been controversial because of the anxieties or even hostility of many infertility specialists, most-

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ly medical doctors. This has been revealed in a number of ways such as refusal to co-operate with the changes, and accusations that supporters of the changes are unsympathetic to the plight of childless couples because infertility specialists usually assume that the removal of anonymity will make donor recruitment more difficult.

A number of ethnographies have focussed on assisted reproductive technology (ART) in which the main exploratory and analytical areas are *in vitro* fertilisation (IVF), human egg donation and the perceptions of women upon whose bodies the technologies are used (e.g. Franklin 1997, Kahn 2000, Konrad 2005). The social aspects of semen donation have been much less researched within social anthropology and the contrast with ova donation is striking and remarkable. The association of semen donation with human male infertility may be significant given the more serious stigma attached to male infertility in comparison to female infertility (Lasker 1998: 25, Inhorn 2004), and the 'elision between potency and genetic reproduction for men' (Thompson 2005: 121). Helene Goldberg goes as far as to assert that there is a 'severe silence' surrounding male infertility, in Israel and in general, and that 'men had been crudely overlooked in studies of reproduction' (Goldberg 2010: 84). Sidelined to some extent have been the male partners in couples seeking infertility treatment, as well as the men providing semen for use in donor insemination (DI).

Also of lesser significance in anthropological research have been the infertility specialists themselves. They tend to be in the shadows, outside of the main ethnographic frame. Doctors and clinical scientists reveal their presence obliquely, as field site gatekeepers, ethical arbiters, policy makers and ambitious entrepreneurs, as well as strategists deeply concerned about involuntary childlessness and strongly motivated to alleviate it by means of co-creation (Bonaccorso 2004, Simpson 2004). I suggest that, in fact, infertility specialists' efforts to treat male infertility gave to them, and in some countries continues to give them, a powerful role in how families are formed. Medical treatment becomes kinship creation of a particular kind: a family in which the biological origins of the child are anonymous to the child and parents, and the record of the identity of the genetic father is kept secret or, as happened in the past in the UK, was destroyed by clinics.

This article is a brief description of how this happened in the UK and how the role of the infertility specialists in co-creating families formed on the basis of the anonymity of the genetic father is affected increasingly now by national, cross-border and international actions. I conclude by noting differences between the UK and the Czech Republic which, I hope, will encourage further research in both countries. The article is based on ethnographic research carried out mostly 'at home' in the UK between 2001 and 2007. The research originated partly in my curiosity that self-appointed advocates, especially in the medical profession, were making claims that semen donors of the past would never have donated if

they had not been promised anonymity. The voices of the donors had rarely been heard and there was no anthropological research into the long term implications, if any, for them and their families that they had donated anonymously, and often for financial rewards, when they were young. My research was multi-sited (Marcus 1995, Franklin 1997, Rapp 2000) in order to capture as much as possible of the diversity and complexity of the field. It included unstructured interviews and discussions with fertility specialists and other health professionals currently or formerly working in clinics providing DI services in the UK, as well as with men who had donated semen between the 1960s and early 1980s mostly when they were medical students. Participant observation was carried out at conferences and other meetings of personal and professional stakeholders in infertility treatment services in Austria, Czech Republic, Denmark, England, Northern Ireland, Scotland and Sweden. Further information about attitudes to anonymity and family formation was gathered in a survey of UK infertility clinics' policies about using semen from donors known personally to recipients, and from the non-confidential written responses to a public consultation on what information on donors, if any, should be accessible for donor offspring.

The research aimed to understand how semen donors of the past were experiencing the culture of secrecy surrounding anonymous donation and the fact that they were consigned to obscurity by the clinics after donating. The research itself provided at times uncomfortable challenges, because of what I often experienced as having to comply with secrecy (Speirs 2007b). Social anthropologists bring their own cultural perceptions to ethnographic fields, giving the work of self-reflexivity an especial importance, and keeping secrets, pretending for example that I did not know that a well-known infertility specialist had been a semen donor, made participant observation a highly dynamic process. We make choices in our own personal and professional lives which reflect or are driven by our own traditions, moral views and beliefs, and our own ideologies of kinship can influence our choice of ethnographic field. Anthropology 'at home' therefore becomes more than making the local 'exotic' (Jackson 1987: 8): it can be a test of how far we are prepared to objectify our own culture. Aleksander Bošković notes the emergence of a form of anthropology which consists of an anthropology of 'one's own tribe' (2008: 14) in which the local is not exotic or other, but normalised. In other words, the local is an appropriate research site. As László Kürti and Peter Skalník assert,

We are not searching for remote locations, faraway tribes, strange and exotic rituals just for the sake of carrying an anthropological badge, even though some of us have conducted research outside Europe; for many of us there are now, we must stress here, pressing issues present in our very own backyards deserving of attention (2009: 8).

Although not a new concept, anthropology at home particularly in the areas of infertility, secrecy and family formation, raises important considerations about the personal beliefs of domestic anthropologists and how we manage the theoretical and methodological challenges that emerge when exploring sensitive local issues.

The development of anonymous DI

The passing of the Human Fertilisation and Embryology Act 1990 in the UK introduced the first legislation anywhere in the world to regulate reproductive technology and to introduce a licensing system for infertility clinics. It also included provisions for regulating DI services and it defined who were to be treated in law as the parents of a donor-conceived child. Until then, the practice of semen donation in the UK had not been considered unlawful, but rather to be legally ambiguous. There was also public concern that DI was immoral because it seemed like adultery and therefore an undermining of marriage and a stigmatising of donor-conceived children. There was considerable concern about the secrecy inherent in the practice and that this could not be in the best interests of the children.

This public concern in the UK about DI led to several official enquiries. A Commission was appointed by the Archbishop of Canterbury in 1945 (Church of England 1948) and a government-appointed Feversham committee was set up in 1958 with the following terms of reference:

To enquire into the existing practice of human artificial insemination and its legal consequences and to consider whether, taking account of the interests of individuals involved and of society as a whole, any change in the law is necessary or desirable. (Feversham 1960: 1)

The Feversham report noted that, apparently, 'human artificial insemination has been practised in the United States on a considerable scale for over thirty years' and that according to estimates perhaps over 10,000 children had been born there since the practice began. It was also practised in Australia, South Africa, France, Germany, Scandinavia, Belgium and the Netherlands. In proportion to population, the country with the second most frequent use of donor insemination was thought to be Israel. In several of these countries, government committees had recommended that the practice should be regulated or criminalized, but in no country had legislation been introduced.

Secrecy was strongly encouraged by infertility specialists. This was for the protection of those involved from accusations of adultery, and because there was thought to be no necessity for the identity of the donor to be known to the parents or children. The parents were advised by clinics not to tell their donor-conceived children about the nature of their conception, clinic records were not always retained, and information about donors was kept from the recipients

(Church of England 1948, Feversham Report 1960). Infertility specialists also insisted that DI should be anonymous partly as a protection for themselves against legal liability if anything went wrong (British Medical Journal 1973), and also to protect patients' marriages from the perceived stigma of male infertility, and children from the stigma of illegitimacy. Donor anonymity and secrecy about the use of DI was thought to be best for the family, and also to be a protection of the donor from accusations of adultery and from claims for financial support of the child.

Despite the public concerns about DI, a reluctance to legislate on the part of successive UK governments is clearly evident: forty-five years elapsed between the publication of an article which described the use of anonymous semen donation and thus brought the practice to public attention in the UK (Barton, et al. 1945) and the passage of the Human Fertilisation and Embryology Act in 1990. The medical profession itself appears not to have taken steps to lobby for legislation even though many doctors, including infertility specialists, were concerned about the safety aspects of DI. Donor Insemination only became subject to regulation in the UK as a result of the introduction of legislation to deal with the technologically more complex and risky practice of *In Vitro* Fertilisation, not because of the longstanding concerns about the legal status of donor offspring.

Defending anonymity

In June 1990, at a crucial stage of the parliamentary process of the Human Fertilisation and Embryology Bill, the highly regarded British Medical Journal (BMJ) published a commentary on the matter. The Bill provided for information about gamete donors to be passed to the proposed new regulatory authority, the Human Fertilisation and Embryology Authority (HFEA), partly so that donor conceived people might seek non-identifying information about their genetic origins on reaching the age of 18. The authors of the commentary note: 'opinions are polarised as to whether this new lack of guaranteed anonymity for donors is a good or a bad thing' (BMJ 1990a: 1410). They give several reasons for it not being a good thing and assert that 'finally and most importantly, if donor anonymity is lost men will be inhibited from coming forward as sperm donors... the loss of anonymity is likely further to reduce the availability of men who are willing to be donors. This has already occurred in Sweden, where the law was changed to allow donors to be named. The donor population has been reduced dramatically...' (1990a, 1411). This allegation was based on a report that the law in Sweden had indeed changed to allow children, when they were considered mature enough, to obtain identifying information about donors. However, the BMJ authors omitted to mention that the number of donors had then recovered, except in clinics where, as social science research later uncovered, some clinicians were so against the new law that

they tried to sabotage it by encouraging their patients to travel to other countries for anonymous DI (Daniels and Lalos 1995).

The BMJ commentary failed to mention research from an Australian clinic in the 1980s which showed that 73% of donors would still be prepared to donate even if it were possible for the donor offspring to obtain identifying information at the age of 18 (Daniels 1989: 121). The research studies in various countries by Daniels, a social work academic in Aotearoa/New Zealand, helped to shift semen donors from a position of obscurity and of definition as a 'non-person' to one of acknowledgement, at least in the social sciences. He has published extensively in social, ethical and medical journals, and is cited by sociologists and social workers, but seldom by practitioners in reproductive medicine in the UK. They give the impression of being averse to his research findings, by ignoring them. During my research, at an annual conference of the HFEA I reminded the audience of Daniel's research findings about the willingness of many sperm donors to be identified to their donor offspring. Thereafter I was referred to by several fertility specialists in the audience who did not know me as 'our colleague from New Zealand', a neat but transparent way of insinuating that Daniels' findings were irrelevant to the UK since they came from a different 'culture'.

Removing anonymity

Debate about amending the 1990 legislation in order to remove donor anonymity increased throughout the 1990s. As a result of lobbying especially by social workers and NGOs working with children and families, public consultation on the matter was promised in 1995, during the parliamentary debate in the House of Lords on the Children (Scotland) Bill, but was postponed due to a change of government shortly afterwards. Finally, regulations were passed which provided for gamete donors to be identifiable to any of their adult donor offspring who were born after 2006 (Department of Health 2004). These donor conceived adults can access identifying information about their donor, if they so wish, at the age of 18 years, or earlier if marriage to a named individual is planned before then. The regulations, which are not retrospective, were introduced after a public consultation which showed a clear majority of respondents in favour of donor conceived people having access to information about the donors (Department of Health 2003). The impetus for the consultation was a court case of a donor conceived person in which the court's decision was that Article 8 of the European Convention on Human Rights could be interpreted to include the right of a donor-conceived person to identifying information about her or his identity (cited in Blyth and Frith 2009: 176).

However, the principle of allowing such access to identifying information for donor-conceived people was not accepted by a number of infertility specialists

who remained resistant to the new regulations even after they had been introduced. There were claims that the government had made a big mistake and that the new regulations should be replaced by the pre-existing system of anonymity, because it was essential that donors' identities should be kept secret from their offspring.

Further, during the public consultation and after the regulations were introduced, many infertility specialists stated their belief that the system of anonymity in DI had worked well and therefore that there was no need to change it: donors remaining unidentifiable to donor offspring had not caused problems. They also pointed out that research showed that very few parents had told their donor-conceived children about their origins, thus implying that keeping secret the fact of donor insemination, as well as the identity of the donor himself, was not having adverse effects. However, they failed to mention the research studies which have found that a large number of parents have told someone else even if they have not told the child (Back and Snowden 1988; Lycett, Daniels, Curson and Golombok 2005). Back and Snowden suggested that for parents, keeping the fact of DI a secret from everyone was stressful. A study by Lalos, Gottlieb and Lalos (2007) of couples who had conceived a child after DI found that 61% of the parents had told all of their children about the DI, but 89% had told one or more persons outside of the family. One woman and three men told the researchers that they were sure that no one apart from their partner knew of the DI, but the researchers found that two of these men had wives who had told a close friend about it, without their husband's knowledge. This study was carried out in Sweden, where the legislation introduced in 1985 provides for donor-conceived children to obtain identifying information about gamete donors, but of note here is the researchers' finding that the attitude of healthcare staff was important to parents' decision-making. The parents reported that infertility clinic staff had not always encouraged them to be honest with their children. One of the reasons given by parents for deciding nevertheless to tell their children was that they wanted to avoid the possibility of the children discovering the truth by accident, and also to avoid the burden which keeping the secret was placing on the parents' marriages.

In addition to the view that the system of anonymity in donor insemination had worked well, it was also asserted by infertility specialists in my research that there was no evidence that it had not worked well. This argument had to rely on disregarding the accounts of an increasing number of donor conceived people asking for the law to be changed. None of the infertility specialists claimed to speak on behalf of donor conceived people as to what they wanted, rather, there were claims about what donor conceived people 'should' want. A good example of this occurred in 2002, during the period of the public consultation on donor information, when a young female doctor had an article published anonymously in the 'personal view' section of the BMJ (British Medical Journal 2002) in which she described her feelings about being donor conceived and why she would like

to know something about the semen donor who gave her 'the opportunity of life'. She pointed out that, although the issues about donor insemination had been debated over the years, "what are lacking are the views of the children created". She pointed out that the studies carried out about people like her 'have only used parental interpretations of our emotional state.....No one has questioned us....We have no voice'.

There were five responses to the article: two from mothers of donor conceived children, one from a professor of social work, and two from doctors. One of the doctors gave an address in Canada and the other an address in India. The response from Canada commented on the importance of knowing about family medical history and made suggestions for minimising any difficulties caused by a donor conceived 'child' receiving information about the donor. The other doctor commented:

Thrilled to know your feelings as a child of DI. But what I personally feel what is the need of knowing your DI father, because once you come to know your DI father you will be interested in knowing other brother and sisters of your DI father and on and on....So better to stop here. Content yourself with being the son of your present parents.

There were no comments on the article from any other doctors and I never heard it mentioned except by social workers, and by parents and donor conceived people. It is possible to speculate that few doctors would actually read the article due to its length and its obvious message from the beginning. Even the reader in India got the gender of the author wrong, as though the reading had been rushed. Perhaps readers agreed with the comment from India, which followed a noticeable pattern of telling donor conceived people not just what they should be doing, but also of what they should be feeling about their origins and the way that their families had been formed. Some infertility specialists have accused donor-conceived people of being 'selfish' for wanting to find out about their origins.

Acknowledgement by infertility specialists that they do not have sufficient professional knowledge to talk about what is in the best interests of donor conceived people is rare, but was readily admitted by several whom I interviewed, who were senior doctors clearly respected in their profession. They described to me how haphazard had been the development of an anonymous donor insemination service in the past, and how the need for patient confidentiality had been the major concern at that time. One of them told me that he did not have any research evidence about the welfare of donor conceived people and that his knowledge came from meeting with parents when they returned to his clinic requesting donor insemination in the hope of achieving a second pregnancy:

Eh, we don't know, you know, I've never been involved in long term follow up studies of the well-being of these children, nor have I been in a position to com-

pare them with the long term follow up of the well-being of children from any other point of view. My impression's always been that, many of these parents who come back for a second baby seem to be very happy with the way things are going.

Another retired doctor admitted to me that 'there may be problems of which I am unaware', but he had never heard of any. He said that he had relied greatly on informal feedback from the clinic's nursing and administrative staff who would be speaking informally with patients when they returned to visit the clinic. He had managed to obtain resources in the 1980s for a small follow-up study of married couples who had a donor-conceived child, but the results were never published and he believed that the data had been destroyed in order to preserve the anonymity of the couples.

European aspects of DI

Legislation and regulations have had a profound impact on the ways in which DI services have developed in the UK, even if some of the infertility specialists have resisted what they view as interference with their professional expertise and knowledge. However, no medical infertility treatment in any European country can be performed in isolation. Changes to medical and laboratory practices as a result of European Union laws have had an impact in all member states, especially the European Union Tissues and Cells Directives (EUTCD 2004) which, through common safety and quality standards, mandates the traceability of donated body parts and tissues including gametes, and the safe keeping of records. The transnationalism of medical practices and ideologies has been noted by a number of social anthropologists from various field sites. Adriana Petryna describes how the clinical trials industry has grown into a 'largely uncharted field of global experimental activity' (Petryna 2007) and Bob Simpson notes from research in Sri Lanka how western medicine carries its ethical systems with it as it takes over in the spread of new reproductive technology (Simpson 2004).

Conferences and professional journals play a key role in the exchange and dissemination of information and ideas about clinical assessment, diagnosis and treatment in infertility treatment. The annual conference of The European Society of Human Reproduction and Embryology (ESHRE) has attracted over seven thousand participants in each of the last four years from all over Europe, as well as from other continents, and journals such as *Fertility and Sterility*, *Human Fertility* and *Human Reproduction*, have worldwide readership. Guidelines produced by ESHRE cross state borders but, unlike EU directives, take care to avoid being prescriptive. Thus guidelines on gamete donation (Barratt, et al 1998) noted that European countries each may have different experiences and practices but should adhere to minimum standards in order to ensure safety and good practice for pa-

tients and donors. The guidelines contain some statements which are considered mandatory for clinic professionals, but otherwise they respect 'autonomy on ethical aspects' in each country, meaning that the guidelines avoid making recommendations about donor anonymity. They focus on technical procedures such as semen analysis, relying on professionally-accepted scientific evidence and omitting any review of the social implications of donor anonymity.

At an international level, the United Nations Convention on the Rights of the Child (UNCRC) sets out the human rights to which all children are entitled, including non-discrimination and respect for their views. Article 7 (the right to know one's parents) and Article 8 (the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference) have both been used to support the removal of donor anonymity, but the application of these articles to donor conceived children has been contentious. Importantly, whilst arguments have tended to be framed around the right of donor offspring children to access identifying information about gamete donors, the continuing pressure for access to information has come from donor-conceived adults, who have asserted that being denied access to information about their origins is discriminatory and even degrading treatment. However, The Council of Europe has stated that 'It is not possible - at the present moment - to draw decisive arguments from the Convention for the Protection of Human Rights and Fundamental Freedoms either in favour or against the anonymity of donors' (cited in Frith 2007).

A European phenomenon which has gained considerable publicity in recent years is reproductive tourism or, as it is often called, cross-border reproductive care (CBRC), particularly involving Americans, Israelis and western Europeans seeking fertility treatment in 'the 'white' post-Soviet Bloc of Eastern Europe including Russia, Slovenia, Romania and the Czech Republic (Inhorn 2011, Nahman 2008). Often this search is prompted by long waiting lists or prohibited use in the country of origin for donated gametes. However, research in the UK by Culley et al. (2011) has shown that reasons for travelling abroad are complex and include lower costs of treatment and higher success rates abroad, treatment in a less stressful environment, and dissatisfaction with UK treatment. People travelled to 13 different countries, the most popular being Spain and the Czech Republic.

There are considerable financial transactions involved in CBRC which are economically important for the destination countries. Ventruba et al. (2007) note that infertility treatment services involving gamete and embryo donation in countries with liberal laws have become lucrative business and therefore a major ethical issue and asserts that 'Nowadays, describing the situation in Czech Republic, we can speak about an embryo and semen banking "industry"'. Amy Speier describes how 'reproductive travellers' seek infertility treatment in the Czech Republic, most often for IVF treatment with donated eggs (Speier 2012 forthcoming) due to the

short or non-existent waiting lists there and the considerably lower treatment costs in comparison to clinics in the travellers' countries of origin. She notes that this tourism is an important source of revenue for the Czech economy. Egg donors at a particular clinic that Speier studied were mostly university students or young mothers on maternity leave. According to the clinic's webpages, the clinic also provides donor insemination but does not explain how the donors are recruited and what compensation they receive. Donors may be as young as 18 and must have no problems in their family medical history² However, there have been concerns about the vulnerability of young egg donors in the Czech Republic to economic, emotional and physical exploitation, and strong calls for more social science research (Whittaker and Speier 2010: 376). Michal Nahman (2008) asserts on the basis of her research in Romania that women recruited to donate eggs there were not donors but sellers. Anecdotal evidence from infertility counsellors in the UK is that the possibility of inducement of gamete donors tends to be glossed over by UK clinics, leaving patients ignorant about donors' motivations. Unsurprisingly, counsellors have wondered what financial rewards, if any, accrue to the clinics and individual doctors for referring patients for CBRC.

In European countries, semen donor anonymity is associated not only with keeping the fact of DI secret from donor offspring, but also with the active support of state authorities in preventing access to records. This resembles the system of closed adoptions which is still operating in some jurisdictions, notably France, where birth mothers can legally abandon their babies. For post-Soviet societies of Eastern Europe, secrecy has an additional layer, a legacy of the management of information (Verdery 2002) and the operation of state surveillance which relied on secret police collaborators. Writing of the opening up of the files of the Stasi, the Ministry for State Security in the former East Germany, Tyler Marshall describes how the system involved 'ordinary citizens - lawyers, doctors, writers, schoolchildren, friends, neighbours, even spouses' supplying information about people's activities, conversations and diary contents (Marshall 1992). The files were opened up to the public in 1992, 'exposing a web of betrayals' in reports on 'friends, family, colleagues or lovers' (Marsh 2009). These essential secrets of the past have become the frustrations of the present, as individuals seek to discover the truth about the manipulations of their past identities. Secrecy in such situations is not only a matter of privacy, the value much emphasised by UK fertility specialists who support donor anonymity, but also of concealment of past behaviour. In the UK, medical practices in DI have been revealed which perhaps seemed right at the time to those involved, but are not so today: one example being the extensive use of semen donations from just a few donors. However, anecdotal evidence from countries in Eastern Europe suggests that if such practices were publicly known, they

2 <http://www.crmzlin.cz/en/page/1749.sperm-donation/>

might raise fears about unwitting incest having occurred. Better that they should not be revealed, it is suggested, in order to avoid unnecessary distress and anger, and to prevent any threat to continuing public trust in the medical profession. For infertility specialists, such public trust may be at risk if past practices are revealed which call into question the integrity of the profession.

Czech Republic and UK contrasts

I have suggested that arguments in the UK about anonymity in DI are indicative of how some people, especially some infertility specialists, think about family formation. What might the apparent absence of argument in Czech Republic mean? Does the silence signify agreement, or a preoccupation with other matters felt to be more important? As an outsider I can only surmise that it is significant, but that it will need ethnographic research by Czech speakers to discover and analyse what the causes might be. Not surprisingly, there are some significant silences in the UK which also need to be explored. These include the extent of infertility specialists' undeclared conflict of interest because they themselves were semen donors when they were young men, and the financial profits which some specialists, mostly medical practitioners, are said to be making at the expense of people who are unwillingly childless and are seeking infertility treatment.

In his introductory article on postsocialisms, Douglas Rogers suggests that comparison, especially if it is properly situated and contextualised, can work to create new insights, but notes that social anthropologists have had reason to be wary of comparative techniques, especially because they are far from being 'politically neutral' (Rogers 2010:9). In this concluding section I wish simply to draw some preliminary contrasts in the hope of providing further insights.

The clearest obvious distinction between the UK and CR lies in the legislation currently operating in each state. Donor anonymity is compulsory in CR and that extends to the exclusion of using donations of gametes from a person known to the recipient. In the UK, anonymous gamete donation is illegal and donation from donors known to recipients is allowed. The use of known donors transfers control from doctors to patients in the process of donor selection. Known donation between male relatives and friends is much less common than between female relatives and friends, but is preferred by some patients (Speirs 2007c). In both countries, the legislation provides for access to information about the donor for health reasons, although in CR the access is mediated by doctors which can be interpreted as emphasising the donor as a provider of reproductive material and not as a person whose health over the life course might be of great interest to donor offspring.

In countries without regulation of infertility treatment, there is the seldom mentioned concern about the number of donor offspring created from the donations of each donor. Before the regulation of DI, there was no legal limit in the UK to

the number of pregnancies which could be created. This is public knowledge in the UK where there are several large groups of people conceived in the 1940s and 50s from the donations of a few men (Blyth 2012), but even so, revelation of past practices reinforces public concern about unwitting incest between donor offspring and even between donor offspring and their (anonymous) donor. The risk of unwitting incest between two individuals who do not know that they are genetically related through a mutual gamete donor, either because they do not know that they were donor conceived or because they do not know that they share the same donor, has been noted as a concern amongst the public in the UK (Edwards 1999, Edwards 2004). In my own fieldwork, the possibility of unwitting incest when gamete donation is anonymous was always played down by infertility specialists because the statistical possibility of it was considered very remote. However, it was viewed as a public policy issue and potential cause of personal tragedy by individual lay people. In this respect there is a contrast between the policies of the UK and the CR, given that people conceived by donor in the UK can apply to the HFEA for information which would help to identify their donor and any half-siblings.

There may be a point of similarity between the policy makers and infertility specialists of the CR, and those in the UK who argue for donor anonymity, which is that keeping apart people who have no legal connection seems to be a response to the fear of the fluid and non-traditional relationships which non-anonymity might introduce. Anonymity cuts off new relationship possibilities and keeps category relationships tidy, provided that everyone involved keeps up the pretence that the social relationships map on to the genetic ones, and of course that the parents can keep secrets. In reality, social relationships can shift over the lifecourse, are strategically manoeuvred, and as the mother of two donor-conceived young people said to me, can be 'messy'. Social anthropologists know this, but for infertility specialists with no continuing contact with families created by donor conception and also with little knowledge of how increasing numbers of adopted people are searching for their birth relatives, anonymity in donor insemination provides structural security. As Bob Simpson describes in his analysis of vernacularisation in gamete donation services in Sri Lanka, medico-legal constructs of relationality 'arrive pre-packaged with ARTs' (Simpson, forthcoming).

Finally, from the perspective in this article of an insider/outsider, an intriguing difference between the CR and the UK is the amount of public 'noise' about donor anonymity. In the UK there continues to be considerable argument, activism and media publicity. At conferences, in the press and in online newsletters such as BioNews, social workers argue with doctors and lawyers, doctors argue with each other, and support groups for donor conception families publicise leaflets and workshops about how to tell their children of their origins. The media frequently report news items about donor offspring finding half siblings or looking for their donor, and about illegal sperm donor provision, donor recruitment

issues, and reproductive tourism. Above all, there is on-going lobbying by donor conceived adults to have the form of birth certificates amended so that the name of the donor is recorded as well as the name of the legal parents. Whereas the historical development of semen, egg and embryo donation provision in the UK has been punctuated by government enquiries, public consultations, legal changes and consistent media interest, the situation in CR seems to be very quiet. The anthropological interest then is for future exploration into whether this is so, and why.

We can ask equally why the UK is so 'noisy'. Perhaps it is relevant that many people in the UK are curious about their ancestry and, in a land that has been spared civil war and invasion for several centuries, have access to rich sources of historical documents. There is a widespread interest in genealogy in the UK, and the Scottish Government in particular has promoted 'roots tourism'. News stories of reunions between siblings separated in childhood by adoption or other circumstances, such as child migration, are given wide publicity in the media. Genealogical research has been described as the next most popular pastime after gardening in the UK, and indeed searching for relatives and roots was described by a semen donor who I met as 'the new gardening'. His point was made in support of the removal of donor anonymity and as an admonishment to doctors complaining about it. In such a context, information about one's genetic parents can be seen not as a sign of 'genetic essentialism,' but rather as an enriched sociality.

However, I found in many of the professionals working in infertility clinics a belief that the nurturing (social) father of a donor-conceived child must be treated 'as if' he is the biological father because 'you cannot have two fathers'. Sally Sheldon (2005) suggests in her analysis of ART regulation that 'the search must be for the candidate (and for one candidate) who will best fit the role of 'real father'' (2005: 546). I suggest that the belief that there cannot be two fathers signifies the fear not only that two men would be in competition for the one role of 'real father', but also that genes are so strong a basis for connection that they will exert more influence than social connection. Frequently during my research, in written texts and in discussions, I encountered the view that donor conceived children might leave their social father in preference for the donor, the genetic father. The presumed power of genetic fatherhood also led to anxiety about whether to allow DI where the donor and recipient are known personally to each other. For some doctors, this brings the practice of DI into an acceptable kinship frame, but for others it confuses family boundaries: there 'might be' fantasies between donor and recipient, and the genetic father 'might interfere' with the donor-conceived child's upbringing. Thus, the insistence that there is still a need to maintain anonymity is based not on empirical evidence, but on deeply held beliefs about kinship and how it ought to work, on a confidence that parent-child relationships will not be harmed by deceit, and that it is possible and correct to keep secrets from children even into adulthood if that serves to protect the parents' status as infertile from being revealed.

In conclusion, I suggest that Jeanette Edwards' research into how lay people approach the question of connections in donor-assisted conception elegantly suggests a framework for the further exploration of views on donor anonymity. Edwards' informants in Alltown in the north of England 'drew on their own experiences of family relationships and on their cultural understanding of the reproduction of persons' when discussing sperm donation (Edwards 1998:168). How we as social anthropologists understand how infertility specialists conceptualise anonymity is related to their understandings of 'identity and belonging, the reproduction of class and gender, and the maintenance and creation of social relationships' (ibid). Beliefs about anonymity and secrecy in donor insemination reveal what people think about connectedness and relatedness in general.

REFERENCES

- Barratt, C., Englert, Y., Gottlieb, C., and P. Jouannet, 1998. Gamete donation guidelines. The Corsendonk consensus document for the European Union. *Human Reproduction*, 13 (2), pp. 500-501.
- Barton, M., Walker, K. and B. Wiesner, 1945. Artificial Insemination. *British Medical Journal*, 1, pp. 40-43.
- Blyth, E., 2009. Access to genetic and biographical history in donor conception: an analysis of provisions permitting disclosure of donor identity. *Human Reproduction*, 24 (S1). 150.
- Blyth, E., 2012. Discovering the "facts of life" following anonymous donor insemination. *International Journal of Law, Policy and the Family*, 26 (2), pp. 143-161.
- Blyth, E., and L. Frith, 2009. Donor-conceived people's access to genetic and biographical history: an analysis of provisions in different jurisdictions permitting disclosure of donor identity. *International Journal of Law, Policy and the Family*, 23 (2), pp. 174-191.
- Bonaccorso, M. M. E., 2004. Programmes of Gamete Donation: Strategies in (Private) Clinics of Assisted Conception'. In M. Unnithan-Kumar, ed. 2004. *Reproductive Agency, Medicine and the State*, New York and Oxford: Berghahn Books, pp. 83-101.
- Bošković, A. ed., 2008. *Other peoples' anthropologies*. Berghahn Books: New York and Oxford.
- British Medical Journal, 1973. *Report of Panel on Human Artificial Insemination*. Supplement, 7th April, pp. 3-5, Annual Report of Council Appendices: Appendix V.
- British Medical Journal, 1990a. June 2: 300 (6737), pp.1410-1412.
- British Medical Journal, 1990b. June 30: 300 (6741), pp. 1721.
- British Medical Journal, 2002. How it feels to be a child of donor insemination, 324 (7340), p. 797.
- Church of England, 1948. Artificial human insemination. *The Report of a Commission appointed by His Grace the Archbishop of Canterbury*. London: Society for the Propagation of Christian Knowledge.

- Culley, L., Hudson, N., Rapport, F., Blyth, E., Norton, W. and A. A. Pacey, 2011. Crossing borders for fertility treatment: motivations, destinations and outcomes of UK fertility travellers. *Human Reproduction*, 26 (9), pp. 2373-2381.
- Cusine, D. J., 1995. *New Reproductive Technologies: a legal perspective*. Aldershot: Gower Publishing Company Limited.
- Daniels, K. and O. Lalos, 1995. The Swedish Insemination Act and the availability of donors. *Human Reproduction*, 10 (7), pp. 1871-1874.
- Department of Health, 2003. *Donor information: providing information about gamete or embryo donors: Responses to consultation*. Available at: www.dh.gov.uk/en/Consultations/ResponsesToConsultations/DH_4071838. [Accessed 4 June 2013.]
- Department of Health, 2004. *Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004*, Statutory Instrument 2004, No. 1511. London: HMSO.
- Department of Health and Social Security, 1984. *Report of the Committee of Inquiry into Human Fertilization and Embryology ('Warnock Report')*, Cmnd 9314. London: HMSO.
- Edwards, J., 1999. Explicit Connections: Ethnographic Enquiry in North-West England. In J. Edwards, S. Franklin, E. Hirsch, F. Price and M. Strathern, eds., 1999. *Technologies of Procreation: Kinship in the Age of Assisted Conception*, London: Routledge, pp. 60-85.
- Edwards, J., 2004. Incorporating Incest: Gamete, Body and Relation in Assisted Conception. *JRAI*, 10 (4), pp. 755-774.
- EUTCD, 2004. European Union Tissues and Cells Directives. Available at www.hfea.gov.uk/2072.html [Accessed 9 May 2012.]
- Feversham Report, 1960. *Report of the Departmental Committee on Human Artificial Insemination*. London: Her Majesty's Stationery Office.
- Franklin, S., 1997. *Embodied Progress: a cultural account of assisted conception*. London and New York: Routledge.
- Frith, L., 2007. Gamete Donation, Identity, and the Offspring's Right to Know. *Virtual Mentor*, 9 (9), pp. 644-648.
- Goldberg, H., 2010. The man in the sperm: kinship and fatherhood in light of male infertility in Israel. In D. Birenbaum-Carmeli, ed., 2010. *Kin, gene, community: reproductive technologies among Jewish Israelis*. Oxford: Berghahn Books.
- Inhorn, M., 2004. Middle Eastern Masculinities in the Age of New Reproductive Technologies: Male Infertility and Stigma in Egypt and Lebanon. *Medical Anthropology Quarterly*, 18 (2), pp. 162-182.
- Jackson, A., 1987. Reflections on ethnography at home and the ASA. In A. Jackson, ed., 1987. *Anthropology at Home*. London: Tavistock Publications, pp. 1-15.
- Kahn, S., 2000. *Reproducing Jews: A Cultural Account of Assisted Conception in Israel*. Durham and London: Duke University Press.
- Konrad, M., 2005. *Nameless Relations: Anonymity, Melanesia and Reproductive Gift Exchange between British Ova Donors and Recipients*. Oxford: Berghahn Books.
- Kürti, L. and P. Skalník, eds., 2009. *Postsocialist Europe: Anthropological Perspectives from Home*, New York and Oxford: Berghahn Books.
- Lasker, J. N., 1998. The users of donor insemination. In K. Daniels and E. Haimes, eds., 1998. *Donor Insemination: International Social Science Perspectives*. Cambridge: Cambridge University Press, pp. 7-32.
- Marcus, G., 1995. Ethnography in / of the World System: the Emergence of Multi-sited Ethnography. *Annual Review of Anthropology*, 24, pp. 95-117.
- Marsh, S., 2009. Stasis files still cast shadows, 20 years after Berlin Wall fell' October 29, 2009, Thomson Reuters. Available at www.reuters.com/assets/print?aid=USTRE59S17-520091029. [Accessed 9 March 2012.]
- Marshall, T., 1992. Regional Outlook: Secret Files Haunting Eastern Europe. *Los Angeles Times*, January 21, 1992. Available at http://articles.latimes.com/print/1992-01-21/news/wr-592_1_Secret-Files-Haunting-Eastern-Europe. [Accessed 9 March 2012.]
- Nahman, M., 2008. Nodes of desire: Romanian Egg Sellers, 'Dignity' and Feminist Alliances in Transnational Ova Exchanges. *European Journal of Women's Studies*, 15 (2), pp. 65-82.
- Petryna, A., 2007. Clinical Trials Offshored: On Private Sector Science and Public Health. *BioSocieties*, 2 (1), pp. 21-40.
- Rapp, R., 2000. *Testing Women, Testing the Fetus: the Social Impact of Amniocentesis in America*. New York and London: Routledge.
- Sheldon, S., 2005. Fragmenting Fatherhood: the Regulation of Reproductive Technologies. *Modern Law Review*, 68 (4), pp. 523-553.
- Simpson, B., 2004. Localising a Brave New World. In M. Unnithan-Kumar, ed., 2004. *Reproductive Agency, Medicine and the State*. New York, Oxford: Berghahn Books, pp. 43-57.
- Simpson, R., 2013. Managing potential in gamete and embryo donation: Reflections on gifts, kinship and the process of vernacularisation. Pre-print version available on-line at www.jstor.org/page/journal/curranth/forthcoming.html.
- Speier, A., 2012. Reproductive Tourism: Health Care Crisis Reifies Globalized Stratified Reproduction. In S. M. Lyon and E. C. Wells, eds., 2012. *Global Tourism: Cultural Heritage and Economic Encounters*. New York: Alta Mira Press Society for Economic Anthropology, pp. 209-226.
- Speirs, J. M., 2007a. Secretly connected? Anonymous semen donation, genetics and meanings of kinship. PhD. thesis, unpublished manuscript. Edinburgh: University of Edinburgh. Available at: www.era.lib.ed.ac.uk/handle/1842/2649. [Accessed 2 June 2012.]
- Speirs, J. M., 2007b. Keeping secrets: ethical and practical problems in fieldwork at home. In R. Lorencová and J. Speirs, eds. 2007. *Reflection of Man*. Praha: FHS UK.
- Speirs, J. M. 2007c. Personal semen donors: Report of a survey of UK clinics' provision of donor-assisted conception treatment to patients using own known donors. Available at <http://aquarius.futurewebsitespace.co.uk/ngdt.co.uk/downloads/Use%20of%20known%20sperm%20donors.pdf>. [Accessed 2 June 2012.]
- Speirs, J. M., 2011. Performing secrecy: Maintaining the hidden identity of research informants in public. In L. Jamieson, R. Simpson and R. Lewis, eds., 2011. *Researching Families and Relationships: Reflections on Process*. Basingstoke: Palgrave Macmillan, pp. 87-89.
- United Nations Convention on the Rights of the Child, 1989. Available at: www.unicef.org/crc. [Accessed 2 June 2012.]

- Ventruba, P., Zakova, J., Pacik D., Crha I., Lousova E. and M. Huser, 2008. Gamete and embryo donation program in assisted reproduction. *European Andrology*, 2 (1), p. 29.
- Verdery, K., 2002. Anthropology of Socialist Societies. In N. Smelser and P. B. Baltes, eds., 2002. *International Encyclopedia of the Social and Behavioral Sciences*. Amsterdam: Pergamon Press.
- Whittaker, A, and A. Speier, 2010. "Cycling Overseas": Care, Commodification, and Stratification in Cross-Border Reproductive Travel. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 29 (4), pp. 363-383.

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Reconsidering the Distinction between Western and Post-socialist Biological Citizenship: Reflections on Developments in Reproductive Medicine in Serbia

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Abstract: This paper analyzes the distinction between Western and post-socialist biological citizenship, formulated by Rose and Novas in terms of “active” versus “passive” biological citizenship projects, in order to propose a refinement of the conceptualization of biological citizenship as a global assemblage. In a global assemblage, global and local elements interact and global forms get transformed in ways that are not reducible to preconceived notions and internal social dynamics. However, Rose and Novas draw a clear-cut distinction between Western and post-socialist biological citizenship that can preclude the investigation of their global and assembled character. Discussion in this paper of recent developments in reproductive biological citizenship in post-socialist Serbia serves to demonstrate the insufficiency of a dichotomous conceptualization of biological citizenship. Civic initiative that challenges the medical management of childbirth, online support groups of women undergoing in-vitro fertilization, and the online reporting of corruption in reproductive medical services are analyzed. Through citizens’ online communication, specific transformations of global forms are examined in interaction with other elements of the Serbian post-socialist context, and in the relations between citizens, the state and reproductive medicine. The paper suggests that the deconstruction of dichotomous notions, together with ethnographic research of emergent forms of biological citizenship, promises further improvements in comparative conceptual frameworks in medical anthropology.

Keywords: western and post-socialist biological citizenship, biosocialities, reproductive medicine, post-socialism

Introduction

Anthropology approaches citizenship not only as political status, as a matter of belonging in a political community, with attendant rights and obligations, but as a practice and process interwoven with many areas of social life.¹ The concept of

¹ I am grateful to reviewers for their helpful suggestions for improving this paper.

biological citizenship draws attention to various practices in which conceptions about biological existence, health and illness interact with political membership and classifications. It is increasingly used in anthropological research, along with similar concepts such as therapeutic citizenship, genetic citizenship, and biosocialities (Casper and Currah 2011; Gibbon and Novas 2008). Enumerating and sorting out phenomena encompassed by the concept of biological citizenship is a work in progress. This concept is still being filled with content, as new developments emerge in the context of global transformations, post-socialist transitions, and biotechnological developments. However, for engaging in research of biologically based socialities today, together with new empirical work we need “a broader range of concepts and more refinement in the ones we already have in our inventory” (Rabinow 2008: 192). As Rabinow (2008) and Whyte (2009) both state, new conceptual distinctions are likely to emerge through ethnographic work, undertaken together with reflexive and critical conceptual work. Since medical anthropology in post-socialist countries is an emerging field of research, its results are expected to have more to contribute to the comparative theorization of biological citizenship. In this paper, I engage in reflection on developments in post-socialist Serbia, as well as in conceptual clarifications aiming to contribute to a refinement of conceptualizations of biological citizenship.

In the contemporary globalized world, projects of biological citizenship are situated at intersections of the global and local, and it is important to understand what they have in common with developments elsewhere, and how they unfold under different constellations of political, economic, and cultural conditions. Post-socialist societies provide a promising field for comparative research of forms of biological citizenship. Post-socialist reforms in different societies do not seem to follow any unified and predetermined path (see: Buyandelgeriyn 2008), and they continue to present us with uncertain and unexpected outcomes. This demands new conceptualizations, which should be able to account for changing and complex interrelations of phenomena that owe their existence to multiple determinations, such as: internal social dynamics, historical and cultural legacies, citizens’ demands, international pressures, awareness about Western developments, and globally influential dynamics and forms. Post-socialist projects of biological citizenship emerge under the global influence of neoliberalism, information technology, and biotechnology which enter into “global assemblages” (Collier and Ong 2005), interacting with local conditions.

Recent reproductive biological citizenship projects in Serbia that are broadly outlined in this paper provide reflections to address the insufficiency of dichotomous conceptualizations of biological citizenship. I discuss emerging developments and conditions of biological citizenship in Serbia: civic activism demanding changes in the medical management of childbirth in Serbia, in-vitro fertilization online support groups, and the online reporting of corruptive behaviours in medi-

cal institutions. I focus mainly on data from the online communication of Serbian citizens who are involved in constructing these biological citizenship projects and debating their conditions. Initiative demanding changes in the medical management of childbirth, as an example of identity politics, and online support groups for women undergoing IVF, as a form of biosociality, are discussed in order to provide reflections on the insufficiency of the distinction that Nikolas Rose and Carlos Novas (2005) draw between Western and post-socialist biological citizenship. I analyze how these forms of socialities are assembled in the interaction of global and local elements, in order to suggest that a conceptualization of biological citizenship as a global assemblage allows for a more useful approach to its different territorializations.

Biological citizenship as a global assemblage

Foucault has shown that, since the 18th and over the course of the 19th century, the historical relationship between sovereign power and the populations and individuals it governs has shifted towards biopower, which is exercised by taking hold over life and which regulates its subjects through their biological properties – insofar as they are living beings (Foucault 2003: 239). Within this shift, biomedicine has gained importance and authority in governing populations, defined through their vital characteristics, upon which the state could intervene. Extending on Foucault’s theory of biopower, new conceptualizations have been formulated in recent years, concerning the emerging relationships between the state and citizens’ biology. Paul Rabinow (1992) proposed the term “biosocialities” originally in 1992, in relation to new knowledge of the human genome and new biotechnological procedures, to point to the “formation of new group and individual identities and practices arising out of these new truths” (Rabinow 1996: 102). More recently, Adriana Petryna (2002) has formulated an ethnographically based account of biopower and biological citizenship in post-socialist Ukraine. Rose and Novas write in the often cited formulation that I focus on in this paper that they use the term biological citizenship “descriptively, to encompass all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species” (Rose and Novas 2005: 440). Their conceptualization of biological citizenship is meant to serve as a general framework for analyzing how “specific biological presuppositions [have] shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome, and impossible citizens” (Rose and Novas 2005: 440).

There are two directions in which biological citizens are constituted, according to Rose and Novas. The direction from above refers to the ways the state authorities and medical services frame their understanding of “what it means to be a citi-

izen” (Rose and Novas 2005: 440), and act upon citizens according to biologically based distinctions. The direction from below refers to the ways in which citizens associate with fellow citizens, and distinguish “themselves from others, noncitizens, partly in biological terms” (Rose and Novas 2005: 441). Associating from below makes it possible to formulate demands directed to state authorities, whether for “particular protections, for the enactment or cessation of particular policies or actions, or [for] access to special resources” (Rose and Novas 2005: 441). It also brings into existence plural perspectives on biology that can challenge medical doctrines. Citizenship projects from below encompass not only what Rabinow calls biosociality, but also health identity politics in which citizens can claim rights, rather than being “mere beneficiaries, clients, or customers” (Whyte 2009: 9).

In many citizenship projects, biosocial subjectivity and identity politics are interrelated. Subjectivities and identities based on biology can be variously positioned in relation to state-supported and medical discourses, and they variously interact with existing identity categories. Within the biopower approach, “the workings of discourse and technology in the shaping of subjectivity and new kinds of social relations” (Whyte 2009: 9) are problematized. As Whyte explains, the analysis of subjectivities is concerned with people’s conceptions of self in relation to medical diagnoses, health conditions, and biotechnological procedures. Identity, on the other hand, is about “similarity and difference between selves and others” (Whyte 2009: 7). Identity politics reevaluates these differences in a struggle for recognition and rights. However, there can be a close relation between biosocial subjectivities and identity politics, “an overlap between movements making claims for justice from the larger society and support groups for people sharing a common problem” (Whyte 2009: 8). Identity politics, moreover, needs “to alter both the self-concepts and societal conceptions of their participants” (Anspach 1979, cited in Whyte 2009: 7).

Rose and Novas write that, like other dimensions of citizenship, biological citizenship is mutating within the dynamics of globalization: it gets de-territorialized, while at the same time it is “undergoing transformation and re-territorializing itself along national, local, and transnational dimensions” (Rose and Novas 2005: 440). The concept of “global assemblage” provides a useful way of thinking about different territorializations of biological citizenship in which anthropological problems are articulated and phenomena are re/formed. It is elaborated by Collier and Ong (2005) in their text in the collection they edited, in which Rose and Novas’ article is also published. Although Rose and Novas’ statements about mutations and about the de- and re-territorialisation of biological citizenship reveal that they conceptualize it as a global assemblage, they then go on to draw a clear-cut distinction between Western and post-socialist biological citizenship projects which undermines the possibility of the analysis of the global and assembled character of these projects. I want to suggest that the framework of global as-

semblages allows for a more useful conceptualization of different territorializations of biological citizenship.

Collier and Ong use the concept of assemblage, originating in the work of Deleuze and Guattari (1987), to point to the way in which anthropological problems and phenomena can be conceptualized today as unities of elements that are “heterogeneous, contingent, unstable, partial, and situated” (Collier and Ong 2005: 12). Their temporality is emergent and they are products of multiple determinations (Collier and Ong 2005: 12). What gives them global quality is that they are not reducible to internal social or cultural determinations, and their origin and significance are global. This is what they owe to “global forms” (Collier and Ong 2005: 11), which are capable to move between contexts, due to their capacity to be de-contextualized and recontextualized. Drawing on Giddens and Weber, Collier and Ong write:

“Global forms are able to assimilate themselves to new environments, to code heterogeneous contexts and objects in terms that are amenable to control and valuation. At the same time, the conditions of possibility of this movement are complex. Global forms are limited or delimited by specific technical infrastructures, administrative apparatuses, or value regimes, not by the vagaries of a social or cultural field” (Collier and Ong 2005: 11).

The authors point to the following examples of global forms: neoliberalism, as “a pervasive form of political rationality whose formal and ‘global’ character allows it to enter into novel relationships with diverse value orientations and political positions” (Collier and Ong 2005: 17); technoscience, “whether material technology or specialized social expertise” (Collier and Ong 2005: 11); and “forms of politics and ethics structured around collectivities to the extent that they are not defined culturally (...) or socially...” (Collier and Ong 2005: 11). In the last sense, the editors consider biological citizenship as conceptualized by Rose and Novas to be “global”.

Global assemblage is a composite concept which suggests, according to Collier and Ong, “inherent tensions: global implies broadly encompassing, seamless, and mobile; assemblage implies heterogeneous, contingent, unstable, partial, and situated” (Collier and Ong 2005: 12). However, global elements are not left untransformed when they enter into assemblages of biological citizenship, when they are territorialized within a specific constellation of conditions and as they interact with other elements of these conditions. Although biological citizenship is a widely encompassing and global notion for Rose and Novas, drawing a clear-cut distinction between the West and post-socialism eventually confines their interpretation of forms of biological citizenship to preconceived internal social and cultural dynamics and determinations, in which the role of the global, as well as the specific interactions of elements in its assemblages, remains unclear. This dichotomous

conceptualization does not provide an adequate framework for an understanding of the specificities of emergent forms of biological citizenship (such as the ones I discuss in this paper), and of the role of global forms (such as neoliberalism and biotechnologies) in its dynamic and complex mutations. In drawing clear-cut distinctions, there is a certain risk that notions of “Western” and “non-Western” could become dichotomized and internally homogenized, and figured as the main determinants of current varieties of biological citizenship, instead of being examined in terms of their emergence and construction by biological citizens and social scientists.

Western and post-socialist biological citizenship

The distinction between Western and post-socialist developments is made by Rose and Novas (Rose and Novas 2005) in terms of “active” versus “passive” biological citizenship projects, assembling two sets of characteristic elements and conditions. The authors focus primarily on documenting current and emerging forms of biological citizenship in the West, and on its biosocialities, which are exemplified in patient support groups and characterized as active. They use Adriana Petryna’s (2002) ethnographic account of biological citizenship in post-socialist Ukraine as an example of a passive variety of biological citizenship and contrast it to what they consider characteristically Western developments.

Rose and Novas recognize a normative element in the Western variety of biological citizenship which presupposes a self-managing and prudent personhood that conforms to a norm of individual “activism and responsibility” (Rose and Novas 2005: 451) in relation to one’s health and biological make-up. What the term “active” in their conception primarily refers to is a specific relationship of citizens to themselves. Although the term “neoliberal” is not mentioned in their article, the kind of active citizens’ relationship with medicine and with themselves that the authors see as characteristic of Western developments can be better understood by turning to two of Rose’s other works that deal with neoliberal subjectivity (Rose 1996) and with mutations in the pastoral power of medical and other experts (Rose 2007).

Rose relies on Foucault, who examined how neoliberals in the 20th century have modelled “the overall exercise of political power ... on the principles of a market economy” (Foucault 2008: 131), and extended economic analysis to the “interpretation of a whole domain previously thought to be non-economic” (Foucault 2008: 219). Within neoliberal governmentality, there is no longer a relationship of individuals and communities to the state and society as a whole which would be unmediated by the market. Neoliberalism relies on a new version of *homo oeconomicus*, who is conceived as “an entrepreneur of himself” (Foucault 2008: 226). In Rose’s analysis of neoliberal governmentality, subjects are conceived “as individu-

als who are to be active in their own government” (Rose 1996: 330). In contrast to the social government of welfare states, “advanced liberal” (Rose 1996: 335) societies govern their citizens through “the activation of individual commitments, energies and choices, through personal morality within a community setting” (Rose 1996: 335).

Rose writes that welfare states were criticized because of the powers and “the discretionary scope that [they] accorded to professionals and bureaucrats” (Rose 1996: 330). In his book on new biological subjectivities (Rose 2007), he analyzes the mutations of the pastoral power of medical and other experts in governing contemporary biological citizens. The pastoral power of medical experts to guide and counsel citizens in managing their health no longer functions by making decisions in the name of citizens, it is not administered by the state and it is no longer concerned “with the flock as a whole” (Rose 2007: 73). It is becoming a plural, contested, and relational field, in which a variety of agencies (medical experts, bioethicists, biotechnological and pharmacological companies, scientists and citizen initiatives) offer guidance according to which citizens can manage themselves as somatic and genetic individuals. This type of relationship with medical authority is described by Rose and Novas as different from that of the past, when medicine encouraged “passive and compliant patienthood” (Rose and Novas 2005: 448). Citizens are now expected to be active participants in their recovery and to make choices in the management of their biology.

Neoliberal subjects who are governed through their self-government and community, and who actively negotiate the recommendations of medical and other experts, correspond precisely to active biological citizens in Western biosocialities described by Rose and Novas. When taking individual responsibility for one’s health becomes a norm, those who fail to be responsible become “new types of problematic persons” (Rose and Novas 2005: 451). Active biological citizens are required to gain expertise about their somatic conditions and their genetic susceptibilities independently of medical authority, but not necessarily in opposition to it. Nevertheless, individuals may still be required to manage their health risks in compliance with medical doctrines in order to be regarded as fully unproblematic (see: Petersen 1996).

Rose and Novas contrast their description of biological citizenship in the West to Petryna’s (2002) account of post-socialist biological citizenship:

“Biological citizenship in the Ukraine is not a matter of contesting the power of medical expertise, nor of sculpting an autonomous life in which collectively shaped self-understandings are a pathway to self-fulfilment: it takes the form of demanding redress from the state for certain ills, in the form of benefits, and activism is oriented toward demanding medical recognition for a condition and obtaining expert judgment as a credential to obtain state benefit” (Rose and Novas 2005: 451).

In the excerpt below, the authors draw a more general distinction between Western and post-socialist biological citizenship:

“In Western nations – Europe, Australia and the United States – this is not taking the form of fatalism and passivity, and nor are we seeing a revival of genetic or biological determinism. Whilst in the residual social states in the post-Soviet era, biological citizenship may focus on the demand for financial support from state authorities, in the West novel practices of biological choice are taking place within a “regime of the self” as a prudent yet enterprising individual, actively shaping his or her life course through acts of choice” (Rose and Novas 2005: 458).

In these passages, demanding benefits from the state in the context of state and medical paternalism is seen as the most central characteristic of passive biological citizenship. In contrast, obtaining state benefits is not a central concern for active biological citizens who relate to the state as entrepreneurial individuals. Petryna's analysis of biological citizenship in post-socialist Ukraine, used to exemplify passive biological citizenship, however, is far more nuanced than this interpretation suggests. Petryna writes that the Ukrainian state “perpetuates its paternalistic role as the giver and taker of social resources and as life insurer” (Petryna, 2002: 118) by extending disability status and state benefits to a great number of citizens after the Chernobyl catastrophe. The state proposed, in cooperation with medical experts and scientists, definitions of symptoms of radiation-caused diseases which could qualify citizens for benefits. Nevertheless, the activity of citizens from below was present in Ukraine. Although she reports that Ukrainians interpreted their inability to work and their adoption of the sick role as “passivity”, Petryna does not use the term “passive” to describe the behaviour and attitudes of citizens who strived to be assigned disability status. She describes how Ukrainians negotiated their health conditions with doctors, engaged in networking and information-sharing and acquired expertise about symptoms and medical conditions that would assure them state benefits. They were “working the system”, and finding corruptive ways to obtain diagnoses and state benefits. She also writes about the activity of non-governmental organizations which advocated the rights of disability status claimers and assisted them in navigating the system, and about some instances of entrepreneurship.

Petryna is aware that the overall economic climate and neoliberal policies, resulting in a stark decline in employment opportunities and in the simultaneous dismantling of social services, form the context in which the Ukrainian state perpetuates its paternalistic role. This is both a legacy from socialist times, and a result of governmental attempts to gain democratic legitimacy and provide some social security for its citizens in the aftermath of the Chernobyl nuclear disaster. The Ukrainian state has resorted to paternalistic measures in relation to large

parts of the population that were provided benefits, made under the claim of biological suffering. When considering post-socialist paternalism, the specific range of choices that are available to citizens should be taken into account. Insofar as the range of choices is limited, the market relations that neoliberal subjectivity relies on seem to be absent. However, the overall economic conditions in post-socialism result in increased social insecurity; they individualize responsibility and make inclusion in society uncertain. Biological citizens in Ukraine negotiated their social inclusion predominantly in terms of state-defined patienthood. Still, there was a space of individual initiative that mediated access to paternalistic forms of social security and that was not regulated according to formal rules, but rather relied on individual social skills and corruptive ties.

Anthropological research has shown how the “market economy in non-Western contexts operates much more on the basis of the rules of local cultures, kinship, and community rather than the rules in force in Western contexts” (Buyandelgeriyin 2008: 245). This is not to suggest that post-socialist societies are simply defined by their lack of formal organization and by social traditions that limit their progression towards Western models. Rather, there is no ideal form of market relations which is not mediated by, and formed in interaction with, local conditions, histories, and modes of government: thus its specific forms should be investigated empirically. Neoliberal governmentality interacts with other elements in assemblages of biological citizenship in post-socialist contexts, as well as in the West. In post-socialism, it can be recognized in the individualization of responsibility for managing citizens' biological existence, insofar as individuals are expected to rely on their own resources (including social connections) in gaining access to forms of social security. The individualization of responsibility poses a problem of unequal resources for both Western and post-socialist neoliberal subjects. Rose acknowledges that there is a difference between “the affiliated and the marginalized” (Rose 1996: 340) in neoliberal societies, where the affiliated are those who are “considered ‘included’: the individuals and families who have the financial, educational and moral means to ‘pass’ in their role as active citizens in responsible communities” (Rose 1996: 340). Neoliberal reforms result in the withdrawal of social responsibility for citizens' health and while paternalistic measures seek to reduce insecurity, they also themselves produce new form of inequality between those who manage to be included, and who gain access to social resources, and those who do not.

Rose and Novas do not engage with mutations of neoliberal governmentality, or with the role of other global elements (such as communication technologies and biotechnologies) in assemblages of post-socialist biological citizenship. Their clear-cut distinction between Western and post-socialist biological citizenship does not indicate how exchange and mutual influences might be possible between them, and how the global character of biological citizenship might be conceived. According to them, active biological citizenship emerges as a result

of several developments: the Western history “of medical activism by those who refuse the status of mere ‘patients’” (Rose and Novas 2005: 442); specifically Western “conceptions of citizenship and personhood” (Rose and Novas 2005: 451); and the availability of communication on the Internet (which is not itself a crucial factor). They write that forms of biosociality, exemplified by patient support groups in the West, still have “no visible presence in whole geographic regions” (Rose and Novas 2005: 451), but it is unclear if they consider that similar forms of biological citizenship could emerge in regions where these developments were absent and to what extent communication on the Internet could contribute to the emergence of new forms of biosocialities in non-Western contexts. They rightly point to the global reach of the human rights discourses of international organizations for health promotion which can be used in identity politics in non-Western contexts. We should also consider the global presence, through international health promotion, of norms of personhood which demand taking active responsibility for one’s health and which might be used to render problematic those who lack the material and cultural resources to act responsibly (see: Macleod 2009; Elbe 2005). I will refer to these globally present forms and discourses in the following discussion of Serbian developments.

Developments in Serbian reproductive biological citizenship

Recent developments in reproductive biological citizenship in post-socialist Serbia emerge in the complex and dynamic environment of turbulent and uncertain post-socialist times. I argue that it is not possible to interpret them as an example of what Rose and Novas characterize as post-socialist, passive, biological citizenship. I do not wish to suggest that in Serbia we are witnessing an evolution towards what these authors describe as Western, active, biological citizenship either. What is interpreted as the Western or post-socialist character of assemblages of biological citizenship projects does not pre-exist their emergence and construction. Instead of framing these developments in dichotomous terms, we should closely examine their global and assembled character, and the specific ways in which citizenship mutates and global forms get transformed.

I will first examine two biological citizenship projects: civic activism demanding changes in the medical management of childbirth in Serbia and in-vitro fertilization support groups. The discourses of women demanding changes in the medical management of childbirth and women undergoing in-vitro fertilization demonstrate different ways in which identity and sociality are formed around shared biological conditions of reproduction. I will also discuss online reports of corruption in reproductive medical services in order to point to the social conditions of reproductive medicine and to the citizens’ subjectivities formed in Serbia in the relations between reproduction, medicine and the state.

Access to the Internet is considered by Rose and Novas as an enabling factor for active biological citizenship. Their focus on the activity of online patient support groups, exemplifying today’s Western biosocialities, is criticized because it makes the discussion of biological citizenship “programmatic and decontextualized” (Whyte 2009: 11) and ignores social differences between people and their lifeworlds. Rose and Novas recognize that there are inequalities in Internet access. At the same time, they assume that the ability to share stories and communicate about one’s biological conditions is a defining feature of active biological citizenship, which makes it attainable only to those who have access to communication, together with media and scientific literacy. Both identity politics and biosocialities depend on subjects who engage in public story-telling and public debates around biological conditions. Human rights discourses, mentioned by Rose and Novas, and norms of personhood originating in Western developments that have gained global influence, can also contribute to the proliferation of stories about biological conditions in non-Western contexts.

Although developments in Serbian reproductive biological citizenship are not confined to their presence on the Internet, online communication plays a crucial role in their emergence and facilitates public story-telling around reproduction. Internet communication is widely, although unevenly, adopted in Serbia, mostly by a relatively educated and affluent urban population. I base my discussion on Internet sources and online discourses with awareness that they only partially represent citizen’s experiences in Serbia. Nevertheless, online communication in which community-making is visible provides an opportunity to investigate collectively created discourses. It is an important source of information for medical anthropology, since health information and advice proliferate on the Internet, where citizens share their stories about health and illness and form networks (Hardey, 2002). Access to other sources of information about medicine is limited in Serbia, both for citizens and social scientists. Knowledge about treatment options and actual medical practice is traditionally considered as an object of institutional discretion, reflecting the professional power and lack of accountability of medical doctors. Furthermore, due to increasing number of public accusations for medical mistreatment and for widespread corruption, doctors have become suspicious toward social scientists who wish to conduct observation in state-owned reproductive medical services.

Complaints about medical mistreatment, as well as reports about widespread corruption, are present on an almost daily basis in Serbian media. Citizens discuss their experiences regarding medical mistreatment and corruption on the Internet. In the context of corrupt and inefficient medical services, and the state’s reluctance to implement ethical regulations and reforms in reproductive medicine, protection from medical mistreatment is not guaranteed and the legal prosecution of doctors is rarely achieved in Serbia. Citizens address their demands for regulation

and reform of medical services to government officials, due to continuing domination of state ownership of medical services. In their online communication citizens may rely on conceptions of self and discourses which originated in the West and have become globally influential, however, I consider that they use and transform them to construct stories according to their specific positioning in relation to medicine and the state in Serbian context.

A civic initiative for changing medical management of childbirth

“Mother Courage” is a civic initiative of women that challenges medical management of childbirth in Serbian state hospitals. It is an example of identity politics in which women demand rights and recognition from society. Rose and Novas write about a Western tradition of health identity politics as a precondition for active biological citizenship. I consider this example of identity politics in Serbia not as a repetition or imitation of Western developments, but as a project that is assembled by a number of conditions, and specifically positioned in relation to global and local discourses.

This civic initiative first emerged on the Internet in the fall of 2008. It started when one blogger, Ms. Stamenkovic, who later lead the initiative, published her story about giving birth to her son in a state-owned maternity hospital in the capital of Serbia in 2002. Following her invitation, other women began to contribute stories about their own experiences of giving birth, and consequently a civic initiative was formed that is still active today. The demands of the initiative were formulated at the beginning by Ms. Stamenkovic, who addressed them to Serbian Minister of health, and they included: the eradication of corruption in maternity services; an improvement in the communication of doctors and nurses with women who give birth; and changing what she saw as inefficient and harmful medical procedures in childbirth.

Women were invited to contribute their stories to a separate web-site established for the initiative and within months several hundred stories had been received and published anonymously.² The stories of women from Serbia were predominantly about the horrible situations and inhumane treatment they had experienced in hospitals, while Serbian women who live abroad told about their satisfaction with giving birth in “developed” countries. Women’s stories served to provide evidence of the problems summarized in the demands of the initiative, to

share information about conditions and medical practice in state hospitals, and as a platform for constructing a shared identity of women based on the experience of giving birth in state-owned maternity wards. However, this initiative remained widely inclusive, and was able to form alliances with other organizations of civic society, organizations of parents, other patient initiatives, some state officials, and with doctors who support reform of the medical management of childbirth and who organize against corruption.

Public narratives about giving birth have never before proliferated in Serbian media. “Mother Courage” relies on women’s stories of their experience as evidence of medical mistreatment and as an authorization of women’s demands. Making women’s experiences public resists a cultural script in which women are advised “to forget” (Kline 2010: 129) the experience of childbirth (presumably because it is traumatic) and which precludes identity politics. The use of women’s stories can be seen as a global technique for identity construction and making claims for recognition and rights, originating in Western developments and embedding the notion of citizenship as a practice of making previously private experiences public. However, Serbian women’s public sharing of stories emerged in a specific context, as a practice that could enable them to make demands, and not as a mere aspiration to conform to Western notions of citizenship.

Awareness of standard practices in Western countries has played a role in women’s dissatisfaction with treatment in Serbia, which has not improved since socialist times. When the “Mother Courage” web-site was started, it stated on its home page that what motivates the publishing of women’s stories is that they are strikingly similar to the “horror” stories that some women tell about their experiences of childbirth in Serbia from thirty years ago. However, while the initiative uses references to Western practices and international standards, it constructs them according to its own vision about desirable course of reforms in the country. In the first story, Ms. Stamenkovic made explicit that her expectations and hopes when she supported the civic movement for democratic government in the 1990s were that reforms, imagined after Western models, would be implemented after the change of political government in 2000. Such a framing of their demands reveals that women gathered around civic initiative see themselves as a part of a larger project of modernization in Serbia. The prospect that future democratic government would establish human rights standards and transparent medical procedures was a part of the social changes envisioned by citizens in civic protests against political government in the 1990s.

Women active in the civic initiative demonstrated that they possess expertise, not only about different models of childbirth management and medical procedures, but also about international human rights standards in health care. Ms. Stamenkovic questioned official state reports about maternal mortality in comparison with international figures and methods for record-keeping; she advocated

2 The web-site of the initiative can still be found at its original address: <http://www.majkah-rabrost.com/>. At the moment, it does not contain the materials (demands, women’s stories, news and links to videos of TV media debates) that I used in my initial research of the online activity of the initiative. The current media activity of “Mother Courage” has moved to online social networks, and to the production of a series of six episodes, featuring women who talk about their experiences in childbirth, which was aired on television during 2012.

lowering the rates of episiotomies in comparison to rates in Sicilian maternity wards; and she advocated the presence of fathers during childbirth, based on its documented benefits for the progression of labor, and refuted doctors' claim that banning fathers from childbirth serves to avoid infections. She was knowledgeable and rational in TV debates with doctors and state officials, who made fewer references to statistical data and established medical knowledge. Nevertheless, doctors addressed women from the initiative primarily as noncompliant patients, and did not acknowledge their arguments for their scientific value.³ They dismissed women's claims as untrustworthy, incompetent, or unrealistic. When women referred to Western or international standards, doctors responded that such standards are not applicable in Serbia, because it could not afford to implement them or because they would not be culturally appropriate. They portrayed women making such demands as agents of Western propaganda (similarly to democratic opposition supporters during the 1990s), or as indoctrinated fans of Hollywood movies, suggesting that references to Western standards of care indicate that women do not formulate their own legitimate demands and that they question legitimacy of childbirth management for the purpose of destabilizing an area of national interest.

"Mother Courage" did not demand the de-medicalization of childbirth. Following Riessman's model of medicalization (Riessman, 1998), we can say that the initiative does not deny that childbirth requires medical assistance; it only contests current medical procedures, the attitude of doctors, and the organization of medical practice. There is a parallel between the demands of the initiative and Western developments in the medical management of childbirth. As Chalmers writes, practices of medical management of childbirth in Eastern Europe at the end of the 1990s were "reminiscent of those prevalent in North America and Europe" (Chalmers 1997: 277) in the 1960s. They were characterized by medical preference for technological intervention, the application of inductions, routine episiotomies, the supine position, and the use of forceps. This description corresponds to practices that Serbian women reported and opposed. Chalmers believes that, under the influence of doctrines promoted by the World Health Organization and UNICEF, the Western "woman-centered and baby-friendly low-technology approach for the majority of women in childbirth" (Chalmers 1997: 273) would eventually prevail in Eastern Europe. This statement assumes that there is a developmental lag in post-socialist countries and that the course of their development is predictable.

3 The concept of authoritative knowledge about childbirth, elaborated by Brigitte Jordan (Jordan, 1997), is helpful in understanding doctors' lack of reliance on scientific evidence. She claims that "[t]he power of authoritative knowledge is not that it is correct but that it counts" (Jordan 1997: 58). Medical discourses thus do not have to refer to scientific knowledge to be authoritative, if they can rely on "cultural authority, economic power, and political influence" (Jordan 1997: 57).

Instead of adopting such a deterministic framework, we could consider that the global influence of human rights discourses of international health organizations, together with the conditions and discourses existing in Serbia, contributed to the formulation of the demands of Serbian women for reforms. In making their demands, the women also rely on the government's proclaimed goal to implement reforms according to the standards of the European Union, and on the identity of active citizens, formed through participation in civic protests during the 1990s.

"Mother Courage" addressed its demands for the regulation and reform of medical services to state officials. At the same time, it redefined women's relationship with the state via a pro-natalist discourse. The worries of the state over declining national birth rates, labelled the "white plague" (Shiffman, Skrabalo and Subotic, 2002), are often represented in catastrophic predictions of the total extinction of the nation.⁴ The "white plague" rhetoric and pro-natalist discourse entail a responsabilization of women as reproducers of the nation (see: Yuval-Davis 1997). By stating in its motto that the Serbian nation should indeed "die" from a "white plague" if it allows the mistreating of women in childbirth, "Mother Courage" redefined women's relationship with the state. Declaring that women's right for self-determination is more important than their obligation to the nation to bear children, it made a demand that the state take responsibility for regulation and implement reforms in line with its own declarative concerns for the growth of the Serbian population.

State authorities initially reacted to the activity and publicity of "Mother Courage" as to a possible threat to their democratic legitimacy. Until the spring of 2009, they engaged in several tripartite debates with the initiator of "Mother Courage" and with medical doctors in television programs dealing with health issues. Although the women's initiative aimed to cooperate with doctors and state officials, the alliance between the Ministry of Health and the medical profession, which is claimed to be the main factor stopping reforms of childbirth management (Wagner 1997), seems to have eventually led to marginalization of women's demands.

Online support groups of women who undergo in-vitro fertilization

Another new development in reproductive biological citizenship in Serbia in recent years is the emergence of online support groups of women who undergo in-vitro fertilization treatment. Since 2006, when the Serbian government made

4 A member of Serbian Academy of Sciences, a body with an influential voice in Serbian politics, says, for example: "We are stricken by the white plague, there is less and less of us. (...) This is our deathly hour, and if we do not snap out of it (...) in a century we will not exist. That is the thought that torments me" (Marković 2006). Politicians, governmental health institutions and citizens reproduce such rhetoric, expressing worries that Serbs might become extinct, or become a minority in "their own" country, by being outnumbered by more fertile ethnicities.

a decision to cover the costs of IVF for a certain number of couples, information about basic facts about IVF, diagnostic tests, and procedures for applying for the state funds started to proliferate in online media, and lately active online communities of women became visible. These communities can be found on privately-owned or public Internet forums, dedicated to discussing parenthood, lifestyle, or health issues. In these communities, women share primarily practical information regarding all aspects of treatment, about maintaining health, dietary supplements, individual practices and routines. The users on a forum I observed know each others' reproductive histories and regularly exchange emotional support.⁵ Communication revolves around IVF schedules, planning and progression toward the goal of achieving pregnancy. Criticism of the procedure is virtually non-existent, while claims about dissatisfaction with doctor's management of treatment are rare.

Through communication in online support groups, women undergoing IVF treatments in Serbia form biosociality around the technological procedure of assisted reproduction, which they hope will remedy their infertility, and they form their subjectivity based on the medically defined condition of infertility and in relation to state benefits. At the same time, they actively manage their treatment, gather knowledge they can apply in their self-management, and share information in order to achieve their reproductive goals. They use communication as a resource to inform themselves about infertility options and procedures, and to share information about "working the system" in order to get state benefits if possible and, if not, to calculate the costs and benefits of treatment in private clinics.

Women in IVF support groups occasionally make appeals for the continuation and extension of state investment in infertility treatments, relying on a pro-natalist discourse and "white plague" narrative, in order to legitimize their inclusion in state subsidies. Serbian law regulates assisted reproduction as a procedure available only to heterosexual couples, which is regarded by women undergoing IVF, and by the general public, as unproblematic. It has often been argued that the normalization of reproductive technologies occurs primarily by interpreting them as "appropriate ways of building a family" (Thompson 2005: 141), that is, a "natural" heterosexual nuclear family. IVF treatment can thus be represented as more worthy of social support, than some other medical interventions. Some comments on IVF forums that are critical of recent government decisions to provide state benefits to persons undergoing sex-change surgeries in Serbia rely on such a strategy of normalization. However, despite the celebratory attitude of IVF forum messages towards motherhood, there are also discussions in which women question the naturalness of the mothering instinct and readiness for motherhood. This indicates that women rely on pro-natalist discourse opportunistically, without fully identifying with compulsory motherhood, or the "taken-for-granted belief that all

5 Discussion topics concerning IVF can be found at the address: www.ringeraja.rs/forum/Zatrudnjanje/forumid_202/tt.htm.

women aspire to having children as part of deep biological programming" (Hertz 2006: 4).

The expertise of women in support groups around IVF treatment is more conformist in regard to medical discourse in comparison to the initiative for changing childbirth practices, but this does not imply that they simply follow doctor's orders. Women undergoing IVF typically use online communication to compare doctors' advice with other women, question certain doctors' attitudes, and seek alternative means to boost their fertility, although they rarely discuss the risks of IVF or accuse doctors for mistreatment. In contrast to the women gathered around "Mother Courage", IVF support groups do not discuss Western standards of care. Women's reliance on state funds to assure them access to IVF treatment and on doctors who administer the treatment brings a certain foreclosure of the possibility to adopt a critical stance towards them. IVF users strive to achieve their goals through individual strategies, rather than through social transformation. However, the way in which women construct community and form their subjectivity around infertility treatment suggests that they actively choose between options and practice self-management.

Women's online communication is based on their own experiences of undergoing treatment, whether in state-owned hospitals or in private facilities and it makes these experiences public. However, not many narratives and discussions of women's experience of infertility and of undergoing IVF treatment can be found outside online support groups. Women are less willing to talk to outsiders or consent to be interviewed about their experience of IVF treatment, especially those who went through treatment that eventually failed, or who had some unsuccessful IVF cycles, but are still continuing treatment. Research in which interviews are conducted with women and couples dealing with IVF failure in the UK (Throsby 2004), and other similar research suggest that this is not the case in Western countries. Unwillingness to talk about IVF failure might reflect the strength of the ideology of compulsory motherhood in Serbian society, even though women might not intimately accept this ideology.⁶ As Throsby argues, if treatment fails to produce a child and the achievement of reproductive goals cannot justify its undertaking, talking about this experience becomes more difficult and demands a negotiation of its naturalness and normality.

Considering the two developments I have described so far, I argue that they do not fit neatly into either side of Rose and Novas' distinction between Western and post-socialist biological citizenship. Rose and Novas' dichotomous conceptualiza-

6 This is an issue for further exploration. My experience so far is that only women who successfully finished IVF treatment, or those who are only preparing to start it, were willing to be interviewed for my research. Some of my colleagues commented that they consider it unlikely that women who underwent treatments unsuccessfully would share their experience for my research.

tion of biological citizenship does not take into account that all its elements interact and get transformed in assemblages that are context specific. Nevertheless, the framework of global assemblages is useful in their analysis because it enables us to chart mutations in citizenship which are emergent and produced by multiple determinations. Thus, the understanding of developments in Serbian reproductive biological citizenship can be achieved only through detailed investigation of a variety of conditions, global and local influences, and the dynamic positioning of actors.

In assemblages of Serbian developments, global elements interact with the social conditions and discourses of differently positioned actors. “Mother Courage”, as an example of identity politics, relies on globally influential human rights discourse, although its environment is not responsive to it due to the invested professional interests and political influence of doctors. It demands rights and changes in medical practice and in social conditions of medicine, not state benefits. Unlike “Mother Courage”, IVF users rely on state benefits and state-supported and medical discourses of motherhood and infertility, insofar as they are instrumental in women’s reproductive strategies. However, state paternalism does not fully define their biosocial subjectivity, formed around globally present IVF technology.

Women involved in these developments form different kinds of expertise and different relationships with medical authority. Although women undergoing IVF are more conformist with regard to medical discourses, they are expected to take active responsibility for self-management as IVF patients. Since affluent women can choose private IVF clinics, there are more choices for infertility treatment than is the case for childbirth which takes place in state-owned maternity wards. However, neither development involves women who are simply passive and compliant patients. Their activity from below brings about the contestation and negotiation of the pastoral power of medical doctors, who predominantly expect patients to be compliant and do not approach them as subjects who are expected to choose their course of treatment and display entrepreneurial qualities with regard to themselves. Public stories and narratives about women’s reproductive experiences that are made available through communication on the Internet play a major role in both discussed developments. Through stories and communication about their reproductive experiences, women construct plural perspectives on biology, which demonstrate how global forms interact with local discourses and conditions, and how emergent forms of biological citizenship are being assembled in multiple, complex, and contingent ways.

Post-socialist corruption in Serbian reproductive medical services

Media and citizens’ online reports of corruption in state-owned reproductive medical services proliferate almost daily in Serbia. For example, the web-site of a popular daily newspaper reported in early January 2012 a story about the death

of an (arguably) over-term baby, writing that its mother was neglected for several days in a state-owned hospital in a large Serbian city (Radišić 2012). The report shows the grieving husband who recalls how doctors ignored his wife’s suffering, only to inform him in a telephone call that their baby eventually died, and threatens to sue for medical malpractice. As the title of the news report states, the dead baby was left in the woman’s womb for two days until it was extracted. Over 400 comments on this report were posted, in which readers blame doctors and call for their prosecution, and even demand retaliation against them, while a small minority contends that they might be not guilty for this unfortunate event. Some male commentators advise other fathers not to wait outside hospitals and hope for the best, but to bribe doctors, or to threaten them, in order to get their partners through childbirth safely. In comments to this and similar reports, some readers presume that what led to the tragic consequences was that it was necessary to perform a Caesarean section, and that this was not done, because women did not bribe doctors in advance to perform it. It is a common opinion that Caesarean sections are acquired through corruption and connections, and we can take this opinion as an indication that citizens perceive a great presence of corruption in Serbian maternity wards.

Conceptualizations and research of corruption still present a challenge for ethnography (Torsello 2011). The most common definition of corruption, as “the abuse of a public office for private benefits and gains” (Torsello 2011: 3) presupposes the “Weberian rationality of the western bureaucratic machinery” (Torsello 2011: 3) as a norm, and assumes a clear distinction between the public and the private. Corruption in different contexts is difficult to research and grasp theoretically, because it functions in interaction with many other social practices. Therefore, it is necessary to approach corruption empirically as it emerges under specific conditions.

The “public corruption talk” (Torsello 2011) of citizens provides an opportunity for the ethnographic investigation of phenomena that are rarely directly observable, and particularly of citizens’ construction of meaning around corruption. Corruption talk does not necessarily reflect or alter citizens’ behaviour in practice. It allows citizens to inform themselves about the social conditions of reproductive medicine, and to reflect on the meaning of corruption, and possible responses to it. Aiming to mobilize citizens against corruption in reproductive medical services, the web-site “For Health – Together against Corruption” was started recently in cooperation between the civic initiatives “Mother Courage” and “Parent”.⁷ It encourages citizens to resist corruption and report corrupt doctors, and it collects and publishes citizens’ experiences regarding the presence (or absence) of corruption in the medical services that they had personal contact with. Citizens

7 “For Health – Together against Corruption” web-site is at the address: <http://korupcija.roditeelj.org>.

report diverse experiences with corruption, and some of them write about their own participation in perpetuating corruption in state reproductive medical services. A perceived lack of legal protection and of opportunities to access appropriate care makes the attitude of citizens who share stories to themselves and others non-judgemental. The need to avoid risks and reduce uncertainties in encounters with reproductive medicine leads to justifying accepting corruption as a realistic choice.

This anti-corruption web campaign, which was started by a civic initiative that demands changes in the medical management of childbirth, demonstrates how the discursive power of corruption talk can be mobilized to generate trust and form sociality, and to contribute to increase public interest for initiatives that demand rights. Online accounts about corruption, according to Torsello, have two effects. One is that they make the rules of the corruption “game” more transparent, they “establish a flow of communication about best practices” (Torsello 2011: 8), and disclose “information on the successful strategies to bribe which can commonly be acquired only through prolonged social interaction” (Torsello 2011: 19). Their second effect, which is intended by civic initiatives, is to “raise public awareness, which can be used for particular (political) goals” (Torsello 2011: 19), such as “civil society building” (Torsello 2011: 19). Making corruption talk public is strategic in this anti-corruption effort, as it draws attention to the initiative’s broader demands in relation to childbirth.

Analyses of corruption in the health sector in Serbia, made by Serbian and international non-governmental organizations, agree that it is widespread, although its full extent is unknown. In one citizen’s response to an online survey, corruption is described as so widespread that it has become the normal way in which the system works, and in this situation, the only important issue is “who is the best in the game” (Beogradski centar za ljudska prava 2012: 15). There are different forms of corruption in the health sector in Serbia. Petty corruption refers to “illegal payments directly to medical doctors and others in public sector to provide some services” (Center for Antiwar Action 2005: 3). Indirect payments are a widely present form of corruption in Serbia, in which patients pay for tests and examinations in connected private services, in order to earn doctors’ greater attention and access to care in public services. However, “connections” represent the most important mechanism of corruption in Serbia, in which patients find intermediaries (insiders from medical institutions or other influential persons), who introduce them to health providers. Therefore, possession of money is not as important as “influence in society, represented in a patient’s own capability to do something in return, or in a patient’s family and friendship connections” (Center for Antiwar Action 2005: 10). What is at stake is access to appropriate medical care. International and domestic anti-corruption reports and campaigns interpret corruption as a violation of human rights: because doctors treat patients unequally, corrup-

tion leads to discrimination, and to the violation of the right to health and sometimes of the right to life. Human rights groups demand regulation from the state and the legal prosecution of corruption. In a recent online survey, 99% of respondents answered that they consider that the Serbian state does not fight corruption in health care efficiently (Beogradski centar za ljudska prava 2012: 15).

In order to explain how corruption relates to citizens’ subjectivity in a post-socialist context, I will return to Petryna’s analysis of Ukrainian biological citizenship (Petryna 2002: 5). She writes that bureaucrats and mediators in the Chernobyl apparatus who granted disability status to Ukrainian citizens remained “unsubordinated to any stable legal system” (Petryna 2002: 143) in their power over individuals’ lives, and that they could profit from their position. At the same time, Ukrainian “economic paralysis [bred] codependencies in which compensation [was] no longer simply moral repayment; it also [served] as a stimulant to new and at times exploitative forms of accumulation” (Petryna 2002: 92). These political and economic conditions “generated new kinds of formal and informal social networks and economies that have allowed some segments of the population to survive on and benefit from politically guaranteed subsidies” (Petryna 2002: 5). *Blat* is the term denoting “the informal practice by which access to state privileges and protections could be obtained with connections or material resources” (Petryna 2002: 25). Persons with resources and knowledge about how to perform *blat* could thus gain access to paternalistic forms of social security. Petryna describes how a person who was exceptionally good in performing *blat* could “buy more diagnoses for his medical records, making his medical condition appear much more severe than it was” (Petryna 2002: 143), while other peoples’ fate was sealed as they did not know how to perform it. The ability to perform *blat* can be read as a form of social capital which is mobilized in corrupt exchanges. Post-socialist economic conditions and modes of government can therefore result in an individualization of responsibility for gaining access to social security, which is “traded” in unequal exchanges and mediated through corrupt social ties.

In exchanges that mediate access to state-owned health care services in Serbia, we can locate the individualization of responsibility for one’s health. Citizens’ subjectivity in the context of post-socialist corruption, under conditions of legal and economic insecurity, is reminiscent of the neoliberal subjectivity of active biological citizens who relate to themselves as entrepreneurial individuals. Corruptive ties provide access to those who are “affiliated”, as Rose would say, while they prevent those who are marginalized from access to health care services, and corrupt exchanges result in the accumulation and redistribution of wealth and citizens’ health outcomes. If responsibility for gaining access to health care and for risks and benefits of medical procedures is individualized, it can be considered prudent to calculate corruption costs against reproductive risks. Serbian citizens who report their experiences with corruption and discuss it online, invest an effort to

gain knowledge and inform themselves about the risks of medical procedures and about the social conditions of health. In the light of the information circulated in public corruption talk, pregnant women might decide that it is prudent to invest in corrupt ties, expecting them to pay off by avoiding complications of vaginal delivery which are common in Serbian maternity wards through prearranged Caesarean sections. Corrupt markets thus have a “rationality” of their own, embedded in the interplay of the conditions of the post-socialist context, just as markets regulated by the formal and transparent rules of exchange are context-specific. This specific form of market exchanges and accumulation forms the context in which Serbian citizens relate to themselves as neoliberal subjects, and find ways to manage the risks of their reproductive biology.

Conclusion

My discussion of developments in Serbian reproductive biological citizenship has provided some insights into the ways in which its specific projects are assembled in the interaction of globally present forms with local conditions, various actors and discourses. Emergent forms of biological citizenship are produced by multiple determinations: by local histories, and cultural and social conditions, but also by the international context and global forms. None of their elements is left untransformed, thus we can only encounter them as they are assembled with other elements and conditions, and as they emerge and are constructed by biological citizens.

Discussing Serbian developments, I have claimed that identity politics around childbirth practices relies on international human rights discourses, and on the conception of citizens as subjects of experience which is publicly narrated in order to make claims for rights. However, these globally influential elements are transformed and given meaning by women as they position themselves within Serbian context. I have also claimed that women undergoing IVF form subjectivity around the global forms of biotechnology of assisted reproduction and in the context of paternalistic state measures, not as mere patients, but as persons who actively manage their infertility. Discussing citizens' public corruption talk, I pointed to economic and social conditions in which responsibility for managing health risks is individualized and in which post-socialist corruption emerges as a specific form of market relations, constructed with and through social ties. I considered the role of public talk and Internet communication in all of these developments, both as an enabling factor, and as a global form which is used and constructed according to the Serbian situation and the conceptions of Serbian biological citizens.

Anthropology aims to engage with practices in their complexity, to contextualize and deconstruct preconceived notions and question conditions of their existence. In order to analyse the ways in which biological citizenship is being assem-

bled, we need to deconstruct the dichotomy between the West and post-socialism which could hinder both research and conceptual work. Nevertheless, the conceptualization of biological citizenship as a global assemblage can be useful in comparative anthropological studies. New research of emergent territorializations of biological citizenship in different contexts promises to bring more nuanced perspectives on the notions and phenomena discussed in this paper and to lead to new conceptualizations.

REFERENCES

- Beogradski centar za ljudska prava, 2012. *Oceni svoja prava*. [online] B92. Available at: http://b92s.net/info/un/Oceni_svoja_prava_-_Izvestaj.pdf. [Accessed 14 September 2012.]
- Center for Antiwar Action (CAA), 2005. *Corruption in health sector in Serbia: report by CAA*. [online] CAA. Available at: <http://en.cemir.org.rs/wp-content/uploads/2011/12/Report-Corruption-in-health-Serbia-1.doc>. [Accessed 16 December 2011.]
- Buyandelgeriyn, M., 2008. Post-post-transition theories: walking on multiple paths. *Annual Review of Anthropology*, 37, pp. 235-250.
- Casper, M. J. and P. Currah, eds., 2011. *Corpus: an interdisciplinary reader on bodies and knowledge*. New York: Palgrave Macmillan.
- Chalmers, B., 1997. Changing childbirth in Eastern Europe: which systems of authoritative knowledge should prevail? In R. E. Davis-Floyd and C. F. Sargent, eds. 1997. *Childbirth and Authoritative Knowledge: cross-cultural perspectives*. Berkeley: University of California Press, pp. 263-283.
- Collier, S. J. and Ong, A., 2005. Global assemblages, anthropological problems. In A. Ong and S. J. Collier, eds. *Global Assemblages: technology, politics, and ethics as anthropological problems*. Oxford: Wiley-Blackwell, pp. 3-21.
- Deleuze, G. and F. Guattari, 1987. *A Thousand Plateaus: capitalism and schizophrenia*. Minneapolis, London: University of Minnesota Press.
- Elbe, S., 2005. AIDS, security, biopolitics. *International Relations*, 19 (4), pp. 403-419.
- Foucault, M., 2003. “Society Must Be Defended.” *Lectures at the College de France, 1975-76*. New York: Picador.
- Foucault, M., 2008. *The Birth of Biopolitics. Lectures at the College de France, 1978-79*. Basingstoke: Palgrave Macmillan.
- Hardey, M., 2002. ‘The story of my illness’: personal accounts of illness on the Internet. *Health*, 6 (1), pp. 31-46.
- Hertz, R., 2006. *Single By Chance, Mothers By Choice*. New York: Oxford University Press.
- International Council on Human Rights Policy, 2009. *Corruption and human rights: making the connection*. Versoix: ICHRP.
- Jordan, B., 1997. Authoritative knowledge and its construction. In R. E. Davis-Floyd and C. F. Sargent, eds. 1997. *Childbirth and authoritative knowledge: cross-cultural perspectives*. Berkeley: University of California Press, pp. 55-80.

- Kline, W., 2010. *Bodies of Knowledge: sexuality, reproduction, and women's health in the second wave*. Chicago: University of Chicago Press.
- Macleod, C., 2009. Danger and disease in sex education: the saturation of 'adolescence' with colonialist assumptions. *Journal of Health Management*, 11 (2), pp. 375-389.
- Marković, D., 2006. Naš poraz je i poraz naše pameti. *Odbrana*, 23, pp. 66-68.
- Petersen, A. R., 1996. Risk and the regulated self: the discourse of health promotion as politics of uncertainty. *Journal of Sociology*, 32 (1), pp. 44-57.
- Petryna, A., 2002. *Life Exposed: biological citizens after Chernobyl*. Princeton: Princeton University Press.
- Riessman, C. K., 1998. Women and medicalization: a new perspective. In R. Weitz, ed., 1998. *The Politics of Women's Bodies: sexuality, appearance and behavior*. New York: Oxford University Press, pp. 46-63.
- Rabinow, P., 1992. Artificiality and enlightenment: from sociobiology to biosociality. In J. Crary and S. Kwinter, eds., 1992. *Incorporations*. New York: Bradbury Tamblin and Boorne Ltd., pp. 234-252.
- Rabinow, P., 1996. Artificiality and enlightenment: from sociobiology to biosociality. In P. Rabinow, ed., 1996. *Essays on the Anthropology of Reason*. Princeton: Princeton University Press, pp. 91-111.
- Rabinow, P., 2008. Afterword: concept work. In S. Gibbon and C. Novas, eds. *Biosocialities, Genetics and the Social Sciences: making biologies and identities*. London and New York: Routledge, pp. 188-192.
- Radišić, N., 2012. Porodilja u Kragujevcu 48 sati nosila mrtvu bebu u stomaku, porodica tuži lekare. Blic Online, [online] 17 January. Available at: www.blic.rs/Vesti/Drustvo/301862/Porodilja-u-Kragujevcu-48-sati-nosila-mrtvu-bebu-u-stomaku-porodica-tuzi-lekare. [Accessed 28 January 2012.]
- Rose, N., 1996. The death of the social? Re-figuring the territory of government. *Economy and Society*, 25 (3), pp. 327-356.
- Rose, N., 2007. *The politics of Life Itself: biomedicine, power, and subjectivity in the twenty-first century*. Princeton: Princeton University Press.
- Rose, N. and Novas, C., 2005. Biological citizenship. In A. Ong and S. J. Collier, eds. *Global Assemblages: technology, politics, and ethics as anthropological problems*. Oxford: Wiley-Blackwell.
- Shiffman, J., Skrabalo, M. and Subotic, J., 2002. Reproductive rights and the state in Serbia and Croatia. *Social Science & Medicine*, 54 (4), pp. 625-642.
- Thompson, C., 2005. *Making Parents: the ontological choreography of reproductive technologies*. Cambridge, London: The MIT Press.
- Throsby, K., 2004. *When IVF Fails: feminism, infertility and the negotiation of normality*. Basingstocke: Palgrave Macmillan.
- Torsello, D., 2011. The ethnography of corruption: research themes in political anthropology. *QoG Working Paper Series*, 2011(2). [online] QoG. Available at: www.qog.pol.gu.se/digitalAssets/1357/1357836_2011_2_torsello.pdf. [Accessed 12 September 2012.]

- Wagner, M., 1997. Confessions of a dissident. In R. E. Davis-Floyd and C. F. Sargent, eds., 1997. *Childbirth and authoritative knowledge: cross-cultural perspectives*. Berkeley: University of California Press, pp. 366-393.
- Whyte, S. R., 2009. Health identities and subjectivities: the ethnographic challenge. *Medical Anthropology Quarterly*, 23 (1), pp. 6-15.
- Yuval-Davis, N., 1997. *Gender and Nation*. London: Sage Publications.

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ARTICLES

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Chad Staddon and Stefan Genchev: *Geographical and Temporal Dimensions of Bulgarian Attitudes towards the Rural Environment*

Jan Váně and Martina Štípková: *The National Religious Environment and the Orthodoxy of Christian Beliefs: A Comparison of Austria, the Czech Republic and Slovakia*

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Medical Anthropology
in Central and Eastern Europe:
State of the Art

Medical Anthropology in Romania – Medical Anthropology on Romania?

Sabina Stan and Valentin-Veron Toma

A discipline becomes established in a particular national context if it is institutionalised. This institutionalisation includes teaching courses and programmes, research projects, groups and institutes, as well as academic societies and conferences in the discipline.

Medical anthropology in Romania had the same difficulty in institutionalising itself at the national level as did social and cultural anthropology more largely. While, since the beginning of the 90s, the latter disposes of an academic society¹, of master's programmes and undergraduate courses offered at different universities around Romania, it still does not have a full undergraduate programme.

The situation of medical anthropology is even more precarious. No courses at any level are currently offered on the subject, and there is only one researcher, Valentin-Veron Toma, based at the „Fr. I. Rainer” Institute of Anthropology in Bucharest, who has developed, over the last twelve years, a number of research projects in medical anthropology.²

However, interest in medical anthropology topics has grown in recent years, as several PhD students have taken them up in Bucharest and Cluj universities.

1 Societatea de Antropologie Culturală din România, SACR (Romanian Society for Cultural Anthropology).

2 V. V. Toma taught a course in *medical anthropology* in 2002 in the Master's programme in Cultural Anthropology at the National School for Political and Administrative Studies, but the course was not subsequently continued. The same thing happened with his course in *Cultural psychiatry* from 2003. In 2004, Toma has also been invited to teach a course in *Applied Medical Anthropology in Health Promotion*, integrated in the *Health Promotion* module of the Course on Competency in the Management of Health Services, organized by the National Institute for Research and Development in Health in Bucharest. The „Fr. I. Rainer” Institute of Anthropology in Bucharest has a long tradition of research at the border between anthropology and medicine. Unfortunately, the dominance of biomedical theories and methodologies place most of the studies conducted at the institute in the realm of biological anthropology and population pathology, rather than in that of medical anthropology as it is currently understood internationally. We will concentrate in this article on research on health, illness and healthcare carried out from the perspective of social and cultural anthropology.

Moreover, interest in these topics has also grown among researchers and PhD anthropology students based in western universities. Through their collaborations with local researchers and PhD students, one can hope that they have started to build the institutional bases of medical anthropology in Romania.

Since the end of the 90s, these research projects have started to put medical anthropology topics on the map of the anthropology of postsocialism. The pioneers were Jack Friedman, with his study of anxiety among the Jiu Valley coal mining regions (Friedman 2003), Anamaria Iosif Ross, with her study of alternative medicine in Romania (Iosif 2003), but also Gail Kligman, with her study of reproduction during socialist Romania (Kligman 1998). The beginning of the 2000s saw the first local studies. Gheorghită Geană published a study on the value of health among Romanian peasants (Geană 2002). Moreover, Valentin-Veron Toma introduced an interpretive perspective in his studies of illness narratives and explanatory models (Toma 2003, 2007), cultural psychiatry (Toma 2003, 2005, 2009b), cultural competence (Toma 2009a), and, more recently, fieldwork studies based on the MINI interview guide (Toma and Ciuhuța 2012b). Collaborations between V. V. Toma and Sabina Stan also resulted in a study on informatisation in the Romanian healthcare system (Stan and Toma 2009). In the same period, Stan introduced the critical perspective in her studies on healthcare reform, marketisation, corruption and informal exchanges in the Romanian healthcare system (Stan 2007, 2012).

At the end of 2000s, a second wave of PhD studies on medical anthropology issues were carried out in Romania. Researchers based in western universities dealt with topics such as reproduction and sexuality (Pop 2011, 2012; Anton 2008a, 2008b, 2011; Kirkham 2012), infectious diseases and public health (Stillo 2010, 2012a, 2012b), ethnicity and health (Singh 2011) and aging (Weber 2009, 2012). Additionally, one of the most important American anthropologists studying Romania, David Kideckel studied labour, the body and working class culture in post-socialist Romania (Kideckel 2008). In the same period, research in medical anthropology started to be conducted by PhD students based in Romanian universities. Some of them are still under way, and their topics include illness narratives among cancer patients (Iacob 2012), pain communities and uninstitutionalized health practices (Dincovici 2012), coping strategies of organ recipients (Mihail 2012), and medical subjectivities in a health care direct selling company (Ionescu-Țugui 2012). Notably, most of these PhD studies are supervised by Professor Vintilă Mihăilescu, one of the main agents of the institutionalisation of social and cultural anthropology in Romania.

On the other hand, in the same period Toma turned to more macro critical approaches in his new research programme on cross-border healthcare in the EU and particularly on medical travel to Vienna (Toma, Ciuhuța 2012a). This is part of a larger trend in medical anthropology of increasing attention to transnational

healthcare practices (Nagy 2011). Since 2009, Stan has developed a research programme on the topic with a focus on Romanian migrants in Ireland (Stan 2012).

As a result of new collaborations between Toma and colleagues in London, in 2012 the first research project on private healthcare in Romania started to be conducted by an MA student (Tommaso De Santis). At the end of the 2000s and beginning of the 2010s, researchers at the Romanian Academy in Cluj carried out a major project on the way medicalisation was received in the countryside during the socialist period (E. Bărbulescu 2010, 2011; C. Bărbulescu 2011). Finally, the same period saw the publication of previous work by J. Friedman (2009) and A. Iosif Ross (2006); and, in 2012, a major textbook in the anthropology of alternative medicine.

The 2012 was also the year when the second conference on “Health in transition. Ethnographies of Biomedicine in Postsocialist Europe”, organised by Stan and Toma with the help of British and American colleagues, took place in Bucharest (7-8 June, see www.healthintransition.org). This helped to make visible research carried out - both inside and outside the country - on medical anthropology issues in Romania and also to place the discipline on the Romanian academic map.

The challenges of medical anthropology in Romania are numerous. On the one side, increased international collaborations help fuel medical anthropology studies by local researchers and PhD students as well as the visibility of the discipline at the national level. On the other side, the challenge is now to pass to the next stage of developing courses and programmes in medical anthropology in Romanian universities. An important preparatory element is increasing the number of publications by local researchers, but also the presence of both Romanian-based and western-based medical anthropologists in the Romanian publishing landscape. The other element is increasing the institutional grounding of medical anthropologists interested in Romanian topics through secure positions in the academic world in both Romania and abroad.

REFERENCES

- Anton, L., 2008a., ‘The Foetus is the Socialist Property of the Whole Society’: Abortion and Pronatalist Policies in Romania’s Golden Era. In T-H. Ballmer-Cao, I. Engeliand, and P. Muller, eds., 2008. *Les politiques du genre*, Paris: L’Harmattan, pp. 195-216.
- Anton, L., 2008b. Abortion and the Making of the Socialist Mother during Communist Romania. In L. Bernstein ed., 2008. *(M)Othering the Nation: Constructing and Resisting Regional and National Allegories Through the Maternal Body*, Cambridge: Cambridge Scholars Press, pp. 49-61.
- Anton, L., 2011. La mémoire de l’avortement en Roumanie communiste. Une ethnographie des formes de la mémoire du pronatalisme roumain. *Revue Sociologie. Santé*, 33, pp. 333-337.

- Bărbulescu, C., 2011. *Tărani, boli și vindecători în perioada comunistă. Mărturii orale II*. Cluj Napoca: Mega.
- Bărbulescu, E., 2010. *Tărani, boli și vindecători în perioada comunistă. Mărturii orale I*. Cluj Napoca: Mega.
- Bărbulescu, E., 2011. *People and the State. Divergent Medical Discourses*. Cluj Napoca: Mega.
- Dincovici, A., 2012. Pain Communities and Uninstitutionalized Health Practices: A Case Study. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Friedman, J., 2003. *Ambiguous Transitions and Abjected Selves: Betrayal, Entitlement, and Globalization in Romania’s Jiu Valley*, PhD thesis, Duke University.
- Friedman, J. R., 2009. The “Social Case”. Illness, Psychiatry, and Deinstitutionalization in Postsocialist Romania. *Medical Anthropology Quarterly*, 23 (4), pp. 375-396.
- Geană, G., 2002. “Health As a Value in Romanian Folk Culture”, *Ethnologia Balkanica*, 6, pp. 209-220.
- Iacob, I., 2012. *Sănătate, boală, vindecare. O perspectivă socio-culturală* (Health, illness, curing. A socio-cultural perspective), PhD Thesis. Cluj: Universitatea Babeș-Bolyai.
- Ionescu-Tugui, R., 2012. Love, support and kindness for all: medical subjectivities in a health care direct selling company. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Iosif, A. V., 2003. *Healing, orthodoxy, and personhood in postsocialist Romania*, PhD Thesis, Tulane University.
- Kideckel, D., 2008. *Getting By in Postsocialist Romania: Labor, the Body, and Working-Class Culture*. Bloomington: Indiana University Press.
- Kirkham, J., 2012. What’s Morality Got to Do With It? A Consideration of the Role of Morality in the Development and Contestation of Sexual and Reproductive Health Services in Romania and Moldova. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Kligman, G., 1998. *The Politics of Duplicity: Controlling Reproduction in Ceausescu’s Romania*. Berkeley: University of California Press.
- Mihail, A., 2012. Life After Transplant: Coping With a New Life as an Organ Recipient in Romania. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Nagy, R., 2011. Migrants and Healthcare Within the European Union. *International Review of Social Research*, 1 (1), pp. 61-72. Available at : www.irsr.eu/issue01/03_Nagy_p.61-72.pdf.
- Pop, C., 2011. Personal, Emerging Medical landscapes, and HPV Vaccination in Post-socialist Romania. *Anthropology of East Europe Review*, 29 (2), pp. 90-110.

- Pop, C., 2012. Rationalizing Births in Post-socialist Romania: Surgical Sterilization During the Second C-section. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Ross, A. I., 2006. Cradle, Manger, Granary: Carving the Body from the Nation's Sacred Flesh, *Journal of Religion and Society*, 8, pp. 1-12.
- Ross, A. I., 2012. *The Anthropology of Alternative Medicine*. London: Berg.
- Singh, D. 2011. Attitudes and Praxis of Traditional Forms of Healthcare in a Post-communist Romanian Romani Community. *Anthropology of East Europe Review*, 29 (1), pp. 127-140.
- Stan, S., 2007. Transparency: Seeing, Counting and Experiencing the System. *Anthropologica*, 49 (2), pp. 257-273.
- Stan, S., 2012a. Neither Commodities Nor Gifts: Post-Socialist Informal Exchanges in the Romanian Healthcare System. *Journal of the Royal Anthropological Institute*, 18 (1), pp. 65-82.
- Stan, S., 2012b. Transnational Healthcare Practices of Romanian Migrants in Ireland: Social Mobility and the Marketisation of Healthcare Services in Europe. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Stan, S. and V.-V. Toma. 2009. High-Tech Romania? Managerialism, the Market and Informal Relations in the Informatisation of the Romanian Health Care System, Joint Journal Edition of *Anthropology in Action*, 16 (1), pp. 56-71.
- Stillo, J., 2010. The Changing Role of TB Sanatoria: From Sarnac New York to Romania's Magic Mountains. *East-West Cultural Passage*, 9, pp. 101-114.
- Stillo, J., 2012a. Who Cares for the Caregivers? Romanian Women's Experiences With Tuberculosis. *Anthropology Now*, 4 (1), pp. 10-17.
- Stillo, J., 2012b. 'We Are the Losers of Socialism': Tuberculosis, Social Cases and the Limits of Care in Romania. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)
- Toma, V.-V., 2003. Narațiuni despre boală și modele explicative la pacienți cu depresie. Studiu de antropologie psihiatrică clinică (II). (Illness Narratives and Explanatory Models in Patients with Depression. A Study in Clinically Applied Psychiatric Anthropology. Part II.) *Psihiatria și psihofarmacologia prezentului*, 1-2, pp. 46-59.
- Toma, V.-V., 2005. Niveluri ale cercetării etnografice aplicate în antropologia psihiatrică clinică. (Levels of Applied Ethnographic Research in Clinical Psychiatric Anthropology.) *Psihiatria și psihofarmacologia prezentului*, 1, pp. 53-62.
- Toma, V.-V., 2007. Câmpul disciplinar al antropologiei medicale – definiția și obiectul de studiu. (The Disciplinary Field of Medical Anthropology – Definition and Object of Study.) *Revista Medicală Română*, 1, pp. 6-8.
- Toma, V.-V., 2009a. Competența culturală și comunicare clinică în domeniul medicinei generale. (Cultural Competence and Clinical Communication in General Medical Practice.) In G. G. Constandache, B. Balgiu, eds., 2009. *Comunicarea – sugestie și influență. Aspecte interdisciplinare și transdisciplinare*, Bucharest: Sigma Publishing House, pp. 70-76.

- Toma, V.-V., 2009b. Contributions of Medical Anthropology to the Psychiatric Practice. Cultural and Linguistic Competence in Mono- and Multicultural Societies, *Proceedings of the Romanian Academy, Series B: Chemistry, Life Sciences and Geosciences*, 1 (2-3), pp. 111-119.
- Toma, V.-V. and M. Șt. Ciuhuța, 2012a. Pacienți români care au călătorit în străinătate pentru tratament. Studiu de caz exploratoriu asupra călătoriei medicale. (Romanian Patients who Travelled Abroad to Seek Medical Treatment. Exploratory Case-Study on Medical Travel.) *Revista Medicală Română*, 59 (1), pp. 60-64.
- Toma, V.-V. and M. Șt. Ciuhuța, 2012b. 'Cruciadele' doamnei C. în căutarea vindecării complete. Studiu de caz asupra strategiilor terapeutice alternative în astmul bronșic. (Mrs. C.'s 'Crusades' in the Quest for Complete Healing. A Case-Study on Alternative Therapeutic Strategies in Bronchial Asthma.) In A. Kozma, C. Glavce, C. Bălăceanu-Stolnici, eds. 2012. *Antropologia și Cultura*, Collection „Zilele Rainer”, Bucharest: Niculescu Press, pp. 400-404.
- Weber, G. 2009. *Forsaken Generation: Stress, Social Suffering and Strategies among Working-Class Pensioners in Post-Socialist Moldova, Romania*, PhD thesis, Department of Anthropology, City University of New York, NY.
- Weber, G., 2012. 'Other Than a Thank-You, There is Nothing Else I Can Give': The Social and Historical Context of Stress among Working-Class Pensioners in Post-Socialist Galați, Romania. (Paper presented at the conference *Health in transition. Ethnographies of Biomedicine in Post-socialist Europe*, Romanian Academy of Sciences, Bucharest, Romania, 7-8 June.)

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Medical Anthropology in Ukraine. The State of the Field

Maryna Y. Bazylevych

Medical anthropology in Ukraine is a vibrant field which yields research of importance to anthropological theory as well as public health policy. Many scholars have contributed to our understanding of health, illness, and well-being more broadly, using Ukraine as a site of investigation. This review may be skewed to include research of those authors who are based in the United States or conduct regular academic conversations with their American colleagues. I apologize for possibly missing significant research of other dedicated scholars based in Ukraine.

In 2002, Adriana Petryna famously proposed the category of “biological citizenship” to illustrate how the Chernobyl¹ accident has created “biological citizenship” in Ukraine. This can be understood as a relationship between state and people whereby citizens find it beneficial to construct their identities as ill people – “sufferers” of conditions caused by the Chernobyl accident. The Ukrainian state places high emphasis on the accident as a crucial element defining the Ukrainian history of struggle for independence. Therefore, the official status of “sufferer” is linked not only to welfare assistance, but also to a status as hero. Petryna views the Chernobyl accident and the corresponding construction of “biological citizenship” as a “political economy of radiation illness” (Petryna 2003). In the same vein, Phillips (2004b) argues that Chernobyl has created “a sixth sense,” or pervasive symbolism that is embodied and shared through the collective memory that informs people about their perceptions of the world. Thus, people go about their everyday lives with a constant awareness of the illusive danger that radiation may be causing, either through the food they consume or the air they breathe.

Sarah Phillips has made invaluable contributions to the field of medical anthropology in the post-socialist space and beyond. Her most recent ethnography

1 In this paper, I transliterate proper names of Ukrainian origin according to Ukrainian spelling rules. In so doing, I join the Ukrainian public and scholars who advocate abandoning transliteration of Ukrainian proper names according to Russian spelling rules, as is widely present in English publications. Thus, I use the Ukrainian spelling Chernobyl, as opposed to currently more widely used russified Chernobyl.

(2010) on disability issues in Ukraine shows how people with disabilities are increasingly mobilizing strategies to establish a social and political sense of belonging in addition to and beyond the fact of their disability. She expands Petryna's understanding of citizenship by pointing out that while economic difficulties influence people's desire to use their “damaged biology” to make citizenship claims, international disability rights' discourses have led many people with disabilities to assert other ways to be a citizen. Phillips (2004a) has also explored the alternative healing system in Ukraine – the medical practices of Ukrainian *babky* – elderly women who possess traditional knowledge and skills to perform magical healing rituals that are imbued with religious symbolism. Phillips argues that this return to non-biomedicalized ways of healing in part reflects the country's general trend towards the revitalization of spirituality. In this sense, the concept of healing acquires double meaning: the direct notion of improving one's health condition, and a figurative meaning of healing Ukrainian society: “Ukrainian *babky* carry out gendered performances that accord them a measure of prestige and power; complement and replace the system of state medicine; act as psychotherapists; and specialize in psychosocial ailments to simultaneously heal persons and communities” (Phillips 2004a: 25-26). Links between gender and health are further explored in a new volume “Gender, Politics and Society in Ukraine” under the editorship of Olena Hankivsky and Anastasiya Salnykova. The contributing authors focus on policy relevant issues, as well as broader understanding of gendered behaviors that lead to particular health risk and statuses, such as a piece by Olena Hankivsky on “Gender and Health in Ukraine.”

Catherine Wanner (2007) broadens our understanding of well-being by focusing on conversion to evangelism in Ukraine. She suggests that the active practice of evangelic religion allows people to reconstitute their sense of self, create helpful networks, and give meaning to the ongoing postsocialist hardships as a price that society needs to pay for the decades of socialist atheism. Wanner shows how evangelism in Ukraine has diversified the social fabric. Similarly, Phillips (2008) argues that women's involvement in socially needed work as leaders of humanitarian-oriented NGOs creates a sense of empowerment and heals their sense of personhood. She suggests that women employ narratives of self-sufficiency and collective action that are empowering, and thus resist being positioned as helpless. Such articulations allow them to build their sense of self as socially worthy agents. In the same vein, Szmagalska-Follis (2008: 348) traces “restoration and redemption” at a collective farm in Ukraine's western borderland where former prisoners engage in collective work to attempt to return to meaningful personhood and restore suspended citizenship. Through the creation of new socialities using old methods and infrastructures, the author argues, Soviet life is not “unmade” (Humphrey 2002), but it is instead remade to reproduce what has been in part lost – the order and domain of collective work and life.

Jennifer Carroll (2012) focuses on knowledge production and agency in the case of methadone therapy programs in Ukraine, arguing that local experiences of Soviet medical paradigms play an extremely influential role in the implementation of new programs regarding addictive behaviors. Ukrainian medical practitioners and public health organizations view Western biomedical approaches as desirable, but they are transformed via daily practices that illustrate the realities of working in a context of distrust in authority and treatment ideologies unique to the Soviet medical sphere. Shelly Yankovsky (2011) discusses this interplay between Western biomedical ideology and the ways they play out in Ukraine through the lens of mental health care. She anchors her discussion in historical trends that have stigmatized mental illness in Eastern Europe. The move from institutional to community-based treatment that has been adopted in Ukraine is surrounded by the overarching issue of figuring out just where the responsibility of the individual resides, as opposed to that of the medical practitioner and the state. Her work illustrates yet another site where neoliberal agendas and accompanying human rights' discourses play out. In my own work (Bazylevych 2011), I continue the trend of discussing the relationship with the state as one of the formative forces in Ukrainian people's construction of health categories, specifically focusing on risk. I trace how vaccination anxieties emerge in response to changing local and global hierarchies. Health risks are constructed not only in biological terms, but rather as a product of relationships between the state, providers, patients and international health policy makers. I highlight the ways in which the knowledge of infection and protection against it is circulating in Ukraine, the ways in which it is shared, and the ways in which it is contested.

To conclude, why should we pay attention to the medical anthropology of Ukraine? Because the dynamism of the healthcare field points to creative spaces for negotiation between the state, care providers, users of the system, society as a whole, and various communities within it. It is an especially revealing site of investigation, for it opens the door for understanding social change more broadly, both on the macro-level and the level of lived everyday experience (Rivkin-Fish 2011).

REFERENCES

- Bazylevych, M., 2011. Vaccination Campaigns in Post-Socialist Ukraine. When Body Politic and Citizens' Bodies Intersect. *Medical Anthropology Quarterly*, 25 (4), pp. 436-456.
- Carroll, J., 2012. Methadone as medicine: The biomedicalization of drug addiction in Ukrainian substitution therapy programs. Paper presented at the "Health in Transition. Annual Conference on the Health and Health Care in the Post-Socialist World".
- Hankivsky, O. and A. Salnykova, eds., 2012. *Gender, Politics and Society in Ukraine*. University of Toronto Press.

- Humphrey, C., 2002. *The Unmaking of Soviet Life. Everyday economies after socialism*. Ithaca: Cornell University Press.
- Phillips, S. D., 2004a. Waxing Like the Moon: Women Folk Healers in Rural Western Ukraine. *Folklorica*, 9 (1), pp. 13-47.
- Phillips, S. D., 2004b. Chornobyl's Sixth Sense: The Symbolism of an Ever-Present Awareness. *Anthropology and Humanism*, 29 (2), pp. 159-185.
- Phillips, S. D., 2008. *Women's Social Activism in the New Ukraine: development and the politics of differentiation*. Bloomington: Indiana University Press.
- Phillips, S. D., 2010. *Mobile Citizens: Living Disability after Socialism*. Bloomington: Indiana University Press.
- Rivkin-Fish, M., 2011. Health, Gender, and Care Work: Productive Sites for Thinking Anthropologically about the Aftermaths of Socialism. Special issue on Health and Care Work in Postsocialist Eastern Europe and the former Soviet Union. *Anthropology of East Europe Review*, 29 (1), pp. 8-15.
- Szmagalska-Follis, K., 2008. Repossession: Notes on Restoration and Redemption in Ukraine's Western Borderland. *Cultural Anthropology*, 23 (2), pp. 329-360.
- Wanner, C., 2007. *Communities of the converted : Ukrainians and global evangelism*. Ithaca: Cornell University Press.
- Wanner, C., 1998. *Burden of Dreams. History and Identity in Post-Soviet Ukraine*. The Pennsylvania State University Press.
- Yankovsky, S., 2011. Neoliberal Transitions in Ukraine: The View from Psychiatry. *Anthropology of East Europe Review*, 29 (1), pp. 23-34.

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Medical Anthropology in Poland

Aleksandra Bartoszko and Danuta Penkala-Gawęcka

Social sciences and medicine in Poland have had a relatively long relationship. Nevertheless, this relationship has long been limited to medical sociology, which has existed as a separate discipline and been under continuous development since the 1960s.¹ In comparison, medical anthropology in Poland is a young discipline. Locally produced research and literature, both theoretical and empirical, are still modest. For a long time, only two universities took the trouble to look at medicine through the lenses of sociality and culture (research started and conducted since the late 1970s by Danuta Penkala-Gawęcka in Poznań and Adam Paluch in Wrocław). Today students from other universities have the opportunity to familiarize themselves with the issues of medical anthropology which is taught as a separate subject at some institutes. Even so, the curriculum consists mainly of international authors, while literature produced by Polish authors reflects the early days of the discipline in the country – it consists mainly of introductions to medical anthropology in general or interdisciplinary works that include some anthropological perspectives (Penkala-Gawęcka 2008a, 2008b; Piątkowski and Płonka-Syroka 2008; Płonka-Syroka 2008; Płonka-Syroka and Marczyk 2009). However, this situation is changing and we can see a significant increase in medical anthropological research in Poland.

The character of the sub-discipline has been formed by the history of general anthropology and its specific place in the academic landscape of the country. Polish ethnology grew from the ground of research on local folk cultures, and when anthropological research developed in Poland, it was connected to ethnological research.² Thus, interest in “folk cultures” has for a long time been central to Polish general anthropology, and this has shaped medical interests as well. “Folk medicine”, ethnomedicine (Dłużewska 1983; Szychowska-Boebel 1972; Tylkowa 1989) and ethnobotany (Paluch 1980, 1984, 1989) dominated research at the ethnological and anthropological institutions in the early days of Polish medical anthropology. Today, we also find a rich body of literature continuing and developing

traditional ethnobotanical research in Poland (Pirożnikow 2008; Kujawska 2011; Adamus 2012) and in countries from the former Eastern Bloc (Kołodziejska-Degórska 2008). Because ethnomedical studies have been connected to historical and museum studies, medical and cultural historians are also engaged in studies of modern ethnomedical practices (Płonka-Syroka 2009; Sikora 2011; Jeszke 1996).

The tradition of ethnomedicine and ethnobotany, as well as of research on local “folk medicine” (Penkala-Gawęcka 1980, 1995; Libera 1995; Bem 1996) was important for the development of medical anthropology in Poland. Nevertheless, the discipline has undergone a gradual change in character. Due to awareness of the status of concepts of “folk culture” or “folk medicine”, Polish anthropologists have turned their analytical attention towards complementary or alternative medicine. Currently the sub-discipline is being strengthened, better defined and focused. Stronger links to general anthropology are developing, as seen in the increasing use of common research methods, concepts, and theories in medical anthropology. Lately Polish researchers, especially the younger generation, have focused their attention on issues from the mainstream of modern medical anthropology. Researchers are both participating in and facilitating specialized conferences.³ Unfortunately, in spite of increasing participation in medical anthropological arenas, the Polish body of literature is still a little meagre.

Because of European geopolitics and financial issues, most Polish anthropologists have done their fieldwork in Poland and Eastern Europe. An exception was research done by Penkala-Gawęcka in Afghanistan (1980, 1988a, 1988b). The situation is changing and increasing numbers of researchers choose ethnographic sites far from Poland; the most researched areas are Central Asia and Latin America. Also, urban medical studies, hospital studies and studies of health policies at the national level are slowly getting attention (Wierciński 2011; Weimann 2011). Regarding research subjects and themes, medical pluralism is certainly the most investigated (Penkala-Gawęcka 1988a, 1988b, 2002, 2006, 2010a; Kołodziejska-Degórska 2008; Kujawska 2010; Wądołowska 2003, 2007, 2010; Charyton 2011a, 2011b). Polish researchers, both anthropologists and sociologists, have also become particularly active in studying complementary and alternative medicine

1 For a history of medical sociology in Poland see Sokołowska (1966); for later developments see Ostrowska (1996), and Piątkowski and Płonka-Syroka (2008).

2 Today both disciplines are still practiced together at Polish universities, at institutes of ethnology and cultural anthropology.

3 An important event was the conference *Antropologia medyczna w Polsce – doświadczenia, pola badań, perspektywy* (Medical anthropology in Poland – experiences, field of research and perspectives) organized in Poznań in 2009. The meeting was organized by The Department of Ethnology and Cultural Anthropology at Adam Mickiewicz University in Poznań together with the Ethnographic Commission of The Poznań Society of Friends of Learning. Papers from the meeting are published in the first anthology of Polish medical anthropological texts edited by Penkala-Gawęcka (2010a). Another important event proving the strength of the environment and engagement of young medical anthropologists was the organization of MAYS (the Young Scholars Medical Anthropology) meeting in 2011 in Warsaw. The meeting was facilitated by the Section for Medical Anthropology of the Student Society for Culture Research at the Institute of Polish Culture (University of Warsaw).

(CAM) (Piątkowski 1990, 2008, 2012; Penkala-Gawęcka 1991, 1995, 2002, 2006, 2010b; Pietrzyk 2011; Kocikowski 2011; Zatorska 2010; Grzywacz 2010a, 2010b; Górny and Marczyk 1997). Other studies reflect problems or developments associated with social changes in Poland and globalization, such as stress (Charyton 2011a); the increase in HIV/AIDS cases (Sznajderman 1994a, 1994b; Krawczyk-Wasilewska 2000; Ratkowska 2005); the increase of cancer patients (Wierciński 2010, 2011); the increase in the proportion of the elderly (Szenajch 2011) and more self-care and use of alternative medicine (Trojanowska 2009; Płonka-Syroka 2009). There is also research on health issues connected to migration (Kujawska 2008, 2010; Węgrzynowska 2011) and religious minorities (Rajtar 2010, 2011). Unsurprisingly, studies of patient-doctor relations are so far being done in a comparative perspective with alternative medicine (Szlagowska 2009).

Anthropologists in Poland seem to appreciate interdisciplinary perspectives and are cooperating on publications and events with medical sociologists and medical historians, but also psychologists, biological anthropologists, medical professionals and pharmacologists.⁴ They are active in strengthening their role amongst medical professions. Another example is cooperation with the Department of Human Sciences in the Faculty of Pharmacy at Wrocław Medical University, which employs anthropologists and organises conferences with an anthropological focus.

Poland has never been a popular field of interest amongst non-Polish medical anthropologists. A notable exception is Adriana Petryna with her book on the pharmaceutical industry based on fieldwork in Poland (2009). The last few years have seen a noticeable growth in interest amongst “halfies”.⁵ The major area of studies undertaken by these anthropologists is reproductive and women’s health (Mishtal 2009, 2010, 2012; Mishtal and Dannefer 2010; Węgrzynowska 2012). Local anthropologists have also shown an interest in the subject, with empirical work from Mexico (Wądołowska 2010). Post-socialist perspectives and studies of post-socialist health care are slowly gaining attention (Owczarzak 2009; Robbins 2009; Bartoszko 2011). Here it is important to mention significant research on post-socialist health care and the transition to democracy after communism within

4 For example, interdisciplinary conferences such as *Zdrowie, choroba i leczenie w perspektywie interdyscyplinarnej* (Interdisciplinary perspectives on health, illness and healing) organized in 2011 in Będlewo by The Committee on Ethnological Sciences of the Polish Academy of Sciences and The Department of Ethnology and Cultural Anthropology, Adam Mickiewicz University in Poznań, or *Stress, nerwy, lęk* (Stress, nerves and anxiety) organized in 2012 in Poznań by The Department of Ethnology and Cultural Anthropology and Association of Students of Ethnology, Adam Mickiewicz University in Poznań.

5 According to Lila Abu-Lughod halfies are “people whose national or cultural identity is mixed by virtue of migration, overseas education, or parentage” (1991: 137). Halfie anthropologists are anthropologists who study societies and cultures to which they partially belong, sharing thus perspectives of both the native and the stranger.

the framework of qualitative sociology conducted by Peggy Watson (2002, 2006a, 2006b).

For now, medical anthropological research in Poland is a rather small contribution in comparison with global anthropology – it is fragmented and yet to find a clear structure. Polish medical anthropology does not have one dominant theoretical or analytical orientation, a factor which is not seen by us as a disadvantage. Many of the cited works are conference papers, or works not yet published or in progress. Therefore, it remains to be seen what direction Polish medical research will take, and how research will evolve with regard to theory application and development, as well as the choice of ethnographic fields and methods.

REFERENCES

- Abu-Lughod, L., 1991. Writing against Culture. In R. I. Fox, ed., 1991. *Recapturing Anthropology*. Santa Fe: School of American Research Press, pp. 137-146.
- Adamus, A. G., 2012. Herbalism in Polish society after 1990. (Paper presented at 13th World Congress on Public Health, Addis Adaba, Ethiopia, 23-27 April.)
- Bartoszko, A., 2011. Post-socialist health care, citizenship and democracy in Poland. How can medical anthropology contribute to studies of societies in transition? (Paper presented at Health in transition: (Bio)Medicine as culture in post-socialist Europe, Prague, Czech Republic, 10-11 June.)
- Bem, M., 1996. Medycyna ludowa - czyli o skutecznych sposobach leczenia domowym sposobem. *Zeszyty Muzeum Pojezierza Łęczyńsko-Włodowskiego we Włodawie*, 4, pp. 61-68.
- Charyton, M. A., 2011a. Stress and stress-coping strategies in the context of medical pluralism. (Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Charyton, M. A., 2011b. Współczesna medycyna ludowa na Podlasiu – oczyma szeptuch. In A. Anczyk, ed., 2011. *Medicina magica. Oblicz medycyny niekonwencjonalnej*. Sosnowiec: Wydawnictwo Instytutu Medycyny Pracy i Zdrowia Środowiskowego, pp. 57-84.
- Dłuzewska, S., 1983. Ludowa wiedza medyczna ludności kaszubskiej okolic Bytowa. *Łódzkie Studia Etnograficzne*, 25, pp. 35 - 58.
- Górny, K. and Marczyk, M., 1997. Poszeptał i pomogło, czyli rzecz o wiejskich lekarzach. *Zeszyty Muzeum Pojezierza Łęczyńsko-Włodowskiego we Włodawie*, 7, pp. 41-44.
- Grzywacz, Z., 2010a. Współcześni uzdrowiciele w Kazachstanie - nosiciele tradycji czy konkurenci na rynku usług medycznych? In D. Penkala-Gawęcka, ed. 2010. *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*. Poznań: Biblioteka Telgte, pp. 67-79.
- Grzywacz, Z., 2010b. *Traditional Kazakh medicine in change*. Poznań: Adam Mickiewicz University.
- Jeske, J., 1996. *Lecznictwo ludowe w Wielkopolsce w XIX i XX wieku: Czynniki i kierunki przemian*. Wrocław.
- Kocikowski, M., 2011. ‘Charismatic healing prayer as a practice of complementary medicine’. Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland 13-14 June.

- Kołodziejska-Degórska, I., 2008. 'The attitude towards official medicine and local healing practices among Polish inhabitants of Pojana Mikuli village in southern Bucovina, Romania'. Paper presented at 10th Biennial EASA Conference, Ljubljana, Slovenia, 26-29 August.
- Krawczyk-Wasilewska, V., 2000. *AIDS: Studium antropologiczne*. Łódź: Wydawn. Uniwersytetu Łódzkiego.
- Kujawska, M., 2008. Leczenie zamawianiem wśród Polaków z Misiones w Argentynie. *Lud*, 92, p. 65.
- Kujawska, M., 2011. Etnobotanika miejska: perspektywy, tematy, metody. *Etnobiologia Polska*, 1, pp. 31-42.
- Kujawska, M., 2010. Nie czas chorować, czas pracować. Stosunek do leczenia się polskich osadników z prowincji Misiones w Argentynie. In D. Penkala-Gawęcka, ed. 2010. *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*. Poznań: Biblioteka Telgte, pp. 37-5.
- Libera, Z., 1995. *Medycyna ludowa. Chłopski rozsądek czy gminna fantazja?*. Wrocław: Wydawnictwo Uniwersytetu Wrocławskiego.
- Mishtal, J., 2009. Matters of 'conscience': The politics of reproductive health and rights in Poland. *Medical Anthropology Quarterly*, 23 (2), pp.161-183.
- Mishtal, J., 2010. The Challenges of reproductive healthcare: Neoliberal reforms and privatisation in Poland. *Reproductive Health Matters*, 18 (36), pp. 56-66.
- Mishtal, J., 2012. Irrational non-reproduction? The 'dying nation' and the postsocialist logics of declining motherhood in Poland. *Anthropology & Medicine*, 19 (2), pp. 153-169.
- Mishtal, J. and Dannefer, R., 2010. Reconciling religious identity and reproductive practices: The church and contraception in Poland. *European Journal of Contraception and Reproductive Health*, 15, pp. 232-242.
- Ostrowska, A., 1996. The development of medical sociology in Eastern Europe, 1965-1990. *European Journal of Public Health*, 6 (2), pp. 100-104.
- Owczarzak, J., 2009. Defining HIV risk and determining responsibility in postsocialist Poland. *Medical Anthropology Quarterly*, 23 (4), pp. 417-435.
- Paluch, A., 1980. Folk Therapeutic Methods Used in Poland for the Relief of Headaches. *Curae*, 3 (4), pp. 203-204.
- Paluch, A., 1984. Świat roślin w tradycyjnych praktykach leczniczych wsi polskiej. *Acta Universitatis Wratislaviensis*, no. 752. Wrocław: Wydawnictwo Uniwersytetu Wrocławskiego.
- Paluch, A., 1989. Roślina w badaniach etnologicznych. In B. Kuźnicka, ed. 1989, *Historia leków naturalnych*, t.2: *Natura i kultura – współzależności w dziejach lekoznawstwa*, Warszawa: Polska Akademia Nauk, pp. 143-153.
- Penkala-Gawęcka, D., 1980. "Hot" and "cold" in the traditional medicine in Afghanistan. *Ethnomedizin*, 6 (1-4), pp. 201-228.
- Penkala-Gawęcka, D., 1983. Antropologia medyczna i etnomedycyna. Rozwój, stan badań, Perspektywy. *Lud*, 67, pp. 9-37.
- Penkala-Gawęcka, D., 1988a. Medical pluralism in Afghanistan: Conflict between, coexistence or integration of various medical systems?. In S. Szykiewicz, ed. 1988. *Poland at*

- the 12th Congress of anthropological and ethnological sciences*. Wrocław: Zakład Narodowy im. Ossolińskich, pp. 235-247.
- Penkala-Gawęcka, D., 1988b. *Medycyna tradycyjna w Afganistanie i jej przeobrażenia*. Wrocław: Polskie Towarzystwo Ludoznawcze.
- Penkala-Gawęcka, D., 1991. Medycyna komplementarna w Polsce i jej badanie (na przykładzie badań w małym miasteczku wielkopolskim). *Lud*, 74, pp. 169-191.
- Penkala-Gawęcka, D., 1995. Folk and complementary medicine in Polish ethnological investigations. *Lud*, 79, pp. 121-141.
- Penkala-Gawęcka, D., 2002. Korean medicine in Kazakhstan: Ideas, practices and patients. *Anthropology and Medicine*, 9 (3), pp. 315-336.
- Penkala-Gawęcka, D., 2006. *Medycyna komplementarna w Kazachstanie. Siła tradycji i resja Globalizacji*. Poznań: Wydawnictwo Naukowe UAM.
- Penkala-Gawęcka, D., 2008a. Antropologia medyczna dzisiaj: kontynuacje, nowe nurty, perspektywy badawcze. In W. Piątkowski and B. Płonka-Syroka, eds. 2008, *Socjologia i antropologia medycyny w działaniu*. Wrocław: Oficyna Wydawnicza Arboretum, pp. 219-241.
- Penkala-Gawęcka, D., 2008b. Kulturowe wymiary zdrowia, choroby i leczenia w świetle badań antropologii medycznej. In B. Płonka-Syroka, ed. 2008, *Antropologia medycyny i farmacji w kontekście kulturowym, społecznym i historycznym*, Studia Humanistyczne Wydziału Farmaceutycznego Akademii Medycznej we Wrocławiu. Wrocław: Akademia Medyczna im. Piastów Śląskich, pp. 19-34.
- Penkala-Gawęcka, D., ed., 2010a. *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*. Poznań: Biblioteka Telgte.
- Penkala-Gawęcka, D., 2010b. "Maladies populaires" et médecine complémentaire en Cachoubie. *Ethnologie française*, 40 (2), pp. 295-304.
- Petryna, A., 2009. *When experiments travel: clinical trials and the global search for human subjects*. Princeton: Princeton University Press.
- Piåtkowski, W., 1990. *Spotkania z inną medycyną*. Lublin: Wyd. Lubelskie.
- Piåtkowski, W., 2008. *Lecznictwo niemedyczne w Polsce. Tradycja i współczesność*. Lublin: Wyd. UMCS.
- Piåtkowski, W. and Płonka-Syroka, B., eds., 2008. *Socjologia i antropologia medycyny w działaniu*. Wrocław: Oficyna Wydawnicza Arboretum.
- Piåtkowski, W., 2012. *Beyond medicine. Non medical methods of treatment in Poland*. Frankfurt am Main, Berlin: Peter Lang GmbH.
- Pietrzyk, A., 2011. Anthropological aspects of biofield energy healing in Poland. (Paper presented at Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Pirożnikow, E., 2008. Tradycje użytkowania dziko rosnących roślin leczniczych i pokarmowych wschodniego Podlasia. In A. Górniak and B. Poskrobko, eds. 2008, *Park Krajobrazowy Puszczy Knyszyńskiej w systemie ochrony przyrody i edukacji środowiskowej*. Białystok: Wyd. Fundacja Ekonomistów Środowiska i Zasobów Naturalnych, pp. 64-80.
- Płonka-Syroka, B. and Syroka, A., eds., 2007. *Leczyć, uzdrawiać, pomagać*. Wrocław: Wyd. Oficyna Wydawnicza Arboretum.
- Płonka-Syroka, B., ed., 2008. *Antropologia medycyny i farmacji w kontekście kulturowym, społecznym i historycznym*. Wrocław: Akademia Medyczna im. Piastów Śląskich.

- Płonka-Syroka, B., 2009. Praktyki samolecznicze wśród mieszkańców Kotliny Kłodzkiej i Jeleniogórskiej w świetle badań terenowych z lat 1983-1984. In B. Płonka-Syroka and M. Marczyk eds., 2009. *Medycyna i okolice t. II. Problemy antropologii medycyny*. Wrocław: KEiAK Uwr, pp. 35-44.
- Płonka-Syroka, B. and Marczyk, M., eds., 2009. *Medycyna i okolice t. II. Problemy antropologii medycyny*. Wrocław: KEiAK Uwr.
- Rajtar, M., 2010. Tożsamość religijna, prawa mniejszości religijnych i nowoczesny autorytet medyczny [Religious Identity, Minority Rights, and Modern Medical Authority]. (Paper presented at The 14th Polish Sociological Association Conference, Kraków, Poland, 8-11 September.)
- Rajtar, M., 2011. Religious minority and healthcare policy of the German state. (Paper presented at The 31st International Society for the Sociology of Religion (ISSR) Conference, Aix-en-Provence, France 30 June – 3 July.)
- Ratkowska, L., 2005. Wszędzie, ale nie tu... czyli kulturowe oblicze AIDS. In B. Płonka-Syroka, T. Srogosz, ed. 2005. *Zdrowie i choroba jako problem polityczny i społeczny. Medycyna w kontekście działań państwa*. Wrocław: Wydawnictwo DiG, pp. 186-201.
- Robbins, J., 2009. Aging, memory and personhood in Poland. *Anthropology News*, 50 (8), pp. 15-16.
- Sikora, A., 2011. Salomea Słowacka-Bécu — a depressed woman or sensible heart? Sentimental emotionality at the beginning of the nineteenth century and modern conceptions of mental health. (Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Sokolowska, M., 1966. Medical sociology in Poland. *Milbank Memorial Fund Quarterly*, 44 (4), pp. 426-36.
- Szenajch, P., 2011. The death we talk about and the dying in the eyes of hospice patients. (Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Szlagowska, A., 2009. Relacje lekarz - pacjent w medycynie oficjalnej i komplementarnej (na podstawie badań terenowych). In B. Płonka-Syroka and M. Marczyk, eds., 2009. *Medycyna i okolice t. II. Problemy antropologii medycyny*. Wrocław: KEiAK Uwr, pp. 45-59.
- Sznajderman, M., 1994a. AIDS - kształt mitu. *Polska Sztuka Ludowa – Konteksty*, 48 (1-2), pp. 160-166.
- Sznajderman M., 1994b. *Zaraza. Mitologia dżumy, cholery i AIDS*. Warszawa: Wydawnictwo Naukowe Semper.
- Szychowska-Boebel, B., 1972. *Lecznictwo ludowe na Kujawach*. Toruń: Muzeum Etnograficzne w Toruniu.
- Trojanowska, A., 2009. Dziewiętnastowieczne koncepcje zdrowego żywienia i niektóre dzisiejsze diety. *Lud*, 93, pp. 159-183.
- Tylkowa, D., 1989. *Medycyna ludowa w kulturze wsi Karpat polskich: tradycja i współczesność*. Wrocław: Ossolineum, Biblioteka Etnografii Polskiej.
- Wądołowska, A. H., 2003. Curandero w szpitalu. In K. Baraniecka, A. Hummel and A. H. Wądołowska, eds., 2003. *Mix Mex. Zapiski antropologiczne z Meksyku*. Kęty: Antyk.
- Wądołowska, A. H., 2007. *Medycyna indiańska w Meksyku. Organizacje lekarzy tradycyjnych w regionie Indian Purhépecha*. Warszawa: Uniwersytet Warszawski.

- Wądołowska, A. H. 2010. Pluralizm medyczny a zdrowie reprodukcyjne kobiet w Regionie Indian Purhépecha w Meksyku. In D. Penkala-Gawęcka, ed. 2010. *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*. Poznań: Biblioteka Telgte, pp. 51-66.
- Weimann, N., 2011. Health centred design. (Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Węgrzynowska, M., 2011. My health in my own hands: Polish women's healthcare strategies during pregnancy and birth-giving. (Paper presented at 2nd Annual MAYS Meeting, Warsaw, Poland, 13-14 June.)
- Węgrzynowska, M., 2012. Though luck, but this is an investment in my peace of mind": empowerment and women's healthcare in Poland. Paper presented at Health In Transition Annual Conference on Health and Healthcare in the Post-Socialist World, Bucharest, Romania, 7-8 June.)
- Wierciński, H., 2010. Nowotwór i technika medyczna w narracjach „ocalonych” pacjentów – na przykładzie chemio- i radioterapii. In D. Penkala-Gawęcka, ed. 2010. *Nie czas chorować? Zdrowie, choroba i leczenie w perspektywie antropologii medycznej*. Poznań: Biblioteka Telgte, pp. 159-176.
- Wierciński, H., 2011. Kinship and experiences of cancer in Poland. (Paper presented at Health in Transition Annual Conference on Health and Healthcare in the Post-Socialist World, Bucharest, Romania, 7-8 June.)
- Watson, P., 2002. Nowa Huta: Politics of post-communism and the past. In J. Edmunds and B. Turner, eds., 2002. *Generational Consciousness, Narrative, and Politics*. Lanham, Md.: Rowman and Littlefield, pp. 165-177.
- Watson, P., 2006a. Stress and social change in Poland. *Health & Place*, 12 (4), pp. 372-382.
- Watson, P., 2006b. Unequalizing citizenship: the politics of Poland's health care change. *Sociology*, 40 (6), pp. 1079-1096.
- Zatorska, M., 2010. Pojęcie energii i jego konceptualizacje na gruncie medycyny komplementarnej we Lwowie i okolicznych miejscowościach. In M. Zowczak, ed. 2010. *Na pograniczu "nowej Europy". Polsko - ukraińskie sąsiedztwo*. Warszawa: Wydawnictwo DiG, pp. 505-518.

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Review on the Development of Medical Anthropology in Latvia

Aivita Putniņa and Zane Linde-Ozola

Three major trends: physical anthropology, ethnography and social anthropology

The beginnings of anthropological research can be dated to the twentieth century with the main focus on issues of traditional beliefs, physical anthropology, health and hygiene.¹ Virtually no study has been done which has attempted to date research prior to that time. Nevertheless, traces of this research can be found at the end of the nineteenth century in descriptions of fieldwork conducted by an ethnographer called Alksnis in the northern part of Latvia and Estonia on child-birth customs (Ploss 1901: 28).

Medical anthropology research became institutionalized in 1938 with the opening of the Institute for the Study of Living Strength² where research was conducted in the tradition of physical anthropology: e.g. it explored population density and eugenics to support and popularize the idea of eugenics. The institution was closed in 1940 after the Soviet occupation of Latvia (Grāvere and Salaks 2009; Zelče 2006). Ethnological and anthropometric study was preserved through the period of Soviet occupation and ethnographic expeditions collected data and artifacts on folk medicine.³ A rich collection of archeological and ethnographic data on folk and professional medicine was also collected and stored in the Pauls Stradins Museum for the History of Medicine.⁴ The Institute of Anatomy and Anthropology was registered at Riga Stradins University (the former Latvian Medical Academy / Institute) in 1997, consolidating physical anthropology research.

Another direction of Latvian medical anthropology conducted within the tradition of social anthropology stems from Western European universities. Vieda

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2 In Latvian: Tautas dzīvā spēka pētīšanas institūts.

3 Online collection of the Latvian Institute of History can be found on www.lvi.lv/lv/etnokrātuve.htm.

4 For more information see the museum home page <http://www.mvm.lv/en>.

Skultans, a medical anthropologist of Latvian origin and professor at the University of Bristol, was already an established anthropologist when she embarked upon her research in Latvia in the 1990s. She started her career in the 1970s exploring spiritualist beliefs and practices of healing in South Wales (Skultans 1974, 1976), the symbolism of menstruation and menopause in Wales (Skultans 1970), the relationship between mental illness, gender, and family structure in rural Maharashtra, Nepal (Skultans 1991a), and the history of madness (Skultans 1975, 1979).

After Latvia regained independence in 1991, it became more open for anthropological fieldwork. The first anthropological fieldwork focused on narrative, memory, autobiography and illness in Latvia (Skultans 1998, 2007a). Skultans directed her research to Latvia, looking at psychiatric practice, narratives of the somatization of the history of Soviet occupation, the relationship between psychiatrics and social and economic changes in post-Soviet Latvia (Skultans 1997, 1998, 1999, 2003, 2004a, 2004b, 2007b). She has also published a number of articles on the relationship between anthropology and psychiatry (Skultans 1991b, 2000a), as well as having reflected on ethics in the anthropological research of psychiatric practice (Skultans 2005). Alongside this, Skultans has co-edited several books on the anthropology of psychiatry and the narrative study of health and illness (Skultans, et al. 2000b, Hurwitz, et al. 2004). Her latest book (2007a) contains a collection of her essays, as well as describing the path of her research in medical anthropology.

Martin Gunnarson (2012) became the first international scholar conducting comparative doctoral research on kidney transplantation and dialysis in Stockholm and Riga, exploring the relationship between the body, illness and transplantation.

Establishing medical anthropology within the field of (British) social anthropology

There are three main reasons for the comparative strength of medical anthropology in Latvia. Firstly, integration within international research networks has allowed the bypassing of often poor local funding opportunities and the acquisition of an international profile. Secondly, this discipline is successfully institutionalized and this has generated second-generation researchers. Thirdly, in Latvia medical anthropology, as well as social and cultural anthropology in general is mostly a public discipline seeking to publicize research results and influence policy making processes.

International research links. Latvian anthropologists working on topics of medical anthropology have obtained degrees from the London School of Economics and Political Science, and the Universities of Bristol and Cambridge thus publicizing their research in an international environment. Aivita Putniņa, in her doc-

toral thesis at the University of Cambridge (1999), focused on childbirth experiences and theoretical issues of agency and change (also Putniņa 2001, 2002). Agita Lūse (2005) conducted her research on mental illness in Latvia while at the University of Bristol.

Study experience abroad seems to foster collaborative projects in medical anthropology and brings research funds to Latvia. So, in 1997-98 a first collaborative EU BIOMED II programme project, "A qualitative assessment of quality of life after stroke," was carried out by Lūse (McKevitt, et al. 2002). Most of the subsequent research projects in the 2000s on topics of organ transplantation, genomics, mental disorders and reproductive health were funded by the EU and international donors.

Institutionalization of academic and research fields. Permanent academic and research positions allow the stabilization of research. The 2000s brought research on publicly relevant topics: population genomics (Putniņa, 2003, 2008), domestic violence and health (Putniņa, et al. 2007, 2009), images of biotechnologies (Putniņa 2010), reproductive health (Putniņa 2004, 2011a), suffering and healing (Lūse and Lázár, 2007), discursive aspects of psychological problems (Lūse 1999), and the support group movement (Lūse 2009).

Medical anthropology also became institutionalized through study programmes and through research institutions opening the way for a cohort of new generation researchers. Topics of student research have included gender and reproductive health issues (Krele 2006, Mileiko 2009), health policy (Dompalma 2007), biotechnologies: genomics (Linde 2010) and stem cell applications (Kalēja 2010). From the 2000s onwards, a course in medical anthropology has been taught in the sociology programme at the University of Latvia. However, in 2009 the university launched bachelor- and masters-level study programmes in social and cultural anthropology including a wider specialization in medical anthropology. This facilitated the building up of the research potential and resulted in the establishment of the Centre for Bioethics and Biosafety⁵ at the University of Latvia in 2006.

The centre coordinates medical anthropology research on biotechnologies and runs several internationally and locally-funded research projects on organ transplantation, genomics, xeno-transplantation, stem cells, new reproductive technologies and reproductive health.⁶ Current research projects at the centre explore the governance of biotechnologies in Latvia. A comparative research project on citi-

5 See more on <http://www.biodrosiba.lu.lv/eng/project/center>.

6 2009-2012 EC FP7 project "Public participation in knowledge intensive policy field", SSH-CT-2008-225327; 2009-2012 ESF project "Capacity building for interdisciplinary biosafety research", Nr.2009/0224/1DP/1.1.1.2.0/09/APIA/VIAA/055; 2011 WHO, "Papardes Zieds" project on reproductive health; 2007 UNESCO funded project "Societal aspects of human genome research in Latvia"; 2007 WHO project National report on domestic violence and health; 2003-2006 EC FP6 project "Challenges of Biomedicine"

zen participation in decision-making on biotechnologies allowed researchers to stress the post-socialist context of policy process and problematize the notion of public participation (Hanson, et al. 2011), risk and trust (Putniņa 2011b), the development of the notion of the body under biotechnologies (Putniņa 2012). Research on assisted reproduction allowed them to argue for the role of ethnic and gender factors in gamete donation (Mežinska, et al. 2011). Doctoral research on fertility is currently being completed as one of the centre's research focuses.

Another centre for medical anthropology research was built around the masters-level programme in social anthropology at Riga Stradins University. The programme allows for a specialization in medical anthropology, psychiatry, communication and understanding of madness as well as death and dying. The research focus is mainly directed towards mental disorders and the stigmatization of mental illness (Lūse 2010; Lūse and Kamerāde 2011; Lūse and Kāpiņa 2011).

Getting public. Most of the anthropologists in Latvia are involved in different civic and public activities, policy planning and analysis. The majority of research projects are designed to have a larger public impact and contain not only academic but also policy components, aiming to produce guidelines and recommendations. Anthropologists have also been active in raising public discussions concerning patient support mechanisms, domestic violence and health, public funding of assisted reproduction services and biobanking.

REFERENCES

- Dompalma, E., 2007. *Sieviešu veselības uztvere un profilaktisko apskāšu apmeklēšana* (Women's health perception and attendance of prophylactic examinations). Masters theses, University of Latvia.
- Grāvere, R., Salaks, J., 2009. *Eugenics and Racial Identity in Latvia*. Podcast of a paper presented in the conference "Eugenics, Race, and Psychiatry in the Baltic States". The Goethe Institute, May 2009. Available at www.pulse-project.org/node/173. [Accessed 27 September 2012.]
- Gunnarson, M., 2012. Concealed by the "Gift of Life": The Complexities of Living with Dialysis and Kidney Transplantation in Stockholm and Riga. In M. Gunnarson, F. Svaneus, eds., 2012. *The Body as Gift, Resource and Commodity. Exchanging Organs, Tissues and Cells in the 21st Century*. Huddinge: Södertörns högskola, pp. 103-136.
- Hansson, K., Lundin, S., Kalēja, J., Putniņa, A., Idvall, M., 2011. Framing the public: the policy process around xenotransplantation in Latvia and Sweden 1970-2004. *Science and Public Policy*, 38 (8), pp. 629-637.
- Hurwitz, B., Greenhalgh, T., Skultans, V., eds., 2004. *Narrative Research in Health & Illness*. Oxford: Blackwell Publishing Ltd.
- Kalēja, J., 2010. *Lēmumu pieņemšana par jauno biotehnoloģiju izmantošanu: cilmes šūnu diskurss Latvijā* (Decision making on new biotechnologies: stem cell discourse in Latvia). Master theses, University of Latvia.

- Krecele, A., 2006. *Vecāku diskursīvās stratēģijas: seksuālās un reproduktīvās veselības gadījums* (Parental discursive strategies: a case of reproductive health). Masters theses, University of Latvia.
- Linde, Z., 2010. *Ģenētiskās biotehnoloģijas ikdienas medicīnas praksēs* (Genetic biotechnologies in everyday medical practice). Masters theses, University of Latvia.
- Lūse, A., 1999. Zināšanas un vara: psiholoģisku problēmu diskursa formas (Knowledge and power: discourse forms of psychological problems), *Kentaurs XXI*, No.48.
- Lūse, A., 2005. *Changing discourses of distress and powerlessness in post-Soviet Latvia*. Unpublished PhD thesis, University of Bristol.
- Lūse, A., 2009. "I am an important and needed person". A study of a support group movement in post-Soviet Latvia. *Atslēgvārdi / Keywords. Academic Journal for New Research in Humanities and Social Sciences in the Baltic States*, 1, pp.23-43.
- Lūse, A., 2010. From social pathologies to individual psyches: psychiatry navigating socio-political currents in 20th-century Latvia. *History of Psychiatry*, 22 (1), pp. 20-39.
- Lūse, A., Kamerāde, D., 2011. Redrawing the Boundaries of Psychiatry and Mental Illness in the Post-Soviet Period: The Case of Latvia. In K. Szmigiero ed., 2011. *Probing Madness*. Oxford: Inter-Disciplinary Press, pp. 55-66.
- Lūse, A., Kāpiņa, L., 2011. Intimacy and Control, Reciprocity and Paternalism: Madness and the Ambivalence of Caring Relationships in a Post-Soviet Country. In K. Szmigiero ed., 2011. *Probing Madness*, Oxford: Inter-Disciplinary Press, pp. 67-80.
- Lūse, A., Lázár, I. eds., 2007. *Cosmologies of Suffering: Post-communist Transformation, Sacral Communication, and Healing*. Newcastle upon Tyne: Cambridge Scholars Publishing.
- McKevitt, C., Lūse, A., Wolfe, C., 2003. The unfortunate generation: stroke survivors in Riga, Latvia. *Social Science & Medicine*, 56 (10), pp. 2097-2108.
- Mežinska, S., Mileiko, I., Putniņa, A., 2011. Sharing Responsibility in Gamete Donation: Balancing Relations and New Knowledge in Latvia. *Medicine Studies*, 3 (3), pp. 185-196.
- Mileiko, I. 2009. *Varas un seksualitātes mijiedarbe: nepilngadīgo grūtnieču gadījums* (Power and Sexuality: A case of teenage mothers). Master theses, University of Latvia.
- Ploss, A., 1901. *Zhenshini*. Vol.1. Moskva.
- Putniņa, A., 2001. Medicine and change: making agency count. In E. van Dongen and J. Comelles eds., 2001. *Medical Anthropology and Anthropology. Contributions of Medical Anthropology at Home to Anthropological Theories and Health Debates*. Perugia: Argo, pp. 381-393.
- Putniņa, A., 2002. Komunikācija un pieredze: stāsti par dzemdībām un grūtniecību Latvijā (Communication and experience: stories about childbirth and pregnancy in Latvia). In A. Lūse ed., 2002. *Cilvēks.Dzīve.Stāstījums*. Riga: LAB, LU LFMI, pp. 126-136.
- Putniņa, A., 2003. Population Genome Project in Latvia: Exploring the Articulation of Agency. In J. Sandor ed., 2003. *Society and Genetic Information. Codes and Laws in the Genetic Era*. Budapest, New York: Central European University Press, pp. 233-246.
- Putniņa, A., ed. 2004. *Reproductive Health of the Population: Study on the Situation in Latvia 1997-2003*. Riga: United Nations Population Fund (UNFPA) and Papardes Zieds. Available at: www.un.lv/files/2004/PAPARDES%20%20Zieds%20ENG.zip [Accessed 10 September 2012.]

- Putniņa, A., Brants, M., Vasiļevska, K., Mileiko, I., 2007. *Vardarbība un veselība. Ziņojums par situāciju Latvijā* (Health and Violence: A Study On The Situation In Latvia). Riga: Ministry of Health of the Republic of Latvia, World Health Organization Regional Office for Europe. Available at: <http://sgdatabase.unwomen.org/uploads/Study%20on%20Health%20and%20Violence%20%20-%20WHO.pdf> [Accessed 10 September 2012.]
- Putniņa A., 2008. *Genoma izpētes projekta Latvijā sabiedriskie aspekti. Pētījuma atskaite [Public Aspects of Genome Research Project in Latvia. Research report]*. Riga: UNESCO National Commission of Latvia, Centre of Bioethics and Biosafety. Available at http://www.policy.hu/putnina/genoms_atskaite.pdf [Accessed 10 September 2012.]
- Putniņa, A., 2010. Footprints of biotechnologies in the changing social landscape. In D. Teters, ed., 2010. *Metamorphoses of the World: Traces, Shadows, Reflections, Echoes, and Metaphors. Proceedings of the International Research Conference 'Metamorphoses of the World: Traces, Shadows, Reflections, Echoes, and Metaphors'*, Riga: Metamind, pp. 172-185.
- Putniņa, A., 2011a. *Iedzīvotāju reproduktīvā veselība: ziņojums par situāciju Latvijā (2003-2011) [Reproductive health: A Study On The Situation In Latvia (2003-2011)]*, Riga: Papardes Zieds. Available at http://www.papardeszieds.lv/index.php?option=com_content&view=article&id=266&Itemid=66 [Accessed 10 September 2012.]
- Putniņa, A., 2011b. Managing trust and risk in new biotechnologies: the case of population genome project and organ transplantation in Latvia. In P. Robbins and F. Huzair eds., 2011. *Exploring Central and Eastern Europe's Biotechnological Landscape*. Netherlands: Springer, pp. 111-130.
- Putniņa, A., 2012. The Relationship between the Body and its Parts: Accommodating Stem Cell, Gene, Tissue, and Organ Transplantation Technologies in Latvia. In M. Gunnarson and F. Svaneus eds., 2012. *The Body as Gift, Resource and Commodity. Exchanging Organs, Tissues and Cells in the 21st Century*. Huddinge : Södertörns högskola, pp. 80-102.
- Skultans, V., 1970. The Symbolic Significance of Menstruation and the Menopause. *Man*, 5 (4), pp. 639-651.
- Skultans, V., 1974. *Intimacy and Ritual: Study of Spiritualism, Medicines and Groups*. London: Routledge.
- Skultans, V., 1975. *Madness and Morals: Ideas on Insanity in the Nineteenth Century*. London: Routledge.
- Skultans, V., 1976. Empathy and Healing: Aspects of Spiritualist Ritual. In J. B. Loudon ed., 1976. *Social Anthropology and Medicine, ASA Monograph 13*. London: Academic Press.
- Skultans, V., 1979. *English Madness: Ideas on Insanity, 1580-1890*. London: Routledge.
- Skultans, V., 1991a. Women and Affliction in Maharashtra: A Hydraulic Model of Health and Illness. *Culture, Medicine and Psychiatry*, 15, pp. 321-59.
- Skultans, V., 1991b. Overview: Anthropology and Psychiatry: The Uneasy Alliance. *Transcultural Psychiatric Research Review*, 28, pp. 5-24.
- Skultans, V., 1997. A Historical Disorder: Neurasthenia and the Testimony of Lives in Latvia. *Anthropology and Medicine*, 4 (1), pp. 7-24.
- Skultans, V., 1998. *The Testimony of Lives. Narrative and Memory in post-Soviet Latvia*. London: Routledge.
- Skultans, V., 1999. Narratives of the Body and History: Illness in Judgment on the Soviet Past. *Sociology of Health and Illness*, 21 (3), pp. 310-28.

- Skultans, V., 2000a. Remembering and Forgetting: Anthropology and Psychiatry: The Changing Relationship. In V. Skultans and J. Cox eds., 2000. *Anthropological Approaches to Psychological Medicine: Crossing Bridges*. London: Jessica Kingsley Publishers.
- Skultans, V., Cox, J., eds., 2000b. *Anthropological Approaches to Psychological Medicine: Crossing Bridges*. London: Jessica Kingsley Publishers.
- Skultans, V., 2003. From Damaged Nerves to Masked Depression: Inevitability and Hope in Latvian Psychiatric Narratives. *Social Science and Medicine*, 56, pp. 2421-2431.
- Skultans, V., 2004a. Narratives of displacement and identity. In B. Hurwitz, T. Greenhalgh and V. Skultans eds., 2004. *Narrative Research in Health and Illness*. Oxford: Blackwell, pp. 292-308.
- Skultans, V., 2004b. Authority, Dialogue and Polyphony in Latvian Psychiatric consultations. *Transcultural Psychiatry*, 41 (3), pp. 337-359.
- Skultans, V., 2005. Varieties of Deception and Distrust: Moral Dilemmas in the Ethnography of Psychiatry. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 9 (4), pp. 491-512.
- Skultans, V., 2007a. *Empathy and Healing. Essays in Medical and Narrative Anthropology*. London, New York: Berghahn Books.
- Skultans, V., 2007b. The Appropriation of Suffering: Psychiatric Practice in the Post-Soviet Clinic. *Theory, Culture and Society*, 24 (3), pp. 27-48.
- Zelče, V., 2006. Vara, zinātne, veselība un cilvēki: Eģēnika Latvijā 20. Gs. 30. gados [Power, science, health, and people: eugenics in Latvia in 30ies of 20th century], *Latvijas Arhīvi*, 3, pp. 94-137.

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Medical Anthropology in Russia

Ekaterina Borozdina

Medical anthropology is a new field of scholarship with approximately ten years of history in Russia, and only preliminary steps have been made to establish it as a separate discipline in the country (Mikhel 2004). There are still no special study programs in medical anthropology in Russian higher education, and only two universities have special courses on medical anthropology. The first one is the Saratov State Technical University, which first introduced a special course in this field named “Medical Anthropology: the History of the Discipline’s Development” in 2001 (Mikhel 2010). The other one is the Russian State University for the Humanities, which also offers an introductory course named “Medical Anthropology”.

However, taking into account that the term “medical anthropology” has been imported into the Russian academic landscape rather recently, we should look more precisely at local intellectual traditions of understanding health and medicine. There are generally two main groups of scientists which investigate issues related to health, illness and medicine. The first one is represented by researchers who explicitly identify themselves as medical anthropologists and who are ethnologists in terms of their educational background. This group focuses on the social and cultural aspects of traditional medicine. Most of these scholars are based at the Institute of Ethnology and Anthropology of the Russian Academy of Science, where they have conducted research in this field since the late Soviet period. In 2005, the “Center for studies of shamanism and other traditional beliefs and practices” of this Institute was transformed into the medical anthropology research group. The members of this group have continued with their previous studies in ethnomedicine and ethnopsychology. The head and leader of the group, Valentina Kharitonova, investigates contemporary Siberian shamanism (Kharitonova 2006), healing practices of shamans (Kharitonova and Topoev 2006), their adaptation to the spreading of modern medical knowledge in the region (Kharitonova 2009a, 2009b, 2011), and the interpretation of health and illness in the frame of neoshamanism and new religious movements (Kharitonova, et al. 2008). The research center also provides training in medical anthropology for several PhD students, and organizes summer schools on the subject. Currently the group is developing a new line of research – anthropological studies of bioethics. This is reflected in

the newly established “Journal of Medical Anthropology and Bioethics”¹, which was established by the Institute of Ethnography and Anthropology in 2010. So far two issues (in Russian) have been published.

As far as concerns the second stream of health related research, the scholars associated with it do not usually consider themselves medical anthropologists, however their research agenda and methodology is close to medical anthropology scholarship. While they come from different disciplinary backgrounds, especially sociology, but also philosophy, gender studies, history, etc., they all employ critical social theory as the epistemological basis of their work. This is reflected in the range of topics which these scholars pursue: most of them address acute social problems affecting contemporary Russian healthcare. These scholars are based at diverse institutions, but the Saratov State Technical University and National Research University Higher School of Economics (Moscow) particularly stand out. The thematic scope of studies conducted in these two centers include the social construction of disability (Romanov and Iarskaia-Smirnova 2010; Iarskaia-Smirnova 2011), the professionalization of traditional medicine in Russia (Iarskaia-Smirnova and Romanov 2011), and the influence of reforms in Russian healthcare on doctor-patient relations (Prisiazhniuk 2009; Romanov, et al. 2011).

The European University at St. Petersburg is another distinguished academic center where scholars investigate issues related to medical anthropology, especially reproductive issues. Since 2005, members and graduates of the Gender Studies Program have been involved in research on reproductive healthcare: Meilakhs (2009) and Temkina (2011) focused on contraceptive practices, Zdravomyslova (2009) investigated the issue of abortions and abortion legislation, and together with Temkina explored trust in doctor-patient relationships (Zdravomyslova and Temkina 2009, 2012). Other studies dealt with the role of informal payments and social networks in access to antenatal healthcare (Brednikova 2009; Borozdina 2010). The researchers from the Program are integrated in the international research community in this field, and have especially established strong ties with scholars from abroad who conduct research on transformations of Post-Soviet reproductive healthcare and doctor-patient relationships. Among these scholars, Michele Rivkin-Fish (Rivkin-Fish 2005) and Finnish sociologist Anna Rotkirch (Temkina, Rotkirch and Haavio-Mannila 2012) belong to the most renowned international collaborators with the center.

Until recently there have not been many cross points between the representatives of the two groups described above, and scholars with a background in ethnography are usually not very familiar with the work of sociologists of health and illness, and vice versa. There is also a clear division among researchers according to research subjects; researchers who investigate topics related to traditional med-

1 <http://jmaib.iea.ras.ru/englishversion/about.html>.

icine and those who study contemporary healthcare systems are usually not very familiar with each other's work. Yet some of the recent academic events, such as the conference “Subjective Meanings of Disease: on the Way to the Narrative Medicine” which was held at the Samara State University in 2012 and attracted scholars with different disciplinary backgrounds, raise hopes that the community of researchers working in the area of health and healthcare will become more integrated in the coming years in Russia.

REFERENCES

- Brednikova, E., 2009. Pokupaia Kompetentsiu I Vnimanie: Praktiki Platezhei vo Vremia Beremennosti I Rodov (Buying Competence and Attention: Practices of Informal Payments during the Pregnancy Period and at Labor). In Zdravomyslova E. and A. Temkina eds. 2009. *Zdorovie i Doverie: Gendernii Podhod k Reproduktivnoi Meditsine*. St. Petersburg: EUSP Press, pp. 211-233.
- Borozdina, E., 2010. Na Prieme u Ginekologa: Zabota kak Sostavliaiushchaia Professionalnoi Deiatelnosti Vracha. (Visiting an Obstetrician: Caring Relations as a Part of Professional Medical Help). *Woman in Russian Society*, 1, pp. 77-90.
- Iarskaia-Smirnova, E., 2011. “A Girl Who Liked to Dance”: Life Experiences of Russian Women with Motor Impairments. In M. Jäppinen, M. Kulmala and A. Saarinen eds., 2011. *Gazing at Welfare, Gender and Agency in Post-socialist Countries*. Cambridge: Cambridge Scholars Publishing, pp. 104-124.
- Iarskaia-Smirnova, E., Romanov, P. 2011. *Traditsionnaia Meditsina: Politika I Praktika Professionalizatsii* (Traditional Medicine: Politics and Practice of Professionalization). Moscow: Variant.
- Kharitonova, V., 2006. *Feniks iz Pepla? Sibirskii Shamanizm na Rubezhe Stoletii* (Phoenix from Ashes? Siberian Shamanism on the Boarder of New Millennium). Moscow: Nauka.
- Kharitonova, V., Topoev V., 2006. Shamanskoe Tselitel'stvo: k Probleme Interpretatsii (Shaman Healing: the Problem of Interpretation). In *Field Researches of the Institute of Ethnology and Anthropology of Russian Academy of Science (2005)*. Moscow: Nauka, pp. 162-178.
- Kharitonova, V., Ozhiganova A. and A. Kupiashina, 2008. V Poiskakh Duhovnosti I Zdorovia. Novei Religioznie Dvizhenia, Neoshamanizm, Gorodskoi Shamanism (In Search for Spirituality and Health .New Religious Movements, Neoshamanism, Urban Shamanism). *Researches in Applied and Emergency Ethnology* 207. Available at www.iea.ras.ru/engine/documents/applied/2008_207_Kharitonova-Ozhiganova-Kupiashina.pdf. [Accessed 16 September 2012.]
- Kharitonova, V., 2009a. Adaptacionnie Mekhanizmi v Sfere Magiko-Meditsinskoi Praktiki (Adaptation Mechanisms in the Field of Magico-Medical Practice). In A. Derevianko, A. Kudelin and V. Tishkov eds., 2009. *Adaptatsia Narodov I Kul'tur k Izmeneniam Prirodnoi Sredi, Sotsial'nim i Tekhnogennim Transformatsiam*. Moscow: Rossiskaia Politicheskaia Entsiklopedia, pp. 353-361.

- Kharitonova, V., 2009b. *Integratsia Meditsinskih Sistem: Ideia, Praktika, Chelovecheskii Faktor* (Integration of Medical Systems: Idea, Practice and Human Factor). In V. Kharitonova ed., 2009. *Problemi Sohraneniia Zdorovia v Usloviah Severa i Sibiri: Trudip o Meditsinskoi Antropologii*. Moscow: "Novosti" Press, pp. 275-286.
- Kharitonova, V., 2011. Sovremennii Magiko-Meditsinskii i Magiko-Misticheskie Praktiki: k Probleme Funktsionirovaniia i Adaptatsii (Contemporary Magico-Medical and Magico-Mystical Practices: Problem of Functioning and Adaptation). *Ethnographical Review*, 3, pp. 61-75.
- Meilakhs, A., 2009. Neslishnie Peregovori, Nevidimiesvazi: Vibor Sposoba Predokhraneniia i Otnosheniia mezhdu Partnerami (Silent Negotiations, Invisible Links: Contraception Choice and Relationships between Partners). In Zdravomyslova E. and A. Temkina eds., *Novii Bit v Sovremennoi Rossii: Gendernii Issledovaniia Povsednevnosti*. St. Petersburg: EUSP Press, pp. 346-372.
- Mikhel, D., 2004. Meditsinskaya Antropologia: Chto Eto Takoe? (Medical Anthropology: What is This?) *Cultural Studies: Theory, Schools, History and Practices*. Available at www.countries.ru/library/antropology/medant.htm. [Accessed 17 July 2012.]
- Mikhel, D., 2010. *Meditsinskaya Antropologia: Istoria Razvitiia Distiplini* (Medical Anthropology: the History of the Discipline's Development). Saratov: Techno-Décor. Available at www.sstu.ru/files/fuss/images/Mikhel%20D%20Medical%20anthropology.pdf. [Accessed 16 September 2012.]
- Prisiazhniuk, D., 2009. Vlianie Natsional'nogo Proekta "Zdorovie" na Status Meditsinskih Rabotnikov (Influence of the National Project "Zdorovie" on status of Medical Professionals). *Economic Sociology*, 10 (4), pp. 72-83. Available at http://ecsoc.hse.ru/data/299/590/1234/5ecsoc_t10_n4.pdf#page=72. [Accessed 12 September 2012.]
- Rivkin-Fish, M., 2005. *Women's Health in Post-Soviet Russia: the Politics of Intervention*. Bloomington, Indianapolis: Indiana University Press.
- Romanov, P. and E. Iarskaia-Smirnova, 2010. Disability and Society: Twenty Years After. *Sociological Research*, 9, pp. 50-58.
- Romanov, P., Iarskaia-Smirnova E., Iarskaia V., Zaitsev D., 2011. *Zdorovie Naseleniia i Natsional'nie Reformy: Sotsial'no-Antropologicheskii Analiz* (Population Health and National Reforms: Socio-Anthropological Analysis). Moscow: Variant.
- Temkina, A., Rotkirch A. and Haavio-Mannila E., 2012. *Sexual Therapy in Russia: Pleasure and Gender in a New Professional Field*. In K. C. K. Hall and C. A. Graham, eds. 2012. *The Cultural Content of Sexual Pleasure and Problems*. London, NY: Routledge, pp. 220-248.
- Temkina, A., 2011. *Chto Delaet Seks "Opasnim": Kontratseptivnie Praktiki Sovremennoi Molodezhi* [What Makes Sex "Dangerous": Contraceptive Practices of Modern Youth]. «Gender Page», Internet project of Heinrich Bell Foundation. Available at <http://gender-page.ru/?p=316>. [Accessed 20 September 2012.]
- Zdravomyslova, E., 2009. Gendernoe Grazhdanstvo i Abortnaia Kul'tura (Gendered Citizenship and Abortion Culture). In E. Zdravomyslova and A. Temkina, eds., 2009. *Zdorovie i Doverie: Gendernii Podhod k Reproduktivnoi Meditsine*. St. Petersburg: EUSP Press, pp. 108-135.
- Zdravomyslova, E. and A. Temkina, 2009. "Vrachamja ne Doveriaiu, no..." Preodolenie Nedoveria k Reproduktivnoi Meditsine ("I do not Trust Doctors, but...") Overcoming

Distrust for Reproductive Medicine). In E. Zdravomyslova and A. Temkina, eds., 2009. *Zdorovie i Doverie: Gendernii Podhod k Reproduktivnoi Meditsine*. St. Petersburg: EUSP Press, pp. 179-210.

Zdravomyslova, E., Temkina, A., 2012. Doveritel'noe Sotrudnichestvo vo Vzaimodeistvii Vrach i Patsientki: Vzgliad Akushera-Ginecologa (Trustful Cooperation in Doctor-Patient Communication: The Obstetricians' Perspective). In E. Zdravomyslova and A. Temkina, eds., 2009. *Zdorovie i Intimnaia Zhizn': Sotsiologicheskie Podhodi*. St. Petersburg: EUSP Press, pp. 23-53.

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Developing and Establishing Medical Anthropology in Serbia

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As a new research field within social/cultural anthropology in Serbia, medical anthropology emerges both as a result of certain theoretical and epistemological changes affecting its wider disciplinary context, and as an outcome of the social and institutional transformations that have facilitated academic production in terms of teaching, research projects and articles and books exploring social and cultural aspects of (bio)medical phenomena.¹ Generally speaking, there has recently been a shift in epistemological positions and research paradigms which can be described as a move away from classical ethnomedicine and towards medical anthropology. Three areas can be pinpointed to characterise the recent development of medical anthropology in Serbia: the researches carried out by certain professors and postgraduate students affiliated with the Department of Ethnology and Anthropology of the University of Belgrade, the introduction of courses related to medical anthropology and international collaboration with research and policy institutions.

The interest in 'popular health culture' or ethnomedicine in Serbia has a long history in both biomedicine (see: Đorđević 1872; Dragić 1991; Živanović 1997; Đurić Srejić and Hadžinikolić 2000) and ethnology (later anthropology), which can be traced back to the works of the scholars who established the discipline (Đorđević 1908, 1930, 1938, 1958, 1965). The Department of Ethnology at the Faculty of Philosophy, University of Belgrade, was founded in 1906. In 1990, it changed its name to the Department of Ethnology and Anthropology and is still the only educational institution where social/cultural anthropology is taught in Serbia at undergraduate and graduate level.

The continuity in studying ethnomedicine during the twentieth century enabled researchers to create a large body of ethnographic material related to local ideas about the cause of various health disorders, ways of maintaining health and a range of prevention, diagnostic and treatment practices (Srđić Srebro 2009)

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throughout Serbia and surrounding countries.² Health, illness and treatment procedures were interpreted as a part of the system of customs, beliefs and magic-religious practices of "traditional", rural Serbian society and culture. Some research focused on the historical development and role of medical institutions and staff (Nikolić 1971, 1972, 1973), and the use of ethnomedical concepts and practices in contemporary health prevention practice (Lazarević 1975, 1977, 1979). However, the ethnomedical approach as a whole can be seen as lacking a wider theoretical perspective, as well as being characterised by a materialistic conception of the body. An important aspect of this approach was a view of illness as a fundamentally natural phenomenon ('disease'), while cultural or local conceptions and healing practices were usually thought of as 'traditional' or pre-scientific responses to pathological conditions of psychosomatic or somatopsychic disorders. Central to this approach was the opposition between conventional, 'scientific' biomedicine, on the one hand, and ethnomedicine and so-called alternative medicine, on the other. The latter was understood as a non-modern, culturally specific knowledge system rather than just as a different form of conceptualising the body, illness and well-being which may be comparable to that of scientific medical thinking. What characterised the theoretical underpinnings of ethnomedicine in Serbia throughout the last century is the abstraction of biomedical knowledge from the social conditions of its production. This approach led to a view of biomedicine as a scientific, socially decontextualised system. In this context, it can be said that recent anthropological interest in modern science as a "culturally specific form of reasoning" of modern Western societies and the understanding of the body as a socio-cultural artefact have encouraged the development of the field of medical anthropology in Serbia. Related to this recent 'reflexive turn', there has been a growing interest in questions of medical anthropology which has given rise to some nascent forms of its institutionalisation (postgraduate courses, research projects, articles and books).

The works published since the end of the 1990s have focused on the analysis of social/cultural aspects of certain (bio)medical systems, practices and phenomena, involving the conceptualisation of sickness in different medical systems (Pavlović 1999), characteristics of contemporary alternative medicine (Romelić and Vasić 1999), the media discourse of the healthy mind in the slender body (Malešević 2000), or the social and discursive construction of menopause (Malešević 2002).³

² Due to a lack of space here I cannot discuss the works on "traditional" ethnopsychology, a perspective which received much criticism for trying to establish "ethnopsychic characteristics", "national mentality", "psychic types" of ethnic and national groups in the Balkans and among the South Slavs (Cvijić 1922, 1931; Dvorniković 1939; on contemporary ethnopsychology see Jovanović 1991).

³ In addition, neuropsychiatrist, Časlav Hadžinikolić, interested in transcultural psychiatry and shamanism, received his PhD at the beginning of the 1990s at the Department of Ethnology (later Ethnology and Anthropology) for his thesis on Hallucinogenic Ritual as a Psychotherapeutic Procedure in Some Tribes of Upper Amazonia (Hadžinikolić 1991).

However, crucial to the development of medical anthropology and its institutional bases are the researches of Bojan Žikić (Department of Ethnology and Anthropology), who was the first to study HIV vulnerability and engage in systematic fieldwork research of the risk behaviour of intravenous drug users in Belgrade (Žikić 2006, 2007), and that of sex workers and the violence they are exposed to (Žikić 2008; see also Žikić 2009, 2011). This encouraged the creation of a network of young researchers interested in these topics. Through collaboration with Professor Žikić and colleagues from London Imperial College and the London School for Hygiene and Tropical Medicine, they participated in a number of different projects (2005–2010) and published their studies in anthropological and medical journals (Baroš 2006, 2010; Baroš and Žikić 2006, Bassioni Stamenić, Baroš and al. 2006; Bernays, Rhodes, Prodanović 2006; Kuneski 2006; Rhodes, Prodanović, et al. 2008; Prodanović, et al., 2006; Simić, et al. 2008; Rhodes, Simić, et al. 2008).⁴ All the projects in which social/cultural anthropologists participated were developed and conducted in collaboration with national institutions (Institutions for Public Health, National Office for HIV) and international organisations, such as the United Nation Development Programme (UNPD) or UNICEF. It is through this process of collaboration and research that the institutional basis has started to develop.

A course entitled “Anthropology of AIDS” was introduced to the postgraduate (Master) programme in 2006. However, with the education reform and departmental changes of academic programmes that occurred in 2009, anthropology of AIDS was dropped as a separate teaching course at Masters level, while medical anthropology was introduced into the PhD programme, but only as a part of a course called “Cognitive and Medical Anthropology”. It is also worth noting that the research and teaching of some medical anthropology topics has been organised as a part of other courses, such as “Anthropology of Gender and Kinship”, “Anthropology of the Body” and “National Ethnology - the Body and Identity” (undergraduate programme), “Urban and Gender Studies” (MA programme) and “Anthropology, Kinship, Biotechnologies” (Phd programme). These subjects discuss, for instance, the body as a socio-cultural artefact (Ivanović, Šarčević 2002; Ivanović 2003; Srdić 2008), cultural conceptualisations and local interpretations of reproduction, kinship and bodily processes and inheritance (Ivanović 2002), biopower, biological citizenship, the cultural phenomenology of suffering, the political technology of “disability” (Trifunjesku 2012), social, cultural and religious aspects of new reproductive technologies (Pišev 2012), and health, kinship and stem cell banking (Krstić 2012).

As a result of recent changes in teaching programmes, there has been a growing interest, among PhD and MA students, in medical anthropology issues and re-

4 In November 2006 a dissemination conference entitled “HIV Risk and Prevention in Serbia and Montenegro: Research, Policy and Action”, organised by UNPD, DFID UK, took place in Belgrade.

lated phenomena. Elena Kuneski (2011), a PhD student, explored aspects of the men who have sex with men (MSM) population in Belgrade. In 2011, Tamara Lepetić started her PhD research project on social and cultural aspects of new reproductive technologies in Serbia, both at the organisational and institutional level (health system, clinics, policy) and at the level of practice and consumer experiences, focusing especially on socially as well as medically identified reproductive pathologies and “stratified reproduction”. Research projects conducted by MA students involve questions of cultural aspects of olfactory experience (Mandić 2008), alternative medicine (Srdić 2009) and “subjects with disabilities” in Serbia (Trifunjesku 2010). Some of the most recent projects that are still in progress include the exploration of the reproductive health of Romani women in Serbia (Tatjana Malinović) and social and cultural aspects of oral hygiene in contemporary Belgrade (Milutin Micić).⁵

5 Some of the former Belgrade anthropology students doing their PhD thesis at various western universities explore medical anthropology issues not in Serbia but in other countries of the post-Yugoslav region. For example, Čarna Brković has completed her PhD thesis entitled ‘Navigating Rules and Wills: Healthcare and Social Protection in a Bosnian Border Town’ (PhD awarded in 2012 at University of Manchester). Her ethnographic study explores the recursive and complex relationship between state-provided social protection services for children with developmental disabilities and “non-state” actions (humanitarian aid, informal social networks). Although her research may not be seen to fit the (sub) disciplinary boundaries of medical anthropology, it provides an analysis of some important aspects concerning illness, costs of medical treatment and social assistance, showing how changing borders, often crossed for health care reasons, have created a specific type of social and charity practice. It is also worth mentioning a number of other western-based graduate students and scholars originating from ex-Yugoslavia, who carry out similar research projects in the region. For example, Goran Dokić completed his MA thesis on ‘Psychosocial Transition in a Postsocialist Context: Post-Traumatic Stress Disorder (PTSD) in Croatian Psychiatry’ (2009, University of Victoria, Canada, available at <https://dspace.library.uvic.ca:8443/handle/1828/1490>, see also Dokić 2008). He analysed the effects of the recent introduction of PTSD to the psychiatric discourse in Croatia and the ways in which local medical professionals reproduce, transform and resist conventional narratives of the effective treatment of war-related emotional traumatization. His PhD research project entitled ‘Between Warfare and Welfare: Veterans Associations and Social Security in Serbia’ (University of Manchester) is focused more on Serbian war veterans as a re-emergent group of welfare recipients and on the influence of informal networks on the organization and provision of social assistance in a postsocialist context rather than on medical anthropology questions *sensu stricto*. Regarding medical anthropology topics in postsocialist and post-conflict Bosnia and Hercegovina, important work has been done by Larisa Jašarević (senior lecturer, Chicago University) on the revitalisation of medical pluralism due to the reappearance of traditional and the appearance of new, more global alternative forms of medical knowledge (Jašarević 2011), on traditional and alternative medicine between the commoditization and gift economy (2012a), and on healing practice of *strava* (“great fear”) that seems to be competing with psycho-pharmaceutical treatments of anxiety and depression (2012b).

Like elsewhere where medical anthropology has emerged recently, the challenges for its further development at the national level are numerous. Although programmes involving some medical anthropology issues already exist and anthropologists are recognised by national and international organisations as partners in projects to some extent, further institutional grounding (funded anthropological projects, and not just medical projects with anthropological participation; separate course/s on medical anthropology, colloquia and conferences, publications and international collaboration) are much needed. It would also be useful to encourage projects concerning applied medical anthropology.

REFERENCES:

- Baroš S., Bojan, Ž., 2006. Kvalitativna istraživanja u okviru „Druge generacije nadzora nad HIV-om“ [Qualitative Researches Within Second Generation Surveillance for HIV]. *Socijalna misao*, 13 (3), pp. 57-75.
- Baroš, S., 2006. Kondom kao simbol profesionalnosti kod osoba koje se bave seksualnim radom u Beogradu [Condom as a Professional Symbol Among the Persons Engaged in Sex Work in Belgrade]. *Glasnik Etnografskog instituta Srpske akademije nauka i umetnosti*, 54, pp. 201-217.
- Baroš, S., 2008. Dejstvo okruženja na upotrebu kondoma među seksualnim radnicima/radnicama u Beogradu: kvalitativno istraživanje [The Effect of Environment on Condom Use Among the Sex Workers in Belgrade]. *Glasnik Instituta za javno zdravlje Srbije*, 80 (3), pp.13-18.
- Baroš, S., Bojan, Ž., 2010. Faktori rizika na mogućnost inficiranja HIV-om i rizično ponašanje među muškarcima koji imaju seks s muškarcima i ženama (MSMŽ) [HIV Risk Factors and Risk Behaviour Among Men Having Sex with Men and Women]. *Istraživanja među populacijom pod povećanim rizikom od HIV-a i među osobama koje žive sa HIV-om. Osnovni rezultati nadzornih istraživanja 2009-2010*. Beograd: Ministarstvo zdravlja Republike Srbije, pp. 333-358.
- Baroš, S., Bojan, Ž., 2010. Kontekstualni faktori koji utiču na nekorišćenje zdravstvenih usluga infektivnih klinika – odeljenja za HIV/AIDS među osobama sa HIV-om (PLHIV) [Contextual Factors Discouraging the Use of Health Services of Infectious Disease Hospitals – HIV/AIDS Clinics Among the Persons with HIV]. *Istraživanja među populacijom pod povećanim rizikom od HIV-a i među osobama koje žive sa HIV-om. Osnovni rezultati nadzornih istraživanja 2009-2010*. Beograd: Ministarstvo zdravlja Republike Srbije, pp. 359-380.
- Bassioni, S. F., and S. Baroš, Z. Čakić, D. Šormaz, E. Kuneski, et al., 2006. *Živeti sa HIV-om* [Living with AIDS]. Beograd: Institut za javno zdravlje Srbije „Milan Jovanović Batut“, Nacionalna kancelarija za HIV/AIDS.
- Bernays, S., and T. Rhodes, A. Prodanović, 2007. *HIV treatment access, delivery, and uncertainty. A qualitative study in Serbia and Montenegro*. Belgrade: United Nations Development Programme Report, Belgrade.

- Cvijić, J., 1922. *Balkansko poluostrvo i južnoslovenske zemlje I* [The Balkan Peninsula and the South Slavic Lands I]. Beograd: Državna štamparija Srba, Hrvata i Slovenaca.
- Cvijić, J., 1931. *Balkansko poluostrvo i južnoslovenske zemlje II* [The Balkan Peninsula and the South Slavic Lands II]. Beograd: Geca Kon.
- Dokić, G., 2008. Embodiment of Trauma through Performative Acts of Remembering. *Platform: Journal of Graduate Students in Anthropology*, 9, pp. 25-41.
- Dokić, G., 2009. *Psychosocial Transition in a Postsocialist Context: Post-Traumatic Stress Disorder in Croatian Psychiatry*. Unpublished MA Thesis. University of Victoria. Available at: <http://hdl.handle.net/128/1490>.
- Dvorniković, V. 1939. *Karakterologija Jugoslovena* [Characterology of the Yugoslavs]. Beograd: Geca Kon.
- Đorđević, V., 1872. *Narodna medicina u Srba* [Serbian Popular Medicine]. Novi Sad: Srpska narodna zadružna štamparija.
- Đorđević, T. R., 1908. *Medicina u Srbiji prvih godina vlade Kneza Miloša* [Medicine in Serbia during the early years of Prince Miloš' reign]. Beograd: Državna štamparija.
- Đorđević, T. R., 1930. *Naš narodni život I* [Life of our people]. Beograd: Geca Kon.
- Đorđević, T. R., 1938. *Zle oči u verovanju i običajima Južnih Slovena* [The evil eye in the beliefs and customs of South Slavs]. Beograd: Srpski etnografski zbornik LIII.
- Đorđević, T. R., 1958. Priroda u verovanju i predanju našeg naroda. *Srpski etnografski zbornik* 72, Život i običaji 33.
- Đorđević, T. R., 1965. *Nekolike bolesti i narodni pojmovi o njima* [Some diseases and their popular conceptualisations]. Beograd: Srpska akademija nauka i umetnosti, Građa XVI, Odeljenje medicinskih nauka knj. 2.
- Đurić S. M., Hadžinikolić, Č., eds., 2000. *Antropologija bolesti i zdravlja* [Anthropology of illness and sickness], Beograd: Želnid - preduzeće za železničku izdavačko-novinsku delatnost, Zavod za zdravstvenu zaštitu radnika ŽTP Beograd.
- Hadžinikolić, Č., 1991. *Halucinogeni ritual kao psihoterapijski postupak u nekim plemenima gornje Amazonije* [Hallucinogenic ritual as a psychotherapeutic procedure in some tribes of Upper Amazonia]. PhD. thesis, unpublished manuscript. Belgrade: Faculty of Philosophy, University of Belgrade.
- Ivanović, Z., 2002. Na koga liče deca? Srodstvo kod Srba i principi percepcije sličnosti među srođnicima [Who Do Children Take After: Serbian Kinship and Principles of Perceiving the Resemblance Between Kin]. In *Životni ciklus u gradskoj sredini*. Beograd: Posebna izdanja EI SANU, knj. 48, pp. 375-408.
- Ivanović, Z., and P. Šarčević, 2002., Uvod: O statusu tela u antropologiji [Introduction: On Body Status in Anthropology]. *Antropologija tela, Kultura*, 105-106, pp. 9-26.
- Ivanović Z., 2003., „Antropologija žene“ i pitanje rodničkih odnosa u izmenjenom diskursu antropologije [„Anthropology of Women“ and the Question of Gender Relations in Changed Discourse of Anthropology]. In Ž. Papić, L. Sklevicky, eds., 2003. *Antropologija žene*. Beograd: Drugo izdanje, XX vek, pp. 381- 435.
- Jasarevic, L., 2011. Lucid Dreaming: Revisiting medical pluralism in postsocialist Bosnia. *Anthropology of East Europe Review*, 29 (1), pp. 109-126.
- Jasarevic, L., 2012a. *Three Lights on the Queen's Face: On Mixing, Muddle, and Mêlée*. Religion & Culture Web Forum. The Martin Marty Center for the Advanced Study of Religion.

- Available at: <http://divinity.uchicago.edu/martycenter/publications/webforum/042012/Jasarevic%20Web%20Forum%20Final%20.pdf>. [Accessed 15 June 2013.]
- Jasarevic, L., 2012b. Pouring out Postsocialist Fears: Practical Metaphysics of a Therapy at a Distance. *Comparative Studies in Society and History*, 54 (4), pp. 914-941.
- Jovanović, B., ed., 1991. *Ethnopsihologija danas* [Ethnopsychology Today]. Beograd: Dom kulture "Studentski grad".
- Krstić, M., 2012. Zdrava porodica i uspešno roditeljstvo: antropološka analiza Internet medija o očuvanju matičnih ćelija u Srbiji [Healthy family and successful Parenthood: an Anthropological Analysis of Stem Cell Banking in Serbian Internet Media]. *Antropologija / Anthropology*, 12 (3). (Forthcomming.)
- Kuneski, E., 2006. Štek: susret dva sveta. Urbana legenda beogradskih intravenskih korisnika droge [„Štek“: When Two Worlds collide. Belgrade Injecting Drug Users' Urban Legend]- *Antropologija / Anthropology*, 2, pp. 35-44.
- Kuneski, E., 2011. *Društvena i prostorna organizacija MSM populacije u Beogradu* [Social and Spatial Organisation of Men Who Have Sex With Men/MSM Population in Belgrade]. PhD. thesis, unpublished manuscript. Belgrade: Faculty of Philosophy, University of Belgrade.
- Lazarević, A., 1975. Seksualna potencija-impotencija kao pojam u našim narodnim običajima [Sexual Potency/Impotence as a Concept in Our Popular Customs]. *Glasnik Etnografskog instituta*, 24, pp. 115-127.
- Lazarević, A., 1977. Hirurgija i ortopedija u narodnoj medicini kod Srba [Surgery and Orthopedics in Serbian Popular Medicine]. *Glasnik Etnografskog instituta*, 26, pp. 95-117.
- Lazarević, A., 1979. Kontracepcija u našoj etno-medicini i njena primena u savremenoj zdravstvenoj zaštiti [Contraception in Our Ethnomedicine and Its Use In Contemporary Health Prevention Practice]. *Glasnik Etnografskog instituta*, 28, pp. 153-160.
- Malešević, M., 2000. Reklamna bajka o zdravom duhu u vitkom telu [An Advertising Fairy Tale of the Healthy Mind in the Slender Body]. In M. Đurić-Srejić, Č. Hadžinikolić, eds., 2000. *Antropologija bolesti i zdravlja*. Beograd: Želnid - preduzeće za železničku izdavačko-novinsku delatnost, Zavod za zdravstvenu zaštitu radnika ŽTP Beograd, Srpsko antropološko društvo, pp. 161-168.
- Malešević, M. 2002. Menopauza-poslednja misterija krvi [Menopause- The Last Mystery of Blood]. In *Običaji životnog ciklusa u gradskoj sredini*. Beograd: Etnografski institut Srpske akademije nauka i umetnosti, Posebna izdanja knj. 48, pp. 199-215.
- Mandić, B., 2008. Kulturni aspekti olfaktornog iskustva [Cultural Aspects of Olfactory Experience]. MA thesis, unpublished manuscript. Belgrade: Faculty of Philosophy, University of Belgrade.
- Nikolić, Stojančević, V., 1971. Prva sanitetska služba i zdravstvene prilike u oslobođenim krajevima 1877-1878. godine [The First Battlefield Medical Service and Health Situation in the Regions Freed in 1877-1878]. In *Zbornik XXI naučnog sastanka, Niš: Naučno društvo za istoriju zdravstvene kulture Jugoslavije*, pp. 69-75.
- Nikolić Stojančević, V., 1972. Uloga Aleksinačkog karantina u migracionim kretanjima u Srbiji i novooslobođenim krajevima do 1878. godine [The role of Aleksinac Quarantine in the Migration Within Serbia and Newly freed Regions Up To 1878]. *Arhiv za istoriju zdravstvene kulture Srbije*, 2 (2), pp. 195-199.

- Nikolić Stojančević, V., 1973. Uputstva i naredbe dalmatinske provincijalne uprave za suzbijanje kuge i kolere na zadarskom području 1814-1831 [Guidelines and Orders of the Municipal Government in Dalmatia for Checking the Spread of Plague and Cholera in the Region of Zadar 1814-1831]. *Acta- časopis jugoslovenskog društva za istoriju medicine*, 13 (2), p. 155.
- Nikolić Stojančević, V., 1973. Prvi medicinski i akušerski kadar vranjanskog okružnog fizikata 1903-1906 [The First Medical and Midwifery Staff in the Municipality of Vranje 1903-1906]. *Arhiv za istoriju zdravstvene kulture Srbije*, 2 (2), pp. 143-146.
- Pavlović, M., 1999. Pojam bolesti u različitim medicinskim sistemima [The Concept of Illness in Different Medical Systems]. *Glasnik Etnografskog instituta Srpske akademije nauka i umetnosti*, 48, pp. 95-106.
- Pišev, M., 2012. "Zovite ih po očevima njihovim". Muška sterilnost i nove reproduktivne tehnologije u svetlu islama ["Name Your Adopted Sons After Their Fathers". Male Sterility and the New Reproductive Technologies in the Light of Islam]. *Antropologija / Anthropology*, 12 (3), pp. 155-167.
- Prodanović, A., Žikić B., Rhodes T., and Kuneski, E., 2005. Delenje pribora za ubrizgavanje droge kao faktor rizika za HIV/HCV među intravenskim zavisnicima u Beogradu [Distribution of Drug Injection Equipment as a Risk Factor for HIV/HCV Among the Intravenous Addicts in Belgrade]. In B. Шуловић, B. Цуцић, and Д. Илић, eds. 2005. *Intervencije i programi za posebno vulnerabilne grupe za SIDU*. Beograd: Srpska akademija nauka i umetnosti – Međudodeljski odbor za SIDU / Asocijacija za borbu protiv SIDE JAZAS. Pp. 173-185.
- Prodanović, A., 2006. HIV risk and prevention in Serbia and Montenegro: Research, policy and action. *Antropologija / Anthropology*, 1, pp. 127-131.
- Rhodes, T., Žikić, B., Prodanović, A., Kuneski, E., Bernays, S., 2008. Hygiene and uncertainty in qualitative accounts of hepatitis C transmission among drug injectors in Serbia. *Social Science & Medicine*, 66 (6), pp. 1437-1447.
- Rhodes, T., and A. Prodanović, B. Žikić, E. Kuneski, T. Pavićević, D. Karadžić, S. Bernays, 2008. Trust, disruption and responsibility in accounts of injecting equipment sharing and hepatitis C risk. *Health, Risk & Society*, 10 (3), pp. 221-240.
- Rhodes T., and M. Simić, B. Slađana, L. Platt, B. Žikić, 2008. Police violence and sexual risk among female and transvestite sex workers in Serbia: qualitative study. *BMJ* 337; a811.
- Romelić, Ž., and V. Tojaga, 1999. Neke karakteristike alternativne medicine danas [Some Characteristics of Alternative Medicine Today], In *Za zdravlje. Iz istorije narodne medicine i zdravstvene kulture*, Zaječar: Narodni muzej Zaječar i Zavod za zaštitu zdravlja Zaječar.
- Simić M., and J. L. Grazina, L. Platt, S. Baros, V. Andjelkovic, T. Novotny, T. Rhodes, 2006. Exploring Barriers To 'Respondent Driven Sampling' In Sex Worker And Drug-Injecting Sex Worker Population In Eastern Europe. *Journal of Urban Health*, 83 (1), pp. 6-15.
- Simić D., and Z. Gledović, J. Zajeganović, S. Baroš, 2008. Procena prevalencije HIV i virusne hepatitisa C infekcije, faktora rizika, rizičnog ponašanja i korišćenja usluga u populaciji injektirajućih korisnika droga u Beogradu, Novom Sadu i Nišu [Assessment of the Prevalence of HIV and Hepatitis C infection, Risk factors, Risk Behaviour and the Use of Ser-

- vices Among the Population of Intravenous Drug Users in Belgrade]. *Glasnik Instituta za javno zdravlje Srbije*, 80 (3), pp. 1-7.
- Šrdić, A., 2008. Telo i telesnost u antropološkoj perspektivi [The Body and Corporality in an Anthropological Perspective]. *Glasnik etnografskog muzeja*, 72, pp. 93-105.
- Šrdić Srebro, A., 2009. Medicinska antropologija i/ili antropologija zdravlja i bolesti [Medical Anthropology and/or Anthropology of Health and Illness]. *Etnološko-antropološke sveske*, 14 (3), pp. 79-92.
- Šrdić, A., 2009. Uticaj dalekoistočnih isceliteljsko-meditativnih tehnika na promenu predstava o telu u Srbiji [Impact of Far East healing and meditative techniques on changing notions of corporality in Serbia]. MA thesis, unpublished manuscript. Belgrade: Faculty of Philosophy, University of Belgrade.
- Trifunjesku, S., 2010. Od telesne razlike do „invalidnosti“ u savremenoj Srbiji: između diskursa i iskustva [From body difference to „disability“ in contemporary Serbia: between discourse and experience]. MA thesis, unpublished manuscript. Belgrade: Faculty of Philosophy, University of Belgrade.
- Trifunjesku, S., 2012. Political technology of „disability“. *Antropologija / Anthropology*, 12 (3). [Forthcoming.]
- Žikić, B., 2006. *Antropologija AIDS-a. Rizično ponašanje intravenskih korisnika droge* [Anthropology of AIDS. Risk Behaviour of Intravenous Drug Users]. Beograd: Filozofski fakultet i Srpski genealoški centar, Etnološka biblioteka knj. 19.
- Žikić, B., 2006. Anthropology of AIDS. Risk environment and injecting routine. The case of Belgrade injecting drug users. *Issues in Ethnology and Anthropology*, 1 (1), pp. 35-46.
- Žikić, B., 2006. Managing HIV/HCV-related Risk at Private Places Among Belgrade Injecting Drug Users. *Bulletin of the Institute of Ethnography*, 54, pp. 189-199.
- Žikić, B., 2006. Antropološka analiza HIV-vulnerabilnosti i rizičnog ponašanja u Beogradu [Anthropological Analysis of HIV Vulnerability and Risk Behaviour in Belgrade]. In Z. Divac, ed., 2006. *Svakodnevna kultura u postsocijalističkom periodu u Srbiji i Bugarskoj*, Beograd: Etnografski institut SANU, 22, pp. 57-75.
- Žikić, B., 2006. Generally Mistreated Bodies: Injecting Drug Users, Their Habits, and Law Enforcement. *Symposia - Journal for Studies in Ethnology and Anthropology*, pp. 259-272.
- Žikić, B., 2007. Injecting Drug Users' Utilisation of Public Space in Belgrade: Places, Risk-management, and Habitual Life. *Bulletin of the Institute of Ethnography*, 55 (1), pp. 103-114.
- Žikić, B., 2008. *Rizik i nasilje. Antropološko pručavanje seksualnog rada u Beogradu* [Risk and Violence. An Anthropological Investigation into Sex Work in Belgrade]. Beograd: Odeljenje za etnologiju i antropologiju Filozofskog fakulteta i Srpski genealoški centar.
- Žikić, B., 2008. „Neukročena goropad“: upravljanje reprodukcijom kao kulturna praksa [The Untamed „Shrew“: Managing Reproduction as Cultural Practice]. *Etnoantropološki problemi*, 3 (1), pp. 143-157.
- Žikić, B., 2009. The Same Risk, the Different Vulnerability? Social Environment as Risk-Generating Factor in Injecting Drug Users and Sex Workers. *Issues in Ethnology and Anthropology*, 4 (1), pp. 149-162.

- Žikić, B., 2011. Društveni činioci zdravstvene vulnerabilnosti marginalizovanih društvenih grupa [Social Factors of Health Vulnerability of Marginalized Social Groups]. *Etnoantropološki problemi*, 6 (3), pp. 783-805.
- Žikić, B., 2011. Reproktivno zdravlje i reproduktivna vulnerabilnost [Reproductive Health and Reproductive Vulnerability]. *Etnoantropološki problemi*, 6 (4), pp. 885-903.
- Živanović, S., 1997. *Medicinska antropologija. Pogledi i razmišljanja* [Medical anthropology. Views and considerations]. Beograd: Akademia nova.

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Medical Anthropology in Slovenia

Katerina Vidner Ferkov

Historical influences

Slovenian anthropology was influenced by scholarship of *ethnologie* und *ethnographie* of German origin. The first university seminar in ethnography in Slovenia took place in 1919,¹ and through this paradigm the first interest in what today forms the subject of medical anthropology was pursued.

The academic subject of medical anthropology in Slovenia² is relatively new when compared to academic endeavors in the English-speaking world. According to Lipovec Čebon (2008: 64), the first academic writings that could be interpreted from the current perspective as fitting in the subject field of medical anthropology were ethnological accounts of traditional folk healing in Slovenia, especially after the Second World War. The main motive of these ethnographic accounts was to capture the 'disappearing traditions' that were giving way to biomedical practices. Traditional healing was thus described as 'delusional', 'magical' and in other pejorative terms. By understanding traditional folk healing practices through the use of the biomedical paradigm, the latter became established as the only valid tool for describing health and healing (Lipovec Čebon 2008: 68-69).³ In Slovenia even today, a negative view on medical pluralism lingers as several critical medical anthropology texts maintain (Lipovec Čebon 2008; Šimenc 2012; Vidner Ferkov 2012).

1 Department of Ethnology and Cultural Anthropology, http://etnologija.etnoinfolab.org/sl/informacija.asp?id_meta_type=72&id_informacija=203. Accessed 9 September 2012.

2 Short historical facts about Slovenia: before becoming a part of socialist Yugoslavia (1945-1991), Slovenia belonged to the Kingdom of Yugoslavia (1918 - 1943) and was strongly influenced by its former ruler, the Hapsburg Monarchy (1526 - 1804). Slovenia gained independence in 1991.

3 Several selected authors and their ethnological accounts of traditional folk healing include Vilko Novak (1960), Slovenska ljudska kultura: Oris; Marija Makarovič (1978), 'Ljudsko zdravilstvo - na primeru Pregare v Istri'; Ivan Moderndorfer (1964) Ljudska medicina pri Slovencih; Anton Mrkun 'Ljudska medicina v dobropoljski dolini'. Detailed references are available in Lipovec Čebon (2008).

Current developments

The crucial step for the development of medical anthropology in Slovenia occurred simultaneously with the independence of the state, in the academic year 1990/91, when *cultural anthropology* explicitly appears in the name of the Department for Ethnology and Cultural Anthropology at the Faculty of Arts of the University of Ljubljana. Medical anthropology became an academic subject in 2003 at the Faculty of Arts, taught by Lipovec Čebon. Šimenc observes that the year 2010 proved to be an impediment in the institutional development of medical anthropology, as two academic subjects in Slovenia were cancelled due to lack of state funding - medical anthropology for graduate students at the Faculty of Arts and the postgraduate module at the University of Nova Gorica (Šimenc 2012). In 2012, medical anthropology became a part of the postgraduate program at the Faculty of Arts. Medical anthropology is also a non-compulsory subject at The Faculty of Humanities in Koper.⁴

In the academic sphere of medical anthropology in Slovenia, female researches represent the majority. For them, medical anthropology is also a tool enabling a critical approach to certain standardized procedures regarding women's health in the biomedical context. The subject of women's health, specifically the biomedical institutionalization and hegemonic approach to birth and birth practices was the focus of extensive anthropological research carried out by Zalka Drglin (2003) and Irena Rožman (2004), who wrote relevant studies intrinsically related to this gender issue. Drglin and Rožman are also publicly involved as advocates for a holistic approach to birth and birth related practices, aiming to empower women to voice their rights in the biomedical context. Mojca Ramšak (2007) conducted her research on the topic of the social and cultural imagery of breast cancer in Slovenia. These female authors opened important topics not only in academia but also in the media, which resulted in an active response from women in Slovenia⁵.

Slovene (medical) anthropologist, associate professor Borut Telban, was the initiator and coordinator of the 'Anthropology of health, illness and treatment' module in the postgraduate study program in Intercultural Studies: Comparative Studies of Ideas and Cultures. Telban enabled Slovene postgraduate students to participate at lectures of acclaimed authors from the field of medical anthropology, including Allan Young, Margaret Lock and William Sax, during a study course at the University of Nova Gorica in collaboration with the Research Center of the Slovenian Academy of Arts and Sciences (ZRC SAZU).

4 The lecturer is Mojca Marija Terčelj, Ph.D., University of Primorska, <http://www.fhs.upr.si/en/courses>. Accessed 9 September 2012.

5 Maternity Care Initiative, <http://www.mamazofa.org/en/akcije/maternity-care-initiative>. Accessed 27 September 2012.

In 2009 at the Faculty of Arts, University of Ljubljana, Lipovec Čebtron and Šimenc⁶ together with their colleagues organized the first international scientific symposium on the subject of medical anthropology in Slovenia: *Medical anthropology and biomedicine in collaboration*. In March 2012, Šimenc and Lipovec Čebtron organized another symposium entitled *Medical anthropology in Slovenia: researches, reflections and dilemmas*.⁷ The papers presented at the symposiums revealed that social changes, as well as the absence of medical pluralism in Slovenia, are subjects that draw the attention of many researches and students. As critical medical anthropologists noted, as elsewhere, many health related questions are also linked to power structures and social stratification in Slovenia, and they cannot just be reduced to often-simplistic biomedical explanations. In times when public health in Slovenia is in decline (Vidner Ferkov 2012) and the quality of medical care is increasingly a matter of financial status, critical medical anthropology has not only an academic potential, but is also acting as a supporter of civil movements (supporters of birth at home, citizens without health insurance, asylum seekers, drug users, parents who do not want to vaccinate their children, vegans, holistic health supporters) that promote accessible health services and medical pluralism.

Slovene Researchers

Maja Petrović-Šteger is a Research Fellow at Peterhouse, and member of the Department of Social Anthropology at the University of Cambridge. Her work and lectures are related to the subject of medical anthropology. Uršula Lipovec Čebtron is researching the field of uninsured persons in Slovenia (ex Yugoslavians), immigrants (in Italy), citizenship and complementary and alternative medicine (CAM); Jana Šimenc was researching the subject of allergies in Slovenia and Croatia and is currently writing about organ transplantation and donation in Europe. Katerina Vidner Ferkov conducted her Ph. D. fieldwork with women using CAM; she is interested in health issues related to gender, the transition from state socialism to a market approach to health in Slovenia and in activism of online communities regarding health. At the conference of the European Association of Social Anthropologists (EASA) in Paris in July 2012, Vidner Ferkov was elected, together with Dominik Mattes (Freie Universität Berlin) as the coordinator of Medical Anthropology Young Scholars (MAYS).⁸ Doctoral students at the Universi-

6 Organising committee: Jana Šimenc, Uršula Lipovec Čebtron, Rajko Muršič. Scientific committee: Uršula Lipovec Čebtron, Rajko Muršič, Jana Šimenc, Katerina Vidner Ferkov, Barbara Hrovatin, Mojca Ramšak.

7 http://etnologija.etnoinfolab.org/dokumenti/79/2/2012/posvet-program_2222.pdf. Accessed 20 September 2012.

8 Medical Anthropology Young Scholars, <http://www.mays-easa.org/>, [accessed 20 September 2012].

ty of Nova Gorica are exploring different subjects of medical anthropology: Barbara Hrovatin, M.D., is researching the understanding of healing in biomedicine through reflections of physician-teachers in Slovenia. Tomi Bartole is involved in studying the influence of psychoanalysis in medical questions, epilepsy and organ donation in Slovenia. Tanja Ahlin conducted her Master's research on eating disorders in India and graduated from the University of Heidelberg. She has published articles about doctor-patient relationships, e-health in biomedicine and Ayurveda (Ahlin 2011, 2012), and is writing on health insurance in Slovenia and India. Ahlin is also actively involved as an IT Officer of the Medanthro network⁹ mailing list and is continuing her Ph.D. studies on the topic of transnational families, new media and care.

REFERENCES

- Ahlin, T., Brijnath, B., 2012. Online empowerment? Examining Patient-Provider Relationships in Biomedical and Ayurvedic Health Forums. Paper submitted to *Science Studies*.
- Ahlin, T., 2011. Technology and Cultural (R)evolution: Can Telemedicine Give Power to the Patients? *Curare*, 34 (3), pp. 165-172.
- Drglin, Z., 2003. *Rojstna hiša: kulturna anatomija poroda* [Birth House: Cultural Anatomy of Birth]. Ljubljana: Delta.
- Lipovec Čebtron, U., 2012. Access to the public health system of Slovenia: paradoxes, dilemmas and strategies. Paper presented at the conference "Health in transition: ethnographies of bio-medicine in post-socialist Europe", Romanian Academy of Sciences, Bucharest.
- Lipovec Čebtron, U., 2011. Bodies of erased as a record of exclusion and resistance. In A. D. Napier, A. Hobart, eds. 2011. *The moral borders of self and other: migration, reconciliation, and human wellbeing*. Proceedings of the international conference, Monte Verita, Ascona, Switzerland, June 3-4 2011. Ascona: Centro Incontri Umani.
- Lipovec Čebtron, U., 2008. *Krožene bolezni in zdravja: tradicionalna in komplementarne medicine v Istri* [The Circling of Disease and Health: Traditional and Complementary Medicines in Istra]. Ljubljana: Filozofska fakulteta.
- Petrović Šteger, M., 2009. Accounting for Remains: Potential and Loss in the Repatriation of Tasmanian Body Parts. Submitted to *The Journal of the Royal Anthropological Institute* (under revision).
- Petrović Šteger M., 2003. Practices of Justice and Conceptions of Truth: Truth and Reconciliation Commissions. Available at: www.eurozine.com/article/2003-12-02-petrovic-en.html. [Accessed 19 June 2013].
- 9 The Medical Anthropology Network of the European Association of Social Anthropologists (EASA) aims at strengthening the subfield by enabling the exchange of information and increasing opportunities for collaboration, <http://www.easaonline.org/networks/medical/index.shtml>. [Accessed 8 October 2012.]

- Petrović Šteger M., 2003. New Reproductive Technologies and the Ideology of the Body in Slovenia. *Časopis za Kritiko Znanosti*, 31 (211), pp. 272-297.
- Ramšak, M., 2007. *Social and cultural imagery of breast cancer in Slovenia*. Ljubljana: Europa Donna.
- Rožman, I., 2004. *Peč se je podrla!: kultura rojstva na slovenskem podežlju v 20. stoletju* [The oven has collapsed! Culture of Birth in the Slovene Rural Areas in the 20th Century] Ljubljana: Slovensko etnološko društvo.
- Šimenc, J., 2012. *Vidni in nevidni simptomi: alergije med družbenim, kulturnim in biološkim* [Visible and Invisible Symptoms: Allergies Among the Social, the Cultural and the Biological]. Ph.D. thesis, unpublished manuscript. Ljubljana: University of Ljubljana.
- Telban, B., 2001. *Andaypa: eseji o smrti v novogvinejski skupnosti* [Andaypa: Essays on the Death of a New Guinean Community]. Maribor: Založba Obzorja.
- Telban, B., 2009. A struggle with spirits: hierarchy, rituals and charismatic movement in a Sepik community. In P. A Stewart and A. Strathern, eds. 2009. *Religious and Ritual Change: Cosmologies and Histories* [Ritual Studies Monograph Series]. Durham, N.C.: Carolina Academic Press, pp. 133-158.
- Vidner Ferkov, K., 2012. *Healing Femininity – Balancing Energies, Women and New Age Spirituality in the context of Non-institutional Complementary Practice in Slovenia*. Ph.D. thesis, unpublished manuscript. Nova Gorica: University of Nova Gorica.
- Vidner Ferkov, K., 2012. "Why do Women do it?" Anthropological Research of a Complementary Practice. In B. Filej, ed., 2012. *Holistic Treatment of Patients – How Close Are We to Achieve Our Goal?* Proceedings book with peer review. Novo Mesto: School of Health Sciences, pp. 73-79.
- Židov, N., 1996. *Alternativna medicina v Sloveniji: etnološki vidik* [Alternative medicine in Slovenia: Ethnological Perspective]. Ph. D. thesis, unpublished manuscript. Ljubljana: University of Ljubljana.

ON-LINE SOURCES

- Anthropological Notebooks.
Available at: www.drustvo-antropologov.si/anthropological_notebooks_eng.html. [Accessed 7 September 2012.]
- Department of Ethnology and Cultural Anthropology, http://etnologija.etnoinfolab.org/sl/informacija.asp?id_meta_type=72&id_informacija=203. [Accessed 7 September 2012.]
- Research Center of Slovenian Academy of Arts and Sciences, <http://iaps.zrc-sazu.si/en/sodelavci/borut-telban-en#v> [Accessed 7 September 2012].
- University of Primorska, <http://www.fhs.upr.si/en/courses> [Accessed 12 September 2012].

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Ethnological Research in Slovakia in Relation to Medical Anthropology

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The discipline of cultural or social anthropology was not institutionalized in Slovakia until 2002, when the Department of Social Anthropology was established at the Comenius University in Bratislava. The counterpart of anthropology has been ethnology, initially oriented to traditional/folk culture. Later, since the end of the 1960s, the research area has been broadened: ethnologists started to explore urban communities, ethnic groups, politics, religious movements and various contemporary social phenomena. Thus far, therefore, medical anthropology has not existed in Slovakia as a specific anthropological sub-discipline aimed at exploring bio-cultural adaptation and health issues in relation to cultural context. Ethnographic research in general was not related to anthropological theories, but corresponded to the particular development of ethnology in socialistic countries. Yet, in some areas, it has been related to the topics of health care and sickness, and therefore could be regarded useful for medical anthropologists. This paper will briefly present the relevant topics of ethnological research and make an allusion to some themes of recent research in other disciplines of the social sciences that might motivate anthropologists and ethnologists exploring medical issues.

The list of the main research topics of ethnology in Slovakia (Horváthová 1995: 23 - 43) includes general research questions, such as employment, food, hygienic practices, cosmetics, and social institutions, that might be important for medical anthropology. But these should be interpreted in relation to corresponding theories, and this has not been done so far. Nevertheless some topics in the list are related to medicine. First of all, this concerns the folk knowledge and oral traditions explored by ethnologists as well as folklorists. Ethnographical monographs dedicated to particular villages or regions usually contained chapters on folk beliefs and practices including folk medicine (see, for instance, Horváthová 1974; Jakubíková 1972); the same could be said about encyclopaedic publications comprising many entries related to folk medicine (Veľký, Vladár 1977–1982). Ethnologists have explored, for example, folk beliefs related to various kinds of sickness or different parts of the human body, healing herbs, childbirth practices, magical healing, and the interpretation of illness in supernatural terms, such as witchcraft or

the evil eye. Magical beliefs and practices were often in the focus of ethnologists' attention. This line of research has been continued by some recent publications on regional traditional healing practices (for instance, Marec 2011) and an encyclopaedia of traditional culture, recently published on the internet, that includes such entries as healers, healing/magic practices, healing herbs, and various kinds of sickness (Kiliánová 2011). The prevalence of research on folk/traditional medicine in the sphere of health / sickness has been determined by the initial orientation of ethnology on traditional culture. However, since the 1990s, magical practices related to illness have become an object of research in cognitive anthropology aimed at exploring the cognitive mechanisms involved in folk beliefs (for instance, Jerotijević 2011). This research is not necessarily concerned with traditional culture and might examine cultural models of health and sickness in the context of esoteric movements and alternative/spiritual medicine (Bužeková 2011).

Recent ethnological research in general has tended to be oriented more on contemporary society than traditional culture. Ethnologists have studied the topics of the human body and ageing (Herzánová 2007) or sport activities (Botíková 2005), which might be relevant for medical anthropology. Yet such vital questions as public health care or health education did not attract their attention. But then again these domains have become an important issue in related disciplines, such as in particular sociology and pedagogy (see, for instance, Matulník, Imrichovičová, Brukkerová 1999; Hegyi, Takáčová, Brukkerová 2004). Sociologists and pedagogues exploring the topics of public health care and health education have often used ethnographic research methods; their works might have inspired ethnologists and a new generation of anthropologists, but so far have not had any response. Their results might be helpful for future ethnological and anthropological research that would explore in detail the social conditions of public health care, cultural models of health and illness and mechanisms of their transmission, as well as processes of children's learning and adaptation to their environment.

It could be said that the discipline of medical anthropology in Slovakia does not exist. Yet some ethnological works, as well as results obtained in related social disciplines might motivate future research in this area. Publications on folk medicine describe representations of health and sickness in a broader cultural context and therefore might be useful for investigating cultural modes of healing. On the other hand, sociological and pedagogical works can provide ethnologists with initial data on public health care and health education.

REFERENCIE

- Botíková, M., 2005. Šport a rekreácia v biografických rozprávaniach žien. *Etnologické rozpravy*, 2, pp. 17-30.
- Bužeková, T., 2011. Tradícia a experti: Legitimizácia neošamanských praktík. In M. Kanovský, D. Jerotijević, T. Bužeková, eds., 2011. *Kognitívne vysvetlenie magických predstáv a praktík*. Bratislava: Eterna Press, pp. 75-130.
- Hegyi, L., Takáčová, Z., Brukkerová, D., 2004. *Vybrané kapitoly z pedagogiky a komunikácie pre verejné zdravotníctvo*. Bratislava: SZU.
- Herzánová, L., 2007. Autobiographies and life records as sources for research into old age in Bratislava and Vienna. In Z. Profantová, ed., 2007. *Small history of great events after 1948, 1968 and 1989*. Bratislava: Academia Press, pp. 420-437.
- Horváthová, E., 1974. Ludové liečenie. In J. Mjartan and E. Plicková, ed., 1974. *Horehronie II. Kultúra a spôsob života ľudu*. Bratislava, pp. 301-322.
- Horváthová, E., 1995. *Úvod do etnológie*. Bratislava: UK.
- Jakubíková, K., 1972. Ludové liečenie. In J. Podolák, ed., 1972. *Zamagurie. Národopisná monografia oblasti*. Košice, pp. 263-269.
- Jerotijević, D., 2011. Magické myslenie a kontaminácia. In M. Kanovský, D. Jerotijević, T. Bužeková, eds., 2011. *Kognitívne vysvetlenie magických predstáv a praktík*. Bratislava: Eterna Press, pp. 22-74.
- Kiliánová, G., ed., 2011. *Tradičná ľudová kultúra Slovenska slovom a obrazom*. Bratislava: Koordinačné centrum tradičnej ľudovej kultúry, SĽUK, Ústav etnológie SAV [online]. Available at: www.ludovakultura.sk/index.php?id=11. [Accessed 16 June 2013.]
- Marec, J., 2011. *Tradičné liečiteľstvo a ľudová mágia na horných Kysuciach*. Martin: Vydavateľstvo Matice slovenskej.
- Matulník, J., Imrichovičová, M., Brukkerová, D., 1999. *Súčasný trendy v sociológii zdravia a choroby*. Bratislava: SSS SAV.
- Veľký, J., Vladár, J., eds., 1977-1982. *Encyklopédia Slovenska*. Bratislava: Veda.

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Medical anthropology and related qualitative research in the Czech Republic

Ema Hrešanová

Czech social anthropologists do not seem to find research topics such as health, illness, healing or medicine particularly “hot”. In two out of the four main anthropological journals (*Český lid*; *Lidé města*¹), we find no study on these or any other issues related to medical anthropology scholarship; only a number of book reviews (e.g. Beranská 2011; Kotrlý 2008) slightly touch the topic. The journal *Český lid: Etnologický časopis* (*The Czech Nation: Ethnological journal*) includes only a single ethnographic study of the body in the school environment (Kaščák, Oberťová 2012); and in another journal *Lidé města* (*Urban People*) a research report by Sinecká (2003) on the community and integration of deaf people is the closest we get to the subject. During its history, the *Cargo* journal has published just one study by Zamykalová (2003) on new reproductive technologies (NRT), which is inspired by theoretical perspectives coming from the social studies of technology and science and sociological perspectives on health and illness. As far as the number of papers relevant to medical anthropology is concerned, the last journal, *Antropowebzin*, seems to be doing best, as it includes two studies by Czech anthropologists on traditional healing practices which are however based on fieldwork outside Europe.

An academic community of medical anthropologists simply seems to be missing in the Czech Republic. Nevertheless, there are several individual researchers, including the guest editors of this special issue, who do engage in this field of anthropological research. Edit Szénássy (Charles University in Prague) conducted her dissertation fieldwork in Eastern Slovakia while investigating the intersections of reproductive decision-making, access to reproductive care and population politics in a poor Roma community (2010). My ethnographic study (Hrešanová 2008) of two Czech maternity hospitals provides insights into the cultures of these institutions, and describes how these cultures have shaped birth care and ways in which midwives and obstetricians approached different women giving birth and their babies. In a current project, I have been focussing on an investigation of the experience of women giving birth (Hrešanová 2011). I am especially interested in

1 See: http://eu.avcr.cz/Casopisy/cesky_lid/index.html, <http://lidemesta.cz/index.php?id=10>.

the perspectives and activities of those women who promote the idea of natural childbirth and struggle to enforce changes in the Czech birth care system within the wider natural childbirth movement.²

Another medical anthropologist and social epidemiologist Andrej Belák (Charles University in Prague) also addresses the issue of health among the Roma in Central Slovakia in his applied research project, while building on long-term ethnographic fieldwork in Roma villages. His dissertation research project aims to improve medical professionals' cultural sensitivity to their Roma patients.³ Jaroslav Klepal (Charles University in Prague) is one of the few (if not the only) Czech medical anthropologist(s) whose fieldwork is situated in another part of the CEE region. He studies the politics and moralities of trauma related to post-traumatic stress disorder among war veterans in Bosnia and Herzegovina (in press; 2012 – see also the HIT conference report by E. King in this issue; 2011). In his previous research on Hare Krishna followers, he investigated their conception of the body and embodiment in relation to their subjectivity and spirituality (Klepal 2006).

There are also Czech anthropologists who investigate traditional medical and healing practices in different parts of the world. Their research interests predominantly focus on medical pluralism and local aetiologies. Miroslav Horák (2010) from the Charles University in Prague, conducted his fieldwork in a drug rehabilitation centre in Tarapoto, Peru. His study provides an insight into local aetiology and healing practices, especially those applying traditional indigenous medicine such as *ayahuasca*. Similarly, Kateřina Mildnerová (2008, 2010a, b) based at the University of West Bohemia in Pilsen, studied local conceptualizations and aetiology of illness in the Bantu-speaking region of Africa. Her dissertation (2010a) is based on long-term ethnographic fieldwork in Lusaka, Zambia, during which she studied local medical cultures and medical pluralism in this urban setting, while paying special attention to spiritual healing practices and the role of witchcraft. The issue of spirit possession is a crucial theme in the work of yet another Czech anthropologist doing research in Africa. Vendula Řezáčová (2011) from the Charles University, conducted research among the Venda in South Africa. In her dissertation, she demonstrates that “traditional” healing practices among the Venda have been a subject of numerous changes and the “tradition” they rely on has been constantly reshaped by wider socio-political changes. It is within this context that she investigates ancestor spirit possession as a means of recruiting traditional healers. Her study provides insights into current transformations of this cult, as

2 The project's full title is “Natural childbirth movement and feminist approaches to childbirth in the Czech Republic: Systems of social actions and thought”; and is funded by the Czech Science Foundation (GAČR P404/11/P089). This contribution builds on this research project.

3 See also Belák's Academia webpage summarizing his research effort: <http://cuni.academia.edu/AndrejBelak>.

well as of the whole Venda society, while paying a special attention to changes in gender relations.

Besides these anthropologists, there is a growing number of other social scientists investigating the issues of health, illness or health care with the help of ethnographic and other qualitative methods. Many of them do not adhere to strict disciplinary boundaries between social/cultural anthropology and sociology, and publish in journals of various disciplinary backgrounds. Coming mostly from sociology, they draw inspiration from other fields, too, especially from social studies of technology and science, gender studies, sociology of health and illness, public health, cultural studies, etc. Jaroslava Hasmanová Marhánková (2008), a sociologist based at the University of West Bohemia in Pilsen, interviewed women with high risk pregnancies who decided to refuse prenatal testing. She analysed the role of such medical examinations in the construction of medical authority and knowledge. Lenka Zamykalová (2001, 2003) was one of the first Czech sociologists conducting qualitative research on practices related to assisted reproductive technologies. Lenka Slepíčková (2009) is another sociologist addressing the issue of infertility treatment. She conducted in-depth interviews with couples suffering from fertility problems, while focusing on their different coping strategies, experience and negotiations. Iva Šmídová (2008) also built on qualitative interviews with couples in her study of fatherhood and a newly emergent social norm determining that fathers should accompany their partners during childbirth. Eva Šlesingerová (2005, 2008) analysed popular representations of DNA and corporeality in their links to ethnicity in popular magazines. Her undergraduate course "Anthropology, body and biomedicine" which she teaches at the Faculty of Social Studies, Masaryk University in Brno, reflects her research interests in biomedical conceptualizations of embodiment and corporeality. In their current research Slepíčková, Šmídová and Šlesingerová study practices of reproductive medicine in the Czech Republic.⁴ Their recently published review essay provides the most up-to-date overview of Czech qualitative studies of biomedicine, especially those related to the concepts of biopower and biopolitics (Slepíčková, et al. 2012: 93-95). Concerning reproductive issues, Radka Dudová (2012) from the Institute of Sociology of the Academy of Sciences studied discourses surrounding abortion in a historical perspective, applying qualitative methodology informed by a Foucauldian perspective (see also the book review in this issue). Her colleague Tereza Stöckelová builds on social studies of technology and science (STS) in her research on politics surrounding GMO (Stöckelová 2008); she also addresses the issue of scientific expertise and knowledge in the course on the ethnography of biomedicine

4 Their research project "Childbirth, assisted reproduction, and embryo manipulation. A sociological analysis of current reproductive medicine in the CR" is funded by the Czech Science Foundation (GAP404/11/0621). All the three researchers are based at the Faculty of Social Studies, Masaryk University in Brno.

that she teaches at the Department of Anthropology, Faculty of Humanities at the Charles University. Inspired by the STS perspective, too, Karel Čada (Charles University) studies drug policy/ politics and medical expertise in the Czech Republic in his dissertation. In another of his research projects related to health, he examined attitudes to air pollution and social strategies regarding health among people living in the city of Ostrava— one of the most polluted places in the country (Gabal, Čada, 2010). Jenda Paleček (2004) examined the construction of mental illness in the context of psychiatric care. Together with Zdeněk Konopásek (2006, 2010a,b), he focused on special types of experience such as hearing (spiritual) voices, and studied their different medical as well as pastoral interpretations. In contrast to previously mentioned sociologists, Kateřina Kolářová comes from the humanities and gender studies background. She conducts research of disabilities and disabled people from a feminist perspective (Kolářová 2010a, 2010b). In another of her current research projects, she investigates discourses surrounding HIV/AIDS and its prevention (Kolářová 2009, 2011).

But the Czech Republic is also an interesting research site for Western medical anthropologists. American medical anthropologist, Amy Speir (2010), conducted fieldwork in spas in a little town named Mariánské Lázně (Marienbad) in Western Bohemia. She focused on balneotherapy as a traditional form of therapy and studied how it was becoming increasingly incorporated into the health tourism industry. In her current research, she investigates reproductive tourism of American couples coming to the Czech Republic for treatment of their infertility issues (see her article in this issue). Heidi Bludau's research also relates to travelling, but in the opposite direction. She studied recruitment companies working in the Czech healthcare sector and explored how they actively "re-modelled" their "clients" equipping them with language skills and cultural competences in order to find them lucrative jobs abroad (Bludau 2010, 2011). Rosie Read (2007) also studied the profession of nursing based on her ethnographic research in a nursing home in Prague. She analysed tensions between nurses and nuns providing care who had very different understandings of their activities. She showed how these different conceptions of care were embedded in different socio-political and historical contexts. The socialist definition of nursing emphasized professionalism and related values of dispassionate, objective, clinical knowledge and has been severely challenged by a new market-driven ideology promoting the consumer choice of clients. In her current research, Read (2010) studies young hospital volunteers in a Moravian town.

Both local medical anthropologists and those from abroad who are involved in research situated in the Czech Republic and other countries of the CEE region had an opportunity to meet and discuss their work in person at the conference "Health in Transition: (Bio)Medicine as Culture in Post-Socialist Europe" organized by Edit Szénássy from the Department of Ethnology, Charles University,

which was held in Prague in June 2011.⁵ The conference provided a platform for future collaboration especially among young researchers in the field of medical anthropology, and was successfully repeated in June 2012 in Bucharest, Romania,⁶ with a prospect of organizing the 3rd HIT conference in Warsaw. Perhaps it is this new conference tradition started in Prague that will help to nurture medical anthropology not only in the Czech Republic, but in the whole CEE region in the near future.

REFERENCES

- Beranská, V., 2011. Book Review: Folk Healing and Health Care Practices in Britain and Ireland. Stethoscopes, Wands and Crystals. Edited by Ronnie Moore – Stuart McClean. *Český lid: Etnologický časopis*, 98 (4), pp. 439-441.
- Bludau, H., 2010. Creating migrant nurses. How recruitment firms create successful migrants for the global market. *Durham Anthropology Journal*, 17 (1), pp. 87-106.
- Bludau, H., 2011. Producing Transnational Nurses: Agency and subjectivity in global health care labor migration recruitment practices. *Anthropology of East Europe Review*, [online] 29 (1), pp. 94-108. Available at: <http://scholarworks.iu.edu/journals/index.php/aer/issue/view/80> [Accessed 20 November 2012.]
- Dudová, R., 2012. *Interrupce v České republice: Zápas o ženská těla*. Praha: Sociologický ústav AV ČR.
- Gabal I., and Čada K., 2010. Postoje a sociální strategie obyvatel Ostravy týkající se znečištění ovzduší a jeho možných dopadů na zdravotní stav. *Ochrana ovzduší*, 5-6, pp. 57-62.
- Hasmanová Marhánková, J., 2008. Konstrukce normality, rizika a vědění o těle v těhotenství: Příklad prenatalních screeningů. *Biograf*, (47): 56 odst. [online] Available at: www.biograf.org/clanky/clanek.php?clanek=v4702. [Accessed 20 November 2012.]
- Horák, M., 2010. Případ Takivasi. Koncept tradiční domorodé medicíny peruánské Amazonie. *Antropowebzin*, [online] 2, pp. 101-107. Available at: <http://antropologie.zcu.cz/pripad-takivasi-koncept-tradicni-domorode-m>. [Accessed 20 November 2012.]
- Kašák, O. and Z. Obertová. 2012. Školská etnografie tela, jej východiská, podoby a potenciály. *Český Lid: Etnologický časopis*, 99 (1), pp. 1-22.
- Klepal, J., 2011. Rage, Grief, and Moral Claims: Enacting Posttraumatic Stress Disorder among War Veterans in Bosnia and Herzegovina. In: University of Alberta, *Wirth Institute's Central European Talks*, Edmonton, Canada, 9 March, unpublished. Event information available at: <http://www.wirth.ualberta.ca/en/PastEvents.aspx>. [Accessed 11 June 2013.]
- Klepal, J., (2013, in press) (Auto)cenzura: O etnografii posttraumatické stresové poruchy u válečných veteránů v Bosně a Hercegovině. In T. Stöckelová, Y. Abu Ghosh, eds., *Etnografie: Improvizace v teorii a terenní praxi*. Praha: Slon.

5 www.antropo-info.cz/index.php?strana=konference&id=54

6 <http://hitconference.org>

- Klepal, J. 2012. Pills, Suicides, Tears: Enacting Posttraumatic Stress Disorder among War Veterans in Bosnia and Herzegovina. (Papere presented at 2nd "Health in Transition" Conference, Bucharest, Romania.)
- Klepal, J., 2006. Tělesné způsoby pozornosti v hnutí Haré Kršna [Somatic Modes of Attention among Hare Krishnas]. In L. Bělka, I. Doležalová, I., E. Hamar, eds., 2006. *Náboženství a tělo*. Brno: Malvern, Ústav religionistiky FF UM, pp. 215-220
- Kolářová, K., 2009. Diskurs rizika v prevenci AIDS/ HIV. *Gender, rovné příležitosti, výzkum*, 1, pp. 16-25.
- Kolářová, K., 2010a. Performing the Pain: Opening the (Crip) Body for (Queer) Pleasures. *Review of Disability Studies. International Journal*, 6 (3), pp. 44-52
- Kolářová, K., 2010b. *Gendered Metaphors of Disability: On Intersections of Gender and Disability*. Ročenka genderových studií FHS UK 2007/2008. Praha: FHS, pp. 129-149.
- Kolářová, K., 2011. Homosexuální „asociál“ a jeho zavírované tělo: vir HIV a nemoc AIDS v socialistickém diskurzu (Československo 1983–89). In P. Himl, J. Seidl, F. Schindler, eds. 2011. *Miluji tvory svého pohlaví. Homosexualita v dějinách a společnosti českých zemí*. Praha: Argo.
- Konopásek, Z. and Paleček, J., 2006. V moci ďábla: Exorcismus věřícíma očima. *Biograf* (40-41): 75 odst. Available at: www.biograf.org/clanky/clanek.php?clanek=4006. [Accessed 20 November 2012.]
- Konopásek, Z. and J. Paleček, 2010a. Apparitions and possessions as boundary objects: An exploration into some tensions between mental health care and pastoral care. *Journal of Religion and Health*, 28, pp. 1-16.
- Konopásek, Z. and J. Paleček, 2010b. The Principle of Symmetry from the Respondents' Perspective: Possessions, Apparitions and Mental Illnesses in Research Interviews with Clerics. *Forum: Qualitative Social Research*, 12 (1), [online] Available at: www.qualitative-research.net/index.php/fqs/article/view/1592. [Accessed 20 November 2012.]
- Kotrlý, T., 2008. Poradenství pro pozůstalé (Naděžda Špatenková), bookreview. *Lidé města* 10 (1). [online]. Available at: <http://lidemesta.cz/index.php?id=172>. [Accessed 20 November 2012.]
- Mildnerová, K., 2008. Nástin společných aspektů afrického tradičního léčitelství bantuské oblasti. *Antropowebzin*, 2-3, pp.1-12, [online]. Available at: <http://antropologie.zcu.cz/nastin-spolecnych-aspektu-africkeho-tradicniho-lecitelstvi-bantuske-oblasti>. [Accessed 20 November 2012.]
- Mildnerová, K., 2010a. *Spiritual healing and witchcraft in Lusaka*. Unpublished Ph.D. Thesis. Plzeň: Západočeská univerzita v Plzni.
- Mildnerová, K., 2010b. Local conceptualization of Health, illness and body in Lusaka, Zambia. *Anthropologia Integra* 1 (1), pp. 13-23.
- Paleček, J., 2004. Opakujte po mně: duševní nemoc - říkáte to stejně?!? O překládání duševní nemoci. *Biograf* (34): 107 odst. [online]. Available at: www.biograf.org/clanky/clanek.php?clanek=3402. [Accessed 20 November 2012.]
- Read, R., 2007. Labour and love: competing constructions of "care" in a Czech nursing home. *Critique of Anthropology*, 27 (2), pp. 203-222.
- Read, R and T. Thelen, 2007. Introduction: Social security and care after socialism: Reconfigurations of public and private. *Focaal - European Journal of Anthropology* 50, pp. 3-18.

- Read, R., 2010. Creating reflexive volunteers? Young people's participation in Czech hospital volunteer programs. *Journal of Youth Studies*, 13, pp. 549-563.
- Řezáčová, V., 2011. *Not so 'Traditional' Healing: Constructions of Illness Reality and Spirit Possession in 'Venda', South Africa*. Unpublished Ph.D. Thesis. Praha: ISS FSV UK.
- Sinecká, J., 2003. Research Report „Zdravotně handicapované skupiny: komunita neslyšících – limity integrace“. *Lidé města*, 5 (10). [online]. Available at: <http://lidemesta.cz/index.php?id=568>. [Accessed 20th November 2012.]
- Slepičková, L., 2009. Neplodnost jeho a neplodnost její: genderové aspekty asistované reprodukce. *Sociologický časopis/ Czech Sociological Review*, 45 (1), pp. 177-203.
- Speier, A., 2011. Health Tourism in a Czech health spa. *Anthropology and Medicine*, 18 (1), pp. 55-66.
- Stöckelová, T., 2008. *Biotechnologizace: Legitimita, materialita a možnosti odporu*. Praha: Sociologický ústav AV ČR.
- Zamykalová, L., 2001. Otcem po smrti? Management trajektorií v asistované reprodukci. *Cargo* 3-4, pp. 242-279.
- Zamykalová, L., 2003. Kdo smí participovat na asistované reprodukci. *Biograf* (31), [online]. Available at: www.biograf.org/clanky/clanek.php?clanek=v3103. [Accessed 20 November 2012.]

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An Outline of the Situation of the Subject of Medical Anthropology in Hungary

Anna Susánszky and Imre Lázár

In Hungary, medical historians and ethnographers started to systematically study healing, healers, and traditional folk treatments early in the twentieth century. From the beginning of the 1990s, when cultural anthropology was gaining ground, the subject of Medical Anthropology appeared as part of curriculum reform in the Semmelweis University, the largest medical school in the country, within courses offered in the frame of the medical humanities. At the Institute of Behavioral Sciences, founded by Maria Kopp, the Department of Medical Anthropology, led by Peter Molnár, was established in 1993.

In the early 1990s, ecological and evolutionary issues of bio-cultural adaptation played an important role in teaching medical anthropology, under the innovative direction of Professor Molnár who played a prominent role also in regulating bodies regarding complementary medicine in Hungary. During this period, staff-members at the Department of Medical Anthropology selected and translated Cecil Helman's comprehensive book, *Culture, Health, and Illness*, as textbook for the subject (2007).

Later on, under the direction of Béla Buda, aspects of social science and an interdisciplinary approach grew stronger; the leadership of Maria Újhelyi drew a greater attention to evolutionary anthropology and interethnic medicine. Although the planned medical anthropological MSc course is still a question of the future, there is a possibility to lead medical anthropological PhD studies and research in the Interdisciplinary Doctoral School of Semmelweis University, a possibility which is open for non-Hungarian PhD students too. After 2004, together with the established topics mentioned above, new themes came into prominence: medical pluralism, complementary medicine, the rites of passage of becoming a doctor, spiritual aspects of medical anthropology, and the medical anthropology of birth and death. Under the direction of Imre Lázár, the working group joined in the activities of the EASA, through convenor activity in EASA conferences and organizing international medical anthropology summer courses.

Two edited books have been presented, based on symposia at EASA Conferences in Copenhagen (2002) and in Vienna (2004) organized by Imre Lazar (Jo-

hannessen and Lázár 2005; Luse and Lázár, 2007). During these years, the idea of organizing an official EASA network on an interdisciplinary theme of sacral communication and healing emerged. The 'Sacral Communication and Healing Network' was established in 2005 and accepted by the EASA as one of its official networks in February 2007. The Sacral Communication Summer courses in every third year offer a regular occasion for reviewing the progress of *interdisciplinary* efforts in exploring the dynamics and diverse nature of the recent revival of spiritual discourses in contemporary healing, medical and religious practices. (Further details and selected videos are available at the website of the network¹).

Teaching medical anthropology serves medical professionalization through promoting an (inter)culturally more sensitive and reflexive medical practice, and this is supported by the double identity of some of the lecturers of the field (psychiatrist/cultural anthropologists, intern/medical anthropologist). As medical anthropology is part of the PhD programme, it includes also research activity in the social scientific exploration of medicine or other institutions related to health and illness.

The curriculum is not exactly the same in all Hungarian medical schools, but the main themes do correspond to each other. These are: cultural differences in the concepts of health, illness, and healing; interactions between patient and healer; anthropology of the turning points of human life (such as birth, death, becoming an adult, and becoming a doctor); cultural differences in pain experience; various fields of pharmacology (especially the placebo and nocebo phenomena); experience of and coping with stress; cultural differences in body image and diet; medicalization; and medical plurality.

Institutional and personal contributions to Hungarian medical anthropology

Lázár's research interest includes medical pluralism, complementary medicine, and spiritual aspects of healing. He has led multi-sited ethnographical research in dance anthropology (Lázár 2002) and has done field work among alternative healers (Lázár 2005a; 2005b). His theoretical orientations also include environmental anthropology (Lázár 2000; 2001; 2011). He is also the editor of several textbooks published by Berghahn and Cambridge Scholar Publishing (CSP) (Lázár 2005b; 2007). Zana works on the comparative study of changes in the fear of death (2009a, b), the relationships between professionalism and fear of death, and the loss (bereavement) experiences of medical professionals and staff members (Hegedűs, Zana and Szabó 2008). She also studies the effects of animal-assisted therapy among cancer patients and in rehabilitation. Her research activities include the field of health, illness, and body image in early 20th centu-

1 <http://79.172.211.165/~sacral/index.php?id=3&lang=1>

ry women's literature. Susánszky studies the continuing transformation of gender roles, the emergence of traditional and modern role expectations as elements of stress, and the relationship between these developments among males (Susánszky and Susánszky 2008; 2009). She is a member of a recently formed research group on the medicalization of birth; she is also active in the field of research on the social situation of obstetrics in Hungary. Zsinkó-Szabó investigates the initiation process involved in becoming a doctor, the course of medical socialization, and the experiences of students and young doctors that can be interpreted as rites of passages. His field of research is the medical school examined as a symbolic home with its educational, pedagogical, model-providing and training capacities. The object of his analysis is the courses, effects, and meanings of transitional rites as experienced during medical training (Zsinkó-Szabó, Lázár and Túry 2012a) (Zsinkó-Szabó 2012b).

Lajtai's study interest, multilingualism and mental health services in Mauritius, is based on his field research in Mauritius. So far his articles have covered traditional healing in Nepal (Lajtai and Eisler 1999) and Sumatra (Lajtai 2003), meditation, addictions, refugees, and some branches of psychotherapy (Lajtai 2012; Osváth, Kovács and Lajtai 2009). His present field of interest is the relationships between multilingualism and mental health.

Medical anthropological research is also present in the Faculty of Medicine at the University of Szeged. Here, Pikó and her colleagues focus primarily on lay perceptions of health, illness, and disease risks among children, they collect data using the so-called draw-and-write method developed for children's studies (Pikó 2006; Bak 2007; Pluhár, et al., 2009; 2010). At the University of Pécs Medical School, research concentrates on the cognitive and philosophical-anthropological aspects of placebo and nocebo effects. One can find PhD students at the Budapest-based international Central European University with medical anthropological interests, but courses in the field are not offered at the present time.

In 2012, a textbook was published as a result of the collective effort of forty authors, pioneers of Hungarian medical anthropology and those who represent the anthropology workshops of the four Hungarian medical schools in this field over 570 pages (Lázár and Pikó 2012). This textbook, integrating the scientific traditions of ethnomedicine and historical anthropology of medicine, gives an overview of the research fields Hungarian anthropologists currently work on.

One could ask whether is it strange for the discourse of medical anthropology to settle at medical universities. But if we trace back the history of medical anthropology, we can find medical doctors among the key founders of this paradigm and authors of key textbooks, as in the cases of Rivers, Foster or Helman. (Even the renewal of social and cultural anthropology in the early 1900s by Boas and Malinowski happened under the influence of Wilhelm Wundt, a scholar completing medical studies first.) It seems unique that in Hungarian medical anthropolo-

gy is taught to medical students as part of medical humanities, as in Europe this topic is usually part of the curricula of social sciences. However, this disciplinary configuration undoubtedly helps medical students – through their own field work – to be familiar with participant observation and other qualitative research techniques, and to develop skills in so-called “narrative medicine” and in intercultural and interethnic medical issues. It is important to consider medical anthropology as a clinically applied discipline of medical humanities and behavioral science on the one hand, and cultural anthropology on the other; on the basis of this duality it is possible to provide students with knowledge that can be utilized in their future medical practice.

REFERENCES

- Bak, J., Pikó, B., 2007. Smoke-free world for children's welfare: Perceptions of smoking in preadolescence. *Child and Youth Services Review*, 29, pp. 283-293.
- Helman, C., 2007. *Culture, Health, and Illness*. 5th ed. London: Hodder.
- Hegedűs, K., Zana, Á., Szabó, G., 2008. Effect of end of life education on medical students' and health care workers' death attitude. *Palliative Medicine*, 22 (3), pp. 264-269.
- Johannessen, H. and Lázár, I. eds., 2005. *Multiple Medical Realities*. New York-Oxford: Berghahn Pbl.
- Lajtai, L., Eisler, O., 1999. Orvosok és sámánok Nepálban [Doctors and shamans in Nepal]. *Tabula*, 2 (2), pp. 121-128.
- Lajtai, L., 2003. A minangkabau dukun from a medical anthropological point of view (in Hungarian). *Tabula*, 6 (1), pp.117-134.
- Lajtai, L., 2008. Kapcsolat roma (cigány) páciensekkel. [Communicating with Roma (Gypsy) patients]. In J. Pilling ed., 2008. *Medical Communication*. Budapest: Medicina, pp. 335-350.
- Lajtai, L., 2012. A pszichiátria orvosi antropológiája [Psychiatric Anthropology]. In Lázár I. and Pikó B., eds., 2012. *Orvosi antropológia*. Budapest: Medicina Kiadó.
- Lázár, I., 2000. Mothers and Mother Nature: Attachment, Detachment and Human Ecological Integrity. In P. Crabbé, et al., eds., 2000. *Implementing Ecological Integrity. Restoring Regional and Global Environmental and Human Health (NATO Science Series: IV. Earth and Environmental Sciences)*, Dordrecht: Kluwer Academic, pp. 249-260.
- Lázár, I., 2001. Humán ökológia és orvosi antropológia. [Human ecology and medical anthropology] In Buda, B. and Kopp, M., eds., 2001. *Magatartástudományok*. Budapest: Medicina Kiadó.
- Lázár, I., Kiss, E., 2001. Gold, Cyanide, and Fish in the River of Life & Death. In P. Miller, L. Westra, eds., 2001. *Just Ecological Integrity: The Ethics of Maintaining Planetary Life*. Rowman and Littlefield Pbl., pp. 167-180.
- Lázár, I. 2002. Spirituality and Human Ecosystems. In L. Zsolnai, ed., 2002. *Spirituality and Ethics in Management*. Dordrecht: Kluwer Academic Publishers, pp. 87-97.

- Lázár, I., 2002. Dance as drug, dance as medicine. *AM Rivista della Società Italiana di Antropologia Medica*, 13-14, pp. 333- 351.
- Lázár, I., 2005a. Unconventional medicine in Hungary: medical eclecticism in a post socialist society. *AM Rivista della Società Italiana di Antropologia Medica*, pp. 19-20,.
- Lázár, I., 2005b. Táltos Healers, Neoshamans and Multiple Medical Realities in Postsocialist Hungary. In I. Lázár and H. Johannessen, eds., 2005. *Multiple Medical Realities*, New York-Oxford: Berghahn Pbl. pp. 35-54.
- Lázár, I., 2007. Embodied and Displaced History: Spiritual Empowerment in Post-communist Hungary, Cosmologies of Suffering. In A. Luse and I. Lázár, eds., 2007. *Cosmologies of Suffering: Post-communist Transformation, Sacral Communication and Healing*. Newcastle upon-Tyne: Cambridge Scholar Pbl., pp. 129-158.
- Lázár, I., ed., 2011. *Environment and Humanscape*. Budapest: Patrocinium Pbl.
- Lázár, I., Pikó, B., eds., 2012. *Orvosi antropológia* [Medical Anthropology]. Budapest: Medicina Pbl.
- Luse, A., Lázár, I. eds., 2007. *Cosmologies of Suffering: Post-communist Transformation, Sacral Communication and Healing*. Newcastle upon-Tyne: Cambridge Scholar Pbl.
- Osváth, P., Kovács, A., Lajtai, L., 2009. A transzkulturális pszichiátria [Transcultural psychiatry]. In J. Füredi, A. Németh, P. Tariska, and N. Belső, eds., 2009. *A pszichiátria magyar kézikönyve* [Handbook of Hungarian psychiatry], 4.-th ed. Budapest: Medicina, pp. 803-816.
- Piko, B.F., Bak, J., 2006. Children's perceptions of health and illness: Images and lay concepts in preadolescence. *Health Education Research*, 21 (5), pp. 643-653.
- Pluhár, F. Zs., Pikó B., Kovács Sz., Uzzoli A., 2009. “Air pollution is bad to my health”: Knowledge of the role of environment in health and illness among 9-11-year-old children. *Health & Place*, 15, pp. 239-246.
- Pluhár, Zs., Pikó B., Uzzoli A., Page, R. M., Düll, A. 2010. Representations of physical activity in environment-related images of urban children in Hungary. *Landscape and Urban Planning*, 95, pp. 151-160.
- Susánszky, A., and É. Susánszky, M. Kopp, 2009. What worries Hungarian men? Characteristics of masculine gender role stress. *Lege Artis Medicinae*, 19 (6-7), pp. 431-435.
- Susánszky, A., Susánszky É., 2008. Férfi nemi szerep stressz és az egészségi állapot összefüggése. [Relationship of masculine gender stress and state of health.] In M. Kopp, ed. 2008. *Magyar Lelkiállapot 2008*, Budapest: Semmelweis Kiadó, pp.254-259.
- Susánszky, A., 2012. Research of gender. International and Hungarian history of men's studies. In I. Lázár and B. Pikó, eds. 2012. *Orvosi antropológia* [Medical anthropology.] Budapest: Medicina kiadó, pp. 467-471.
- Zana, Á., 2009a. The development and change of death image in Hungary. Differences in value judgement according to age and analysis of possible measurement methods. Is death still a taboo? *Clinical and Experimental Medical Journal*, 3 (2), pp. 353-359.
- Zana, Á., 2009b. Attitudes toward death in Hungary using the Multidimensional Fear of Death Scale. *Clinical and Experimental Medical Journal*, 3 (2), pp. 327-335.
- Zsinkó-Szabó Z., and I. Lázár, F. Túry, 2012a. A test gyarmatosítása - a civilizáció vadhajtsái [Colonization of body]. *Lege Artis Medicinae*, 22 (3), pp. 148-149.

Zsinkó-Szabó Z., 2012b. Beavatási jelenségek az orvossá válás folyamán [Initiation rites of medical professionalization.] In I. Lázár and B. Pikó, eds., 2012. *Orvosi antropológia* [Medical anthropology]. Budapest: Medicina kiadó, pp. 505-516.

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Understanding Care, Pain and Responsibilization - Making Sense of Policy and Practice. An Interview with Susanna Trnka

Edit Szénássy

Susanna Trnka is a social and medical anthropologist of Czech-American heritage, working at The University of Auckland. Her research interests include the politics of health, the impact of violence on people's everyday lives, and perceptions of national identity. She has a long-standing interest in post-socialist societies in Eastern and Central Europe, and the Fiji Islands.

Your previous work, based on long-term fieldwork in Fiji, is centered on the embodied experiences of political violence. You also researched how women's pain is shaped by, negotiated and accounted for in clinical settings in which social and gendered inequalities translate into health professionals' puzzlement and unequal acknowledgment of some of their patients' experiences of pain. Specifically, you explore the range of meanings that expressions of physical pain convey for Fijian women of Indian ethnic origin who live with chronic pain, and the health professionals who try to make sense of it.

Actually, the Fiji project started out in quite a different direction. It began as a project intending to explore issues of history, memory, and the body, but soon after the research began, I realized both how much my informants talked about physical pain in the *present*, and how *gendered* this discourse was.

The people I worked with were descendants of the Indians whom the British brought over to work on Fiji's sugar cane plantations in the late 1800s, up until 1920. Part of what I came to understand is how their experiences of physical pain in the present are related to that history, and how the pain that they expressed on a day-to-day level was actually part of a larger political and historical identity, as physical pain was often used to index physical labor – the very labor that Indians were both brought to Fiji to undertake and on the basis of which they currently make claims about their ongoing right to remain there.

Much of Indo-Fijian public discourse on suffering is moreover very masculine. More often than not, story-telling and popular culture tend to highlight the figure of an Indo-Fijian *man* who is working hard and therefore economically productive, thus promoting the interests of not only himself but the entire nation of Fiji. At the same time, in clinical settings I found that a lot of the talk about suffering and physical pain was in fact voiced by Indo-Fijian women whose daily work, be it in a garment factory or household-based agricultural labor, was often not granted explicit recognition. I looked at what women say to each other, to their families and to medical personnel when they talk about pain and came to realize that often they were drawing attention to themselves and their work in one of the few fora in which they could do this.

Another aspect that contributed to this research was that we were living in a predominantly Indo-Fijian village and I found that expressions of pain were almost part of women's daily greetings; when someone asked "How are you?", not infrequently, the reply they received was "I'm in pain" or "My back is in pain". When people first said this to me, I would take it very seriously and would ask "Oh, has something happened?" or "How can I help you?". My reaction took the women by surprise. It was only by seeing how these women talk to each other, that I later realized that expressing that one is experiencing pain is connected to a moral economy of physical labor in that expressions of pain indexed the amount of physical work they had carried out. Upon further inquiry it became quite clear why these women were in pain. They would say "I'm in pain because I've been washing the laundry", i.e. working hard. I realized that this was a sort of proclamation, a way of claiming "I'm a good, industrious woman, a really active member of this community" (see also Trnka 2008). In this case, expressions of pain thus act both as 'idioms of distress', in the sense of Arthur Kleinman's (1992) analysis of pain expression, and what I like to think of as an 'idiom of pride'. One of the ways I explain this to my students is that when they meet another student during exam time and say "How are you?" and the other student answers "Ok, but I'm really stressed right now," the other student is not usually taken to be asking for *help*, rather they are seen as signaling that they are a 'good' student, i.e. a student who studies hard and takes their exams seriously.

When you looked at pain in clinical settings, however, you analyzed how health professionals, irrespective of ethnic origin, find it difficult to acknowledge pain expressed by Indo-Fijian women, often classifying it as 'unreal'.

Yes, this was because the medical professionals did not see the reason, the cause, for the pain as something they could readily treat. One of the arguments they made is that there is 'real' and 'unreal' pain. 'Real' pain was based on physical causes and would respond to treatment. 'Unreal' pain was pain that *seemed* to be real because the patients were visibly hurting, yet the causes, at least according to the

doctors, were work-related, social or psychological and thus not within the realm of what can be 'fixed' within the medical clinic. Indo-Fijian women would in these cases normally leave the examination room with a prescription of Panadol (paracetamol), which validated their experiences of pain. The prescription would allow them to communicate to the community that their pain was valid in the sense of having their experience legitimated by clinicians. Instead of saying "my back really hurts," women would say "I went to the doctor today and look what he gave me [i.e. the prescription] because of my back pain" (see Trnka 2007).

How did researching embodied experiences of pain shape your own individual experience of pain or the way you look at expressions of pain around you?

That's an interesting question. I think one of the most profound things I learnt in Fiji was the way people would *not* talk about pain. I come from a culture that encourages the expression of pain. There is a widespread understanding that if you want to deal with your pain, then you have to be open about it, you have to express it – if not publically then at least with the people with whom you are close, such as your family, friends, or members of your wider community. You should not hide things because if you conceal painful things, then they begin to fester. Such discourses draw upon on popular understandings of the Freudian concept of repression, suggesting that once pain is articulated, then it can be dealt with.

Indo-Fijians often actively engage in helping people silence very traumatic events. They do so out of the belief that by limiting conversation and *not* talking about something that is painful, one can actually help contain it. Keeping the trauma firmly within 'the past' and not bringing it into the present and not returning to it, not exploring it, helps the healing process. The pain becomes part of the past and is therefore considered to be over.

The way this influenced my life in particular is that my second child was born whilst we were in Fiji and she was very ill and had to be medically evacuated. My husband, my eldest daughter, who was three years old at the time, and I went to New Zealand with the baby. We stayed in Auckland for six weeks and then came back with her to Fiji. Once we were back in Fiji, I tried to talk about the experience with women I had seen daily for almost two years, who had supported me throughout my pregnancy and during the very difficult times of political violence and upheaval that we lived through together during the 2000 Fiji coup. What really struck me was that nobody wanted to talk about the baby's illness and when I started to speak about this experience, the women not only kept quiet, but cut me off and silenced me. I gradually understood that by being silent and making me be silent, they wanted to help me. They were trying to help me to *not* talk about it, and thus to contain the experience instead of narrating and re-living it. With their silence, they were suggesting that I do not need to bring this pain into the present, that I leave it behind and let it settle as part of my past.

*You explore sensory experience and how it collides with national identity in your recent work as a co-editor of the volume, *Senses and Citizenship: Embodying Political Life* (Routledge, 2013, co-edited with Christine Dureau and Julie Park). Can you tell us more about the book and the ideas behind it?*

The book was published in April of this year. We have twelve contributors all of whom focus on the political aspects of sensory experience, analyzing a variety of senses: not only the classical Aristotelian ‘five senses’, of smell, touch, taste, hearing, and sight, but also things like the sense of movement, disgust, and sensations of pain. Our focus is on how sensory experience gets taken as natural and thus thought to convey something objectively ‘real’ whilst it, like many aspects of bodily experience, is similarly politically, socially and culturally shaped. More importantly, from my perspective, the book goes a step further by revealing the political *significance* of sensory experience: i.e. how it is that we as a society come to say that something *is*, and indeed *must* be, a certain way because we experience it as such. To give an example, a group of people can come to be deemed as “disgusting” by others because, it is argued, their food “really does taste disgusting.” But does it? Or, as Bourdieu (1984 [1979]) has long pointed out, is taste a socially constituted category and in fact a learned response? At the end of the day, it is one thing to change people’s rational perspectives of others (or of themselves), and quite another to convince them that what they *feel* might actually also be socially and politically inflected. Our aim in this book is to show how the association between sensory experience and politically-charged categories of difference, inclusion and exclusion, come to be inter-linked, and therefore naturalized.

Your ongoing research explores accountability, responsibility and the politics of health in relation to asthma treatment, understanding these concepts as healthcare strategies in an emerging neoliberal framework of choice, self-management and consumerism. How did you start researching these discourses through the lens of asthma treatment and why the focus on the Czech Republic and New Zealand?

The Czech Republic and New Zealand are two excellent locations to choose if you want to compare both different modes of neoliberal health care, and more specifically asthma care. New Zealand is at the forefront of neoliberal reforms of healthcare, and is one of the leading nations in terms of instituting self-management techniques of asthma care. Most of our asthma care is set up by a general practitioner or by emergency services; usually only people with the severest asthma receive specialist care. But the key to this program is that much of the day to day management is to be carried out by the patient themselves, or in the case of young children, by their parents, to the extent that many patients, even with moderate or in some cases severe asthma, do not receive regular checkups for their asthma, but generally receive medical attention when they are experiencing a cri-

sis, or are on the verge of one. Patients are expected to keep track of the status of their asthma, and adjust their medication depending on either the symptoms they are experiencing or on their own measurements of their airflow which they carry out using portable peak flow measurers. Whilst this is often represented in terms of “empowering” patients to look after themselves, for many of the patients or parents of asthmatic children with whom we spoke, it can feel onerous, confusing and difficult, especially initially when one is struggling to learn how to cope with a potentially life-threatening condition. I have also found a number of people who turn ‘self-management’ into ‘self-blame’, assuming that there is something *morally* wrong with respect to their capacities to manage themselves if their asthma is not under control.

When I discuss this topic with top respiratory physicians in the Czech Republic, they explain that self-management is something that they are just trying to introduce, but also express a lot of reluctance over the possibility of shifting the burden of care onto patients. I think there is a much stronger sense in the Czech Republic of the necessary role of specialists and the need for ongoing medical oversight and management of pharmaceuticals. And yet, with the economic restructuring of the health services, the adoption of world-wide guidelines (GINA), and the global economic crisis, there is also pressure to devolve services onto patients. It is this tension between neoliberal logics of “responsibilized patients” and post-socialist ethics of the state’s duty of care to its citizenry that I find incredibly fascinating.

Beyond this theoretical interest, the reason for this topic and the two locations is entirely personal. I wanted to get back to doing research on medical anthropology, rather than political violence, in Fiji, but could not return there because of ongoing political issues. The situation in Fiji became increasingly unstable exactly at the time when I was granted research leave for half a year and I had to go somewhere to undertake a new round of fieldwork. I suggested to my dean that I could do a project on memory and political violence in the Czech Republic, instead of in Fiji. So in 2006 I came to Prague, on my own with two young children, to undertake fieldwork about memories of the Communist period. Within a few hours of landing in Prague, my eldest daughter had a significant asthma attack and was taken to hospital. During the first three weeks of our time, I was running from one respiratory physician to another with her. Because this was her very first attack and we did not really know much about asthma, I was learning about this condition through the help I received from Czech specialists. When we came back to New Zealand, which has one of the highest children’s asthma rates in the world, I went to see a doctor to continue her treatment and was absolutely stunned to see how distinct his approach was. The style of intervention he proposed was completely different from what we had gotten ‘used to’ in our admittedly brief time in the Czech Republic. He basically gave us a few different kinds of inhalers and that

was just about all the oversight and ‘care’ she received. When we tried to come in to see him for follow up visits, we were told that such things are only necessary if she is in distress. There followed a few years – and I do mean *years* – during which we would ring up the clinic and receive repeated prescriptions, without anyone even looking at her and assessing what was necessary and what was not.

This prompted me to think about the possibility of looking to asthma as a lens through which to see how ideas about accountability and responsibility are played out. It is a fascinating area in terms of patient-doctor relationships, relationships within the family and between family members as children grown up to ‘take responsibility’ for their own care (or not). Even ideas about relationships between citizens and the state, and citizens and corporations, get played out with respect to debates over what kinds of forms of healthcare are deemed appropriate as well as over the role of air pollution (in the Czech Republic) and damp, poor-quality housing (in New Zealand) in exacerbating this condition.

One way I’ve been trying to get a handle on this is by developing, with my colleague Catherine Trundle, the concept of ‘competing responsibilities’ as a means of trying to locate how responsibility and accountability get vested and played out across different domains. Nikolas Rose (2001; 2006) writes very compellingly about the idea of ‘responsibilization,’ in order to capture how, within neoliberal states, citizens have come to take over some of the activities and responsibilities previously vested in the state. Rose suggests that in increasingly neoliberal healthcare systems, citizens are compelled to carry much more of the burden in taking care of themselves, preventing disease, and proactively engaging in things like dieting or watching their cholesterol or sugar level. But it seems to me that there are counter-weights against these moves towards inculcating more responsibilized citizen-subjects – namely other forms of responsibility, such as the responsibility of corporations to the wider public (as represented in debates over CSR or Corporate Social Responsibility); responsibilities of states to citizens; responsibilities within and amongst members of a family, etc. So even in a highly neoliberalized state like New Zealand, you have instances when Asthma Societies advocate for shifting responsibility for administering medication from the family to a state entity like a school – when, for example, young children are simply not receiving the asthma medication that they are supposed to be given by their parents on a daily basis, and instead a school receptionist might be given the child’s asthma inhaler and asked to administer it to her or him at the beginning and end of each school day. Other non-individualizing modes of ‘care’ include healthy homes initiatives in which the state, various corporations, and charities are involved in creating better living spaces for families who live below or near the poverty line. In these respects there are some interesting parallels to groups like the citizens’ initiatives in Ostrava which hold the state and corporations to account over the environmental pollution that is seen as exacerbating or even causing asthma and other respiratory

conditions, though of course they are articulated in different ways and ultimately create different kinds of biosocial collectivities.

When making sense of Czech asthma policies and practices, you are confronted with two major frames of reference: the legacies of socialist healthcare and the newly emerging effects of EU enlargement. When talking about being ‘in transition’ in terms of asthma care in the Czech Republic, where do you position this transition, what are the types of narratives that shape it?

One thing that interests me about Czech approaches is the wide variety of different treatments for asthma. There are plenty of pharmaceutical options, but there is also a very strong and vibrant tradition of what in the West might be referred to as “alternative therapies” such as health spas, massage, physiotherapy, *míčkování* [a type of therapeutic massage that uses a foam ball], hydrotherapy, salt therapy, visits to Croatian or Greek beach resorts, etc. Many respiratory physicians are also quick to embrace and promote things like music therapy, alongside pharmaceutical interventions, on the understanding that you necessarily want to limit the amount of corticosteroids you administer and that some of these methods may help you to achieve these goals. Some of these ideas are now being brought over to the Southern Hemisphere, with the establishment of “salt rooms” for improving respiratory health in Australia. I recently did an interview with one of the founders of such an establishment in Sydney and perhaps should not have been surprised upon meeting her to discover that she is a Ukrainian living in Sydney. Not only had she ‘imported’ the idea of halotherapy or salt therapy from the Ukraine, but the very ‘salt bricks’ that lined the therapy room were brought over from Ukrainian salt mines. But such approaches are much less established in New Zealand and Australia than they are in Central and Eastern Europe.

More generally, there is a very different philosophy of what healthcare means and how it should be distributed across a society. During my most recent fieldwork visit to Prague in 2011, I conducted an interview with a representative of VZP (*Všeobecná zdravotní pojišťovna*) insurance company, the largest health insurance company. She started off the interview by explaining to me the principle of *solidárnost* or ‘solidarity’ to highlight how the Czech system, from her perspective, remains solidly rooted in Communist ideals of insuring a baseline of healthcare for all citizens, regardless of their capacity to pay for it. This led to a very impassioned defense of how a health insurance company such as VZP can justify paying for things like spa treatments or overseas trips to the seaside such as the *Mořský koník* program. Whilst these services are becoming more costly, from an outside perspective it is fascinating that they still exist, revealing just how firmly entrenched these legacies are, despite the health services being under ever-increasing financial pressure.

What are your experiences of conducting medical anthropology research in Central and Eastern Europe as a researcher with Czech heritage, having a complicated migration background and working in a setting where medical anthropology is at best regarded with suspicion by healthcare professionals?

I have an excellent time working in the Czech Republic. New Zealand has the highest asthma rate in the world, so most of the specialists or general practitioners I contact in the Czech Republic are curious to talk to someone from here, especially someone who has a Czech surname – especially a woman with a male surname, which strikes them as very strange! – and who speaks reasonable-enough Czech to be able to conduct interviews in their language. Coming from literally the other side of the world also enhances access, as people are more willing to make an appointment for an interview. When I am in New Zealand it is easier for people to say no, because they know I can come and see them next week or the week, or month, after. Whereas when in the Czech Republic, I say to them “I’m here for two weeks, can I see you?” and people tend to say: “Certainly, come by tomorrow”.

A lot of people here don’t know what anthropology is, so I tend to explain to my Czech informants that it is “a lot like sociology” which makes it familiar and recognizable to them. But of course one of the things that makes anthropology so exciting is its methodology, in particular the privileged role of fieldwork and participant observation as a mode of producing knowledge. My colleague Cris Shore and I have just finished editing a book (*Up Close and Personal: On Peripheral Perspectives and the Production of Anthropological Knowledge*, Berghahn Books, 2013) that engages in an examination of fieldwork and the methods that we use to produce anthropological knowledge. This project has encouraged me to reflect more deeply upon the profound significance of inter-personal relationships in our work. Whether we focus on health or some other topic, I don’t think we should lose sight of the unique role that anthropology plays in terms of taking other people’s experiences and points of view so seriously that we are willing to engage them in our analysis and re-shape the very concepts by which we understand the world we live in.

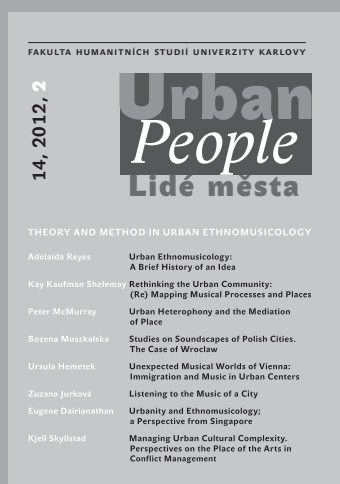
REFERENCES

- Bourdieu, P., 1984 [1979]. *Distinction: A Social Critique of the Judgement of Taste*, trans. R. Nice. London: Routledge & Kegan Paul.
- Kleinman, A., 1992. Pain and Resistance: The Delegitimation and Relegitimation of Local Worlds . In *Pain as Human Experience: An Anthropological Perspective*, edited by Mary-Jo Delvecchio Good, Byron Good, Arthur Kleinman, and Paul Brodwin. Pp. 169-97. Berkeley: University of California Press.
- Rose, N., 2001. The politics of life itself, *Theory, Culture and Society* 18, pp. 1-30.
- Rose, N., 2006. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-first Century*. Princeton, NJ: Princeton University Press.

- Shore, C. and S. Trnka, eds., 2013. *Up Close and Personal: On Peripheral Perspectives and the Production of Anthropological Knowledge*. London & New York: Berghahn Books.
- Trnka, S., Dureau, C., and J. Park, eds. 2013. *Senses and Citizenships: Embodying Political Life*. New York: Routledge.
- Trnka, S., 2007. Languages of Labor: Negotiating the ‘Real’ and the Relational in Indo-Fijian Women’s Expressions of Body Pain. *Medical Anthropology Quarterly*, 21 (4), pp. 388-408.
- Trnka, S. 2008. *State of Suffering: Political Violence and Community Survival in Fiji*. Ithaca: Cornell University Press.

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Teaching Medical Anthropology in Durham: An Experience of a Czech Student

Karolína Dobrovská

Social anthropology is a discipline which stands, above all, on two major assumptions and conditions; contextualisation and reflexivity. These are skills which are very hard to learn as it is usually only a direct personal experience which can help anthropologists to grow into them. Educational institutions play a crucial role in this process of gaining anthropological skills, as they provide students with both theoretical knowledge and opportunities for fieldwork in which they need to employ these skills. In this article I am going to discuss, on the example of teaching medical anthropology in Durham University, the importance of both departmental flexibility and integrity, for the students' development as future anthropologists. I am going to argue it is precisely this very co-operative and open-minded attitude of the institution and its teachers which lead to a better understanding of reflexivity and contextualisation, and hence anthropology.

I visited Durham for the first time as an Erasmus student in 2010. I was leaving my home anthropology department at the Charles University in Prague with a very unclear idea of what anthropology was. The main area of my research was human ethology, and so I received the "label" of a "natural scientist" which I was not much sure I liked. Indeed, I could sense quite a strong rivalry between the naturally and socially oriented scientists in the department, with the ethologists being in a minority, as the whole course, taught at the Faculty of Human Sciences, was mainly socially-based. Also, the name of the course, *general anthropology* was rather vague, demonstrating the non-fully established nature of Czech anthropology, where there are no clearly defined sub-disciplines and authorities who would represent them. The combination of these factors could be quite confusing and discouraging at times, leaving me in a limbo of a personal scientific identity crisis.

Nevertheless, my studies in Prague provided me with a lot of undoubtedly crucial theoretical background which every anthropologist should have and which has helped me greatly in my future studies abroad. I learned that essentialism as well as relativism were better avoided, I understood fieldwork was a crucial experience every "real" anthropologist had to undergo, and much more. However, what I did *not* learn was how to actually *do* something with all this knowledge and how

to combine it into a meaningful, integrated form. For anthropology is a tricky discipline. Its range of interest is essentially endless and it is this very characteristic that can easily become a double-edged sword. It gives you the possibility of studying almost any phenomena imaginable, but it can also easily leave you rather lost without any specific direction.

Hence, arriving in Durham, I was quite confused about what I was doing and about what kind of scientist I was (or whether I was any scientist at all). However, it did not take me long to understand that “Czech” anthropology was something very different than its British counterpart. What struck me most was the fact that no one was making any distinction between a social or natural orientation in anthropology in Durham. There were no ethnographers, linguists or evolutionists. There were only anthropologists excited to learn anything new from anybody, no matter their background. On the other hand, given the history of the discipline in the United Kingdom, there was already a number of clearly defined and highly specific anthropological sub-disciplines I had never known before. Thus, the very general and rather unpronounced concept of anthropology I knew from home was suddenly replaced by a well structured map of many different yet, comprehensively described paths of anthropological endeavours, all leading to the same destination; a better understanding of human kind. And that was where I finally found my direction; medical anthropology. As a result, after completing my Erasmus year I decided to take the opportunity to become a regular international student in Durham, and I left Prague behind.

The medical anthropology I encountered in the UK was a very well-defined and traditional discipline with a long history. Indeed, even though the majority of the best known medical anthropologists are American, many greatly influential researchers, such as Margaret Lock, are British. In Durham, the discipline stands on clearly pronounced concepts, emphasising the application of theory in practice and achievable goals. This is well demonstrated in the importance which is given to practical anthropological exercises and experience. For instance, while Czech universities do stress the importance of fieldwork, they do not directly provide students with many contacts abroad or fieldwork opportunities. Also, teachers are often overwhelmed by administrative work and different bureaucratic duties which leaves them with very little time for their own active research. As opposed to that, even though Durham lecturers are also usually very busy with teaching, they still manage to do their fieldwork at the same time, offering students not only their constantly expanding knowledge and experience, but foreign research contacts as well. For instance, Dr. Kate Hampshire, who teaches many modules in Durham and supervises both undergraduate and postgraduate students (including myself) works on several projects in Africa, including fertility decisions and practices among the Fulani in Burkina Faso, child malnutrition in Niger or health-seeking practices of young people in Ghana. Thank to her contacts and experi-

ence, many medical anthropology students travel to Africa for their dissertation research every year.

Indeed, sharing personal experience from fieldwork is one of the key elements of teaching medical anthropology at Durham university. Firstly, it is the thing which brings excitement, enthusiasm, and motivation into lectures, and secondly, it helps students with their assignments and exams as they are expected to demonstrate their theoretical knowledge through specific ethnographic examples. However, the essence of all the teaching is nonetheless traditionally made by the seminar readings and discussions which follow lectures.

The Medical Anthropology course in Durham consists of several core anthropological modules which are compulsory for all the students in the department as they cover the basics from anthropological theory and methodology. For example, “Theories & Methods in Medical Anthropology” is a compulsory, specifically targeted class, however, several of the lectures are attended by the rest of the department, as they are relevant for students from other courses as well. The “Research & Training Skills” module is then fully attended by all the anthropology students as it discusses general topics, such as effective ways of anthropological promotion, job application or communication with media. Being at least partially shared, these lectures provide students with the opportunity to work together no matter their specialisation, a feature which I found very helpful not only in terms of getting acquainted with every member of the department, but also in reflecting various opinions from different backgrounds.

There are also two compulsory methodological modules: “Statistical Analysis” and “Computational Methods” which cover quantitative and qualitative data analysis. The classes are mainly based on practical exercises which help students to manage the basics of the methods and use it for their future dissertation research. These highly practical classes are very useful and essential for any future anthropological work, however, unfortunately each student can choose only one of the modules even though he/she uses both types of the data in his or her research. For the rest of the modules, medical anthropology students are free to choose from a variety of lectures and seminars, including those from other courses: “Evolutionary Medicine”, “Evolutionary Anthropology”, “Sustainability, Culture and Development Anthropology” or “Socio-Cultural Anthropology”. Again, this system allows students from different sub-disciplines to meet in seminars and to critically discuss a shared topic while bringing together different perspectives. This is also the main idea of the departmental seminars attended by most of the teachers and very often a guest speaker from a different department, university or country.

Hence, students are taught to become specialists in their own course-based expertise by being provided broad theoretical knowledge relevant for their discipline, yet they are also given the opportunity to take a range of cross-disciplinary classes and seminars (both social and “biological”) in order to broaden their gen-

eral anthropological perspective. As a result, they view anthropology as a science which can be very fragmented and distinct, yet also capable of connecting all the little pieces into one meaningful branch of knowledge. Indeed, it was this very bridging of seemingly completely opposite perspectives that taught me the most throughout the whole year in Durham as, in a way, this in itself was an ongoing exercise in contextualisation and reflexivity.

The composition of the student collective is also very interesting and stimulating in the Durham anthropology department. There is a mixture of British and international students from all over the world, who can exchange their life as well as academic experiences. The Medical Anthropology course is very specific for the presence of medical students from Newcastle University who take a year off their studies to gain a different perspective on medicine somewhere else. Again, this is excellent not only for enriching the discussions, but more importantly, these graduates then become active physicians/medical anthropologists who apply their gained knowledge in everyday practice, making medical anthropology a meaningful discipline with real outcomes and impacts on health care.

In short, my experience with medical anthropology in the UK can be summarised as follows: while in Britain anthropology is a traditional and fully established discipline, in the Czech Republic it is still finding its way. Indeed, clearly defined anthropological sub-disciplines, including medical anthropology, are practically non-existent in Czech universities. As a result, there can be some confusion about the discipline as a whole, leading to unnecessary and contra-productive rivalry and competition. In the case of Durham University and its teaching of medical anthropology, the very opposite is true. The teachers motivate their students by showing them the vast possibilities of all the different sub-disciplines and perspectives, yet they actively encourage them to put everything in context, and both to see and use their knowledge as a whole. Consequently, students already learn how to contextualise and reflect on what they see and experience during their fieldwork through the dynamics of their everyday academic encounters. Durham anthropology students are taught to become specialists who do not set themselves as set apart in their expertise, but rather bridge their knowledge with that of others and thus form a meaningful discipline with practical, applied results contributing to further academic, social and professional developments.

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Teaching Medical Anthropology at Durham University. A Lecturer's Perspective

Andrew Russell

Medical anthropology is one of the exciting and innovative areas of contemporary anthropological theory and practice.

It has grown from being something of a minority interest to a sub-field that takes its strength from both biological and social aspects of the discipline and the way in which it speaks to some of the most serious and important issues facing the global community in the 21st century. Superbugs, the interaction of genetic inheritance with environmental stressors (e.g. such as early life influences on health), increasing levels of chronic illness worldwide, the role of medicine and other therapeutic modalities cross-culturally, what works in terms of enhancing the health of a population and dealing with ill-health, international health policy and practice – these are just a few of the elements that constitute a training in medical anthropology. We try and impart this variety and our excitement in exploring these and other issues in the breadth and depth we cover in our medical anthropology teaching at Durham University. We are fortunate in having a department that spans both the biological and social sides of Anthropology – this helps students to ‘keep their options open’ as well as fostering interesting interdisciplinary (or should I say ‘intra?’) collaborations.

We are also unique in offering degrees in medical anthropology at both undergraduate and postgraduate levels. Students can study medical anthropology for a three year undergraduate degree at Queen's Campus, Durham University's satellite campus in Stockton, a town approximately 25 kilometres south of Durham. Queen's Campus is the location for the Wolfson Research Institute for Health and Wellbeing, and several members of staff in the Anthropology department are also Fellows of this Institute, benefitting from the cross-disciplinary conversations and research opportunities it offers. Queen's Campus also houses several important laboratories run by the Anthropology Department such as the sleep and endocrinology laboratories. There is also a four year integrated masters degree in medical anthropology at Queen's Campus as well as a ‘standalone’, one year master's degree in medical anthropology which is predominantly taught at Durham City campus. All these programmes offer ‘hands-on’ research experience to vary-

ing degrees. Students can also undertake research masters and PhDs at either site. All teaching staff are research active and bring the insights (and dilemmas!) they face in the course of their research careers into their teaching and research supervision work with students. Staff and students come together in fortnightly Medical Anthropology Research Group seminars where current issues and cutting edge research findings are disseminated and discussed.

Another defining feature of medical anthropology at Durham is its applied and engaged aspects. Many members of staff have undertaken research that responds to real human needs or identified gaps in knowledge. We have close links National Health Service with healthcare practitioners and institutions, as well as what is called 'the wider public health workforce' – those people who would not regard themselves as health practitioners but who, through their work in other statutory, voluntary or private sector organizations, make a positive (or, unfortunately, sometimes negative) contribution to the sum total of human health and well-being. We also have numerous contacts and associations with people working in the field of international and global public health. We use these links, depending on students' interests, to help devise research projects and programmes that enable students to feel they are making a contribution to knowledge that is of more than 'blue skies' benefit. For some students it has been the start of a life-changing new career trajectory.

We value the presence of students from around the world in our classes and corridors. The following websites give more information about medical anthropology in the Department of Anthropology and some of the research that staff and students are involved with.

Medical Anthropology undergraduate degrees:

<https://www.dur.ac.uk/anthropology/undergraduatestudy/>

Medical Anthropology postgraduate degrees:

<https://www.dur.ac.uk/anthropology/postgraduatestudy/>

Medical Anthropology Research Group:

<http://www.dur.ac.uk/anthropology/research/marg/>

Wolfson Research Institute for Health and Wellbeing:

<http://www.dur.ac.uk/wolfson.institute/>

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Health in Transition: Annual Conference on Health and Healthcare in the Post-Socialist World. June 7-8, 2012, hosted by the „Francis I. Rainer Institute of Anthropology” of the Romanian Academy of Sciences („Academia Română”) in Bucharest, Romania

Elizabeth King

Scholars convened at the Romanian Academy of Sciences to discuss and critically think about the theme of “Ethnographies of Bio-medicine in Post-socialist Europe”. The idea for a continued, annual event resulted from a meeting last year in Prague. In 2011, Edit Szenassy, a doctoral student at Charles University organized a space for social scientists to discuss anthropological perspectives on health and healthcare in the post-socialist world. This year the conference was organized by a group of international scholars, including Heidi Bludau (Indiana University, USA), Jennifer Carroll (University of Washington, USA), Michael Rasell (University of Lincoln, UK), Sabina Stan (Dublin City University, Ireland), Edit Szenassy (Charles University, Czech Republic), and Valentin-Veron Toma (Romanian Academy, Romania). The conference consisted of a key note by Dr. Erin Koch from the University of Kentucky (USA) and seven thematic panels during which scholars made presentations on their ethnographic fieldwork experiences from across Eastern Europe.

Representatives from the Romanian Academy of Sciences provided the welcoming remarks for conference participants. Participants in the first panel “Bodily experiences”, chaired by Maryna Bazylevych, offered examples of how groups organize around shared experiences of pain, illness and the body. We heard from Alexandru Dincovici about how understandings of pain and injury are shared among the jiu-jitsu community in the absence of well-developed sports medicine specialists in Romania, from Hubert Wiercinski about the social organization of cancer

patients and their relatives in Poland, and from Andrei Mihail about the limited social space for organ transplant recipients in Romania. Michael Rasell chaired the second panel “Negotiating mental health and healthcare”, in which participants highlighted how specific populations have been affected by recent political, social and economic changes. We heard two papers on how people are coping with trauma from the recent war in Bosnia and Herzegovina. Jaroslav Klepal showed video footage of a war veteran speaking about post-traumatic stress disorder, and Peter Locke shared examples of how nongovernmental organizations were providing mental health services to survivors in Sarajevo. Gerard Weber contributed to the dialogue on mental health with his paper on how working-class pensioners are suffering from chronic stress in post-socialist Galati, Romania.

Participants in the third panel “Reproduction and moralities”, which I had the pleasure to chair, explored issues of how moralities, perceptions of fee-based versus government-provided health care, and gender and power influence reproductive and sexual health services. Maria Wegrzynowska discussed how women perceive they are empowered and exercise control over their health by purchasing medical services rather than attending government facilities in Poland. Christina Pop analyzed how obstetricians use their status and power to regulate against women having more than two children through female surgical sterilization. Pop argued that the state, the market and the Orthodox Church are implicitly and explicitly regulating reproduction in post-socialist Romania. Jackie Kirkham explained morality’s role in shaping reproductive and sexual health services in Moldova and Romania.

Erin Koch concluded the first day with her keynote, “Re-conceptualizing the bio- and the social: Shifting contours of medicine, post-socialism, and ethnography”. She urged us to exercise caution in the use of the terms “biological” and “social”, and to examine how our ethnographies from this region of the world can contribute to medical anthropology, policies, and intervention. During her keynote, Dr. Koch also shared some heart-wrenching excerpts from fieldnotes during her most recent research with internally displaced persons in Georgia.

The second day of the conference opened with the fourth panel, “Trust and power in medical encounters”. Erin Koch chaired this discussion on informational payments in the health care setting, patient safety as a reflection of trust, and the power dynamics between health care providers and patients in these interactions. We heard from Maryna Bazylevych about physicians’ understandings of the acceptance of informal payments and the extent to which this influences their medical practice in present day Ukraine. Athena Peglidou’s paper complemented Dr. Bazylevych’s presentation through its description of a similar phenomenon known as “fakelakia” in Greek society. Zane Linde presented on the changing understandings of patient safety in medical institutions in Latvia as the country moves away from the Soviet understanding of “clean” to the European Union’s framing of the issue as “safety”.

Participants in the fifth panel, “Expert knowledge and medical subjectivities”, chaired by Gerard Weber, focused on examples of how diseases and health categories are framed and the influence this has on how a society addresses these issues. We heard from Jennifer Carroll on Ukraine’s response to, and the international community’s impact on, the HIV/AIDS epidemic in the country. Michael Rasell provided insight into how disability is viewed in Russia through an illustration of the bureaucratic process of objectifying disability. We heard from Razvan Ionescu-Tugui about medical subjectivities in a company that is selling health care in Romania. Participants of the sixth panel, chaired by Jackie Kirkham, presented research on populations that have been marginalized from society and particularly vulnerable to illness. Jonathan Stillo presented on people in with tuberculosis in Romania that were once industrial and agricultural workers and are now social cases, or as they refer to themselves “losers of socialism.” Ursula Cebon presented on the nearly quarter of a million “erased” people in Slovenia (those who were removed from the official registry of citizens in the newly independent country after the fall of Yugoslavia) and their inequitable access to health care. I presented my research with female sex workers in Russia, exploring how these particularly vulnerable women are deterred from getting HIV testing and treatment services, in part because of a perceived stigma from health care workers and society in general.

The final panel was “Healthcare in a neoliberal world” and was chaired by Ann Dill. We heard from Tanja Bukovcan about perceptions of shifting medical systems in Croatia. Sabina Stan discussed how Romanian immigrants to Ireland negotiate where and how they get their medical care. Tommaso De Santis presented his joint paper with Valentin-Veron Toma on the practice of Romanians traveling to Vienna for their medical needs.

Professor Vintila Mihailescu, a leading cultural anthropologist in Romania, provided closing reflections based on his reading of the conference papers. Professor Mihailescu noted several themes in the conference, one of which was the body and power, or how “being healthy” is a strong ideological statement and that healthcare is embedded with many power relations. He noted that throughout Eastern Europe we are seeing the state being replaced by the market, and that this has great impact on healthcare and health institutions. He re-emphasized the importance of focusing on the body of the marginal, including embodied social memories, nostalgia for a time when one felt secure, the marginalization of groups to get rid of them, and women as a marginal category in healthcare. He ended his remarks by reflecting on the issue of trust and asking, “Is it in God we trust, or in hospitals?”

More information about the conference and conference participants can be found at www.hitconference.org. We anticipate an equally engaging conference next year in Poland.

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Research Project Report “A Sociological Analysis of Current Reproductive Medicine in the Czech Republic”

Iva Šmídová

There are only few projects in the region of the Czech Republic analysing issues of health and illness from a critical social-science perspective. I, as a member of the research team, take the opportunity to introduce one of them that had Czech reproductive medicine as its core analytical field. The aim of this short research project presentation is to initiate international collaboration and critical debate on the issues under study, so – kind readers – do not hesitate to let us know your reactions and to discuss the theme with us. Our research is supported by The Czech Science Foundation and lasts for four years (2011 – 2014; GAP404/11/0621) – so there still remains time for engaging with us.

The core areas of study are childbirth, assisted reproduction, and embryo manipulation. The core analytical tools are biopower, biopolitics and governmentality. The research team deals with current reproductive medicine in the Czech Republic and focuses on biomedicine, as a particular manifestation of the normalization of modern society through the Western approach to human health and illness (Cahill 2001). The research is based on the concept of biopower as an analytical idea of a method of governance and administration of modern populations (Foucault 1978). We understand contemporary biopower/biopolitics and their demonstrations as fundamental for the understanding and interpretation of contemporary Czech reproductive medicine. In particular, it is relevant for a comprehension of how the process of medicalization accentuates categories of power, gender and the constitution of bodies. Along the same lines, our inspiration is also derived from texts by Brigitte Jordan and, in particular, her concept of authoritative knowledge, which enables analyses of hegemonies in the field – professional, gender, etc.

The aim of our endeavour is to conduct a critical sociological analysis of reproductive medicine, as one of the key poles in the current form of biopower (Rabinow, Rose 2003, 2006). Through qualitative sociological studies, the project explores the negotiation of power, boundaries between health and illness and the medical defining of normality. The reasons for focusing research on this area is the

relation between reproductive medicine in the Czech Republic and technology, the commodification of health and illness, and the normative character of reproductive medicine with its consequences in the wider social field.

When rereading the project annotation text above in our second project year (already!), I feel caught in the midst of our team's reconceptualising work, as well as in the starting to dive into the fieldwork itself. As already mentioned, the research focuses on three specific fields of reproductive medicine: childbirth, assisted reproduction, and embryo manipulation. Each subtheme is guaranteed and taken care of by one researcher. There are three of us, sociologists: Eva Šlesingerová, Lenka Slepíčková and myself, Iva Šmídová (formally the principal investigator, but in practice a researcher with the same share of input and insight as her colleagues).

Eva Šlesingerová, currently the head of the Social Anthropology Program at the Department of Sociology, at our home institution, the Faculty of Social Studies, Masaryk University (FSS MU), Brno (Czech Republic), concentrates on the question of how the status of bio-medicine – the manipulation with genes and DNA, and embryos, in her case – becomes the norm, and how such a normality is sustained through biomedicine. Analytical work on this issue has led her towards further elaborations on the ethical and moral aspects of practices in reproductive medicine. Her main argument focuses on an analysis of the specific discourses surrounding reproductive medicine, such as religion, legislation and popular culture as well. Through the use of critical theory, Šlesingerová examines the narratives concerning different strategies in the production of knowledge in the interpretation of various imaginative frames concerning DNA, genome and the embryo. The emergence of a new idea of immortality and new definitions of subjectivity, such as the main theme of the boundaries of humanness, are critically analysed within a broader area of contemporary forms of biopower: involving questions of "race", reproductive medicine or genomics. The direction of her further (ethnographic) research follows the theme of embryo DNA manipulation by posing questions such as: How is the icon of the human embryo represented? What kind of struggle between various discourses representing/talking about/acting on the embryo and DNA can be found in the Czech context? How is the moral/scientific/religious status of the human embryo/DNA negotiated?

Lenka Slepíčková, a researcher in the Office for Population Studies, also based at the FSS MU, has concentrated on researching involuntary childlessness resulting from physical infertility and its medicalization through the use of reproductive technologies. Following her successfully defended doctoral research on this topic, she contributes to answering our research question on the negotiation of the borders between normality/legitimacy in definitions of health and illness. In the area of infertility treatment, medical doctors openly admit that their practices do not always correspond with official limits, that their judgment of specific cases is indi-

vidual, and that they provide treatment even at the cost of violating official regulations. The whole process of differentiating between fertile and infertile, deserving and undeserving, normal and other is marked by moral discourse and it is a genuine example of Foucaultian biopower as a control over bodies, interaction and norms within the population performed by medical professionals and through the administration of medical treatment. The aim of the research is to analyse clinicians' perceptions of their patients and the decision-making process during infertility treatment and to indicate groups of patients defined by clinicians as "others", as less appropriate candidates for infertility treatment. This research focus is complemented by an analysis of discussions concerning the proposal to legalize infertility treatment for single women, as took place in the Czech Parliament in 2008. The research goal is to frame medical discourse within political discourse and to study the norms and moral values concerning reproduction and motherhood, as represented by politicians and other stakeholders. So, Lenka Slepíčková's questions explore the mechanisms of intervention of moral discourse into the process of infertility treatment.

Iva Šmídová, assistant professor at the Gender Studies program at the Department of Sociology FSS MU, has directed her research activity towards answering the project research question on the establishment of trust in the system of modern reproductive medicine, i.e. biomedicine, by researching the professional relations of medical personnel (doctors) towards established practices of childbirth (bio-medical, as well as potential alternative approaches) in the Czech context. The goal is to understand the relation between hegemonies of expert/authoritative knowledge and gender. Within the subtopic of "childbirth – representations, practices and hegemonies," Šmídová concentrates on internal debates within the profession (doctors advocating alternatives and gate-keeping the normative approach; hospital midwives often supporting the hegemonic approach vs. independent midwives advocating the alternative) rather than rivalries and clashes between representatives of distinct professions. She is also interested in "exits" – mechanisms and processes leading to adopting ideologies of childbirth alternative to the mainstream, often resulting in change of organizational affiliations of the medical staff concerned. The core research focus is directed towards re/production of hegemonies in the medical profession (dominance concerning both expert knowledge and the gender universe).

The next phases of our work will synthesise the particular research findings. Besides publications, we also plan to open a forum for critical debates on a planned international conference in the Fall of 2013. In the meanwhile, please do not hesitate to contact us at our alias e-mail: leviv@fss.muni.cz or find basic info at the project webpage: www.reprobiomed.fss.muni.cz.

REFERENCES

- Cahill, H. A., 2001. Male appropriation and medicalization of childbirth: a historical analysis. *Journal of advanced Nursing*, 33 (3), pp. 334-342.
- Foucault M. 1978. *The History of sexuality*. New York: Pantheon Books.
- Rabinow, P., Rose, N., 2003. Thoughts On the Concept of Biopower Today. [online] Available at: www.intentionalbiology.org/research/publications_pdf/Rose_Rabinow_Biopower_Today.pdf. [Accessed 1 April 2010.]
- Rabinow, P., Rose, N., 2006. Biopower Today. *BioSocieties*, 1, pp. 95–217.

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Interupce v České republice: zápas o ženská těla

Jaroslava Hasmanová Marhánková

Dudová, R., 2012. *Interupce v České republice: zápas o ženská těla* (Abortion in the Czech Republic: A Struggle for Women's Bodies). Praha: Sociologický ústav AV ČR, v.v.i.

Legal access to abortion and issues surrounding reproductive health traditionally represent key topics of the feminist movement as it exists in the West. The process of the construction of the idea of the autonomous subject, her/his responsibility and ability to decide about herself/himself, and the role of the state in such decisions are an integral part of the discourses surrounding debates on the right to abortion. Analysis of such discourses, therefore, always also provides an insight into the way power techniques operate through individual bodies and the way the subjectivity of the (gendered) citizen is established. Dudová takes this opportunity to study the techniques of biopolitics and the concept of bodily citizenship through an analysis of the discourse on abortion. Her aim is to "describe and analyze the discussion that led up to the changes in legislation on abortion in the 1950s, and how abortion policy was formed in Czechoslovakia" (pp.12).

The book relies on three main theoretical concepts. The first is the idea of bodily citizenship. In this respect, Radka Dudová follows current efforts to redefine the narrow concept of citizenship and enrich it with other crucial dimensions. The significance of health, (dis)ability and the body and their relations to the way (state) power is constituted and invoked has been rather neglected in Czech sociology, as has been their role in the process of the construction of what it means to be an autonomous subject. In this respect, the study by Dudová represents a welcome effort to fill the gap in the conceptualization of citizenship in Czech sociological thinking.

The work of Michel Foucault and his concepts of biopolitics and governmentality represent the second conceptual framework. Dudová analyzes the debates and practices surrounding abortion legislation as a part of the disciplination and control of the population through individual (women's) bodies. This analysis also provides a unique insight into the mechanism of state socialist power. As Du-

dová (pp. 23) points out: “while in liberal regimes freedom and a lack of freedom can be clearly separated, freedom in state-socialist systems was projected into the future in the image of “new socialist man”, whose morals, self-control, desires and needs were meant to represent an ideal self-controlling subject of communist society. Until that time, women and men were not able to control themselves in the proper way and had to be controlled by other means including compulsion and discipline”. We might argue whether such a clear distinction can be made between techniques of power in liberal and non-liberal countries, especially in the case of the medical surveillance of reproduction. The analysis of governmentality in the non-liberal context, nevertheless, represents one of the most inspiring aspects of Dudová’s book.

The concept of discourse represents the third and most developed conceptual frame of the book. Dudová is interested mainly in discursive frames as patterns of argumentation based on widely shared knowledge that define a problem, its solutions, and the actors that are legitimized to speak about it. She endeavors to analyze the ways abortion was framed by the discourse surrounding the process of its legalization in Czechoslovakia and the Czech Republic after 1956, and the position of women asking for abortion in such a discourse, as well as the influence of such a discursive frame on the politics of reproduction.

Dudová combines various data sets to analyze the discourse on abortion. And a reader cannot but appreciate the diversity and amount of data that help the author to build a colorful and exhaustive picture of the debate on abortion. Laws, parliamentary discussions, and newspapers are analyzed, as well as the popular “women’s” magazine *Vlasta* and sociological and psychological studies from the 1950s to the present. Dudová also conducts ten interviews with significant actors involved in the debate surrounding abortion and women’s rights (such as medical authorities and representatives of NGOs). The book chronologically maps the development and transformations of abortion legislation and simultaneously analyzes the key topics, actors, and representations that have framed the prevailing discourses.

The Czech Republic legalized abortion relatively early (in 1957). Dudová, however, points out that this fact cannot be seen as evidence of women’s emancipation. In fact, the enactment of such legislation was connected neither with the feminist movement nor with pressure from civil society. The legalization of abortion was interpreted as a pro-population act, the aim of which was to improve women’s reproductive health. Abortion legislation was part of a discourse that did not challenge the notion of motherhood as a woman’s natural role and mission. On the contrary, the legalization of abortion was intended to help women to become better and healthier mothers. Its aim was to eliminate illegal abortion (and its negative impact on women’s reproductive health) and enable women in difficult social situations to have children at a time when they would be able to properly look af-

ter them. To sum up, the enactment of legal abortion was supposed to help women to fulfill their natural role as mothers, not to enable them to make decisions about their own bodies. As Dudová shows, women’s voices and pro-feminist ideas were invisible in the discursive framing of the discussions. Women were not perceived as autonomous actors that were able to decide about abortion by themselves. The abortion commissions were supposed to “protect” women by making decisions on their behalf and served as a form of state control over women’s bodies. Their aim was also to designate those whose motherhood had the potential to be “good” and therefore who had no right to refuse it.

The prevailing discourse changed slightly in the 1980s and abortion legislation became again a subject of discussion. Dudová identifies two factors that initiated such a change – the expansion of methods of mini-abortion and the publication of the “Prague study of unwanted children”, which significantly deconstructed the myth of unconditional and natural maternal love that always appears after a child is born. The dominant discourse was, however, still framed by medical rhetoric and the right to abortion was still related mainly to the issues of women’s health and the psychological well-being of their children rather than to their rights to decide about their bodies. Dudová also shows how abortion legislation together with forced sterilization functioned as eugenic practices used to control the fertility of those who were not considered to be desirable mothers – in particular, Roma women.

The situation after 1989 opened up space for an alternative framing of the abortion discussion. An unsuccessful attempt to restrict access to legal abortion framed by a discourse involving moral and religious reasons took place in 2003. This event also represented an impetus for the emergent civil society and newly established women-centered organizations to take part in the debate. However, although they highlighted the need to conceptualize the right to abortion as a basic human right, they participated in the production of a discourse that focused mainly on medical and psychological issues rather than issues related directly to women’s rights. The persistence of the medical framing of the debate surrounding abortion and the inability of the new actors to effectively re-frame it highlight the continuity of a discourse, the roots of which can be traced back to the 1950s.

In her book, Dudová presents a unique attempt to map the bodily citizenship of Czecho(Slovak) women through the politics of abortion. I read the book with bated breath. She is a skillful narrator and careful researcher. Her analysis is detailed and provides ample evidence of her keen interest in the topic and the vast amount of data she collected and interpreted. The analysis itself is mostly descriptive. This is, for the most part, due to the lack of similar studies that map the development of abortion legislation in Czechoslovakia. Dudová, therefore, has to dedicate much space to the chronological depiction of the development of legislation and to the history of the engagement of various actors. This chronological descrip-

tion is, without question, interesting and valuable in itself. Unfortunately, it sometimes detracts from the interpretation of the roots of the prevailing discourses. Nevertheless, Dudová clearly and precisely identifies the key frameworks of the discourse, though her reflections on the particular reasons why these discursive frames prevailed with respect to the wider social context is sometimes marginalized.

These critical remarks should not, however, detract from the value of this book. Dudová, by means of a highly specific and under-researched subject in Czech sociology, maps also the wider topics of individual freedom, state control, and the relations between medical authorities and individuals. Her analysis of the historical transformations and the persistence of discursive frames of the “truth” about abortion are helpful also for our understanding of current processes – e.g. the position of women and medical authorities in the debate surrounding “natural” childbirth and the strategies of women-centered organizations and NGOs in the Czech Republic.

The book offers several levels of reading. The first and most visible level gives the reader a rich and detailed insight into the development of abortion legislation in Czechoslovakia and the Czech Republic, and into the discourses that have framed the public debate. Such analysis can, however, also be read as an insight into the history of techniques of biopolitics. Dudová tracks the various actors and discursive frames to show how a certain version of “truth” was/is used to control the population through women’s bodies. The history of the discourse on abortion also represents a history of the metamorphosis of state control and the definition of who counts as a “good” citizen. It also shows how this definition is always gendered and that gender represents one of the key factors framing not only the discourse on abortions but also the possibility to participate in its production. In this respect, Dudová’s book can also be read as an analysis of the processes through which the positions of medical and other authorities are established as subjects capable of deciding about individual (women’s) bodies. Last but not least, Dudová’s book offers a unique analysis of the development of feminist discourses and the politics of women-centered organizations in the Czech Republic since the 1950s. Hand in hand with the analysis of the debate surrounding the legal access to abortion, she also maps the history of women’s emancipation and women’s organizations and their position in Czecho(Slovak) society. Especially insightful is her description of the problematic position of feminist discourses and the transformation of women-centered organizations after 1989, and the impact of the politics of the EU on their agenda.

All of these aspects and topics make Dudová’s book an important contribution to the field of the sociology of medicine, body and gender. It maps the ways the body and expert (medical as well as sociological) knowledge are integrated into power techniques. I hope that this book could also become a starting point for the

study of the subjectivities of women who were the subjects of such state control. The profound question of how the discourse on abortion and practices of governmentality impact (not only) women who have undergone abortion is still open for further investigation.

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Cosmologies of Suffering: Post-Communist Transformation, Sacral Communication, and Healing

Maria Vivod

Lázár, I. and Luse, A. eds., 2007. *Cosmologies of Suffering: Post-Communist Transformation, Sacral Communication, and Healing*. Cambridge: Cambridge Scholars Publishing

In the editors' preface, it is stated that the book is a result of cooperation between members of the *Sacral Healing and Communication* network belonging to the EASA (European Association of Social Anthropologists), a group of anthropologists interested in medical anthropology and sacrality that began its activities in 2003. A conference in Hungary at the Balaton Lake crowned their work in 2005. EASA accepted the network *Sacral Healing and Communication* network as one of its official networks in 2007. While reading this insightful book edited by Agita Lüse and Imre Lázár, one becomes convinced how important the biennial conferences of the EASA truly are and how collaboration established through this huge organization of anthropologists can result in marvelous publications in the domain of medical anthropology and religion.

The title of the book comes from, as Laszlo Kürti who wrote the foreword of this volume states, two basic concepts in (medical) anthropology: cosmologies and suffering. These are elaborated in ten chapters or articles, offering specific ethnographical settings from Russia to Croatia, across Hungary to Slovenia, Poland and Zimbabwe. As the two commentators of the book – Iain Edgar from the University of Durham and Krisztina Fehérváry from the University of Michigan – explain (on the cover of the book), the linking leitmotif of this joint publication is the so-called 'Post-Soviet' societies which are dealing, in various ways, with the harsh realities facing social, political and economic transitional states. The choice of field-works reunited in this book comes from, as the editors state, "societies emerging from the social and political upheaval accompanying the so-called post-socialist transition in the former Soviet-bloc countries of Central and Eastern Europe" (p. 1). The introduction written by the editors offers a fresh approach to the sci-

entific examination of different worldviews and diverse social settings. This scientific production also complements earlier anthropological studies exploring the themes of suffering, cosmologies in a broader meaning, and medical treatments or other productions relating to state of mind and spirituality. From the standpoint of medical anthropology, the methodological model offered by the editors has the goal of provoking deliberation about bodily suffering and those on other levels of being for the purposes of discovering concealed cosmological theories, inner (social) laws and the thinking patterns of diverse societies. When defining one of the basic concepts of the volume, the western solipsism of 'cosmology' is challenged as individuals and their societies mobilize resources to communicate, to grasp the 'higher forces' of their existence, developing new thinking patterns and practices.

The nine contributors to this volume provide concrete examples revealing specific ethnographical settings, and underlining the connection and the importance of the links between physical and spiritual models of human condition(s). For this purpose, the so called 'Post-Soviet', or rather the 'post-communist' countries have provided over the past two decades – and indeed are still providing – an in vivo laboratory where rapid social changes, and collective and individual transformations are felt as vivid and tangible. The aim is to uphold the awareness, as the editors underline, that suffering may be construed as a social production transecting individual and collective aptitudes to steer social conduct and reality-representations (p. 27-28) – no matter whether culturally appreciated, expectant or penalized – as is well demonstrated by the choice of the articles and topics elaborated in them.

From a diachronic perspective, this book filled a gap which was already palpable through the 90s in the field of medical anthropological literature: for the seemingly stable and pre-established conditions of the social arena and the fields of political and economic settings underwent tremendous changes which turned a number of societies into 'transitional states'. The book's timing was apposite as an interpretation of the events which shaped the 90s and are still constructing social realities across Europe and the world is much needed in order to fill the voids in understanding the human condition in general. This collection of case-studies addresses the relationship between suffering and the fall of soviet-style state-socialism, in which the term 'post-communist' society is more broadly employed to denote societies that come in the wake of "state imposed policies rather than socialism as political system" (p. xi Editor's preface). The reason why the cases from these societies were taken under the magnifying glass of anthropological interest is the paradoxical permanence of the state of 'transition' which had lasted before the publishing of the book for more than a decade and in which the swift change of circumstances has caused reactions interpreted as suffering on an individual level and even more visibly so on the social body as a whole. Each case examined in

the collection centers on a different ethnographic setting (Hungary, Poland, Zimbabwe, Croatia, Russia, Slovenia), however, the differences and similarities in culturally constructed and rationalized complexes of suffering are staggeringly similar. As responses to the omnipresent suffering in the human condition, alternative religious and medical practices, as well as the world views they imply, are still being constructed and (re)shaped. Suffering seems to be an unavoidable by-product of the economic, social and political changes which were examined as cases in every chapter of this book.

The task undertaken by the editors was to place into the focus of anthropological reflection the concepts of individual suffering and suffering felt at a social level through specific perceptions of reality drawn from the contexts of sacrality, religion and healing. In their effort to place these concepts in an anthropological frame, the editors proposed as a first step of analysis a methodological approach to the interconnection between the themes of suffering, cosmologies and other related anthropological concepts.

Several concepts, such as 'cosmologies', 'nature' and 'culture' and 'religion,' are closely examined by the contributors of the collection in which a pertinent place is given to the concept of human distress. Suffering is not merely an economic or bodily category in which loss, misery, illness and poverty are its metonymical extensions: suffering is culturally and socially valued, measured, expressed, negotiated and even prohibited. It can also empower the individual and the group and permit a reinvention of identities. A structural approach of examining cosmological structures and their relations in the creation of the symbolic meanings of the human condition(s) in which suffering is an ever-present leitmotif is proposed as an autonomous category of thought. In the domain of medical anthropology, the quest for the meaning of bodily and social suffering still remains to be explored and this book offers a significant step in the anthropological effort to understand concepts which are often subordinated to more popular classifications that are 'easy to think with'. The alternative healing practices which abundantly resurged after the fall of communism in these societies indicated a necessity to reposition individuals in a newly organized system in which human beings are not just social actors of (dysfunctional) societies in which liberties were carefully displayed and therefore constrained, but an active part of a greater, universal order, in which everything was theoretically possible, while in reality nothing truly was. Religion and religiousness came first as a mechanism of claiming back lost values and truths. Other forms of inner and outer displays of quests of spirituality broke through as well. In this sense, spirituality, as the editors propose, might be a universal answer and a coping-mechanism when facing social injustices, uncertainties and individual and collective sufferings.

The sacral and religious practices, alternative medical practices and New Age movements can be interpreted as ways of coping in a Geertzian manner to regain

some sort of control – which it is felt has been lost in the past – a control over individual and social realities, over a world which seems to be in chaos. The social arena becomes a universe in which one suffers and copes against it/with it: new realities are desperately shaped and (re)constructed. Change is inevitable – how to cope with it remains a choice, as the case studies reaffirm.

The motif of suffering is explored by the authors and editors with much creativity as an unavoidable fact of human existence. The meanings which are administered to the changes and the felt uncertainties caused by it on the personal and social level are fundamental semiotic processes. One symbolical context is exchanged for another notion, and uncertainty is installed (and with it suffering): therefore, phenomena declared as 'past' and/or 'superstitions' or alternative explanations of truths (re)emerge as substitute-cosmologies, parallel to hegemonic, mainstream realities. These substitute-cosmologies are the litmus-paper for all changes in society, as the case-studies also prove.

The revitalization of myths and revival of (old) beliefs (such as, for example, shamanism, religious processions, etc.) are just one way of interpreting coping with uncertainties. The editors call upon the scrutiny of other possible paradigms, such as ontology and metaphysics in the domain of medical anthropology. The supranatural cannot be discredited just as a simple survival technique; it has a constructive role in the shaping of human understanding of the world and the cosmos, in which meanings are not randomly attributed. The analysis of the supranatural underlines the necessity to examine further individual and social realities. Mysticism as a response to social suffering and shaping of diverse modes of representativeness and truths is an essential area for study in medical anthropology; therefore sacral cosmologies and communication are a necessity for the anthropological revision of various truths. The decreased capability of individuals and groups to navigate in culturally constructed universes in which suffering is an overwhelming theme pushes toward a reinvention of personal and social solutions which are often 'imports', introductions from other cultural settings, but which nevertheless prove to be functional. The foreign or once lost, forgotten truths are (re)employed, negotiated and lived.

When the social realities of human existences and universes undergo change, beside economic flashbacks, it is the health of an individual and simultaneously the health of a society – the social body – that are the first fields in which cosmological 'beingness' have to be sociologically examined, because these are the moments in which they are reinterpreted and re-negotiated. For this reason, this book, although published a half decade ago, has lost none of its pertinence for a fuller understanding of 'Post-Soviet' universes. It remains a must read for all anthropologists examining universes of suffering, in which coping with uncertainties and transformations of beliefs, practices and worldviews remain keywords.

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