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Comforting the (Exile) Afflicted in Croatia – Around and Beyond the Analytical Approaches of Critical Medical Anthropology

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A B S T R A C T

Recently, there has been a growing recognition that any research conducted with those that suffer should definitely be critical of the continuing policy of group equalizing, either in relation to ones ethnicity or any other salient parameter. However, it is seldom that this critical knowledge is applied from »outsiders« when a negation and re-evaluation of history, especially concerning the medical systems and their historical development within nations and populations, is used. The propositions within this paper are given on the basis of knowledge gained in the course of a long-term study dedicated to the exiled in Croatia, and are tightly linked to theoretical perspectives of critical medical anthropology, yet exceed its limits. Critical medical anthropologists deeply engage in ongoing debates that stress how there needs to be more understanding of the necessity to study the wider social context of any population we approach and analyze. However, the knowledge about wider social contexts is unachievable without the new grounds of dialogue being created between professionals and researchers of all disciplines and equally – regardless whether they are »insiders« or »outsiders« to the problem in focus. The knowledge about developments in developing countries, and especially of countries in post-war transition cannot be solely built on strategies of globality and theoretical explorations disconnected from people and their experiences on ground, especially when they concern the delicate issues of social and health care. Hopingly, the given examples in this paper will add to dialogues of corrective kind that should be raised more often.

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Introduction

There is a mutual virtue that some researchers of worldwide afflicted populations share which gives hope to those of us that come from developing countries. This paper is written with the aim of supporting their »outsider« observations with an »insiders« testament that rises a further plea for their demonstrated scientific sensitivity. The mentioned virtue concerns the frequent practice of doubting whether when studying the rural poor[1,2], the refugees[3,4] or the suffering patients[5,6] the presentation of reality falls short of promises made, and the practice of engaged willingness to prevent this through a change of methodological, analytical and overall strategic approaches. Certainly, there must be an interplay of research creativity and rigorous scientific honesty that produces such an awareness of this level in which the complexity of observed problems dispels the illusion of »belonging« of certain populations to a field of scientific thought, proscribed methodological approaches or a pigeon-hole of scientific classifications. Not surprisingly, anthropology provides a solid ground for scientific contributions that are aimed at correcting this myopia of comfortable approaches that fake reality. Ten years ago, while contemplating about the new praxis of a »reinvented« medical anthropology, Merrill Singer[7] inspiringly cited the old journalistic saying and stated that we are »*…comforting the afflicted while afflicting the comfortable*«. Ten years after, the »reinventing« can further inspire the open dialogue about how we approach the afflicted in our studies. Simultaneously, it also helps those in underdeveloped countries to better understand the many »helping« approaches they are faced with. However, even if the major grant foundations, economy distribution institutions and leading aid agencies are more open to the scientific inputs of social scientists (especially anthropologists), the past experiences of dealing with exile problems in Croatia teach us that methodological and conceptual changes of world wide policies are still not favorable for the majority of afflicted populations in targeted countries. It would be wrong to state that the problems of differently afflicted populations in these countries are not (were not) addressed, it is (was) just that the focus is often shifted towards the classification of different »sufferings«, uncritical unifying of cultural meanings, value-systems, and consequently the development of international research strategies/programs that are most frequently based on regional, national and even ethnical rather than population specific demands. Through the examples that are given in this paper I argue that the benefits of mentioned corrections are of twofold importance: a) the funds that are donated through foreign agents (such as the International Monetary Fund, the World Bank, WHO, the U.S. Agency of International Development, Stability Pact Working Tables, European Union policy makers, etc.) would be more profitably distributed following and respecting the population specific demands, rather than politically strategic ones; and b) the main ethical concerns would be finally met after recognizing the ways in which frequent re-traumatizing of already traumatized individuals and populations happens in the course of their undergoing the process of conditional funding that proceeds in a repeatedly traumatic fashion.

Ironically, although the approach to any afflicted population should start with ethical dilemmas and an honest appraisal of how science, international policy making and humanitarian-development responses treat salient problems and what part they can play in further burdening of the already complex socio-cultural contexts – it never does. The *a priori* focus that scientists firstly must en-

gage in is that of obtaining funds. It is a well known fact that funding of social sciences and applied work, regarding any severe problem that intersects the social, cultural and biomedical disciplines is perceived as unprofitable*. Taking an even broader picture, bureaucrats of all levels seek flows of condensed analysis, that even if done by local professionals, is seldom expected to have a feedback quality which would enable true plural dialogues, rather than plural monologues[8].

The Questions of Ethics vs. Funding Ethics

If analyzed through case examples in forced migration studies, the proneness towards making false »constructions« of reality has been rightfully criticized[9,10], and it has been observed for over two decades that much of the international and national response to the afflicted populations is *imposed*[3,4]. Yet, many times the ethical doubts and dilemmas concerning power relations, institutional fundings and responsibilities of international funders remain widely unrecognized concerning their connection to the wider socio-economical global dynamics that shape the social and health systems in certain parts of the world. The plethora of detrimental consequences are manifold and reevaluations we are in urgent need of taps directly into the overall tendency of current anthropological research where the presentation of history and otherness is seen to be based on negations that follow an ethnocentric line of thinking and is heavily under the influence of power and contest[11]. The ways in which the growing problem of exiled population's forces the international community of policy makers and aid givers to rethink their approaches is a case in point. On one hand, there is an urge to depoliticize the fields of expertise and professionalize the approach on ground (as in the case of the acknowledging that we need to state our »accountability« when addressing forced migrants and their numbers)[12], while on the other hand there is a failure to recognize that the »politics of numbers« is even more dangerous given the hidden interests that can get perpetuated on more than one level.

In a recent paper entitled »*Are refugee camps good for children?*« Harrell-Bond concludes[4]:

»*With all the evidence mustered against camps, why does this approach persist? The reasons lie in the answers to the question: whose interests do refugee camps serve? And are there alternatives? Yes, there are, but exploring them is an immediate threat to the interests that refugee camps serve. Over the past decades, powerful bureaucratic and institutional interests have developed in keeping refugees in camps and dependent on relief. Most international aid available for refugees is only available for relief programs. These interests exist at both the international and national level. Relief programs by-pass local institutions, they set up expensive parallel systems to deliver services targeted to refugees, then normally destroy them when they go away.*«

It is of no surprise that this paragraph delivers us into an arena of no easy questions. After all, Harrell-Bond has long ago started asking the questions that the »insiders« themselves would like to ask, and that many »others« have ambivalence when answering. Through the work I have conducted with those in exile and through the experience of receiving first-hand impressions on the reasons of their suffering, I am convinced that we

* A good example of this is given in the chapter »Aids: A disease of the global system« where Bear and colleagues (1997: 179)[7] discuss the reasons why anthropology has been »slow« to engage in the research of Aids.

have long ago entered into the domain of politics of the »un-political« interpretations. The unrevealed danger lies in the end results of forming deviated optics of »reality«, programs of deleterious action and measures taken that never succeed in their possible beneficial aims. Thus, however political we may sound, answering the questions about *whose interests are being served*[4] plays a critical part, together with understanding *who knows what and why*[13], and coming to reason with the fact that we are all endangered with forms of our intellectual ethnocentrism[14] and dilemmas upon »*Whose reality counts?*«[2].

In the past decades medical anthropologists were especially confronted with an inherent danger of proclaiming »unified« (exile) populations on the basis of observed regional affiliations, typizations of poverty, sufferings and underdevelopment, thus further supporting the discourse of scientific stereotyping. However, it was also precisely for this reason that, through confronting their various theoretical perspectives, this growing anthropological sub-discipline became the leading one in which »matters« of suffering, pain and persistence dominate the debates in which the most *painful* questions are being raised[10,15]. Although today, this field nurtures an intensive and dynamic debate concerning the indivisible connection of institutional, political and economical power with the social and physical sufferings, it still faces a great challenge in acknowledging that we are repeatedly invited to learn the historical conditions that motivate our conceptualizations and a historical consciousness about our current developments[11,16]. This is seen as the only way in which we can meet the ethical dimensions of our research and which can only then carry a virtue of testifying the reality on ground. Hopefully this change will coincide with a time when the contest of projects that get funded through international agencies, will not be governed by the skillfulness of their writers in tracing the agencies preferentials concerning political strategies and discourses of global economic importance[**].

Issues of Exile and Health in Croatia – Taking a Critical Interpretative Approach

The anthropological long-term research of exile and return processes in Croatia confirmed that economical factors of exile/return populations are inseparable from the psychological and health problems they are faced with[***]. It has seldom been the case that these populations were targeted by appropriate international intervention programs. Local practitioners were widely aware of this fact, but were also dependent upon the funding sources and therefore not in power to focus, neither time nor money, to needed areas of attention. The most painful experiences of the majority of professionals within the whole region concerns the unbelievable number of mental health programs that were provided in the past ten years, especially those dedicated to concepts such as PTSD and alike, of which a minority left a lasting impact. A colleague psychiatrist from Slovenia[21]

** It is frequently heared among the international scientists interested in the Eastern European region that in order to get a project funded you need to closely follow the instructions of the Stability Pact for South Eastern Europe (adopted at a Conference of Ministers, Cologne, 1999), which means include the majority of significant »partners« of the region.

*** For more detailed information see Rudan et al. (1997)[17], Špoljar-Vržina et al. (1996)[18], Špoljar-Vržina (1996)[19], Špoljar-Vržina (2000a)[20].

described some of these experiences in the following way:

»*The tendencies and efforts of some western mental health institutions to transplant the clinical models of work – individual or group psychotherapy in a situation with literally thousands of psychologically harmed persons was irritating. The reflection of some of my colleagues in such cases was: We have to be thankful for any money they give us. If they would not be here, there would not be any mental health programme. But soon many among us became aware, that the money for mental health programs was given by the international community or by some country and that nobody had the right to use the money in a wasteful way*«[21].

In many similar cases being the »local professional« also involved being a presenter of the many unperceived realities of forced migrants in Croatia and the whole region. Additionally, historical processes of the past decade created many populations of »*lost worlds*« characterized by invisible yet painful misery[20], while the problems of »categorized« subpopulations became solidified into a state of social suffering regarding high rates of unemployment, widening poverty, a downfall of health standards and social well-fare, to mention only a few of the transitional adversities. The state is not facilitated through the expertise given by World Bank and IMF experts on further budget restrictions that have detrimental effects on all social sectors[2,15]. Although it may sound cynical, the populations within Croatia are becoming experienced in being included into the global problems of the world. In this sense, while the *boundaries* of violence, human suffering and existential agony seem lost, the ones that are marked by rising poverty, social insecurity and the instability of health care are clearly pronounced and not necessary tied to a western/non-western dichotomy. The popularity of some problems is media driven and oriented towards short-term spans of attention. For instance, why has the categorization of an individual that is displaced, stricken by a famous syndrome and has tuberculosis (IDP/PTSD/TB) never made the headlines in International communities, while the massive rapes were recognized over night (although afterwards it was hard to prove the status of victims and protect them from further stimulated media aggression)? [19] Has no one been concerned with the long-term aspects of health in this region? I believe that part of the answer has already been given by Paul Farmer (1996)[22] in his seminal article dealing with social inequalities and emerging infectious diseases:

»*…why are some epidemics visible to those who fund research and services, while others are invisible? In its recent statements on TB and emerging infectious, for example, the World Health Organization uses the threat of contagion to motivate wealthy nations to invest in disease surveillance and control out of self-interest – an age-old public health approach acknowledged in the Institute of Medicine's report on emerging infections: »Diseases that appear not to threaten the United States directly rarely elicit the political support necessary to maintain control efforts«. If related to a study under consideration, question of power and control over funds, must be discussed. That they are not is more a marker of analytic failures than of editorial standards.*«

However, this is only a scientifically and technically correct argumentation of issues relating to the contest of power and money in the domain of health care on the world wide scale, while the one that comes from experience is more dramatic and emotional. In the words of one interviewee (with an experience of being an asylum seeker in more than one European country) the attention your health

status gets is varying, yet never according to the realistic needs. Your needs are ascribed to you according to the presumptions about the endangered health status you might have or develop in exile. Although this estimation might be over-emotional and exaggerated, it is a result of feeling categorized and boils down to the issues of stigmata of a profitable kind and the fact that »*.....infections pass easily across borders-social and geographic -while resources, including cumulative scientific knowledge, are blocked at customs*«[22,20]. Or are they?

A Croatian Case Example

While the multitude of similar opinions by local practitioners and researchers can be heard and read, the ones of the people that underwent exile are silent and dependent on the potential interest that the international scientific society may choose to audit through strategic financing. Even my own presentation that is given through this paper is selective in nature and represents the most salient themes of recorded voices. Drawn from a recent study**** that was dedicated to a long-term follow-up of families in prolonged exile, one of the prominent findings was the level of expressed concerns regarding health and its prospects. This was not surprising given the circumstances of war and post-war processes, together with the stresses and illnesses that were gained during the prolonged years of exile and return. However, the surprising fact is that descriptions of ones health status was always accompanied with an awareness that Croatia is a poor country and that there is a certain level of freight about being sick and dependent upon the weakening health care system. Among the frequent remarks that followed these fears were known sayings such as »*...Ne daj Bože bolesti!*« (»*...God prevent us from being sick!*«); »*... samo da je zdravlja*« (»*...only health is important*«) or »*Sve je dobro dok si zdrav*« (»*All is well while you are healthy*«). Accordingly, a number of examinees were also very concerned for the state of our health system and the fact that it is largely dependent on foreign investments. A 62 year old professor of economy, living in one of the hotels in the center of Zagreb for the seventh year observed: »*There is no way out. Patience is of no importance since we are faced with loans on all levels. The children of your children will still be paying the debts. But that is not the worst fear. The worst one is what to do when you get sick. It makes me sad to think of the times I used to be unaware of the importance of health to me and my family. And look at us now. We have to beg for a prescription. Is this not an irony? We had a health care of the highest social concern.*«

Indeed, our health care system was exemplary in many ways and regarding the many levels of social and preventive health care it nurtured. This was fortified by the fact that it was created by a team of specialists gathered around one of the founding fathers of the World Health Organization. The whole system was built on a strong conviction, energetically proclaimed by Štampar (1966), that changes in health occur only when health politics becomes the most important part of a na-

**** The study was conducted through the usage of genograms, a highly clinical tool of rigorous ethical demands, developed within the framework of the family system therapy[22]. The genograms oriented us upon the basic structure, family demographics, the functioning and relationships contained within families and provided information about families emotional climates, areas of conflicts and restrained relationships[23,24]. It proved to be good in orienting the work with families towards the positive relationships and protective factors of family living. For further information of its application in the research done among Croatian exile families see Špoljar-Vržina (2000b)[25].

tional economy[27]. Almost thirty years later an American anthropologist, Jay Sokolovsky[28], when studying the functioning of the self-help hypertensive groups and the elderly in Croatia observed that there is plenty to be learned from the efficiency of established community health centers in Croatia and former Yugoslavia. Among other benefits he also observed the high level of empowerment that individuals received from these self-help groups and the primary health protection offered[28]. Today, in contrast to this, one only needs to open the World Bank internet site[29] to quickly grasp the essence of our transitional health system and its development. The large financial loan that Croatia has been given for the support of its health care system is arranged around five areas of health system enhancement (Health Services Delivery, Public Health, Pharmaceutical Waste Disposal, System Wide Initiatives and Project Management) of which only that of pharmaceutical waste disposals is substantially new. Of course, there are many specifics concerning the economical contract that binds our health care system to these projects, as well as the benefits that are not momentarily apparent to the laymen with no knowledge of complex mathematics involved in investments made into developing countries. However, to those familiar to the prior system this transition of our health care system seems as a total negation of the beneficial historical specifics and as such in need of a greater cautiousness and constructive critique[2,15]. To all (»insiders«) dependent upon the necessity of its implementation the comment might be one of politeness, present through all the years of being on the receiving end of funding – *»You should not bite the hand that feeds you!«* However, the moral question remains – can the money be used in a proper way, adding to the already existing resources, with respect to the historically conditioned development of our medical system and regardless of any hidden agendas.

Beyond the Biomedical and Critical Medical Approach

The genogram interviews with former refugees and displaced revealed that the majority of families share a general concern over health and health prevention. However, future investigations should be aimed at gaining much more information concerning the consciousness and concern expressed about the health system functioning among those of the most vulnerable populations[26]. This is especially important concerning the insecurity regarding rapid health system changes that presents a stressful factor, in itself. By now, it is a well known fact, confirmed by many national studies, that transitional societies such as ours are marked not only by a high level of stress and sickness, but also freights concerning ones worsening health[30]. Consequently, current studies orientate towards explaining the ways in which known social factors are responsible for health and its decay, especially concerning the war/post-war/reconstruction effects[31]. Coming from a transitional, post-war country that faces so many complex problems in the domain of socio-economic and health issues it is easy to forget that even the most highly advanced countries (in terms of material and health accessibility) do not necessarily reach a status of diminishing all ilnesses[32]. Nonetheless, the capitalist solutions to health problems are promising and always represented with all its technological might. Accordingly, more emphasis is given to the compatibility with market-driven economies and less to the quality of the health care reform within each transitional country[15]. However, the knowledge that we can gain from the biomedical and critical medical theoretical perspectives is not sufficient in explain-

ing the processes that the transitional (especially post-war) countries are currently faced with on all levels. There are simultaneous pressures of reforming the health/social systems, accelerating the pace at which it is expected to form new patterns of market economy functioning, and above all heal the sufferings of post -war traumas. We are daily confronted with issues of economic reconstruction, development, reconciliation, international cooperation, security, human rights and many other democratization processes. In such a bombardment of challenging issues we are involved with, it is very hard to maintain a sense of answering the dilemmas through any strict theoretical perspectives. Our answers might very well be beyond any of the explanations we are to seek within our own discipline. When concluding his Introduction in »*Moral Culture« Tester*[33] stated:

»*All the sociologist can do is propose that there might be much more to being human than all of this, but then have the honesty to refuse to say what that more might be. After all, sociologist does not know«* – and in all honesty – does an anthropologist?

Conclusion

The relevancy of anthropological thought in the changing world of today is confirmed through the exercised processes of self-doubt, correction and the willingness to apprehend the complex gaps in knowledge concerning the »insider«/»outsider« positioning[2]. In the words of Shalva Weil[34], there has come a time when the methodological difficulties in studying non-mainstream populations have become as important or even more so than the ones done about the same populations, that disregard their complexity of appearance, as well as the negotiated reality between the researcher and »the Other«[34]. This is especially important if one takes into account that the most scientifically recognized facts are those pertaining to the numbers or any other salient and easy-to-handle descriptors of populations. Although numbers, statistical analysis and categorizations give convenient and »clean« evidence, the vulnerability of populations under research obliges us to take a more critical approach[35].

The validity of our data is a direct outcome of the accountability that we are able to establish through a good communication level with our informants, as well as the extent to which we are aware of our own biases and those that are produced by abiding to the socio-economic and political frameworks of our funding realities. Medical anthropology should also take into account the pressures both researchers and their examinees are subdued to. More and more we are in a position that is described as keeping track of populations that are often »*...generally thought of as not worth keeping track of at all«* and »*...finding better ways of getting at crucial but elusive data*« in order to present them realistically[36]. However, knowing all the ramifications of thought in the debate over a »militant« anthropology, we must be aware that we are in a position of joining a dangerous arena of potential anthropological solipsism. Being aware and debating about all the above facts makes us no more or less immune to making mistakes in our accountability and ethical stance.

Ethics, politics and knowledge are everywhere intertwined and changing[37]. Thus, no domain of science should claim power of its maintenance, yet all should be aware of the areas in which the lack of it is most visible. The effect of globalization upon this problem is crucial and begs for questions that we should always be able to answer when envisioning future scientific and practical accomplishments – Do the benefits that worldwide exile populations receive justify the not modest

salaries that professionals take claim in their internationally claimed budgets? Does the support they receive truly heal the consequences of accelerated transitional processes?

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TJEŠENJE NEDAĆAMA (EGZILOM) POGOĐENIH U HRVATSKOJ – U BLIZINI I S ONE STRANE ANALITIČKIH PRISTUPA KRITIČKE MEDICINSKE ANTROPOLOGIJE

S A Ž E T A K

Ne tako davno, prepoznato je da svako istraživanje ljudi u egzilu nalaže kritičnost u odnosu na problem česte generalizacije na razini grupa, bilo u smislu etniciteta ili bilo kojeg drugog parametra. No, kritične spoznaje o generalizacijama nisu praćene i kritičkim razmatranjima o negaciji i prevrednovanju povijesti osobito u odnosu na tekovine razvoja medicinskih sustava pojedinih nacija i populacija. Postavke ovog rada, iznesene na temelju saznanja prikupljenih kroz dugotrajno praćenje obitelji prognanika, u uskoj su vezi s teorijskim okvirom kritičke medicinske antropologije, no isto tako ju i ponegdje nadilaze. Rasprave kritičkih medicinskih antropologa bile su okrenute prema stvaranju većeg razumijevanja o potrebi istraživanja širih socijalnih uvjeta populacija koje istražujemo. Međutim, razumijevanje socijalnih uvjeta i njihove šire ekonomske, političke i povijesne uvjetovanosti nemoguće je doseći bez boljih dijaloga između pojedinaca različitih disciplina, »iznutra« i »izvana«. Saznanja o događajima u zemljama razvoja, a osobito onima nakon i poslije rata ne mogu biti razvijana na isključivo globalističkim strategijama i teorijskim postavkama odvojenim od populacija i iskustava sa terena. Primjeri u ovom radu imaju za cilj obogatiti dijaloge i rasprave koje bi trebale biti vođene, i to poglavito o osjetljivim pitanjima iz domene socijalne i zdravstvene skrbi. Primjeri i razmatranja ovog rada izneseni su s nadom da će doprinijeti budućim dijalozima korektivne prirode.