spring/summer 2010 volume XII number 2-3

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viennese ethnomedicine newsletter

Old woman caring for family members

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

unit ethnomedicine and international health

Frontispiece

The woman in front (aged 75) is living with her mother (aged 100), and with several grandchildren in one household. Six of her 14 children died at a young age, two died from Aids. As a result of HIV/Aids older men and women in northwest Tanzania bear a growing responsibility within families – caring for sick relatives and raising orphaned children. These care giving tasks increase at a time when physical strength is declining due to old age. While the family remains the main care giving unit, relations within the family have become severely strained. (photograph: Josien de Klerk, see article this issue)

Viennese Ethnomedicine Newsletter

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

Content

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ISSN 1681-553X

Introduction: Medical Anthropology in the Netherlands

Erica van der Sijpt, Trudie Gerrits, Sjaak van der Geest

This special issue of the Viennese Ethnomedicine Newsletter focuses on the Medical Anthropology Unit of the University of Amsterdam and reflects some of its present research strands and activities. In this introduction, we will briefly describe the roots and current standings of medical anthropology in the Netherlands, and more specifically in Amsterdam. This overview serves as a framework for the five papers which will be shortly introduced at the end of this section.

Roots of Medical Anthropology in the Netherlands

In the Netherlands, the number of medical anthropologists is high and increasing. The roots of the relatively strong presence of medical anthropology in this country are clearly connected with its colonial past, as well as with its intensive involvement in the international field of health and development in the postcolonial era (Diasio 2003, Streefland 1986, Van der Geest 2007). In addition, the large number of foreigners – migrants and asylum seekers – who have come to the Netherlands in the past four decades and started to make use of the Dutch health care system, has also increased the interest in issues of culture and health. The confrontation in medical practices with people from various cultural backgrounds underlined the social and cultural character of health, illness and health care. It turned the understanding of cultural differences and their implications for health care into an urgent question (see, for instance, Braakman 1986, Van Dijk 1998, Van Dongen and Van Dijk 2000). Health practitioners themselves turned into "medical anthropologists" and – at a later stage – also came to seek the insights from anthropologists. Simultaneously, Dutch medical anthropologists have become increasingly interested in doing research in their own society and have sought collaboration with the medical field at home (Van der Geest 2007).

As medical anthropologists have come "home" for more than a decade now, their studies within the Dutch biomedical field do not only concern issues related to migrants, but have extended to much wider areas of concern and relevance. The broad range of current research interests reflects present day health concerns in Dutch society, such as those related to chronic diseases, health care arrangements, medical technologies, ethical dilemmas, patient participation and empowerment. Despite some major challenges which medical anthropologists continue to encounter in various health care settings, their perspectives and research methods seem to gain in recognition and relevance within the broad field of biomedicine in the Netherlands.

As much as some of these medical anthropologists have thus "come home", others have "gone – or remained – abroad". Dutch medical anthropologists have conducted research on all continents of the world, studying subjects and phenomena which are locally as relevant as the research topics described for Dutch society above. The increasing interconnectedness of places and people will probably only reinforce this trend in the future. The current teaching and research programs at the University of Amsterdam reflect this international character of medical anthropology in the Netherlands. Not only do these programs explicitly situate the subjects they study and teach within diffuse contexts of globalization, but they also aim to attract students who inhabit different corners of this globalizing world.

Current Situation: Teaching and Research Programs

The growing interest in doing medical anthropology both "at home" and "abroad" as described above is visible in a substantial institutionalization of medical anthropology in the Netherlands in the last three decades: fourteen chairs in medical anthropology (or closely related to it) currently exist; several courses in medical anthropology have been offered over time; and about 50 PhD dissertations in the field of medical anthropology have been produced in the Netherlands since the late 1970s[1].

Especially the Bachelors and Masters courses in medical anthropological subjects have played an important role in the growth and recognition of medical anthropology. Courses were offered from 1978 onwards at the University of Amsterdam, as well as at a number of other institutions in the Netherlands - both anthropology departments and medical faculties (Van der Geest 2007). They attracted and still attract not only many anthropology students, but also medical students and health professionals from various backgrounds – including, for instance, nurses, doctors, physiotherapists, occupational therapists, midwives, and psychologists. Currently, the University of Amsterdam offers two international Masters courses: the regular Masters in Medical Anthropology and Sociology (MAS)[2], and the international Amsterdam Masters in Medical Anthropology (AMMA)[3], in which students from both "western" and developing countries participate. Most students who enter these courses seek for an intensive preparation for research or clinical work in multi-cultural health care settings and environments – either in the third world or among migrants in the Netherlands. Others take these courses as a starting point for a professional career in the medical field. The inclusion of health professionals in these Bachelor and Master courses might have contributed to the success of medical anthropology in the Netherlands, since – even if many of them are currently not working as (academic) researchers – they have taken medical anthropological insights and approaches into their various fields and have enhanced research collaboration with and access to medical domains for medical anthropologists.

Next to these teaching programs, the University of Amsterdam offers, in collaboration with the Amsterdam Institute for Social Science Research (AISSR), a Research Program entitled "Anthropology of Health, Care, and the Body"[4]. This Research Program has an interdisciplinary character, including researchers from within and beyond the university working in the fields of medical anthropology and sociology, gender and sexuality studies, and the social studies of (bio)medical science and technology. The current research projects within this Research Program can be divided into four strongly related sub-programs.

The first sub-program deals with globalization and the science and technologies of health policies and practices. The point of departure is that developments in techno-science bring about radical transformations in contemporary health care and society at large. This sub-program therefore focuses on the production, distribution, deployment impact and meaning of biomedical knowledge and technologies (like pharmaceuticals, vaccines, reproductive and genetic technologies) – both in clinical and in everyday settings. HIV/AIDS research is a major focus of this sub-program.

A second sub-program studies young people's health and wellbeing. Considering young persons as social actors, this sub-program focuses on the understandings and actions of youngsters concerning their own health and wellbeing. Theoretically, it critically analyses adult-centered discussions on agency and structure, competence, cognition, vulnerability, accountability, and power for its applicability on youngsters. Methodologically, it develops cross-culturally applicable methods for qualitative research with children and youth of different ages.

The anthropology of crime and violence forms the focus of the third sub-program. It departs from the idea that crime and violence are products of complex socio-cultural relations and scientific and medical interventions, rather than natural or innate qualities residing in individuals. While one strand of research centers on issues related to crime prevention and detection, another stream aims to enhance understanding of violence within historical, social and cultural contexts. Both strands of the sub-program are concerned with the production of sexual and racial subjectivities and the normativity and morality of the practices studied.

Finally, a fourth group of researchers focuses upon postcolonial bodies and subjectivities. It takes into account the historic trajectories in relations between "centers" and "peripheries" or "north" and "south", as well as concomitant changes in our understanding of "the subject". This subject is embodied and located in time and space, and an object of power and power relations – in different fields, such as illness, health care, medicines, sports, crime, beauty, dance and food, for instance. Special attention is paid to specific discourses and practices with regard to the body and health, and how these contribute to the construction of racial, sexual and gendered identities.

These four subprograms show partial overlaps between research methods and topics, contributing to a synergy between the researchers and their current and future projects. Part of this synergy will be reflected in the current special issue; however, while some similarities between the approaches of the five papers might be discovered, they also represent the diversity of topics, settings, and issues which characterizes the current sub-discipline of medical anthropology at the University of Amsterdam.

Since 1989 the Medical Anthropological Unit has been publishing the journal "Medische Antropologie" which appears twice a year (about 350 pages per volume). Medische Antropologie discusses social and cultural aspects of health, illness and health care. It welcomes contributions, which connect familiar and foreign cultural issues and cross-disciplinary boundaries. At first the journal accommodated mainly articles in the Dutch language; at present nearly all contributions are in English. One issue each year is a special issue with a selection of papers that were presented at an annual symposium. Themes of the last years include: "The Bed", "Intersubjectivity as analytic tool", "Sickness & Love", "Resilience and Poor Health", "Beauty & Health" and "Care & Health Care." The journal is accessible on the internet, except for the last five issues[5].

Five Contributions

This special issue presents the work of five colleagues who are currently affiliated to the Medical Anthropology Unit of the University of Amsterdam. It starts with a methodological contribution in which an age-old anthropological dilemma is applied to the field of medical anthropology – and more specifically, hospital ethnography. Benson Mulemi critically assesses how "insider" and "outsider" positions of medical anthropologists in hospital settings affect their access to fieldwork sites, their research methods, as well as related ethical considerations. His exploration of the possible advantages and disadvantages related to both positions reflects current thinking within medical anthropology – both at home and abroad.

From the hospital we move to the outside world and explore how biomedical notions and artifacts are incorporated or contested in local settings and health situations. The contribution by Sjaak van der Geest addresses social and cultural meanings of pharmaceuticals. Pharmaceutical anthropology has been a constant field of interest in the Amsterdam research group, studying the production, sale, distribution, prescription, consumption, interpretations and meanings of medicines. In this article, Van der Geest contrasts and discusses two views on medical drugs. On the one hand there is a wide popularity of pharmaceuticals in both high income and poor societies. At the same time, however, a more skeptical and reluctant attitude towards pharmaceuticals occurs, formulated in both individual and cultural categorical terms. The author reviews the reasons for the worldwide popularity of drugs, and then suggests that some of the same factors may help to understand the reluctance to use them in other circumstances.

Erica van der Sijpt looks into local interpretations of both pregnancy and pregnancy loss in Eastern Cameroon. She argues that local conceptions of variable blood strength of parents and gradual force development of fetuses are at odds with strictly linear and time-based biomedical models of pregnancy evolvement and disruption. Local flexible understandings are shown to allow for strategic interpretations of pregnancy loss – which, paradoxically, might be combined with biomedical modes of explanation.

Similar dynamics between local and biomedical notions are also found to exist around HIV/AIDS in Western Kenya. Ellen Blommaert situates the way youngsters explore sexuality and deal with HIV-related risks in historical and current contexts. While tracing certain aspects of youngsters' sexual behavior and notions of risk back to former times, she also analyses how new inventive sexual strategies have come to be at play in current uncertain paths to female and male adulthood. These strategies are shown to be intrinsically social and seem more pertinent than contraceptive campaigns or biomedical testing and treatment of HIV/AIDS – which all take the *individual* as a starting point.

Josien de Klerk steers the discussion on HIV/AIDS and its consequences for people's daily lives into a different direction. She focuses on the growing responsibility and care for sick family members and orphaned children by older men and women in Tanzania. These elderly people face a paradoxical situation in which their care-giving tasks increase, while their physical strength is declining and family care for themselves is disintegrating as result of migration, declining economic capacity and HIV/AIDS. The author argues that family relationships have become severely strained and that more attention for the ageing process of older caregivers is indispensable to understand these dynamics – now and in the future.

Notes

[1] The remaining part of this section focuses on the Medical Anthropology Unit of the University of Amsterdam.
[2] See http://www2.fmg.uva.nl/sma/ or http://www.studeren.uva.nl/msc-medical-anthropology-and-sociology/ or http://www.graduateschoolofsocialsciences.uva.nl/gsss_education/mas_amma.cfm.
[3] See http://www2.fmg.uva.nl/amma/ or http://www.graduateschoolofsocialsciences.uva.nl/gsss_education/mas_amma.cfm.
[4] See http://www.assr.nl/research/clusters/health.html or http://www.fmg.uva.nl/aissr/research/programme-groups.cfm/98B15AC4-1321-B0BE-682E1F8A243DBA95
[5] See www.medical-anthropology.nl, click top right on "journal".

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On Being "Native" and "Outsider" in Hospital Ethnography

Benson A. Mulemi

Participant observation is a hallmark of classical ethnography. Many anthropologists value "going or being native", as an outstanding quality of ethnography. The basic premise for this perception is that being an insider, or acting as one, facilitates adequate grasp and representation of emic perspectives of events and people's experiences. Research and discourse on hospital ethnography at the University of Amsterdam, however, highlight both limitations to and advantages of true or fake insiders in medical settings. The opposite position of an "outsider" is taken by ethnographers who are foreign to either a local ethnic culture or medical sub-culture. Most hospital ethnographers fall in either category and only a few are trained in both anthropology and medical sciences. The statuses of "native" or "stranger" in medical settings affect access to fieldwork sites and different actors' life worlds. These in turn affect the quality of data and ethical considerations in hospital ethnography. This article examines the implications of outsider and insider positions for hospital ethnography. It argues that either status does not necessarily mean advantage or disadvantage.

Nevertheless, both statuses of “insider” and “outsider” require the obligation to be aware of the associated biases.

Introduction

Anthropologists and other social scientists working in medical settings without medical training face various challenges. They have often contemplated what roles to take for effective research – as either “outsiders” or “insiders”. The researcher‘s membership in the study group or site is germane to qualitative methodology because being an insider can affect the quality of collected date and the analysis process. Some considered disguising their research roles and collected data under cover as either fake patients or medical staff. They assume that non-obstructive research preserve the natural flow of events and enhance rapport and cooperation in qualitative research. Rosenhan (1973), Goldman et al. (1970) and Caudill (1958) report on research in psychiatric hospitals where the researchers collected data in unnoticeable, fictitious patient roles. Van der Geest and Sarkodie (1998) attempted a similar approach to hospital research in an experiment in Ghana. The second author in this experiment sought admission and made research observations in hospital as a fake patient. Other researchers such as Coser (1962) preferred doing hospital studies disguised in hospital staff roles by taking up medical accoutrements, especially the lab coat. Attempts by other ethnographers to conduct participant observation in medical settings, as either fictitious or real participants, have led to ambiguities and ethical dilemmas with regard to the researcher’s role (Goodwin et al. 2003, Parker 2001). These aspects challenge entrée efforts – to both the physical study sites and life worlds of the participants in the clinical settings. This has implications for rapport building and the quality of data elicited from the study participants.

Since the last two decades, social scientists, and particularly anthropologists revived the interest in hospital studies. This in turn renewed the question as to whether or not ethnographers should be members of their research populations in order to safeguard validity and reliability of qualitative research in clinical settings. It touches upon issues of acceptability and access as well as (participant) observation as the hallmark of ethnography. This article discusses the notion of insider and outsider with regard to hospital ethnography. It argues that qualitative researchers in specialised contexts such as the hospital are neither fully insider nor outsider. Anthropologists oscillate between the two positions due to the complexities of different ethnic or cultural, scientific, personal and professional experiences during fieldwork.

Ethnic Insider as Professional and Experiential Outsider

Doing ethnography in an institution such as a hospital ward requires initiation and continuous socialization of the “native anthropologist” (Mulemi 2010). I undertook ethnographic fieldwork to characterize how patients and their families coped with cancer in a national referral hospital in Nairobi, Kenya. I was both an insider and outsider in the hospital due to two reasons. First, being a “native” in the country, I share the cultural background of many of the hospital actors. Specifically, interaction with most patients and their relatives was easier for me than for the more specialized hospital staff. We shared a lack of professional training in medicine, as opposed to nurses, doctors and other patient support staff. However, Kenya is a multicultural society and no ethnographer can effectively straddle the diversity of cultures to present a good enough emic perspective of different actors’ experiences in the hospital.

Second, as an anthropologist without a biomedical health care background, I was an outsider to the hospital staff’s subculture. Conversely, I could easily participate in some of the day to day social roles that do not require specialized medical training. While I tried to keep to the neutrality of ethnography as a scientific method, I reminded myself each time that this does not preclude ethical concerns about my research subjects. In this regard, an ethnographer in a context of intense human suffering as the cancer ward can not be completely indifferent and non-empathetic to the experiences of patients, family members and other hospital actors struggling to alleviate misfortune. This disposition further sets the ethnographer apart from the “hospital natives” – such as the doctors and nurses – who can not help shunning empathy and emotional involvement with patients as dictated by their training.

Professional and ethical neutrality may actually amount to indifference which characterizes the desire for scientific objectivity. This further implies the construction of clinical professionals as outsiders to patients' subjective experiences with health care and illness. To this extent ethnographers, as cultural insiders among patients, may have more access to patients' lived experience, than clinical experts as professional insiders in the biomedical realm.

Social scientists are often concerned with the question of outsider-insider positions in qualitative research. This is the case because we often study groups to which we do not belong. I was not a trained hospital staff; neither was I a patient or a relative to any of them. My personal position and experience shifted from being a social science researcher to a non-professional actor on the ward – just like the majority of patient, relatives and visitors were. As an ordinary social being on the cancer ward, I participated in mundane activities as well as the emotional experiences of visitors and staff helping patients to cope. It gradually dawned on me that the hospital ethnography process was a venture of continuous negotiation to access the life worlds of the other actors in the cancer treatment centre and ward. Patients may share some perspectives on illness and hospitalization with a native ethnographer owing to their common cultural background and worldview. However, both social and medical scientists are outsiders to cancer patients' lived experiences. These constitute the domain of suffering which is a subjective rather than entirely objective reality. Healthy people in the hospital only attempt to have access to this experience by the degree of their empathy. Patients perceive other hospital participants as outsiders to their lived experiences most of the time. A patient, for instance noted:

> "We comfort each other [here] more than at home. You know that somebody who is not sick can not comfort you [the sick]. You tell him/her (healthy person) you are not experiencing the pain that I am enduring. You are not feeling it!" (Marina)

Ethnographers, clinical experts and other hospital actors encounter communicative and subjective challenges in attempts to understand and describe patients' suffering (Van der Geest 2007a, Frank 2001). At the same time, ethnographers too may not describe the emic perspectives of personal experiences of hospital actors adequately. In other words, researchers are outsiders to other people's personal worlds.

In my study, however, not being an insider was advantageous as my role as a neutral "outsider" in the hospital guaranteed me flexibility to interact with different actors. For this reason, patients considered me a suitable audience for an array of their personal concerns. They would "open up to complain" as I was available to "listen to their stories". Respondents who wish to safeguard their relationships with people who offer essential care and support often hesitate to complain to and about them. Patients' attempts to tell their stories and complain to biomedical actors were barely successful. They find a researcher, especially one who is an outsider to their context of care, as a safe audience for their complaints (cf. Van der Geest 2007b). In this regard, collaboration between the hospital ethnographer and medical professionals would facilitate improvements in patient care, satisfaction and their quality of life during hospital treatment. This was evident in the reaction to my presentation in a seminar organized for postgraduate researchers in the hospital. My presentation titled: "Patients' perspectives on hospitalization: experiences from the cancer ward" drew on my preliminary findings. One senior hospital staff commented rather disappointedly:

> "We have listened to the stories, now we are going to listen to real research, real PhD and scientific research."

Another biomedical hospital staff present in the seminar added however:

> "It is good to have more of such researches, so that we present our work, and anthropologists tell us where we go wrong (...)."

Social scientists have observed that medical institutions worldwide are reluctant to grant non-medical researchers access to their sites (Freidson 1963, Martin 2009, Zaman 2008). Medical practitioners are often suspicious that social scientists will infringe on their autonomy and subject their profession to undue criticism (cf. Mathews 1987, Van der Geest 1995: 870).

Moreover, the ethnographer may fit the description of "professional stranger" in the hospital, since he or she lacks the research rigor and quantification akin to biomedical experiments and perceptions of science. As a consequence, ethnography often remains unnoticed in healthcare practice and research – both in developing and some developed countries. Ethnographers without medical training find difficulties in realising adequate participant observation in clinical settings, save for a meaningful interaction with non-professional patients and their relatives. Anthropologists thus often resort to participant observation as social beings, rather than as actors sharing in the skills of trained hospital workers or in actual emotive experiences of patients and their relatives. To the contrary, one who considers himself or herself as a cultural "insider" faces other challenges; he or she has to collect data with the "eyes open" but assuming that he or she knows nothing about the phenomenon being studied (Asselin 2003). Especially when the researcher is part of the culture under study, but unfamiliar with the subculture at hand, there is a need to control preconceived ideas about issues and themes under study. In my own study (Mulemi 2010), I chose to be visible and did not attempt to do participant observation in disguised roles of any categories of the actual participants in the hospital.

Being an outsider professionally in institutional ethnography constrains participant observation in a similar manner as being an outsider with regard to subjective experiences of the study populations. Hospital ethnographers who share professional background with some of their research subjects may correspondingly content with the position of marginal observers rather than full participant observers as they may not be members of local cultures.

Professional Insider Versus Ethnic Outsider

> "There is nothing unusual about anthropological research: being human always implies observing and participating, being insider and outsider… Being white and left-handed in Ghana makes it impossible to be a fly on the hospital wall." (Böhmig 2010: 12).

One of the aims of participant observation is that the research subjects accept the ethnographer as one of them. The basic assumption from classical ethnography in this sense is that the quality of ethnography depends on the potential and level of researchers' immersion in the study situations and events to the point of obliterating the investigator role. The presence of the ethnographer would not affect the flow of activities, events and expression of experience anymore. As such, the hospital ethnographer desires to be the "fly on the wall" whose presence does not interfere with the natural flow of events. "Professional insiders" may nevertheless not share the training experiences that are specific to the socioeconomic circumstances of their counterparts in institutions in different cultural settings. This is particularly true for hospital ethnographers working in foreign countries. In this regard, cultural differences and personal biases can infiltrate ethnographic observations, interpretations and conclusions of hospital ethnographers working in countries other than their own. In view of this, Böhmig (2010) further observes:

> "Being a Western trained nurse who had worked in Europe, I was aware of the basic and general procedures of nursing on the ward. This made me partly 'native' and withheld me from certain questions. I was not 'blank and ignorant' and the nurses knew that I knew how they were supposed to work. On the one hand, they felt extra critically observed and apologised for irregularities, even though it was never my intention to point on those. Also, they used my knowledge to have me join the team… I represented both the outsider and the member of the group. I was part of the imaginary worldwide professional nurses' network and familiar to the hospital routine at large and at the same a foreigner in the Ghanaian culture and emic realisation of the work." (ibid. 39)

Lack of the professional skills which would allow a complete immersion into the clinical setting, leaves the anthropologist only with the option of engaging in "negotiated interactive observation" (Wind 2008). Through this process, the ethnographer does not assume that she or he has become one of the study subjects. While the ethnographer observes them, she or he in turn becomes the object of observation by the study population. The researcher generates data and interpretation through critical dialogical relations with members of the study group. This creates an on-going negotiation that shapes ethnographic interpretation and influences which stories are told and whose voices are heard or muted (ibid. 87). This is also true for professional insiders who lack the cultural skills and training background similar to the one research subjects have.

Such contexts pose difficulties in understanding and describing experiences communicated in cultural forms, such as languages that the insider to the medical culture is not familiar with. Similarly, the fact that hospitals in different sociocultural contexts are not identical clones of global biomedicine (Van der Geest and Finkler 2004) negates the status of a "professional insider" from a foreign country. Hospital ethnography shows that and how local factors play an important role in the daily routine of the hospital, reflecting the culture in which it is rooted (Gibson 2004, Mulemi 2008, Van der Geest 2005, Van der Geest and Finkler 2004, Van Dongen 2004). Therefore, the most applicable mode of observation for the ethnographer in the hospital or the clinic is social participation. The success of observation depends on the ethnographer's precision in observing, recording, and reporting what he or she sees (Kottak 1991). Although a combination of hospital staff roles may be possible for those with cross-disciplinary training, this compromises the research role. Active participation can therefore inhibit the quality of observation.

While I strove to be flexible and position myself socially in the ward in order to build trust, I could not join professional situations and activities in the hospital as I collected the data. I was a mere observer of the activities of nurses, doctors and other patient support professionals. Flexibility of direct observation is an important attribute that can facilitate social interaction and participation – which allows making ethnographic records in clinical settings without significant disruption of the natural flow of events and procedures. Some advocates of qualitative research design hold that if researchers share the skills, experiences and worldviews of the study subjects, they are able to safeguard natural setting of events and the ultimate quality of the ethnographies. This is arguably the essence of being a double native in ethnography. The apparent preference for this label in ethnography is that it improves the representation of emic perspectives on different ethnographic domains.

The "Double Native"

As aforementioned, hospital ethnographers with medical training may construe themselves as "professional natives". They are doubly natives as they have both the qualitative research skills as social scientists and medical qualification that ease their access to clinical settings. Sharing cultural backgrounds with the study population in clinical settings further augments the quality of being "native among natives" (Zaman 2008). The ability to do actual participant observation as professional insiders gives them an edge over the mere ethnographer-anthropologist. Such researchers and other social scientists also suppose that double natives have better access to the life worlds and experiences of research subjects of their own sub-culture. This has been the basis for the argument that anthropologists in clinical settings would do better if they had a medical training; social scientists may need more skills for "speaking medicine", "knowing biology" and "taking care of patients" (Poland 1985: 61). However, anthropologists can acquire basic knowledge that is necessary to follow treatment discourse in clinical settings in due course. This is an equivalent to acquisition of essential language skills for verification of data in ordinary settings of qualitative research in an alien culture. The unique case of double native involves local ethnographers who have both medical and anthropological training. Zaman (2005, 2008) for instance describes his twofold "nativity": as a Bangladeshi doing fieldwork in the country and as a medical doctor studying a hospital, the domain of doctors. His entrée and access were relatively easy as a doctor – hospitals have qualms about admitting outsiders such as social scientists, fearing that they could engage in "doctor bashing" or being unduly critical of physicians and other hospital staff. Vermeulen (2004: 2072), a Dutch nurse and sociologist who studied a Dutch neonatal ward, reiterates: "It is important to carve out a position of an impartial onlooker for oneself and one should continue efforts to stay in that position as the fieldwork progresses. (…) The social life on wards is full of conflicts. (…) the investigator needs to be able to shift between the groups without being associated with one group by others." In my own study (Mulemi 2010) some staff thought I was evaluating their performance. During a ward round, a senior nurse-in-charge asked:

> "Are you going to say in your report how badly we are doing? People will say according to research done by so and so it was found that things are going in this manner ... Are you investigating to report how efficient or inefficient we are?"

Although a "double native" ethnographer has higher chances for acceptability and participant observation, this position also raises some practical and ethical concerns. In the first place, the native among natives has to grapple with the challenge of being unable to fully keep an objective distance from the research subjects. Similarly, Zaman (2008: 145) admits: "While my knowledge of medical practice greatly reduced the time required to complete my fieldwork, the disadvantage is that it might have clouded my eyes at points and caused me to take certain things for granted."

Thus, the double insider role may entail role conflict as the researcher may not effectively discern the boundary between cultural and professional insider roles and the objective researcher position. In the words of Zaman (2008: 150), being an insider greatly reduces the cognitive and emotional efforts necessary for adjustment and comprehension of an otherwise foreign culture. Dual roles can cause role confusion. Attempts by ethnographers to conduct participant observation in medical settings, as either fictitious or real participants, lead to ambiguities and ethical dilemmas with regard to their roles (Asselin 2003, Goodwin et al. 2003, Parker 2001). Nevertheless, Dwyer and Buckle (2009) argue that being a member of the group under investigation does not necessarily influence the research process negatively. This is because ethnographers can still maintain rigorous selection of information and engage in meticulous reflection on the subjective research process and reflexivity. Although ethnographers do not necessarily need to be insiders in their research contexts to appreciate the experience of their subjects, some still prefer "going native" in medical settings.

"Going Native"

I consider going native in hospital ethnography as efforts by the ethnographer(s) to act out the role of some genuine hospital participants. These may entail the aforementioned non-obtrusive participant observation in the fake roles of patients, doctors, nurses, and other hospital workers. Initially in my study (Mulemi 2010) I thought it would be appropriate to conceal my researcher identity by wearing a lab coat, but I soon dropped the idea, realizing that by wearing my own clothes, the hospital staff would not see me as usurping any of their roles. It would have been easier for me to disguise my identity by passing myself off as a medical social worker. However, hiding my identity as a researcher and taking on a double role in the hospital study would have posed ethical and practical challenges. Going native in medical settings for mere anthropologists may be as tricky as attempts by non-ethnic ethnographers with training background in health sciences.

I dropped the idea of being an ethnographer in disguised role of any of the hospital actor categories. I chose to be a conspicuous "outsider" (cf. Maseide 1987, Roberts 1977) in the cancer ward and related space. I was the only person on all occasions without the hospital staff symbols, particularly the lab coat and a name tag. As a neutral, visible observer, my participation in the ward was limited to general tasks and those discussions I could indulge in as any person taking ordinary social roles. I tried to empathize with patients and other informants, but not as a person possessing the skills of the hospital staff, nor as someone with a similar background to the patients. Going native for me therefore entailed ephemeral empathy on multiple occasions with everybody. I focused on learning from everybody rather than being linked continuously to one particular group in the hospital.

On occasion hospital staff and patients associated me with students on apprenticeship in the cancer ward and clinic. I did not dispute being associated with this group of insiders, since I undertook my hospital ethnography as a doctorate student. Contrary to expectations about my student role, I could not go fully native in this sense because my student role was not similar to that of pharmacy, nutrition and other students of health sciences. However, I gradually became a familiar part of the cancer ward and clinic, and some staff even described me as being "one of them". This facilitated my interaction with those I was meeting for the first time. Since I did not have any hospital attire or badge on, hospital staff who were meeting me for the first time needed assurance with regard to my presence among them. This did not interfere with my research role among patients, but instead facilitated their gradual recognition of my neutrality. I could easily shift my association with all the participants through informal social interactions.

The combination of research with actual or improvised hospital staff roles might have resulted in role ambiguity that could compromise the quality of ethnographic data. Patients, for instance, might find the dual role of health adviser and researcher confusing. They may not have been able to identify the end of the health adviser role and the beginning of the research role (Parker 2001). Attempts to perform formal job duties simultaneously with research may also have affected concentration on the research activity. I was an outsider in the field because I am neither a medical practitioner nor an employee of the hospital. However, I took advantage of the medical setting as an arena of social relations that facilitate treatment. As a social being, I managed reasonable empathy with the study groups – both professional and non-professional. This entailed a limited degree of going native due to the fact that I could not immerse myself fully in the experience of any category of actors. This further entailed constant oscillation between being an insider and outsider, depending on the demands of the social contexts and themes of the research.

Discussion and Conclusions

Ethnographers can not occupy the exclusive role of either outsider or insider. They occupy the *space between* (Dwyer and Buckle 2009) due to at least two reasons. First, the researcher position shapes a trained anthropologist's view of reality. An anthropologist goes to the field only after review of literature, and additional reflection on theoretical and practical issues on the research topic – notwithstanding attempts to become an "insider" afterwards. Second, ethnographers who consider themselves outsiders learn about their subjects and create rapport owing to intersubjective human experience, as social beings. Therefore anthropologists can not fully take one or the other of the two positions; native or outsider.

Various issues are embedded in the question of whether a hospital ethnographer is either an insider or outsider. Central issues relate to entrée and accessing of clinical areas as social science fieldwork sites (Mulemi 2010). Admission of social scientists into hospital settings for research takes at least two forms. First, both biomedical and social science researchers can access clinical settings through (informal) negotiation with hospital managers or unit supervisors (Halford and Leonard 2003; Kirkpatrick 1980). Physicians and other hospital staff who do ethnographic research in their own or other hospitals often use this approach to access clinical sites. Zaman (2005, 2008) for instance used his role as a physician to gain informal access to conduct an ethnographic study of a hospital ward in Bangladesh. The second mode of access to medical settings for research is through research and ethics clearance committees, which vary in their organization and rules among different hospitals and countries. Some individual members of research clearance committees may use their power to restrict "outsiders" from "using their patients" or intruding in their research fields or disciplines. Likewise, some researchers might decide not to get approval from a research committee; in some cases, ethics committee approval is only necessary when the research involves patients (Halford and Leonard 2003).

Being an insider enhances more comprehensive understanding of research groups that would otherwise be inaccessible to other researchers. The insider status facilitates ready acceptance by participants, and especially health professionals in clinical settings. Arguably, research participants open up with researchers whom they regard as one of them and this may facilitate collection of more in-depth qualitative data. However, many barriers can arise to block an anthropologist's access to a hospital or clinic space and this issue cannot be taken for granted (Long et al. 2008: 71). The hospital research clearance committees, for instance, are often unfamiliar with qualitative research and its significance to patient care. This limits acceptance of ethnography. Therefore application for access to the hospital for qualitative research entails a negotiation process. This requires finding the elusive balance between meeting the demands of the hospital research project protocol and respecting the principles of ethnography. While the insider may be the most acceptable in the study group, this status might compromise objectivity, reflexivity, and authenticity of the ethnography. The admission procedure for "outsider" researchers to the hospital can be very rigorous and prolonged. This may compromise ethnographic designs because members of ethics and research clearance committees may not be familiar with qualitative research designs. However, outsiders – with or without hospital research approval – would be better positioned to examine issues that insiders may take for granted. This is because an insider may assume that he or she already knows and this couples with too much familiarity with issues at stake, which may hinder scientific objectivity.

Ethnographers face the challenge of hospital participants' social and subjective experiences. Accessing hospital actors' perspectives requires constant rapport building. However, career and professional differences between anthropologists and medical staff could influence their interaction. "Hanging around" some medical personnel while they work could make them uneasy, especially if the anthropologist merely observes them without some participation. Biomedical practitioners may appreciate hospital ethnography, but they have qualms about the qualitative fieldwork approaches that are unfamiliar to the insiders' quantitative techniques. Biomedical practitioners may resist social science studies in hospitals claiming that they lack objectivity and relevance (Mulemi 2006). However, ethnographers need to popularise and demystify anthropological approaches in hospital studies and collaboration with other professionals. The place of ethnography in hospital studies can be strengthened by an emphasis on its methodological uniqueness. This has the potential to facilitate useful professional interaction between anthropologists and other healthcare specialists. This is an important principle that can foster cooperation between ethnographers and medical scientists. Anthropologists (and social scientists in general) need to make themselves useful in clinical settings (Kleinman 1985) in order to realise the interdisciplinary cooperation. It is worth noting here that the ethnographic method can help in the realization of the link between biomedical and psychosocial paradigms. An anthropologist working in the hospital can deal directly with some significant issues in patient care, including quality assurance, patient satisfaction, and evidence-based medicine (Press 1985).

Many anthropologists and ethnographers consider "going or being native" as a superior feature of their research methods. They associate being "an insider", or acting as one, with better grasp and representation of emic perspectives of events and experiences. However, being an outsider or insider does not make a better or worse researcher – just a different type of researcher (Dwyer and Buckle 2009). However, both "insiders" and "outsiders" are bound by similar expectations with regard to the subjectivity in their analyses. Since hospital ethnographers fall on the insider-outsider borderline, constant awareness of personal biases in qualitative research can improve their contribution to healthcare. The central feature of a good enough ethnography does not lie in the insider or outsider status, but in an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience (Dwyer and Buckle 2009: 59). The gap between being insider and outsider in hospital ethnography may be constantly obliterated by the fact that the fieldwork strategy entails attempts to understand bits of shared human experience.

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Why Are Pharmaceuticals Sometimes Liked and Sometimes Disliked?

Sjaak van der Geest

I was first drawn to the study of pharmaceuticals when I was doing fieldwork on sexual relationships and birth control in a rural town in Ghana. During that research young people repeatedly told me that they used a certain medicine to prevent pregnancy and that they used the same medicine to terminate a pregnancy that they had failed to prevent. Students at the university, I soon found out, were using the same medicine for the same purposes. The medicine, which was for sale in all drugstores I visited, in Accra as well as in rural towns and villages, was a purgative produced by a company in Detroit. How this product had come to play the role of the most popular contraceptive among Ghanaian youths was a riddle. My curiosity – and concern – grew further when I found out that doctors and other medical professionals had never heard of it.

The popularity and widespread use of foreign produced medicines outside the knowledge and control of the professional medical world was not only intriguing to me but also of life importance to those using them. Suddenly I began to see pharmaceuticals everywhere: in shops, at the market, in small kiosks and in private houses. Some of them were relatively harmless; others were dangerous prescription-only drugs.

A few years later I started my research on the distribution and use of pharmaceuticals in Cameroon. I was most interested in the flourishing informal market of pharmaceuticals, but I soon discovered that that informal market also existed on the doorsteps and in the wards and consultation rooms of health centers and hospitals (see: Van der Geest 1988, 1991).

This paper reviews the reasons for the worldwide popularity of drugs, and then suggests that some of the same factors may help us to understand reluctance to use them in some cases. Popularity and skepticism may be dialectically related, as is suggested by an overview of pharmaceutical practice in the United States, the country with the highest consumption of drugs in the world, and home to some of the most explicit critiques of synthetic pharmaceuticals (Vuckovic, Nichter 1997).

Popularity

When I speak of "popularity" I do so from the point of view of the consumer. I discern five grounds for the popularity of medicines: practical experience, the tangibility of drugs, xenophilia, the symbolic exchange of medicines and their empowering potential.

Practical experience

Before we move to analytical abstractions, we should pay attention to more mundane matters: common knowledge and practical experience. When people are asked why they prefer modern pharmaceuticals, their most common reply is clear, almost tautological: Because they work! Antibiotics in particular have contributed to the popularity of pharmaceuticals. They performed miracles that had not been witnessed before and confirmed their epithet of "Magic Bullets". Historical studies suggest that the successes of antibiotics in curing infectious diseases in Africa, Asia and Latin America greatly facilitated the rapid acceptance of biomedicine, and pharmaceuticals in particular.

The quick cure provided by antibiotics in an era which had not yet been struck by resistance convinced the general public of the superiority of "Western" drugs and contributed enormously to their popularity. As they became more easily available, not only at formal health facilities, but also from shops and vendors, they became a kind of folk medicine with which most people had first hand experience. But there was more.

Tangibility

The concreteness of medicines answers what Cassel (1976) has called the "it-ness" of disease. As tangible substances, which can be swallowed or applied to a specific part of the body, medicines help to capture subjective experiences of not feeling well and make them object-like. Substances from the physical world transform elusive sensations of pain and discomfort into concrete phenomena and facilitate explanation, communication and therapeutic action.

The explanatory power of medicines lies in the fact that they help the patient (and his/her environment) to localize and intellectually grasp (the causes of) ill health. Their effect on communication is that the illness can be pointed out to others with the help of medication. A particularly important type of communication is legitimization. The prescription of medicine "proves" the sickness and justifies the patient's behavior. In fact, the very availability of medicines invites action in the form of medical intervention.

One could say that medicines have an inherent quality of curing (by being concrete) and, therefore, a natural disposition for attracting patients and curers. That inherent quality applies to all medical substances, including herbs, amulets and other non-biomedical medicines. Western products, however, have special "charms".

Xenophilia

An exotic provenance of medicines is easily seen as a promise that these are superior. The way in which a medicine's connection to another cultural context may be emphasized to enhance its charm is strikingly illustrated by a Philippine television ad for "Alvedon", a brand name for paracetamol, manufactured by Astra of Sweden. Pictures show a Swedish doctor taking the drug, while an announcer explains that Alvedon is the product of "the same Swedish technology" that produced the Volvo. This is followed by pictures of the tennis champion, Björn Borg, and the Nobel Prize ceremony in Stockholm (Michael Tan, personal communication).

It is against this background of the metonymic connections of medicines that we may also understand the extreme importance of appearance and packaging. The immediately apparent form of a medicinal commodity has the potential for suggesting such connections. The particular appeal of "high tech" forms of Western medicine, such as injections and capsules, is that they are so obviously products of advanced technology. To this must be added the power and prestige that accrue to political and economic dominance. A capsule is a bit of Western technology with all that implies of potency and possibility.

Tokens in Social Exchange

Medicines lend themselves eminently to meaningful exchange. They facilitate, mark and reinforce social relationships. They express and confirm friendship, dedication and concern, particularly in the meeting between a patient and his/her doctor.

Medicines are tokens of the doctor's concern and, reversibly, that concern fills the medicines with therapeutic power. This is beautifully shown in a study by Nichter and Nordstrom on medicine use in Sri Lanka. Whether a medicine works is thought to depend on the person who prescribes it. "[M]edicine is imbued with the qualities and intention of the giver" (Nichter and Nordstrom 1989: 379). The medicine thus becomes a mediator between the person of the patient and the person of the practitioner. During an illness a patient will look for a doctor who is sensitive to his particular physical and social circumstances. The authors quote an informant who emphasizes that the same medicine may be effective in one case and ineffective in another: "You see, even though it is the same medicine, it answers better if it is given by a person who has the gift of healing for you." (ibid.: 383).

The prescription, and later on the medicine, is a metonymic extension of the doctor. There is, as it were, a dose of doctor in the medicine. The healing hand of the doctor reaches the patient through the prescription and the medicine. The prescription and the medicine are the material proof that doctor and patient are still connected to one another. The confidence awakened in the patient by the doctor is recaptured in the concreteness of prescription and medicine.

Medicines also perform the role of expressing and strengthening relationships between people outside a medical context. Cosminsky and Scrimshaw (1980) write that bottles of intravenous glucose solutions are offered as wedding gifts in Guatemala (also cited by Nichter and Vuckovic 1994). Tan (1999: 60) remarks that Filipino husbands fulfill their pregnant wives' craving by buying vitamins for them. Also in the Philippines, Hardon (1991) writes that a mother shows her goodness by purchasing medicines for her children. In Ghana people may give medicines as a gift at the birth of a child.

Empowerment

Periods of illness are occasions of dependency and social control. They provide an opportunity to review social relationships and conceptions of the person in the world. In explaining and treating illness, ideas of obligation and morality are often mobilized, as countless ethnographers have shown. Family meetings, confessions, sacrifices, rituals of exorcism and collective prayer are kinds of therapy embedded in kinship and community relationships. To these kinds of therapy, medicines are an alternative, a treatment which can be carried out privately and which focuses on the individual body (Whyte 1988, 1992).

Thus medicines can become vehicles of individualization, useful exactly at that point where more "relational" forms of therapy might have emphasized the person's involvement with other people and/or subjection to spiritual forces. In many Third World societies, this potential of medicines fits with a general process of individualization associated with changing economic structures, school education, and the creation of national popular cultures.

The fact that medicines are used individually and privately is particularly important when discretion is valued. Those suffering from venereal diseases are generally strongly motivated to cure themselves before others get to know their shameful condition. The great popularity of antibiotics, in particular tetracycline, is probably explained by this concern.

The same applies to medicines used to induce abortion. In many societies abortion is seen as a serious offence against one of the most cherished values, the production of offspring. Modern pharmaceuticals as well as traditional herbs or other substances are used privately and secretly by women to terminate their pregnancy (Bleek and Asante-Darko 1986, Koster 2003). Lack of social support, impoverishment, or the wish to complete an education may offset the prestige that used to accrue to high fertility in many societies. When pregnancy does occur, abortion may seem the best rational alternative to the woman concerned. "Medicines" may provide her with the means to solve that problem without the interference of others.

Thus, medicines seem to empower the individual, diminishing dependence on biomedical practitioners, spiritual experts and kin. The social control exercised by therapeutic specialists, from witchfinder to psychiatrist, from ancestor-priest to family doctor, can be evaded. Also the influence of family elders, neighbors, religious leaders, and others can be greatly reduced, as the individual may be able to circumvent their interference by the private use of medicines. Divination, collective prayer, sacrifice, surgery, and counseling put the patient in other people's hands. Medicines enable him to take his condition in his own hands.

At a very practical level as well, Western pharmaceuticals are often seen as advantageous, if not exactly empowering. They are convenient and ready for use. Many indigenous herbs have the disadvantage that they have to be collected, usually outside the village, and prepared before they can be applied. This process is time consuming; and it also diminishes the privacy of using medicines, for it may prove impossible to carry out the preparation of the herbs without others noticing it. Moreover, a person may have to depend on others to find and prepare a certain herb. That a medicine is ready for use assumes increasing importance, as time becomes more precious in the lives of individuals (Sussman 1988: 208f).

Skepticism

The popularity of pharmaceuticals is punctuated by recurring expressions of mistrust, disparagement and resistance. In contrast to those who accept them as precious gifts, others refuse them or take them grudgingly. Some people reject the substances themselves as being toxic, unnatural, aggressive, and debilitating for the natural immunity of the body. Others object to how medicines are used as a substitute for other ways of dealing with problems. Sometimes these concerns are expressed in an individual idiom, as personal decisions by men and women trying to take charge of their own lives and enjoy relationships not mediated by medicines. Sometimes objections to medicines are phrased in terms of what might be called cultural idioms, where biomedical drugs are compared unfavorably to natural or indigenous medicines or to virtues of spiritualism or lifestyle. Obviously these two categories overlap empirically. I distinguish them here for purposes of analytical exposition.

Medicines, Control and Communication

One kind of disinclination towards medicines has its roots in relations between patients and doctors and issues of personal autonomy. In a study about “medicalization” among thirty patients in London, Britten (1996) found some people who, without informing their physicians, decided not to fill their prescriptions. They criticized the doctor for over-prescribing and experienced his prescription as an easy way out of the consultation. Britten’s respondents emphasized that they wanted more attention to their problem instead of medicines and said it was difficult to get away from a consultation without a prescription. Some said they were pleased when the doctor had *not* prescribed any medicine but had given them personal advice on how to go about dealing with the problem.

Resistance to medicine use is called “non-compliance” in medical terminology. Non-compliance could be regarded as an attempt by patients to assert themselves against or outside the control of the medical professionals and should also be studied from the patient’s point of view. Indeed “non-compliance” is often the outcome of skepticism about the doctor and his medicines.

In another study among people with epilepsy in the United States, Conrad (1985) pointed out that although medicines can increase self-reliance by reducing seizures, they are at the same time experienced as a threat to self-reliance: “Medications seem almost to become symbolic of the dependence created by having epilepsy” (p. 34). The drugs, in other words, have come to represent the disease and – paradoxically – recall what they are supposed to suppress.

Van Dongen (1990), who described the role of medication in a psychiatric ward for chronic patients in the Netherlands, presented yet another type of “non-compliance”. That role is intensely ambiguous. Medicines replace words in the communication between staff and patients. For some they are tokens of concern but for others, means of oppression. Medicines provide staff members with the power to maintain order in the ward. Medicines quell the disturbing symptoms of a psychosis or depression. One of the staff put it frankly: “When we get very difficult clients, we have medicines.” In reaction, some patients resist thus being controlled by medicines and complain of nasty side effects. Medicines become hostile substances, means of oppression, “poison” and, by refusing to take them, weapons of rebellion.

These examples of non-compliance illustrate the way that not taking medicines can be an assertion of autonomy on the part of sick people, who feel that medications or doctors impinge on their lives in undesirable ways.

Medicines and Cultural Critique

Another form of skepticism is cast less as a matter of specific relationships and control, and more generally in terms of qualities of the medicines themselves – their meanings, provenance, and effects on the body. There is a kind of cultural politics at work here, which can be a critique of the pharmaceutical industry, an opposition to foreign influence, or unease with alienating high tech hegemony. Enthusiasm for “natural medicine” or prevention-rather-than-cure is widespread in today’s world.

In her London study Britten (1996) found that aversion to medicines was sometimes explained by the assertion that medicines are artificial, chemical and unnatural. The fact that they had been made in a factory was in itself a reason to suspect them. Some people were reluctant to put something manufactured into their bodies. They preferred natural products. Pharmaceuticals were described as “foreign to the body”, an “alien force”, or “intruding on the body”. Britten’s informants mentioned various mechanisms by which pharmaceuticals caused damage. Medicines, some said, lowered the body’s resistance to infection and disease. Some objected that pharmaceuticals only fight the symptoms and not the causes. Others noted that pharmaceuticals offered uniform treatments that did not consider the specific problems of the individual patient.

In some non-Western countries, the critique is phrased as an opposition between indigenous and imported medicinal traditions, and the indigenous is sometimes associated with the natural. In India, for example, the contrast is made between Ayurvedic and allopathic (biomedical) treatment. Bode (2002, 2008), in his study of Ayurvedic and Unani medicines, shows how these indigenous medicines are presented and promoted as antipodes of the Western "chemical substances". Indian medicines are natural and have no side effects. They preserve and restore bodily and spiritual balance according to ancient guidelines for a healthy life. Western drugs, on the contrary, destroy the natural order and cause allergies and loss of immunity.

Consumers can be skeptical because biomedical products do not tally with their cultural perception of illness and cure or because they are uncertain and worried about their effects. In relating biomedical pharmaceuticals to local medical cosmologies, people often reject some of them for some types of patients. They may be seen as too strong and aggressive. Nichter and Nichter (1996) report that villagers in Southwest India consider "English" (or "allopathic") medicines as powerful yet dangerous. In contrast to Ayurvedic medicines that are believed to maintain or restore balance, English medicines are seen as heating and liable to have dangerous side effects. Injections, in particular, are believed to be very hot and are therefore not given to children. Pregnant women may avoid injections for the same reason, as they fear that the medicine will harm the fetus or cause an abortion. They may also reject pills because they think that these are difficult to digest and thus remain in the body, sharing the same space with the fetus for some time and causing it damage.

Injections, finally, deserve special attention. They may enjoy wide popularity because of their perceived potency and "high tech" foreign origin, but their power and foreignness may at the same time constitute their menace. The risks in connection with HIV/AIDS have made that reservation more acute. Reservations about the value of injections are reported in various studies (e.g. Bierlich 2000, Birungi 1994, Oths 1992).

Conclusion

This article explored the dialectical appreciation of pharmaceuticals, from high popularity to doubt and dislike. This conclusion, based on a review of the literature, can only be tentative, but will hopefully inspire further study and discussion.

Five grounds for the widespread popularity of pharmaceuticals which were investigated in the first part of this article (practical experience, tangibility, xenophilia, symbolic exchange and empowering potential) were almost systematically reversed in the second part. Practical experience of iatrogenic problems can make patients skeptical about pharmaceuticals and reluctant to use them. They may feel the concreteness of medicines as a misunderstanding of their more complex and elusive health complaints. They do not experience the prescription of pharmaceuticals as a token of concern by medical professionals but rather as a denial of their real needs and a tool to pacify them. The predilection for foreign remedies leads to oppositional thinking in which biomedical substances are contrasted to natural or indigenous ones, and come to be regarded as poisonous and "alien" to the body. Finally, more and more patients view pharmaceuticals as oppressive rather than liberating and decide to stop taking them or to take them in their own way.

There is a "temptation" to distinguish between skeptical consumers in '"Western" and "Non-Western" societies, but it is more useful to look for analytical distinctions that cut across that contrast. Pharmaceuticals are caught in global processes of attraction to and rejection of dominant political, cultural and ideological values. Their position is inherently ambiguous. They are both weapons of domination and resistance.

Doubts about medicines can derive from increased biomedical knowledge among consumers, but may also be the result of lack of such knowledge leading to cultural misunderstanding and suspicion. Skepticism can be understood as a kind of incipient cultural politics, in which medicines are used to place oneself critically in opposition to something, whether it is the doctor, the medical establishment, biomedical technology, or the power of cosmopolitan (Western) ways. Expressing skepticism about pharmaceutical drugs can be a way of asserting (or constructing) a contrast: nature vs. scientific technology; the ancient Ayurvedic tradition vs. Western modernity; individual agency vs. professional authority; or even, people vs. international capitalism. Medicines are a strategic point for formulating such oppositions because they are commodities in a commercial system, elements of biomedical technology, as well as personal products for use on and in individual bodies. They are part of everyday life and also of national and international economy.

Acknowledgement

This paper draws on two earlier publications (Van der Geest, Whyte 2003, Whyte et al. 2002). I thank Susan Whyte for her permission to quote from our common publications.

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“Filling With Force”: Reproductive Loss Reconsidered

Erica van der Sijpt

Thinking and theorizing about pregnancy, childbirth and reproductive loss often take a linear time frame as a starting point. Within and beyond biomedicine, for instance, embryology is conceptualized as a gradual process evolving over a specific period of time, with clear time-based distinctions between developmental stages and concomitant viability of the fetus. Not surprisingly, biomedical definitions of reproductive *loss* also rely on these chronological notions of gestational creation; different categories of reproductive mishaps (miscarriages, early and late stillbirths, perinatal losses, early and late neonatal losses) are based on temporal divisions. While some recent studies have indicated that in people’s practices and experiences these temporal distinctions can be overcome or deemed irrelevant, they do not question the *underlying rationale* of time as a valid basis of distinction. This paper, however, puts this chronological commonsense in context and perspective. Based on 15 months of anthropological fieldwork among the Gbigbil people in Cameroon, it shows how factors other than time also play a role in people’s interpretations of embryology, pregnancy, and loss. By focusing on the forms and the “force” of their babies, Gbigbil women shed new light on notions of “prematurity” or so-called “wrong deliveries”. For them, it is a particular, person-dependent process of “filling with force” during pregnancy which determines when a baby is viable or not. This same process underlies the differentiation between various forms of loss: reproductive mishaps get defined according to the forms and amount of force of the lost fetus – which only indirectly touch upon its exact gestational age. This paper describes how these flexible understandings relate to time-based and pre-established definitions of loss as existent in biomedicine – and how Gbigbil women might strategically make use of both.

Introduction

Thinking and theorizing about pregnancy, childbirth and reproductive loss often take a linear time frame as a starting point. Dominant biomedical embryological notions trace the development of a fertilized ovum into an embryo and, finally, a fetus which is believed to be viable at a specific gestational age. Consequently, pregnancies are conceptualized as gradual processes evolving over time and expressible in days, weeks, months and trimesters. Recent innovations in reproductive technologies have made this process not only detectable but also visible from a very early embryological stage onwards; the influence of these visualizations on people’s perceptions and embodiments of pregnancies, as well as on conceptions of personhood of the fetus, has been documented for different locales in the Western world (Gerrits 2008, Layne 2003, Petchesky 1987, Rapp 2000, Thompson 2005).

This time-based notion of the creation and viability of the conceptus dominates biomedical definitions of different forms of pregnancy loss as well. A miscarriage entails the loss of a pregnancy when the conceptus is believed to be unviable; the loss of a fetus that would have been able to live outside the womb but dies *in utero* or immediately following delivery is called a stillbirth. However, as viability is legally defined and changes by national context, there is no universally uncontested agreement on the precise divide line between miscarriages and stillbirths – which generally varies between 20 weeks and 28 weeks of gestation. A similar ambiguity surrounds the term of "perinatal death", which next to deaths at birth or in the first week afterwards also includes stillbirths during "late" pregnancy – the exact starting point of which is again contested and variable between different national frameworks. Yet, whatever the precise demarcations in different definitions, what holds true for any of them is the persistent effort to distinguish between (more or less mutually exclusive) categories of pregnancy loss on the basis of temporal divisions. Definitions of loss *after* birth are not less time-based; neonatal, infant and child deaths concern the deceases of live-born babies within the first 28 days, one year or five years of life respectively.

These time-based divisions are often taken for granted by social scientists involved in pregnancy-related research. Many anthropological studies on reproductive loss, for instance, distinguish between miscarriage, stillbirth, neonatal and infant death on the basis of the above described biomedical definitions. Some limit their interest to one of these categories and aim at an in-depth study of loss at a specific gestational phase (Bansen and Stevens 1992, Layne 2003, Letherby 1993). Others *do* treat various categories together. These studies acknowledge that the meanings and (social or emotional) effects of early and late pregnancy loss might not be as different as the separate classifications suggest (Jones 2001, Njikam Savage 1996). However, while the distinct classifications are thus discarded on the basis of their *comparability* – in content or effect – the underlying time-based *rationale* remains unquestioned. Indeed, the mere rhetoric of comparability of "early" and "late" pregnancy losses somehow maintains the separate terms and the inherent conception of a linear gestational process which can be divided into fixed, successive phases.

In this paper, I will put this chronological common-sense in context and perspective. I hereby build upon the insights of Caroline Bledsoe et al. (2002), who, by deconstructing the idea that linear time is the essence of fertility, also denounces the biomedical time-based distinction between miscarriages and stillbirths. She points out that in non-Western contexts, different forms of pregnancy loss might be distinguished on the basis of other criteria. I will explore how women in the East province of Cameroon think and talk about different forms of reproductive loss – and how these ideas relate to time-based distinctions as prevalent in biomedicine.

Research Site and Methods

The insights presented in this paper were developed on the basis of fifteen months of anthropological fieldwork between 2004 and 2009 in the East province of Cameroon. The particular research site was a village in the rainforest area, inhabited by approximately 1000 Gbigbil people. Most of the data were gathered through participant observation, which in this specific context implied accompanying women to their fields, caring for their children, cooking and eating together, participating during their deliveries and abortions, or visiting the market, church, hospitals and healers with them. Next to the informal conversations which took place during these daily events, in-depth interviews were held in French with 25 informants. This group included women from all age groups, with different educational histories, economic backgrounds, marital statuses, and reproductive experiences – the latter covering primary and secondary infertility, losses during various stages of pregnancy and in the neonatal period, as well as both successful and unsuccessful abortion attempts. The interviews with this varied group of women centered upon specific themes, such as embryology, sexuality, marriage, kinship, witchcraft, religion, and matters of life and death. Specific issues related to fertility and reproduction were discussed in ten focus groups with younger and elder women as well. Local conceptions of embryology were further investigated through body maps (see figures 1-3). Women were given three white papers showing only the contours of a 'transparent' female body and were asked to draw the contents of a pregnancy of one month, three months, and seven months, respectively. The variety of drawings and explanations, as well as the problems that arose from the time-based assumptions underlying this method, form the starting point for the discussion presented in this paper.

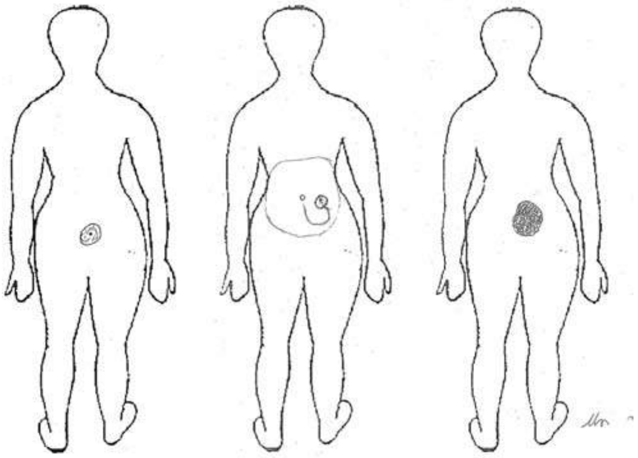

Figure 1: Body maps for a pregnancy at one month

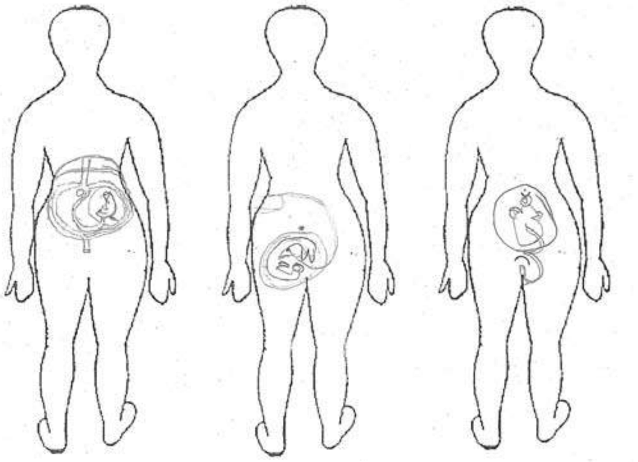

Figure 2: Body maps for a pregnancy at three months

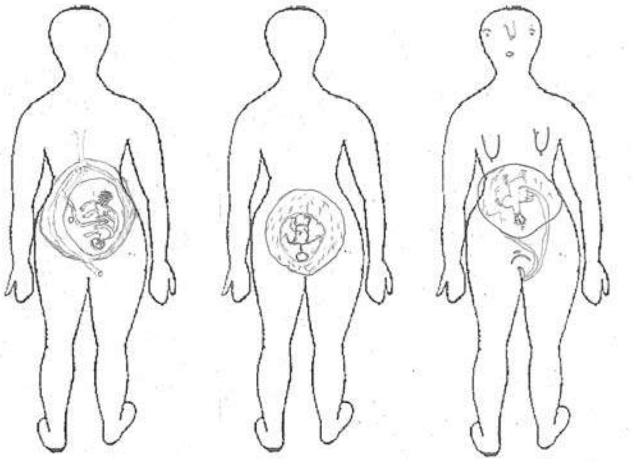

Figure 3: Body maps for a pregnancy at seven months

All interviews, focus group discussions and body mapping-sessions were recorded and transcribed verbatim in French. The quotations cited in this paper have been translated from French into English as accurately as possible.

Filling with Force: On Pregnancy and Prematurity

According to Gbigbil conceptions, the first months of a pregnancy (*abum*) are not only invisible at the outside, but are also considered merely "void" at the inside. At most, people speak of "water", "blood", or a "lizard-like creature" which develops inside a ball of blood. This "loose" substance which is to become a child (*mon*) is called *z∂ng mon* as long as it does not display clear human forms. Once it has developed into something more firm and human-like, the fetus is called a child (*mon*). However, despite this distinction between *z∂ng mon* and *mon*, the exact divide line between the two is fluid and contested. The division is not so much time-based but rather contingent upon a particular process of growing and "filling" of the fetus which happens during pregnancy. This process depends on the strength of the blood of both father and mother – a strength which is in itself variable over life time. Fetuses of parents with strong blood develop quickly; those inheriting weak blood transform themselves more slowly from *z∂ng mon* into *mon*. Even when all human features are formed – which informants broadly considered to be accomplished somewhere between three and five months after conception – the process of growing and filling continues. This process is now essential to provide *mon* with force (*ngul*). It is only when a fetus is filled with a certain level of force, that he or she might be viable. Some attain this level after five or six months, others only at seven or eight months, and the very slow ones or twins might even need ten or eleven months. Once viability and life force abound, it is the fetus who decides when a pregnancy comes to term (*tun abum*), by initiating childbirth with his or her own force. Therefore, the final point of a "normal" pregnancy does not depend on a fixed time frame, but varies according to a mother's blood strength and thus a child's development pace.

Consequently, what is called "a premature birth" or "being born before the time" is – paradoxically - *not* expressible in terms of fixed months or a particular length of gestation. Rather, it indicates a birth which takes place before the necessary development of physical substance and life force has been completed – whenever that might have been. Premature babies are therefore described to be "not hard yet" (*mon atɔka detaa*) or "not filled yet" (*mon kolonde*). With the pace of this "filling" being variable and contingent on blood force of the parents rather than on a set time interval, newborns can be considered to be premature at either five, six, seven, eight, or even nine months. Indeed, that it is not *time* but the amount of *force* which determines the maturity or prematurity of babies, was made clear to me in a discussion with Charlotte during a body mapping session:

> "If you give birth at five months, and if you have some chance, the child can live. For example, the husband of my aunt was born after five months of pregnancy. He is so old now that people call him 'papa'. When he quarrels with his wife, he says: 'Even if I was born at five months, I am more solid than you are. I can hit you and you will fall'. And it is true: he is very strong!
> *How do you call these children who are born at five months and continue to live?*
> We call them *mon kolonde*. So the child is not born entirely. Like when you fetch water in a bucket that you haven't entirely filled. You can use the same word *kolonde* to say that the bucket is not entirely full of water.
> *From which moment can you call a child 'kolonde'?*
> From five months. But even at six months it can be *mon kolonde*. And they often tell me that even some children of seven months can be *mon kolonde*. And still, many women give birth at six months. I know a girl who always gives birth at six months. And all these children are normal and alive. But at five months, you should be lucky."

Charlotte's first example is insightful: the man's assurance that he is solid and strong is not only a reaction to the perception that children born at five months are "unfilled" and in lack of force, but it also proves that whether a premature baby continues to live or not depends exactly on this amount of physical force present at birth. Of all babies born at a certain gestational age, some might live while others die. That is, some have reached their full maturity while others are "born before their time" with too small an amount of force to ensure survival. The irrelevance of fixed time frames as a basis of prematurity and viability was again stressed by Peggy, who carried a pregnancy of eight months and wondered why her baby waited so long to initiate childbirth. Since she had always given birth around seven or eight months, she assured me that her child must already be "growing old" in her belly now. She reasoned:

> "In the hospital they often say that a child is premature from seven months onwards. But that is not necessarily the case. There was a woman here who always gave birth after seven months. And all her children were born normal and alive. Well, and in the hospital, they say that at eight months, the child is dysmature [*dysmaturé*]. So that means that he can already be born, he has already everything, but certain organs or functions are not totally developed. But I don't understand. How can that be? Certainly not all children are dysmature at eight months, since others can be born normally at seven months already.
> *How would you recognize a baby born at seven months to be normal or premature?*
> A premature baby doesn't cry with force. He doesn't have force. Whereas other children can be born at seven months and cry with force. The child is strong as he should be. And the premature baby also has no reflex to suck your breast. He has no force to drink. You should even press your breast in his mouth. And his jaws are not well developed. It is still very tender."

These Gbigbil conceptions of vital force are at odds with predefined biomedical categories of viability, which take gestational time or birth weight as its exact, independent, and measurable indicators. Medical specialist have increasingly come to phrase the uncertain survival chances of premature children in terms of calculated risk assessments which downplay physical strength and bodily fitness in favor of measurable time and weight (Downe and Dykes 2009, Einarsdóttir 2009). In this paradigm, lack of force is only a mere *consequence* of a premature birth at a certain, fixed, time interval rather than a *contingent constituent* of prematurity – as it is seen by my Gbigbil informants. Indeed, although the latter also portray the "filling with force" as a linear embryological process, it is not exact time but the strength of parents' blood which underlies the gradual creation of a viable, human creature. The next section explores how this specific view on embryology influences Gbigbil notions of pregnancy loss as well.

Losing Pregnancies and Children

Taking into account the particular contingencies of reproductive *successes* as described above, it is not surprising that Gbigbil distinctions between different forms of reproductive *loss* also disregard gestational age in its fixed and exact sense. When talking about reproductive mishaps, Gbigbil women differentiate between the loss of a *pregnancy* (*abum*) where no clear human being is formed and the loss of a *child* (*mon*) presenting human forms. A loss happening at the beginning phase of a pregnancy which contains only the bloody substance of *zɘng mon* is usually depicted as a "wasted pregnancy" (*abum ia diggela*), a "leaving pregnancy" (*abum ia vawa*), or a "falling pregnancy" (*abum ia song*). The specific workings of this "fall" at the initial stages of gestation were metaphorically explained by my informant Sophie through the expression *abum ia bugiye:*

> "We use the word *bugiye* if you break something partially. When you break a pen, for instance, the inner part remains, the outer part falls down. The same happens during pregnancy. The small fetus that develops inside is surrounded by blood. So when it does *bugiye*, this surrounding blood breaks off and falls down. The inside remains, but cannot stay for long by lack of blood and will come out afterwards. So when the blood flows and the fetus is still inside, we can say: *mekil me bugiye abum* ('the blood breaks down from my belly/pregnancy')."

Sophie specifies that this process can only take place when the developing fetus is still surrounded by its constituting blood – that is, in its phase of *zɘng mon.* Once a pregnancy is conceived to contain *mon,* it has become "hard" and cannot "fall" or "break" anymore. Consequently, denotations of loss change; the expulsion of the fetus is now phrased in terms of the delivery of a dead child. Common expressions relate that "the child has passed" (*mon ia nul*), "the child is dead in the belly" (*mon ia wa abum*), "she has given birth to a child who is dead" (*abiali mon ia wa*), or simply "the child has died" (*mon awali*). Most of these expressions are also used to designate perinatal and neonatal losses or even infant and child deaths after birth; indeed, since the filling, hardening, and "enforcement" of *mon* is a continuous process which starts somewhere during pregnancy and extends to well after delivery, all these cases concern the loss of a formed child embodying the potential of life (force) – irrespective of its exact gestational age.

Tellingly, biomedical temporal divisions between early and late stillbirth, perinatal death, and early and late neonatal death all dissolve into the Gbigbil use of the word *fausse couche*. Although this French term is formally translated into "miscarriage" in its biomedical sense and thus meant to be associated with the first few months of gestation, my Gbigbil informants used it as a synonym for *faux accouchement* ("wrong delivery") which could only happen after a *mon* had been created out of a *zɘng mon* in a later stage of a pregnancy. Indeed, once a *mon* exists, its expulsion is automatically termed a delivery – whatever the gestational age. "Wrong deliveries" thus encompass all cases of reproductive loss where contingent circumstances make it impossible for a *mon* to continue to live. These circumstances might first of all be related to a fatal "prematurity" of *mon* being delivered "before his time" and not able to survive it – the flipside of the success-stories alluded to above. This is what Dorine tried to convey in an interview where I explored the meanings of the term *fausse couche* – a notion which I found to be used in many cases where I, with my time-based assumptions, did not expect to encounter it:

> "*When can you call something a* fausse couche*?*
> Here, we talk about a *fausse couche* when you are over time for four or five months for instance. You go to the field and you carry your cassava, plantains, nuts, and bananas on your head. If you fall with this baggage, you might have a *fausse couche*; the child will leave.
> *During which phase of a pregnancy can a* fausse couche *happen?*
> It doesn't have to do with time. If you

> should deliver tomorrow, but you have an accident today where you fall very badly and your child leaves, we call it a *fausse couche*.
>
> *From which month onwards?*
>
> It is not dependent on the month. Even if you have a pregnancy of 9 months or 10 months and you had a bad accident, the child will leave. All this, we call a *fausse couche*."

Despite my insistence to pinpoint a time interval, Dorine's insistence to come back to the example of the accident is insightful; it highlights how all births which happen "accidentally" – that is, before the appropriate moment of birth which only the fetus knows – are considered "wrong deliveries" if they end dramatically. "Wrong deliveries" can occur at all moments in time, exactly because they are not dependent on time in its exact sense. At most, as with prematurity, they represent bad relative timing – with the discrepancy between the actual birth and the envisaged birth being too substantial to allow for survival. This contingency of "wrong deliveries" reappeared in Elianne's answer to my (time-based) question of whether a six month old fetus would be able to live:

> "No, I'm not sure. Some women give birth at eight and a half months, others at ten months, others at nine months. Shortly, it depends on the duration…whether your child takes a long time to develop or not. Sometimes you deliver at eight months and your baby is able-bodied [*bien portant*]. Like when I delivered my second daughter at eight months and three days. I thought she would be a *fausse couche*, since my first boy had lasted for eleven months! So when my daughter came out at eight months and three days, I believed I had a *fausse couche*. But it was a normal delivery. I now know that girls don't take as long as boys do. My son could never have survived a delivery at eight months."

Next to *fausse couches* being related to incomplete internal developments of *mon*, other "wrong deliveries" might result from negative outer forces – such as witchcraft or illnesses – attacking babies, both inside and outside the uterus. Indeed, many women noted that even a child who is born seemingly healthy but dies within a few hours or days due to external causes, might still be called a *fausse couche*. "You didn't deliver normally, did you? The child has passed anyway" would be their rhetorical answer to my initial confusion. Thus, different losses which might be termed perinatal, early and late neonatal deaths in biomedical terms, were all called "wrong deliveries" (*fausses couches*) in French or "passing children" (*mon ia nul*) in Gbigbil; what counts is that the *mon* that developed in a woman's belly finally "passed by" – whatever the specific moment and cause of loss.

Alternative Thoughts on Time

The above described distinction between losing a "pregnancy" and losing a "child" builds upon a framework of gradual, person-dependent development of *z∂ng mon* into a *mon* with human forms and force. In this respect, Gbigbil notions of embryology and its concomitant losses are as linear as biomedical models are. The point is, however, that this development cannot be traced to *fixed* time patterns; it is rather variable and contingent upon the amount and quality of the blood of both parents. Consequently, the boundary between the loss of a "pregnancy" and the loss of a "child" is more fluid, ambiguous, and contested than the strictly time-based definitions of reproductive mishaps in biomedicine. Especially in cases of disruption during the initial stages of pregnancy, this leaves some room for women to strategically appoint what is actually lost – mere "blood" or a "child". Different losses happening at similar gestational ages might thus be defined as "pregnancy loss" in the one case and as "child loss" in the other; alternately and paradoxically, both labels might also be applied to one and the same instance of loss. In a patriarchal context where women's reproduction is at stake but at the same time at risk – through both spontaneous and induced losses – and contested by many stakeholders, this flexibility offers women a possibility to either downplay or attract attention to their reproductive losses within the given circumstances, stakes and contestations surrounding their pregnancies. Thus, more than a fixed temporal framework, this person-dependent and flexible embryology allows for person-dependent and flexible interpretations of loss as well.

This is, however, not to say that women do not at all try to strictly differentiate between losses or are unconcerned with timing and evolvement of pregnancies. To the contrary, at certain moments these issues become crucial in women's reproductive narratives – like when they accurately count their late periods, calculate the precise age of their infant in order to know when to safely get pregnant again, invoke the hours or days a *mon* had spent alive outside the uterus in order to indicate the gravity of its subsequent loss, or describe the distinguishable limbs of an aborted fetus of a particular gestational age to discuss its degree of development. Thus, while at certain points it seems irrelevant to try to strictly distinguish between miscarriage, stillbirth or infant death on a temporal basis, at other moments it becomes critically important for women how long exactly a late period or pregnancy has lasted. In a paradoxical way, biomedical time-based models or Christian notions of immediately existent life after conception might then be invoked, and replace – or complement – Gbigbil notions of blood strength and gradual force development. Depending on what is at stake at different moments, different notions of child development might become relevant. The variety of these ideas allows for a whole array of possible reactions to and interpretations of reproductive loss – which might not be completely captured if the fixed, biomedical framework would be taken as the only valid reference point.

Conclusion

This paper has shown how Gbigbil women in the East of Cameroon interpret embryology in terms of a specific process of "filling with force", which – although conceived as a gradual process – depends not on *time* in itself but rather on the strength of the blood of both parents. This idea influences conceptions of pregnancy duration, viability, and prematurity, as well as denotations of different forms of pregnancy loss. Biomedical time-based distinctions between various reproductive mishaps become blurred in notions of "passing children" or "wrong deliveries". This does not mean that Gbigbil women never apply notions of time in their evaluations of pregnancies, losses, or children; rather, they strategically use alternative modes of explanation and interpretation in different contexts and circumstances.

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“Playing Sex” and Strategies for Avoiding Risks Among Young People in Asembo, Western Kenya

Ellen Blommaert

Introduction

Young people living in the village of Asembo, situated in Western Kenya, explore masculinity and femininity today as much as they did in the past: through “playing sex” with different girl- and boyfriends. In this paper, I will argue that the way young people deal with the consequences of having sex nowadays has not changed significantly as compared with the past, in spite of all the changes that have taken place in the context of modernization and the HIV/AIDS pandemic. While in former times youngsters were taught how to avoid pre-marital pregnancy, they are nowadays, on top of that, urged to abstain from sex before marriage in order to avoid HIV. They, however, act very pragmatically to avert the so-called “health risks”. For them, the “health risks” linked to sex are by no means more severe than other “health risks” such as malaria. Nevertheless, they develop strategies for minimizing their exposure to HIV/AIDS by doing “research” on their lover’s background and past, especially on his or her sexual network, in order to determine their chances of being exposed to the virus. Yet, they are aware that their alternative strategies for protecting themselves from HIV are by no means watertight.

The data on which this article is based stem from an ethnographic study carried out between 2005 and 2007. The target research group consisted of young people between 16 and 25 years old and living in the Asembo area, situated close to Lake Victoria and encompassing a few dozens of small villages scattered over 178 km^2 with a population of 58,707. Over 95% of the population belongs to the ethnic group of the Luo. Asembo is part of Nyanza Province which has the highest rate of HIV prevalence in Kenya: 15% compared to the national average of 7% (DHS 2006). It is an impoverished region that has been characterized since colonial time as a labor reserve for other areas of Kenya. Nowadays, most of the inhabitants of Asembo depend on subsistence farming, small-scale businesses, fishing and on the small remittances that are sent home from household members living in town.

“Playing Sex” and *Chodo* During (Grand-) Parents’ Time

When I tried to reconstruct the past in order to better grasp the sexual socialization process of young people, I collected personal memories with elder family members of my informants and established family genealogies focusing on this topic. I complemented this with the descriptions of observers of that time, like Evans-Pritchard (1949) or Omindhe (1952). However, the accounts of sexual practices in the past among “the Luo people” made by (colonial) ethnographers have to be viewed as products of complex historical processes. Moreover, the stories of the “Luo past” rely heavily on information provided by Luo elders and elites, who were trained in missionary schools and who manipulated “tradition” as a means for increasing their local power. Observations on sexual education were documented as if traditions were unchanging (Ranger 1983: 262ff., Fabian 1983). Memories of past sexual practices by the elder family members were shaped by nostalgia. Therefore, we should be cautious whenever informants talk about “Luo tradition” and regard their way of living as having changed drastically in comparison with younger generations. Informants’ narratives cannot be taken as objective indications of social reality, but this does not mean that no changes have occurred (Cole and Thomas 2009: 4ff., Ringsted 2008). Memories are always framed as a commentary on the present. On many occasions we talk about the past to mark a contrast with the present (Smith 1986). As a consequence, it alerts us to the process of using certain elements from the past in order to interpret the present.

In Asembo, the sexual intermingling of bodies (*riwruok*) was woven into the fabric of everyday life, as well as into specific ritual events, including those related to birth, the building of a *simba* (bachelor's hut), harvesting, death or widow inheritance. The Dholuo verb *riwo* means mixing or coming together by sharing substances, including blood, sperm, food, etc. to prolong life, fertility or relationships. One aspect of *riwo* is sexual intercourse where bodily fluids are exchanged (Prince 2007: 98ff.). However, according to observers from that time, such as Evans-Pritchard (1949) or the elders I worked with, sexual penetration and thus the exchange of bodily fluids between unmarried people, was not allowed. Nevertheless, as Evans-Pritchard documented, there was considerable intermingling between boys and girls before marriage. Young people could meet and experiment "playing love" in the boys' *simba*[1]. The interviewed grandparents mentioned that probably until the 1930s it was the task of the grandmother (*pim* or *dayo*) or the elder wife *ma owuok e ria* ("who had reached menopause"), and of the grandfather *ma otiek e ria* ("who had left the active, sexual life"), to teach unmarried girls and boys how to intermingle with each other. The grandmother explained to the girls the practice of *chodo* (non-penetrative thigh sex), the pre-marital sexual play, in order to prevent pregnancy before marriage[2]. The girls were warned to guard their virginity (*ringruok*: protecting the hymen (*ringre*), because on their day of marriage they were supposed to prove it.

Most of the observers of that time remarked that restricted sexual contact before marriage was mainly imposed on the girls (Evans-Pritchard 1949, Omindhe 1952, Blount 1971). However, Omindhe (1952) noted during colonial time that it was also a source of worry if the girl did not associate with men since the main desire of the parents was to see their daughter married. For parents would receive a bride price when their daughters married. As a result, parents often looked the other way to give both the boys and the girls a certain amount of freedom (Omindhe 1952: 37ff.). Yet, pre-marital relationships that resulted in pregnancy were discouraged. Girls who became pregnant were usually forced to marry an old man. According to Omindhe's experiences, he observed a change in attitude towards pregnant girls during his fieldwork (around mid 1940's): mother and baby were welcomed in the maternal grandmother's home (Omindhe 1952: 41f.). Some grandmothers confirmed this, highlighting that when they were girls (around the 1940s-50s), becoming pregnant had no bad connotation. In general, becoming pregnant was perceived as a "gift from God". An unmarried pregnant girl was described as someone who had "had an accident" (*ochwanyore*). Nevertheless, the social stigma attached to pre-marital pregnancies continued to weigh most heavily on women.

According to Cohen and Odhiambo (1989) and some of the interviewed parents and grandparents, the practice of *chodo* was probably abandoned as early as in the 1930s-40s. Christian missionaries had played an important role in reshaping courtship practices and marriage. They banished initiation practices and denigrated sexual practices, such as *chodo*. They promoted monogamy as a way to become a true Christian (Ranger 1983, Arnfred 2004, Thomas 2009). In the context of this social change, many parents and grandparents felt that they had lost grip on their children and grandchildren. In general, they described their "imagined past" as having been on the whole more positive than the present. For instance, they often blamed the younger generation of beginning their sexual relations earlier (Stewart 2001). Some grandmothers also held them responsible for more "unwanted" pregnancies[3]. By idealizing the past and presenting young people's "immoral behavior" as a contemporary phenomenon, the older generations ignored their own behavior as adolescents. Some of the interviewed indeed revealed that though they were taught about *chodo*, they nevertheless enjoyed their sexual freedom and had penetrative sex, just like the young people of today.

Continuity and Change in a Context of HIV

There is a continuity with the past concerning the importance of intermingling between boys and girls in Asembo. Sexual penetration before marriage is still to some extent considered immoral, even though it is also considered inevitable. Hence while pre-marital sex commonly happens, acknowledging it is a taboo. I would argue that this primarily results from pressures created by the moral discourses of Christian churches and HIV/AIDS prevention campaigns, both of which stress sexual abstinence. Where the Christian moralistic discourse describes sex outside marriage in terms of sin and pollution, the educational discourses on

AIDS highlight that with sexual intercourse comes HIV risk. The AIDS control strategies encouraged people to abstain or be faithful to one monogamous partner and endorsed a "responsible use of condoms" (the "ABC" campaign[4]. This included promoting condoms only for "high risk groups", such as sex workers. Condoms were not advocated for young people as they were supposed to abstain (U.S. Department of State 2009). Although abstinence and chastity appears to be the norm, it does not make sense for most of the young people in Asembo. Gaining sexual experience is part of exploring their own masculinity or femininity. Nevertheless, while they enjoy the pleasure and the advantages that they gain through these relationships, young people understand that having sex is not without "health risks". Whereas pre-marital pregnancies were perceived as an "accident" in former times, nowadays, due to the economic hardship, they are regarded as an occurrence which limits a family's progress. Yet, their preoccupation is no longer only control of sex for procreation, but also their struggle to steer clear of HIV.

Historically, women in Asembo were held responsible for restraint and moral behavior in the context of sexuality. In current contexts, they are once again called to take up this task, while men are let off the hook due to their apparent inability to resist the desire for sex and pleasure. Yet, it is interesting to note that while boys often flatly refuse to take responsibility for a pre-marital pregnancy, nowadays both partners have to bear the additional consequences of HIV. They can literally run away from their girlfriend's pregnancy, but they can no longer escape HIV. However, they do not necessarily rely on biomedical measures, such as a consistent use of condoms, and VCT (MacPhail and Campbell 2001, Setel 1999). Instead, they prefer conducting their own "research" on their sexual partners to determine their chances of being exposed to the virus.

Doing "Research" on Sexual Partners

Young people look at the physical appearance of their sexual partner in the hope to minimize AIDS risk exposure. They try to determine whether the other person shows symptoms of HIV infection (change in hair texture, rashes on the skin and the color of the skin or lips). In addition, they trust their ability to figure out their partner's background and past relationships (Poulin 2007, Dilger 2003, Moyer 2003). My informants mentioned that they should not take "porridge with lumps" because it does not taste nice. The porridge stands for the beautiful girl/boy whom they meet for the first time. The girl/boy might have bad sides which they do not know about, including for instance that (s)he might have a (sexually transmittable) disease. The porridge without lumps is the porridge that they can drink without having to worry, meaning that you can have unprotected sex.

Although ideally they would choose their sexual partner carefully before they have sex for the first time, in reality their desire to have sex is much stronger than any preconceived convictions. They usually do not take the time to uncover the upbringing of the person and mostly discover the background once they are already engaged. They might find out that their lover had other sexual partners, is a widow or widower[5], or had already a child from a previous relationship[6]. Or even worse, he or she had been going out with a person suspected of being HIV positive.

Most of my male informants liked to inquire about the girl's past and background through people who knew her. Geoffrey, a twenty year old carpenter and only sporadically seen with a girlfriend, explained how he tried to figure out a girl's past over time:

> "Now if you want to know a girl's past, you just need to connect with a villager [...]. He will tell you the background of that girl. Or even some girl from there who also knows her walk [behavior]. [...] So those people are the ones you will just be asking slowly, slowly, and you do not ask it when you are very serious. Because when you are serious, someone may get alarmed [that you are interested in the girl] so you just ask people slowly, slowly. You are not even in a hurry. So that is the way that you can know how a person is: maybe the girl is a witch or the girl's behavior is like this, or the girl has given birth. Maybe the girl [who you admire] lied to you that she does not have a child, but her child is big, is herding at home so she might only tell you this after you get

> married. So it is just that the person, who is close with her, is the one who can tell you her cleanness [the truth about her]".

The boys try to get the opinion of different persons since they believe that one person might not tell them the truth. Boys assume that if a man talks negatively about a certain girl, his motivation for this might be that he is himself interested in the girl. Similarly, when a girl talks negatively about her female friend to a boy, the boy will assume that she does so, because she is interested in him and wants to discourage competition from another girl. Hence, it becomes really difficult for young people to find out the background of their sexual partner. Other interests -imagined or real- potentially bias the truth. Even if the information is correct, especially when it is negative, the boys or girls might not believe it. This can lead to ignoring warnings about the HIV status of their lover since they suspect other motives behind this. Moreover, girls usually do not inquire as much about their boyfriend's past and background as compared to the boys. When girls are confronted with bad rumors about their boyfriends, the girls would ask the boys directly if they are true. Yet, the men are usually very clever in "sweet talking" (using nice words) their lovers to prove their innocence (see also Van Reeuwijk 2010). Additionally, if the man is financially capable enough, the woman is more easily convinced of his virtue[7].

In general, my informants disliked having a relationship with someone who had a reputation of having many lovers simultaneously. A person (female or male) who has many lovers at the same time would usually be referred to by the insulting term *ochot* (prostitute). Also a girl, who already *ong'eyo mang'eny* (knows a lot), meaning that she is already well experienced in sex, would be called as such because girls are supposed to be innocent and passive in sexual encounters. The term *ochot*, which is derived from *chodo* (playing between the thighs), nowadays indicates an immoral, sinful practice associated with "prostitution" (see also Geissler and Prince 2007: 131f.). The persons who are labeled *ochot* are assumed to "carry death", because young people imagine that on various occasions, they have already run the risk to get HIV infected. Yet, the boys clearly differentiate between girls who have many boyfriends simultaneously or real prostitutes who earn their living by selling sex, although they are both called *ochot*. The latter usually hang around at disco places and in the bars close to the lake in Asembo. Sometimes the disc jockeys also "hired" real prostitutes to stand in front and dance. The boys took for granted that real prostitutes are definitely HIV positive. Only the "newcomers" in the village or some occasional fishermen, who come to stay temporarily in Asembo, do not know about their "bad reputation" and may have a one-night stand with them. Others, like desperate older men and drunken boys, may also hire their services.

When a sexual partner is suspected to be HIV positive, age mates and other community members would start to gossip about him/her. The community members would say that it is risking your life to engage with such a person. The question posed by a classmate of Omondi's girlfriend: "Do you really value your life? You are handsome but you have lost direction in life", made Omondi, a 16-year-old boy by that time, realize that he had to inquire about his girlfriend's behavior. He wanted to find out the truth behind these rumors:

> "I started to gather information from my friend who lives near Eve's school. She explained that Eve was having a relationship with a conductor of a matatu [local bus] who was HIV positive. All Eve's classmates were aware of this relationship: the conductor could come and collect Eve every time the school closed. Eve's classmates knew that this conductor was HIV positive but Eve was being lured by money. My friend who told me the real story, advised me to quit the relation with Eve for my own good. I knew the conductor and I was aware of his health status though I did not know that he was having an affair with Eve. I decided to trick Eve to prove this allegation. Eve confirmed that she was having an affair with the conductor and even told me that she got pregnant from him. The baby died in the process of delivery and later, also the conductor died. Eve attended the burial. Eve was embarrassed by confirming this to me. I had a good reason to quit our relationship and Eve could never come after me again".

Through rumors about who has had sex with whom, which are very common among youngsters, young people receive a wealth of information about each other's sex life. For Omondi, it was certainly embarrassing that almost everyone, except himself, was aware of the fact that his girlfriend was dating another boy, who was HIV positive. It revealed his inability to do proper "research" about his lover and affected his pride. Although Omondi at first believed that Eve was "seriously in love" with him, he later began to think that some people, who are HIV positive, intentionally want to infect others. Also other informants raised this idea, arguing that "(…) they want many people to die after them. They don't want to die alone":

> "Sometimes Eve could visit me abruptly at night and would insist to spend the night together. Sometimes she even demanded for unprotected sex to prove my confidence in her. Why was she demanding unprotected sex? I believe that Eve did this with the aim to infect me: she wanted me dead and that's why she never revealed her health status to me."

However, ending his relationship with Eve was not enough to stop the gossip about his health status. He had to convince his peers and other community members that he still remained HIV negative, even after dating an HIV positive girl for some time.

> "People from [Asembo] knew that we had been dating each other and some people started to murmur about my health status once they also realized that Eve was HIV positive. Even my brother questioned my health status and it forced me to visit a VCT centre and invite my brother to witness the result. I had been visiting VCT centers on a regular basis and always obtained negative results so I was not surprised when I received that time a similar result. However, my brother was not convinced that I was HIV negative until he could witness my negative result for the second time".

Usually on the basis of young people's own "research", they decide whether the use of a condom[8] or knowing each other's health status[9] is necessary. Thus, biomedical measures come only second best after their own strategy.

However, young people realize that their alternative strategies for protecting themselves from HIV are by no means watertight. They know that in certain cases, they might run the risk of getting HIV infected. They are aware that they are not able to imagine the entire coverage or the pattern of the sexual (sub-) network they belong to. Their girl/boyfriends might as well have been "unknowing participants" (Thornton 2008) of other sexual sub-networks. This is because my informants' sexual relationships extend far beyond Asembo since they are very mobile. Young people, however, are realistic and know that they cannot prevent everything. When confronted with this reality they often respond by putting HIV in perspective, saying there are many diseases that can kill them these days, not only AIDS.

Dhiang' Tho gi Lum e Dhoge

When I asked my informants if they were not afraid of contracting HIV, they usually stated that though they were, they would "rather die with sweet grass in [their] mouths", making reference to the Dholuo proverb, *Dhiang' tho gi lum e dhoge* (A cow dies with grass in the mouth). This means that while a cow is eating, it does not choose which grass to pick or leave; it eats everything but still survives, knowing that the grass is good for it, it does not kill. Thus, the same counts for the young people: the grass stands for their lovers with whom they have sex, which they view as an important aspect of life. If this means that it may kill them, then they prefer to die from that "sweet" thing of having sex.

Petrus, a 16-year-old man who had just finished Class 8, said: "AIDS is just like any disease and cannot deter me from having sex." Similarly, Augus, a 22 year old man who was earning his living as a *matatu* conductor after finishing Form 4 in 2003, expressed: "AIDS is just a sickness like any other, and anyway, everyone will die. It is not necessarily AIDS that will kill you, you can die of anything."

It was not that young people were "ignorant" or fatalistic about AIDS, as I often heard from missionaries, outsiders or elders. They were informed about the negative consequences of engaging in unprotected sex, but primarily experienced the sexual act as very pleasant and enjoyable. Furthermore, they sometimes thought only after the sex about the possible consequences of their action and realized the life threatening risks. However, HIV is a long-term disease. Some of the young people have not turned ill so far, or at least, do not associate the illness with the opportunistic infections of HIV since they did not go for an HIV test. A social scientist of a youth intervention program explained in an in-depth interview: “These are young people who are not even getting sick [ill] and they even conceive, give birth to these young children and even continue walking. Maybe the CD4 count is still very low, they are still strong”. Moreover, adolescents, who are perceived to be strong and full of new energy, do not want to be reminded all the time about that threatening disease that follows them on their path to adulthood.

Conclusion

In this article, I explained how “playing sex” in contemporary Asembo takes place and how young people deal with its associated consequences. I highlighted that the intermingling of boys and girls continues to be highly valued today although sexual penetration before marriage is still considered immoral, even though it is considered inevitable. I pointed out that we need to be careful when parents and grandparents contrast the present with a “better” past where there was less pre-marital sex, as they claim. Young people then and now have always experimented with sex since this is part of becoming an adult. Moreover, women have always been the ones responsible for restraint and moral behavior in the context of sexuality. Consequently, boys could at all times literally run away from their girlfriend’s pregnancy. Yet, the contemporary preoccupation is not only control of sex for procreation, but also the struggle to steer clear of HIV, from which neither partner can escape. Thus, although sex is inevitable, it is commonly understood as having potentially “negative” consequences. Young people are aware of the risk of HIV/AIDS infection, and I have highlighted that as a response they devised their own strategy, doing “research”, in the hope to minimize their chances of being exposed to the HIV virus. This means rather than individual and private strategies based on biomedical measures, such as HIV testing or condom use, the young people use a social strategy that examines the place of the individual in a community and that highly relies on social gossip.

The young people, however, know that their strategy is not watertight; yet, as the proverbial cows, they prefer to die with the grass in their mouths – i.e. from having sex. Sex is for them as vital as grass for the cow and while the cow might also watch out for poisonous weed in between the grass, it will only find out once it has eaten it. However, an issue which merits more detailed discussion and which this article could only touch upon by using the proverb, is the relationship between sex and the poverty in which the young people in Asembo live. Young people perceive that in order to live, they need to take risks on various fronts, including in sexual relations. They need to extend their social network in order to “maximize their social capital” (Thornton 2009). The question remaining is then why should young people not take risks if that holds the promise of a better life in the future.

Notes

[1] The boys moved out of the *siwindhe* (the grandmother’s hut) at the age of eleven when they were considered to be mature enough. Due to fear that the boys could impregnate their sisters in the *siwindhe*, the boys were moved to sleep in their own *simba* in their father’s compound.

[2] A similar practice of *chodo* was observed in Kwa-Zulu Natal, described as *ukusoma* (Hunter 2002). Also in Owamboland, unmarried people could enjoy an unrestrained sexual freedom until the *efundula*-ceremony marked the transformation from free playful sexuality to a different stage where women (and men) must take responsibility for procreation (Becker 2004).

[3] We also have to take into account that in the past, girls used to marry at an earlier age (12-13 years old compared to nowadays around 18-20 years old) and thus, there were fewer pregnancies which happened outside marriage.

[4] The international “ABC campaign” was launched in 2003 and mostly sponsored by the US President’s Emergency Plan for AIDS relief (PEPFAR).

[5] Young people know that engaging with a widow or widower might also increase their chances of getting HIV. The partner might have died from opportunistic infections caused by HIV, which means that he/she might be infected as well.

[6] However, young people claimed that a child from a previous relationship also demonstrated the good health of the woman, meaning that the young woman was free of HIV and was able to conceive.

[7] Within the framework of this paper, it is not possible to elaborate on this issue in more detail (Ellen Blommaert, PhD dissertation, forthcoming).

[8] The issue of condom use and young people's perceptions regarding this has not been possible to discuss within the framework of this article. I discuss the issue of condom use at length in my PhD dissertation (forthcoming).

[9] Contrary to public health arguments for routine testing, my research illustrated that knowledge of HIV status does not necessarily bring a change of behavior (PhD dissertation forthcoming).

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The Dangers of Losing Strength: Physical Ageing and Family Care in the Era of AIDS, Northwest Tanzania

Josien de Klerk

Abstract

As a result of HIV/AIDS older men and women in northwest Tanzania bear a growing responsibility within families: caring at length for dying patients or patients on ARV medicine, as well as raising orphaned children. These care giving tasks increase at a time when physical strength is declining and family care for older men and women is disintegrating as a result of migration, declining economic capacity and HIV/AIDS – all processes which lead to the growing nuclearization of the family. In this paper I show that while the family remains the main care giving unit, relations within the family have become severely strained and that there should be more attention for the physical ageing process of older caregivers.

Introduction

> "If I did not believe in God, I would have thought I was bewitched… So many problems. First my daughter dying, the illness of my father. And now my cows all died…. [silence]. Let's forget about those who died."

Talking is Ta Stephen[1], a slender grey man of 66 from Tanzania's Kagera Region. As an old man in a patriarchal society he has many responsibilities. Both of his parents are still alive, though very aged, and need fulltime care. Ta Stephen has provided his adult sons with land – the means to build their lives – and is schooling the youngest of his 16 children. He also owns a coffee plantation where he grows several varieties of coffee and plantains which his wife uses to produce beer and *konyagi*, a local gin. Moreover he is a clan elder, advising clan families who care for patients, financing care for relatives suffering from AIDS, and deciding on what to do with orphans and inheritance. In the time we have known each other he has been faced with multiple adversities, both related and unrelated to AIDS. His divorced daughter came home ill from town, suffering from HIV. Together with his wife, who provided physical care, he cared for her, providing money for medication and hospital admittance, arranging transport, sending family members on errands and advising his family on how to care. He is left with her 9-year-old son to raise. The death of his daughter in the summer of 2003 followed the death of his son and his 3-year-old grandson, both from AIDS. Ta Stephen took the full responsibility for his small grandson as other family members did not want to waste energy and resources traveling to three different hospitals on a child who was dying. These deaths are just the ones within his nuclear family. His elderly father of 93 is also severely ill and his mother of 86 is old. Both need fulltime care which is provided by Ta Stephen, his brother and an adult granddaughter. To make matters worse Ta Stephen's livestock became infected with a virus and all died, a serious financial blow. When Ta Stephen says, "Let's forget about those who died" he refers to a common notion in rural Kagera; one has to push the problems aside in order to survive in the face of constant and multiple adversities.

This is one of many personal stories I collected during fieldwork on the changing roles of older men and women (> 60 years) within their families as a result of the AIDS epidemic in Tanzania. It is a story of a man because, although care is gendered, both old men and old women play distinctive but important roles in caring. In the era of AIDS, older people bear more responsibilities within family care arrangements and, at the same time can count on less support from the family. At the same time, physical strength is also rapidly declining as a result of these demands on older bodies and the natural ageing process. I argue this aspect of the impact of AIDS on older people – attention for the ageing body – has been neglected in research and writing on older people's changing roles in family care arrangements.

This study took place in Kagera Region, northwest Tanzania, over 12 months in 2003-2004 and during periodic follow-up visits since. The sub-village comprised of 105 households (in 2002) and 51 people aged older than 60 – 19 men and 32 women. 13 of the 51 were above 80 years old. In the initial sample I did not focus on AIDS affectedness to be able to situate AIDS in the everyday lives of older people. The core method of the study comprised the regular visiting of seven older men and women over the course of one year. Four of these were selected from the 51 original interviews, 3 older people were added. In addition 20 interviews were carried out in three villages – the research village and two comparative sites with older men and women who had been severely affected by AIDS to compare and contrast with the original sample. In total 71 older people were interviewed.

Kagera Region is home of the Haya people, who live on the plateaus. Plantains and coffee are the main crops – plantains for food and coffee for income, especially for older people. HIV/AIDS has been present in the area since the early 1980s; the older men and women over 60 years today were in their early 40s when the epidemic started. They have literally aged with the epidemic.

Older People and Family Care in the Era of AIDS

Rather than focusing specifically on older people as primary caregivers for AIDS patients this study looked at older people's roles in families and family care. Family care responsibilities of older men and women in the era of AIDS are not just related to AIDS. Men in their sixties, as long as they are healthy and strong, often have many family obligations – towards spouses, teenage and adult children, and grandchildren, but also towards their parents and siblings. Older women have responsibilities towards their children, grandchildren, in-laws, and also to remaining parents in their natal homes. As old people might live into their nineties it is not uncommon to find households where 70-year-old children are caring for 90-year-old parents.

Older people's possibilities for providing and receiving care are strongly related to gender. Most older men are married, often to younger wives. This also means that women are often widowed in old age. Of the 32 women above 60, two were married, 20 widowed and 10 divorced. Socio-economic status amongst older people was diverse. Some were relatively wealthy and owned land and had educated children, others, particularly childless women, were living on the brink of destitution. The increasing necessity of money in the monetized economy, the limited economic capabilities of adult children, and migration to the cities have influenced possibilities for family care in general (Kaijage 1997, Ankrah 1993, Weiss 1996, 1997).

Within this context, older people face growing responsibilities as a result of AIDS, including financial, physical and emotional support for patients who come home to die and raising those who remain – orphaned children, but also elderly parents, both of which often demand intimate care. Older people mainly provide care to their dying adult children, but sometimes also to their partners, siblings, and grandchildren (Chepngeno et al. 2008).

Table 1: Care for relatives with AIDS (as assumed by old person) amongst 21 older people older than 60*

	Women (13)	**Men (8)**
Partner	2	1
Children	14	7
Sibling	3	5
Siblings children	4*	4
(Adult) grandchild	1	1
In-laws	1	1

* In this table only those older people who took active care as a primary caregiver are mentioned. 21 of the older people in my sample of 50 were active caregivers. Most patients were not tested for HIV/AIDS, but their symptoms resembled HIV/AIDS and their caregivers assumed they suffered from HIVAIDS.

** One childless woman lost three children of her sibling, but was counted as she considered them to be her children.

Older men take care of siblings more often than older women. In Haya society men remain in their natal homes where they inherit land and women move to their marital homes. When a woman divorces, she usually moves back to her natal home. Historically, one option for divorced women has been commercial sex work and, in the mid-1980s, many women who contracted AIDS moved to their natal homes and those of brothers, or parents, to die. Care for AIDS patients is shared within the family of the primary caregiver. While a grandmother might cook and spoon-feed a patient, an adult son might bring some Panadol (a painkiller) and assist his mother in work on the land. AIDS in this way mobilizes the broader family.

Care giving in the era of AIDS has material, social and psychological consequences for older people (Knodel and Saengtienchai 2005, Knodel et al. 2006, Bohman et al. 2007). The stress and burnout that comes with care giving and the material consequences (costs of treatment, sale of assets, food insecurity resulting from decreased time for farming) can cause disruptions in family care arrangements (Ankrah 1993). In the next three sections I discuss how older people's strength plays a key role in different family care situations: nursing patients, raising grandchildren and ensuring old age care.

Strength to Nurse Patients

The social organization of family care for patients is structured by gender, both in terms of work division and in terms of what is "good" care. Older women are expected to provide physical care for patients whereas men are expected to provide financial and practical support. When a widow is caring for a dying relative, she sells assets, works where possible as a casual laborer, or receives assistance from male relatives such as sons or brothers. For older women, providing good care involves intimacy and closeness – showing love to a patient. To show love is hard work, in particular in the terminal phase (Du Preez and Niehof 2008).

Care for patients implies physical labor. To cook the food a patient needs, older women need to collect firewood, buy eggs or milk, and sometimes work on the land to buy necessities, and then spoon-feed the patient. To nurse a patient requires lifting the patients, washing the sores, hand-washing bed sheets and assisting patients to the toilets outside. And then there is the emotional strain of living with a terminally ill patient who may die at any time that often requires sitting vigil through the night. As a woman of 65 said about the care for her daughter:

> "It is hard. You know, where you are sitting now (on the sofa, with a cup of tea in front of me), if the patient is terminal she cannot even reach for that cup of tea. You have to place it in her hands. And then the patient wants an egg so you go to the neighbors and buy an egg and send a child to collect firewood and light the stove and cook the egg, and then she says, no, I am sorry I am not hungry, maybe some milk, so you go to the neighbors to buy milk. It is very tiring [...] and sometimes you get angry but you excuse the patient as she is ill."

The position of older men as caregivers in families is often forgotten as the visible daily care tasks fall to older women. Yet in patriarchal societies, older men occupy central roles in large extended families, making decisions about care, fostering of orphans and inheritance conflicts and bearing the financial responsibilities. As Ta Stephen said:

> "When I saw that she [daughter] was ill, I prevented her from returning to the city ... I sat down the family and explained exactly what the problem was and what we would have to do."

Older men and women need to engage in activities which generate income to manage the demands of care giving. Casual labor groups, where women conduct work on the land together, prefer young strong women, so older women often work as individuals with, for example, wealthier older neighbors. In this sense ageing bodies have trouble managing the demands of care and consequences of death within a context in which money increasingly plays a central role and where remaining adult children are struggling to survive with their own nuclear families. Old people sometimes sell assets such as land, or take out loans with high interest rates, compromising future food security. Care giving thus involves physically demanding tasks – in direct care giving and in income generating activities – as well as psychologically straining experiences, as there are often close ties to caregivers and patients, a closeness that extends to those who are left behind. Literature about older people's health during care giving showed that the BMI of older people decreases during care (Ainsworth and Dayton 2001, Dayton and Ainsworth 2002).

Care giving also causes anxiety for future health and wellbeing (Ssengonzi 2007). Older people attribute many severe physical problems, such as strokes and heart problems and high blood pressure to the worries and the sleepless nights that result from increased care demands and grief. Months after a death of a patient, older people would still report having trouble sleeping at night.

Older people therefore actively push thoughts away. The word for "putting up with", *kwegumisirisa*, in Kihaya stems from the word *kuguma*, which means to be hard, but also to be healthy. Active caring for AIDS patients undermines older people's bodies in several ways: providing care is a strain on the body, nutrition declines as time and money is diverted to care, and grief and anxiety have physical consequences.

Strength Needed for Raising Orphans

A second area of care in which older people need strength is orphan care. Taking in orphans is a long term commitment. Often orphans are fostered when they are small infants and raised into adolescence and adulthood. Each of these stages requires physical strength. An infant wakes up several times a night and needs milk and porridge, which are expensive foods. An infant also needs to be carried on the back. Moreover older women cannot leave toddlers at home alone, which confines them to the house and deprives them of socializing with friends, visiting children or friends in other villages or simply going to the market or to work as a casual laborer.

When children reach adolescence a core problem is the lack of authority grandmothers have over their grandchildren. "Grandchildren turn to pee in your mouth," is what one bitter grandmother mentioned, indicating the lack of control she feels. Often a sibling of the deceased father or an uncle is asked to discipline the children. At the same time, care between grandparents and grandchildren is mutual; as both older grandchildren take up responsibilities of caring for grandparents.

Care for orphans is neither a one time commitment. In instances when a grandmother loses several children, she may foster new children at a time when other grandchildren are finally growing up. One grandmother, who at an age of 72 had been caring and raising orphans for 14 years, was confronted with three more grandchildren, the youngest of whom was six years old. "I will raise children until I die," she said. When I came back a few years later, she had temporarily left the children and gone to the city for 8 months to regain strength at her adult granddaughter's house. In this sense families tend to assist the grandmother with active care. Grandfathers have a less active role in the physical tasks of raising grandchildren but are often financially responsible for putting grandchildren through school and have a key role in securing inheritance.

Responsibilities of grandparents also relate to securing the future of their grandchildren. In this area children belong to the clan of their father and girls move to their husband's home when they marry. When a widow has children she can remain on the land of her husband, to safeguard it for her children. Orphans are therefore preferably fostered by the brothers or parents of their father, in order to grant them access to their father's land (Nyambedha et al. 2003). In Kagera there are many court cases as a result of land grabbing and stealing land that orphans are entitled to. NGOs in the district stimulate the writing of wills in order to prevent this problem and assist in court cases.

Physical ageing is a source of concern for grandparents who intend to provide security for their grandchildren and many grandparents worry over what would happen with grandchildren should they die themselves (Madoerin 2008[2] personal communication). Older people's strength ensures the possibility to take on elements of a "parental" role, to generate money and exercise authority over orphaned grandchildren and, in that way, create security for grandchildren.

Loss of Strength and Care for Older People

> "The worst thing of growing old is losing your strength. You say I look youthful but I am not. Look at that man tending my garden [coffee plantation]. My son had to hire him to do the work. If he had not had been able to pay for the man, who would have cut my banana trees? And do you remember that old neighbor? She said if she would lose her

> strength, she would just sit there and die ....It is bad." (65-year-old woman who lost husband and daughter to AIDS)

As old men and women are confronted with long term care for patients dying from AIDS, with the responsibility of raising grandchildren, and with diminished care from the extended family, strength and physical capacity become a primary asset. The Kihaya words for older people link strength to respect: A *mkaile* and *mzee* are respectively independent old women and men. *Mkaikuru* and *mgurusi* are terms for dependent older people. Only recently did attention for this essential experience of ageing, the physical body, and how family care arrangements for older people change as a consequence of AIDS become included in discussions on the impact of AIDS on older people (Ssengonzi 2007: 341, Seeley et al. 2008: 4).

In discussions on how older men and women experience their old age within this context of increased care demands, it is important to differentiate between age groups of older people as the physical capacity of a 50 or 60-year old woman is often vastly different than the physical capacity of a woman of 75 years (Seeley et al. 2009: 115). AIDS does not only play a role in experiences of old age through nursing patients or raising orphans, but also presents challenges in care for older people in advanced old age (Williams 2003, Seeley et al. 2008).

The insecurity of old age care has made the *ability* of the ageing body an even more central part of wellbeing (Bohman 2007 et al.). Older people try to live independently for as long as possible – older women usually with grandchildren as company who also assist with daily chores. When strength would fail, either older women moved in with a son and his family, or an adult grandchild would move in and adult children would check up on the older person on a daily basis. Women without children often lived with siblings or with a trusted relative or close friend.

The process of physical ageing lays bare the state of remaining relations of older men and women. Everyday care for older people, such as assisting with household chores, food assistance, income for basic needs, including remittances, but also less visible care practices such as greeting and checking on an older person, was organized within the extended family and carried out by the immediate household and children living nearby (Shaibu 2000; Shaibu and Wallhagen 2002). Good care is to make sure the older person always has some money, can eat well and has a proper place to live.

Within families there are often specific persons who assist older people when strength starts to fail; a wife, a daughter-in-law or a close relative performs the bodily care: washing intimate clothes, applying body lotion to dry, wrinkled skin, and removing bugs from the older person's feet. A good appearance, a well fed, shining body, is the key to dignity; it shows that a family cares properly. These close relations have often been built up over periods of time; a grandchild that the older person has raised from infancy, a son who went to study and do business, a warm relation with a daughter-in-law or one's younger sister. In the era of AIDS, old people are often confronted with the loss of these loved ones.

This insecurity of care in the era of AIDS has lead to a strong paradigm that one has to prepare for old age by maintaining assets that are of value to younger people. Land can be promised as inheritance to those living in poverty. As one woman of 65 said about her neglected neighbor of 86:

> "She sold all her land, she should have remained with land. No-one is going to care for you if they themselves have to do casual labour to get money. It is not easy to get care."

Care in old age was not just about having material assets, also dignified behaviour was important and many older people, both men and women acted as well respected advisors to their families and communities far into old age. Old people who did not prepare well suffer.

Conclusion: Giving Care – Losing Care

The position of old men and women in the era of AIDS has shifted to a situation of increased responsibility and a loss of security. The caretaking process for both patients and orphaned children often seems to be a lengthy vicious cycle, raising orphans to adulthood, fostering

young orphans again. A central element in care giving is strength. Strength is needed to perform the physical tasks of care giving but also the physical tasks of raising grandchildren; lifting small children, exercising authority over adolescent grandchildren. Strength is also needed to work in order to generate income. The care roles of older people in families are sometimes a strain on family relations as demand is high and capacity of young adults to assist is limited. For older people, care giving for both patients and grandchildren is physically and emotionally straining and the health of older people is declining as a result of a natural ageing process. This combination as well as the limited capacity of remaining adult children to provide care for old men and women makes their future insecure, the future of old women more so than that of men, because of their position in the patriarchal family. Older people therefore tried to prepare their lives by acquiring assets and by building relations over their lifetimes. Strength in this situation is a key asset, it allows older people to be independent for as long as possible. A focus on the physical ageing process of older people in the era of AIDS and how loss of strength interplays with already overburdened families, brings to the fore another aspect of the care burden: how older caregivers are limited by their own physical capacity both in providing care and in securing care.

Notes

[1] All the names in this article are pseudonyms.
[2] Founder of an NGO providing monthly cash transfers and psychosocial support to older people in the village.

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Reports

ImPulsTanz-Festival 2009 – Introduction of the New Side Major "Dance Medicine" Causes Discussions

The yearly international dance-festival ImPulsTanz, Vienna, offers a wide range of various classes for beginners, lays and professionals in very different types of dance-styles. It is known as one of the best educational institutions for dancers and provides grants for the needy young dance-generation. The side-major of body-work with all the offers of workshops dedicated to methods of improving the feelings of well-being in one's own body, such as Yoga, Tai-Chi, Pilates, Myoreflex-Training or Feldenkrais, has already become a tradition. For the first time, there has been a workshop on dance-medicine for body-workers specializing on dancers.

Seven teachers offered their medical and therapeutical knowledge in a mixture of theoretical and practical explanations. Professional dancers and choreographers who are often dealing with injuries and phenomena of usage in their own body are profiting most of it. Strains and sprains are common in the trainings. Major focus of the Dance-Med-Team at ImPulsTanz is working with the spine (Michael Matzner), orthopedics (Gobert Skrbensky), pain-therapy (Reinald Brezovsky), physiotherapy (Daniela Schnell and Marie Sophie Kiepe) and a special module "Pilates – System Europe" (Anna Schrefl and Rudolph Wächter). This module aims at the improvement of medical information and care in the dance-area. Motivated by the conviction that working and educating together with the dancers should not be disturbed by injuries and illness – a seemingly senseful approach in a field where hundreds of students and lays come together each year to work, learn and train together. This year, the new focus dance-medicine as well as the variety of courses in additional methods (see above) initiated the first discussions concerning the meaning of dance and so-called alternative measures.

In addition, there were coaching-projects of various themes, music and voice-classes held by musicians specialized in dance, combined with breathing-techniques which are of great importance for all fields in dancing and styles. The coaching-project "Voice and Rhythm – Mediating Intimacy" of the Canadian musician Charmaine Leblanc, together with Marlene Millar – a documentary-producer specialized in dance –, for example, offered exercises for participants that we traditionally know from logopedics: voice- and sound-exercises, single or within the group, partially combined with some movement, not only help to reduce inhibitions and learn about each other, but also to discover the whole range of one's own voice, lubricate the vocal-cords and train the breathing – all this being very important things for people working a lot with the voice and/or being on stage.

A well-known difficulty is movement and dance for the handicapped and the elder. The Vienna festival meanwhile offers possibilities for both groups, according to the limited preconditions in an accordingly limited frame. Special workshops for these groups of people with specially trained dance-pedagogues are dedicated to the work with the handicapped and elder. A further side major is the offer of special children's classes, scaled according to the differing age groups, thus completing the program.

Small physical breakdowns due to exhaustion and circulation-problems during the intensive- and advanced classes are normal, especially in hot summers. Dancing is full physical training, requiring the whole body. This not only shows in the muscles of the dancers, but also in the soken wet T-shirts after the classes, even among the professionals. More than any other sportive discipline, dancing moves every single part of the muscles, from top to toe.

ImPulsTanz offers the participants the possibility of warm and cold showers during and after the workshops in the halls of the ART-for-ART-workshops, as well as the possibility to obtain healthy and unhealthy food and drinks at the bar in the provisional cafeteria. There are tables and chairs as well as inviting deck chairs to regain strength and relax, being well used by students and teachers.

Dancing is not only "l´art pour l´art", even it may appear like this. Presently, dancing is an underestimated medium of communication, especially in the field of artistic dance: Nothing on stage works, if the communication between the dancers does not work. This often happens without words, only through the body and its movements – thus meaning, that dancing trains the capability of physical and emotional awareness among the participants in a high grade which is an absolute necessity for professionals. Besides, dance training educates the capability of coordination and discipline of each person and the consciousness for one's own body. At the same time, the feeling for balance and stability is strengthened – a problem as well as a basis in dance (and everyday walking and moving). New York dancer Risa Steinberg expressed it as follows: "Do not make gestures that are more important than your standing legs!" "Danced and Limón is a technique, and a technique is like an alphabet you can and have to learn to communicate. It's an ABC. Once you know it, you can start putting things together to create words – or movements!"

Besides this, dancing is the basic form of expression of the human body by moving which is fundamentally bound to the function of the self, the breath and, therefore, health and life: It is it's own instrument and tool.

The political dimension of dance and movement is mostly only realized when it is prohibited to some or all human groups in a defined society, as for example in fundamentalist-religious regimes, who consider movement, sports and dance as being a thorn in their eyes. Usually, the participation of Muslim dancers is internationally rather low, similar as in sports.[1]

Two of the founders of ImPulsTanz, Vienna, are the Brazilian dancer and choreographer Ismael Ivo, presently also the artistic counselor, and the dancer and choreographer Joe Alegado from Corpus Christi, Texas. The artistic and organizational management lies in the hands of Rio Rutzinger, Vienna. In the year 2009, the festival celebrated its 26th anniversary – and new challenges, because a good part of the city's financial support was cancelled, due to general saving-measures always hitting the cultural sector first, and here, extensively the dance-sector.

The recognition of the art form dance in its social, political and medical-therapeutical dimension still lacks the one of other art forms. Whereas especially this art form is using a tool which is the most original of the human being: the body and its universally existing natural capability of moving and expressing.

Notes and impressions from the public talk with dancers and audience during the ImPulsTanz-Festival on July 26th, 2009.

Moderation: Sri Louise, Yoga-teacher from San Francisco.
Podium: Risa Steinberg, Kerstin Kussmaul, Storm, Marjorie Smarth, Kurt Mosetter, Ori Flomin, Tanzmed-Team, and more.

The announced questions were:

1. How can somatic practices influence dance-pedagogy and contemporary performances?
2. The Body on Stage: Subject or Object?
3. Politics of movement: Who does the work? Vs. – Who owns it?
4. Dancers' Rights: Oxymoron or longtime overdue?
5. Colonial conventions among contemporary choreographers?

6. Alternative models of production? Dance cooperatives and dance cooperations: Can they decentralize the dance-machinery?

Sri Louise welcomed the audience and introduced by presenting her approach of the term “somatic” as concentrating on the body (after Thomas Hanna), but in a holistic sense, including the spiritual and emotional levels. The lecture of Hanna had helped herself a lot, but it had to do much with her own life. Today, she has a lot more order in her own life, she can put things and events more precisely together and put them into boxes, having found her own system of arranging them.

Risa Steinberg:[2] I am very trained and well educated. The information in traditional lessons was usually not personalized. Today, we have an anatomical consciousness we did not have when we were young.

Steinberg expressed her concern that the Alexander method, Laban, Feldenkrais and others of this kind are not dance-techniques. Herself, she believes in technique and is not willing to give up all the knowledge of passion and the existence as animal. She strongly emphasized the differentiation between “additional offers” and the dance-techniques/-styles.

Steinberg: I want the people to learn and know about anatomy, but there are different views: There is anatomy, there is technique, and there are the somatic practices.

There is a lot of confusion among audience and co-talkers on the podium around the term “somatic” which is understood quite differently. Internal discussions increase as well as misunderstandings.

A voice from the audience tries to clear the understanding.

Voice from the audience: When I have a stomachache – is it physical, is it emotional or is it spiritual?

Increasing uneasiness arises among the audience, trying to clarify the term.

Question from the audience: Can we try to get the contours clearer, when we take the original meaning of the term “somatic” which – as far as I am informed – is of Greek origin and means “referring to the body”?

Steinberg: We dancers know so much about the body, the body-functions, about anatomy, that it would be very sad to meet a dance-teacher without any knowledge of the body. Myself, I enjoyed a very disciplined education, rather rigid. I believe that one can repair the body in a somatic class, that you can restore it, and I have to admit that Alexander[3] helped me a lot during the last years. But there is a big difference between dance-techniques and the additional methods. I am only saying that the latter is not dancing. Under the umbrella of the art-form dance: Would “somatic” mean that it includes everything especially the skeleton is doing? This appears clearly somatic to me. How can the (so-called) somatic techniques simplify the art of movement?

This initiates a longer discussion around the term “somatic”, obviously being understood completely different from the ones coming from Yoga and similar, eastern inspired methods who rather understand the term as “holistic”. This means: They are trying to acquire a unit of body, spirit and soul in the sense of a “holistic understanding of harmony”. So, the whole thing quickly gets an esoteric-spiritual touch.

Marjorie Smarth: Everything I do is spiritual. There is a certain easiness that helps you to do what you do. We not only see our own energy, we also experience the energy of another person we are working with, also the one of the musician.

Sharing or participation seems to be a very important aspect. First of all, teaching seems to mean the somatic aspect, which means: With an anatomical background.

Steinberg: I became very critical towards the large offer of additional practices. Dancing still is essentially physical. The saying „Dancing is a life-style, not a job“[4] has touched me very much. We dancers know so much about anatomy that it would be very sad to meet a dance-teacher without any anatomical knowledge.

Then, Steinberg gives the fundamental definition of teaching dance which has already impressed the students during the lessons in the intensive-class:

Risa Steinberg: Technique is an alphabet. From there, you can do anything you want to. The alphabet has to be learned; from there, you can start putting things together in a new way. Life is a process and development, just like growing-up. We search when we are ready to search, and we pick up when we are ready to pick up. Let's assume that every human being has the spirit to dance. Our task as a teacher is not to blow out this flame.

Here, wide parts of the audience agree with, even those ones from the complementary techniques and Yoga. Storm from Berlin tried to unite everybody under a harmonic umbrella expressing that we were all here to do and enjoy the same thing: Dance and dancing.

Marjorie Smarth: I have the impression as if there is little respect for the Hip Hoppers. They seem to be a little pushed aside from the rest of the dance-hierarchy. I feel a kind of separation.

Another contemporary dancer and Hip Hipper Storm shared this opinion. Dancer Ori Flomin said this is also true for contemporary dance-styles. At the same time, another participant from the audience expressed that the various styles and traditions united at this festival are unique and wonderful to enjoy for everybody.

Question from the audience addressed to Smarth: Don't you think that Hip Hop and Street jazz are still quite young disciplines, in comparison to others, which have not yet fully reached the consciousness and attention in general?

Smarth: Oh, but it does exist already for a long time, for over thirty years now! There are old elements in it.

Steinberg: We also have dance-groups and traditions that are marginalized.

Another participant from the audience: For example, the local Vienna art-community is almost not represented.

The latter is supposed to be changed; ImPulsTanz will cooperate more with the Tanzquartier Vienna in the future.

Sri Louise finished the talk: There are still many needs not being covered, and a lot of open questions. We will organize further discussions, also in the following years.

Assia Maria Harwazinski

Notes

[1] Cases like the one of Algerian athletic (sprinter) and Olympia-winner Hassiba Boulmerka at the beginning of the nineties caused attention when Islamists tried to force her to give up her career in sports and finally tried to destroy it. The fact of a female veiled Iranian soccer-team is new and an exception. Basically, sports and physical training in full-body-veiling only allows limited movement and is anything else than comfortable.

[2] Risa Steinberg is presently considered to be the best dance-pedagogian alive in the field of Modern Dance. Herself, she does not work on choreographies, but developped a sort of dance-collage of the history of American Modern Dance as a

solo-concert. She is specialized in training the young generation of artists at Juilliard School, New York and is the artistic director of the works of José Limón in New York.

[3] Referring to the „Alexander method".

[4] This repeats a former remark of dancer and choreographer Pina Bausch who died in June 2009, five days after the official diagnosis of cancer.

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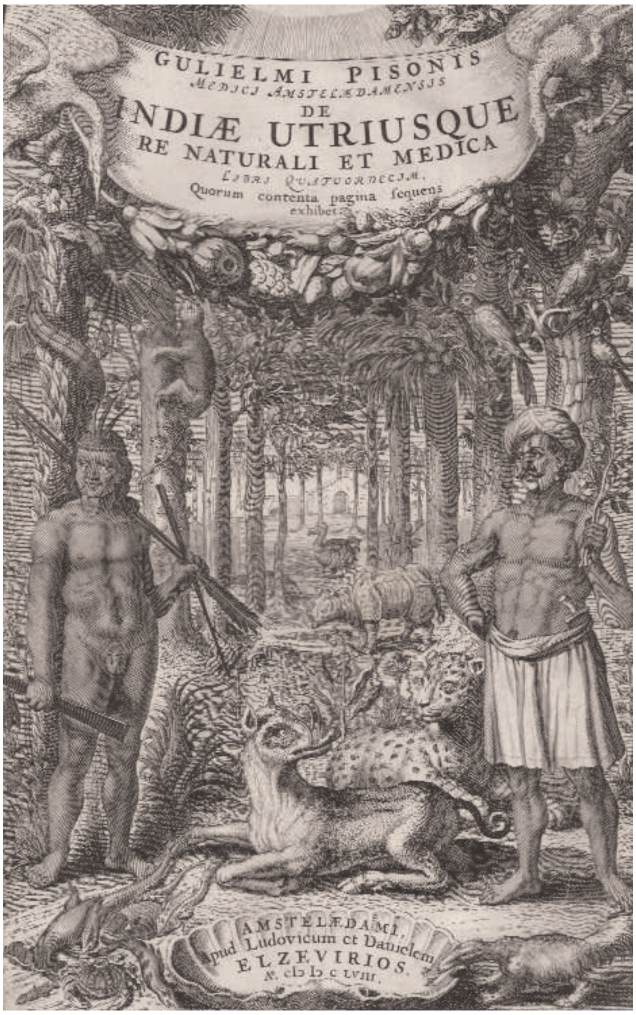

Willem Piso´s “De Indiae utriusque re naturali et medica” (1658)

Willem Piso (1611-1678) was the founder of scientific Tropical Medicine but he was as well the first Dutch Medical Anthropologist. His father Harmen (Hermann) Pies (1580-1654) belonged to a famous German family of doctors and judges. 1607 he moved from the German Kleve to Amsterdam and later to Leiden, where he worked as an organist in the Sint-Pancratius or Hooglandse Kerk. 1609 he married Cornelia van Liesvelt. Son Willem studied medicine in Leiden and Caen and received his MD in 1633. He became physician in ordinary to Count Johann Moritz von Nassau-Siegen, Governor of Dutch Brazil in 1637. During his seven years stay in South America he studied not only the pathology of tropical diseases but also environmental aspects und nutritional conditions of the people. His special interest concerned the traditional medicine of the Tubinamba. Among their healers he discovered the *Ipecacuanha* root, which he introduced into the therapy of tropical enteritis, and other American specifics such as *Sarsaparilla*, *Sassafras*, and *Guiacum*. He published the results of his work in two main books. 1648, together with the Geman natural scientist Georg Marggraf (1610-1644), the *Historia naturalis Brasilae*, and 1658 his *De Indiae utriusque re naturali et medica*. He died as an honoured physician in Amsterdam and was buried at the side of Rembrandt in the Westerkerk.

Armin Prinz

Illustration last page

Frontispiece Piso, G. & Marcgrave, G. 1648: Historia naturalis Brasiliae auspicio et beneficio illustriss. I. Mauritii Com. Nassau illius provinciae et maris summi praefecti adornata. In qua non tantum plantae et animalia, sed et indigenarum morbi, ingenia et mores describuntur et iconibus supra quingentas illustrantur. Hack and Elzevier Leiden-Amsterdam

Willem Piso’s “Historia Naturalis Brasilae” (1448)