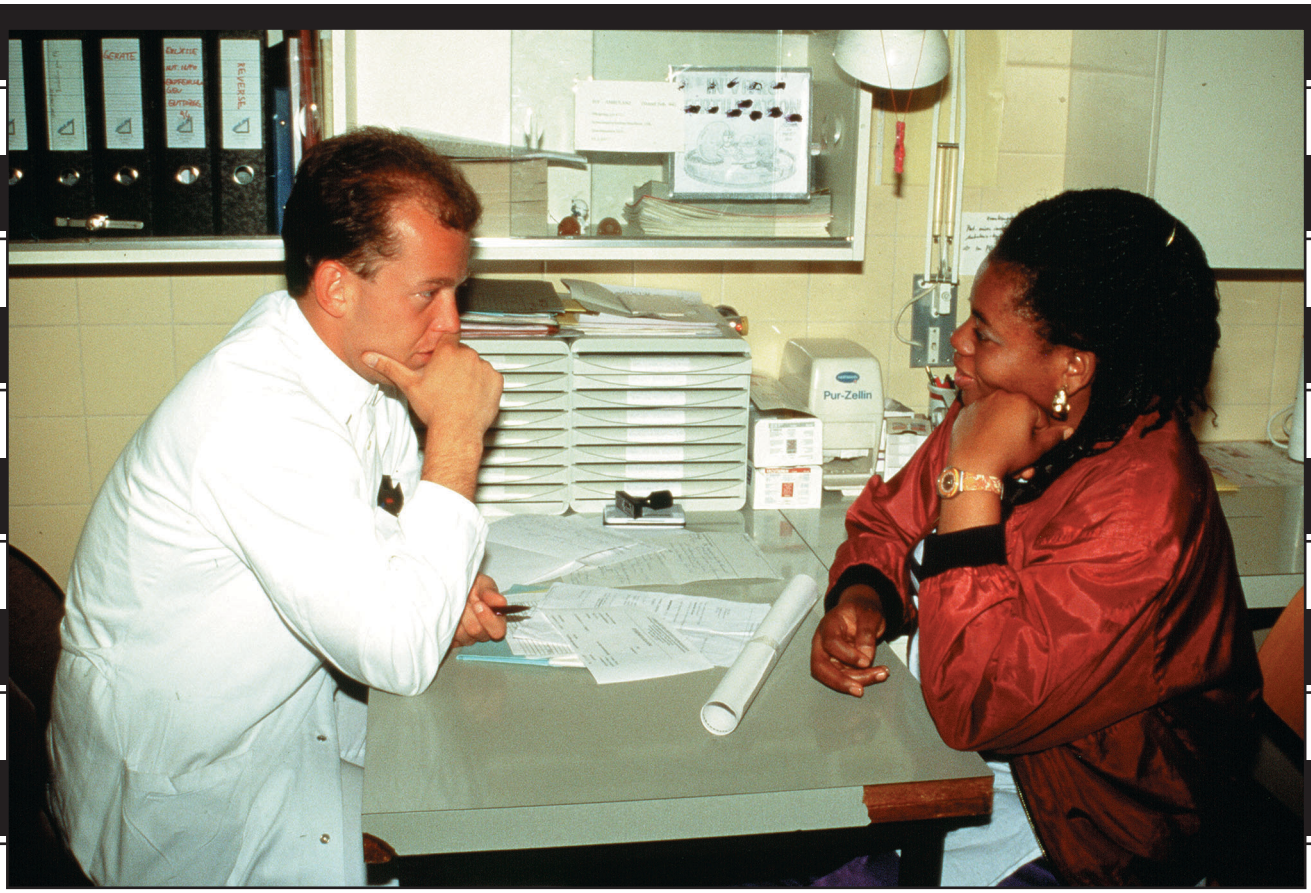
february 2000 volume II number 2

ven

viennese ethnomedicine newsletter



Transcultural Health Care

INSTITUTE FOR THE HISTORY OF MEDICINE, UNIVERSITY OF VIENNA
quondam ACADEMIA CAESAREO - REGIA IOSEPHINA 1785

department of ethnomedicine

Frontispiece:
African immigrant in the gynaecological department at the General Hospital in Vienna

The medical care of a growing subpopulation of immigrants represents a challenge for the Austrian health system. Because cultural barriers, in addition to language barriers, hinder optimal health care. In the context of international migration the subject of Female Genital Mutilation is also of evident significance.
In regard to the call of the Women´s World Conference in Beijing 1995 for equal, appropriate, acceptable, available and affordable health care for women all over the world, specific services for ethnic minority women in Austria have to be developed. Thus it has to be recognised that to address reproductive health issues successfully behavioural and cultural practices must also be addressed.

Photograph: Ch. Binder-Fritz

Viennese Ethnomedicine Newsletter

is published three times a year by the Department of Ethnomedicine,
Institute for the History of Medicine, University of Vienna, Austria.

Content

Submissions, announcements, reports or names to be added to the mailing list, should be sent to:

Editors, Viennese Ethnomedicine Newsletter, Institute for the History of Medicine, Department of Ethnomedicine, Währinger Strasse 25, A-1090 Vienna, Austria
FAX: (++)43-1-42779634, e-mail: armin.prinz@univie.ac.at

Editorial

Political Change in Austria

In accordance with the members of the VEN editorial board we have decided to comment on the political change that has recently occurred in Austria.

This newsletter is meant to be a medium that advances understanding people from different cultural backgrounds. If our contributions are intended to show the common features of medical beliefs and activities all over the world, they also will contribute to the comprehension of other cultural systems. Therefore, we are firmly opposed to discrimination against any people based on their citizenship, skin color, religion, or other social and cultural attributes. As an ethnologically oriented science we do understand movements trying to safeguard identity and ethnicity, but we will never accept a militant nationalism – a nationalism that is meant to create xenophobia and to lead to psychological and physical aggression against other peoples. We will do everything possible to fight against these tendencies in our country. We feel the need to comment on the situation, even if we might be criticized for including a political statement in a scientific journal. We are convinced that our silence is unsupportable and could be interpreted as complicity with this inhuman political situation.

Armin Prinz

Transcultural and Ethnomedical Perspectives of Women's Health

Christine Binder-Fritz

Introduction

In 1989 I carried out a six months ethnographic field study among the New Zealand Maori communities in the Bay of Plenty and Waikato area for my Ph.D. in social and cultural anthropology. The research focused on the rapid social and cultural change and its impact on the tradition-orientated Maori society, particularly on the changes that took place in the traditional birthing system alongside the influence of Western medicine. Furthermore I was interested in the effects of "medicalization" on women's sexual and reproductive health.

Since 1995 I am very engaged in health issues in regard to ethnic minority groups in Austria. During my work as a medical technician on genetics and prenatal diagnosis in the General Hospital in Vienna (1977-1994), I had realised the growing number of migrant women in our gynaecological and obstetrical departments. The medical care of a growing subpopulation of work-migrants, refugees and foreign guests from non-Western societies represents a challenge for the Austrian health system, because cultural barriers, in addition to language barriers, hinder optimal medical care. As a response to this need I personally have initiated vocational training courses for nursing staff on "Transcultural Nursing-Care" provided in the General Hospital of Vienna, to improve the staff's cultural awareness and sensitivity for medical ethics and health care for these population groups.

Research on Women & Health

On these grounds, I have developed a project proposal "Ethnomedical perspectives of women's health: A framework for a transcultural and gender-sensitive health care", which was

applied at the Austrian Science Fund (FWF) for a so-called "Hertha Firnberg Nachwuchsstelle für Frauen". The following article will sum up this project, which was accepted by the scientific committee in June 1999. This scholarship will be in the form of a middle-dated occupational employment program at our university department. I would like to thank Prof. DDr. Armin Prinz, the head of our department, for acting as co-applicant and agreeing with my research project, which has started on October, 1st, 1999 and will run for three years, including an other twelve months of research study in New Zealand. It is planned to submit the final documentation as a habilitation thesis.

In recent years there has been an increasing call for promoting research in the area of women and health by several institutions for women's health care. Research data on women, health and medicine was provided by medical scientists, medical anthropologists, psychologists, sociologists and historians (Oakley 1993). Feminists of all disciplines have contributed enormously to theory as well as practice in women's health care (Mac Cormack and Strathern 1980; Rosaldo and Lamphere 1974). Women's studies have defined sex and gender differences in health issues and sex-specific health problems (Caplan 1987; Miles1993.) As a result institutions for women's health care have been developed and some attempts have been made to implement these new insights and practices in medicine, psychology and public health (Artschwager-Kay 1982; Groth 1997; Mixa/ Malleier/Springer-Kremser/Birkhan 1996).

"Cultural" Views on Health

While we usually think about health using the language of scientific medicine, because this is part of our Western culture, other societies and cultures have totally different perceptions in regard to health and illness, that are based on their ethnic traditions (Kleinman 1980, Pfeiffer 1970 and 1980; Wulff 1978). The influence of culture on views of health is most apparent when other societies are being studied (Ludwig and Pfleiderer-Becker 1978; Pfeiffer 1970 and 1980; Pfleiderer et al.1985 and 1995).

The discipline of medical anthropology is studying the cultural diversity of human reactions, experiences and explanations in regard to the phenomena of illness and disease. Cross-cultural comparison to define strategies for health promotion and analyses of therapies, that fulfil the basic needs of human beings and promote the coping with fear and illness, are in the centre of this discipline. As the great variety of illness-concepts and therapies in different cultures offers an abundance of models to deal with crisis and illness, research studies may provide new impulses for the Western Medicine as, among some others, Norbert Kohnen and Armin Prinz have pointed out (Kohnen 1990; Prinz 1984).

Studies of women as recipients and providers of health care have greatly expanded in recent years, but there is an urgent need for cross-cultural research studies especially on the topic of reproductive health. Although reproductive and sexual health issues are only one facet of a woman's health concerns throughout her life, they are for many women defined at an early age, (Rosaldo and Lamphere 1974; Mac Cormack and Strathern 1980). Furthermore recognition has been made to develop an approach which acknowledges that reproductive health is not limited to the child-bearing years as Margaret Lock has shown (Lock 1987). This approach also recognises that to address reproductive health issues successfully, behavioural and cultural practices must also be considered. On these grounds medical anthropologists, who have done field research studies in non-Western societies might be predestined to work in the area of transcultural medicine, promoting a cultural sensitive health care for ethnic minorities, as the aspect of "cultural change and health" (Pfleiderer et al. 1985) often is an integral part of their research studies in postcolonial societies

It is important to give a short comment on the term "ethnicity" in regard to health statistics, although due to the limited space, this can not be done in detail. The term "ethnicity" is used here as a personal and social characteristic to define a certain population group in the context of health and disease, but without prior assumptions about the causes of health differences between different ethnic or racial groups. Referring to Alastair Gray (1993:126) there are "many difficulties in defining and using the

concept of ethnicity". The question for example is if, "a person's own country of birth, or their parent's country of birth, is of more relevance?" Another problem is, that many routinely collected statistics on health and disease do not provide information on different ethnic groups, although the society might be multi-ethnic. To determine the validity of statistical data on New Zealand Maori for instance, can create major difficulties. Before the 1986 census statistical definitions generally employed a biological base and used the criterion of half or more "Maori blood". For electoral purposes in 1975 and for statistical analysis at the 1986 census, "self-identification" has been the accepted method for ethnic classification. The decisive factors in determining this identification are family background and upbringing, as well as personal commitment, rather than degree of ancestry" (Pool 1991:14). It is important to observe variations between statistical sources, especially when using health data.

Regarding my project and the issue of sexual and reproductive health, I will draw my attention to the autochthone minority group of Maori women in New Zealand. On the other hand ethnic minority immigrant women in Austria will be of interest too. On the ground of previous research in New Zealand I would like to state, that every minority experience is of course unique, but it is not without parallels elsewhere. Referring to Ken Blakemore and Margaret Boneham this allows comparative perspectives between different groups. One experience ethnic minorities living in different societies do share: the experience of being a minority community opposite to a majority. In the context of "ethnic identity" some other questions are raised by the authors: "Over time, continuity may be threatened by social change among the second, third and fourth generations" so it is to question if "ethnic identity is inevitably eroded over time?" (Blakemore and Boneham 1994: 27) and if so, what effects will it have on the people in their old age?

Gender Aspects of Women's Health

There are many factors that have a major influence on the ways individuals act in matter of health. Among other factors class, gender and culture play a major part for women. Women live longer but suffer from more health problems during their lifetime than men, as many of these problems are specific to the female gender. Research on health and illness behaviour and gender differences has been extensive (Sich/Diesfeld/Deigner/Habermann 1993 b; Miles 1993; Strasser 1995). Focusing on the interaction between women, health and medicine Agnes Miles states that social class, gender, occupation and ethnic origin will affect the women's concepts of health (Miles 1993). Ann Mc Pherson and Deborah Waller have shown clearly, that different people are likely to hold different views on health and there may be several conflicting views simultaneously (Mc Pherson and Waller 1997).

Medical anthropologists and sociologists usually make a distinction between disease and illness. The term disease refers to a biological or clinicallly identified abnormality which is considered pathological by Western medicine. In contrast illness refers to a person's experience of being unwell. In such sense illness is a "subjective" feeling of symptoms, self-assessed by the individuals (Helman 1990).

Between health, illness behaviour and gender there is an important interaction and attention to variations in illness behaviour had been given more than thirty years ago. The term "illness behaviour" has been used by writers since David Mechanic in 1962, where he pointed out that systematic variations are to be found in the ways people perceive, evaluate and act with respect to health and illness (cit. in: Miles 1993:58). Mechanic's more recent definition points out that "illness behaviour describes the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilise the health-care system" (Mechanic 1982:1).

Numerous female scientists call for more research in the field. As Beate Schücking states, there are still "white spots in the landscape" in the context of women's studies in medicine: "Gender research is almost or completely lacking (…) in every field of clinical medicine" (Schücking 1996:229). She hopes therefore, that future women's studies will question body-political issues, sexual autonomy and discrimination against women by medicalization in the history of medicine (1996:242).

Gender studies on ethnic minority groups in Western European societies evoke some well known dilemma for the anthropologist. Following the postcolonial "Cultural Critique" of Edward Said (1978), Lila Abu-Lughod regards "culture" as the powerful tool "for making "other"", and that is as effective as the former distinction of "races" has been (Abu-Lughod 1991:147). Edward Said had put some pressure on this aspect in his "Orientalism" when he stated (Said 1978: 25): "What is another culture? Is the notion of a distinct culture (or race, or religion; or civilisation) a useful one, or does it always get involved either in self-congratulation (when one discusses one's own) or hostility and aggression (when one discusses the "other").

The feminist anthropologist Chandra T. Mohanty has shown clearly that feminist researchers originally based gender studies on a double differentiation of "gender" and "culture" and hereby continued the hegemonic "distinctive-other tradition" in the field of anthropology (Mohanty 1988). Criticism from feminists on these power structures which are involved in the construction of the distinction between the "own" and the "others" have led to new statements on "multiple differences" and the necessity to focus on "differences within" and their intersections or "intersexions" as Gerlinde Schein & Sabine Strasser (1997) have termed it as a wordplay. Viewing on cultural differences should then not only focus on the "differences between" (categories), but also question "differences within" (Moore 1993:20). This is for instance also of major concern in regard to research on female immigrants with Muslim background in Austria, as these different groups of women (Turkish, Bosnian, Middle East, Arab Peninsular) with different class and educational background may have very different concerns about sexual health issues.

Project Design

The goal of this Hertha-Firnberg project is to discuss selected issues of women's reproductive and sexual health. Special reference will be made to ethnic minority groups in Western societies hereby focusing on trans-cultural aspects. The approach will be from the perspective of a woman's lifecycle to determine her special needs in regard to a gender sensitive and culturally appropriate sexual health care. The main focus will be on the research in New Zealand to continue data collection on "Maori Women and Health", as new initiatives and integrative therapies from Maori Health Groups are of great interest.

The other task will be to discuss the integration of female immigrants into the Austrian Public Health System, by identifying their special health needs, as social class, gender, ethnic origin, occupation and life-style do affect the concepts of reproductive health and illness behaviour. Another task will be to promote cross-cultural understanding and to facilitate the migrant's access to our health services. The New Zealand data may serve then as a framework of ideas for our own health care system towards a holistic and client-friendly medicine.

New Zealand Maori Women

Maori women's health can not be discussed without the historical perspectives and the cultural changes in this society. Previous ethnographic research studies in New Zealand have revealed that acculturation and socio-economic changes have led to a shift from the rural to urban areas and to a change in family structure, among other problems. Due to the medicalization of pregnancy, birth and menopause some important, culturally based rituals that accompanied such "potentially critical moments" in a woman's life cycle were lost (Binder-Fritz 1996). At the present the average Maori population still belongs to low social income groups. Therefore Maori health has to be seen in a wider context of Maori social development, as their low socio-economic status is also responsible for some of their health problems. There are links between unemployment, low income, cheap and "unhealthy" nutrition, and alcohol and drug abuse – and as a consequence – a greater demand on health services. An "unhealthy" lifestyle, with too much fat and carbohydrates in the food, not enough recreation and sport and excessive smoking are linked to adiposity, diabetes and coronary heart diseases. Alcohol, drug abuse and a high rate of mental health problems are another source of concern.

Comparing Maori and non-Maori standards of health show a lower life expectancy for Maori,

and high death rates from ischaemic heart disease, asthma, chronic lung disease, diabetes, cancer (bowl, cervix, mamma) and accidental injuries. Another source of concern is that the neonatal and the infant mortality are about three times higher, the rate for suicide is six times, and the rate for psychiatric problems almost three times higher than within the Pakeha (European origin) population. (Public Health Commission 1995)

Fig. 1: Maori mothers in urban areas are missing the traditional psychosocial support systems within the family (Hamilton, N.Z. 1996).

As Mason Durie (Durie 1994) and the Public Health Commission (1995) state, there has been a growing realisation in the health sector over recent years, that New Zealand´s health services, being essentially monocultural, often failed to respond to the needs of the female Maori-population. Some tape-recorded narrative interview passages from 1996 and 1997 contain interesting data and are very supportive to the assumption that there has been a number of socio-cultural barriers concerning sexual and reproductive health care. Some Maori women described their experiences and feelings in regard to public health services that are strongly linked with their ethnic origin as Maori. The informants did not make full use of public health services: they did not attend prenatal classes, they missed medical check-ups such as breast screening or cervical smear tests. The planned data collection will have to question what kind of social and/or cultural barriers may hinder the access to health care services.

The aim of the New Zealand study will be to define the differences between the monocultural public health services and those initiatives and

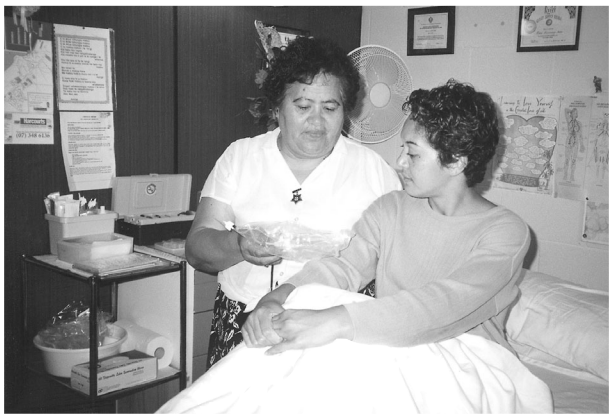


Fig. 2: Millie Heke, a special trained nurse as cervical smear taker. (Korowai Aroha Health Centre, Rotorua 1996).

integrative therapies from Maori health groups themselves. It will focus on the question how behavioural and cultural practices can be addressed to make reproductive health issues gender-sensitive and successful. Special emphasis will be put on strategies for sexual health promotion (e.g. STD, HIV- and AIDS-Prevention), as different concepts of health and illness, different socialisation of men and women, different body perception, strongly based on traditional concepts have hindered optimal health care for the indigenous women in the past.

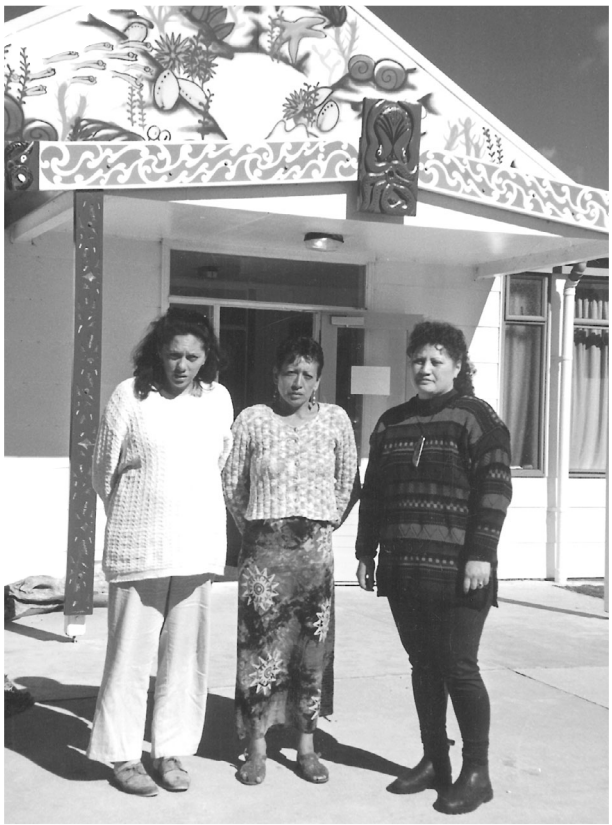


Fig. 3: A Maori Women's Health Center and staff members (Whakatane, N.Z. 1997).

Maori women's activities in the health sector focus on health promotion programmes and are based on "empowerment" and encouragement for self-determination in the health sector. Data from previous research in 1997 on the integration of culture-linked therapies into the Public Health Care of New Zealand are of special interest. The future task will be then to identify effective models for health care delivery among different population groups of women. Another aim will be to analyse those culture-linked concepts that help to maintain health, and to identify preventive measures, that are able to cope with fear and help to accompany "critical moments" in the woman's lifecycle. In regard to the high prevalence of mental health problems some complementary therapies will be analysed and discussed for their possible contribution to reduce physical and psychological distress. Women who show particular clinical syndromes with mental and psychic disorders, that are often culture-linked, can make use now of special integrative therapies in Maori Health Clinics (Binder-Fritz 1999).

Methodology

A qualitative wholistic and semantic approach combined with quantitative techniques has been chosen for data collection in New Zealand. It will combine interview techniques, observational methods and video-taping, as the aim of this ethnographic research is to acquire a deeper insight into the embeddedness of Maori concepts of well-being, health, illness prevention and healing in the particular socio-cultural context. Using a qualitative approach with data collection by tape-recorded narrative and explorative interviews was also chosen as oral culture has always played a major part in Maori society. Up to the present public discourse and decision-making is oral and confirmed in the consensus not in the document (Mc Kenzie 1985). As rhetoric ability is highly regarded as a great skill in Maori society, people are used to express themselves in a rich, compact and "colourful" language, which is full of semantic analogues, cultural symbols and meanings. As Silverman has noted for interviewers in the interactional tradition, the interview subjects do not just construct narratives but social worlds (Silverman 1993:91). The qualitative approach by using open and explorative interview techniques has also been chosen because of former field research experiences in New Zealand. Narrative and explorative interviews, as well as semi-structured interviews will be conducted with selected recipients and providers of health services.

Data will be analysed and single-case studies will be presented, to get a deeper insight. The approach will be based on the hermeneutic and phenomenological concept (Oevermann 1979; Schütze 1973), usually practised in social studies. The resultant responses from the semi-structered and structured interviews and interview-parts will be coded in categories, considering different needs of women at different age-groups, with different socio-economic and educational background. Based on "grounded theory" (Glaser and Strauss 1967) the specific coding categories for the questionnaire will be developed with help of Maori experts during the field research in New Zealand. Observational field notes and videotapes will be checked especially on the aspect of social and face to face interaction and communication of recipients and health providers. Videotapes will be revised by sequence analysis based on the works of Silverman (1987), Goodwin (1995).

Female Migrants and Austrian Health Services

For the year 1995 demographic statistics quoted app. 720.000 persons living as immigrants and refugees in Austria (Österreichisches Statistisches Zentralamt 1995). The most numerous migrant group originates from former Yugoslavia (Serbs, Croats, Bosnians, Albanians) and the second group are people from Turkey and other Muslim societies, as well as Kurds, Assyrian, Armenians. A smaller group of immigrants originates from other non-Western societies in Latin America, Africa and Asia. But there is an unknown number of families who have got Austrian citizenship, but still belong to these ethnic minority groups (Wiener Frauengesundheitsprogramm 1998:127).

As many others scientists, Agnes Miles emphasises the requirement for more research on the complexity of the correlation between class, gender and health concepts. Concerning minority women she points out, that "less

attention has been paid to the health beliefs of minority ethnic groups living in contemporary Western societies" and therefore she emphasises that "information on the culture of such groups would increase understanding" of differences to the majority in these societies (Miles 1993: 41).

Another important aspect in the context of refugees is the vulnerability especially of women, as they are threatened to be exposed to violence and rape (Peltzer 1993; UNFPA 1993: 27). Until the present, there has been not enough acknowledgement of the increasing number of female migrants and refugees from African and South-East-Asian countries, and their specific needs in health care issues. In the context of health risks for these women the topics of sexual violence and the practice of female circumcision, better defined as genital mutilation, are of some actuality. Given the current influx of refugees and immigrants, the question of ethnicity in relation to health care is of some urgency in Austria. The need for debate on the subject was emphasised in the study "Wien – Gesunde Stadt: Ausländer und Gesundheit" / Vienna – Healthy City: Migrants and Health (Schmid et al. 1992) and in the "Wiener Frauengesundheitsbericht 1998" (Vienna Women's Health Report).

As a response to this need my project furthermore includes data collection in Vienna. Structured interviews and focus group discussions with a questionnaire will be tape-recorded with selected staff members (medical doctors and nurses) at gynaecological and obstetrical departments in two hospitals with a high percentage of migrant women. A smaller number of patients will be asked for their consent to be interviewed too. Interview respondents will be mainly chosen from selected nursing staff, who had attended one of my vocational training courses in "transcultural nursing care" within the last three years. Analysis of the data will be based on "grounded theory" (Glaser and Strauss 1967): Further categories for coding the data will be developed in the progress of the data collection.

Vocational training in "cultural awareness"

The increasing number of female migrants with different cultural backgrounds from different regions (Turkey, South-East-Europe, Middle East, Asia, and Africa) has led to some misunderstandings and conflicts in Austrian maternity services. In addition to language barriers, there are interactional and emotional aspects that have to be considered. Health care providers need to improve their cultural awareness and sensitivity in the area of sexual and reproductive health for ethnic minorities. The cultural conceptions in regard to fertility and religious principles, the observance of physical taboos in addition to the symbolism of blood and the concept of desecration (Zimmermann 1994) are of special significance in obstetrics. Varying birth practices and cultural conceptions on prenatal and postpartum period can be observed, as childbirth is an integral part of the social and cultural framework (Jordan 1978; Kitzinger 1978). Although the sociocultural framework of female migrants might be quite different, some basic patterns in social behaviour and concepts in regard to birth, health and illness are of significance for medical staff (Habermann 1992; Kayankaya 1995).

The integration of ethnic minority groups is a challenge for Austrian Health Services. To overcome language barriers community interpreters are available in some hospitals now. In addition to language barriers, cultural barriers hinder optimal medical care. As a response to this need in 1995 I started to give vocational training courses for nursing staff on the topic of "Transcultural Nursing-Care". The themes focus on "cultural foreignness" and on interactional situations between medical staff and patients in our units. Turkish and other Muslim women represent the largest patient-group. On these ground an explanation of the most important Islamic religious principles alongside

Fig. 4: With nursing staff in a vocational training course. (General Hospital of Vienna, 1999).

an elucidation of the different socialisation of men and women, concepts of illness, body perception and the expression of pain is given. One topic of these training courses is the "cultural construction of health and illness" (Kleinman 1980) and the "sick role".

The growing numbers of female migrants from non-European societies are a challenge for the Austrian Health Care System and there is a need for the development of migrant specific health services. Ethnomedical field studies in other cultures sharpen the researcher's critical view on his/her own medical system, as was stated by Beatrix Pfleiderer in her comment on "cultural construction of Biomedicine" (Pfleiderer 1995:163). I am convinced, that the documentation of the research data in New Zealand will serve as a "Model of Good Practice" and will be of relevance for public health services in Austria too, as it will provide an abundance of ideas to stimulate the development of similar, migrant specific health services for ethnic minority women in Austria.

The majority of New Zealand Maori women and female immigrants in Austria have something in common: Both belong to the so-called "doubly disadvantaged group". Non-German-speaking immigrants in Austria, who are also female, or refugees, or young or elderly are classified as a doubly disadvantaged group. This term refers to categories such as low income and inadequate housing. Many of them suffer stress and lack of family and community support, lack of access to information and health services. Women are even more marginalised when they are old, poor and lack family support (Miles 1993).

Women and the sick role

Sensation of pain and discomfort, feeling of fear and disorientation are intensively individual and personal. Nevertheless being sick is not only an individual experience but a social state too. Freidson (1975:208) made the notion of sickness as a social state very clearly. The cause of a disease may be one aspect, but the social interplay between a sick woman and other members of her society may be another aspect. A woman who is experiencing an indication of a biological malfunction of her body, may assume the "sickrole", meaning the social role of the sick person. During the 1950s Talcott Parsons developed the theoretical concept of the sick role (Parsons 1958). Although he has been criticised by some writers the concept provides a useful framework for our discussion. Parsons described certain social expectations and defined the sick role in terms of four components, including that sick persons are allowed by society to withdraw from some or all their social obligations (e.g. work, duty.) and that there is no blame attached to this.

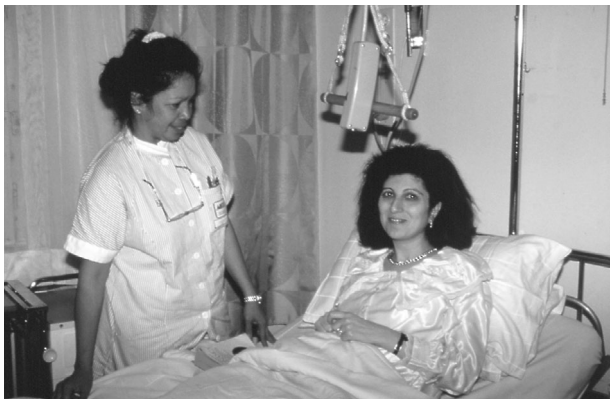


Fig. 5: Muslim women in hospital. Being sick is an individual experience and a social state too. (General Hospital in Vienna, 1994).

In regard to Muslim immigrants in our health services it is important to consider that in the Islamic Middle East illness can be a method for legitimating behaviour which deviates from conventional social expectations. (Turner 1987; Strasser 1995). Bryan Turner adds that the sick role as a form of social withdrawal is widespread in human cultures.

The symbolism of blood, the concept of desecration and decreed ritual cleaning can be of the same significance for everyday hospital work as the observance of physical or dietary taboos. Last but not least – the subject of female genital mutilation (FGM) is also of evident significance in the context of migration, as there is a growing number of women living in Austria, who originate from those African countries where FGM is practised. This aspect will be dealt with in the following pages.

References

Abu-Lughod, L. (1991) Writing against Culture. In: Fox, R.G. (ed) Recapturing Anthropology. Working in the Present. Santa Fe, New Mexico
Artschwager-Kay, M. (Ed.). (1982) *Anthropology of Human Birth*. Philadelphia.
Blakemore, K, Boneham, M. (1994) XXX

Binder-Fritz, C. (1996) *Whaka Whanau.Geburt und Mutterschaft bei den Maori in Neuseeland*. Peter Lang. Verlag. Frankfurt.
Binder-Fritz, C. (1999) Western Medicine Alone Does Not Cure Maori Sickness. A Discussion on the Integration of Traditional Maori Therapies in the Health Care System of New Zealand. In: VEN 1, 2, 1999: 4-13.
Caplan, P. (ed.) (1987) The Cultural Construction of Sexuality. London/ N.Y: St. Martin's.
Durie, M. (1994) Whaiora. Maori Health Development. Oxford University Press. Auckland.
Freidson, E. (1975) Profession of Medicine. New York. Dodd Mead.
Glaser, B. and Strauss A. (1967) *The Discovery of Grounded Theory*. Chicago.
Goodwin, C. (1995) Seeing in depth. in: *Social Studies of Science*, 25 (2): 237-74.
Gray, A. (1993) World Health and Disease. U.K. The Open University Press.
Groth, S. 1997. PatientInnenorientiert und frauengerecht. in: Grundböck, A., Novak, P., Pelikan, J. (ed.) *Gesundheitsförderung – eine Strategie für Krankenhäuser im Umbruch*. Projekte aus Österreich und Deutschland. Reihe Gesundheitswissenschaften/ Gesundheitsförderung Band 4. Wien. Facultas Universitätsverlag.
Habermann, M. (1992) "Viel Schmerz" oder das "Mamma Mia Syndrom". Überlegungen zum Kulturkonflikt in der klinischen Betreuung ausländischer Patienten. *Pflege* 5 (1): 34-40. #
Helman, C. G. (1990) Culture, Health and Illness, 2nd. Edition. London: Wright.
Jilek-Aall , L., Jilek W. , Flynn F. (1978) Sex Role, Culture and Psychopathology: A Comparative Study of Three Ethnic Groups in Western Canada. In: Journal of Psychological Anthropology. Vol. 1/4: 473-488.
Jordan, B. (1978) *Birth in four Cultures:* A Cross-cultural Investiga-tion of Childbirth in Yucatan, Holland, Sweden and the United States. Montreal. Eden Press.
Kayankaya, I. (1995) Vorstellungen und Konzepte türkischer Frauen für den Bereich der Gynäkologie und Geburtshilfe. in: *Gebären – Ethnomedizinische Perspektiven und Neue Wege*. Curare Sonderband 8 / 1995: 43-46.
Kitzinger, S. (1978) *Frauen als Mütter, Mutterschaft in verschiedenen Kulturen*. München. Kösel.
Kleinman, A.M. (1980) *Patients and Healers in the Context of Culture*. Comparative Studies of Health Systems and Medical Care. Berkley.
Kohnen, N. (1990) Ethnomedizin in der Bundesrepublik Deutschland. *Dtsch. Ärzteblatt* 87: 17-19.
Lock, M. (1987) Productivitiy, Sexuality and Ideologies of Menopausal Problems in Japan. In Health, Illness and Medical Care in Japan: Cultural and Social Dimension. Norbeck, E. & Lock (Ed.), M. Honolulu: University of Hawaii Press.
Ludwig, B & Pfleiderer-Becker, B. (1978) *Materialien zur Ethnomedizin*. Kübel-Stiftung Gmbh. Bensheim in Zusammenarbeit mit der Arbeitsgemeinschaft Ethnomedizin e.V. Heidelberg.
Mac Cormack, C. P. and Strathern, M. (1980) *Nature, Culture and Gender*. Cambridge, University Press.
McKenzie, D.F. (1985) *Oral Culture, Literacy & Print in early New Zealand: the Treaty of Waitangi*. Victoria University Press. Wellington: Alexander Turnbull Library.
McPherson, A. and Waller, D. (1997) Women's Health. Fourth Edition. Oxford General Practice Series. 39, Oxford University Press. Oxford
Mechanic, D. (1982) The epidemiology of illness behaviour and ist relationship to physical and psychological distress. In: Mechanic, D (ed.) Symptoms, Illness Behaviour and Help-Seeking. New York: Prodist.
Miles, A. (1993) *Women, Health and Medicine*. Open University Press. Philadelphia.
Mixa, E. Malleier, E. Springer-Kremser, M. Birkhan, I. (Ed.) (1996) Körper – Geschlecht – Geschichte. Historische und aktuelle Debatten in der Medizin. Wien. Studienverlag.
Mohanty, Chandra T. (1988) Under Western Eys: Feminist Scholarship and Colonial Discourses. In: Mohanty, Chandra T. et al. (Ed.) Third World Women and the Politics of Feminism. Bloomington. Indianapolis 1991:51-80.
Moore, H. (1993) The Differences Within and the Differences Between. In. Del Vaslle, T. (Ed.) Gendered Anthropolgy: 193-204. London: Routledge.
Oevermann et al. (1979) Die Methodologie einer "objektiven Hermeneutik" und ihre allgemeine forschungslogische Bedeutung in den Sozialwissenschaften. in: Soeffner, H.G. (Hg.) *Interpretative Verfahren in den Sozial- und Textwissenschaften*. Stuttgart.
Österreichisches Statistisches Zentralamt 1995. Statistisches Jahrbuch 1995.
Parsons, T. (1958) Definitions of health and illness in the light of American values and social structure. In: Jaco; e.G. (ed.) Patients, Physicians and Illness. New York: Free Press.
Peltzer, K. (1993) Psychotherapie mit Flüchtlingen aus der Dritten Welt. in: Badawi, I (Ed.) *Beratung und Therapie im Kontext psychosozialer Arbeit mit Flüchtlingen:* 52-62. Stuttgart.
Pfeiffer, W. (1970) *Transkulturelle Psychiatrie*. Stuttgart.
Pfeiffer, W. (1980) Kulturgebundene Syndrome. in: Pfeiffer, M. & Schoene, W. (Ed.) *Psychopathologie im Kulturvergleich:* 156-169. Stuttgart. Enke.
Pfleiderer, B. Greifeld, K. & Bichmann, W. (1985) *Krankheit und Kultur*. Berlin. Reimer.
Pfleiderer, B. Greifeld, K. & Bichmann, W. (1995) *Ritual und Heilung*. Eine Einführung in die Ethnomedizin. Berlin.
Pool, I. (1991) Te iwi Maori. A New Zealand Population. Past., Present &Projected. Auckland University Press.
Prinz, A. (1995) Kranksein in fremden Kulturen. In: Frischenschlager, O. Kantner-Rumplmayer, W. Ringler, M. Wisiak; U.V. (Ed.) *Lehrbuch der psychosozialen Medizin* – Grundlagen der Medizinischen Psychologie, Psychotherapie und Medizinischen Soziologie: 77-87. Frankfurt /M.

Public Health Commission (1995) Progress on Health Outcome Targets. The haere whakamua ki nga whainga hua mo te hauora. The State of the Public Health in New Zealand. Wellington.
Rosaldo; M.Z., and Lamphere, L. (Ed.) (1974) Woman, Culture and Society. Stanford, CA: Stanford University Press.
Said, E. (1978) Orientalism. London 1978.
Schein, G. & Strasser, S. (ed.) (1997) Intersexions. Feminstische Anthropologie zu Geschlecht, Kultur und Sexualität. Reihe Frauenforschung Bd. 34. Milena Verlag. Wien.
Schmid, G. Giorgi, L. Pohoryles, R. Pohoryles-Drexel, S. (1992) Wien – Gesunde Stadt: Ausländer und Gesundheit. Im Auftrag des WHO-Büros "Wien – Gesunde Stadt" und des Zuwanderer-Fonds der Stadt Wien.
Schücking, B. A. (1996) Weiße Flecken in der Landschaft: Frauenforschung in der Medizin. in: Mixa, E. Malleier, E. Springer-Kremser, M. Birkhan, I. (Ed.) Körper – Geschlecht – Geschichte. Historische und aktuelle Debatten in der Medizin. Wien. Studienverlag.
Schütze, F. et al. (1973) Grundlagentheoretische Voraussetzungen methodisch kontrollierten Fremdverstehens. In: Arbeitsgruppe Bielefelder Soziologen (ed.) *Alltagswissen, Interaktion und gesellschaftliche Wirklichkeit*. Reinbek.
Sich, D. & Diesfeld, H.J. Deigner, A.& Habermann, M. (Ed.) (1993) *Medizin und Kultur – Eine Propädeutik für Studierende der Medizin und der Ethnologie*. Frankfurt/M.
Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction. London:* Sage.
Strasser, S. (1995) *Die Unreinheit ist fruchtbar:* Grenzüberschreitungen in einem türkischen Dorf am Schwarzen Meer. Wien. Wiener Frauenverlag.
Turner, B. (1987) Medical Power and Social Knowledge. London: Sage.
Wulf, E.V. (1978) Grundfragen der transkulturellen Psychiatrie. in: Wulff, E.V: (Ed.) Ethnopsychiatrie: 157-187. Wiesbaden. Akademische Verlagsgesellschaft.
Zimmermann E. (1994) Ausländische Patienten und klinische Praxis. in: *Kränkung und Krankheit. Psychische und psychosomatische Folgen der Migration*. Edited by D. Kiesel, S. Kriechhammer-Yagmur and H. von Lüpke: 25-38. Haag und Herchen Verlag. Frankfurt a. Main.
WHO (1998) Division of Reproductive Health, Technical Support, World Health Day – safe motherhood. 7 April 1998. Geneva.
Wiener Frauengesundheitsprogramm (1998) Bericht der Expertinnenkommission. Oktober 1998. Vienna.

Acknowledgement

I would like to record my warm appreciation of help and assistance from Ngaire Whata (chief-coordinator), Millie Heke, Ngaroma Grant and the other team-members of the Korowai Aroha Health Center; from Adelaide Waata (chief-coordinatior) and the team-members of the Tuwharetoa Health Clinic and Piritata Kirkwood, head of the Hamilton Health clinic, for their excellent cooperation.

A Cross-Cultural Meeting on Female Genital Mutilation

Christine Binder-Fritz

About seventy women attended a cross-cultural meeting on the sensitive topic of female genital mutilation, which took place at *ega*, a women's culture and communication centre in Vienna, on 1st of December 1999. Since 1995 I have organised a series of events in *ega* to create a platform for women with different cultural background to meet there, to exchange experiences and to discuss matters of common interest. The idea behind is "to build a bridge " between Austrian women and immigrant women mainly from those societies that are still quite "tradition-orientated". Such meetings may contribute to an improved inter-ethnic relationship between different population groups.

Women from different African countries were invited as speakers for this evening. These were Dr. Ragaa El-Terriefi and Ishraga Mustafa Hamid (M.A) from Sudan, Beatrice Achaleke from Kamerun and Hadis Etenesh of Ethiopia. By the way, quite a few of those speakers and discussants invited to participate in cross-cultural discussions, I have known for some years now. First contacts with these women, mainly from Turkey, Middle East, Africa, Asia and South America, were made between 1992-1994, when I was offered to co-operate with Dr. Ruth Gamsjäger from the Asian-African Institute (AAI) in Vienna to organise a monthly discussion group for female stipends there. I still have got very good memories of those interesting and very special women's meetings, when women from at least six different ethnic groups shared their opinions and "gender related" experiences. Some of

these students have finished their studies or "post-docs" in the meantime.

The Practice of FGM

We started our discussion with an introduction on the diverse attitudes, beliefs and practices related to Female Genital Mutilation (FGM), an ancient and deep-rooted practice that is still performed in many African countries. The term FGM defines the removal of some or all of the external female genital, for ritual or religious reasons. This operation is practised routinely in more than twenty countries, comprising the belt of countries across the African continent, as well as Egypt and the southern part of the Arab Peninsula, Malaysia and Indonesia. The estimated total number of women mutilated is about 112 million. As most of the initiation rites have been abandoned in the different ethnic groups, the importance and meaning of FGM has changed profoundly and as a consequence the girl's age at excision has significantly dropped (WHO 1994). There have been described two main types of mutilation: (1) Excision, that means the removal of the clitoris and of adjacent parts, or the whole of the labia minora, and (2) infibulation, which means the removal of the clitoris, parts or all of the labia minora and sections of the labia majora. This operation includes the stitching together of the two sides of the vulva to leave only a small opening for the passage of menstrual blood and urine. The detrimental effects on physical and psychological health can be considerable, especially if infibulation is practised. Severe immediate and long-term complications, such as haemorrhage, shock, infection, urine or menstrual blood retention, keloid formation, problems during pregnancy and childbirth and sexual dysfunctions have been described (Hosken 1982; WHO 1994).

Fig. 6: A discussion on Female Genital Mutilation at ega. From left to right: Hadis Etenesh, Christine Binder-Fritz, Beatrice Achaleke, and Ishraga Mustafa Hamid (December 1999).

The first African speaker in *ega* was Dr. Ragaa El Terriefi, born in Khartoum (Sudan), who has studied sociology in Beirut. She came to Vienna in the 1990s to finish her Masters Degree at the University of Vienna on the topic of "Refugee's Women Development in Sudan". She got her Ph.D. on the "Role of youth training centres in community development" in 1998. In Sudan she worked as a social worker and social researcher. For many years she has been an active member in different associations and she participated in conferences on family planing and youth development. In 1992 she was the Sudanese Representative in the meeting of the International Women Committee organised by the UN. At the moment she is employed at the Sudanese Embassy in Vienna. In her presentation on FGM she focused on the situation in her home country Sudan and talked about organisations like SNCTP (Sudan National Committee on Traditional Practices) in Khartoum, and the different mechanisms that keep this ancient tradition alive. Many men and women believe, that a mutilated woman represents the "ideal of a woman": A faithful, pure, nice, decent and respectable woman and mother. Women who are not mutilated, and who dare to deny this tradition, are regarded as ugly, indecent and sexually promiscuous. Thus FGM is practised for the sake of purity, sexual moral and control. Ragaa gave us an interesting example of how fast an old practice can be abandoned: She talked about the old tradition of the scarification of the women's face, the cutting of lines into the cheeks and the tattoo of the lips, that was abandoned in Sudan, because the husbands of women and the fathers of girls did not longer want to hold close to this practice, as they stopped to regard these scars as beautiful. Ragaa emphasised hereby the role of the male Elders and the male partners, if policies and programmes to stop FGM should be successful.

Ishraga Mustafa Hamid (M.A), also born in Sudan, has long been involved in topics such as women & education, women & health, women & environment, women & politics. She came to Vienna to finish her Master Degree in Political

Journalism and Communicative Science ("Role of the radio for the development of an environmental consciousness"). At the moment she is working on her Doctoral thesis on "Social, economic and political situation of African female immigrants in Vienna in comparison to Berlin". Ishraga has been a member of different NGOs for a long time and she is engaged as a political journalist in issues of human rights and the issue of FGM. Ishraga stated again, that information on health consequences after FGM have to be incorporated into educational programmes in schools. Strategies and educational interventions have to be on a broader level. In a collaborative effort international NGOs as well as provincial health authorities have to be involved in policy making.

The next speaker, Beatrice Achaleke, was born in Cameroon and studied law at the University of Yaounde. She is presently studying sociology at the University of Vienna, where she focuses on human rights and gender issues particularly in development and international cooperation. She has taken part in several research activities both at national and international level and carried out projects with particular reference to human rights of women and gender related issues. She collaborates with several human rights NGOs. Presently she is engaged in human rights education projects and international networking. She was an organising team member of the African Seminar on "training on Human Rights and Gender Issues" in Cameroon in1998, commemorating the 50th anniversary of the Universal Declaration of Human Rights. Although she is not directly involved in issues relating to FGM, she maintains that FGM is an act of human rights violation as stipulated in international and regional human rights instruments. Therefore her contribution at this discussion was mostly from the legal point of view, whereby she paid more attention to the provisions of the UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the African Charter on Human and People's Rights as well as its Optional Protocol relating to Human Rights of the African Women, a document which is presently in its drafting phase, and which handles FGM in detail, considering its practice as an act of violation of women's rights, and therefore urging African states to take appropriate measures including legislature, to ensure the eradication of such a practice. Beatrice discussed the aspects of, and impact of so-called "cultural values" an argument often used by particularly male dominated societies, as justification not only to inflict injuries on women, but also to assign and maintain them in inferior positions and exercising control not only over them but mostly over their sexual and reproductive roles without paying attention to the damages such practices cause to the physical mental and moral health of women. Beatrice is currently working on a field research project in the North of South Africa early this year, based on "Gender Cognitions and Perceptions of Human Rights".

Hadis Etenesh, the head of the African Women's Association in Vienna, gave an overview about the actions of international institutions and NGOs to stop FGM and stressed Nahid Toubia's call for global action (Toubia 1993). Among others the following groups have been active to stop FGM for a long time. These are: Terres de Femmes in Germany, Fran Hosken's Women's International Network WIN, FORWARD (Foundation for Women's Health, Research and Development) and the Inter African Commitee (IAC). Hadis finished by giving a comment on a planned research study about the situation of mutilated African women in Austria. Hadis had taken a friend of hers to *ega*, who is secretary of *amnesty international* in Vienna. So we invited Karin Ortner to give a final statement on campaigns and global actions of *amnesty international* with the aim to eradicate FGM.

There was an enormous interest from the women in the audience to discuss several aspects with our African guests. Questions were raised in regard to differences in the motivations for the operation between different ethnic and religious groups. Questions were answered in regard to women and gender in Islam, the role of modernisation and the kind of mechanisms that hinder the eradication of FGM. To sum up the outcomes: Guidelines on the prevention of female genital mutilation were discussed and we stressed those strategies and educational interventions have to be on a broader level to bring about change. All speakers emphasised the importance of cooperation between international and local organisations, between official institutions and NGOs in their collaborative

efforts to bring about change. Claims to Human Rights were made and in this context FGM was seen as an act of violence against children. In policy making and programme designing it has to be considered that FGM is still regarded as important traditional practice in many ethnic groups and that the operation is often performed by persons, who regard it their inherited right to work as "professionalists" in this field. Last but not least the role of provincial authorities was stressed. Listening to both sides of the female circumcision debate is essential. It is important to keep in mind, that educational interventions on the physical and psychological consequences of FGM should not only target the concerned women and their husbands, but also the women who perform the excision and above all the community- and religious leaders.

Migrants in Austria

Finally I would like to state that in the context of increasing international migration the topic of FGM is of relevance also for Austrian health authorities in regard to the increasing number of African women in our gynaecological and obstetrical departments. A considerable number of immigrants or refugees, from those countries where FGM is practised, might be affected by some physical consequences. The health care givers will have to find ways of dealing with this problem. Considering the findings from obstetrical practice medical staff

Fig. 7: Mutilated women have special needs. These have to be considered in regard to a gender-sensitive health care policy. (Department for Gynaecology; General Hospital in Vienna 1994).

should be informed on the risks of medical complications after female genital mutilation. There are two major problems in regard to FGM: Firstly the need for adequate medical care for mutilated women in gynaecology. Secondly the prevention of genital mutilation of girls in Austria. Many immigrants hold on to their traditions and take with them their cultural heritage to their new home countries. Therefore – at least theoretically – some of the Austrian immigrants or their family members might consider performing FGM on their little girls who were born here. It has already been reported to have happened in some Western European countries and this problem was discussed a few years ago in Switzerland (Beck-Karrer 1995; Nyfeler & Stöckli 1994). Thus Austria's legislation might be challenged too to deal with this problem and to formulate resolutions, especially in regard to child protection on the grounds of the International Human Right Declaration.

On these grounds we are planing a pilot study in Vienna with two students of our department as co-workers as they want to write their M.A. thesis on this topic. It is planned to work in a little project-team. Collaboration is planned with health institutions and organisations of African Women in Vienna.

Listening to both sides of the female circumcision debate is essential too. This aspect will be dealt with in the following article by Hwiada AbuBaker.

References

Beck-Karrer, Ch. (1995) Prävention von weiblicher Genitalverstümmelung/ Prevention des mutilations génitales feminines. In: Asylon 1/März 1995:4.

Dorkenoo, E. and Elworthy, S. (1992) Female Genital Mutilations: proposals for change. The Minority Rights Group. 379/381. Brixton Road London SW 9, 7 DE UK.

Hosken, F.P. (1982) The Hosken Report. Genital and Sexual Mutilation of Females. International Network News, Lexington.

Nyfeler, D. & Stöckli, D. B. (1994) Genitale Verstümmelung Afrikanischer Migrantinnen in der schweizerischen Gesundheitsversorgung. Arbeitsblätter Nr. 10 des Instituts für Ethnologie der Universität Bern.

Schnüll, P. /TERRES DES FEMMES (Ed.) (1999) Weibliche Genitalverstümmelung. Eine fundamentale Menschenrechtsverletzung. Textsammlung. Göttingen.

Toubia, Nahid (1993) Female Genital Mutilation: A Call for Global Action. New York: Women, Ink.

WHO (1994) Division of Family Health. Female Genital Mutilation, 31 July, Working Sheet G. 1. Geneva.

Female Genital Mutilation in Sudan: Policies and Information Dissemination

Hwiada AbuBaker

Many scholars, cultural anthropologists and feminists have exhaustively discussed the issue of FGM, yet it continues to come up at the table of negotiation every now and then. In this contribution I would like to make some comments on the issue of FGM, however, I would limit myself to comment on the point of the strategies by which information is to be disseminated concerning the practice in the Sudan.

To start with, any criticism of FGM, which is based on an incomplete understanding of the cultural context of the practice, is usually useless. We claim that the practice is irrational and unhealthy. We feel disgusted when describing how the practice is performed and the types of operations practised by the people concerned, but rarely do we bring those who are really concerned with the problem to our tables of negotiation. In most of our workshops and conferences the "fighters" against FGM are usually those who either experienced FGM and believe in its "maladaptiveness" or those who "think" that it is "bad" and should be eradicated. Those "voiceless" who believe that it is good and that it performs certain "rational" functions in their cultures, they are normally absent from our tables of negotiation. "We" usually disqualify them from sitting at our tables of negotiation, because either we think that they are incapable of expressing themselves and unable to see our point of view. In the end of the day we end up by implying "our" policies and deliver our strategies "on" them based on what we decide "for" them. Another better alternative is to qualify those who are really concerned with the problem and to get them to speak for themselves at our tables of negotiation, and this is exactly the point I will try to emphasise.

Have we asked ourselves what function FGM does perform and who are the different partners for whom it does perform that function, despite all the criticism we pronounce against the practice? Despite my respect to those who have spoken about the issue of FGM, I think that somehow, somewhere there is some lack of understanding concerning the issue of practising FGM in the Sudan.

First of all, since the implication of the law in 1946, many actions and movements have been organised concerning the practice. To cut it short I am going to quote Ellen Gruenbaum (1996): "In the field research in the summer of 1989, I observed that changes in female circumcision practices had taken place since my first fieldwork in Sudan from 1974 to 1979. In the 1970s many rural and urban women believed that the practice of infibulation was part of being a Muslim. They interpreted their "way of life" as being synonymous with religion and were not fully aware of the degree of cultural variation within the Islamic world. By the 1970s numerous individuals and organisations within the Sudan had already spoken out against female circumcision. Some supported the modified Sunna type over the pharaonic; others supported total abandonment of all of its forms. It seemed that efforts for change were poised to take off after the 1979 Khartoum Conference and the renewed commitment of doctors and the Ministry of Health to pursue a policy against all forms of female circumcision. This policy shift was attended by wide discussion among health workers and educators on the need for change and by the survey documenting the extent and variation of female circumcision practices in several provinces reported in El Dareer (1982) and Rushwan et al. (1983)" (Gruenbaum 1996:463).

Secondly, to speak about the Sudan as an urban and a rural community is far beyond simplification. The Sudan is a country with "over 450 ethnic groups" (Burr and Collins 1995:1), speaking a total of "over 400 languages" (Verney: 1995:5). Apart from the ethnic and language variations each ethnic group has got its own customs, traditions and practices as well as symbolic meanings they assign to their practices. In such a context it becomes important to try to understand the meaning of FGM in each

ethnic group separately before any strategy is implemented "for" or "against" it.

Another point is, that our understanding of the forces that help to perpetuate the practice in each community should be modelled not through "our" opinion of how do "we" consider FGM, but through the eyes of those who practice it themselves. An effective way is to get those people to our tables of negotiation and let them share and exchange the experience of what we say "about" them and how do we consider "their" practice and behaviour. Ahfad University for Women in Omdurman (Sudan) has gone far in implementing some strategies based on this light. Introducing explanation about the harm of the practice into the school syllabus will serve only those who go to school, and those who know how to read and write (having in mind that most people in the rural areas are still illiterate. Not only that, but also most of the time they do not prefer to send their children to school). The Beja ethnic group in eastern Sudan, for example, who are believed to be the first to practice FGM in the Sudan (Abdin 1953), are counted to be among the poorest, and least educated (Al-Hassan: 1995:3). However, as part of my fieldwork at Ahfad University concerning customary laws in the area, I found out that the Beja prefer to send their children (males as well as females) to the *Khalwah* or the Quranic School rather than the normal school. Like that ideologies that "we" consider in "our" workshops and conferences as harmful may probably be strengthened. Besides, in such a static community like the Hadandowa (a branch of the Beja ethnic group) of Sinkate, where women are forbidden even to go to the market place, where women dress with shining and coloured *toobs* (national dress) to be distinguished in every single step they conduct outside their private sphere. Where the community is most lacking in medical and other services including water and electricity: in such a circumstance it is not only the "men" who perpetuate the practice of FGM, it is the women themselves as well. In such a circumstance women consider FGM as their first and most significant life crisis event (the second is marriage, the third is their giving birth to a baby-boy and the last will be their death).

It is relevant here to mention that women in the Hadandowa group have got three phases for what we call FGM. The first phase is the pharaonic circumcision that takes place at a young age. The second phase is the refibulation the Hadandowa women undergo deliberately and of their own voluntary option each time they give birth to a child. The third phase is what they themselves call the "grave infibulation". This phase takes place when the woman is in her menopause. She deliberately demands this enclosure which sometimes is as well accompanied by a ceremony. It is a symbol that she is no more interested in any sexual intercourse. It is also done because she does not want the people to see her not enclosed when she is on her death bed and people come to bathe her as recommended by Islam! Thus it seems as if the life of the woman in the Hadandowa consists of continuous phases of infibulation, de-infibulation and re-infibulation. Thus it is clear here that these women are not only serving the interest of men in their community, they are as well serving their own interest reinforcing their position in their own patriarchal community. They consider it as a rite of passage that creates somehow a preferable activity in their stagnant life, whereby the accompanied ceremony is the only important event that takes place for a girl in the community. The ceremony is obviously telling the patriarchal community that women are existing mainly in regard to their "reproduction". So it seems as if women are inducing a kind of dialogue with the patriarchal community in the ethnic group (Abu-Baker 1997). The accompanying ceremony reinforces their own existence as an effective partner in the community before it reinforces their own role as women, and renders them capable of performing their future assigned gender role. As such it is difficult to change such "ideological" orientation, but through the community members themselves as well as through a radical change in all sectors of the small society.

Through its rural extension program, which was initiated in 1976, when the school of Rural Extension was first opened, Ahfad University was able to bring some women from different rural areas of the Sudan to the tables of negotiation, to discuss fundamental issues related to "their" lives. Furthermore we have (through the accompanied fieldwork activity) participated in many public relation campaigns, that were focusing on the topic. Our activities included performing activities such as role-plays, puppet

shows, drama, poster exhibition and the like. In addition, through the generous grants by different beneficiaries, women are allowed to start their schooling at Ahfad till they acquire some "qualifying" education. Throughout the mentioned period, those ladies are exposed to different types of experiences in which they themselves are allowed to negotiate their problems and help to implement rules and strategies that may benefit their community. In the end these ladies are the elite of those ethnic communities who will go back with all the experiences they have acquired from their study period and disseminate that information in the concerned communities. FGM is one issue among many where thus some serious steps were taken to implement strategies and to bring about a realistic change.

References

Abdin, A. (1953) The Influence of the Arab Culture in the Sudan (ARABIC), 2nd edition. Beirut, Lebenon.

AbuBaker, H. (1997) Research Work on the Customary Laws among the Ethnic Group in the Sudan: The Hadandowa of Sinkate. A Research work submitted to Ahfad University for Women Department of Women's Studies

Al-Hassan, I (1996) Gender Religious Experience: Women And the Quranic Schools In Eastern Sudan. In: Eastern Africa Social Science Research Review 1996: xi:1:1-20.

Burr, J. and R. Collins (1995) Requiem for the Sudan: War, Drought and Desertification Relief on The Nile. Westview Press. Boulder, San Francisco and Oxford.

Gruenbaum, E. (1996) "The Cultural Debate over Female Circumcision: The Sudanese Are Arguing This One out for Themselves" In Medical Anthropology Quarterly, 10, (4): 455-475.

El Dareer, A. (1982) Women Why Do You Weep? Circumcision and Its Consequences. London: Zed Press. In Gruenbaum, E. 1996.

Rushwan, H. et al. (1983) Female Circumcision in The Sudan. Attitudes and Changes. University of Khartoum. In: Gruenbaum, 1996.

Verney, P. et al. (1995) Sudan Conflict and Minority. Minority Rights Group International Report.

The Making and Unmaking of the World: Considerations on Medical Anthropologists' Recent Contributions to Anthropology of Pain

Bernhard Hadolt

After Zborowski opened the field for a sociology/anthropology of pain with his classic study "People in Pain" (1969), showing that the pain experience is not only a physiological process but also a cultural one, this field was scarcely explored further until about the mid '80's. According to Encandela (1993), the reasons for this lack of interest on the one hand can be found in the general orientation of social scientists towards measurable, objectively verifiable phenomena, which neglects hardly measurable pain. On the other hand social scientists were preoccupied with the broad social issues during the late '60's and the '70's, such as civil unrest or the Vietnam War. Although this analysis may apply more to sociology rather than to anthropology, I agree with Encandela that the growing concern of social scientists with subjective experience since the beginning of the '80's accounts for the re-emergence of "pain" as an academic topic of interest.

In medical anthropology this movement manifested itself through the partial paradigm shift from the study of *disease/illness/sickness* to *suffering* and *embodiment*. Although medical anthropologists had always emphasised the specific and manifold impact of society and culture on disease and healing, until the early '80's their conceptual tools remained restricted to rather abstract and static notions such as *explanatory models or semantic illness networks* (Kleinman 1980, Good 1977). The introduction of the concepts of *suffering* (Hahn 1984) and *embodiment* (Csordas 1990, Ots 1990, Scheper-Hughes and Lock 1987) met the growing discontent with these oversimplifying, rational and more or less non-contradictory models by providing a broadened conceptual

frame for addressing the actual flow of people's experiences and their worlds.

Besides this movement towards experience, a second motive of medical anthropologists for their interest in pain can be found in the problematic nature of pain for biomedicine. Pain is not only an important source of power and legitimation for biomedicine, as will be shown later in this paper; pain also fundamentally challenges biomedicine from at least three angles.

Firstly, and as already indicated, pain is located outside the "objective" world of measurable space and time, and is only indirectly visible through physical signs located in and on the body in connection with diseases and abnormalities and through so-called "pain behaviour" (Helman 1990:158ff). When such physical signs cannot be discovered by the various techniques of visualising (like X-raying, computer tomography, endoscope or simply the "medical gaze" examining the surface of the body), as is often the case for chronic pain sufferers, pain hardly fits into the biomedical system and resists biomedical reasoning, naming and treatment. Such pain challenges the axiomatic basis of biomedicine: unilinear relation between cause and effect, material bodily manifestations of diseases, body-mind- and subject-object-dichotomy, geometrical space and linear time, etc.; or as Byron Good puts it: "Chronic pain challenges a central tenet of biomedicine – that objective knowledge of the human body and of disease are possible apart from subjective experience." (Good 1994:117)

Secondly, pain retains its subversive power over biomedicine where biomedical pain treatment fails, notwithstanding a possibly successful localisation and naming of a cause in the body of a pain sufferer. This is also often the case for chronic pain sufferers or for women giving birth (cf. Adam et al. 1986). Unfulfilled expectations and promises may become sources of suspicion towards the feasibility of biomedical treatment. Alternatively, patients may turn to other treatment offers of relief such as acupuncture or may lose any belief that their pain is at all treatable. Pain challenges biomedicine from a third angle, when the usual negative and immediate relief seeking attitude towards pain, which links pain to pathological states, is replaced by a non-pathological view, as in the case of the *natural birth movement*. The re-evaluation of pain as being "natural" and as being an indispensable part of the birthing experience impedes the appropriation and objectification of pain through biomedicine. However, pain is not only problematic for biomedicine. It also poses epistemological difficulties to medical anthropology, in particular to its phenomenologically orientated strands (Csordas 1994a, Good et al. 1992). If pain demolishes the integrity of the self, objectifies the body, dissolves the intentionality of the self into the world, – in one word – if pain destroys the world, how can the paradigm of embodiment be maintained? Attempts have been made to resolve these problems by looking at sufferers' struggles to re-make the world, even if the outcome of such permanent processes is not the world we know when not in pain (Good 1994, Daniel 1994, Good 1992, Brodwin 1992). Attempts have also been made to understand the experiencing of pain not as the destroyed everyday world, but as a "world of pain" on its own, having its own distinct features and language (Jackson 1994, Stylianoudi & Stylianidis 1998).

These various motives for the recent interest in pain may also partly explain why medical anthropologists pay almost exclusive attention to the mechanisms of how pain *unmakes* the everyday world, and how pain sufferers *re-make* it. Thus pain as a factor which is also constituting the everyday world is left almost entirely unconsidered (Seremetakis 1991 and Frykman 1998 are exceptions to this to some extent). In this essay I argue that pain – or better, some forms of pain - can not only forcefully interrupt the everyday world, but can also play an indispensable part in its construction. My considerations in this regard focus on three closely interlaced aspects:
(1) Starting with the paradox that we all know what pain is and yet do not know it, which I see as being connected to our tendency to take a specific form of pain as "the essence" of pain, I argue for an understanding of pain as always contextualised in particular sociocultural settings. The broad, abstract label "pain" has to be contrasted by specific, actual forms of "pains".
(2) Despite the obvious huge difficulties of e.g. chronic pain sufferers or torture victims in

expressing and communicating their painful experiences, I argue that not all forms of pain are necessarily primarily meaningless and inexpressible, but can constitute important realms of everyday worlds referencing rich languages of suffering and pain.
(3) Finally, by looking at the power, which is enforced and legitimated by pain in social processes – rather than focusing only at the destructive power of pain on the individual sufferer, I intend to shift the usual phenomenological view, which merely attends to the individual person, onto a social level. Only within a social dimension can the appropriation of pain by the pain sufferer and by social groups in their interactive strategies be addressed.

From Pain to Pains and from Pains to Pain

Everybody knows what pain is and nobody really asserts that pain is not "real". However when we try to grasp this "thing" called pain with our intellect, these self-evident statements become suddenly paradoxical. This immediately becomes obvious when we leave the physiological explanation of stimulus and sensation aside and when we have used up the dozen or more usual adjectives to describe a pain. As soon as we start to get hold of this elusive "ghost" it escapes, waiting at a distance, and entices us to another attempt. It seems that we come closest to it if we do not stretch out our hand but just accept (even if only temporarily) the unsatisfactory distance. How can we know with certainty and yet not know at the same time?

One answer to this could be that there are different kinds of knowledge at our disposal: experience, which more or less eludes our consciousness, and conscious abstract knowledge. Following Dreyfus (1992) I would like to refer here to experience as *knowing-how* and to abstract knowledge as *knowing-that*. Examples of the former are the ability to tie one's shoelaces without consciously thinking about the necessary movements, to play a musical instrument fluently or to use the pedals of a car in a proper way. The whole range of Marcel Mauss' *body-techniques* can be seen as falling into this category. Examples of *knowing-that* are understanding how an engine works, the ability to reproduce arguments from a certain book for an academic paper, and knowledge about the sun's role in producing climates, seasons and weather. It is due to the difficulties of translating the *knowing-how* of pain into the *knowing-that* of pain that the paradox of *knowing and yet not knowing* arises.

Another more important answer to this paradox lies in the word pain and its actual usage. We use this word in order to refer to a huge variety of sensations and feelings in very different situations, which are related to specific meanings, circumstances and conditions. We may think or speak of pain in relation to sunburn, an insect bite, a child suffering or dying, in connection with circumcision, a "traditional" trepanation without anaesthesia in East-Africa, Jesus' crucifixion, torture, kneeling too long on the floor, childbirth, hearing a scream (caused by whatever reason or without a reason), surgical operations, beating children for educational purposes, having eaten too much, rape, pricking one's finger on a spindle, car accidents, self-inflicted pain as punishment for a committed sin, menstruation, hearing a dentist's drill, banging one's toe on a stone, child abuse, cancer, shamanistic initiations, war, skinheads, firewalking, lumbago, seeing a jab, sado-masochism, betrayal, Munch's picture "The scream", stretching, appendectomy, industrial accidents, flagellation in order to reach states of altered consciousness, etc.
This enumeration could be infinite: pain can seemingly be everywhere. The differences between all these examples are not only constituted along a matrix of varying degrees of sensory intensity, as the physiological model of pain suggests. Also crucial in this regard are their very diverse meanings, associations, values, social relations and interactions with "nature", all of which influence and build up the experience, expression and communication of pain/s. In view of this huge number of differing pains one could be surprised how they can all be labelled pain. The paradox of *knowing and yet not-knowing*, therefore, is bound to the wide semantic, associative and situational field of pain, and we always become puzzled confusing the particular with the general. Pain always has a context and when we screen it out we end up with almost nothing.

So should we stop talking about pain and only study pains in specific given situations instead taking the risk of getting lost in relativism? YES – case studies about persons (M. Good 1992,

B. Good 1994, Brodwin 1992 and Csordas 1994b) or small groups (Horton 1984 and Jackson 1994) in particular settings can be very helpful in moving our understanding away from a monolithic and rather essentialistic to a more polymorphic attitude towards pain. However this may only be the case as long as such studies do not present their specific pain as *the* pain, something which is often a tendency in work on pains. NO – pain permeates and sometimes determines our lives in one or another form, and it is therefore necessary to find a language of/for pain which refers to it not only in relativistic terms. A combination of the YES and the NO could allow us to handle this question on an interpersonal and intercultural level without losing the peculiarities of particular pains.

The Making and Re-Making the World

The relationship between pain-experience and pain-expression is a major issue in many studies about pain, where it is described as a both very difficult and very important one. In his description of Brian's experience of chronic pain, Byron Good (1994) stresses the difficulties for Brian in expressing and communicating his painful experiences. Jean Jackson (1994) describes how patients with chronic pain in a North-American pain clinic struggle to find a language of pain. On the one hand they try to avoid everyday-world language because of its inadequacy to express their experiences. On the other hand they have to use it lacking other options of expression. Valentine Daniel describes pain's "sheer resistance to language" (1994:232) for two torture victims in Sri Lanka, and how shamanistic séances are used as "therapeutic terror" which "dislodges pain from its fixed site" (1994:239) in the body. In her book "The Body in Pain" about torture and war, Elaine Scarry states that pain "shatters" and "actively destroys" language (Scarry 1985:4f) and brings a sufferer in torture "to a state anterior to language, to the sounds and cries a human being makes before language is learned" (1995:4). All authors stress the importance of language and other forms of expression such as painting to the re-making of the world after torture, and to the continuously keeping-upright and re-building of everyday life for chronic pain sufferers. The naming, objectifying, expressing and communicating of pain are fundamental issues in the search for meaning and relief for pain sufferers.

These difficulties in expressing pain are partly related to the incompatibility of pain with Galileo's "objective" world, which is expanded into measurable space and time and which provided the basis for the modern natural sciences. Pain, which refuses measurement in these dimensions, belongs to the "subjective" world, together with feelings, taste, smell or values. Thus pain must be made "objective" in both Galileo's sense of "real", and in the sense of creating an object which can be addressed, in order to be understood in the everyday world by the sufferer and other surrounding persons. According to Scarry it is the objectlessness in the latter sense which distinguishes physical pain (which she contrasts with psychological pain) from any other perceptual state: "(…) desire is desire of x, fear is fear of y, hunger is hunger for z; but pain is not 'of' or 'for' anything – it is itself alone. (…) objectless, it cannot easily be objectified in any form, material or verbal" (1985:161f).

Although severe pain from torture, from which she initially draws her conclusions, has certainly very powerful destructive qualities requiring the difficult re-making of the world by the torture victim, I disagree with Scarry that all physical pain/s (the distinction between physical and psychological pain itself is ambiguous) lack an object. The *unmaking* and *making* of the world and of objects are not bound to temporal linearity, but can happen at the same time. Not all pain is necessarily first of all meaningless and inexpressible, but fits well into boxes of explanations and meanings of our everyday world, such as pain undergone at the dentist in order to have healthy teeth. Such forms of pain do not dissolve the everyday world, but on the contrary, they contribute to the building and the moving of the everyday world. In Scarry's words, pain does not only and always unmake the world, which then must be re-made by the pain sufferer, but also makes the world. Barbara Duden (1987), who studied the bodily experiences of women in Germany at the beginning of the 18th century, a time when the daily flow of symptoms and pains were not yet categorised as bounded diseases separate from people, links the impoverishment of vocabulary to describe pains to the fact that in modern

Western society it is not people who fall ill, but their bodies and organs. Her several pages long description of expressions for complaints and pains gives us a vivid example of a rich language of suffering and pain.

From my reading so far I am not aware of anything comparable for non-Western societies in the past or present. Closer attention to the usage of forms of language – verbal and non-verbal –, which themselves are – from a phenomenological point of view – embodied *in-the-world*, could give us not only a better understanding of the experience-expression complex, but also of the significance of pains for the constitution of everyday worlds.

The Power of Pain and the Power through Pain

Drawing on Schütz's features of the *common-sense reality*, of the everyday world, Good (1994:124) shows how the pain of chronic pain sufferers can have the power of *unmaking the world* (Scarry 1985). Although Schütz distinguishes six features, I would like to mention here only three of them. Firstly, pain has the power to destroy the integrity of the usually undivided and total self (Good 1994:124). In the everyday non-painful world the body is a part of the self and therefore part of the acting subject. When in pain, though, the body becomes an object to the self: pain is experienced as located in the body, which develops its own agency and enters into a battle over control with the self. The everyday world of the self is permanently in danger of being taken over by the bizarre "pain-full world" (Jackson 1994) of a demanding, aversive body. Secondly, pain has the power to alienate the sufferer from other persons, and the usual assumption of everyday life, that we share the same world with others, breaks down in the face of the immense difficulties of communicating and verifying pain to others. Or as Scarry puts it: "To have pain is to have certainty; to hear about pain is to have doubt." (Scarry 1985:13). The third and last aspect here is that pain has the power to subvert our usual experience of time, fracturing it into "inner and outer time" (Good 1994:126), and dissolving it as an ordering dimension of the everyday world. "Time caves in. Past and present lose their order. Pain slows personal time, while outer time speeds by and is lost." (Good 1994:126). Likewise, Scarry (1985:52ff) puts forward eight attributes of pain, which all contribute to the *unmaking* of the pain sufferer's world. The most important of these, in my opinion, are the "sheer aversiveness" (1985:52) of pain, the destruction of language through pain, the totality of pain ("Pain begins by being 'not oneself' and ends by having eliminated all that is 'not self'" [1985:54]), the resistance of pain to objectification (already discussed above) and the obliteration of the contents of consciousness when in pain.

Although these aspects of pain may be appropriate for condensing the experiences of torture victims or chronic pain patients, – again – they may fail to describe other pain experiences and situations. However, it is also important to ask what the "unmaking" of the everyday world of a *single person* in pain means for the *society*. In other words, how and to what extent does the *unmaking* (and *making*) of the everyday world for a person in pain constitute and legitimise the *making* and reproduction of the everyday world on a societal level? Most phenomenologically orientated accounts of pain focus only on the individual pain sufferer and on social relations exclusively from his/her point of view (Horton 1984, Scarry 1985, Seremetakis 1991 and Frykman 1998 are exceptions to this to some extent); the political economy of pain is almost completely ignored.

The importance of this issue becomes obvious when we try to imagine what the everyday world would be like without pain. Now I could reiterate all the examples given at the beginning of this paper and try to scrutinise how the situation would change when pain did not exist any more: a futile task, perhaps comparable to the attempt to imagine a world without death. Pain in all forms and contexts permeates our everyday world and therefore is entangled in all sorts of power relations. Pain as a source of power, legitimation and profit is perhaps most salient in connection with biomedicine, the pharmaceutical industry and related institutions and fields in Western societies. One of the outcomes of my comparative study about childbirth among a rural group and a group of students in Austria was that the fear of pain and the fear, that "something could happen" during and immediately after the birth, are crucial considerations in the decision about where to give birth. About

98% of all births in Austria take place in a hospital, otherwise at home with the partner or a close friend and an attending midwife (Hadolt 1992). Home-births only become thinkable (usually among urban "alternative" people with a "critical" attitude towards biomedicine) when the dominant attitude in society, which sees pain in childbirth as unbearable and avoidable, is replaced by one which renders pain as meaningful and important to the birthing experience. Furthermore, the usual ideology of risk needs to be changed from *everything-can-happen* to *why-should-it-happen-to-me-out-of-all-people* during pregnancy (a change facilitated by "alternative" literature about birth, talks with acquaintances who already have given birth at home and midwives practising outside the hospital,). In fact, where the prevailing hospital-birth is not questioned (as in case of the village studied), the fear of pain and especially the fear of complications are usually reinforced and grow during pregnancy (as a result of visits to the gynaecologist, popular medical magazines, talks with relatives and acquaintances, etc.). The medicalisation of childbirth in Austria and other Western societies, which has been strongly pushed forward since the '60's, (and the *natural birth movement* since the '80's) is, in my view, directly connected (together with efforts to control human reproduction and female sexuality) to the notions of pain and risk. Pain must be both conceptualised as treatable and negatively valued, in order to gain power for those who offer the promise of relief from such pain. Thus, not only can the experience and infliction of pain be translated into power, as stated by Scarry (1985) in connection with torture, but so too can the fear of pain and the promise to relieve it. It would be interesting to trace changes of values towards pain from various pains and complaints as expressions of an essentially incomplete world which awaits redemption in early 18th century Germany (Duden 1987), to the mainly negative and treatable pain quasi-monopolised by biomedicine and by related fields. It would also be interesting to look at how the broad label pain itself developed, linking more and more aspects of pain-permeated life to the realm of biomedicine.

Conclusion

It was my purpose in this paper to draw attention to the *making*-qualities of pain, qualities, which I have found to be under-represented in the recent literature about pain in favour of the *unmaking*-qualities of pain and the struggle for a *re-making* of the world by pain sufferers. In my line of arguments I focused on the de-contextualising usage of the notion of pain, and argued for a contrasting view on different forms of pain in their specific contexts, in order to counteract an essentialistic search for "the" pain. I then tried to show that some forms of pain do not throw the pain sufferer into an objectless, meaningless dimension requiring the sufferer to re-make his/her world, but rather constitute integral aspects of their everyday world. In the last section, I intended to point to the fact that even pain in its most severe forms produces and reproduces our everyday world when viewed as located in social dimensions. The very unmaking quality of pain for one person can establish its making property for others.

Although these questions certainly need further exploration and have only suggested a direction of inquiry, I deem it essential for an anthropology of pain to supplement the micro-view of the phenomenological approach towards pain with a broader view on social processes. Scheper-Hughes/Lock's *mindful body* (1987), which combines phenomenological aspects, Mary Douglas' social body and a Foucaultian body politic, or Bryan Turner's (1987) similar suggestion, that we be concerned with perspectives of phenomenology, sociology of roles and the political economy of illness, may be usefully employed and developed in this regard.

References

Adam M. et al. (1986) Kinder kriegen: Schwangerschaft, Geburt und Stillen ohne Angst und Zwang. Köln: Kiepenheuer & Witsch.

Brodwin P. E. (1992) Symptoms and Social Performances: The Case of Diane Reden. In: Mary-Jo D. Good, P. Brodwin, B. Good and A. Kleinman (eds.), Pain as Human Experience: An Anthropological Perspective. Berkeley: University of California Press.

Csordas T. J (1994b) Words from the Holy People: a Case Study in Cultural Phenomenology. In: T. J. Csordas (ed.), Embodiment and Experience: The Essential Ground of Culture and Self, Cambridge: Cambridge University Press.

Csordas T. J. (1990) Embodiment as a Paradigm for Anthropology. In: Ethos 18(1), 5-47.

Csordas T. J. (1994a) Ed., Embodiment and Experience: The Essential Ground of Culture and Self, Cambridge: Cambridge University Press.

Daniel, E. V. (1994) The Individual in Terror. In: T. J. Csordas (Ed.) Embodiment and Experience: The Essential Ground of Culture and Self, Cambridge: Cambridge University Press.
Dreyfuß H. (1992) What Computers Still Can't Do: A Critique of Artificial Reason. Cambridge: MIT Press.
Duden B. (1987) Geschichte unter der Haut: Ein Eisenacher Arzt und seine Patientinnen um 1730, Stuttgart: Klett-Cotta.
Encandela J. (1993) Social Science and the Study of Pain since Zborowski: a Need for a New Agenda. In: Soc. Sci. & Med, 36(6), 783-791.
Frykman J. (1998) On the Hardening of Men. In: J. Frykman, N. Seremetakis & S. **FEHLT** Ewert (Eds.) Identities in Pain. Lund: Nordic Academic Press.
Good B. (1977) The Heart of What's the Matter: the Semantics of Illness in Iran. In: Culture, Medicine and Psychiatry, 1, 25-58.
Good B. (1994) The Body, Illness Experience, and the Lifeworld: a Phenomenological Account of Chronic Pain, Chap. 5 in Medicine, Rationality, and Experience, Cambridge: Cambridge University Press.
Good Mary-Jo D. (1992) Work as a Haven from Pain. In: Mary-Jo D. Good, P. Brodwin, B. Good and A. Kleinman (eds.) Pain as Human Experience: An Anthropological Perspective, Berkeley: University of California Press.
Good Mary-Jo D. et al. (1992) (eds) Pain as Human Experience: An Anthropological Perspective, Berkeley: University of California Press.
Hadolt B. (1992) Geburtssysteme im Kulturvergleich: Ethnologische Untersuchungen über den soziokulturellen Kontext von Geburt anhand von Beispielen aus Österreich, Nordindien und Ostmalaysien, unpubl. M.A. diss., Vienna.
Hahn, R. (1984) Rethinking 'Illness' and 'Disease'. In: Contributions to Asian Studies, 18, 1-22.
Helman C. (1990) Culture, Health and Illness, Second Edition, Oxford: Butterworth-Heinemann Ltd.
Horton C. F. (1984) Women Have Headaches, Men Have Backaches: Patterns of Illness in an Appalachian Community. In: Soc. Sci. & Med. 19(6), 647-654.
Jackson J. (1994) Chronic Pain and the Tension Between the Body as Subject and Object. In: T. J. Csordas (ed.), Embodiment and Experience: The Essential Ground of Culture and Self. Cambridge: Cambridge University Press.
Kleinman A. (1980) Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press.
Ots T. (1990) The Angry Liver, the Anxious Heart, and the Melancholy Spleen. In: Culture, Medicine & Psychiatry, 14(1), 21-58.
Scarry E. (1985) The Body in Pain: The Making and Unmaking of the World. Oxford: Oxford University Press.
Scheper-Hughes N. and Lock M. (1987). The Mindful Body: a Prolegomenon to Future Work in Medical Anthropology. In: Medical Anthropological Quarterly, 1(1), 6-41.
Seremetakis N. (1991) The Last Word: Women, Death, and Divination in Inner Mani. Chicago: University of Chicago Press.
Stylianoudi M.-G. L., & Stylianidis S. (1998) Maria: Her Body and Her Stare: Imprinting of Evil and Re-investment of Body Image. In J. Frykman, N. Seremetakis & S. Ewert (eds.). Identities in Pain. Lund: Nordic Academic Press.
Turner B. (1987) Medical Power and Social Knowledge. London: SAGE Publications.
Zborowski M. (1969) People in Pain, San Francisco: Jossey-Bass.

Acknowledgements

A former version of this essay was drafted while I was a student at Brunel, The University of West London. I thank Ronald Frankenberg, Monika Lengauer, Penny Marriott and Andrea Stöckl for their helpful comments.

Guest-Professors

Professor Dr. Rogasian L.A. Mahunnah, Director of the Institute of Traditional Medicine, Dar es Salaam, Tanzania, will be in Vienna from mid May to mid June 2000. He will give the following lectures:

"Ethnobotany and conservation of medicinal plants"

"Socio-cultural and environmental dimensions in traditional medicine pratice"

"Seminary"

The lecture programme for 4 weeks will focus on Traditional Medicine and Medicinal Flora of Tanzania with the historical and political dimensions of Traditional Medicine Practice in precolonial, Colonial and Post-colonoal era and the role of Traditional Medicine in Health Care of Tanzanian people.
The topic of socio-cultural and environmental dimensions in Tanzanian Traditional Medicine Practice

will include the following aspects: Traditional Medicine and ethnicity, Traditional Medicine and Traditional Medical Practicioner's Organizations, the role of Traditional Birth Attendants in Health Care Delivery and Specialities of Traditional Medical Practicioners in Tanzania.
Bridging the gap between Traditional Medicine and Modern Medicine in Tanzania will be an other topic of the lecture, including: Rural and Urban Traditional Medical Practicioner's Practice; Utilization, domestication and conservation of medicinal plants; Plant Dietary additives in traditional subsistence communities; scientific basis of food plant additives to the health of people and, Role of Traditional Medicine in the treatment and Management of specific degenerative human diseases.
Ethnobotany and conservation of medicinal plants in Tanzania; Bioresources, indigenous knowledge and drug prospecting (the Tanzanian experience); Intellectual property rights and indigenous people; Tanzania's policy in bioprospecting and Traditional Medicine in schools; University curricula; marketing of indigenous non-forest products: prospects and retrospects.

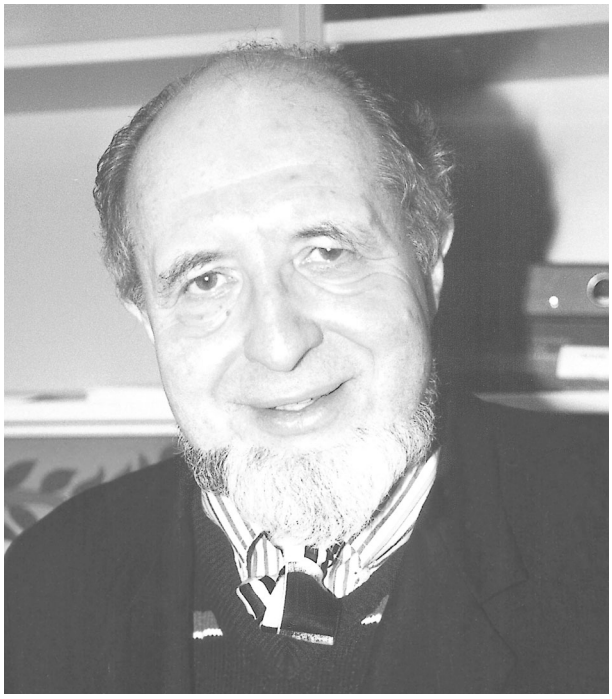
An Interview with Wolfgang G. Jilek

Ruth Kutalek
15 Dec. 1999, Vienna

Wolfgang Jilek is clinical Professor emeritus of Psychiatry at the University of British Columbia, Canada with the speciality in transcultural- and ethnopsychiatry. In November and December he was Guest-Professor at our Department.

As an introduction I would like to ask you about your life history. You had four different citizenships in your life. How comes?

Well, the reason for that is that I am from an old Austrian family of physicians and teachers. One of my ancestral relatives was for instance a doctor Jilek who was the personal physician of Archduke Maximilian. My father was a medical officer in the Austrian army, highly decorated, and after the war he went to Czechoslovakia to take over a sanatorium near Tetschen in Northern Bohemia and I was born there in 1930. I was Czechoslovak citizen then until the German annexation of Bohemia in 1938. I became German citizen then automatically by law and in 1945 we had to leave Bohemia, being classified as of ethnic German background. I was given the Austrian citizenship in the 1950s on the basis of being of an old Austrian family. In the 1960s I emigrated to Canada and we both, my wife Louise and myself, had to apply for Canadian citizenship in order to practice medicine. At that time double citizenship was not possible. So I lost my Austrian citizenship. However, in 1997 the Austrian Federal Government and the City of Vienna awarded me the Austrian citizenship again on the basis of scientific merit and for this I am especially grateful to the colleagues of the faculties of the University of Vienna, medicine and anthropology, especially to Prof. Prinz who promoted this award. So, I was originally Czechoslovak citizen, then German citizen during the war, after the war Austrian citizen, then Canadian citizen and now I am both Canadian and Austrian.



Wolfgang G. Jilek

What is your scientific background? What positions did you hold and still have?

I studied medicine at the universities of Munich, Innsbruck and Vienna. When I graduated I went to the United States to do a rotating internship in Chicago. I decided to become psychiatrist and did some psychiatric training at the upstate New York Centre in Syracuse. Then I returned to Europe, went to Switzerland and trained in neurology at the Swiss Institute of Epilepsy in Zurich and in psychiatry at the Sanatorium Hohenegg which was affiliated with the Burghölzli University Clinic of Psychiatry under the direction of Prof. Manfred Bleuler. There I met Louise and we went to Africa where she had already established a clinic for epilepsy in the interior of Tanzania. Together we had applied for a position at McGill University to train in transcultural psychiatry under Prof. Wittkower and Prof. Murphy. There I took my Master of Science in social psychiatry and my diploma of psychiatry and also repeated all Canadian medical and psychiatric exams. When we completed our studies we actually wanted to stay at McGill University but because of the political unrest in Quebec we went to British Columbia. There we first spent about twelve years in the field as regional psychiatrists in the Upper Fraser Valley where we were the only psychiatrists and consultants at the hospital, at the clinics and ambulances and the mental health service and also consultants to the prison system. There we became interested in the North American Indians. Later in 1974 we were appointed to the faculty of medicine at the University of British Columbia in Vancouver. We have been with that faculty since. Besides being at the psychiatric department of the University of British Columbia we were also affiliated with the department of anthropology and sociology were we had already made a master of arts in social anthropology.
In more recent years we became interested in international studies. While Louise continued her research in epilepsy in Africa, which is still after 30 years going on, I had the opportunity to work for WHO as a consultant and also for the UNHCR (United Nation's High Commission of Refugees). I worked for WHO in Papua New Guinea and for the Ministry of Health of the Kingdom of Tonga and for the UN in Thailand in refugee camps as a refugee mental health coordinator. Since 1983 I have first been secretary then chairman of the Transcultural Psychiatry Section of the World Psychiatric Association, which position I just gave up a few weeks ago.
I am very happy now to be guest professor at the University of Vienna, working with you and under Prof. Prinz.

Could you explain what is transcultural psychiatry and ethnopsychiatry?

Transcultural psychiatry actually goes back to Prof. Emil Kraepelin who in 1904 after a trip to Indonesia and South-East Asia published papers under the title of "comparative psychiatry" – "Vergleichende Psychiatrie". He already defined this field as the identification and the study of mental illness in various cultures to compare and to elicit differences and similarities. It is by no means true that he was only interested in similarities. He thought actually that transcultural psychiatry which he called comparative psychiatry would become also an auxiliary science for anthropology, because he felt that the ethnic norm finds an expression, if even a distorted expression in mental illness, which would therefore be of interest for ethnopsychology. Later on the name transcultural psychiatry was coined by Prof. Wittkower at McGill in the 1950s. I think the term ethnopsychiatry was coined by Georges Devereux in the 1950s. As later defined by Prof. H.B.M. Murphy who formalised the field at McGill, transcultural psychiatry is the field of study and investigation and verification of the links between psycho-social and psychiatric conditions and disorders with the different social-cultural characteristics of definable ethnic groups or human societies in a comparative manner. I would define ethnopsychiatry, but this is my definition, as the study and investigation of the culture inherent, the emic therapeutic customs, beliefs and concepts as they relate to psychosocial and psychiatric conditions.
Ethnopsychiatry and transcultural psychiatry however is often considered as synonymous but I would think that transcultural psychiatry is a comparative, analytical science – in the customary terminology an etic science-, while ethnopsychiatry is based on the information which comes from culture immanent sources – emic sources. Both approaches have to be combined.

What kind of projects did you work on?

First we became interested in ethnopsychiatry and transcultural psychiatry in Africa where I accompanied Louise on one of her trips, in 1962 actually. We then had a concrete project namely to investigate the herbal treatment of epilepsy and psychiatric conditions. We collected also many samples of herbs from healers with whom we cooperated. Then, when we were regional psychiatrists, the only psychiatrists in the Fraser Valley in British Columbia, we had to do with ethnically variegated populations. There were an important population of North American Indian people, of the Salish ethnic linguistic group. We also did outreach service along the whole North Pacific coast, including Alaska. So we had to do with other coastal Indian populations, the Kwakiutl, the Tsimshian and also with Eskimo populations. During that time we tried to explore the therapeutic approaches of these people. They were under a heavy acculturation pressure. There were still original shamanic healers with whom we had close contacts and who gave us valuable information. At the same time, in the 1960s, was the beginning of the great Indian renaissance, the native Indian renaissance in North America, where the cult dances and other ritual practices were revived. We witnessed this very closely and we reported on this and I published a book on the Salish spirit ceremonial and its therapeutic aspects. Later on, during my activities with WHO and with the Kingdom of Tonga Ministry of Health I had the opportunity to become acquainted with healers in Papua New Guinea and in Tonga and in other South Pacific islands, the Salomons, the Trobriand islands and so on, and also to study cargo cult prophets. In general my main task there was to investigate the psycho-social sequelae of the alcohol problems that originated in the flooding with alcohol of the South Pacific in the early 1960s and had reached the peak then by the 1980s. Later on in Southeast Asia, Thailand, Laos and Malaysia, I had an opportunity to study traditional healing and especially traditional resources used to rehabilitate drug addiction, opiate addiction. While working with refugees in the refugee camps under UN supervision in Thailand I tried to integrate shamanic healing in order to motivate opium and opiate addicted refugees, especially Laotian refugees and hill-tribe refugees, to undergo the actual voluntary detoxification. There were rehabilitation programs that were offered by several non-governmental organisations in the camps and I was especially successful to have the cooperation of IRC, the International Refugee Committee in doing this. More recently I was active as chairman of the Transcultural Psychiatry Section of the World Psychiatric Association, organising symposia and meetings in several continents and encouraging research among our membership and the affiliated psychiatric associations.

That's a very interesting life!

Well, it was time enough to have had an interesting life.

What in your opinion can transcultural psychiatry and ethnopsychiatry contribute to medicine and anthropology?

Well, transcultural psychiatry and ethnopsychiatry should be included in the training of all health professionals, especially those that have to do and deal with non-European populations whether outside Europe or in Europe and North America with immigrant and migrant populations. The recognition of the findings of comparative cultural psychiatry, which is my preferred term (if I had the choice I would call transcultural psychiatry comparative cultural psychiatry) and ethnopsychiatry, that is the study of emic concepts and healing in non-European cultures with regard to psychiatric and psycho-social conditions, is essential for practising health professionals. With regard to anthropology already Kraepelin thought that these subjects could contribute to the study of other cultures and I think very much so because they point out core complexes and emphasis and stress situations in various cultures. For instance, the so called culture bound syndromes are not culture bound at all but they are bound to a certain period and to a certain stress and emphasis situation in certain societies and they obviously provide important information on these societies, both sociologically and anthropologically.

I would emphasise that in future the curriculum of the training of health professionals and of psychologists should certainly include courses in ethnomedicine, and ethnopsychiatry I con-

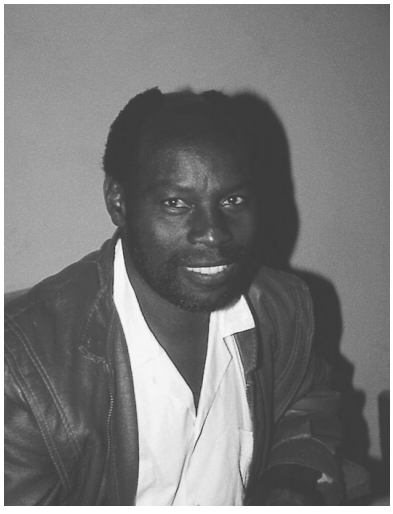
sider as part of ethnomedicine, and comparative cultural psychiatry in order to give them both a culture immanent view through ethnopsychiatric information and a comparative transcultural view.

It is important for psychiatric and psychotherapeutic practice to avoid ethnocentric and eurocentric errors, that means basing one's view and diagnosis and evaluation entirely on one's own western culture and to avoid positivistic errors, which means excluding everything that doesn't fit into the framework of positivistic experimental science. On the other hand it is quite possible that by overemphasising cultural peculiarities one would miss general parameters of psychopathologies that are definitely there in all cultures and recognised by the knowledgeable healers.

When you asked what ethnopsychiatry and transcultural psychiatry could contribute to medicine I would broaden the view and say to therapy in general. Both psychotherapy and probably also in the future pharmacological medicine. Medicine is of course an art, the practice of medicine is an art, and we can perhaps look to traditional folk healing and extrapolate the effective therapeutic principles as I have tried to do and these effective therapeutic principles I consider universally applicable. The form, the format is culture bound, but the principles are certainly universal because they are represented in nearly all cultures to various degrees in traditional folk healing. Some very effective modalities and principles are missing in the so called psychotherapy that is practised by western schools. I would not say by therapists, because the good therapists do not belong to a school, they are eclectic, they take from every school. I would say … every school of psychotherapy is an ideology, it is not a scientific body of knowledge but an ideology, and the more flexible and eclectic a therapist the better for his patients. And then if he is flexible he can also take effective therapeutic principles from traditional folk healing.

Thank you very much!

The Social Forum, Networking and Department News



Goodby Edmund!
Edmund Kayombo was ÖAD student at our department for more than three years. In December he delivered his Ph.D theses and did his final examination. We say good by to you Edmund. It was nice working together with you. We wish you all the best for your future and your work at the Institute for Traditional Medicine, Muhimbili University College in Dar es Salaam, Tanzania!

A new colleague!
The Austrian National Bank has granted Armin Prinz and his cooperator M.A. Alexander Weißenböck a sum of 640.000 Austrian Shillings for the project "Scientific documentation of the collection from the Department of Ethnomedicine, Institute for the History of Medicine, University of Vienna". The project, which will run for two years, documenting and digitalising our whole collection of videos, slides and objects.

Congresses

First International Conference on Science and Shamanism 2000/2001

The purpose of this conference is to launch a forum for the development of a scientific framework for the study and research of shamanism and the processes underlying its phenomenon, such as shamanic states of consciousness, healing, and journeys. It intends to focus on the understanding of some of the techniques employed by the shamans in their practices, both in terms of western empiricism and traditional cosmologies. The exchange is open to behavioural, social, physical, and biological scientists who can shed empirical light on the phenomenon of shamanism. Preliminary proposals and abstracts can be submitted either by electronic or regular mail. Final acceptance is contingent upon review of the actual paper by the conference committee. The final versions of all accepted papers and accompanying illustrations will be published in the Conference Proceedings, and should be submitted by regular post. The abstracts of accepted papers will be published in a booklet for use at the conference.

The conference is planned for March 2001, in the Palm Springs/Palm Desert area of the Southern California desert, which offers exceptional sightseeing attractions, as well as world-class conference, resort, and hotel facilities. It is about a 2.5 hour drive from Los Angeles (UCLA, USC), a 2 hour drive from Pasadena (CalTech), a 2 hour drive from San Diego, where three major universities are located, and a 1 hour drive from Riverside (UC Riverside).

For regular updates on the conference, please, check the webpage:
http://www.shamanicdimensions.com/confer1.html
For further information and proposals, please, contact:
Prof. Dr. Michael Ripinsky-Naxon
PMB 504
44489 Town Center Way, Suite D
Palm Desert, CA 92260-2723
U.S.A.
Fax: (760) 773-5168
conference@shamanicdimensions.com
www.shamanicdimensions.net

The 4th European Colloquium on Ethnopharmacology **"From the Sources of Knowledge to the Medicines of the Future"** organised by the Société Francaise d'Ethnopharmacologie, Institut Européen de'Ecologie and the European Society of Ethnopharmacology is going to take place in Metz, France from May 11-13, 2000. The symposium will cover some new aspects of ethnopharmacology. It will try to establish the modes of transmission and the access to therapeutic knowledge in different cultures and civilisations. Main topics are sustainable development, the origins of traditional pharmacopeias, the development of scholarly pharmacopeias and medicines of the 21st century. Société Francaise d'Ethnopharmacologie, 1, rue des Récollets, F-57000 Metz. Tel/Fax: ** 33-(0)3 87 74 88 89, e-mail: sfe-see@wanadoo.fr

World Conference on Shamanism: Wanderers between the Worlds from October 24 –29, 2000 in the Conference Centre Garmischpartenkirchen, Germany. The conference is a cooperation of AGEM (Society for Ethnomedicine) and ZIST (Humanistische Medizin). More than 30 shamans and scientists form all over the world are invited. The programm is available at Reichert Organisation, Achstr. 63, D-82386 Oberhausen, Tel.: ++49-8802-1250, (Fax 1255)

Symposium Women 2000 from March 31 to Mai 1, 2000. The topics are: women's health; alternative concepts to women's health, motherhood and birth; cooperation, new concepts and the future of wome's health. AGEM (Society for Ethnomedicine), Melusinenstr. 2, D-81671 Munich, Tel. and Fax: ++49-89-40 90 81 29, e-mail: 100042.1504@compuserve.com

Publications of the Department of Ethnomedicine 1999

Binder-Fritz, Christine: Western Medicine Alone Does Not Cure Maori Sickness. A Discussion on the Integration of Traditional Maori Therapies in the Health Care System of New Zealand. In: VEN 1, 2: 4-13.
Binder-Fritz, Christine: Transkulturalität im Krankenhaus (Transcultural care in hospital) In: Book of Abstracts. 4. Österreichische Konferenz Gesundheitsfördernder Krankenhäuser.
Binder-Fritz, Christine: Neue Strategien der STD- und HIV/AIDS-Prävention bei der adoleszenten Maori-Bevölkerung Neuseelands (New strategies of STD-, HIV/AIDS-prevention for adolescent Maori in New-Zealand). In: Mitteilungen der Österreichischen Gesellschaft für Tropenmedizin und Parasitologie 21: 15-22.
Burtscher, Doris; Heidenreich, Felicia: Plants in Traditional Healing Practices of the Seereer in Senegal. In: VEN 2, 1.
Eigner, Dagmar: The Life and Work of a Healer in Nepal. In: VEN 1, 3: 5-13.
Hadolt, Bernhard: Epilepsie in nicht-westlichen Gesellschaften (Epilepsy in non-Western Societies). In: ZAK 17(1): 5-11.
Hadolt, Bernhard: Shit and politics: the case of the Kolig-debate in Austria. In: Medische Antropologie 11(1): 179-199.
Hadolt, Bernhard: An interview with Els van Dongen. In: VEN 1(3): 21-25.
Hadolt, Bernhard: Performing sickness: considerations on Victor Turner's 'social drama. In: Ethnopsychologische Mitteilungen 8(2):176-191.
Kassa, Afework: History and Practic of Ethnopharmacology in Ethiopia. In: VEN 2, 1.
Kellner, Martin: Organ Transplantation in the Legacy of Islam. In: VEN 1, 3.
Kutalek, Ruth: Interdisciplinarity: Case Studies of Misunderstandings between Anthropologists, Ethnopharmacologists, and Indigenous People. In: VEN, 2, 1.
Kutalek, Ruth; Prinz, Armin: Hans Dieter Neuwinger - Afrikanische Arzneipflanzen und Jagdgifte. (African medicinal plants and arrow poisons. Book review). Buchbesprechung in GAMED - Zeitschrift der Wiener Internationalen Akademie für Ganzheitsmedizin, 1, 5.
Prinz, Armin: Ethnopharmacologic Research on Poisonous and Medicinal Plants from the Azande, Central Africa. In: VEN 2, 1.
Prinz, Armin: Our Department of Ethnomedicine: A Presentation. In: VEN 1, 3.
Prinz, Armin; Kutalek, Ruth: Exorzismus im Kloster von Waliso, Äthiopien. diii-film.
Teshome, Wondwosen: Indigenous Medicinal Plants Used in Ethiopia. In: VEN 2, 1.

PH.D. Thesesis 1999

Kayombo, Edmund: Traditional Healers and Treatment of AIDS Patients in Tanzania. A Case of Njombe Rural District, Iringa Region. University of Vienna

Biomedicine practices in treatment of AIDS are well documented. But in traditional medicine, the practices are not well spelt out.

The goal of this study was to learn the practices of traditional healers in treating AIDS patients and AIDS related complex (ARC) in rural settings in developing countries, and specifically assess the process of treatment and analyse the outcome.

The research method was composed of fieldwork participation through observation, interviews with traditional healers, patients, caretakers at Njombe Rural District from September to February 1998.

I found out that traditional healers were combining biomedicine and traditional medicine in treating AIDS patients. The result of the treated patients showed that they can alleviate some of the clinical symptoms of AIDS if the patients consulted the traditional healers earlier on the onset of infection.The question that remains here for such patients is that for how long they will remain in such a state.

Based on my findings I recommend that training should be given to traditional healers in disease recognition and it should incorporate folk belief about the disease, side effects of using biomedicine and counseling techniques to help the patients cope with illness. Tanzania and other developing countries have inadequacy of health facilities and drugs. In order to improve the health well-being of people in these countries they should incorporate traditional healers in treating AIDS and other illnesses.

Kutalek, Ruth: Steven Lihonama Lutumo. Leben und Arbeit eine traditionellen Heilers der Bena Südwest Tansanias. (Steven Lihonama Lutumo. Life and work of a traditional healer among the Bena of SW-Tanzania) University of Vienna

This dissertation is about a traditional healer, Steven Lihonama Lutumo, his work and life in Bena society, in Southwestern Tanzania.

In the first part the methods of fieldwork – participant observation and interview-techniques – and their problems are discussed, as well as the personal situation in fieldwork, the aim of the research and general questions of traditional medicine in Tanzania.

The second part is the main one dealing with Lutumo as a traditional healer. His biographical datas are explained, how he became a traditional healer, from whom he learned his profession and how he was taught. His concepts of disease and its perceived causes are described intensively. Further on Lutumos ways to diagnose sickness (counseling, divination) and his methods to treat them (with medicinal plants, through rituals) are shown. The patients of him were also analysed as to who is coming and out of which reasons. The last chapter of this part is dedicated to Lutumos medicinal plants and his concepts of botany.

The third part, finally, is a theoretic reflection dealing with general features of the mentioned topics - initiation, rituals, and ethnobotany.

Starzacher, Angelika: Auf dem Weg in die Moderne. Das traditionelle Geburtssystem der Quiché im westlichen Hochland Guatemalas. (On the way to modernity: The traditional birth-system of the Quiché in the western Guatemalan highlands). University of Vienna

The Midwife-system of the Quiché is described as represented by the Totonicapán highland community. Midwives are highly respected and belong to the group of the healer-specialists. Divine election as "fate" is prerequisite for acceptance to this occupation. Instructive as well as threatening dreams, initiational illness and tragic life events are punishment for an unfulfilled destiny. They instruct the candidate to change her life. The complex of nomination consists of this phase and ends with acceptance into midwifery. Midwifery is usually practised by middle-aged women. Reasons for this are: Sufficient experience of life, the own children are grown up, taboos have become less binding. The midwife's duties during pregnancy, delivery and puerperium are described. The Quiché obstetrics combine midwifery and ritual. This includes massage, rotation of abnormally positioned fetus, providing information on diets, birth assistance, post partum binding and massaging of the abdomen to reposition the uterus as well as spiritual support to the patients and the performance of cleansing and ceremonies for the new born infant.
Quiché midwives are only allowed to practise after they had been trained in modern obstetrics and hygiene. The traditional birth attendant (TBA) training program, which is worldwide propagated by the WHO, will be introduced. The contents of the training are based on the contents of western classic medicine, which are mostly foreign for the traditional birth attendants and their patients because midwifery in this region is settled inside an own cultural view of life. In addition there is the condescending treatment of the midwives within the training program. Guided by the idea and the practise of the TBA-program the question occurs, whether and how well it is qualified to make birth attendance better and safer for women or whether it even does more harm than good.

M.A. Thesesis 1999

Dachs, Petra: Transkulturelle Pflege in einer multikulturellen Gesellschaft. Die interkulturelle Pflegeproblematik in der Praxis. (Transcultural care in a multicultural society)

Doralt, Katharina: Padma 28 – ein komplex zusammengesetztes Phytopharmakon aus der tibetischen Heilkunde als Beispiel eines kulturübergreifenden Medizinexports. (Padma 28 – a complex phytopharmacon from Tibetan Medicine)

Göd, Irene: Abtreibung und Verhütung. Ein Kulturvergleich mit besonderer Berücksichtigung der pflanzlichen Abortivdrogen. (Abortion and Contraception. A cultural comparison with focus on plant derived Abortiva)

Kadlik, Erwin: Der Weg zum Heiler. Berufung und Initiation mit Beispielen aus Indonesien. (Becoming a healer. Vocation and initiation with examples from Indonesia).

Kellner, Martin: Islam und Medizin: Aufgaben und Grenzen medizinischen Handelns im sunnitischen Recht. (Islam and medicine. Tasks and boundaries of medical treatment in sunnitic law)

Millbacher, Ines: Natürliche traditionelle Heilmethoden bei landwirtschaftlichen Nutztieren von rumänischen Hirten des Gebietes Márginimea Sibiului. (Traditional treatment of useful animals among rumanian pastoralists in Márginimea Sibiului)

Mosetig-Pauleschitz, Gabriele: Bikausalität von Krankheit in Afrika. Eine kulturelle Konstruktion von Krankheit. (Bi-causality of disease in Africa. A cultural construction of illness).

Nechtelberger, Rena: Gesundheit – ein Traum? Der Einfluß der weißen Zivilisation auf die Gesundheit der Ureinwohner Australiens. (Health – a dream? The influence of white civilisation on the health of Australian aborigines)

Prevedel, Walter Erich: Ethnomedizin und die Culture-Bound Syndromes unter besonderer Berücksichtigung von Latah in Südostasien einschließlich eines Vergleiches zum Tourette Syndrom in den Industrieländern. (Ethnomedicine and "CBS" under special reference of Latah in South-East Asia, including a comparison with the Tourette Syndrom in Western societies).

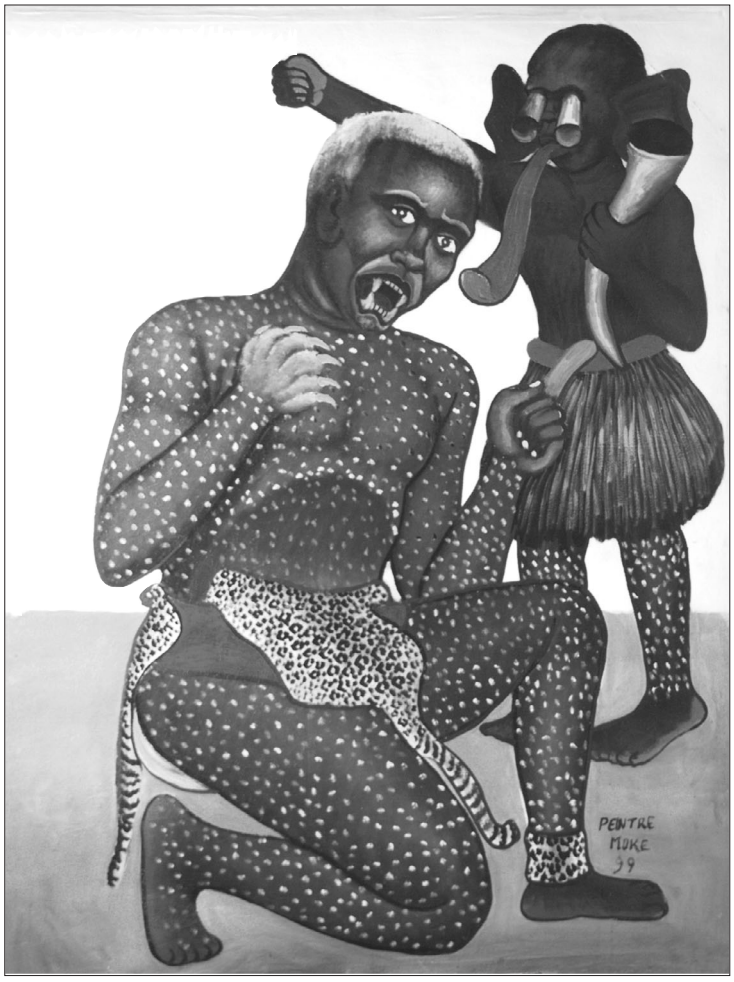
Unterberger, Silvia: Der Einfluss kultureller Faktoren auf psychische Belastungsreaktionen bei Flüchtlingen in Österreich. (The influence of cultural factors on psychic stress among refugees in Austria)

Weissenböck, Alexander: Geisterglaube und Besessenheit. Medizinische Strategien in afrikanischen Gesellschaften. (Belief in Ghosts and Spirit possession. Medical strategies in African societies)

Exhibition of popular paintings from Kinshasa (see last page)

The Department of Ethnomedicine is organising an exhibition on popular painting from Kinshasa, which is sponsored by the Vienna International Airport. This art style is the most manifold of Africa. It comprises abstract paintings as well as photorealistic. The subjects of the realistic paintings focus on the present sorrowful situation of the people in the cities, on dramatic events like plundering, warfare, serious mass accidents like the crash of an aeroplane down on a market some years ago, or on religious allegories, that condemn the evil in mankind. Of special nature are the works of the so-called Sablists (from French sable = sand), who bring impressing paintings on to the canvas by using variously coloured sand. Two artists will be invited to this exhibition, M. Moke and M. Shula, who will paint at the airport for ten days. Their works can be purchased from the artists directly. All the paintings from the exhibition should be sold also and the profit will be provided to the artists. We therefore ask for animated visits of the exhibition and your brisk demands. If you will tell us your address we will send you an invitation to the vernisage.

Location of the exhibition: Vienna International Airport, B-Gates.
The opening of the exhibition: April 11, 2000, at 7. p.m. Time of the exhibition: approximately two months.



A witch, assisted by his accompanying spirit, is transforming in a leopard.
The artist Moke works in Kinshasa/Kasavubu and had already several exhibitions in Europe and USA.

News of the Austrian Ethnomedical Society

Dear friends and colleagues!

If you want to become a member of the Austrian Ethnomedical Society and to get the VEN regularly (three times a year), please send the completed form back to:

ÖSTERREICHISCHE ETHNOMEDIZINISCHE GESELLSCHAFT
(AUSTRIAN ETHNOMEDICAL SOCIETY)
c/o Abteilung Ethnomedizin
Institut für Geschichte der Medizin
Währingerstraße 25
A-1090 WIEN
AUSTRIA

MEMBERSHIP ENROLLMENT

Member (annually öS 200.- = Euro 14,53) ❑

Student Member (annually öS 70.- = Euro 5,09) ❑

MEMBER NAME:
……

……

ADDRESS:
……

……

FAX: …… PHONE: ……

E-MAIL: ……

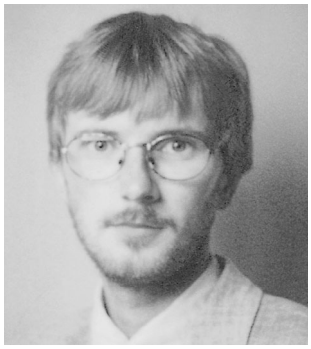
DATE: SIGNATURE:

With your membership you help us to publish this newsletter.
If you are already a member, please hand forward this application form to somebody who might be interested in our work.

Contributing Authors

Hwiada Abu-Baker, M.A. (sociology and anthropology), research assistant at the Ahfad University for Women, Omdurman, Sudan; Ph.D. student at our Department.

Christine Binder-Fritz, Ph.D. (social and cultural anthropology), research assistant at our Department (Hertha Firnberg Nachwuchsstelle); Trained medical technician on genetics; trainee for transcultural nursing care in the General Hospital in Vienna. Research project on Maori-medicine 1996, 1997 financed by the Austrian Fund for Scientific Research (e-mail: christine.binder-fritz@univie.ac.at).



Bernhard Hadolt M.A, M.Sc. (social and cultural anthropology, medical anthropology), part-time lecturer at our Department and at the Institute for Educational Sciences, University of Innsbruck, researcher at FIKUS, the Research Institute for Cultural and Social Sciences, Vienna (e-mail: Bernhard.Hadolt@univie.ac.at).

Photograph last page: "*Le Tradipratitien*" by Shula

In this painting the uncontrolled increase of self-designed "healers" in African cities is caricatured. With the bible in the pocket and a "Fetish" in that special basket that keeps an eye on the remedies, the patients are offered an syncretistic ambience, which meets their Christian believes as well as their traditional ideas. To the "Fetish" in the basket money is offered by the patients. The healer himself feels indignant about that he might make money through his patients but of course the healing "Fetish" has to be paid tribute. His advertising pamphlet overbearing tells us that he not only is able to treat tuberculosis, jaundice, yellow fever, cancer and sterility, but he also can treat SIDA (Aids), establish fortune and arrange marriages and employment. Of course the hint on his international connections is not missing. The painted mortar on the head of the female patient, where remedies are pounded, is in accordance with a frequent therapeutic act in Central Africa. The healing power that is coming from the container should enter the patient's body through his head. Thus removing the evil, which is leaving the body through the legs into a bath. The patient's mother is watching the treatment with attention. The chicken is waiting to be offered to the healing powers at the end of the treatment. On the left side there are two women sitting, one looking for a husband, the other one wanting a child. On the right side above a sick person is brought about, supported by a relative.
The artist Jean-Bosco Monsengo, who has given himself the synonymous name Shula, was a pupil of and has worked with the famous artist Moke. At the moment he works together with the artist Cheri-Cherin in a studio in Avenue Ndolo in Kinshasa-Ndjili.

"*Le Tradipratitien*" by Shula

A-1090 WIEN · WÄHRINGERSTRASSE 25 · AUSTRIA · TEL ++43(0)1/427763412 · FAX ++43(0)1/42779634