february+june 2008 volume X number 2+3

ven

viennese ethnomedicine newsletter

Special issue: Medical Anthropology at the University of Kansas

Children of Tamahú

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

unit ethnomedicine and international health

Frontispiece

In many indigenous Guatemalan Maya communities, anemia is an abnormality of health that is a normality of everyday life. Results from blood samples showed all 87 school children in the village of Onquilha' were anemic. The physical and psychological symptoms of anemia are pervasive throughout daily experience and intricately tied to Maya cultures and the broader postcolonial social order (see article Herynk this issue).

Viennese Ethnomedicine Newsletter

is published three times a year by the Unit Ethnomedicine and International Health,
Center for Public Health, Medical University of Vienna, Austria.

Editors in chief

Ruth Kutalek, Unit Ethnomedicine and International Health,
Center for Public Health, Medical University of Vienna, Austria
Armin Prinz, Unit Ethnomedicine and International Health,
Center for Public Health, Medical University of Vienna, Austria

Guest editor

John M. Janzen, Department of Anthropology, University of Kansas, USA

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, Centre for Public Health, Unit Ethnomedicine and International Health, Währinger Strasse 25, A-1090 Vienna, Austria
FAX: (++)43-1-42779634, e-mail: ruth.kutalek@meduniwien.ac.at
homepage: http://www.univie.ac.at/ethnomedicine

ISSN 1681-553X

Global Medical Anthropology in the U.S. Heartland

John M. Janzen

Introduction

Medical anthropology at the University of Kansas – heartland USA – has a distinctive profile that evolved in the context of a four-field department and the particular faculty and student research programs at the university since the 1970s. The papers in this collection by a set of current graduate students reflect not only these distinctive perspectives, but a cross-section of issues and emphases of medical anthropology practiced worldwide.

This special issue of VEN originated in a spring 2007 seminar in advanced medical anthropology in which we studied the new volume edited by Francine Saillant and Serge Genest "Medical anthropology: regional perspectives and shared concerns" (2007). We also studied Paul Farmer's "Pathologies of power" (2005) and Veena Das' "Life and words" (2006) before turning to current student work. It was my hope that these volumes would inspire and guide the enrolled graduate students in their own projects.

Kathleen Ragsdale, editor of the medical anthropology section of "Anthropology News" (the newsletter of the American Anthropological Association), and former program committee member of the Society for Medical Anthropology (SMA) special sessions, on a visit to the University of Kansas in spring 2007 encouraged us to consider a panel at the joint Society for Applied Anthropology and the Society for Medical Anthropology (SfAA/SMA) in nearby Memphis. I wrote a session abstract and invited current students in medical anthropology to produce abstracts of their work, reflecting dissertations in process of being written (Melissa Filippi-Franz, Mary Sundal), doctoral research in the proposal stage (Shawna Carroll, James Herynk, Maria Weir), and M.A. thesis work (Sarah Sobonya)[1]. Several other students would have qualified but were unable to attend. After consulting the students, Maria Weir agreed to serve as session chair.

Another feature of the plan for this session was to invite a prominent medical anthropologist to serve as discussant of the session, to comment on the papers and to situate them in light of the Saillant-Genest volume's themes. Saillant and Genest were invited, but neither could attend the meetings in Memphis. Ellen Gruenbaum of California State University, a former member of the SMA Executive Committee, agreed to be discussant. Here is the near final version of our session abstract:

> JANZEN, John (U Kansas) Medical Anthropology in the U.S. Heartland.
> This session presents research from sites around the world – Guatemala, Uganda, Rwanda, Kyrgyzstan, and the US – with a view of how medical anthropology in "heartland USA" is situated in relation to national and world orientations and trends, as defined by "Medical anthropology: regional perspectives and shared concerns" eds. Saillant & Genest (2007). Research emphasizes effects of power relations associated with transnational institutions and globalization upon topics such as: iron deficiency anemia, access to medical insurance, distribution of avian flu aid, genocide drawings, and cattle loss among pastoral nomads.

The program committee placed our session at 8:30 on the first morning of the meetings. Despite the early hour, our audience was approximately 15 people. The most auspicious outcome of audience/panel interaction came in the moments after the session ended when Armin Prinz, PhD, M.D. and Ruth Kutalek, PhD of the Medical University of Vienna, who observed the entire panel, invited the panelists to submit their papers to the "Viennese Ethnomedicine Newsletter" for the summer 2008 issue. We withdrew to coffee in the Marriott Hotel lounge to get better acquainted and to plan such a volume.

In order to situate the panel papers within a wider world of medical anthropology, I take up the question of last year's seminar, and the session's ostensible reason as stated in the abstract. How do the themes of the present papers resonate with those articulated in the Saillant/Genest volume? By implication, how does medical anthropology at the University of Kansas reflect global medical anthropology? The Saillant/Genest collection features anthropologists they regard as most significant in the national traditions they select (Canada, the U.S., Mexico, and Brazil in the Americas; France, Britain, Germany, the Netherlands, Spain, Italy, and Switzerland in Western Europe). This is not a comprehensive listing of national traditions in medical anthropology: Asia, Australia, Africa, or even Eastern Europe, Scandinavia, or Austria are not represented. By contrast, Quebec and France are privileged by the editors; the U.S. is downplayed with just one essay. Kansas figures fleetingly in the U.S. chapter by Arachu Castro and Paul Farmer as having begun a course of study in medical anthropology in 1976.

The Saillant/Genest volume portrays medical anthropology as a field in a number of ways. First, they suggest a succession of paradigms. Thus, after the field's emergence in the 1970s, it was "very empiricist, with the paradigms of ecology and sociocultural epidemiology; then it took up its interest in the symbolic, becoming increasingly textualist and hermeneutical; and more recently, it has become a multi-faceted critical enterprise, with Foucauldian, feminist, deconstructionist, and political economy influences that we feel are well represented in this book" (2007:xxi). A second portrayal of medical anthropology, more in keeping with the organization of the volume, moves away from the linear developmental history of paradigms to a kaleidoscopic perspective of national traditions and themes (2007: viii). This structuring tactic, suggests Jill Fleurit in her review of the volume for the American Anthropologist (2007: 777f.), deconstructs medical anthropology in order to free it from domination by American – U.S. – scholarship. A third approach to defining the field emerges from the apparent fragmentation that results from the kaleidoscopic view. The field has been re-unified by a few major current debates, namely: issues of the sovereignty of the body; accounts of medical cultures and professions; the implementation of technologies in all spheres of life; ethical debates over what or who is most worthy of consideration or humane in situations of medical uncertainty, such as who deserves to live (2007: xviii).

Margaret Lock's portrayal of medical anthropology's history and current and future status, in her concluding essay to the volume, goes one step further to raise one of the above issues as paramount. She suggests that the ability and tendency to manipulate the natural world through "new technologies of all kinds, ranging from multinational driven agricultural practices to technologies of the self" has transformed anthropology's approach to representation as well as social change, regardless of whether the theoretical approach is structural, materialist, or semiotic (2007: 267).

Do the Kansas papers demonstrate adherence, or at least some echoes, of the current trends in medical anthropology as described above? Are there topics raised in the papers that are outside the pale of the above themes? A brief review of the papers will suggest areas of overlap and differentiation with the Saillant/Genest themes.

The transformation from Ethnomedicine to "Medicoscapes" is one debate theme of medical anthropology raised by Saillant and Genest. Lock writes of "rethinking culture". In this regard, Mary Sundal's portrayal of East African pastoralist women and children's struggle for health care shows them juggling Karimojong healing with whatever biomedicine they can find, which isn't much. Both are evolving, intertwined, traditions that presuppose a global, historicizing, perspective. James Herynk and Maria Weir focus on global epidemics – anemia, avian flu – in particular places. The first is a chronic debilitating disease, and the second a new potentially deadly disease pandemic. Both begin with epidemiological and clinical analyses that the paradigm count above would well call "empiricist," "epidemiological", and "ecological". Yet both couch their deliberations in terms of local culture, structure, resources and power in global relief in the perspective of Paul Farmer. James Herynk's research on chronic anemia in Mayan Guatemala grapples with how to analytically combine blood analysis that clearly establishes serious anemia, with environmental and ecological pressures on the populace, and "structural violence" in the political economy, and narrative and discourse analysis of the community members' formulations of their condition. Some of the papers of this set reflect distinctive U.S. issues, such as Shawna Carroll's work on images of risk of cardiovascular disease among working women, and the peculiarly American dynamic of large numbers of citizens in this global superpower lacking health insurance.

"Languages of the Body" are a particularly powerful crystallization of medical anthropology today, for Saillant/Genest. Lock writes of "rethinking the body" (2007: 269-271). Embodiment, habitus, and biopower are the buzz terms here. This perspective is echoed in a number of papers. Herynk tries to figure out how to read the diffuse effects of the Mayan bodily experience of anemia. Sobonya reads Rwandan children's drawings to understand how they have internalized, and imagine, the violence of war upon them. Filippi-Franz, in an explicitly phenomenological ethnography, depicts Somali immigrant women in Kansas City as they strive to put the violence in their individual, family, and clan histories behind them and to create new situations for their children and community. Somali rituals such as Zar provide frameworks to both act out painful memories and forge new more favorable lived worlds. Shawna Carroll's focus on individual and societal constructions of risk for cardiovascular disease may also be seen as a language of the body, or a societal language that uses the body to control individuals through messages of health and disease.

"From Illness to Suffering" and "Right to Life and Social Justice" conclude the broad themes of the new medical anthropology, in Saillant/Genest's overview. Many of the papers deal with violence and suffering, and the politics of health, or the "politics of life" (Fassin). Sundal's study of how Ugandan pastoral women are "bribed, beaten, and berated" demonstrates the place of health in marginalizing a segment of society that is seen as a threat to the dominant structures. Herynk couches his work on anemia among Guatemala's Maya in the framework of structural violence. Weir notes that avian flu and other prospectively global epidemics reveal the fault lines of economic disparity, as does Carroll's paper on the disparity between insured and uninsured in America.

It is expecting a lot of six graduate students in one department to cover all the current "hot" paradigms and research agendas proposed in medical anthropology. "New technologies of control", "local biologies", the "social life of artifacts", and the "reinvention of the normal" through biotechnologies also echo in the heartland halls, although they do not figure front and center in these particular essays. Then too, as I have suggested in writing on "origins and theories in medical anthropology" (Janzen 2002: 21-49) the depth of biological anthropology at Kansas and the four-field approach represented in core courses adds to student and faculty research greater prominence of the biocultural paradigm and a more objectified universalist biology than that which is portrayed by Saillant and Genest, or suggested for the future by Lock.

Meanwhile, in the spirit of Saillant and Genest, if medical anthropology is to be seen more as light and color refracting through a kaleidoscope than a linear progression, there is plenty of room for formulations of research in medical anthropology as diverse and divergent as the unique societies in which we live and work, and as common as the conversations we hold from time to time in conferences, projects, and publications. May a thousand – prairie – flowers bloom (see photo on back).

Note

[1] These students are advised by the following faculty, whose interests as listed may reveal the influences upon the students: **Bartholomew Dean** (social anthropology, critical theory, kinship, politics, symbolic forms, material culture, health and human rights; Amazonia, Latin America); **Sandra Gray** (biological anthropology, human population biology, human growth and development, maternal and child health and nutrition, etabolic adaptation, pastoralists; East Africa); **Majid Hannoum** (anthropology and history, social theory, cultural identity, political modernity, historiography and memory, religion and politics, violence and the state; post-colonialism, Egypt, North Africa, France); **F. Allan Hanson** (social anthropology, semiotics, social impact of technology, social theory; Polynesia, contemporary U.S.); **John M. Janzen** (social anthropology, medical anthropology, semiotics, violence, trauma and healing; Central Africa, Euro-American Mennonites); **Brent Metz** (Indigeneity, indigenous reformulation, culture and power, collective memory, ethnographic representation, masculinity; Ch'orti' Maya, Mesoamerica, Latin America); **James Mielke** (biological anthropology, population structure, historical demography and

historical epidemiology; Finland); **Donald Stull** (applied anthropology, policy studies, rapid growth communities, meat and poultry industry, modern agriculture; U.S. Great Plains, Upper South, contemporary North American Indians). The Kansas Department of Anthropology website may be found at http://www2.ku.edu/~kuanth/

References

Farmer, P. (2005) Pathologies of power: Health, human rights, and the new war on the poor. Berkeley, Los Angeles, London: University of California Press.

Das, V. (2006) Life and words: Violence and the descent into the ordinary. Berkeley, Los Angeles, London: University of California Press.

Fleurit, J. (2007) Review: Medical anthropology: Regional perspectives and shared concerns, eds. F. Saillant and S. Genest. In: American Anthropologist 109, 4: 777-778.

Janzen, J. M. (2002) The social fabric of health: An introduction to medical anthropology. Boston: McGraw Hill.

Saillant, F. & Genest S. (eds.) (2007) Medical anthropology: Regional perspectives and shared concerns. Oxford: Blackwell. Translation of Anthropologie medicale: Ancrages locaux, defies globaux. Quebec City: Les Presses de l'Universite Laval (2005).

"It's Been 9 Years and She Needs to Take the Test!" Somali Women's Pursuit of Citizenship

Melissa Filippi-Franz

Introduction

The dissolution of Somalia's state and its failure to support its citizens produces a contradiction among those in the diaspora. On one hand, Somalis undertake the ordeal of learning cultural knowledge in a new setting. On the other hand, Somalis try to reformulate a social world that is based on past circumstances and one that articulates with current living conditions. Thus Somalis living in the diaspora, specifically in the US, have a uniquely challenging task. Individuals find it difficult to superimpose old ideas of what one believed to be true in terms of state functioning, security, and protection onto a new society. At the same time, Somalis often feel "suspect" for being Somali, African, and Muslim in a post 9/11 state. Arthur Kleinman's (1995) notion of local moral worlds goes beyond aspects of the state. Forming a new perspective of a local moral world is difficult when people are displaced to a society where morality is perceived to be different. How does one evaluate and negotiate choices in a new framework in view of a ruined social world, i.e., after the extreme failure of Somalia's state structure compounded by its inability to find a viable solution in the last 17 years?

To gain insight into this quandary, my research describes the practical considerations one takes into account in striving for and/or maintaining a functional household, a sound community, and family abroad. Specifically my research addresses what Somali women living in Kansas City, Missouri do to assist their households and community after undergoing forced migration(s). The research entails how individuals negotiate and contribute to the betterment of households and the overall community. It also discusses those situations that lack strategizing in resolving problems. Thus, the research relates to what women do to promote wellbeing (or lack thereof) within their households, community, as well as kin living in Somalia and Kenya.

In this presentation I discuss women's roles in the promotion of wellbeing and pursuit of citizenship. I examine strategies and actions employed by women as they contribute to their individual households, local community, and families residing abroad. Their activities include sharing information, practicing impressions, searching for advocates, and attending Pre-ESL, ESL[1], and/or citizenship classes. The strategies employed act as a motivating force in attaining US citizenship. How does citizenship become intertwined with wellbeing? Citizenship can be viewed as a symbolic step as well as one that has practical implications in shaping future actions and perhaps redefining local moral worlds.

Description of Field Site

The field work took place in an area known as the Northeast located in Kansas City, Missouri. It is nestled between east of downtown and the small city of Independence. It lies directly south of the Missouri River. The Northeast, considered to contain Kansas City's oldest residential neighborhoods, is not new to immigrant communities. Irish and Italian immigrants settled in the Northeast during the 19th and early 20th centuries. Today, the streets of the Northeast buzz with many different communities including but not limited to Somalis, Sudanese, Latinos, Pakistanis, Iraqis, Vietnamese, and Hmong. General agreement among Somali community leaders is that 3,000 Somalis resided in the Kansas City metropolitan area at the time of the research (now the number is around 4,000).

Research Design and Methods

I began volunteering for one of the local Somali organizations in January 2005. I also attended functions outside of the classroom and of the center. My research began in June 2005 and continued through September 2006.

My research primarily relies on qualitative data. I obtained data through participant observation and interviewing. I interviewed 32 females and 8 males who came to the US seeking asylum as a result of Somalia's civil war. Overall, the semi-structured interviews entail women's productivity and positive role in families affecting health and wellbeing within the household, community, and familial relationships abroad. I spent time with women in households and neighborhoods, along with women's daily activities: attending ESL classes, going to social service agencies, helping with doctor visits, preparing meals, applying for jobs, and organizing community events. Since I was in the process of learning Somali, I hired a female interpreter who was present during most of the interviews. She speaks Somali, Maay-Maay, and some Baraawe. The majority of participants preferred to converse in Somali.

I participated in the seemingly insignificant domestic happenings on a daily basis. My intent was to look at "mundane" experiences and connect traumatic events to everyday life, under the premise that this approach would illuminate how people cope and continue life in their new environment (Das 2006).

Many of the comments pertaining to citizenship relate to women who are classified as Pre-ESL or beginning ESL learners. I focused on this segment of the population because there are a disproportionate number of women in Kansas City, Missouri that have no or little formal education before arriving to the US.

Strategies Employed while Earning Citizenship

Individuals who do not communicate well in English or who are nonliterate face many challenges in the process of becoming a citizen. Sharing information among members who have both passed and failed the exam provides a background as to how to approach the interview, examiner, and questions. Knowing what kind of attitude and behavior to display during the interview is talked about as well. Based on the experiential stories that individuals divulge, modeling the interview is a technique that many students engage in before the exam. Continuing practice, holding mock interviews, critiquing spoken words, using appropriate body language, showing how to exude confidence, and partaking in conversations, are some of the strategies employed. Impressions cannot be underestimated in the process. It is believed that these impressions affect examiners' assessments. Therefore, individuals want to be "doing everything right" by shaking hands (even though some women would not ordinarily do so), saying key phrases in English (that would make one appear to be competent in English even if one struggles with the language), and smiling at appropriate times. Exam testers feel that these actions may help offset other deficiencies examiners notice.

The rumors and stories which people share about exam experiences are beneficial because they demonstrate a network of support for increasing positive outcomes for those seeking US citizenship. The stories and rumors about other people's experiences during the exam have the potential to turn into legendary status

– whether they detail someone raising the left hand for swearing in or inadvertently speaking Somali – people learn from others' mistakes or mishandling of situations.

The discussion is not limited to local experiences. These stories transmit to others across state lines. Some individuals who experience difficulties consider their chances in other state exams. How do other states handle their interview process and how do they compare with Missouri? The fact is if you are a pre-ESL learner, then the exam produces more stress and anxiety than if not. At the time of my research, some of the older ladies I spoke to were frustrated with the slow progress they had made toward gaining their citizenship. There was an account of a woman who spoke little English and the examiner picked up on this quality. The examiner deviated from the standard script and asked for word definitions. The woman did not expect this and became nervous. She failed and discussed going to another state to take the exam in the hope that the examiners would be more understanding. This is an example of how one strategizes alternative ways to pass the exam.

An accepted practice that individuals utilize is to pay for an advocate. It is common and recommended by participants, ESL instructors, and social service agencies. An advocate proves beneficial especially if one does not express herself well or if incorrect information exists on the application; an advocate can assist in clearing up such matters. At the time of the research, the price for the submission an application was $ 390 and the standard fee paid toward an advocate was $ 150, totaling $ 540[2].

Intertwining Citizenship with Identity

Due to the significant time and energy put forth toward one's citizenship, I inquired about the factors for becoming a citizen. I will discuss the top four: belonging to American society, contributing to society, sponsoring relatives, and accessing benefits.

Belonging to American society and being "fully accepted" act as a driving force for some people in attaining citizenship. Individuals want full rights as opposed to partial rights. The discussion of partial and full rights underlies the issue of being official. Labeling someone "official" contributes to being legitimate. So if someone is not "official" she does not feel legitimate. Or perhaps she perceives herself as not possessing the right to be here, i.e., the fear of deportation. In the following case, a woman wants to become a citizen because she no longer wants an ambiguous status. She desires a place where she can take care of her kids and live without worry. "I want to stay here and get a passport. I want to be like you and other Americans. I want to be part of American society by being official."

"To be like other Americans" is a phrase I often heard as a motivating force for becoming a citizen. The desire to be part of a functioning society, to just live daily life, describes the sentiment. It is the idea that citizenship is preferable because a citizen has more rights and has more protection. For example, if a noncitizen was to commit a crime and be punished, she would not get the same treatment as if she were a citizen. The aspect of equality evokes the notion of full rights. This is in agreement with themes seen in anthropological scholarship, i.e., citizenship promotes equality (Holston and Appadurai 1999).

Once individuals successfully pass their exams, many envision their lives contributing to society in some capacity. While some individuals may have very specific ideas in mind of how to do this, others are not sure how to accomplish their goals. Regardless, the image of people reaching their aspirations and harboring the desire to give back so others can achieve their dreams is powerful. As an example, I spoke with a family where the matriarch just successfully passed her exams. Her son joked and said now that his mother is a citizen, she wants to be president. She wanted to attend a local university and do "more" than what she is now. Even though she is old, she spoke of wanting to do something important with her new status. She would vote in upcoming elections, but beyond that she was unsure as to how she could contribute to society. She wanted to be a productive member even though she is aware of her own limitations, i.e., her professed lack of literacy and English skills.

Even though the woman is unsure how she can contribute to society, she already does. This woman holds the idea of giving back in high esteem. As a way of contributing, older ladies often assist others who settle in Kansas City. They take care of children and help them stay out of trouble in the hope that those children will learn to be productive people. These activities do not require one to be a citizen. Positive contributions can be made regardless of status. Dreams of citizenship may inspire an individual to do something beyond normal activity, but in reality, everyday living (taking care of children, attending classes, working outside the home, shopping, and cooking) consumes much of one's time and energy.

One action people take with their new found status is to sponsor others. An unforeseen problem that accompanies sponsorship is money. Some people feel stretched as they save money for citizenship, sponsorship, remittances, and bills. As one woman explains, "I have two kids in Ethiopia. I want to bring them over but I have no money. I'm a citizen but there's no money so what I do is limited." Depending on one's social network and the network's access to capitalize on so-called "opportunities," particular circumstances influence the process of sponsoring family members. In the following case a woman describes her future plans, "I don't have a job, so I can't help. I want to send money, but I can't. I can't work. I went to SSI[3] for help and they didn't help me there. Since I am sick, I can't do anything and I am not able to help. If I am able to get my citizenship, I will bring others here. I am able to help in that way." Some individuals are not able to financially contribute to the household or send money abroad. Yet, they coordinate with other people in their networks who earn money or who have access to money.

At the time of the research, the participants' average length of stay in the US totaled seven years and three months. This timeframe is significant because a person can apply to be a citizen after one has been a permanent resident for five years. However, if one does not become a citizen after seven years of being a permanent resident, then she loses her benefits. Therefore, when I conducted my research the incentives surrounding citizenship were on people's minds. As one daughter discussed her mother's study habits she exclaimed, "It's been nine years and she needs to take the test!" The immediacy of the situation impacted the household (and two of her daughters who no longer live with her) where individuals absorb the expense of lost benefits. The threat of losing government assistance is a real motivational force to pass, although some unrealistic expectations seeped into the psyches of some. Some believed that once a person has attained citizenship everything becomes easier and access to services is more or less guaranteed. A point of contention is Medicaid. A woman comments, "When I go somewhere, you need to be a citizen and I need my Medicaid. I don't get food stamps even though I'd qualify … I need my Medicaid. Medical costs are expensive. What am I to do?" The harsh reality is citizenship will not solve all of her problems, including access to Medicaid. It is true that her chances will improve, in this sense that she will meet one level of eligibility, but there are other requirements that need to be met. The expectation that gaining citizenship will make life remarkably better is somewhat overrated for those who depend upon false information.

Conclusion

Overall, my research focuses on redefining local moral worlds. To do that, Somalis attempt to preserve aspects of their culture along with making accommodations and adjustments while living in the diaspora. Individuals strive to attain citizenship for a variety of reasons. The string that ties citizenship to redefining local moral worlds is the desire to legitimately participate in a functional democratic society which provides security and protection. Citizenship lessens the fear of deportation. Many believe that citizenship is a major factor for living a quiet, peaceful life. The longing for a return to everyday living without an underlying fear of something bad happening is motivation for citizenship. Although some people may dream of a better life through their new found status, for some not much changes. Also gaining citizenship is a way to "pay it forward" because if sponsorship is made to a family member, than that family member is looked on to do the same for someone else, meaning that those who are in a "fortunate" situation are obliged do to something with their good fortune or privileged position for being in the US. It is a signal to help others, like others helped individuals who arrived here.

Notes

[1] ESL stands for English as a Second Language. Some social service agencies and schools offer ESL classes for those who wish and/or need to have a better command of the language. Pre-ESL classes are offered to those who need additional assistance. Often, these individuals are non-literate in their native language.

[2] Note USCIS fees changed on July 30, 2007. Now, one can expect to pay a few hundred dollars more. This is important because the majority of employed Somalis living in KCMO have low wage jobs. It is often perceived that citizenship application is a one shot deal due to financial constraints.

[3] SSI refers to Social Security Income (formally known as Supplemental Security Income). The program is sponsored by the US Social Security Administration. Adults with disabilites, children with limited economic resources, and non-disabled adults who are 65 years and older who meet the necessary income requirements receive benefits toward living expenses.

References

Das, V. (2006) Life and words: Violence and the descent into the ordinary. Berkeley: University of California Press.

Holston, J. Appadurai, A. (1999) Introduction: Cities and citizenship. In: J. Holston (ed.) Cities and citizenship. Durham and London: Duke, 1-18.

Kleinman, A. (1995) Writing at the margin: Discourse between anthropology and medicine. Berkeley: University of California Press.

Bribed, Beaten, and Berated: How Biomedicine Fails Karimojong

Mary B. Sundal

Risking an attack from enemy cattle raiders, a Karimojong mother rushes her dying infant to the nearest Western health clinic – a four hour walk in the middle of the night. The mother gives her child an herbal mixture while praying the baby will survive until she reaches the clinic. She waits at the door for the staff to arrive; today they are only one hour late. Because the clinic's drugs are out of stock, the workers tell the mother to walk to the hospital in town. Upon arrival the nurse slaps her immediately and berates her for being dirty and not bringing the sick child in sooner. During the examination the nurse says that not only is the hospital's drug-stock empty, but the mother must also tip the staff before any additional treatment is administered. Even though this is a free hospital, the mother pays the nurse and then walks to a neighboring drugshop – a store which is likely owned by one of the hospital's staff – to buy a list of pharmaceuticals. Later in the day, the mother stealthily removes her baby from the hospital to visit a renowned local healer. The healer consults her gourd, removes evil eye, and prescribes an herbal remedy. The mother quickly returns to the hospital to avoid further punishment – if the nurse learns of her afternoon trip her baby may be discharged immediately.

This is a typical story Karimojong mothers told me about their healing strategies. The crux of today's paper is not to discuss how indigenous Karimojong and Western-based medicines differ, but to examine the factors Karimojong mothers stated would improve existing biomedical services to give them a broader range of healthcare options. I will discuss how barriers, such as harsh punishment for using local remedies, inhibit community use of biomedicine and the importance of incorporating indigenous methods into the overall healthcare program in Moroto District, Uganda.

The Karimojong are one of several agropastoral populations living in northeast Uganda. These communities participate in armed cattle raiding with neighboring groups, prompting the Government of Uganda to mount several disarmament campaigns since the 1980s (Gray et al. 2007; HRW 2007; Stites et al. 2007). Rather than reducing conflict, however, these exercises have resulted in livestock loss, widespread migration, and increased human mortality and morbidity. Furthermore, because child mortality is high (30% of children die before the age of ten), healthcare improvement constitutes a large portion of aid programs in the area (Gray et al. 2003).

Moroto District is comprised of both semi-urban communities and rural villages divided into two counties: Bokora County and Matheniko County. Both are further divided into subcounties with each containing one biomedical health unit. The Ugandan Ministry of Health ranks units; level II health centers are equivalent to drug dispensaries, whereas level IV centers are hospitals. Moroto District has sixteen biomedical health centers including two hospitals, eight level III centers, and six level II dispensaries (MoH n.d.)

Sample Health Centers

I lived among Karimojong communities working primarily within two subcounties of Moroto District from October 2006 to August 2007. To determine community usage and reliance on biomedicine (and to evaluate conflicts with local healing) I collected data on the following: causes and treatments for child illnesses; factors which inhibit or promote biomedical usage; and interactions between local healers and the biomedical community. I conducted a total of 57 individual, multi-session interviews: 34 in-depth interviews with Karimojong mothers and 23 interviews with Karimojong healers. I toured the facilities, visited patients, and spoke with biomedical staff at my informants' subcounty units and the two hospitals.

Health unit A is a level II free dispensary in Bokora County run by the Government of Uganda. As of May 2007 no staff lived on the premises. All staff lived at least a thirty minute car ride away, although they traveled via bicycles or on foot; thus, the dispensary's operational hours were limited. The dispensary did not employ doctors nor certified midwives. In contrast, the level III Matheniko unit (Unit B) provided both in-patient and out-patient care, required payment, took patients on a twenty-four hour basis, and had a small laboratory facility. Moroto Hospital is the government district hospital located in the center of Moroto Town and is "poorly equipped" (Mkutu 2007: 39). Moroto Hospital maintains free services, although as I will explain later this is misleading. St. Kizito is a fee-based, missionary hospital in Bokora County. In addition to the in-patient facilities, St. Kizito Hospital has an HIV/AIDS clinic, a laboratory, and supports the peripheral centers (Kizito 2007).

Reported Obstacles

To improve existing biomedical facilities, Karimojong mothers suggested the following: ensure an adequate drug supply; have nurses live on-site to maintain proper operating hours; eradicate the practice of tipping biomedical staff; and train biomedical staff to respect local beliefs and accept local healing practices. First, mothers stated that the government units lacked pharmaceuticals more regularly than missionary-based centers because government staff sold the drugs in privately owned stores. In addition, mothers confessed they used neighboring district units – a practice technically not allowed – when their units' drug supplies were low. Second, mothers' opinions were very different for the Bokora dispensary (health unit A) and the Matheniko one (health unit B). Because health unit A did not maintain staff living quarters, the dispensary was an unreliable healing resource. Staff at this dispensary stated they could not live on the grounds because the fence did not enclose the entire property and there were successive cattle raids in the neighborhood. These security complications also restricted patient access because it was generally deemed too unsafe to walk to the dispensary before day-break. This has severe implications for emergency situations and is a very different scenario than those experienced at the Matheniko level III unit which took patients at any time. Third, mothers spoke about the discrepancy between free health centers and staff's insistence of collecting money for services. I asked mothers why they gave bribes. One woman said, "Sometimes the nurses say if you don't give them money they won't treat you. This is not good, but the sickness is what brings you to the hospital and nurses control the drugs. The hospital is to be free, but what can you do?" Tipping staff was most often noted at Moroto Hospital; however, I heard and witnessed staff at the Matheniko level III unit overcharging patients and withholding food relief.

Finally, mothers exhibited disgust and frustration when discussing abusive behavior of some biomedical staff. Women specifically spoke about Moroto Hospital's nurses who slap patients, initiate bribes, or cause drug stocks to run low. For instance, one mother stated, "They shout at people who bring patients in who are really sick or who have delayed. If it is a very severe sickness the staff will just tear up your health form and tell you to go away. This happened to me when my daughter was sick. I was slapped because they thought I had delayed and my child was about to die." I did not hear the same severity of comments pertaining to St. Kizito Hospital, nor the other two sub-county units, but one mother said she heard of St. Kizito nurses slapping patients, but never experienced it herself. In fact, discussions pertaining to St. Kizito Hospital were overwhelming positive with only one of twenty-seven comments suggesting St. Kizito Hospital would be better if it gave food relief. All other women responded this hospital had either good drugs or medical equipment, saves peoples lives, and did not need improvement. This is a stark contrast to the statements made regarding Moroto Hospital which were predominately focused on staff's corrupt and cruel behavior.

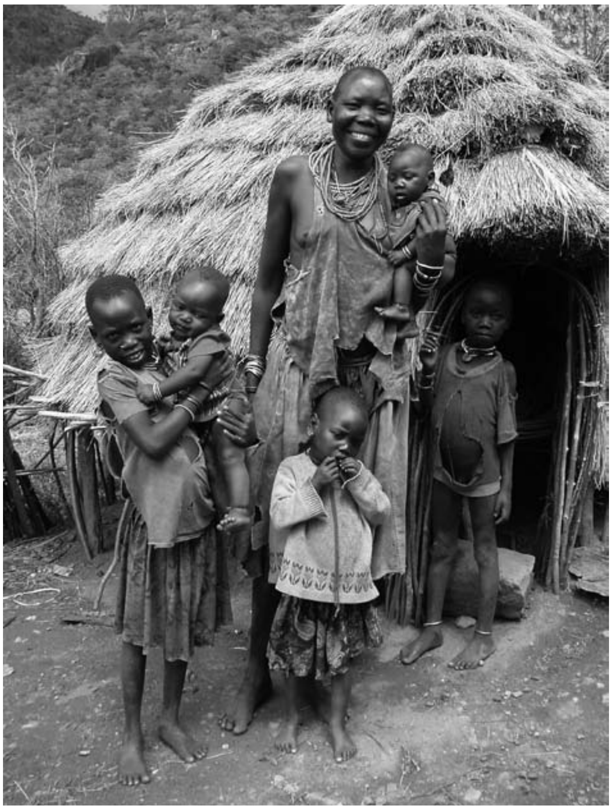

Fig. 1: Karimojong mother with her children

Overall, mothers believed the larger biomedical community, even at the "better" units did not respect Karimojong villagers. Although mothers feared retribution from biomedical staff for using local remedies this did not dissuade them from doing so. What is accomplished, however, is that mothers hid their local healing choices from biomedical staff or waited to take an ill child to the biomedical centers after all signs of local healing disappeared. Mothers related experiences in which biomedical staff simply denied services to patients who admitted to using indigenous methods. I will give one general example to illuminate this point. Karimojong typically remove children's un-erupted canine teeth as a curative measure in response to severe diarrhea and vomiting. Before removing the teeth, mothers use a myriad of other strategies including biomedicine. If the baby's symptoms persist Karimojong specialists remove the canine teeth. Because the wounds are left open and untreated, it is likely the baby will suffer from an additional illness; however, if this occurs, mothers admitted they avoided biomedical facilities out of fear. "They (hospital staff) don't like this and say 'why do you make a child suffer by cutting?' They can beat the mother and cause her pain because the mother caused the child pain". Mothers were adamant that biomedicine could not completely cure "false teeth," but was useful for treating other illnesses that may be affecting the baby at the same time or immediately after the false teeth were removed. But with the above scenario this avenue of healing is shut down because biomedical staff objective to the removal of "false teeth" rather than work with in conjunction with local practices.

Ending Thoughts

Mkutu (2007: 40-41) notes four reasons the Karimojong underutilize biomedical health facilities: cost; mandatory clearance from police for all injuries; precarious travel and long distances; and preferential use of local healers. During my interviews I found several of these reasons also given by Karimojong mothers. Considering these barriers, what is surprising is how much the Karimojong do rely on biomedicine; mothers repeatedly spoke about how all the biomedical units save lives and help their communities. However, biomedicine is not the sole healing method for the majority of Karimojong but healthcare programs in Moroto District do not acknowledge this fact.

The Karimojong are a marginalized group. During colonialism the Karamoja region was segregated from the rest of Uganda, creating few opportunities for Karimojong to travel outside designated zones. Karimojong today are subject to intense harassment. Once AK47s replaced spears for use in cattle raids, both Ugandans and foreigners alike became scared to travel in this region. Furthermore, biomedical facilities have difficulty staffing the most rural units and employ mostly non-Karimojong for the professionally trained positions. This point is essential to the relationship between nurses and patients with tensions between Karimojong and their non-Karimojong neighbors being expressed through the discriminatory behavior described by the mothers in this sample. Can the Karimojong get quality and comfortable health services from an historic enemy or from institutions which continue to define the Karimojong as primitive peoples?

By refusing indigenous methods, biomedical staff further perpetuate the stereotype that Karimojong ethnomedicine, and thus the Karimojong, are backward, and that indigenous medicine should be completely abandoned in exchange for Western-based methods. But, the Karamojong do not make such a simplistic statement by saying all biomedicine should be abandoned for local methods. In Moroto District, underutilization of biomedicine does not exist because the Karimojong are unaware or unwilling to use biomedicine. Karimojong mothers, and importantly local healers, are convinced that biomedicine is incredibly effective for certain healing strategies. Underutilization exists because the healthcare sector is unwilling to recognize the legitimacy of local healing. Discrimination also expresses itself in the abusive and corrupt behavior biomedical staff direct at patients who use Karimojong indigenous medicine. One must note, however, these are the same staff who also secretly visit Karimojong healers for treatment. So, nurses are berating, bribing, and beating women who utilize the same strategies for healing and both are forced underground – the mothers from fear of reprisal and the nurses from guilt of hypocrisy. These complexities are but some of the issues in my complete research on healing practices in Karamoja, and show that the devil of introducing external health strategies is certainly in the details.

References

Dyson-Hudson, N. (1966) Karimojong politics. Oxford: Clarendon.

Gray, S. J.; Akol, H. A.; Sundal M. B. (2007) Social and demographic effects of the crisis in Karamoja: A preliminary report. In: Uganda Journal 51: 15-26.

Gray, S. J.; Sundal, M. B.; Wiebusch, B. L.; Little, M. A.; Leslie, P. W.; Pike, I. L. (2003) Cattle raiding, cultural survival, and adaptability of East African pastoralists. In: Current Anthropology 44: 3-30.

Human Rights Watch [HRW] (2007) "Get the gun!" Human rights violations by Uganda's national army in law enforcement operations in Karamoja Region. Human Rights Watch.

Kizito, S. (2007) St. Kizito Hospital Matany annual analytical report financial year 2006/07.

Ministry of Health [MoH] (n.d.) The Republic of Uganda. www.health.go.ug

Mkutu, K. A. (2007) Impact of small arms insecurity on the public health of pastoralists in the Kenya-Uganda border regions. In: Crime, Law, and Social Change 47: 33-56.

Stites, E.; Mazurana, D.; Akabwai, D. (eds.) (2007) Out-migration, return, and resettlement in Karamoja, Uganda: The case of Kobulin, Bokora County. Medford, MA: Feinstein International Center.

Cultural Construction of Disease Risk: A Measure for the Social Reproduction of Health

Shawna Carroll Chapman

When you think of someone at risk for cardiovascular disease (CVD), what do you they look like? Are they obese or overweight? Do they eat fried food, smell like cigarette smoke, or alcohol? Is there something wrong with them beyond disease? In 2006 as President Bush launched the Healthier US Initiative, an initiative designed to improve health by encouraging Americans to make easy, small adjustments to prevent premature death, he declared, “Better health is an individual responsibility” (Bush 2007). Public Health interventions like this usually emphasize agency and responsibility over socio-structural factors also associated with disease (Farmer 2005: 149). And, as intended, this affects culture. Consider the words of a 42 year old cleaning women from Kansas City (KC) who describes someone at risk for CVD as, “someone who sits on their duff all day, does not eat right, and has it come back to haunt them”. But chronic conditions are not simply a matter of individual responsibility. Researchers recognize inequality is the most significant contributor to disease and CVD disproportionately affects the poor (Steptoe and Marmot 2004). It is unclear how this disjuncture affects people’s interpretations of disease, risk, and each other. Ethnographic research is underway in the KC Metropolitan Area to answer these questions through an assessment of how working women with and without health insurance culturally construct CVD risk. It incorporates anthropological theories on risk and hegemony into the theory of the Social Reproduction of Health (SRH) to determine if risk is a normalizing agent that legitimates disparity or if women resist because individual messages fail to fit within their everyday experiences.

Social reproduction is a theory that considers how groups, notably classes, reproduce the social structures and patterns that work to preserve their advantages from one generation to the next (Bourdieu 1977; Bourdieu and Passeron 1977; Meillassoux 1981; Foster 1995; Katz 2001). SRH combines this with analysis of how these structures perpetuate conditions of health and ill-health through consideration of how commitment of resources to relationships, institutions, and support organizations directly or indirectly affect health (Janzen 1992: 173; 154; Feierman and Janzen 1992; Janzen 2001). The distribution of health resources depends on how societies assign value to the lives of their members. Since the drafting of the United Nations Declaration of Human Rights, the idea of healthcare for all has become deeply woven into the social fabric of many Western countries’ cultural identity, but even within these variation exists in regards to who is thought worthy of care (Becker 2007: 302). This is because the right to care depends on one’s status as a cultural citizen, determined from how attributes fit dominant ideological beliefs about what is normal (Ong 1996: 737-738; Appadurai 2006). Those who do not fit a society’s picture of itself are a threat to the system (Appadurai 2006). In the West, access to health resources is controlled by cultural citizenship and predicated on ability to obtain health insurance. Thus those who have insurance are acceptable and worthy (Becker 2007: 303).

The US ideal says people are worthy simply because they exist (Quebedeaux 1982: 141). In reality worth assignation is more complex. Terms of cultural citizenship are more strictly defined here than in other nations evidenced by how health insurance is distributed (Becker 2007: 304). Those most threatening to a dominant ideology rooted in equality are those unable to escape poverty and insurance distribution is primarily based on type of employment and income (Kuttner 2005: 99). While 71 percent of the 47 million Americans (15 percent) without insurance come from families where at least one person works full time, 36 percent of those 47 million fall below the Federal poverty line and an additional 29 percent are low income (KFF 2007: 1, 4). When associated with insurance, this marginality becomes a bio-political divide that allows the worthy to live lives "managed with the goal of enhancement", while those not worthy are allowed to die (Becker 2007: 300).

This divide is socially incorporated into the norms that define citizenship and are legitimated through risk, a cultural construct often seen as natural even though things identified as risks are socially selected based on how dangers affect valued cultural institutions (Douglas 1992: 29). Medical descriptions of risk deny social responsibility in its creation and replace features of social identity with risk markers that blame individuals for their disease (Sobo 1995: 13f.). In this way, risk defines normal, pressures people to conform, and forces them to act as self regulating agents in such a way that current social use of risk is comparable to past social use of sin (Douglas 1999: 284-309; 1992: 29; 1990: 7; Cartwright and Thomas 2001: 219). This turns disease burden into an individual characteristic and makes the unequal allocation of health resources morally acceptable (Fassin 2007). Risk is thus tied directly to the moral economy and is not only about the production of health, but also the production of indifference (Fassin 2005: 365f). The medical system presents risk this way, but people's daily experience with risk and disease are interwoven with their spirituality, events related to their socio-economic status, family dynamics, and more. Many studies consider disease narratives to understand how social structures influences disease, but few use them to understand how these same structures influence the cultural construction of risk.

Methods

I am in process of conducting a multi-site ethnographic study focused on insured and uninsured working women in KC to compare their CVD and CVD risk models. KC is a nine county area that straddles the border of Kansas and Missouri. It was selected as a research site due to a strong history in the promotion of women's heart health. It was home to the first woman's cardiac center in 1994 and the national Heart Truth Campaign[1] was launched here in 2003 (MARC 2003). In 2006 KC's estimated population was 1,967,405 (US Census Bureau 2007). In 2004 11 percent lacked health insurance (Elwell et al. 2006: 4f.). Choice of specific KC locales is based on average annual income by zip code and percent of uninsured persons by county cross-referenced so areas provide the greatest potential to meet working, uninsured women (Cover the Uninsured 2004: 5; Elwell et al. 2006: 405).

The study began February 1, 2008. Study areas visited so far are Tonganoxie, Leavenworth, and Kansas City, KS and Kansas City, MO. Ethnographic sites within each area include: coin laundries, hair salons, cafes, community centers, libraries, and mechanic waiting rooms. Site visits generally last for several hours. While at each site, I take photographs and notes of objects associated with CVD or CVD risk such as: ashtrays, exercise equipment, public health posters, and pharmaceutical ads. I note specific attitudes and behaviors towards these items or people present who are engaged in known risks. I also interview women in an unstructured format and, for the purposes of this paper, have conducted six semi-structured interviews with women using a preliminary question protocol developed to elicit narrative responses.

Four of the women interviewed had insurance. Two did not. One interview, with an uninsured woman, was conducted in Lawrence, KS located 14.3 miles from Tonganoxie. It is included here for discussion and will be removed from later analysis, but does not differ markedly from other interviews. Five of the women interviewed were Caucasian and one African American. Ages ranged from 31 to 44 years with a mean age of 36.5. One participant had a Master's Degree, one a Bachelor's, the other four indicated some college with one still working on her BA, two leaving school after two years (both to have children), and one with only a semester. There was variation in women's professions, but they primarily included service work from general office duties to tailoring.

Scratch notes were taken in the field and field notes recorded immediately upon leaving it (Emerson et al. 1995). Interviews were: recorded, transcribed, divided by insurance status, and analyzed separately for comparison. Women's interviews were reviewed specifically for themes or the topics that appeared most often (Becker 2007: 306 citing Kaufman 1986).

Women's Experience with CVD

There was a great deal of variation in conditions women associated with CVD. Two, both insured, identified CVD as a respiratory problem or something that interfered with a person's ability to breath. Two, also both insured, indicated it referred to heart attack. Two women, both uninsured, initially identified CVD as high cholesterol. References appeared to relate primarily to women's experiences. Of those who identified CVD as a respiratory problem, one was a smoker and one's father was a heavy smoker diagnosed with CVD. Of the two who identified it with heart attack, one had a grandmother who passed away from a heart attack. The other had an uncle that had survived a heart attack. One of the uninsured woman indicated her sister and father both had a high cholesterol diagnoses. The other talked about an ad for pharmaceuticals she had seen several times on Television.

Risk Narratives

Women's descriptions of persons at risk for CVD were morally charged. They initially focused on someone lazy, out of control, and visibly obese. Descriptions varied based on women's reference points. Two women actually referred to their own bodies as indicative of a dangerous size, but both were quick to remove themselves from the risk category through explanations of the measures they were engaged in to reduce their weight. As one woman said, "I'm on the downsizing thing." All women indicated it was an issue of personal responsibility and control. As a 33 year old office worker said, "Someone out of control who can't take responsibility for them-self."

The most predominant themes that occurred throughout women's risk narratives were heredity, eating bad or fatty-fried foods, and cigarette smoking. Meaning of heredity varied. Two women used it to refer to learned habits, or as a 37 year old African American hair-dresser said, "There are lots of Black people whose parents who had diabetes, they get diabetes, their parents had heart attack, they get heart attack, stroke cause it's the same eating habits that get passed on, passed on, passed on." The other women associated it with genetic predisposition.

When asked to explain heredity, two women revised their descriptions of someone at risk for CVD to include persons with bad genes, which was not visibly evident. This did not reduce moral connotations, however, as one woman said, "You can still work to fix what you've got. Those are your cards, so you deal with it."

Identified foods were based on background. They included foods women or their families ate and ranged from chitlins to McDonalds. All except one, who abstained for religious reasons, said they indulged in a limited way. They often emphasized their control over the times they ate these foods saying "it was a treat" or "special occasion."

Three women were never smokers. Two were former and one was an active smoker. While all of them indicated smoking increased risk, neither former smoker said it was the primary reason they quit. Both talked about the "nasty" smell, about being stigmatized or treated like "second-class citizens," and loss of prestige associated with their smoker status. The active smoker had no desire to quit and insisted it was an important individual right.

Differences in Model

The sample is too small to make conclusive comparisons, but there were notable differences between insured and uninsured women's models. Uninsured women described a complex web used to obtain health information and services. They sought information from the internet, health fairs, doctors, nurse hotlines, health pamphlets, the news, talk shows, family, friends, and both spontaneously recited the commercial for a cholesterol lowering medication. Insured women referred to family members, friends, doctors, the news, and talk shows. Uninsured women's views of causation were also considerably more robust and included more risks. Both women identified stress as a risk. One prioritized it as the most important and referred directly to stressors in her life as the kind of stress that was detrimental. The other included it as the third most important. She also talked about stressors in her life that were detrimental including the stress of not having ready access to health care.

> "It's really scary sometimes. You don't know what to do. They say go to the emergency

> room. Everyone says, oh the uninsured, they get care at the ER, but you can't go to the emergency room really cause they won't let you in unless you're about dead. And being sick. I don't know. Sometimes you just don't know what's wrong and you just want to know. Is this going to go away?"

With a strong family history of CVD, she also found her potential genetic risk for this condition problematic. She told a story about making an appointment for a cholesterol test when her younger sister was diagnosed with extremely high cholesterol, but admitted even though her sister gave her the money she was unable to go through with it. She explained the decision was better for her because if she had the condition there was nothing she could do about it, but worry.

> "What was I gonna do if it came back positive. I couldn't afford the medicine. She (her sister) pays like a couple hundred dollars a month and has insurance. I already work out and stuff. It isn't worth it. The stress of just having it would kill me."

Based on the data collected thus far, individualized health messages influence women's interpretations of each other, but do not significantly affect their interpretations of themselves or cause women to alter their behavior. Women are able to internally rationalize or justify their behaviors and explain how they counteract those associated with poor health to negate their risk. The stigmatization created by messages can cause women to alter behavior, as in the case of the smokers in the study, but how effective this is depends on women's existing place in the social hierarchy. For example, both former smokers were white, from two parent families where both parents had college degrees, and one had a Master's while the other was actively pursuing her BA. The active smoker was also white, but came from a family where no one had attended college. She had briefly tried a semester, but found it was not for her. When we talked she also indicated working two jobs, one as a clerk and a second as a cocktail waitress. It is possible the negative stigmatization felt by the former smokers was unaccustomed, but something the active smoker dealt with regularly.

Conclusion

While research remains preliminary, these results are suggestive. Women incorporate individual health messages into the lexicon they use to construct reality. Risk is a normalizing agent women use to judge what is socially acceptable, but only in terms of other people. How this affects their health behaviors and their social interactions remains unclear, but I look forward the information future narratives will provide.

Note

[1] The Heart Truth Campaign is a national campaign to raise women's awareness of CVD and is sponsored by the National Heart, Lung, and Blood Institute, a division of the National Institute of Health.

References

Appadurai, A. (2006) Fear of small numbers: An essay on the geography of anger. Durham: Duke University Press.

Becker, G. (2007) The uninsured and politics of containment in US health care. In: Medical Anthropology 26: 299-321.

Bourdieu, P. (1977) Outline of a theory of practice. Cambridge: Cambridge University Press.

Bourdieu, P. and Passeron J. C. (1977) Reproduction in education, society, and culture. Beverly Hills: Sage.

Bush, G. (2007) President outlines health and fitness initiative at White House fitness expo. Speech delivered on June 20, 2002.
URL: www.whitehouse.gov/new/releases/2002/06/20020620-2html. (December 2, 2007).

Cartwright, E. and Thomas J. (2001) Constructing risk: Maternity care, law, and malpractice in birth by design. In: R. De Vries, C. Benoit, E. van Teijlingen, S. Wrede (eds.) Birth by design: Pregnancy, maternity care, and midwifery in North America and Europe. New York: Routledge, 218-228.

Cover the Uninsured (2004) Health care coverage in America: Understanding the issues and proposed solutions. Washington DC: Alliance for Health Reform.

Douglas, M. (1992) Risk and blame. London: Routledge.

Douglas, Mary. (1999) Implicit meanings: Selected essays in anthropology (second edition). London: Routledge.

Douglas, Mary (1990) Risk as a forensic resource. In: Daedalus 119: 1-16.

Elwell, D.; Morgan, G.; Greene, S. (2006) Kansas City metropolitan health access policy assessment final report. Kansas City: Health Management Associates. URL: http://www.marc.org/gif/HMAFinalReport.pdf (July 10, 2007)

Emerson, R.; Fretz, R.; Shaw, L. (1995) Writing ethnographic field notes. Chicago: University of Chicago Press.

Farmer, P. (2005) Pathologies of power: Health, human rights, and the new war on the poor. Berkeley: University of California Press.

Fassin, D. (2005) Compassion and repression: The moral economy of immigration policies in France. In: Cultural Anthropology 20: 362-387.

Fassin, D. (2007) The politics of life: Beyond the anthropology of health. In: F. Saillant and S. Genest (eds.) Medical anthropology. Regional perspective and shared concerns. Malden: Blackwell, 252-266.

Feierman, S. and Janzen J. (1992) The social basis of health and healing in Africa. Berkeley: University of California Press.

Foster, R. (1995) Social reproduction and history in Melanesia. Cambridge University Press: Cambridge.

Janzen, J. (1992) Ngoma: Discourses of healing in central and southern Africa. Berkley: University of California Press.

Janzen, J. (2001) The social fabric of health: An introduction to medical anthropology. New York: McGraw Hill.

Katz, C. (2001) Vagabond capitalism and the necessity of social reproduction. In: Antipode 33: 709-728.

Kaufman, S. (1986) The ageless self. Madison: University of Wisconsin.

Kaiser Family Foundation [KFF]. (2007) The uninsured: A primer. Key facts about Americans without health insurance. The Kaiser Family Foundation. URL: http://www.kff.org/uninsured/ upload/7451-03.pdf. (November 20, 2007)

Kuttner, R. (2005) The American health care system: Health insurance coverage. In: J. Watson and P. Ovseiko (eds.) Health care systems: Major themes in health and social welfare. New York: Routledge, 97-107.

Mid America Regional Council [MARC]. (2003) Kansas City women are on red alert: Heart disease is killing more local women than any other illness. URL: http://www.marc.org/RedDress9-11-03.pdf. (July 5, 2007)

Meillassoux, C. (1981) Maidens, meals and money: Capitalism and the domestic economy. New York: Cambridge University Press.

Ong, A. (1996) Cultural citizenship as subject-making: Immigrants negotiate racial and cultural boundaries in the United States. In: Current Anthropology 37: 737-762

Quebedeaux, R. (1982) By what authority. San Francisco: Harper & Row.

Sobo, E. (1995) Choosing unsafe sex: AIDS-risk denial among disadvantaged women. Philadelphia: University of Pennsylvania Press.

Steptoe, A. and Marmot, M. (2004) Socioeconomic status and coronary heart disease: A psychobiological perspective. In: Aging Health and Public Policy: Demographic and Economic Perspectives. Supplement to Population and Development Review 30: 133-150.

US Census Bureau. (2007) Population change in the 100 metropolitan statistical areas with the largest numeric gain: April 1, 2000 to July 1, 2006. Washington DC: United States Census Bureau. URL: http://www.census.gov/PressRelease/www/releases/ archives /cb07-51tbl1.pdf. (April 16, 2007).

Witnessing Genocide: The Effects of Violence on Rwandan Children as Expressed Through Drawings

Sarah Sobonya

Introduction

Pacifique Kavuma is twenty-six years old now, if he is still alive. Although his name means peace, he has experienced more violence and upheaval than most of us will in a lifetime. He and his family feared for their lives as they fled from their home in Rwanda to a refugee camp in Zaire, ahead of the approaching Rwandan Patriotic Army (RPA). In this drawing (Fig. 1), he shows a huge RPA soldier with an enormous gun aiming at the plane of President Habyarimana, whose death triggered the 1994 Rwandan Genocide. Below the soldier's feet, tiny people carrying bundles on their heads flee, heading for safety in Zaire. This is Pacifique's story, as a witness to violence and a survivor of war. In this paper, I will attempt to both analyze the visual stories told by Pacifique and other child-survivors of this genocide and explain why they must be told.

Fig. 1: RPA soldier aiming at the plane of President Habyarimana (drawing by Kavuma Pacifique, 13 years)

The history of the Rwandan genocide begins not during the 1990s but over seventy years earlier, during the colonial period of first German and then Belgian control (Salem 2000). Privileges and leadership roles were awarded to Tutsis based on the colonizers' beliefs about this group's inherent superiority over the Hutus. Rwanda gained official independence in 1962, two years after a coup lead to Hutu leadership and death or displacement for many Tutsis. In 1973, another coup brought Hutu General Juvenal Habyarimana to power. Although Habyarimana made some attempts to increase cooperation between Hutus and Tutsis during the seventies and eighties, disenfranchisement and discrimination towards the Tutsis continued (Clark 2006). By 1990 somewhere between 500,000 (Janzen and Janzen 2000) and one million (Salem 2000) Rwandan Tutsis had been displaced and were living outside of their country. In an effort to return to their homeland and regain political power, a group of Tutsi exiles in Uganda created the Rwandan Patriotic Front (RPF) in 1987. When Habyarimana bowed to international pressure in August of 1993 and signed the Arusha Accords, which ensured the right of return and government representation for Tutsi refugees, he enraged many radical Hutu groups, who began forming militias known as the Interahamwe.

On April 6, 1994, Habayarimana's plane was shot down as he returned home from Tanzania, sparking a massacre of Tutsi men, women, and children, as well as the murder of United Nations peacekeeping forces and of Hutus who refused to murder Tutsis (Salem 2000). The Rwandan Patriotic Army (RPA), the military force of the RPF, entered the country from the north and after 100 days of fighting finally subdued the Hutu militants, killing thousands and driving over 100,000 more across the border into Zaire (now DR Congo). Although some of the Hutus killed or exiled had been active participants in the genocide, many others had not (Clark 2006).

During late 1994 and early 1995, Dr. Reinhild Janzen and Dr. John Janzen spent two months as relief workers with the Mennonite Central Committee, working in Rwanda, Burundi, and Zaire (Janzen and Janzen 2000). Their mission was to listen to survivors of the Rwandan genocide – Hutu and Tutsi, as well as foreign nationals who had been caught up in the violence –

and give voice to their stories. Dr. Reinhild Janzen, currently a professor of art history at Washburn University and then an assistant professor, brought with her a collection of crayons, markers, pencils, and paper and invited both Hutu and Tutsi children to draw about their experiences.

This paper will discuss and interpret 54 of these drawings. Twenty-five were created by fifteen unaccompanied children, ranging in age from 5 to 15, who were living at a refugee camp in Bukavu, Zaire. The other 29 were drawn by 29 different children of approximately the same age who were living with their families at Camp Mushweshwe, southwest of Bukavu. All of the children at Camp Mushweshwe were Hutu. Both Hutu and Tutsi children live at the camp in Bukavu, but the subject matter of the drawings selected for this study suggests that all were created by Hutu children as well.

The Bukavu drawings were produced over the course of three afternoons, and Dr. Reinhild Janzen was present during their production. One group of children was instructed to draw about their homes and families in Rwanda on the first day, and on the next was asked to depict their journey to Zaire. A second group of children at this camp drew once, and was asked only to show their journey.

Children living at Camp Mushweshwe created the drawings during their school hours, under the direction of their teacher. Dr. Reinhild Janzen provided the teacher with art materials and asked him to invite the children to share their experiences through this medium. Many of the children saw their assignment as a kind of visual correspondence to their peers in America and created a linear progression of drawings detailing their stories.

Review of the Literature

These drawings embody an intersection of art and violence, and their interpretation draws on anthropological theory from both realms. A number of recent researchers have studied artwork as visual communication, with many spotlighting children's drawings. Williams and Bendelow (1998) asked children with cancer to draw about their illness, and then analyzed the drawings to better understand the children's conceptualizations of their bodies and their cancers. Geissler (1998), as part of his work on intestinal parasites with the Luo people of central Kenya, asked children to draw body maps and images of worms. Mitchell (2006) discussed the use of children's drawings in her research with children living in an impoverished region of the Philippines and Stockrocki (2006) used participant observation and drawing to identify the meanings of different socio-cultural influences on children in Brazil.

The anthropology of violence is a growing field within medical anthropology, and many researchers have written specifically about the effects of war and genocide. In her 2000 article about violence in Sri Lanka, Reynolds described oracles in the war zone who embodied the pain of silenced families. Reynolds also addressed the effects of state violence in South Africa on the family unit, particularly children. A few years later, "Annihilating difference: The anthropology of genocide" (Hinton 2002) reflected anthropology's interest in this ultimate manifestation of state violence. Although this anthology reflected a number of different perspectives, a core paradigm was that anthropology must now include a concern for human rights.

Das (2007) explored "everyday" violence, reconceptualizing violence not as an interruption of ordinary life but as part of it. Rather than conceptualizing people as witnessing violence and moving beyond it, in Das' analysis violence shares time and space in the ordinary life of the sufferer. Das also looked at the state and its place in violence, closing with a statement on the ethics of responsibility and the importance of witnessing truths and exposing official lies.

Methodology

In writing about the semiotic analysis of art, Shapiro states that although elements in art may exhibit iconic or indexical character, "the central relation of an art-sign to its object is … symbolic" (1974: 35). Because the objects of human-made art-signs are necessarily human experiences or intentions, the signs cannot be necessary or natural but must instead be symbolic. Their interpretation, then, is a search for interpretant or continuum of interpretants, rather than for the real object represented by the art-object.

Hanson (1983) sees the art created by a culture as a "map" of the structural principles that underlie a culture. I believe that these drawings are a map of the violence experienced by the children who created them, and I sought to identify the symbolic meanings of some of the art-signs repeated frequently in their drawings. Using the method described by Hanson (1982), I began by gathering data. I made color copies of the drawings and pile sorted them according to a number of categories. Through this process, I was able to discover some key redundant elements in many of the drawings. I also gathered information on Rwanda culture and the Rwandan genocide, which allowed me to understand some of the events these children probably saw and experienced. The interpretations I offer for three of the key signs in these drawings are consistent with the available data and with current theory about the effects of violence.

Discussion and Results

The Shooting of Habyarimana's Plane

Sixteen of the 44 children in this sample (nine from Mushweshwe and seven from Bukavu) drew an airplane that iconically represents President Habyarimana's plane as it was shot down from the sky. Some of the drawings show the plane being hit with bullets, or dripping red dots of blood (Fig. 2). Others show men with guns simply aiming at the plane. A few label the plane in their drawings in French, captioning it as *avion du presidentielle* (the presidential airplane) or *mort du president* (the death of the president).

Understanding the iconic character of the airplane as an art-sign allows us to understand its symbolic meaning. The airplanes in the drawings vary greatly in their actual physical characteristics. They are yellow, pink, blue, purple, and many more colors, including green camouflage (Fig. 3). Some resemble helicopters, while others look like jumbo jets. It is probable that none of the children ever saw the airplane in question, even in a photograph, and many may not even have a clear idea of who the president was – such would certainly be true of many American 6 year olds today. Therefore, I believe that the intention behind the drawings of the airplane was not communicate the death Hutu children, the violence they experienced most directly was not the initial massacre by machete-wielding Interahamwe fighters, but rather the bloodshed caused by RPA soldiers armed with machine guns who came in from Uganda and took control of the country. Although it seems likely that at least some of these children witnessed or knew about the first wave of killings, they did not include this as part of their visual story. Instead, they drew RPA soldiers, often labeled as "Inkotanyi", a Kinyarwanda word for "warrior" that was used by the Hutu to describe the RPA soldiers (Fig. 4).

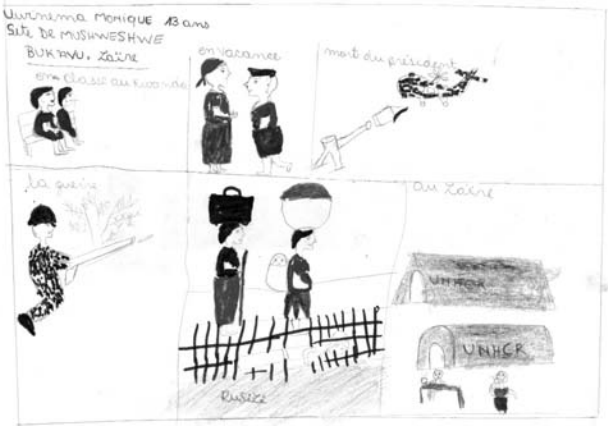

Fig. 3: Monique has to flee her home (drawing by Uwinema Monique, 13 years)

In many of the drawings, the soldiers were structurally different from other people. Some children drew the soldier figures as much larger than other people in the drawing. Others used color to distinguish them. In this picture (Fig. 5), the four other people in the drawing are simply sketched with a ballpoint pen, while the RPA solider is fully colored in brown, orange, and black, making him seem more solid and more "real" than the other figures.

Symbolically, then, the "Inkotanyi" figures communicate the violence and terror experienced by the children. Although the soldiers themselves were terrifying, in the drawings they represent not only themselves, but also the entire nightmare-world into which the children were thrust, the world in which they felt small and insubstantial.

The Bridge

Eleven of the Mushweshwe children and two of the Bukavu children drew the bridge across the Ruzizi River, which forms the border between

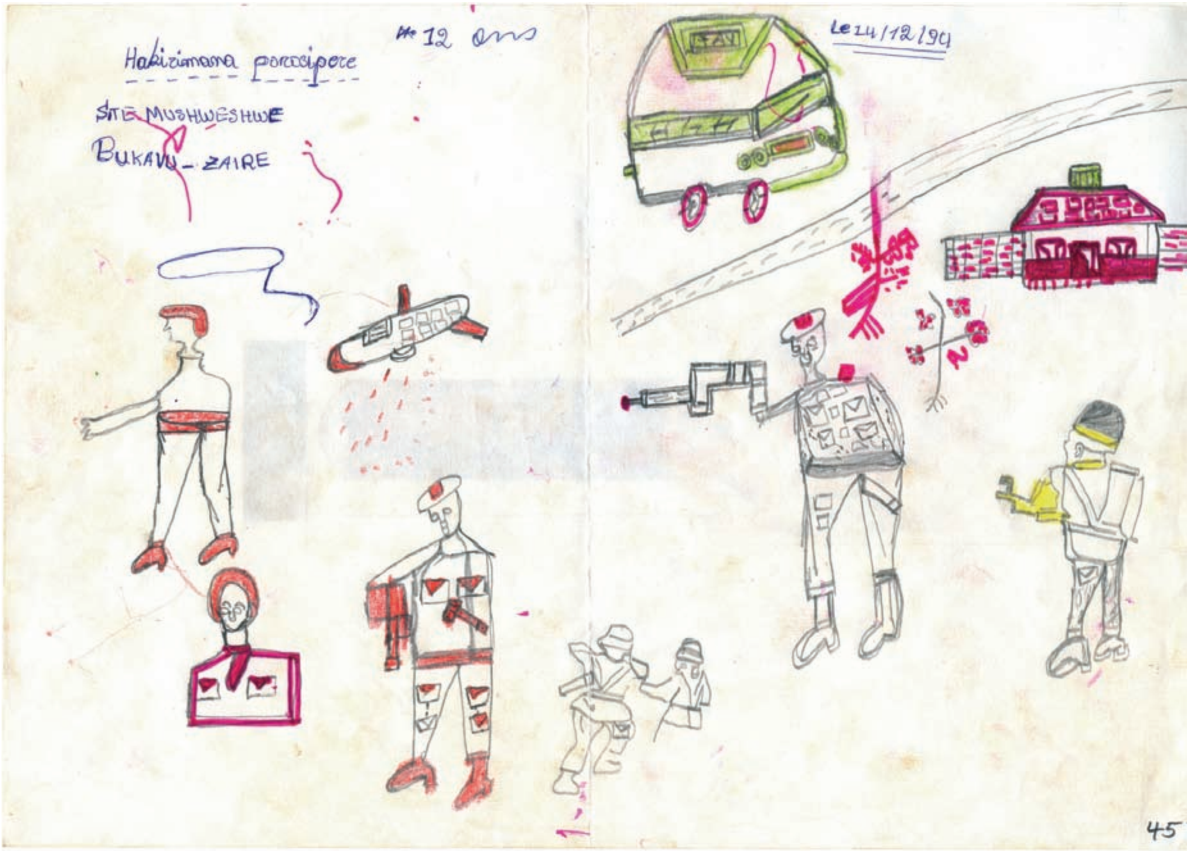

Fig. 2: The shooting of President Habyarimana's plane (drawing by Hakizimana Porosipere, 12 years)

Fig. 4: 4 RPA soldiers, often labeled as "Inkotanyi", armed with machine guns (drawing by Twagirayezu, 13 years)

Fig. 5: The RPA solider is fully colored in brown, orange, and black, making him seem more solid and more "real" than the other figures (drawing by Nsanzimana Phirbert, 15 years old)

Fig. 6: Soldiers aiming guns at travelers and military vehicles shooting at houses. On the Zaire side of the bridge, the refugee camp is a peaceful, orderly collection of blue tents. (drawing by Rutacengwa Yves)

Rwanda and Congo. Many of the children left Rwanda by crossing this bridge, although some also arrived by boating across Lake Kivu. In many of the drawings the bridge is positioned in the center of the drawing, creating a clear line between the children's old lives in Rwanda and their new lives in the refugee camps.
In some drawings the Rwanda side is a chaotic scene, with soldiers aiming guns at travelers and military vehicles shooting at houses (Fig. 6). On the Zaire side of the bridge, the refugee camp is a peaceful, orderly collection of blue tents. Other drawings contrast an idyllic life in Rwanda with current life in the refugee camp. Rwanda, in these drawings, is a place of sunshine and flowers, while the camp is a sterile collection of tents, with tree-covered hills visible in the distance.

Just as the real bridge marked the transition from Rwanda to Congo, the bridge in the drawings represents the line between the children's old life and their current one, as refugees in a foreign place. Symbolically, the bridge allows some of the children to leave the pain and violence they suffered behind, and to find safety on this side of the bridge. To others, perhaps those who were less directly affected by the violence in Rwanda, the bridge marks their separation from their old ways of life, in their own homes. To both groups, however, the bridge marks the separation between the old and the new.

Conclusion

In writing about survivors of ethnic or communal violence, Das (2007: 60f.) describes how they were "able to both voice and *show* the hurt done to them as well as to provide witness to the harm done to the whole social fabric – the injury was to the very idea of different groups being able to inhabit the world together". These drawings provided a vehicle for child-survivors to voice their own pain and show their experiences, and most importantly, to act as witnesses and tell their stories.

If anthropology is to be concerned with human rights and human suffering, we must understand the importance of listening to this witnessing. Children often "speak" more easily through actions, such as drawing, and we can also "listen" by examining their drawings and trying to understand them. The use of art as a way to understand children's experiences of violence is a methodology that shows promise, and future research in this area may provide new insights, as well as benefits to child survivors of violence.

References

Clark, J. F. (2006) Rwanda: Tragic land of dual nationalisms. In: L. W. Barrington (ed.) After independence: Making and protecting the nation in postcolonial and postcommunist states. Ann Arbor: University of Michigan Press, 72-106.

Das, V. (2007) Life and words: Violence and the descent into the ordinary. Berkeley: University of California Press.

Geissler, P. W. (1998) "Worms are our life", part II: Luo children's thoughts about worms and illness. In: Anthropology and Medicine 5, 2: 133-144.

Hanson, F. A. (1982) Method in semiotic analysis; or, how the Maori latrine means. In: F. A. Hanson (ed.) Studies in symbolism and cultural communication. Lawrence, Kansas: University of Kansas Publications in Anthropology (14), 74-89.

Hanson, F. A. (1983) When the map is the territory: Art in Maori culture. In: D. K. Washburn (ed.) Structure and cognition in art. Cambridge: Cambridge University Press, 74-89.

Hinton, A. L. (ed.) (2002) Annihilating difference: The anthropology of genocide. Berkeley: University of California Press.

Janzen, J. M., and Kauenhoven Janzen R. (2000) Do I still have a life: Voices from the aftermath of war in Rwanda and Burundi. Lawrence, Kansas: University of Kansas.

Mitchell, L. M. (2006) Child-centered? Thinking critically about children's drawings as a visual research method. In: Visual Anthropology Review 22, 1: 60-73.

Reynolds, P. (2000) Oracles in Sri Lanka's eastern war zone. In: V. Das, A. Kleinman, M. Ramphele, P. Reynolds (eds.) Violence and subjectivity. Berkeley: University of California Press, 141-170.

Salem, R. A. (2000) Witness to genocide, the children of Rwanda: Drawings by child survivors of the Rwandan genocide of 1994. New York: Friendship Press.

Shapiro, G. (1974) Intention and interpretation in art: A semiotic analysis. In: The Journal of Aesthetics and Art Criticism 33, 1: 33-42.

Stockrocki, M. (2006) Searching for meaning: Visual culture from an anthropological perspective. In: Art Education 59, 1: 46-52.

Williams, S. J. and Bendelow G. A. (1998) Malignant bodies: Children's beliefs about health, cancer and risk. In: S. Nettleton and J. Watson (eds.) The body in everyday life. New York: Routledge, 103-123.

Liminality and Structural Violence in the Guatemalan Maya Experience of Anemia

James W. Herynk

Preface

This paper is about a severely malnourished Maya community in Guatemala. I provide a biological and cultural snapshot of this experience. I will use the concepts of structural violence and liminality to show how health and illness are experienced by the individual. First, however, I want to provide the image of a person in a wheelchair. A person in a wheelchair trying to enter a building with no ramp is an accurate analogy for understanding structural violence. It is a structure in the most literal sense that prevents the normal human action of entering a building. It is a barrier to entrance, status, admittance, incorporation, and socially defined acceptable meaning. Structural violence, however, only explains the situation, not the experience. Liminality offers a means to understanding moments of interstructural positioning or moments apart from normally meaningful structures explicit to the individual contextualized in culture. Liminality captures the symbolic world that refers to structure and meaning of the inaccessible building from a distance. It systematically grasps the lived experience of the individual living in a wheelchair within a culture that does not allow him or her into the building.

Murphy et al. (1988: 238) write that "[p]eople who live in wheelchairs are painfully aware of the fact that when they are out in public, they are given wide berth by the able bodied, who shy away from their chairs as if from a pox." Murphy et al. also note that their condition makes those around them act as if contagion were a threat, a clear example of Mary Douglas's notion of matter out of place, or pollution (Douglas 1994). Murphy et al. point to another phenomenon experienced by the disabled. "All users of wheelchairs know that when they are in public places, they are commonly noticed by everyone and acknowledged by nobody" (ibid.: 238). Consequently, they are "treated to the paradox of nobody 'seeing' the one person in the room of whom they are most acutely, and uncomfortably aware" (ibdi.: 235). It is hard to imagine a more antisocial or violent human behavior than denying another's existence. In reading this paper, ask yourself if you are merely looking at the image of the person in front of the building, or, can you grasp the experiences held in their thoughts?

In order to better grasp this relationship of illness as experienced by the individual in relation to their surroundings, social scientists must look at disease as structural violence and social inequality. We need to examine the illness a population comes to bear as manifest within the community as well as the context beyond it. Illness embodied in the individual is a richly symbolic world. If the concept of structural violence represents exclusion from meaningful status and structure that produces a slow systemic death, then the study of disease and illness using liminality as a tool can analyze and isolate the specific source of violence as reported by individuals and aggregated from the population. In this paper I examine anemia, which can best be understood through its heavy cultural component. The model of this research is applicable to similar ambiguous illness where aspects of causes and symptoms are neglected or misunderstood within a society. In the United States we may examine illnesses such as obesity, overnutrition, asthma, sexually transmitted infections, attention deficit disorder, drug and alcohol abuse, depression, stress, or a number of other illnesses in this way.

Introduction

The municipality of Tamahú is located in an isolated valley in Guatemala's Central Highlands accessible only by 4-wheel drive. The valley is actually a deep fault line bordered by steep mountains that divides the North American Plate from the Caribbean Plate. A one lane road of eroded gravel begins at the mountain pass entering the valley and follows the accumulating waters of the Polochic River all the way to Caribbean coast. Along this often-impassable road through the Polochic Valley live both Poqomchi' and Q'eqchi' Maya. The relative distribution of population in the villages and power in the town immediately points out systemic inequalities. There are 12,000 people living here, with 1000 people in the main town of Tamahú and the remaining majority who live in 26 surrounding villages. Most individuals living in the main town consider themselves indigenous. The vast majority's first language is either Poqomchi' or Q'eqchi'. Despite an indigenous majority, possibly over 90 percent, they hold few institutional positions of power.

Dozens of foot paths ascend the slopes of the valley to the small communities of 25 to 200 families. Little is known about the population of this region, especially what lies along the honeycomb of trails. As the smallest municipality in the country, Tamahú is at the bottom of the list in terms of political importance. Most travel books actually recommend avoiding Tamahú. The Peace Corps has forbidden its volunteers from entering the region. The geographical and political neglect have been detrimental to the health and well being of the population. Its rates of infant mortality, malnutrition, and fertility are some of the highest in Latin America reflective of the fact that it was left decades behind in terms of development. Anemia, a form of malnutrition, is the most prevalent indicator of this neglect. In this paper, I present preliminary research and analysis on anemia from both a biological and cultural perspective.

Anemia: Definition and Symptoms

Anemia is defined as an abnormally low level of healthy red blood cells which supply oxygen to the organs. It is measured by examining blood samples and counting a molecule inside the red blood cells called hemoglobin. The shape and size of the red blood cells also indicates the type of anemia (Wardlaw et al. 2004). The symptoms of anemia are numerous and pronounced, as well as complex and elusive. The condition significantly impairs cognitive development, growth, and general well being of the afflicted (Fig. 1). It increases susceptibility to all other diseases, in particular respiratory infections such as tuberculosis, the leading cause of mortality in Guatemala. The anemic individual is pale, sallow, and appears disheveled. The sufferer of anemia has an acute awareness of the pulse and the beating of one's heart; one feels fatigued, faint, and succumbs to a series of inabilities (e.g. to work, to walk, to lift, to sleep, to eat, to focus etc.). Mentally, anemic individuals may appear debilitated with slowed cognitive abilities, light headedness, frequent vision of floating lights, and constant headaches. Its victims are irritable and fearful of the world around them and remain reserved and withdrawn; they appear irrational when they do step forward. Ultimately, both the development and function of the mind and body are compromised due to a lack of oxygen (Herynk 2006). I focus on what it is like to be anemic in light of the following extensive list of symptoms (Fig. 2).

Fig. 1: Extremely anemic three year old girl in a regional hospital

Symptoms of Anemia

- angina pectoris (chest pain, often accompanied by a choking sensation that provokes severe anxiety
- cravings for ice, paint, or dirt
- headache
- inability to concentrate, memory loss
- inflammation of the mouth (stomatitis) or tongue (glossitis)
- insomnia
- irregular or rapid heartbeat
- loss of appetite
- nails that are dry, brittle, or ridged
- rapid breathing
- sores in the mouth, throat, or rectum
- sweating
- swelling of the hands and feet
- thirst
- tinnitus (ringing in the ears)
- unexplained bleeding or bruising
- problems with movement or balance
- tingling in the hands and feet
- confusion, depression, and memory loss
- damage the spinal cord
- weakness
- fatigue and listlessness
- shortness of breath
- faintness or dizziness
- pasty, sallow, and pallid skin
- does not want to work
- cannot walk
- does not want to bathe
- tingling in the legs
- see stars
- poor vision
- fearfulness
- lack of color in palms, gums, nails, and eyelids
- stand-on-end-hair
- puffy eyes in the morning
- irritability
- brittle nails

Fig. 2: Symptoms of anemia (adapted from Blanchfield and Longe 2002; Herynk 2006)

Past Research

Prior to starting my PhD at the University of Kansas, I worked in Tamahú and its many villages in agricultural and food procurement projects and as a medical translator. I gained a strong sense of the symptoms and suffering experienced by the local people for whom I translated and families with whom I worked with on farming techniques. Through this practical involvement, I was able to gain confidence of and access to the highly guarded villages. In a later work season to follow up on agriculture projects, I conducted focus group interviews to get a more systematic understanding of how the people of the region talk about illness. In my preliminary dissertation research, I focused on figuring out what has caused such widespread anemia. I constructed a biological, environmental, and behavioral profile of the disease including its prevalence. I also continued preliminary ethnographic inquiries in order to better frame my future research on the experience of anemia.

Anemia: Prevalence and Etiology

The World Health Organization estimates that over two billion people worldwide suffer from anemia (WHO/UNICEF 2004). In Guatemala, anemia is the leading cause of morbidity (MSPAS 2001). In the village of Onquilha', where my research is based, I found that 74% of the population is anemic (N=140 and hemoglobin levels < 12 g/dl): 100% of children, 78% of women, and 43% of men (Herynk 2006). It is important to note that there is little research on nutritional anemias among men; within the biomedical community, it is as if it does not exist or it is discussed as a symptom of ulcers, cancer, HIV or other diseases. Among women, anemia accounts for 70 percent of illness and is the third leading cause of maternal mortality in the country; however, in Onquilha' with a fertility rate of seven (nationally 5.4) maternal mortality may be even higher (MSPAS 2001; Tamahú Health Clinic 2007). One doctor at a regional hospital told me, "Some women walking around here are so anemic that they should be dead … the walking dead" (Herynk 2006).

The symptomatology of this illness is complex, but so too is the biological etiology of the disorder. The biological, environmental, and behavioral profile of anemia breaks down into over 60 synergistically related variables; all with a significant role in its prevalence in this population. A multivariate model would be almost impossible; it is too complex for a classic biomedical causality model. I argue that the cultural investigation of anemia and illness in general requires a less quantitatively driven portrayal. My research into the sociocultural experience of anemia beckons a more general accounting of the variables that lead to illness, those variables that can be more consciously grasped in the human experience. Examples of these variables include: vitamin and mineral deficiencies, nutritional inhibitors, parasitic infections, blood loss, environmental and behavioral factors, and genetics, which compose the proximal causes and then there are the more distal or second tier of variables that are structural.

Structural Violence and Liminality

Despite the quantitative shortcomings, such a framework depicting chronic disease must be a backdrop for ethnographic research in such marginalized communities. In this precarious population of Guatemalan Maya, anemia inauspiciously controls the daily rhythm of life. The experience of anemia is thematically multifaceted and extremely detrimental to health and well being. Community members' consequent healthcare activities parallel and often translate into an equally complex language of suffering. Early colonial patterns of subjugation and slavery, arguably, laid the ideological framework for the current situation in Guatemala (Nelson 1999; Thompson 2001; Warren 1978). As stated earlier, I argue that anemia reflects structural violence or exclusion from meaningful and useful structures, resulting in pervasive liminality surrounding the experience of chronic and ubiquitous anemia (Farmer 2003; Janzen 2002; Turner 1968).

Let us return to the image of the person in a wheelchair. Liminality is crucial to understanding illness because structural violence alone is not powerful enough as analysis to account for the depths of experience of one who lives in such a world. The individual in context is the unit of analysis when applying liminality. Basic methodologies for collecting data include narrative and discourse analysis collected from participant observation, interviews, surveys, and the plots of case studies. Situated narratives may be used to draw out the semiotics of redressive meaning. Other established tools include relationships of subjectivity and objectivity, subjunctive constructions of grammar and concepts, situational identities, alterity, embodiment, as well as the bifurcating social relationships seen in the social reproduction of health – where two extremes of one phenomenon, such as nutrition, exist in the same time and space (Biehl et al. 2007; Cohen 1998; Daniel 1996; Das 2007; Farmer 2003; Janzen 2002).

Analysis with liminality provides insight into the realm of "what is really going on" during the experience of illness. It may be used in a methodology for investigating situations where the mind or body assumes an abnormal identity, what we might broadly consider illness. Liminality's power is as a guide out of the quagmire of misunderstandings and miscommunicated notions that block empathy. Using liminality begins with the identification of the subject, i.e. the person. The next step is to identify in the language of the individual's narrative that which is in the subjunctive mood or what they say they are "not". A deeper understanding of the "not" position is found by looking at the symbolic meaning, imagery, metaphors, and objects or artifacts. Then these "not" situations can be isolated or aggregated to find themes and binary oppositions. This is what pinpoints the source of structural violence.

In a survey of liminality in health care, I found this concept used extensively and systematically in fields as widely varied as nursing, disability studies, gerontology, public health, occupational therapy, and a few examples of its application in medical anthropology. Examples of subjects that were illuminated by liminality include: treatment, therapy, disease in society, identity, chronicity, and physical/mental abnormalities. As a tool of analysis liminality is used to understand moments of experience found in illness narratives. The studies exposed themes such as a people's quest for healing and their entanglement with an ever more institutionalized secular society. Or, journeys into the ontological meanings of one's own suffering and a community's suffering as well as the need to invent meaning in context, ostracized from structure and status. Or, the need to constantly battle for a piece of perceived normality (Forss et al. 2004; Gardner 1988; Honkasalo 2001; Little et al. 1998; Mahon-Daly and Andrews 2002; Martin McDonald and Biernoff 2002; McGuire and Georges 2003; Molzahn et al. 2008; Navon and Morag 2004; Philpin 2007; Shomaker 1989).

Preliminary Findings

Preliminary ethnographic investigations have revealed anemia to be tied to several cultural constructions, most notably the use of the concept *fuerza*, or "force" in daily life. "Force" translates into one's general strengths and abilities, as determined by one's health. This notion is tied to understandings of having *mala sangre* or "bad blood". However this conceptualization includes other diseases and illnesses and is not exclusively tied to anemia (Herynk 2006).

The rapidly evolving village of Onquilha' gained its freedom from the plantation on which it is located only four years ago. My exploratory research there focused on four of the very few standing social institutions that appear to have resisted or evolved from continued subjugation: church, village council, households, and trails. The role of evangelical religious services and ceremonies are a crucial and powerful voice for normally quieted and subjugated emotions; it is a performance of social drama. Community meetings held on Wednesday evenings illustrate dynamic discussions of village politics and how community members cope with incursions of outsider postcolonial institutions. The households showed a marked resilience in finding strategic ways to procure food and health for the family using both communitarian and individualistic strategies. Along the trails people communicate information and rumor about events such as births, deaths, threats, lynching, or reclamations of plantation land; this is the primary source for case studies and the dramatic plots they contain. In these four areas, I grasp a deeper understanding of the meaningful dialogues that face this community. Ubiquitous and chronic illness within any population often assumes a prominent rubric for daily experience, raising questions about the nature of culture and its relationship with human biology.

Ambiguity is one of the most important qualities of liminality in health. Illness is expected to be named, treated, and eliminated (Gardner 1998; Wittgenstein 1989). Any affliction that does not follow this tripartite process becomes problematic. Anemia among the Maya is problematic in this way. The evasive and complex nature of its symptoms prevents sufficient identification to provide substantial remedy. Anemia is tolerated to a certain degree, but severely anemic individuals fail to fulfill the expectations of their own villages. They cannot physically or mentally integrate into the community and are thus pariahs among themselves. Additionally, in the context of another dominant postcolonial institution, the village is seen to be entirely sick. For the village community, this is the identity of a *sufrimos* or "we suffer" often expressed in individual narratives and performed in religious ceremony. If the village cannot put its best foot forward to the postcolonial superstructure, then it too is denied status and treated as a problem community, inhumanely, as merely a source of agriculture labor. Exclusion from the normative structures of postcolonial elite culture coalesces into chronic ambiguity, insecurity, and fear. In this context beginning with the individual, one will view oneself in a variety of ways, but layers of society will view that individual as it pleases – as polluting perhaps. This suffering is discussed in both the "I" and "we" as well the past and present as if suffering were the human burden to carry through time and eternity and in one's identity. From a biocultural perspective, the experience of anemia and structural violence begins with the individual's physical body full of symptoms and symbols. It then flows into the subjective self, positioned objectively in the community, a community that marginalizes its own chronically ill. However, that community is contextualized against the backdrop of the community's own marginalization of its indigenous personhood. With these relationships examined, our interpretations of oppressive structural violence from beyond the community are a bit more lucid.

Conclusion

Current research on liminality and health reveals that ambiguous positioning on the thresholds of time and space constructed in social structure can be chronic and contagious as well as physically unhealthy. It appears that cultural pluralism, i.e. different cultures within one population, is a close cousin of structural violence. It is a challenge within anthropology to explain institutionalized status and hierarchy of meanings within such a population. However, it is even more difficult to examine the lived experiences of those located on the margins of culture, those who exist outside hierarchical meaningful constructions in a world of ambiguity and dissonance, and perhaps in a distinct culture. Liminality and its qualities go a long way toward describing the lived experience of oppressed or marginalized peoples and the nature of oppression and marginalization itself. The Maya of Guatemala exist in a bifurcated society, stratified; two sociocultural realities in the same time and space, but these two cultures could not be more distant neighbors.

Under extreme subjugation the indigenous people of Guatemala lost a great deal of cultural know-how. Agency of the communities was seemingly stripped and placed into the post-colonial agricultural economy. Looking inward for solutions leaves both the individual and the community at a loss for meaning. Reaching out to the Spanish postcolonial society, the Maya encounter symbols with no relevant meaning or reference to positive status of Maya self identification. Rather the symbols reify what a Maya women will experience in a biomedical health clinic; she will be chastised for being dirty and not taking care of her kids and in light of having no money to purchase medicine or treatment will be given no solution to her problems. She will be identified by the proverbial and archetypical construct of the sick, dirty, poor, and lazy Indian, which paradoxically is symptomatically related to anemia.

References

Biehl, J. G.; Good, B.; Kleinman, A.(2007) Subjectivity: ethnographic investigations. Berkeley: University of California Press.

Blanchfield, D. S. and Longe J. L. (2002) The Gale encyclopedia of medicine [electronic resource]. Detroit: Gale Group.

Cohen, L. (1998) No aging in India: Alzheimer's, the bad family, and other modern things. Berkeley: University of California Press.

Daniel, E. V. (1996) Charred lullabies: chapters in an anthropography of violence. Princeton: Princeton University Press.

Das, V. (2007) Life and words: violence and the descent into the ordinary. Berkeley: University of California Press.

Douglas, M. (1994) Purity and danger: an analysis of the concepts of pollution and taboo. London: Routledge.

Farmer, P. (2003) Pathologies of power: Health, human rights, and the new war on the poor. Berkeley: UCLA Press.

Forss, A.; Tishelman, C., Widmark, C.; Sachs, L. (2004) Women's experiences of cervical cellular changes: an unintentional transition from health to liminality? In: Sociology of Health and Illness 26, 3: 306-25.

Gardner, G. (1998) The human dimension of nosocomial wound infection: a study in liminality. In: Nursing Inquiry 5, 4: 212-9.

Herynk, J. (2006) Suspended personhood and the bio-puzzle of anemia: Forming an inclusive and effective approach to health among the Maya of Guatemala. Presented at Society for Applied Anthropology Meetings 2006.

Honkasalo, M. L. (2001) Vicissitudes of pain and suffering: chronic pain and liminality. In: Medical Anthropology 19, 4:319-53.

Janzen, J. M. (2002) The social fabric of health: An introduction to medical anthropology. Boston: McGraw Hill.

Little, M.; Jordens, C. F., Paul, K.; Montgomery, K.; Philipson B. (1998) Liminality: A major category of the experience of cancer illness. In: Social Science and Medicine 47, 10: 1485-94.

Mahon-Daly, P. and Andrews, G. J. (2002) Liminality and breastfeeding: Women negotiating space and two bodies. In: Health Place 8, 2: 61-76.

Martin-McDonald, K. and Biernoff, D. (2002) Initiation into a dialysis-dependent life: An examination of rites of passage. In: Nephrology Nursing Journal 29, 4: 347-52, 376; discussion 353.

McGuire, S. and Georges J. (2003) Undocumentedness and liminality as health variables. In: Advances in Nursing Science 26, 3: 185-95.

Ministerio de Salud Pública y Asistencia Social (MSPAS). (2001) Memoria annual de vigilancia epidemiologica: Presentación de servicios morbilidad y mortalidad. Guatemala: Ministerio de Salud Pública.

Molzahn, A. E.; Bruce A., Sheilds, L. (2008) Learning from stories of people with chronic kidney disease. In: Nephrology Nursing Journal 35, 1: 13-20.

Murphy, R. F.; Scheer, J.; Murphy, Y.; Mack, R. (1988) Physical disability and social liminality: a study in the rituals of adversity. In: Social Science and Medicine 26, 2:235-42.

Navon, L. and Morag, A. (2004) Liminality as biographical disruption: Unclassifiability following hormonal therapy for advanced prostate cancer. In: Social Science and Medicine 58, 11: 2337-47.

Nelson, D. M. (1999) A finger in the wound: Body politics in quincentennial Guatemala. Berkeley: University of California Press

Philpin, S. (2007) Managing ambiguity and danger in an intensive therapy unit: Ritual practices and sequestration. In: Nursing Inquiry 14, 1: 51-59.

Shomaker, D. J. (1989) Age disorientation, liminality and reality: the case of the Alzheimer's patient. In: Medical Anthropology 12, 1: 91-101.

Tamahú Health Clinic. (2007) Data collected by the local health clinic for 2006 and entered into the computer in 2007.

Thompson, C. E. (2001) Maya identities and the violence of place: borders bleed. Aldershot: Ashgate.

Turner, V. W. (1968) Drums of affliction: A study of religious processes among the Ndembu of Zambia. London: Oxford.

Wardlaw, GM; Hampl, J.S; DiSilvestro R.A. (2004) Perspectives in nutrition. 7th ed. Boston: McGraw-Hill Higher Education.

Warren, K. (1978) The symbolism of subordination: Indian identity in a Guatemalan town. Austin: University of Texas Press.

Wittgenstein, L. (1989) Tractatus logico-pilosophicus. Frankfurt am Main: Suhrkamp.

WHO/UNICEF (2004) Focusing on Anemia: Toward an integrated approach for effective anemia control. Geneva: World Health Organization. (http://www.paho.org/English/AD/FCH/NU/WHO04_Anemia.pdf, accessed February 22, 2008).

"Already the First Victims of the Next Pandemic": The Impact of Avian Influenza on Developing Nations and Vulnerable Populations

Maria Weir

Introduction

In 1997 the avian influenza virus H5N1 jumped from birds to humans. Since 1997 the virus has spread to a number of continents, causing sickness and death. H5N1, or "bird flu," has also had significant economic impact on developing countries, with losses estimated at more than $10 billion (WHO 2005b: 4). The virus has increased in pathogenicity and geographical spread, prompting fears that it may spark a human pandemic. Countries around the world are taking steps to protect themselves, and developing nations are struggling to meet preparedness standards imposed by the West. This paper raises the question: What has been the impact of bird flu and pandemic preparedness on developing countries?

Theory and Methods

To answer this question, I turn to the critical medical anthropology (CMA) framework developed by Singer and Baer (1995: 5). Bird flu's impact cannot be understood simply in biomedical terms, but must be contextualized within a larger economic and political framework. CMA "emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and health care" (ibid.). It advocates studying health issues by addressing various "levels of analysis," from the "macrosocial level," which encompasses the capitalist world system and the corporate and state sectors, to the "individual level" (ibid. 63). At the macrosocial level I examine how the bird flu-related experience of developing countries is directly shaped by their disadvantaged position within the global political economy. At the microsocial level I examine the effects of bird flu on some of the most vulnerable populations within these developing countries.

This paper also draws on concepts related to poverty and health that Paul Farmer has developed in his recent book “Pathologies of power” (2005). Farmer has addressed the dire effects that poverty has on the health of countries, groups, and individuals. He decries structural violence, which he defines as “suffering that is ‘structured’ by historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual, or as is more commonly the case, the hard surfaces of life – to constrain agency” (ibid.: 40). Farmer states that analyses of health issues that address the “macrologics of power” as well as the poor’s point of view often reveal the poor to be “targets of structural violence” (ibid. 13, 142).

To write this paper, I conducted a thorough review of medical literature, national and international news articles, and the publications of organizations such as the World Health Organization (WHO) and the World Bank. The literature review was carried out in spring 2007.

“Irrational Complacence” or Overwhelming Odds? H5N1 and Pandemic Preparedness in the Developing World

WHO states that the current risk for a pandemic is great, and given the potentially devastating effects of a pandemic and the growing threat that bird flu poses, it is no surprise that many countries and organizations are moving forward aggressively to prevent a global epidemic and to develop strategies for dealing with a future outbreak. Wealthy countries are presently the best prepared; countries where bird flu is endemic, and where a pandemic virus is most likely to emerge, lag far behind (WHO 2005b: 2). Some critics have charged that the failure of poor countries to enact adequate preparedness measures is due to “irrational complacence” (Poland et al. 2007: 3057). I will address this alleged complacence by examining three areas in which developing countries are struggling: 1) vaccine and antiviral therapy stockpiling, 2) developing the capacity to prevent and control bird flu outbreaks, and 3) financing pandemic preparedness efforts.

“The Unforgiving Arithmetic” of Pandemic Vaccine and Antiviral Drug Supplies

WHO states that vaccination and the use of antiviral treatment are two of the most important response measures for reducing morbidity and mortality during a pandemic (2005b: 4). It strongly recommends that all countries stockpile vaccines and antiviral therapy as part of their pandemic preparedness plans.

The world’s limited manufacturing capacity, however, is a major obstacle to reaching recommended levels of production (ibid. 2). Given current production capacity, it is estimated that less than 1% of the world’s 6 billion people could be fully immunized (Poland et al. 2007). A full decade would be needed to produce enough antiviral drugs to treat 20 percent of the world’s population (WHO 2005b). Also problematic is the issue of global access to vaccines and antiviral therapies. The world’s major drug manufacturers are overwhelmingly concentrated in the West (WHO 2005a: 4). Developing countries depend on Western countries for 99 percent of their vaccines (ibid.). Given limited global production capacity, the amount of vaccine that could be produced during a pandemic would not meet the needs of vaccine-producing countries themselves (ibid). WHO has reached the harsh conclusion that, given present trends, most developing countries would have no access to vaccines or antiviral drugs throughout the duration of a pandemic (WHO 2005c).

Farmer states that “local and global inequalities mean that the fruits of medical and scientific advances are stockpiled for some and denied for others” (2005: 221).The current situation of pharmaceutical inequity underscores the disadvantaged position that developing countries occupy in the current global political economy, and points to the deadly effects that such inequality could have should a pandemic occur.

Developing the Capacity to Prevent and Control Bird Flu Outbreaks

There has been growing consensus that stopping the spread of bird flu is the best strategy for reducing the chance of a human pandemic (Wright 2005). Many countries, however, lack the capacity to carry out adequate surveillance. In some regions, such as Africa, surveillance for avian disease is basically non-existent (WHO 2005a: 3). WHO (2004) recommends that once a suspected outbreak is reported, human blood samples and dead animal specimens be collected for investigation. Many developing countries lack the means (such as dried ice and refrigeration) to adequately preserve and store the samples until they can be tested (Bradsher 2005). Once specimens are collected, they must be analyzed. Many countries, however, do not have the necessary epidemiological and laboratory capacity (WHO 2005b: 8). Once an outbreak is confirmed, one of the most common ways of containing bird flu is culling affected birds as well as birds in surrounding areas (Vallat and Mallet 2006: 390). Many countries lack the recommended equipment, or find such equipment ill-suited for the arduous task of culling millions of birds. During recent outbreaks some countries such as Thailand, Egypt, and Indonesia did not have the resources to hire a brigade of cullers, so they instead dispatched soldiers, police officers, and prisoners (Bradsher 2004; Slackman 2006; Anon, Indonesian-language author cited in Pawitan 2006: 756). These "recruits" were not always well trained or motivated to perform adequately. In other areas, such as the Kurdish region of Iraq, hiring or forcibly recruiting cullers was not an option, so villagers were asked to kill their own chickens (Oppel and Adham 2006).

Poor countries face many challenges in developing the capacity to prevent and control bird flu outbreaks. Necessary measures such as surveillance, specimen collection and analysis, and culling are costly. Developing countries either forgo such measures or mobilize their limited resources and implement plans that are often inadequate.

"Lending a Hand" to the Developing World: The Problematic Nature of Bird Flu-Related Funding

There has been growing awareness that the international community must provide financing to the poorest countries. At a donors' conference held in January 2006, $1.9 billion were pledged to global pandemic flu-related efforts (U.S. Dept. of State 2006). While the donors were praised for their generosity, almost half of the pledged funds will be dispersed as loans (Normile and Yidong 2006: 457). Developing countries have resisted loan programs and have protested about having to borrow heavily to fight a disease that has become a global problem (Bradsher 2006).

Aid is also problematic because such "help" often comes with strings attached. Donor countries retain great control over how the money should be spent. Of the almost $ 400 million that the U.S. contributed to the Global Fund, a large portion was already earmarked for specific initiatives (U.S. Dept. of State 2006). U.S. funding also includes support for the U.S. Department of Defense to finance military-to-military training and exercises and to "assist other countries in developing military preparedness and response plans" (ibid.). The U.S. government makes explicit that aid fulfills many objectives, including promoting "fundamental changes in governance, economic structures, and use of human resources" (McConnell 2006).

Another result of funding initiatives is that the demands of donor countries may be given priority over the needs of recipient nations. One effect has been decreased attention towards non-bird flu health issues. Of the funds that the U.S. pledged, $ 31.3 million is being transferred from money previously earmarked for survivors of the Asian tsunami and an additional $ 22.7 million comes from money that had been set aside for international health issues (Bradsher 2006). Developing countries are also being pressured to divert national public health monies to bird flu-related issues. Concerned experts have stated the obvious – focusing so intently on a single disease could quite literally be condemning people to die of a host of other diseases (ibid).

"They Don't Have Anything Left if You Kill all the Chickens": The Importance of Poultry for the Poor

Just as developing countries have borne the brunt of the negative effects of bird flu due to their disadvantaged position within the global political economy, some of the poorest and most vulnerable groups within these countries have also been disproportionately affected.

The importance of poultry for economically disadvantaged people around the world cannot be overstated. For millions of rural residents these "backyard birds" serve as a major source of nourishment and income. In Viet Nam, one of the countries most severely affected by bird flu, approximately half of all households keep chickens (Otte et al. 2006: 1). For Vietnamese farmers whose annual per capita income is less than $ 200, poultry is a lucrative investment – owners get back seven-fold (700%) of the chicken's initial purchase price (ibid.). Poultry also represent a rudimentary form of a savings account – they can be easily "cashed in" for small amounts of money throughout the year as the need arises (ibid.). Widespread culling has disrupted the poor's food security and income.

Another problematic aspect of culling is that it disproportionately impacts some of the most vulnerable populations in developing countries – women and children. In many countries, women and children are largely responsible for poultry keeping (FAO 2006; Polgreen 2006). Poultry may represent a small but essential source of income for women who have few means of securing cash (Polgreen 2006; Faden et al. 2007). Poultry also represents a major food source for vulnerable populations such as children, whose nutritional needs are met by the extra protein these birds provide. In 2006, bird flu hit the Kurdish area of Iraq, and at the urging of authorities, villagers culled their flocks (Oppel and Adham 2006). The Kurds reported hardship, as eggs were a major food source for Kurdish children (ibid.). For the "most dependent and vulnerable members of the community" the destruction of domestic birds may mean that they become "even more dependent and vulnerable" (Faden et al. 2007).

The Rural Poor and Non-Compliance

The poultry-related practices of the rural poor have come under intense scrutiny. Their continuing engagement in what has been deemed "high-risk behavior" has led to them being labeled as "non-compliant" and therefore deserving of sanctions. One "high-risk" behavior for which the rural poor have been criticized is for failing to voluntarily surrender their domestic birds. From Indonesia to Turkey to Nigeria, resistant villagers hid birds in their homes or in fields far away from the eyes of inspectors, or bribed cullers to spare their flocks (McNeil 2006; Slackman 2006). Given the importance of poultry to the poor's livelihood, it should come as no surprise that rural poultry owners have actively resisted governmental culling efforts.

A major reason the rural poor have been reluctant to cooperate is that they believe they will receive little to no compensation. To a large extent, their fears have been justified. In Viet Nam, Cambodia, and Laos, farmers received 10-20 percent of market value, but for flocks only (Bradsher 2004; McNeil 2006). In Indonesia, compensation has only been given for infected birds. Because most birds culled are healthy, the owners receive nothing (Faden et al. 2007). In China and Turkey, owners were promised reimbursement, but given only vouchers; in China, villagers found they could not cash their vouchers (McNeil 2006).

Farmer (2005: 151) provides a particularly insightful analysis of the label "non-compliant" as applied to the poor. He posits that economic factors strongly influence people's health-related behaviors and that structural barriers are often to blame for "noncompliance". He states that the focus should not be on people's "shortcomings" but on the conditions that structure their risk such as lack of access and unfair distribution of the world's resources.

Conclusion

Bird flu is ostensibly a biomedical phenomenon, a treatable disease in both animals and humans. Yet, as medical anthropologists have amply demonstrated, the disease experience does not occur in a vacuum, but is shaped by social, cultural, economic factors. A critical reading of bird flu's global effects reveals that poverty and unequal power relationships at the global and national levels shape the disease experience of countries and their populations. Bird flu control and pandemic preparedness must be understood in the context of western hegemony, biomedicine's connectedness to global capitalism, and the grinding poverty that circumscribes the actions of disadvantaged countries and individuals. The developing countries and impoverished populations that have born the brunt of bird flu and flu eradication efforts can be said to be victims of structural violence, as they disproportionately bear the cost of the disease, and because bird flu has served to further indebt them to wealthier nations. Only by understanding the role of structural violence in shaping the global and local disease experience can we move beyond labels such as "irrationally complacent" and "non-compliant" and seek solutions that address the inequality that lies at the heart of bird flu-related challenges.

References

Bradsher, K. (2004) Governments across Southeast Asia work to contain bird flu. In: The New York Times, January 26. Available online: http://query.nytimes.com/gst/fullpage.html?sec=health&res=9C0CE2DC1738F935A15752C0A9629C8B63; Accessed April 20, 2007.

Bradsher, K. (2005) Poverty and superstition hinder drive to block bird flu at source. In: The New York Times, November 2005. Available online: http://www.nytimes.com/2005/11/03/international/asia/03bird.html?ex=1288674000&en=d4532895897ec3d1&ei=5088&partner=rssnyt&emc=rss; Accessed April 20, 2007.

Bradsher, K. (2006) Global effort attracts $1.9 billion in pledges to battle bird flu. In: The New York Times, January 19. Available online: http://www.nytimes.com/2006/01/19/international/asia/19flu.html?ex=1177214400&en=34526cc4a7acd8d2&ei=5070; Accessed April 20, 2007.

Faden, R. R.; Duggan, P. S.; Karron R. (2007) Who pays to stop a pandemic? In: The New York Times, February 9. Available online: http://query.nytimes.com/gst/fullpage.html?sec=health&res=9C06E4D6113FF93AA35751C0A9619C8B63; Accessed April 21, 2007.

Farmer, P. (2005) Pathologies of power: Health, human rights, and the new war on the poor. London: University of California Press.

FAO (Food and Agriculture Organization) (2006) Bird flu a ‘marker’ for the future. In: FAO News. Available online: http://www.fao.org/docs/eims/upload/214351/nabarro_6oct06.pdf; Accessed April 16, 2007.

McConnell, K. (2006) USAID increases funding for bird flu preparedness. USINFO.STATE.GOV, U.S. Department of State. Available online: http://usinfo.state.gov/xarchives/display.html?p=wash-fileenglish&y=2006&m=February&x=20060223151657AKllennoCcM0.3290064; Accessed April 21, 2007.

McNeil, D. G. (2006) In war on bird flu, U.N. looks to recruit killer army. In: The New York Times, January 29. Available online: http://www.nytimes.com/2006/01/29/international/29chickens.html?ex=1296190800&en=46359438563ebdee&ei=5088&partner=rssnyt&emc=rss; Accessed April 20, 2007.

Normile, D. and Yidong, G. (2006) Avian influenza: Donors draw plans to disburse $ 2 billion war chest for bird flu. In: Science 311(456a): 456-457.

Oppel, R. A. and Adham, Y. (2006) For Kurds, chickens mean food, cash, and now death. In: The New York Times, February 1. Available online: http://www.nytimes.com/2006/02/01/international/01flu.html?ex=1177214400&en=79b39c2be37feef7&ei=5070; Accessed April 20, 2007.

Otte, J; Roland-Host, D.; Pfeiffer, D. (2006) HPAI control measures and household incomes in Viet Nam. In: Pro-Poor Livestock Policy Initiative (PPLPI). PPLPI Features. April. Available online: http://www.fao.org/ag/pplpi.html; Accessed April 15, 2007.

Pawitan, J. A. (2006) Averting avian influenza pandemic: SOS from a developing country. In: The Lancet Infectious Diseases 6, 12: 756-7.

Poland, G. A.; Jacobson R. M.; Targonski P. V. (2007) Avian and pandemic influenza: An overview. In: Vaccine 25, 16: 3057-3061.

Polgreen, L. (2006) Nigeria tries TV jingles, anything to chip away at ignorance of spreading bird flu. In: The New York Times, February 26. Available online: http://www.nytimes.com/2006/02/26/international/africa/26nigeria.html?ex=1298610000&en=3ecc688e18b4c948&ei=5088&partner=rssnyt&emc=rss; Accessed April 20, 2007.

Singer, M. and Baer, H. (1995) Critical medical anthropology. Amityville: Baywood Publishing Company.

Slackman, M. (2006) In the Nile delta, bird flu preys on ignorance and poverty. In: The New York Times, April 14. Available online: http://www.nytimes.com/2006/04/14/world/africa/14egypt.html?ex=1177214400&en=5d9b47b78033522f&ei=5070; Accessed April 20, 2007.

U.S. Department of State (2006) United States international engagement on avian and pandemic influenza. Bureau of Public Affairs. Available online: http://www.state.gov/r/pa/scp/2006/77772.htm; Accessed April 19, 2007.

Vallat, B. and Mallet, E. (2006) Ensuring good governance to address emerging and re-emerging animal disease threats: Supporting the veterinary services of developing countries to meet OIE international standards on quality. In: Revue Scientifique et Technique (International Office of Epizootics) 25, 1: 389-401.

WHO (World Health Organization). (2004) WHO interim recommendations for the protection of persons involved in the mass slaughter of animals potentially infected with highly pathogenic avian influenza viruses. WHO Regional Office for the Western Pacific, Manila. Available online: http://www.wpro.who.int/NR/rdonlyres/7693BAF7-13E7-42DB-B92B-004CF5D517E7/0/WHOinterimrecommendation26012004.pdf; Accessed April 19, 2007.

WHO (World Health Organization). (2005a) Influenza pandemic risk assessment and preparedness in Africa. WHO, Regional Office for Africa. Available online: http://www.afro.who.int/csr/epr/epidemic_prone_diseases/afr_avian_flu_31_10_05.pdf; Accessed April 15, 2007.

WHO (World Health Organization). (2005b) Responding to the avian influenza pandemic threat: Recommended strategic actions. WHO, Communicable Disease Surveillance and Response Global Influenza Programme. Available online: http://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_05_8-EN.pdf; Accessed April 15, 2007.

WHO (World Health Organization). (2005c) Avian influenza frequently asked questions. WHO. Available online: Http://www.who.int/csr/disease/avian_influenza/avian_faqs/en/index.html; Accessed April 21, 2007.

Wright, T. (2005) Bird-flu battle in Eastern Asia is to be joined by World Bank. In: The New York Times. Available online: http://www.nytimes.com/2005/11/08/international/asia/08geneva.html?ex=1177214400&en=772804ea31f537f5&ei=5070; Accessed April 20, 2007.

The Future of the Anthropology of Health

Ellen Gruenbaum, discussant

Who is the audience for medical anthropology's kaleidoscope of approaches to understanding health and illness? In our recent past, medical anthropologists have endeavored to make our research interests distinctively "anthropological" and relevant to anthropological theory at the same time as we sought to prove ourselves useful to biomedical and public health agendas without sliding into a "handmaiden" role. Often, we favored unusual or culturally specific syndromes or practices that anthropologists find fascinating, but which biomedical practitioners considered quirky or irrelevant to medical research and practice. Biomedical establishments must have been truly puzzled by cultural anthropologists' intense attention to the methods of shamans, curanderos, and faith healers – if they were even aware of them – and yet this line of thinking has eventually penetrated biomedical thinking on the mind/body interface. There were also the paradigms of ecology and sociocultural epidemiology, which critiqued the biomedical research and practices that glossed over social class and cultural diversity. These insights were useful to public health and policy-making, but since they often dealt with minority populations they did not achieve extensive recognition – unless of course there was an epidemic that threatened the majority populations.

Biomedical audiences have taken more interest when our research outlines "harmful traditional practices" or exposes beliefs that interfere with "compliance" with biomedical treatment regimens, as these have practical medical consequences. Ethnomedicine and its discoveries of pharmacologically effective traditional medicines that might provide useful new drugs have also caused biomedical science to take an interest in medical anthropology. Public health actions have benefited from understanding the cultural and social class impediments to improvements in health or obstacles to treatment.

But medical anthropologists who want to address such audiences so that our analyses will effect change have often had to struggle to get the attention of those who might be able to mobilize resources on any large scale to assist the poor and marginalized in their quest for health and well being. Perhaps we have not spoken eloquently enough the language of practical applications or policy-making; perhaps health policy makers hear our theoretical profundities as an alien dialect. How can medical anthropologists mobilize our care and concern publicly, so that we effectively articulate our insights and analyses to make a difference for a healthier world? More than ever, the potential for disaster on a global scale that we see with the new technologies for manipulating the natural world requires the perspective that we have to offer in the broad field of medical anthropology: evolutionary time-depth and dynamics, biological diversity and processes of change, the way humans give meaning to experience, and how humans try to change situations. But how shall we be influential?

This set of papers – the "prairie flowers" that have bloomed in the spring of 2008, to which Professor Janzen referred in the introduction (see photo on back) – are presented by a new generation of medical anthropologists from the University of Kansas who have embraced the need for social change to end the "structural violence" that has created so much human suffering and damage to health and well-being. Their papers show the range of medical anthropology's role in creating a more livable future. These American medical anthropologists are directing themselves toward practical issues that are at the center, as well as the margins, of biomedicine and public health while contributing with theoretical sophistication to the debates within anthropology. The paradigms of medical anthropology – not just the most recent ideas, but all of the good ones, from the political economy critiques, through the textual and semiotic, to the Foucauldian and feminist – are represented here, as these studies strive to use the best tools of analysis for the problems they address. These authors seek to ameliorate the human condition by staying close to the heart of the larger perspectives and ultimate questions raised in the Saillant/Genest volume and by its contributors, while raising their own questions to contribute to the future of medical anthropology.

James Herynk's study of anemia in a Maya community in Guatemala is an example of the fruitfulness of utilizing the structural violence concept, a concept that is usually associated with Paul Farmer's work, but which also echoes the influential work of Vicente Navarro, Ray Elling, and other medical social scientists of the generation before. Herynk brilliantly links the damaged health of the Maya to their damaged environment and their loss of power due to the long oppression of colonial and contemporary agricultural economic policies. But his work is not only about the oppressed but also about the bifurcated society: a condition of stratification places a middle class near the oppressed, living better not because of a superior culture or belief system, but because of an economic and political advantage of long duration. This situation is mirrored in the treatment he describes in the clinics with a sick Mayan patient. The patient receives on economic benefits that would allow her to take better care of her children, but rather she is chastised for being dirty and not taking better care of her children's nutrition or health care – which she cannot afford to improve. Racism and class oppression keep the Maya marginalized in this region, Herynk argues, which echoes the fate of the marginalized poor in many other countries.

Can the mobilization of biomedical data on a health problem – anemia – known in wealthy countries as well as poor countries draw attention to the Maya? Or are the biomedical causality models too complex (with more than 60 variables) and the numbers too horrifying (with 100% of Mayan children, more than three-quarters of the women and nearly half the men being anemic) for outsiders to focus on the problem? But Herynk finds some hope in the fact that the Maya people of the community of his research have begun to exercise more resistance to the situation, organizing through local institutions (household, church, and village council) to gain freedom from the plantation system.

In this situation, the anthropologist is not influencing the biomedical system to change – at least not yet. But he is bearing witness to the structural violence in a way that will give a different interpretation to peasant uprisings – whether peaceful or assertive – and may make it more difficult for national governments and international bodies to suppress their quest for improved health and living conditions. Herynk's questions seem to me to be central to medical anthropology today: Once we understand a situation, where do we go to get help? Paul Farmer and the Partners In Health organization have not hesitated to rattle the gates of the powerful, negotiate more affordable drugs, and expose the oppression of the poor. Is that what all of us will have to do? International organizations like WHO and UNICEF set high goals for improvement of health measures and influence governments and funders to join in the efforts. But can public health goals address the inequalities of economic systems? Can we medical anthropologists contribute to the reduction of anemia incidence and severity by analyzing it and reporting our findings, or must we become agents of social change ourselves?

Mary Sundal's shocking images of a Ugandan biomedical system's corruption similarly address the political and economic context of health. For the Karimojong, the long-standing competitions and raiding among cattle-keeping groups was exacerbated by the introduction of AK-47s, increasing the danger of normal life, including visits to clinics. For the hapless parents she describes, just getting to a biomedical treatment facility is a major challenge, but then they must also face inadequate staffing, lack of drugs, corruption (demands for bribes, or "tips." and perhaps pilfering of supplies), insults and assaults, ethnic discrimination, and failure to accept multiple, ethnomedical treatment modalities. It is hard to imagine a more hostile treatment environment, and yet the clients continue to want biomedical help to cope with their devastating conditions and high death rates for children. Clearly the audience for her work should be those who hold control over the biomedical system, as a start. While underlying economic disparities need addressing, too, Sundal's expose sends a powerful message to the government and international agencies about the urgent need for change.

Melissa Filippi-Franz and Sarah Sobonya raise questions about meaning, coping, and social connection for people whose experience of violence was not only structural violence but also bloody conflict: Somali refugee immigrants to Kansas City, Missouri, USA, and children who survived the Rwandan genocide. In Filippi-Franz's study of the Somali immigrant women in Kansas City, she found that they, like other populations in diaspora, experience displacement of their moral worlds, and they must struggle to create new meaning so that they can live mentally healthy lives and find ways to normalize their situations. Passing citizenship tests and securing employment are key, since these will enable them to help others as well as protecting themselves against something bad happening to them. Helping other immigrants – particularly sponsoring others to migrate to the U.S. – is a new moral goal that resonates with traditional loyalties to close kin and clan members but perhaps goes beyond that to helping others outside of one's traditional circles of moral responsibility. It will be interesting to see, as this work progresses, how the Somali-Americans "pay it forward" by sponsoring individuals for migration, helping families back home, and helping other immigrants – perhaps beyond the traditional loyalties to kin and ethnicity – who are experiencing what they have gone through already.

The child survivors of genocide in Rwanda must have much in common with past generations of Armenians, European Jews, Cambodians, and populations of the former Yugoslavia and the children of Darfur today – among many others – who experienced genocide and displacement of war from a child's perspective. The anthropology of war and violence are areas of growing interest and major public health concern, as the world faces dozens of conflicts simultaneously creating death, trauma from rape and witness of killing, fear, suffering as refugees, and a deep sense of loss as homeland, livelihoods, loved ones, and safety are ripped away. The children, with their long lives ahead of them, must be understood, both for the improvement of their treatment and recovery and so that the future world will be led by people who can cope with the scars of trauma without perpetuating it. Survivors of ethnic and communal violence experience injury "to the very idea of different groups being able to inhabit the world together," as Sobonya quotes Das (2007) as saying. And indeed this is a central issue for all of us in an increasingly crowded world where peace should be a central agenda for health.

Maria Weir's study of how the world anticipates an epidemic – in this case avian influenza (or "bird flu") – makes it very clear that this biomedical disease is not a biomedical phenomenon that the biomedical system can handle. Instead, we see the entire political economy of the epidemic – how the poor countries are already suffering tremendous loss of livelihood (both poultry and tourism) through preventative measures. The poor of developing countries are already victims of the possible future pandemic. The stark clarity of her question about why the poor must lose their livelihoods while we in the developed countries simply get a flu shot demonstrates again how political and economic disparities can be at the heart of what we think of as a biomedical issue.

Finally, Shawna Carroll Chapman's questions are central to the effort to improve health in developed countries through emphasis on individual responsibility for lifestyle. The idea that health education will help people make healthier decisions for themselves is widespread, and it certainly works for some of the people some of the time. But Chapman's work – starting with participant observation in the Kansas City areas – promises to reveal another sort of consequence. The “blaming” quality conveyed by individual risk assessment can lead people to avoid applying the lessons of health education to themselves – they may be “in denial” about their own risky behaviors yet seeing the ill-health of others as their own fault. Chapman’s is an intriguing exploration of the question of social worth as it is manifest in health. Are those with higher social class more “worthy” of efforts to provide “health for all,” since they are more likely to be aware of, able to afford, and comply with healthy lifestyles?

When taken together, this set of studies suggests that the future of medical anthropology is in good hands. Not only do these papers offer a kaleidoscope of approaches to the anthropological study of human health, but they have left behind the “handmaiden of medicine” role that an earlier generation of medical social scientists worried they would fall into. Nor are they simply critiquing the medical system. Instead, their questions are far larger, concerning the very conditions of human health, well being, and survival. These questions demand a larger audience.

Forthcoming Conferences

2008

Mental Health Europe Conference, "Diversity in Mental Health and Well-Being – An Opportunity for Intercultural Dialogue", Aalborg, Denmark, **7-9 August, 2008**, Hotel Hvide Hus.
Info: www.mhe-aalborg.dk)

10th International Congress of Ethnopharmacology (ISE) – 20th Symposion on Brasilian Medicinal Plants, Sao Paolo, Brasil, **16-19 September, 2008**
http://www.plantasmedicinais.unifesp.br/en/home.htm

"Culture, Health and Ageing. Vulnerability in Africa-Asia-Latin America and Europe", 26-27 October, 2007, Kollegiengebaeude der Universitaet Basel, Petersplatz 1, 4051 Basel. Switzerland. Contact: Piet van Eeuwijk (Ethnologisches Seminar der Universitaet Basel)
http://www.agem-ethnomedizin.de/download/
DOC-NL18-6_MAS-Symposium_2007_Ageing_Flyer_August_2007.pdf

International Colloque "Consumed Nature: Biological Diversity for Food", French commitee of the International Commission for Anthropology of Food, **15-16 December, 2008**, Musée de l'Homme, 17, place du Trocadero – Paris, 75016. Contact: Françoise Aubaile -Sallenave (**aubaile@mnhn.fr**) Eco Anthropologie, UMR 5145, CNRS- MNHN, Museum National d'Histoire Naturelle, cp 135, 57 rue Cuvier, 75005 Paris, tel. : 33 (0) 1 40 79 36 77, fax : 33 (0) 1 40 79 38 91

2009

"Food and Migration", 2-3 February, 2009, School of Oriental and African Studies, University of London. Info : Monica Janowski, Department of Anthropology, University of Sussex (M.Janowski@sussex.ac.uk), Paru Raman, Department of Anthropology and Sociology, School of Oriental and African Studies, University of London (pr1@soas.ac.uk)

50th Annual Meeting "Plants and Spirituality" Society for Economic Botany, Charleston, South Carolina, USA, **31 May-4 June, 2009** http://www.econbot.org/_organization_/index.php?sm=07|meetings_by_year/2009

The Austrian Ethnomedical Society

President: Manfred Kremser, Vicepresidents: Wolfgang Kubelka and Armin Prinz,
1. Sectretary: Ruth Kutalek, 2. Secretary: Christa Kletter, Treasurer: Doris Burtscher

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 Unit Ethnomedicine and International Health
Zentrum für Public Health
Institut für Geschichte der Medizin
Währingerstraße 25
A-1090 WIEN
AUSTRIA

MEMBERSHIP ENROLLMENT

Member (Euro 20,–) ☐

Student Member (Euro 10,–) ☐

MEMBER NAME:
………

………

ADDRESS:
………

………

FAX: ……………………………………………… PHONE: ………………………………………………

E-MAIL: …………………………… PAYMENT BY VISA AND MASTERCARD POSSIBLE

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

Shawna L Carroll Chapman MA, MPH, PhD candidate in cultural anthropology. Her work is currently focused in the Midwestern United States where she is interested in how Public Health initiatives affect culture especially in terms of health disparities.

Melissa Filippi-Franz is a doctoral candidate at the University of Kansas. Her interests are forced migrations, refugees and internally displaced persons, healing, Somalia, the Horn of Africa, the US, and interpretations and experience. She is currently writing her dissertation and serves on the board of the Somali Foundation, Inc. located in Kansas City, Missouri.

Ellen Gruenbaum, Ph.D., is Professor of Anthropology at California State University, Fresno, and in fall 2008 will be Head of the Department of Anthropology at Purdue University. Her medical anthropology research has focused on female genital cutting issues in Sudan and Sierra Leone, where she has served as a research consultant for UNICEF. She is the author of The Female Circumcision Controversy: An Anthropological Perspective (University of Pennsylvania Press, 2001).

James W. Herynk is a PhD student in medical anthropology at the University of Kansas; his MA is in Political Science. Before Guatemala, he worked on research and applied projects in maternal and child health in relation to identity, oppression, violence, and political economies in Mexico, Austria, Bosnia-Herzegovina, Kosovo, Netherlands, and Argentina.

John M. Janzen is Professor of Anthropology at the University of Kansas. He researches and writes on the socio-cultural dimensions of African health and healing, and theoretical issues in medical anthropology. He has studied healing traditions, narratives, and institutions in Africa, their characteristics and interactions. Currently he works with other scholars on postwar trauma healing in African conflicts and on therapies and restorative social arrangements in African diaspora communities in the United States.

Sarah Sobonya is a graduate student in medical anthropology at the University of Kansas. Her interests include the anthropology of violence and suffering. This summer she is studying at Al Akhawayn University in Ifrane, Morocco.

Mary Sundal is a PhD candidate at the University of Kansas. She has worked on two ethnographic projects in Karamoja, Uganda examining the impact of armed cattle raiding and the introduction of biomedicine on local health and healing methods. She has also conducted research among Karimojong migrants residing in Kampala, Uganda.

Maria Weir is a Ph.D. student in sociocultural anthropology and a master's student in public health at the University of Kansas (KU). She is also a research associate in the public health department at Kansas University, where she takes part in collaborative research with the Kansas City-area Native American community. Her regional interests are Central Asia and the U.S. Her research interests include the political economy of health, global health security, and medical pluralism.

Relaxing after the panel in the hotel cafeteria. Left to right: Armin Prinz, Unit Ethnomedicine and International Health, Medical University of Vienna; Karla Kral, University of Colima, Mexico; Melissa Filippi-Franz, Heather Meiers, Shawna Carroll, James Herynk, John M. Janzen. Photo by Ellen Gruenbaum. Other members of panel not shown.

Photograph last page

Disciplinary paradigms, like wildplants, thrive in a community of complementarity. Here the Dotted Gayfeather (*Liatris punctata* Hook.) grows luxuriant on the fall Kansas prairie surrounded by tallgrasses and forbs – big bluestem, switchgrass, Indiangrass, Western wheatgrass and sunflowers. The boiled root of the gayfeather has been used in native American medicine for swellings and intestinal pains.

Dotted Gayfeather (*Liatris punctata* Hook.)