autumn 2010 volume XIII number 1

ven

viennese ethnomedicine newsletter

Children in Romani *osadas*

CENTRE FOR PUBLIC HEALTH, MEDICAL UNIVERSITY OF VIENNA
quondam ACADEMIA CAESAREO - REGIA IOSEPHINA 1785

unit ethnomedicine and international health

Frontispiece

Children are everywhere in Romani *osada*s. They play, shout, dance and *keren bengipen* (do mischief) on the streets, alleys and yards. These semi/segregated, poor Romani settlements, especially frequent in the eastern part of Slovakia, are characterized by a fertility rate several times higher than that of the non-Romanies. In the rural areas, an aging, relatively affluent non-Roma population is thus confronted with growing numbers of young, marginalized Roma raised in dire poverty. Relations are tense, prejudices fervent, dialogues few.

(photograph: Susann Huschke, see article by Edit Szénássy 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.

Content

Getting In, Getting Along, Getting a Grasp: Reflections on Doing Hospital Ethnography in a Psychiatric Ward "At Home" (Nina Grube) 3
Culturing the Population Bomb: On Slovak Fears of Roma Wombs (Edit Szénássy) 9
Forms that Transform: The Role of the Crescent and the Minarets in the Creation of Homosocial Healing Communities among Turkish and Muslim Migrant Women in Vienna (Hwiada Abubaker) . 19
MD Theses 2009–2010 28

Submissions, announcements, reports or names to be added to the mailing list, should be sent to:
Editors, Viennese Ethnomedicine Newsletter, 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

Getting In, Getting Along, Getting a Grasp: Reflections on Doing Hospital Ethnography in a Psychiatric Ward "At Home"

Nina Grube

Introduction: Two Scenes From the Field

Entering

It is a sunny but chilly afternoon in October and the crisp air fills my lungs while I am riding my bike to the local general hospital, a mere 20 minutes away from my house. I am on my way to the psychiatric clinic, part of the district's hospital, to introduce myself and the topic of the research that I intend to carry out there a few weeks later. The bungalows that accommodate the psychiatric wards are set apart from the main hospital-building. Arriving at the glass-door of the ward, I find it locked and ring the bell on the wall next to it. A nurse unlocks the door, shoos me in, and quickly closes it behind me again. Upon my introduction she points me towards the staff-room. I cross the dimly lit hall that smells of detergent, unwashed bodies and lunch. A few patients are lingering about, and I can hear familiar ping-pong noises from a nearby room. When I enter the staff-room, the team-meeting has already been in progress for some time, and 20 or so curious faces are looking at me. People sit around a group of tables put together in the middle of the room. I am assigned a chair and the head nurse, whom I have met before, introduces me to everyone. I have about 15 minutes to talk about my research-plan. I briefly lay out my research-question, which concerns the psychiatric treatment of patients with a migration background and thus with the encounter of different cultural models of mental illness in a psychiatric ward. I also quickly describe the methods I plan to use, participant observation, interviews and all. Everyone follows attentively, but after I have finished and encourage them to ask questions, there is a long silence. At last, the music therapist comments, how nice it will be to have a non-clinical view on mental illness and to learn something about "other cultures". A few people nod in agreement. Then, one of the nurses looks at me critically and says: "Well, you are most welcome here. But, to be honest, I don't know if you will find out anything important. An illness is an illness and we treat everyone the same, migrants or whatnot. There is nothing cultural about that."

Immersing

Half-way through my time on the ward, an acute psychotic patient, from an African background, is committed to the ward. Despite having been treated intermittently on this same ward for about two years now, the staff does not know which country he is originally from. When I talk to him, he tells me that he is from Ghana. Other than very detailed descriptions of the symptoms and the behaviour that the patient is displaying on the ward, his patient file contains no information about his socio-cultural background at all. According to the staff, he is a chronic schizophrenic with a long history of hospitalisation and difficulties with living on his own outside the clinic. One day, the patient and his family are the subject at the weekly team meeting. The discussion centres on the problem of finding a solution for his difficult living situation and how to get him to agree to move into an assisted living facility. In this matter, the patient's family is unanimously perceived as ignorant and unsupportive by the staff. They are alleged to not understand the structures and responsibilities of the district's mental health services. The discussion of the staff is heated at first and then dies down, leaving a helpless atmosphere hovering in the room. With a sigh, one of the nurses turns to me and asks: "This patient is African, isn't he? So please tell us, what's cultural about this situation now?" Puzzled by such a general question, I tentatively begin to explain that based on past experiences, the patient's family might be suspicious of official authorities or they may not even speak German well enough to understand the structures of the German health care system. But another staff member soon cuts me off: "Well, I don't agree with you here, not everything can be explained by culture.

I think these things are always individual problems. We always have to look at the unique and individual situation of the patient."

Institutional Psychiatry As a Fieldwork Setting: Getting In

In this article, I reflect on my experiences of getting access to the research field and on interacting with people in the field during my ethnographic research at a psychiatric ward of a general district hospital in Berlin[1]. I claim that the process of understanding the role one gets allocated as an ethnographer by others in the field and of coming to terms with the difficulties one encounters during the research is inherently connected to the generation of knowledge about the field.

Hospital ethnography is a relatively recent subject of research in social anthropology. For decades, hospitals held hardly any appeal for ethnographers, with the exception of a handful of studies (Caudill 1958, Coser 1962, Fox 1997 [1959], Goffman 2006 [1973]). This might be due to the fact that hospitals were seen as too close to home and not "exotic" enough to spark the interest of ethnographers; they were also considered mere examples of a globally homogenous biomedicine (van der Geest, Finkler 2004: 1995). Since the postcolonial turn in the social sciences and social anthropology's interest in the ramifications of globalisation, biomedical cultures have received new attention from medical anthropologists, and hospitals are now being investigated as culturally varied social institutions. Recently, several ethnographies in different cultural settings have shown how locally specified norms and values are being played out in clinical spaces (Anderson 2004, Finkler 2001, Mulemi 2010, Zaman 2005). In that regard, hospitals hold a particular position at the interface between global and local flows. At present, however, there are still relatively wide gaps in regard to ethnographic hospital research. This might also be due to the difficulties that ethnographers have in accessing hospitals. Hospitals are extremely structured and hierarchically organised institutions; they are "protected and exclusive/excluding spaces" (Long et al. 2008: 71). Hospital administrators as well as medical staff might be very reluctant to let outsiders, particularly non-medical researchers, conduct fieldwork on their grounds. This applies even more to the case of psychiatry where staff and hospital ethical committees consider patients to be particularly vulnerable to scientific abuse and demand that ethnographers follow various bureaucratic requirements. Oeye et al. (2007) describe the challenge of employing participant observation as a research method during their ethnography of a psychiatric ward when the regional committee of medical research ethics requests that they obtain every patient's informed consent for every single observational act they are undertaking. In my own research, I was mainly confronted with the staff's protective attitude towards patients when I was more or less actively discouraged from interviewing them. The reason which I was given for their precautions was a medical one: the stress of talking about their diseases could cause patients to relapse into psychosis or delusions. Seeing that patients are actually required to talk about their diseases on various occasions during any given day on the ward, such as on ward rounds, in group therapies, or in informal conversations with staff, I suspected that the real reasons for the staff's behaviour lay somewhere else. The hospital insisted that I formally introduce myself to the patients, which in addition to presenting myself at several weekly patient meetings on the ward, I did by putting up an information sheet on the blackboard of the ward describing my research-plan in simple words. Although I was also intending to focus on the patients in my research, the head doctor requested that I should refrain from stating this explicitly on the information sheet as to "not disturb the patients". Instead, on paper I had to officially make the staff the focus of my work. It appears that in the history of psychiatry an inverted development has taken place from its beginnings when patients were locked up to protect society from them (Porter 1987: 16) to the current view of protecting the patients from society[2]. Describing his own ethnographic research in a Kenyan hospital, Mulemi confirms the experience of the staff's protective attitude regarding contact with patients and their reluctance towards the ethnographer's use of the hospital facilities during the research process (Mulemi 2010: 26). The reasons for the staff's attitudes might not always be immediately apparent to the ethnographer. Coming to terms with them is part of the process of negotiating the ethnographers'

position in the clinical setting and can methodologically be used for gaining knowledge about the field, as will be further illustrated in the course of this article.

The ethnographer's encounter with hospital regulations starts even before the actual research can take place by facing the challenge of actually gaining access to a clinical space. I began to search for an adequate hospital almost five months before I finally got an appointment at one to introduce myself. It took me five months to find my actual research field even though I was at home in the city where my research should take place and was thus familiar with the local conditions. Regarding the access to hospitals as research sites, van Ginkel questions the usefulness of the concept of "anthropology at home" as a distinguishing feature versus "anthropology abroad". He emphasizes that despite the deceptive appearance of familiarity to the Western ethnographer, a hospital in the US or Europe can have as many gatekeepers as a secret society in Africa (van Ginkel 1998: 261).

I started out my quest for my research site by writing emails to a number of doctors in random hospitals all over Berlin (and even in other cities) and asked if I could send them my research outline. I was mainly interested in the encounter of clinical psychiatry with patients with a migration background who might hold differing concepts to the biomedical view in regard to their diseases and their treatments. I was curious to find out if these patients consulted other medical or religious specialists outside the clinic and if they sought alternative ways of treatment besides the biomedical one, and how clinical psychiatry deals with that fact. But as a response to the lack of research in hospital ethnography of German psychiatry, my research was also very generally concerned with the question of how biomedical psychiatry treats its patients. Well, I did not hear back from most of the hospitals that I contacted, but a few responded and showed some interest. Social anthropology as an academic discipline, especially the work of medical anthropologists, is not widely known among the German public, when compared for example to the UK, where medical anthropologists already work in health research alongside medical staff in hospitals[3]. Therefore, most of the time, once I sent out my research outline, I was then required to further explain what social anthropology is concerned with in general and what I was focusing on in my research in particular. I thus sent numerous emails to which I mostly never got a response again; some hospitals showed interest in collaborating, but actual meetings were postponed until it became clear to me that they were never going to happen. It was frustrating. The whole process of finding "my field" got stalled again and again and I was never really successful. In the end, the only way that I got this particular hospital in Berlin interested in a collaboration was through a personal connection. It turned out that I knew one of the doctors working there as we are both members of the same association for transcultural psychiatry. The difficulties of ethnographers with gaining access to clinical spaces have been described before (van der Geest, Finkler 2004; van der Geest, Sarkodie 1998). Often, the only way for anthropologists to obtain entry can be to resort to personal connections. Zaman, for example, who before becoming a social anthropologist has also received training as a medical doctor, states that in order to be able to conduct hospital ethnography in his native Bangladesh, he had to evoke his "physician identity" and fall back on his former training hospital (Zaman 2008: 137). After drawing on my contact to this doctor to have my research proposal looked at by the responsible officials at the hospital, it took another two months before I got an invitation to an introductory meeting with the chief of psychiatry at this hospital. Hospitals are bureaucratic institutions whose mills grind slowly.

The introductory meeting with the ward's staff, described in the first scene of the introduction, was just one of many meetings with different staff members and administrators of the hospital as part of gaining access to the research field. Hospitals are hierarchically sub-divided into different compartments, so that I had to work my way down from the top-level of the hospital administration via the chief of psychiatry to the level of the psychiatric ward that was appointed to me as my research field. Curiously, my research proposal was not required to be signed off on the hospital's committee for research ethics. It is possible that the hospital did not have any previous experience with social anthropologists as researchers on

their premises. Therefore, once I obtained the consent of the chief of psychiatry, I was handed over a contract for an internship in the psychiatric clinic.

Losing One's Bearings in the Field: Getting Along

As part of my internship position and for the duration of my presence at the clinic, I obtained a key to the psychiatric ward. The psychiatric clinic's policy is generally one of "open doors", meaning that the doors to the wards are usually kept unlocked except if a patient is involuntarily committed and the staff feels that there is a considerable risk of him or her absconding from the ward. This key not only unlocked the doors to the staff room, the patients' lounge, and the ladies' bathroom for me; it most importantly gave me admission to the nurses' room right next to the door of the ward. There, the patients' files and other important documents as well as the medicine cabinets are stored. It also contains the wards telephone switchboard. The nurses' room has a glass front overlooking the hall and the door to the ward, thus simultaneously serving as a monitoring room and as reception. During the day, it is the busiest room on the ward with doctors, nurses, and therapists coming in to drop off and gather files, make calls, or write down notes at the computers, quickly exchanging their views on patients, who come strolling in to collect their pills. For this reason, I spent a lot of my time there, observing the staff performing their work and the general comings and goings of the ward. Because of my presence in the nurses' room and my possession of a key, the patients never mistook me as one of them. I cannot help but think that this key, on the one hand, was literally opening the doors to my research field; on the other hand, because of its association with a professional position, it may also have closed some other doors that would have led to a closer contact with patients. In psychiatry there is a sharp distinction between staff and patients, not only because the former are professional helpers and the latter are on the receiving end of the help but due to the fact that the staff is considered sane or normal whereas the patients are seen as the insane or abnormal ones. So once I was associated with the professional side, I was also on the other side of the sane/insane split from the patients. Like the patients, the staff members commonly wear their plain clothes during their presence on the ward instead of a uniform. The external distinguishing feature between them, besides the staffs' possession of keys, is their badges stating their names and professional positions. For whatever reason, I was given a key but no badge, so that patients were continuously trying to figure out my position and my role on the ward. As were the staff members. As I was myself.

Wind (2008: 82) points out that there are three different roles available in a hospital setting: the role of patient, the role of professional team member, and the role of relative or visitor. None of these roles is practicable for most anthropologists (Zaman 2008: 139), the only viable role is that of the researcher. But, as Wind describes vividly, to most non-anthropologists the working methods of an anthropologist seem incomprehensible, insignificant or even bizarre: "hanging around, asking weird or even dumb questions, drinking coffee, taking notes, chatting" (Wind 2008: 83). However, on a psychiatric ward there a re generally a lot of people – staff, patients, and visitors – just hanging out, writing things down, or behaving in a weird way so that at first glance my own actions such as observing others and scribbling down notes were not obviously out of place. Wind also states that hospital staff members going about their daily work might often feel watched, monitored, or judged by the ethnographer's presence, in addition to the constant clash between the fulfilment of urgent tasks required of medical professionals, often revolving around matters of life and death, and the unoccupied anthropologist who apparently does nothing. On a psychiatric ward, medical treatment seldom is a question of life and death. And despite the heavy workload that the staff members have to master, they were always making time to answer my curious inquiries. In addition, during my time on the ward there were frequently new faces among the staff such as nurses from temporary employment companies, medical or clinical psychology interns, or nursing students. Since all these interns and students are mainly learning through observing the work of others, I did not stand out to a great extent by doing ethnographic observations. Despite this fact, I was still continuously asked by staff and patients alike to explain

what I was doing on the ward and what exactly I was interested in finding out there. Wind introduces the notion of "negotiated interactive observation" to replace the concept of participant observation in the research setting of a clinical ward. She argues that the highly specialised work activities of health care professionals make an actual *participation* of the anthropologist in the clinical setting almost impossible and also collide with the seemingly trivial ethnographic work routines, thus leading to a stressful encounter between the two parties (Wind 2008). The concept of participant observation emphasizes the anthropologist's agency over her fieldwork but in a hospital setting we often simply do not have this agency. With her notion of "negotiated interactive observation", Wind highlights instead the process of reciprocal sense-making that is continuously going on in the interaction of hospital staff and anthropologists. As I have just described, in my fieldwork setting I did not experience these same methodical problems as Wind. Instead, the re-appearing friction between the staff and me were regarding to the *content* of my research. I would, however, still like to take up Wind's notion of "negotiated interactive observation" in regard to my own fieldwork, by this emphasizing the aspect of the negotiation of my own position and the role that I was allocated in the clinical setting as well as its interconnection with my progress in gaining insight into the field.

As I mentioned briefly at the beginning of this article, my research on the ward was concerned with the interaction of mental health care professionals and patients from different socio-cultural backgrounds and the encounter between different cultural models of mental illness. During the course of my ethnographic fieldwork, the staff continued to emphasise that there existed no significant difference between the illness experience and the psychiatric treatment of patients with and without migration background and that the treatment was always focusing on the individual and unique situation of every patient. As far as I could observe myself, transcultural encounters did in fact not play an obvious role in the ward's routines. Despite numerous examples from transcultural psychiatric as well as anthropological literature about the difficulties of migrants within the biomedical mental health care system (Assion 2004; Gaines 1992; Littlewood, Lipsedge 2004) and regardless of the fact that approximately one third of the patients on "my ward" were from a non-German socio-cultural background, I could not notice cultural factors playing an apparent role in encounters between staff and patients. Even though staff members were thus, on the one hand, negating the relevance of cultural aspects regarding their biomedical psychiatric practices, they were, on the other hand, assigning me the role of expert on cultural questions. They were trying to make sense of my research goals, my actions and behaviour on the ward exactly as I was seeking to understand theirs. Furthermore, they were intentionally staging aspects of life on the ward or patients histories that they were considering relevant to my research-question. For example, during one of my attendances at a music therapy session, the therapists encouraged a Turkish patient to play a traditional instrument and perform songs from "his culture" for me because I was interested in "culture". Since the staff discouraged my interviewing the patients, I continued to observe their work and life on the psychiatric ward, meanwhile being afraid that I might have lost track of my actual research-question and my agency as an ethnographer, and doubting my original assumptions.

Conclusion: Getting a Grasp

Only now, after having recently finished my research in the psychiatric ward and just starting to look over the collected data, do I notice several things: the absence of *obvious* encounters between different cultural models of mental illness does not mean that cultural factors do not play a role in the clinical setting at all; they are just not as evident as I expected them to be. Cultural differences do not emerge on the ward in terms of disagreements between clinic staff and patients concerning the interpretation of symptoms or the treatment of illnesses. Instead, they are mainly referred to by the staff in regard to the management of organisational problems on the ward. These problems consist, for example, of dealing with language barriers between patients and staff or the handling of patients' families that do not observe visiting hours, since, so it is said, in "their culture" they have difficulties adhering to official rules and regulations. Structural problems are thus perceived as cultural differences by the staff.

The apparent absence of references to cultural factors in the daily work routines of the psychiatric staff and their negation of any relevance of socio-cultural aspects to patients' illnesses reveal that in the space of the ward a distinct *psychiatric culture* itself is being enacted; it refers to biomedical values and a distinctively Western social-psychiatric tradition of preoccupation with the individual, itself of course being a Western concept (Morris 1994). This becomes clear when taking into account Wind's notion of negotiated interactive observation and reflecting on my role as an ethnographer researching "migrants and culture" in a psychiatric ward. When considering the role that the staff assigned to me on the ward as an "expert on culture" versus their claiming roles as "experts on psychiatry", concepts of culture versus psychiatry/biomedicine that are deeply rooted in Western European thought are rendered visible. In this view, psychiatry is understood as a scientific, objective, universal practice designed to treat individual but universally identical bodies, minds and diseases, as opposed to particular cultures which are perceived as accessories attached to patients, like for example the ability to perform Turkish folksongs. Inherent in this perception is also a reference to local German socio-political discourses on "culture" and cultural diversity.

In this article, I have reflected on doing ethnography in an institutionalised psychiatric setting. On the basis of empirical data presented here, I have illustrated the process of gaining access to a clinical research field and negotiating research conditions with gatekeepers. In following Wind's approach, I have shown the difficulties I have had in conducting participant observation in a clinical setting; as an alternative possibility I have applied her concept of "negotiated interactive observation" to my own fieldwork. Lastly, I have claimed that by making sense of the research process and reflecting on relations to counterparts in the field as well as the ethnographer's assigned role, research insights can be gained.

Notes

[1] This article is a revised version of a paper presented at the "1st meeting of the Medical Anthropology Young Scholars (MAYS)", organized by the student representatives of the Medical Anthropology Network, European Association of Social Anthropologists (EASA), held in Berlin, Germany, February 11th-12th 2010. I thank the Fritz Thyssen-Stiftung for granting generous project funding enabling me to carry out research.

[2] I am grateful to Dr. Helene Basu for pointing this out to me (personal communication, April 2010).

[3] Workshop on "Applied Medical Anthropology" with Dr. Rachael Gooberman-Hill and Dr. Kathryn Tomlinson, February 12th 2010 (personal communication).

References

Anderson, H. M. (2004) "Villagers": Differential treatment in a Ghanaian hospital. In: Social Science and Medicine 10, 59: 2003-2012.

Assion, H.-J. (ed.) (2004) Migration und seelische Gesundheit. Berlin: Springer.

Caudill, W. A. (1958) The psychiatric hospital as a small community. Cambridge: Harvard University Press.

Coser, R. L. (1962) Life in the ward. East Lansing: Michigan State University Press.

Finkler, K. (2001) Physicians at work, patients in pain: Biomedical practice and patient response in Mexico. Durham, N.C.: Carolina Academic Press.

Fox, R. C. (1997) [1959] Experiment perilous: Physicians and patients facing the unknown. New Brunswick, N.J.: Transaction Publishers.

Gaines, A. D. (ed.) (1992) Ethnopsychiatry: The cultural construction of professional and folk psychiatry. Albany: State University of New York Press.

Goffman, I. (2006) [1973] Asyle: Über die Situation psychiatrischer Patienten und anderer Insassen. Frankfurt a.M.: Suhrkamp.

Littlewood, R., Lipsedge, M. (2004) Aliens and Alienists: Ethnic Minorities and Psychiatry. East Sussex & New York: Brunner-Routledge.

Long, D., Hunter, C. L., van der Geest, S. (2008) When the field is a ward or a clinic: Hospital ethnography. In: Anthropology and Medicine (special issue: Guest editors C. L. Hunter, D. Long, S. van der Geest) 2, 15: 71-78.

Morris, B. (1994) Anthropology of the self: The individual in cultural perspective. London: Pluto Press.

Mulemi, B. A. (2010) Coping with cancer and adversity: Hospital ethnography in Kenya. Leiden: African Studies Centre. https://openaccess.leidenuniv.nl/bitstream/1887/15029/2/ASC-075287668-1048-01.pdf (05.09.2010).

Oeye, C., Bjelland, A. K., Skorpen, A. (2007) Doing participant observation in a psychiatric hospital: Research ethics resumed. In: Social Science and Medicine 65: 2296-2306.

Porter, R. (1987) A social history of madness. The world through the eyes of the insane. New York: Weidenfeld & Nicolson.

van der Geest, S., Finkler, K. (2004) Hospital ethnography: Introduction. In: Social Science and Medicine 10, 59: 1995-2001.

van der Geest, S., Sarkodie, S. (1998) The fake patient: A research experiment in a Ghanaian hospital. In: Social Science and Medicine 9, 47: 1373-1381.

van Ginkel, R. (1998) The repatriation of anthropology: Some observations on endo-ethnography. In: Anthropology and Medicine 3, 5: 251- 267.

Wind, G. (2008) Negotiated interactive observation: Doing fieldwork in hospital settings. In: Anthropology and Medicine (special issue: Guest editors C. L. Hunter, D. Long, S. van der Geest) 2, 15: 79-90.

Zaman, S. (2005) Broken limbs, broken lives: Ethnography of a hospital ward in Bangladesh. Amsterdam: Het Spinhuis.

Zaman, S. (2008) Native among the natives: Physician anthropologist doing hospital ethnography at home. In: Journal of Contemporary Ethnography 2, 37: 135-154.

Culturing the Population Bomb: On Slovak Fears of Roma Wombs

Edit Szénássy

Abstract

The present paper analyzes some of the current taken for granted discourses produced by media and public actors around the reportedly excessive nature of Romani reproduction in Slovakia. It examines allegations about the dangerous consequences of Romani women's high fertility rates and emphasizes that they are built around socially constructed stereotypes and prejudices about the Roma, rather than empirical facts.

From a theoretical point of view, this paper is inspired by the anthropology of reproduction, which understands reproduction as not a merely biological, but also a culturally mediated and politically influenced act. In this contested field women as reproducers of the nation, bearers of the collective, gain a particular significance. Therefore, the discouragement of the reproduction of some segments of the population, while encouraging others, is an important means of governance. In Slovakia, demographic concerns about the falling birth rates of the nation have widely discussed increasing Romani births in the context of a future threat about Roma outnumbering Slovaks. Such essentializing perceptions of the reproductive other, this paper suggests, are harmful in various ways, and lead to the further exclusion of Romanies in the region.

Introduction

> When now and then I see those photo shots from the *osadas* [segregated Romani settlements] in which herds of naked, chubby and ragged children are chasing gaunt dogs and cats while their incestuous parents are watching them with a satisfied smile – the question I'm thinking of is – which community is going to integrate into which one … It is a population bomb that is bound to explode. Pjotr (SME, discussion board, 2009)

> The myth of overpopulation is destructive because it prevents constructive thinking and action on reproductive issues. Instead of clarifying our understanding of these issues, it obfuscates our vision and limits our ability to see the real problems and find workable solutions. Worst of all, it breeds racism and turns women's bodies into a political battlefield. It is a philosophy based on fear, not understanding. (Hartman 1995: 4)

When I tell people about my ongoing anthropological fieldwork research[1] focusing on Romani reproductive decision-making and population politics in an East-Slovakian Romani *osada*, a slum-like Romani settlement, I tend to get striking responses. Immediate reactions of friends, acquaintances, family, or non-Roma (*gadže* in Romanes) field-informants

range from outrage that once again, further funds are invested into research and advocation of Romani issues, to detailed explanations about what their own version of a solution for the "Romani problematics" (*rómska problematika* in Slovak) would be. This obscure, simplistic term is frequently used by laymen, politicians and the media to refer to the enormous social and economic costs resulting from the systematic, historical discrimination of hundreds of thousands of extremely poor Roma living in fully or semi-segregated settlements in Slovakia. Not wishing to confront the same suggestions for the so-called "solution" over and over again, I tend to interrupt by explaining that I am looking into who, when and why has children, in other words, I am researching contraceptive usage and reproductive care among Roma living in dire poverty. Reactions tend to be no less trenchant. Anecdotes follow of Romani women leaving their new-borns in the hospital maternity ward, or of conscious Romani attempts to milk the state by accumulating a fortune on child-benefits, etc. Dumbfounded by such openly racist remarks, what puzzles me even more is the vehemence by which these accounts are delivered.

Inspired by the anthropology of reproduction, a domain of social and medical anthropology that understands reproduction as not only a biological act but as a culturally mediated and politically contested field, an "ongoing social and political construction" (Greenhalgh 1994: 5), this paper explores the processes through which the reproduction of Roma in Slovakia is imagined and constricted. The author of this paper does not aspire to answer the question of why Roma have many children, as I am often asked point-blank by *gadže*. That particular question can only be satisfactorily answered by pointing out all the complexities of reproductive decision-making among people living in dire poverty – the subject of my future dissertation. Currently being six months into my year-long fieldwork, the question I hope to clarify is: Why do *gadže* in Slovakia feel so strongly about the high reproductive rate of Roma? What are the recent public discourses that shape these sentiments?

The first part of this paper draws on anthropological literature about reproduction, power, and population politics, asserting that these are closely related, inseparable fields. Reproduction, from an anthropological point of view, involves many more actors besides the parents, the family/community, and their reproductive wishes and strategic choices. Through policy action, medical, and social care, it also encompasses the state's choices about the kind of citizens it wishes to legitimize as its future population. Public discourses around the reproduction of a poor and marginalized ethnic minority often, as will be shown by this paper, evolve around two topics: the claim that the given minority is reproducing at a greater speed than it "should", and that this poses a threat to the majority which bear fewer progeny. The media actively participates in the construction of such alarmist claims by offering normative, but also discriminatory, understandings of Romani reproduction. As a rule, these accounts are supplemented by vivid audio-visual material featuring a high number of preferably semi-naked, unclean, *osada*-living Romani children. Using textual analysis of recent popular material (especially Slovak daily newspapers) I will then show how journalists and other public figures, such as physicians and demographers construct the image of Roma as "polluting" the Slovak nation. In these accounts, the Roma are often pictured as a time bomb which is bound to explode, leading to unforeseeable consequences. Another way Romani reproduction is portrayed as dangerous is through the metaphor of endlessly reproducing malign cells that threaten the bodily integrity of the Slovak nation. The image of the Slovak social body as suffering from an illness that is to be cured brings up the topic of considerably higher Romani reproduction rate in the discourse of best health interests for "all". This logic is reminiscent of the past regime's paternalistic suggestions for lowering the Romani fertility rate for the sake of a "healthier nation", which were employed to justify discriminatory policies toward an already marginalized ethnic group.

Quantifying the "Romani Problematics"

With its capacity to reproduce, women's bodies have long been seen as loci of public interest, as various social actors such as families and states understand themselves as having much at stake in the control of childbearing and childrearing (Gal and Kligman 2000: 17). Who should conceive, have babies, how many, and under what

circumstances is a highly politicized matter which can be best grasped from the perspective of complex relations between state politics, nationalism and gender roles as the number of babies one has becomes one of the main ways to trace power (Kanaaneh 2002: 8). Anthropologists Ginsburg and Rapp have theorized women's bodies as sites of politicized battles over reproduction, and employ the concept of "stratified reproduction" to describe the "power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (Ginsburg and Rapp 1995: 3).

It is false to dichotomize natural and controlled reproduction, as reproduction as a biological process also takes place in specific social, political, and economic processes which constrict it. Reproduction is also highly gendered: women's bodies have always been instrumental in ensuring the interests of the state, namely, not only a large population, but also a population of an adequate quality, for as biological producers of children, women are also bearers of the collective (Yuval-Davis 1997: 26). The quality and quantity of both the reproducing women and their offspring is thus an issue of foremost concern to the state, a *savoir* of government that is manifested in population policies all over the world.

Similarly to the European trend, birth rates in Slovakia are on the fall, yet the country still has one of the youngest populations in Europe with a natural increase slightly above zero. Due to a striking lack of research in this area (as also noted by Potančoková et al. 2008: 976), knowledge about reproductive plans and intentions of Slovak women is scarce. In demographic research, compared to other Western European countries, Slovak society is described as conservative, characterized by the strong influence of the church, a relatively low divorce rate, and early age at marriage as well as first birth. The strong pro-natalist fertility policies of the 1970s (resulting in 2.1 child per woman) were followed by a steep downfall in the reproductive rate after the collapse of the communist regime, reaching its lowest in 2002 with a rate of 1.18 per woman (Potančoková et al. 2008: 975ff.).

The socio-economic transformations of the 1990s were starkly reflected in reproductive regimes. As birth rates are falling below replacement level, women (but not men) are encouraged to fulfill their reproductive roles, and are suspected of giving preference to "the enlarged opportunities for studying, building a professional career, traveling", while other factors setting back child-bearing, such as growing social insecurities, insufficient infrastructural child-care support and the continued discrimination of women coupled with shifting gender relations are reduced to "difficulties of young adults in the labor-market" (Potančoková et al. 2008: 980).

Slovak Roma exhibit an entirely different reproductive pattern. While the tendency for the "majority population" (Potančoková et al. 2008: 991) is a one-child per family model (Potančoková et al. 2008: 985), the Roma, who constitute about seven percent of the overall population, are claimed to have "disproportional influence" on demographic development in Slovakia (Potančoková et al. 2008: 991), their fertility rate being several times higher than that of Slovak women. The failure to specify just who exactly qualifies as Roma and who passes as a member of the unmarked "majority population" sheds light on the self-evidence of a colorful vision in the country. Strangely enough, Potančoková et al. included the second significant minority, ethnic Hungarians, who constitute about nine percent of all inhabitants and supposedly exhibit a fertility pattern similar enough to that of ethnic Slovaks so as not to be noted otherwise, in the "majority population". This strikes an especially sensitive chord in the anthropologist writing these lines, as the ethnic group she belongs to would as a rule be portrayed as a sovereign, but often also problematic and hostile national minority in Slovakia. To be sure, we are talking about a clandestine agreement, signed by both ethnic Slovaks and Hungarians, on white hegemony conceptualized in skin color: my *gadže* informants are quite comfortable with using the terms *biely* ("white" in Slovak) and *čierný* ("black" in Slovak) when referring to ethnic Slovaks versus Roma in the village (also see Scheffel 2005 in general).

Apparently, the will to know the precise quantity of poor Roma in Slovakia was the main motivation behind a research by the Bratislava-based Demographic Research

Centre. Their statistical survey of the *osada*-living Romani population "The reproductive behavior in municipalities with low living standard" (Vaňo and Mészáros 2004) was discussed in a number of newspaper articles at the time of its publication, and raised much public interest. Although it does no verify popular fears of a possibility of Romani population explosion in the country, it sees Romani "culture" and "tradition" as important factors that regulate the reproductive behavior of Roma, especially those living in segregated *osadas*, whose fertility is 4.5 times higher than what is denoted as the "other population" (ibid.: 17).

Although high fertility-rate is justifiably linked to the extent of segregation/integration, culturalist explanations of why this is so abound. Accordingly, one of the "traditions" that "seems to be very strong" is child-bearing at an early age. Cohabitation, in which a high proportion of these children are born (instead of wedlock, as among the non-Roma "other population") is also understood as a specific Romani attitude to the family, arising from a "different cultural tradition and value orientation" (Vaňo and Mészáros 2004: 10). Besides the fact that such generalizations leave integrated Roma's (whose fertility is identical to that of *gadže*) cultural identity unclear, it also hopelessly conflates concepts such as culture, tradition and values. True enough, anthropologists, so-called specialists in culture, are far from reaching a unanimous agreement about what it actually means and how (not) to use it, yet as Hammel notes after reviewing demographic usage of the concept before 1990, demographers tend to draw on structural-functional definitions of culture that are "about 40 years old, hardening rapidly, and showing every sign of fossilization" (quoted in Greenhalgh 1995: 19, also see Kertzer 1995). In this case, they turn their backs to a long history of discrimination, stay blind to the power differentials arising from socio-economic inequalities, and ignore the complex and contradictory character of access to contraceptive care and individual/group fertility decisions.

Even when Vaňo and Mészáros explicitly argue against seeing the Roma as a homogeneous group, they maintain that "*It is common knowledge* that the Roma/Gypsy population differs from the other in the way of living, living and education standards and reproductive behavior, too" (2004: 16, emphasis added). This otherness is summarized as an overenthusiastic, uniquely Romani attitude to child-bearing that the "other population" lacks: "Maybe the majority society should be more inspired by the Roma/Gypsy attitude to family and children, and the reproductive characteristics of the Roma/Gypsy population and the other could meet somewhere in the middle. The Roma/Gypsy population is lacking in more responsibility for reproductive plans and the other population is short of greater passion for family and children. Just the connection of natural Roma/Gypsy relation to families with many children and the other population [sic!] responsibility for family living standard might be the appropriate reproductive model in the future [sic]." (Vaňo and Mészáros 2004: 18)

According to the study, Roma are enthusiastic child-bearers – a popular stereotype. Yet their reproductive decisions are non-decisions: their presence is but an absence. In a context of limited ethnic Slovak births, opting for numerous children proves Roma's absence of conscious planning, a failure to craft a better future. Such "irresponsible" behavior delegates Romani parents out of the domain of rationality, assigning them a passive concept of reproductive agency (Carter 1995: 55). Yet Roma are captivated by a passion that the "other population" does not posses. Deliberately regulating the size of their families through abstract rationality, the latters' is and active reproductive agency (Carter 1995: 55), a calculated rationale instead of an ephemeral infatuation. Nevertheless, neither of these attitudes, the authors of the study conclude, are desirable in themselves. Nature and culture must be connected, as only by meeting somewhere in the middle can a brighter demographic future be reached. However, creating such links between development and fertility rate is tantamount to looking a fertility in an evolutionary way (also see Greenhalgh 1995: 10). Within this logic, rich, modern bodies are created by careful calculation, whereas the fertility regimes of the poor enact a bygone tradition, thereby casting a shadow on national progress.

Where demographers see "vital events" such as fertility, the number of live births per woman

conveyable in statistics, trends and population forecasts, anthropologists look at the myriad ways how biological fertilities are translated into social families. The complexity of reproductive decisions is impossible to quantify in the language of science, as it would obscure the different kinds of power positions, pressures, wishes and hopes that such a resolution entails.

The Political Economy of Romani Fertility

> Nane čhave, nane bacht.
> No children, no happiness.
> (Romani proverb)

The above demographic accounts illuminated a number of popular arguments behind the so-called population explosion of Roma in Slovakia. These discourses are often conflicting: Romani women's high fertility is often portrayed as a calculated attempt to exploit the ostensibly generous welfare system , yet at the same time, it is interpreted as the sole source of agency and control over their lives. In an article of SME, the largest Slovak daily paper (Jesenský 2008a), a Roma man from Jarovnice is quoted: "For Roma, children are holy. Who doesn't have children is seen as inferior. You can hardly do something about this." Reductionist assumptions such as these obscure the complex experiences, life-worlds and agencies that individual Romani women (and men) demonstrate throughout the course of their lives as well as with regard to making particular reproductive decisions.

An internet search of Slovak newspapers with the keyword "rómska populačná explózia" (Romani population explosion) yields multiple results. When discussing the lack of school places for Romani children, a 2002 article form East-Slovakian Korzár daily (Kaleta 2002) offers the following explanation: "(…) the ultimate cause of the problem is well-known. Population explosion in the *osadas*" (settlements). The situation is numerically illustrated by the headmaster of the school: "When I came here in 1991, we had 121 pupils. Today there are 426." Somewhat illogically, "Population explosion" is the subheading of a 2008 article which in fact deals with a successful integration of local Roma into the workforce. Allegedly, before American investors decided to provide local Roma the opportunity to work at the steel factory, the latter would calculate the number of children they need to bear in order to compensate for the decrease in welfare benefits after 2000 – according to the author, out of the 3160 population of Veľká Ida there are 1200 Roma, and every year there is an increase of 60 Roma newborns (Jesenský 2008b). A decade after the devastating flood that killed almost sixty Roma in Jarovnice, the mayor said to the reporter of SME: "What has changed within these years is mainly the number of inhabitants. Last year there were two hundred newborn babies, 199 out of these of Romani parents". The article continues saying that "the population explosion in the settlement is unstoppable" (Jesenský 2008a).

One is left to wonder about the origins and social lives of these numbers, manipulatively used to demonstrate the gravity of the "Romani problematics". While official ethnic data are non-existent in the country, informal racial statistics are kept by many municipalities around Eastern Slovakia. Anthropologist David Scheffel suggests that race-based statistics on Romani versus Slovak births are gathered by municipal administrations with governmental support (Scheffel 2005: 26). The current Slovak prime minister, sociologist Radičová sees what she denotes as the "rapid growth of the Romani population" (Radičová 2005:11) throughout the communist regime as a result of high quality health care. Her introductory words to Scheffel's ethnography abound with quantitative data about the size of the Romani population, and these statistical data, numbers upon numbers, are given mostly in bold letters. When reading a short historical perspective of the Roma in Slovakia, the reader is confronted with astounding numerical evidence of their growing presence. These numbers are meant to illustrate the seriousness of the issue, and the author calls upon the reader to not to close their eyes as "the problem quantitatively increases" and "from the perspective of our future it is a time bomb" (Radičová 2009: 12).

A commentary in daily Pravda asserts that majority populations tend to be concerned about their own low fertility rates, and alarmed by the population explosion of minority ethnicities (Potocký 2008). Presumably, "(…) in central Europe this concerns Roma, in the west its Muslim ghettos." The Polish writer Stasiuk

conjures a catastrophic scenario in SME, when he connects Romani fertility with the end of the republic as we know it (Sastiuk 2007): "Slovakia will historically be the first gypsy state, because already during the next half-century the descendants of Indian vagabonds are to gain demographic dominance. We are going to cross the southern [Polish-Slovak] border and right away we will find ourselves in Punjabi Europe."

Similar pathologizing formulations are prevalent in popular medical discourse about Romani health. This is perhaps best demonstrated by a 2008 SME article titled "Romani health – a disaster" (Slováková 2008), where Roma living in settlements are described as dangerous to both self and others as they often spread infections which put the entire population at risk. The online regional newspaper rimava.sk features a contribution from Július Bugár, who contributes a physician's perspective on the "Romani problematics" (Bugár 2007) by pointing to the recent "population explosion" of Roma in the region of Rimavská Sobota, and the higher than average Romani infant mortality rate as a proof of hindrance to national progress. Gross generalizations lacking empirical evidence are prevalent – a gynecologist from East-Slovakia told SME reporters (anonymous 1995): "The health status of Romani women is bad. (…) Their children are born malnourished with serious genetic and mental disorders. At the beginning, they do bad at primary school, when they grow up, entire generations just fall into the welfare net."

In this account, poor Romani mothers figure as multiple sources of threat. Not only do they carry the increased possibility of abnormal genetic codes that supposedly lead to increased prevalence of genetic and mental disorders among Romani newborns, but this is explicitly linked to their bad health as a result of neglect, rather than a consequence of inadequate health care. Poor school performance and poverty go hand in hand in Slovakia: about one-third of Romani children, a disproportionate number, attend what is euphemistically called 'special schools', which are designed for mentally challenged pupils. And although it *is* a fact that many young Roma have never had paid employment, this has little to do with their mother's health or genetic dispossession. Most importantly, Slovak settlement-living Roma are not passive onlookers of their own free fall into a ragged social fabric.

Indeed, such reasoning is reminiscent of the past regime's population policy on Roma. Communist policy makers' neo-Malthusian arguments pathologically emphasized the different reproductive behavior of Romani women and its allegedly catastrophic consequences for the national body (see Sokolova 2005). One of the purposes of the sterilization law that introduced monetary rewards specifically targeting Romani women in return for voluntary sterilization from the 1970s to 1991 was to ensure a "positive" population trend as a means of improving "population quality" through which the undesirable birth rate of mentally backward children would be dealt with. While the law was officially race-blind, according to my Romani informants at my field site, it was only Romani women (yet never men) who were given a special lecture about the benefits of tubal ligation.

In return for their reproductive abilities, women would be given (or promised) a "compensation" in the form of a monthly to half-a-yearly average salary. Coercion might have been employed by doctors, social workers and other officials to persuade Romani women all over the country, but especially in the East-Slovakian region which has a high number of poor Romani settlements (see "Body and Soul: Forced Sterilisation and other Assaults on Roma Reproductive Freedom in Slovakia", the first elaborate human rights report of its kind to address the potential abuse of Romani women's reproductive rights. Also see the Helsinki Watch Report "Struggling for Ethnic Identity. Czechoslovakia's Endangered Gypsies" from 1992). As an international scandal about the illegal, coerced or secret sterilizations of Romani women is enfolding in what is now the former Czechoslovakia, there are suspicions that up until the very recent past an undefinable number of Romani women were sterilized by doctors upon giving birth either secretly, or without due informed consent.

Concluding Remarks

Societies leave their fingerprints on the bodies of their citizens, and "bodies are the concrete articulations of abstract social paradigms"

(Weiss 2002: 4). Although individual decisions of getting pregnant, keeping (or not) the fetus and delivering a baby are deeply personal, emotional issues, at the same time, reproduction is a wholly contested terrain.

Reproduction and its control have been shaping political processes in East-Central Europe both before and after the communist regime fell. State encouragement of certain segments of the population to reproduce while discouraging others (such as stigmatized minorities whose reproductive behavior is seen as "out of control" or polluting) has been particularly pervasive in the region (Gal and Kligman 2000:23). The present article was an attempt to point out some of the sources of this discouragement: the public images and narratives that imagine Roma as an "over-breeding" ethnic group in post-communist Slovakia. It was also inspired by an outrageous amount of common-sense racism present in expert debates and academic discussions that help along the construction of a homogenizing image of Romani culture of deserving poor, whose reproductive behavior threatens the integrity of the Slovak national body. In these accounts, complex socio-economic and historical reasons behind the high fertility rate of marginalized Roma living in extreme poverty are simplistically interpreted as essential cultural traits at best, and as a cause for national alarm at worst.

When Romani field informants ask me about the kind of research I conduct, I tend to tell them that I would like to write about how Romani women live, how many children they have, and how they are treated by doctors. Well-aware of negative *gadže* public opinion on the high Romani fertility rate, many informants would start explaining the financial costs of child-raising and the psychological costs of motherhood. Others would silently pity me for my childlessness and presumed infertility, yet others would eagerly discuss that there is no need to hurry with children. In fact, being *their* reproductive other, I am told I should only have two or three – the important thing is, that they be healthy.

Note

[1] The funds for my ongoing dissertation fieldwork research were granted by the Wenner-Gren Foundation for Anthropological Research. An earlier version of this paper was delivered at the Young Scholars of Medical Anthropology workshop in Berlin, February 2010. When not indicated otherwise, quotes from Slovak including publication titles are my own translation.

References

anonymous (1995) V kežmarskej nemocnici za pol druha roka zomreli pri pôrode tri rómske ženy (Three Romani women died while giving birth in the Kežmarok hospital during the last six months). SME Sept 19, 1995. http://dennik.sme.sk/c/2130964/v-kezmarskej-nemocnici-za-pol-druha-roka-zomreli-pri-porode-tri-romske-zeny.html.

Bugár, J. (2007) Rómska problematika v okrese Rimavská Sobota z pohľadu lekára (The Romani problematics in the region of Rimavská Sobota from a physician's perspective). Rimava.sk March 19, 2007. http://www.rimava.sk/view.php?cisloclanku=2007031901

Carter, A. T. (1995) Agency and fertility. For an ethnography of practice. In: S. Greenhalgh (ed.) Situating fertility. Anthropology and demographic inquiry. Cambridge: Cambridge University Press, 55-85.

Centre for Reproductive Rights and Poradňa pre občianske a ľudské práva. (2003) Body and Soul: Forced Sterilisation and other Assaults on Roma Reproductive Freedom in Slovakia.

Gal, S. and Kligman, G. (2000) The politics of gender after socialism. Princeton: Princeton University Press.

Ginsburg, F. D. and Rapp, R. (1995) Introduction. In F. D. Ginsburg and R. Rapp (eds.) Conceiving the new world order. The global politics of reproduction. Berkeley: University of California Press, 1-18.

Greenhalgh, S. (1994) Controlling births and bodies in village China. In: American Ethnologist 21,1: 1-30.

Greenhalgh, S. (1995) Anthropology theorizes reproduction. Integrating practice, political economic, and feminist perspectives. In: S. Greenhalgh (ed.) Situating fertility. Anthropology and demographic inquiry. Cambridge: Cambridge University Press, 3-28.

Hartman, B. (1995) Reproductive rights and wrongs. The global politics of population control. Boston: South End Press.
http://www.sme.sk/autor_info.asp?id=124

Helsinki Watch. (1992) Struggling for Ethnic Identity Czechoslovakia's Endangered Gypsies. Human Rights Watch.

Fig. 1: Young mothers breastfeeding (photo: Edit Szénássy)

Fig. 2: Kids playing in the streets (photo: Edit Szénássy)

Fig. 3: Romani settlement (photo: Susann Huschke)

Fig. 4: Romani settlement (photo: Susann Huschke)

Jesenský, M. (2008a) Na mieste, kde prívalová vlna zmietla chatrče a zabila 50 ľudí, opäť stoja búdy. Jarovnice zaplavila beznádej (In the place where storm-sewage swept the shacks away and killed 50 people, once again huts are erected. Jarovnice is flooded by desperation). SME Jul 18, 2008. http://www.sme.sk/c/3981004/jarovnice-zaplavila-beznadej.html.

Jesenský, M. (2008b) Namiesto dávok im dali prácu (Instead of welfare money they were given work). SME Oct 21, 2008. http://www.sme.sk/c/4134535/namiesto-davok-im-dali-pracu.html. 21.10.2008.

Kaleta, P. (2002) Populačná explózia v rómskych osadách kladie enormné nároky na školské priestory (Population explosion in Romani settlements puts enormous demands on school spaces). Korzár Sept 24, 2002. http://korzar.sme.sk/c/4643955/populacna-explozia-v-romskych-osadach-kladie-enormne-naroky-na-skolske-priestory.html.

Kanaaneh, R. A. (2002) Birthing the nation. Strategies of Palestinian women in Israel. Berkeley: University of California Press.

Kertzer, D. I. (1995) Political-economic and cultural explanations of demographic behavior. In: S. Greenhalgh (ed.) Situating fertility. Anthropology and demographic inquiry. Cambridge: Cambridge University Press, 29-52.

Pjotr (pseudonym), SME, discussion board. Jul 9, 2009. http://blog.sme.sk/diskusie/1531551/3/Navrh-hodny-holohlavych.html.

Potančoková, M., Vaňo, B., Pilinská, V., Jurčová, D. (2008) Slovakia. Fertility between tradition and modernity. In: Demographic Research 19, 25: 973-1018.

Potocký, E. (2008) Milujte sa a množte sa! (Make love and reproduce!). Pravda Dec 12, 2008. http://nazory.pravda.sk/tlac.asp?r=sk-komentare&c=A081212_092221_sk-komentare_p09

Radičová, I. (2009) Predslov k slovenskému vydaniu (Introductory words to the Slovak edition). In: D. Scheffel. Svinia v čiernobielom. Slovenskí Rómovia a ich susedia (Svinia in black and white. Slovak Roma and their neighbours). Prešov: Centrum antropologických výskumov, 9-12.

Scheffel, D. (2005) Svinia in black and white. Slovak Roma and their neighbors. Peterborough, Ontario: Broadview Press. http://www.sme.sk/autor_info.asp?id=46

Slováková, A. (2008) Obyvateľov osád nezaujíma ani vlastné zdravie. Umierajú často už po štyridsiatke. Zdravie Rómov – katastrofa (The ihabitants of osadas are not interested even in their own health. They often die around the age of forty. Health situation of Roma – a disaster). SME Dec 12, 2008. http://primar.sme.sk/c/4220164/zdravie-romov-katastrofa.html.

Sokolová, V. (2005) Planned parenthood behind the curtain. Population policy and sterilization of Romani women in communist Czechoslovakia, 1972-1989. In: The Anthropology of East Europe Review 23,1:79-98.

Stasiuk, A. (2007) Dobre je mať túto krajinu poruke (It's good to have this country at hand). SME Jul 14, 2007. http://komentare.sme.sk/c/3393784/dobre-je-mat-tuto-krajinu-poruke.html.

Vaňo, B., Mészáros, J. (2004) The reproductive behavior in municipalities with low living standard. Bratislava: Infostat.

Weiss, M. (2002) The chosen body. The politics of the body in the Israeli society. Stanford: Stanford University Press.

Yuval-Davis, N. (1997) Gender and nation. London: Sage Publications.

Forms that Transform: The Role of the Crescent and the Minarets in the Creation of Homosocial Healing Communities among Turkish and Muslim Migrant Women in Vienna

Hwiada Abubaker

It was one of the warm autumn days in October 2006 in Vienna (Austria). The whole morning surroundings were being lightly heated by a bright early sun. The air was overloaded with the smell of the flamboyant display of the shaded leaves that were filling the empty park and soundly blown away here and there with the whispering morning breeze … The nice picture had only being disturbed by my irritated mood as I was crossing the park with my sick daughter rushing to catch up with the pediatrician. She had a bad flu, could not sleep and kept me up all night fretting and crying. She had ear pain and complained of headache. I was anxious when the thermometer read 39.5 and sometimes even 40 degrees. Her eyes were red and tired! Suddenly, I was startled by the view of a Turkish lady (I used to refer to her as the "woman in black" whenever I spotted her in front of the school gate accompanying her children). She was in her thirties, always dressed up in black from head to foot and never changed it in all seasons. I never dared to speak to her before. Shyly, she approached and asked me in a low tone and a broken mixture of Arabic and German: "*Salam alikum*, sister! What happened? Why is your daughter not going to school?" Reluctantly, I stopped to answer her questions: "The girl is sick today and I have to hurry up to the pediatrician." She barely heard me, ignoring my hastily manner of response, turned towards my daughter and touched her forehead with the palm of her right hand. She started talking as if speaking with herself: "Oh! The poor child is very hot." She totally faced my daughter, then turned her towards the North (later on, I realized that she headed towards Mekka in Saudi Arabia) and while still having her palm touching my daughter's forehead, recited a verse (*sura*) from the holy Quran in a clear Arabic. She nearly took ten minutes of my precious time. While I was trying to maintain my patience, I could hardly concentrate on what she was doing. Nothing of what she said was strange to me. In the end she blessed the child with some prayers to Allah before she abruptly let go of us. By the time we arrived at the pediatrician clinic and he could see the child, he asked me why did I bring the child? I had to run through the history of her sickness. To my surprise he found out that everything was almost normal, no fever, no infection and the symptoms of the flu were vanishing to the extent that I could not justify the reason behind bringing the child to the clinic. Only because of my insisting manner did the doctor give her some medicine. During the next days the child maintained her health and shortly could go back to school.

That was my first acquaintance with my Turkish friend (anonymously I will address her as Nazli[1]. Several days later, I was the one who grew interested to look for her. When I met her again she addressed me as "sister" and asked if I could come and attend a session of reading the Quran with a group of Muslim women from different nationalities, gathering in her own apartment. Since she perceived that I can speak Arabic and read the holy Quran[2], she wanted me to hear whether they could correctly read the Arabic text or not. My role was decided as a listener to what they read. I was offered 30 Euros a month for the time I would spend in the process till we would finish reading the whole holy book. Later on, I used the money to fund the coffee sessions offered to us as an entertainment every time we finished reading a part of the Quran. Nazli said that she was spending that money as a *zakat* (which is the money every Muslim has to spend to others either in sum or in other forms such as building a mosque, reading and spreading the instructions of the holy book among the believers or publishing the holy Quran and distributing it for free). My growing curiosity in Nazli's healing powers even expanded to include the

communion gathering and the religious and spiritual life they were employing. My visits were guided by two main inquiries:
– What are the healing powers that Nazli was implementing and what secrets of the holy book does she perceive to encompass healing potentialities?
– Does Nazli demonstrate her healing powers, other than that I went through with my daughter to the women's homosocial gathering?
Overloaded with ambivalent feelings of fear and skepticism I thought first to drop by to observe and from the first encounter I decided to feed my rising interest by joining the women's assemble.

The contact with the group provoked even more questions and growing interests to inspect the daily problematic life-events these women were suffering in migration, and the ways in which they respond to those problems. The gathering environment was loaded with challenges related to migration, so many fundamental enquires about the women's uncertain future and their inability to understand, explain and predict fundamental issues associated with their continuity and survival. I was then, totally oriented towards documenting the experiences of the women's group in trying to make sense of their uncertainties. My objective was to explore how this group of migrant women knitted their social worlds into their social gatherings and tried to give meaning to their sufferings by creating healing references which they trusted in their quest for certainty.

The Research Process

Driven by a feminist stand point that perceives "everyday life as problematic", I am going to adapt an institutional ethnography initiated and developed by Dorothy Smith (1989, 1996) to explore the essentials that shaped Nazli's women's group everyday experiences. Institutional ethnography is a way of understanding the social determinants of the "everyday lives" and to do so I began by acquainting myself with how experience is talked about in the social gatherings as I mentioned earlier and will describe later in this paper. I will include descriptions of the strategies those women were implementing to make sense of their experiences.

I will draw heavily on participant observation technique and some encounters with informal questioning. In the participant observation I tried to read the internal component of the group that made it so attractive to catch the attention of women from different cultural backgrounds, while they even speak different languages. However, I will explain and quote some of the "social problems" raised during the meetings. As the time passed I grew more attentive to the healing practices applied within the communion and the detailed processes implemented that led them to develop a collective conscious in relation to their problems.

In the discussion I will relate every woman's individual experience and how it was shared with the other members of the group. When I started attending the meetings the group consisted of six women, three of whom were Turkish (one of them is Nazli), two were Egyptian and one was a Bosnian. All of them could read Arabic (only in the Quran text), to a variant extent of clarity but not peak or understand it with the exception of the Egyptian who could read, speak and understand Arabic. Nazli read the Quran in a very good manner, as well she expressed knowledge of verses which she believed to have healing effects. Most of our discussions were in broken German. Arabic was used as a tool of communication sometimes when I was to address or to be addressed by the Egyptian ladies. The six women belonged more or less to the age group thirty to forty. Later on the group was extended to include three other Muslim sisters. One was a Tunisian, and two were Turkish. Three of the Turkish women were working either in cloth-washing centers or in the cleaning sector. One of the Egyptian ladies stood alternatively with her husband in his grocery, while the other ladies are housewives. Thus all of them belong to the middle class migrants in Austria.

All sisters were veiled and Nazli got to know them the same way she knew me. One observation I could early mark out was the absence of interest in knowing each other's names or nationality. We were more interested in sitting together and reading the holy book to get the promised reward. One Egyptian lady also read very good Arabic and we used to help each other in correcting what we perceived as not making sense with the texts in hand as the

women were reading. Reading of the holy book took place in a one by one trend (every woman had to read some parts). To improve my reading ability I used to practice reading and listening to expert readings in tapes the evening before each session as well as searching in the internet and books for the interpretations of some of the verses and difficult words.

The gatherings were designed to take place three times a week: Tuesday, Wednesday and Thursday. The duration of the meeting ranged between two to three hours during the time when the children were in school: started around 8 o'clock in the morning and ended around noon. The whole period of the meetings was about three months between November and the end of February. The sessions ended up when we finished reading the thirty parts of the Quran. Yet, we still have good relations and we exchange informal visits.

Nazli's apartment was big (135 square meters). It was characterized by a strict division across gender between the women's boundary and the rest of the house. The room in which we used to meet in was nicely furnished, and we were to sit down on the floor during our sessions. It has its own in-let/out-let door to the apartment designed by Nazli's husband and was constructed in a way that we could not see any other part of the house. It is attached to toilet and a bathroom.

Much of the time we used in the process of reading the Quran, upon finishing the decided part, we moved on to an interesting everyday activity in the Turkish socio-cultural life: The coffee drinking in which we had to get our future read to us by Nazil and the other Turkish women after we finished drinking.

Our conversations related to different daily problems that faced every one of us at that time. Feedback in a form of exchange of information took place. The chat themes fluctuated between children's illnesses and misfortunes, concern with the family future, visa and documents that are delayed or underwent bureaucratic processes and problematic familial relations.

Homosociality and Group Formation in the Context of Healing

In the following part I will try to review patterns in the literature related to the issue of the mechanisms associated with the formation of groups in general or homosocial groups in particular as a strategy to cope with the life challenges and the efficiency of these mechanism to the individuals who belong to those groups. To remain loyal to the "institutional ethnography" I will base my analysis on how the experience of the members within the group were documented and displayed and whether the conclusions drawn are reflecting the experience of the individuals in the group or not.

Studies on group formation are not new in social research. The concept of homosociality as a bond that attract individuals to a group has been an issue of interdisciplinary concern and is often analyzed in social psychology, political science, anthropology as well as gender and women's studies.

While group formation in psychology is often understood in the sense of interpersonal relationship (Berscheid, Peplau 1983; Fincham, Beach 2010), in anthropology, gender and women's studies it is often examined in relations to its dynamic association with the gender roles and differences between male females' groups (Sedgwick 1985). However, there is a lack of consensus among scholars who have studied the formation of human groups on their functionality in relations to the health of the individuals belonging to these groups. Furthermore, in many of these studies the experiences of the individuals within the group are not the elements out of which conclusions on the efficiency of the group are drawn.

Leading psychoanalysis practitioner such as William (1941) was not only skeptical, but he even criticized usefulness of the formation of groups to serve individual's expectations. He assumed that the individual is often absorbed in the group and his/her ego is not even recognized as an entity let alone to be cured through any dynamic activity the group carries out. He described an individual within a group to be "shallow", "impulsive" and "ineffective" (William 1941: 199).

Other studies view group formation in a relatively positive attitude that provide a supportive dimension to those who belong to it and help them overcome life crises. In their study Gable et al. perceived that positive or "good happenings" also demand coping mechanisms what Selye (1975) referred to as "eustress". They examined the intrapersonal and interpersonal consequences of seeking out others when positive life crises happen. Their study showed that individuals normally share "negative life events" with each other but tend to share "positive life events" only when the members in a group are perceived to respond "constructively" and not "destructively" to their attempts (2004: 228).

The problem with this study is that the formation of the group is described as a form of "sharing sentiments" rather than a coping strategy in which the role of each individual is fully appreciated. The results are discussed in terms of the theoretical and empirical importance of understanding how people "cope" with positive events. However it remains unclear how members in such groups enhance social bonds.

Adolescence studies differentiated between the formation of girls and boys' homosocial bonds and related to girls' attachments as inefficient in serving its member than that of boys'. Sias and Bartoo (2007) found out that homosocial relationships with friends play a significant role when teenage girls think about suicide. The same homosocial relations were found to have little impact on suicidal thoughts among boys. The research ascertained that girls are nearly twice as likely to think about suicide if they have friends but felt isolated from their peers for one reason or another. Girls are also more likely to consider suicide if the homosocial group with whom they identify is not strong enough to cope with their problems and locate solutions to them.

Yet, in the case of boys these relationship factors have no significant effect on whether boys consider suicide or not (Jeff and James 2004). Still, in such study conclusions are drawn without assessing the internal mechanisms within the group through which the individuals try to create sense of their experiences and every day life problems. Such a study raises many unresolved questions that have to be considered in future investigations, such as whether the members within the group play a negative or a positive role in the suicidal attempts of their friends and whether a heterosocial group formation is better or worse in serving its individual members.

Other dimensions in the study of groups and their functionality which touched upon both disciplines, social psychology and women's studies, particularly in the Arab and Muslim worlds, were concerned with the functional analysis of the Zar cult as a healing group as well as a translation of the gender structure of the community (El-Nagar 1975; Hall and Ismail 198). Many of these studies as well evaluated the Zar cult and the related ceremonies as, "A vehicle for expressing hostility against the social order in general or against particular people, especially those with a superior status rather than a healing processes" (Berger 1976: 127). Although such researches ignored the benefit of the group as a whole in the mental health of the women concerned and paid more attention to the performance of the group as a phenomenon expressing psychological disorder or reflecting cultural conflicting discourse "even expressing gender war between spouses" (Abdalla 1987: 41). I believe that these studies paid considerable attention to the active role of the individual woman within the group. The studies allowed a space to review on the experiences of the members of the group and the healing strategies they process. It is through this point that we get to understand the mechanism that run the group.

A negative view and awareness to the formation of groups in general has dominated the psychological, anthropological and political science in the beginning of the century due to its perceived association with political conflicts. Groups are perceived to cope with the going on political and social marginalization whether they are heterosocial or homosocial (Hamlin, Jennings 2004; Hechter, Okamoto 2001). Such studies reflected a regression position in the study of the groups and displayed a rather hostile attitude towards the whole process. The ideological attitude of the "charisma" (heading the group) was perceived to dominate the activities of the other members similar to earlier studies in the group formation (William 1941). Even the coping

mechanisms the members implemented were not considered as innovation rather as demon to the individual members.

A real turning point in the groups' formation that demanded new methods in evaluating the role in the life's of its members is urged by the shift in traditional patterns of the group. We can speak now about cyberspace and cyber groups which are in touch with each other in the digital domain. On-line groups are becoming increasingly prominent due to the growth of community and social networking through sites such as MySpace and Live-Journal. Some of these groups are innovative and create mechanisms applicable to the health of the individuals in the group. Nevertheless, some studies criticized such formations because of their reputation in abusing members who identify with them and due to the ambiguity that surrounds the members in the group, which made it difficult to trace its efficacy (Kuo, Yu 2001).

As it is shown many of these researches failed to spot the individual's role within the group and the mechanism that can enhance the group development. These researches have relied on interpretive methods which have an unfortunate tendency to isolate the cultural phenomena from the dynamic aspects that created and maintained the function of the groups. In the case study under investigation, this factor is even important. The social group consisted of different individuals of a relatively heterogeneous character with different outlooks, in a foreign community which is different from their own. Thus the study is joining force to the already going on debate that questions the voluntarily formed bonds, spatial analysis and the role they play in healing the members who belong to them. It also contributes to the efforts on studies that try to identify factors that can help in integrating the migrants in the host community.

Findings

Informal healing practices are considered as systems that monitor, diagnose and heal their own internal problems using self contextual and innovated techniques (Abubaker 2000). In this part I concentrate my discussion around how the mentioned system of the women bond, the space created in which they could manage the perceived problematic situations as well as the healing techniques that were practiced were successful or unsuccessful in serving these women's needs. I try to organize the analysis around two components relevant to the healing system under investigation namely: identification (diagnosis) of the women's problems and healing approaches that were offered within the group.

Forms that Transform: Diagnosing Social Problems

Despite the pessimistic attitude of the social researches explored in the literature on and around the formation of groups earlier in this study, I agree with Smith that when the social institutions pay attention to the members' experience rather than to the institutional power relation, the individuals get to be more productive and innovative in finding solutions coping with their problematic life events (Smith 1989, 1996). In this study the motive Nazli referred to as a reason to initiate the formation of the women's group, emerged from her interest, as a "good" Muslim believer in the reward she is promised (by the Quran) to gain in the "world after" when she masters good knowledge of the Quran and teaches it to other sisters. Nazli developed a strong conviction, which she used to pronounce openly that: "Women who allow 'the *hilal* and the minaret'[3] to guide them, have to properly trust the religion these symbols represent, understand and respect it, then they will discover solutions to their life problems". Different members in the group, however, revealed different reasons for the motive of their "coming together" which range from their interest in the project: "reading the Quran to obtain the promised blessing", to their interest in joining the women's group to spend the time with other women, to the reason of their friendship with Nazli. Women spoke about their lives and living in an informal, relaxed way that was not purposely meant to be treated in a diagnostic way.

Healing Techniques. Reading the Holy Quran

The women exhibited a strong belief in the reading of Quran as a healing component of the soul. Sometimes they even shed tears when Nazli read some of the verses. Feeling that they could develop self-representation as "good

Muslims" was in itself soothing to them and "provided the mode of access to divine power" (Nourse 1996). Aishea, one of the Turkish ladies, stated, "I usually perceive myself very clean and wholesome every time the session of Quran is finished". The private sphere provided for women to privately read the Quran for the public (other women in this case) offered the necessary space for the expression of their spiritual manifestation, a privilege they were denied in the mosque and other social forms dominated by the Muslim patriarchy. Kandiyoti and Azimova (2004) mentioned that this dimension of the provision of space for religious manifestation is part of the local and cultural requirements needed for every believer and constitute an important component of the self-ascription as Muslim.

Asma-nour, one of the Turkish women in the group, informed me one day as we were leaving Nazli's house that when Nazli reads the Quran she feels that her spirit was initiated to access some divine power and that she really sensed herself near to God that her Muslim selfhood was fully confirmed. Amna, the Egyptian sister, said loudly one day, "The only time I feel myself important as a Muslim veiled woman is here, when I am in Nazli's house!" Nazli ended the session of reading the Quran by *dua'a* (during which she raised her hands and asked the blessing from God to herself and to the women around). Usually that was the time when the other Turkish ladies cried followed gradually by (myself and the other Egyptian ladies) who often did not even understand what she was saying in *dua'a* but following her by saying "*Aamin*" meaning, "we confirmed what she said". In fact in the course of action a spectrum of healing was created that shifted between reading the holy book, divination using the coffee cup technique, befriending advices as well as herbs' descriptions and healing tips.

The social aspect of the healing process even took a further functional dimension when it extended to reach these women in their own living and proved to be very efficient. One day I was informed that Asma-nour's mother in law passed away while she was visiting them in Vienna and the condolences ceremony was to take place at Asma-nour's house. That was the first time in my life that I attended the dead bathing ceremony when I found out that Nazli was the one who would do it. She carried it out in an expert way and read the Quran in front of the dead body while she was covering it with the white clothes.

In some other pattern Nazli initiated a communion activity in which she asked every one of us to prepare a dish during a Muslim festival. Afterwards she sold that together with other items in front of the mosque. The resulting income was given to the Imam of the mosque as a contribution to the victims of war.

Divination as a Form that Transforms Uncertainty

"Drinking Turkish coffee is a centuries-old ritual, enjoyed best in company and sometimes followed by fortune telling" (Mills 2009: 2). A Turkish proverb says:"A cup of coffee commits one to forty years of friendship". Coffee, *kahve* is an important part of the tradition of the Turkish women socialization. It is a communal activity that is enjoyed in a group. Turkish coffee is a strong black coffee prepared in a tiny pot called the *cezve* and distributed in the cups to the group. An important issue in the coffee drinking is the future reading using the remains of the coffee beans in the special coffee cups, an interesting activity that every woman in the group appreciated, anticipated and enthusiastically joined.

An important dilemma in the process is that Islam categorizes fortune telling and divination as non acceptable acts. The future telling is a deed that is of divine nature and solely associated with God. However, in the Turkish tradition fortune-telling through the coffee cup is an activity that takes place almost everyday, is considered a part of the entertainment of the guests and an important aspect to reinforce friendship. The space, time and amusement that are related to the experience draw women towards the activity known by the Turkish as the *fal*, and at the same time provoke thinking as to how Islam is read, understood, lived and practiced by the beholders. Nazli used "creative language" and constructive prophecies to affect indirect suggestions that would lead our imagination to fit the pictures she describe into a real character in mine and other women's daily life events. She used monotonous repetitive semantic words such as: "Oh! Oh! Oh!" when she was

about to introduce an important finding. The accompanied ceremony symbolized by the smell of the roasted and boiled beans and the special cups used for the purpose induce a sense of mystery and spirituality which is different from the one induced when we read the Quran.

Unfolding solutions to the doubtful situations demanded the act of the coffee reading technique. As such uncertainty was not displayed as an objective experience, rather a matter of collective consciousness, where every one in the group fully understood and was aware of the others' troubles. That was exactly the strong point amidst the problematic encounters where the roles of both religion and divination were important. Zahia, one of the Egyptian ladies, came to Vienna as a visitor to her husband. When the entry visa expired, Zahia continued to stay and was trying all possible solutions to extend it, in vain. She grew very apprehensive to her being deported, leaving her husband and son behind. Zahia was the first to have her cup of coffee read every time we met. She was talkative and nervous. Nobody could tell her what would happen in the future but through her cup of coffee. For Zahia the group solidarity, sharing of the same experience and exchange of information were important. Women of the group were informative in transmitting news about good advocates to help in the visa process, asylum seeking processes and other ways in which she could legalize her status in Vienna.

Amina, the Tunisian lady, wanted to disclose the future of her family that was constituted of three members. Her husband worked as a butcher in one of the Vienna market places. He was an alcoholic addict, and either sent his money to the other wife back in Tunisia or used it for drinking. She used to ask Nazli to read the future and to pray for the betterment of her life.

Mira, the Bosnian sister, wanted to know whether some of the family members she lost during war time were still alive and to locate their place. Jameela, another Egyptian sister, wanted to know the fate of her daughter. She kept an eye on her own sister's son who lives back in Cairo and interrogated possibilities to attract his attention that he would offer to marry her eighteen years old daughter. For her that was a dear, wish: her daughter should marry back in Egypt rather than having a friend in Vienna. The issue was playing on her nerves that she was always suffering a feeling of uneasiness and unable to concentrate in matters other than her troubles.

For me, I grew very interested in Nazli and Asma-nours' abilities to read the cup of coffee. They were very clever and doing it as if they were reading an open book in front of them. In the end of the day all women used to get a hint to the future in relation to their social problems in Vienna.

Befriending

Apart from the above mentioned practices, befriending and advices, exchanging different experiences which were related to every day life, either diagnostic or non diagnostic in nature, were often disclosed.

Nazli exhibited a very expert skill not only in the Quran, but in the prophetic therapy which extended to cover use of herbs for medicinal purposes as well as advices related to the personal hygiene, cooking, intimate relations with the partner, interrelationship with siblings (children's or adolescence), etc. and she always used to refer to Quran and *Sunaa* (in relation to prophet Mohamed's instructions). Women developed such a strong trust in her that difficult and taboo themes became an issue of discussion during the sessions.

Zeinab's husband was impotent. He was a business man and developed the problem during the last few months. He tried philandering with prostitutes, but could not perform with his wife for more than two months by that time. Zeinab sought Nazli to teach her verses of the Quran that could help "fix" the problem. Zeinab loved her husband and feared most that the unfortunate scenario could become a public knowledge among his peers. He tried some medicines and herbs in vain. Nazli taught her some of the verses to read. Advices were even given from the different members of the group.

General themes of concern among immigrant women were to address the ways in which they seek to control children's common diseases and informal medical advices. Befriending talks

were often exchanged. Guiding principles linked to some of the practices that were believed or experienced by the members of the group to cause illnesses were discussed and in all cases relevant stories were recited. For example, walking without slippers is directly related to the formation of stomach gas, as well as eating cheese and certain vegetables. Eating onions or garlic in the evening meal is not good for reproductive ability of the female and male as well. A red-colored cloth has to be worn by the woman in her postpartum period to cast the evil from her and her baby. Certain butterflies, when crossing the way of somebody, are indicators of the death of a near relative. Birds, dogs, plants and many other elements found in nature are always in a state of sending messages from the sky to inform us about what is canceled off our common senses.

Conclusion

In this study I tried to analysis the healing technique a group of women created in the domestic context. The healing process was run exclusively by women invisibly and even unrecognizable to their own awareness. The boundaries between sexes (men and women group) constituted part of the theme of the discussion and an inseparable part of the every day life problems.

The event proved its efficiency in dealing with the women's social problems spiritually and sometimes even socially. The group created its own monitoring means of healing and was accepted as a system to deal with these difficulties by the beholders. Certain patterns of healing activities that revolve around the concept of Islam and its doctrine, namely religion, spiritual healing and divination, were examined. The usage of Islam and divination in the healing sessions reflect an interconnection between the sacred represented by the Quran and the profane represented by the coffee fortune telling. Group solidarity, the space created for the individual women within the group and the role of the gender created space were prominent healing achievements together with the divination process itself.

Through the healing sessions women spoke openly of their everyday life problems to each other: That sharing aspect in itself remained a necessary technique for their psychological health. I believe that future research on the issue has to take place to unfold more patterns in relation to the internal forces that attract migrant groups to accumulate around certain objects. Solution to problems of full integration of the migrants can build up from such findings.

Notes

[1] I use anonymous names in referring to all women in the study.
[2] Nazli knew about my Arab background in an incident that took place on the 21st day of Ramadan in the Islamic Center. The night pray at this day (*trawih*) is believed to be rewardable to the beholders. On this day in every Ramadan, the Islamic Center Mosque in Vienna is usually overcrowded with Muslim Women of different nationality to perform the night prayer of Ramadan and to celebrate the remarkable holy night. That year the microphone in the women's section in the Islamic Center was not working properly. We could not hear the Imam so as to follow him in our prayers. As I have had some sessions in reading the Quran and learnt some of its sections by heart I took over the prayer in the women's section starting to read loudly in the place of the Imamm. Some women followed me and we finished our prayers in the right time.
[3] The *hilal* (the crescent) and the minaret are the symbols through which the Muslim community in migration identifies places where from they can get their everyday needs. Groceries and butchers who have these symbols affixed outside their shops are usually targeted by the Muslim community in search of the *halal* (the allowed) food, particularly meat that is slaughtered according to the Islamic commands.

References

Abdalla, H. (1987) Neither friend nor foe: The malam practioner – Yan Bori relationships in Hausaland. In: Lewis, N., Alsafi, A. and Hurreiz, S. (eds.) Women's medicine: The zar Bori cult in Africa and beyond. Edinburgh: Edinburgh University Press for the International African Institute, 37-48.

Abubaker, H. M. (2000) Cultural belief systems and women's indigenous knowledge in relations to fertility problems. Unpublished PhD Thesis, University of Vienna

Berger, I. (1976) Rebels or status-seekers? Women as spirit mediums in East Africa: Studies in social and economic change. Stanford: Stanford University Press.

Berscheid, E.; Peplau, L. A. (1983) The emerging science of relationships. In H. Kelley (et.al.) Close relationships. New York, San Francisco: W. H. Freeman and Company, 1-19.

El Nagar, S. (1975) Spirit possession and social change in Omdurman. Unpublished Msc. Thesis, University of Khartoum.

Fincham, F. D.; Beach, S. R. H. (2010) Marriage in the new millennium: A decade in review. Journal of Marriage and Family 72: 630–649.

Gable, S., Reis, H., Impett, E., and Asher, E. (2004). To whom do you turn when things go right? The intrapersonal and interpersonal benefits of sharing positive events. Journal of Personality and Social Psychology 87: 228-245.

Hall, M.; Ismail B. (1981) Sisters under the sun: the story of Sudanese women. Longman: London and New York.

Hamlin, A.; Jennings, C. (2004) Group formation and political conflict: Instrumental and expressive approaches. Public Choice 118: 413–435.

Hechter, M.; Okamoto, D. (2001) Political consequences of minority group formation. The Annual Review of Political Science 4:189–215.

Jeff, G.; James, M. (January 6, 2004) Friendships play key role in suicidal thoughts of girls, but not boys. Ohio State University. http://www.eurekalert.org/pub_releases/2004-01/osu-fpk010604.php. Speech published in the internet in relation to the publishing the findings of The National Institutes of Health on the national longitudinal study of adolescent health , downloaded October 2010.

Kandiyoti, D.; Azimova, N. (2004) The communal and the sacred: women's worlds of ritual in Uzbekistan. Journal of the Royal Anthropological Institute (N.S.) 10: 327-49.

Kuo, Feng-Yang; Yu, Chia-ping (2001) An exploratory study of cyber group development process. PACIS 2001 Proceedings. Paper 12.

Mills S. (2009) Citizenship and faith: Muslim scout groups. In R. Phillips (ed.) Muslim spaces of hope: Geographies of possibility in Britain and West London. Zed Books, 85-103.

Newcomb, T. (1953) An approach to the study of communicative acts. Psychological Review 60, 6: 393-404.

Nourse, J. W. (1996) The voice of the winds versus the masters of cure: contest notions of spirit possession among the Lauje of Sulawesi. Journal of the Royal Anthropological Institute (N.S.) 2: 425-42.

Sedgwick, E. (1985) Between men: English literature and male homosocial desire. Columbia: Columbia University Press.

Selye, H. (1975) Confusion and controversy in the stress field. Journal of Human Stress 1: 37-44.

Sias, P.; Bartoo, H. (2007) Friendship, social support, and health. In L. L'Abate (ed.) Low-cost approaches to promote physical and mental health: Theory, research, and practice. New York: Springer Science and Business Media, 455-472.

Smith, D. E. (1989) The everyday world as problematic: A feminist sociology. Northeastern University Press.

Smith, D. E. (1996) The conceptual practices of power: A feminist sociology of knowledge. Toronto: University of Toronto Press.

William, B. (1941) Psychological methods of healing. An introduction to psychotherapy. London: University of London Press.

MD Theses 2009-2010

Völkel, Vanessa: Viszerale Leishmaniose im Südsudan. Historische, epidemiologische, klinische und ethnomedizinische Aspekte. (Visceral leishmaniasis in Southern Sudan. Historical, epidemiological, clinical and ethnomedical aspects.) Diplomarbeiten Ethnomedizin und International Health, Vol. 18, November 2009, ISBN 978-3-902633-17-0

Visceral leishmaniasis (VL) is one of the most important contagious diseases in the Sudan. Civil war and the resulting displacement of refugees have led to a dramatic spread of the pathogen.

The state of A'ali an-nil in which the district Melut is also situated, is the home of many of the Dinka tribe. Serious VL epidemics have spread through this district and have claimed the lives of innumerable local inhabitants. The medical capability in this region can still be considered to be lacking. Questions: The objective of the research work was to assess the extent of the population's knowledge, using the example of the South Sudanese Dinka in the village of Nyeyok – with reference to symptoms, cure and prevention of VL. Furthermore details concerning dealing with the disease were to be established, as well as documenting subjective views and traditional healing methods. Methods: The collection of data took place during July/August 2008 via a one-month field-trip to the Melut district. With the help of an interpreter 20 partly structured interviews were completed, including with VL patients and their families as well as medical personnel. The documentation of the discussions using recording equipment enabled subsequent transcription and evaluation of the data.

To the local inhabitants the details of VL are well known. Nevertheless many are unclear about its cause and also protection against it. Most people are aware of the importance of adequate medical treatment in case of contracting VL. However many will resort to local plants as an initial remedy. Scarification is also still used today to combat VL.

Schießl, Elisabeth: Die weibliche Genitalverstümmerlung (FGM): Wissensstand, Emotionen und Meinungen von Studierenden an der medizinischen Universität Wien. (Female Genital Mutilation (FGM): knowledge, emotions and believes of students at the Medical University of Vienna.) Diplomarbeiten Ethnomedizin und International Health, Vol. 19, December 2009, ISBN 978-3-902633-18-7

Weber, Yasmin: Tschetschenische Asylerberinnen und ihr Zugang zur Schwangerenvorsorge. Ethnomedizinische und strukturelle Aspekte. (Chechen asylum-seekers and their access to maternity care. Ethnomedical and structural aspects.) Diplomarbeiten Ethnomedizin und International Health, Vol. 20, January 2010, ISBN 978-3-902633-19-4

Concerning health care provision, refugees and asylum seekers are in many aspects an especially vulnerable ethnic group. Due to their past and present status they face problems and obstacles in accessing health care and might have special medical needs. Barriers to appropriate health care can be caused by legal and structural, as well as social and cultural factors.

The purpose of this study was to examine asylum seekers' access to health care in Austria focusing especially on pregnant Chechen women and their access to maternity care. Due to the high birth rates among Chechens, many women either come to Austria being already pregnant or becoming pregnant during their asylum-seeking-process. In order to get an accurate impression of the currant situation, a closer examination was required of the above quoted factors (legal, structural, social and cultural).

The study took place in the area of Vienna, Austria between December 2007 and August 2009. Qualitative methods, such as semi-structured and narrative interviews were conducted with 17 Chechen women, as well as medical and social workers. Participant observation was another important source for information.

The main problems and barriers detected were due to language and communication difficulties, lack of knowledge of the medical and social system and resulting dependence on social workers/NGOs, discontinuity and lack of documentation in maternity care and finally discrimination towards and marginalisation of asylum seekers. Furthermore asylum seekers orillegal migrants, who have lost their medical insurance, are facing additional barriers andobstacles in accessing appropriate health care. Therefore they must be considered as even more vulnerable.

König, Veronika: Transkulturelle Kompetenz in der Medizin. Fakultät für Human- und Sozialwissenschaften, Universität Wien, 2009.

Rotter, Kerstin: Transkulturelle Aspekte von Schmerz. (Cross-cultural aspects of pain). Masterthesis Intercultural Studies, Danube University Krems 2010.

Austria is a country of immigration, offering a broad range of cultural and religious diversity. Consequently health care providers face certain challenges, such as comprehension problems due to language barriers and patients' varying socio-cultural backgrounds.

Response to pain can be seen to be a major issue. In an attempt to understand cross-cultural aspects of pain, parameters that influence interaction between migrant patients and hospital staff have been found and are described in this study.

Utilizing qualitative interviews, the following research questions have been pursued: How do health professionals at Viennese municipal hospitals deal with their multilayer patient clientele? How do personal attitudes influence relationships? What are the staff's concernsand what are possible approaches to address these concerns? What supports could be offered by the hospital manage- ment?

Seen in the larger context, the worldwide existing problem of pain handling is illustrated: In order to understand the origin of pain, which is essential if a patient is to be treated successfully, we must acknowledge that pain is influenced by physical, psychological and socioeconomic factors. Migration creates additional challenges in health care as frequently patients' pain is inaccurately attributed to their cultural background. Thus it is necessary to recognize that whilst expertise is necessary to diagnose pain, more important is direct humane interaction, acknowledging the fears and frustration of all parties involved.

Seebacher, Simone: "Del VIH a una vida positiva" Analyse alltäglicher Lebensbereiche HIV positiver Frauen im Großraum San Salvador. Fakultät für Human- und Sozialwissenschaften, Universität Wien, 2010.

El Salvador has one of the highest HIV infection rates in Central America. The female population appears especially affected. This paper is based on a medical anthropological approach, which tries to identify socioincidence of the infection.

Starting on the fact of higher infection risk for Salvadorian woman, this work tries to represent everyday life parts of an hiv should be characterized, which may explain the increased risk infection for woman. The project was implemented using qualitative and quantitative oriented methods, realized mainly in the capital San Salvador. Thematically focussed narrative interviews with eight hiv observation in support groups and prevention activities as well as a quantitatively oriented survey within 86 hiv which have had changed significantly due to the infection. Especially the economic situation as well as personal life and social relationships transform dramatically.

The results highlight that unequal gender contributes to the fact that women are at an increasing risk of HIV infection. Unequal access to employment, lack of educational opportunities and inadequate health care facilities push the Salvadorian woman in a highly vulnerable position. As well they show the strong prevalent machismo and frequent acts of violence put the Salvadorian woman in a highly vulnerable position.

Charles University Prague invites papers for the conference

Health in transition: (Bio)Medicine as culture in post-socialist Europe

to be held in Prague, Czech Republic, on June 10-11, 2011

While medical anthropologists have done considerable research on both the global south and north, the larger region of East-Central, Eastern, and post-socialist Europe, with notable exceptions, has received limited attention so far. At the same time, medical anthropological research by 'native' East-Central and East European social scientists is scarce, as this field of social anthropology enjoys little institutional support in the region.

The aim of this conference is therefore twofold. Firstly, it is an attempt to bring together medical anthropologists and other health care researchers from social science-related fields who study the changes that have taken place in post-socialist regimes of medical care and explore the novel challenges medical systems of these countries have faced in the course of the last two decades of market economy and capitalist transformation. Secondly, this conference also aspires to serve as an open space to rethink the place of anthropology among social science disciplines in the region, and to raise awareness and acknowledgment of medical anthropology while highlighting its potential for applied, critical and engaged research.

With a strong regional focus, the organizers welcome contributions from a broad range of topics, including, but not limited to,

- *contemporary forms of biomedical governance*
- *impact of EU regulations on pre- and new accession states*
- *patterns of medicalization and disease*
- *gender and health*
- *migrant and ethnic health*
- *poverty and unequal access to health*
- *state-ownership/privatization of health care.*

There is no conference fee, yet participants are responsible for arranging their own accommodation and travel expenses.

The deadline for brief abstracts (300 to 400 words) is **March 7th 2011**, complete papers are due by May 2nd 2011. Work in progress is welcome. For further inquiries please contact Edit Szenassy (szenedit@gmail.com), PhD candidate of the Institute of Ethnology, Charles University Prague.

The keynote speaker of the conference is Dr. Adriana Petryna (University of Pennsylvania). The event is supported by the Institute of Ethnology, Charles University Prague.

Contributing Authors

Hwiada AbuBaker, has got her Masters Degree in Psychology, Sociology, Anthropology from the American University in Cairo, and her PhD from the University of Vienna in Ethnomedicine (2000). She is an assistant professor at Ahfad University for Women where she teaches Medical Anthropology in the School of Medicine. Currently she is a lecturer at the Medical University of Vienna and working together with the staff of the Unit of Ethnomedicine to initiate a master program research in medical anthropology and international health at Ahfad University in Sudan. She is interested in women's health issues particularly in relations to folk beliefs and practices.

Nina Grube, M.A., studied social anthropology, sociology and political sciences at the Free University Berlin, Germany, obtaining her masters in 2007. Since 2008 she is a research fellow and lecturer at the Institute for Social Anthropology, Westfaelische Wilhelms-University Muenster, Germany. She is currently conducting research for her PhD on bio-medical and religious models of mental illness in a psychiatric clinical setting and among African migrants in Berlin.

Edit Szénássy holds an M.A. in American Studies with a specialization in Gender Studies. Her research interests lie in medical anthropology, reproduction, and the anthropology of Roma. Currently she is a Ph.D. candidate at the Institute of Ethnology, Charles University Prague.

Photograph last page

Disadvantage works in many directions, and not everyone within the *osada* is equally poor. Yet for most Slovak Roma, everyday, structural discrimination is a reality.

photograph: Edit Szénássy

Differences that matter

Sponsored by

Vienna International Airport

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