MATERIALITIES OF PASSING

EXPLORATIONS IN TRANSFORMATION, TRANSITION AND TRANSIENCE

EDITED BY
PETER BJERREGAARD,
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AND TIM FLOHR SØRENSEN

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Chapter 5
Understanding Self-Care: Passing and Healing in Contemporary Serbia

Maja Petrović-Šteger

The so-called Yugoslav Wars ended in 1999. To what extent has the post-war period brought healing and to what extent has the war fully 'passed'? How is the transition to a post-conflict society understood in Serbia? How can we register – ethnographically but also through narrative and metaphor – the persistence of states of mind associated with the war and with attachments not extinguished by the war ending?

The word 'post-conflict' typically evokes images of a shattered human environment, whose strewn bodies denote a bruised social psyche in sore need of mending and healing. Following the 1990s wars, the international community insisted that the witnesses to, and perpetrators of, war crimes could only reconcile themselves to a post-war polity, and start on a course of healing, on the condition of their facing up to the evidence of their wrongs. The assumption was that it would be possible to create, or indeed restore, a 'healthy' civil society only through people spontaneously saying what they thought politically, as they cooperated with locally and internationally run programmes of interstate reconciliation.[1] Through framing the terms of Serbia's role in the wars, and its relation to Europe and the world, Serbia would be able to consolidate itself democratically, reduce any stigma associated with looking backward, and symbolically attenuate inequalities and tensions among its population. Yet the terms of Serbs' participation in these programmes – regarding their culpability for events in their recent past – were not uncontentious. Political, civil society organisations and NGOs in fact clashed over Serbia's role in the wars and how this should relate to the work of the agencies dealing with war's human fallout.

Numerous anthropologists have examined the impacts that radical social and political change, economic hardship, structural violence, humanitarian interventions and conflict have on health (see, for example, Adams 1998; Asad 2011; Briggs and Mantini-Briggs 2003; Brotherton 2008; Farmer 2003; Fassin 2005, 2008; Gibson 2001; Kleinman, Das and Lock 1997; Petryna 2013; Scheper-

1 For an excellent analysis of the significance of psycho-social intervention as a new form of 'therapeutic' international governance based on social risk management, see Pupavac 2001, 2005.

Hughes 1992; Tapas 2006).[2] This chapter takes its cue from this scholarship, but focuses distinctively on the body and on health as the sites of medical and humanitarian intervention. It traces debates over whether Serbia is healthy, not only in the sense of being reconciled with its neighbours but more literally – does Serbia's post-conflict social health apparatus actually function? Examining practices through which people monitor and manage their bodily conditions and health as forms of medical and humanitarian intervention and production, my analysis shows how certain personal and social aspirations towards societal changes in Serbia are transacted through biomedical and political categories of healing. It also complicates certain representations of Serbia as an emotionally dysfunctional society, asking whether such a depiction and such an intervention serves to rehabilitate or further pathologise the society in question. The discussion of a range of practices, desires and agencies relating to conceptions of health also illuminates some of the modes by which ideas of Serbia's post-conflict and post-socialist transition or passing are publicly understood. This chapter is based on intermittent fieldwork in Serbia between 2004 and 2009 and builds off an ethnographic data encompassing extended interviews and close interactions with more than a hundred respondents (including patients and doctors) from various sections of Serbian society.

Health in Pre- and Post-War Serbia

The transition of post-conflict states is often captured in statistical indicators such as GDP per capita, people's access to health, education, and other measures tracking the development of a civil society. In the early 2000s these indicators marked undeniable progress for Serbia. Today, however, over 15 years after the last of the 1990s wars, the country seems to have returned to a state of dissatisfaction and uncertainty – the economy is faltering, living standards are poor and levels of public health are worryingly low. In such a situation, providing conditions for politics of accounting, economic investment and humanitarian assistance in medical resources and equipment has become an important marker of international willingness to speed the country's recovery, as (possibly) compelled by a notion on the world community's part of its obligations and of the value of reconciliation in Serbia.

This form of international justice, typically and increasingly articulated in the language of healing, has in the former Yugoslavia attached itself closely not just to

2 There is a copious literature analysing the influence of conflict on public health. For interesting sociological, medical, epidemiological, human rights and security specialists' research relating to former Yugoslav territories, see Banatvala and Zwi 2000; Cardozo et al. 2000; Hjelm et al. 1999, Hjelm et al. 2005; Jones et al. 2006; Kunitz 2004; Luta and Dræbel 2013; McCarthy 2007; Nelson et al. 2003; Pupavac and Pupavac 2012; Thoms and Ron 2007; Toole, Galson and Brady 1993; Vlajinac et al. 2008.

questions affecting the health of the living but also to human remains and to claims made in their name. Estimating that more than 40,000 persons remain unaccounted for after the Yugoslav Wars, various organisations, most notably the International Commission on Missing Persons, have established, under a 'strictly humanitarian mandate', a 'mission to bring relief' to the families of the missing (both former combatants and civilians), regardless of families' religious, national or ethnic identity.[3] The recovery of bodily remains, and their return to the bereaved families, has thus been identified as crucial to restorative and reconciliatory processes. In ambiguous ways, the project came to signify ideas of modernity, Europeanness, and of health and rehabilitation at a societal level (see Petrović-Šteger 2009).

Besides the financial and infrastructural support tied to the identification of human remains, Serbia has over the last 15 years or so received hundreds of millions of euros' worth of international aid earmarked for the housing, healthcare and psycho-social support of refugees, displaced persons and the relatives of the war missing.[4] During the war, a sudden influx of internally displaced people placed a heavy burden on primary healthcare centres already struggling with staff shortages and unreliable supplies. This help has thus proved essential for a vast number of people, especially given that in the post-war period the health of Serbia's population has visibly worsened. Life expectancy is falling and the incidence of cardiovascular diseases, various forms of cancer, stroke, depression and suicide rate is on the rise (Institute of Public Health of Serbia 2009; see also Marković 2010). The quality of healthcare has also deteriorated dramatically.

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3 The Commission has mounted a major public health campaign involving the DNA-sampling of the population as a precondition for the identification of remains exhumed from mass gravesites. In the hope that a secure method of attribution would stimulate people to exchange information concerning missing people with more speed and candour, the proponents of national reconciliation have styled DNA in public discourse as a figurative basis on which people previously at loggerheads could be brought together. The effect of these campaigns and, most of all, of identification results, was to give rise to a notion that one could cope with the loss of loved ones, and attempt to secure justice on their behalf, by searching for them on the molecular level of their DNA profile. If atavism and conflicts had torn Yugoslavia apart, science would, as it were, put it back together again.

4 The EU is the main international donor to Serbia. Through programmes managed by the European Agency for Reconstruction, the support that came from the EU for the Serbian health sector, from 2000 to 2007, has totalled almost €100 million. Further, the US Agency for International Development (USAID) represents the largest bilateral donor. Other donors and agencies providing assistance to the health sector include the World Bank, World Health Organization, United Nations Children's Fund, United Nations Development Programme, International Committee of the Red Cross, UK Department for International Development, Canadian International Development Agency, South African Development Community and Government of Germany (as listed in the DFID Health System Resource Centre Report on Serbia and Montenegro Health profile 2003, London). See also http://ec.europa.eu/enlargement/archives/ear/sectors/main/documents/HEALTH_SERBIA_EN.pdf (accessed 21 July 2015).

This reduction in the quality of Serbia's healthcare system, along with the development of an unofficial health economy incubated by discrimination and corruption in public healthcare provision, has reduced people's incentives to cash in their state-run health insurance, and likewise to make their social contributions, thereby substantially undermining the public's previous relationship of trust with state healthcare.

The current situation of public healthcare in Serbia, then, is a far cry from that which prevailed before the 1990s conflicts. Under the socialist regime, the Yugoslavian healthcare system was not financed, as in the rest of Eastern Europe, through a Health Ministry Budget, but rather drew on a social insurance fund modelled on the Bismarck system (as opposed to a British-style welfare state arrangement). The system made contributions compulsory for all employees who, together with their families, benefited from insurance. Those unemployed came under a separate system financed out of the state budget. Healthcare – that is, treatment, medicine and prosthetic interventions – was free at the point of delivery, and regarded by Serbia's public as highly efficient and trustworthy.[5] The collapse of Yugoslavia, leading to Serbia's impoverishment, and the destruction of its middle class under a series of wars and the embargo, has hugely changed the landscape of which the healthcare system formed a part. Internationally renowned institutions, such as the Torlak Institute of Immunology and Virology, a major vaccine producer, for example, lost their external markets. The then government under Slobodan Milošević re-centralised the system, but did not re-size or reform it, leaving a painful incongruity between an unwieldy legacy structure of the communist era and any realistic possibility of financing (FIDH 2005: 5).

Further, during the early war years, a number of highly qualified doctors left the country, creating a supply–demand imbalance that even in a managed system pushed costs up to the highest level, for patients, in the region. Although the situation has changed somewhat over the years, leaving health institutions over-resourced in terms of locally educated personnel, those medical practitioners who could get jobs (in 2005, around 25,000 in Serbia) attested in the media to poor working conditions, wrecked facilities,[6] supply shortfalls and a constant need to appeal for money. An inadequately supervised and regulated private healthcare sector emerged, with members of what is perceived as a *nouveau riche* class bankrolling

5 The healthcare system in Serbia is still mainly financed through a network of employee contributions to a centralised social security system. Total expenditure on health per capita amounted in 2007 to $899 and in 2011 to $1,195, of which general government expenditure per capita in 2007 was $665 (see Marković 2010 and WHO 2011).

6 The ratio of hospital beds to patients is very low (1 bed for 184 patients), yet they are under-utilised (70 per cent) because of inefficiency. A 2002 European Agency for Reconstruction study further found that only a third of hospitals had functioning sterilisation equipment and 75 per cent of the medical equipment in health facilities was more than 10 years old. Patients had to buy their own hospital supplies out of their own pocket, even items such as bandages and catheters (McCarthy 2007).

a number of expensive gynaecological, reproductive, aesthetic, dental and other clinics to serve a wealthy minority. The state health apparatus has also fallen prey to massive corruption, with many documented cases of the misappropriation of funds. Poorly paid doctors, many with family obligations, began to take on additional work in private clinics, often referring patients who came to see them in the morning to their private clinics in the afternoon.[7] Those patients who could pay frequented these clinics because, as in the words of one respondent, 'they were sick of waiting and of the unreliable diagnoses of time-pressed state practitioners'. Medical equipment in state hospitals was often broken (or said to be broken), forcing those in need of ultrasound scanners, ECG exams or X-rays into the hands of the private clinics. Despite a formal prohibition on private clinics' contracting with the state for reimbursement of patients' social insurance, those able to pay for exams and treatment typically abandoned the state sector. This move was hastened by instances of the habit, even of eminent doctors', of asking for cash-in-hand payment (so-called 'red-handing'), as repeatedly exposed in the media. Even if the corruption in healthcare was not necessarily or systematically more prevalent than in other professional fields such as customs, shipping, the judiciary, the universities and accountancy, it was sufficiently marked and documented to figure as one of the major factors preventing rationalisation of the health system (Gredelj, Gavrilović and Šolić 2005: 24). My fieldwork interviewees would repeatedly tell me they simply could not afford to get ill.

My field notes from 2008 of a middle-class conversation in Belgrade illustrate the contempt in which all forms of healthcare, private and public, are held in contemporary Serbia:

> It's a Sunday morning in December and the Belgrade streets are full of people wearing thick coats, fur collars swaddling their necks, heads, and hands to protect them from the wind and biting cold. Their heavy boots and high heels crunch on the icy, snowy pavements. I'm on my way to a children's birthday party hosted by Marina, who is four, and her parents, in their early thirties. He's an investment banker and she an economist with an exceptionally successful career. The house – a children's play and party centre they've hired especially for the occasion – smells festively of winter foods, cinnamon and chocolate. On the upper floor, the children's playrooms are spilling over with soup, fruit, yoghurt, pastry, and puddings. The grown-ups party downstairs, tucking into lamb, different kinds of beans, peppers, potatoes, cheese and salads. Two vegetarian guests are sent upstairs, with the remark that food there might be healthier. A woman responds by bemoaning her child's newly developing food allergy and is consoled by two other women, whose kids similarly suffered from illnesses, infections and intolerance. Their conversation depicts the city's

7 In 2000, the average monthly salary for a doctor was €130 and for nurses €90, compared with the national monthly average of €176, according to the World Bank (McCarthy 2007).

> kindergartens as breeding-grounds for bacteria. Since all the women speaking are employed, they see nursery care for their children as a necessary evil. The boy with a food allergy is summoned from upstairs. His back and his hands are covered with tiny red marks of inflammation. All the women in the circle come closer and start weighing in on the causes of the boy's rash, though none has any medical background. One prescribes a Swiss antihistamine, another the restorative properties of honey; a mother of three hopes that quails' eggs and thyme tea could clear the problem up. The addresses of health food shops selling gluten-free food are written down, even as the boy's mother denies that her child suffers from coeliac disease. Somebody inquires about the level of the boy's erythrocytes. The mother answers that his latest check-up came up perfect. Another woman asks about the paediatrician's diagnosis and how many allergy tests the hospital ran on the child. Rolling back the child's jumper and sending him to rejoin his friends, the mother raises her eyebrows, gives a quick, ironic smile and says that the paediatrician in their local hospital is a joke. He is always endlessly kind, but ceaselessly apologetic, saying that he cannot run any tests as the hospital laboratory is out of reagents. She suspects he is lying, aiming to lure her family to his private practice. They wouldn't object in principle to going private, but have heard that the clinic where he works is no good. The alternative specialist found by her husband has as yet been unable to pinpoint their child's exact food allergy. Everybody nods and empathises. The hostess of the party, Andrijana, offers to make a phone call to their family doctor who is also an immunologist to check whether the child can be seen to at once. In a courteous but business-like tone, she asks to speak to doctor Lidija. From what we can hear the doctor and Andrijana exchange pleasantries in the most polite language. Andrijana apologises for phoning on a Sunday morning in the festive season, and makes an appointment for the mother and child to see the doctor the very same day, Sunday. The mother is excited, grateful and ready to leave for the private clinic at once. Andrijana says: "Don't worry. They won't charge you much. I know them well. And you will be so pleased to send Nikola [the child] there. They have a beautiful, sparkling new clinic, done up with the most contemporary medical equipment brought from Belgium. You will like it, I know".

How to interpret this – in some ways not at all untypical – story? Many of my interviewees, regardless of their financial background, seemed obsessed with their health, with the stories of their scars, injuries and recovery. Elder respondents tirelessly informed me about their frail bodies, mounting varicose veins, bad circulation, high blood pressure, rheumatisms, water retention, kidney trouble and heart problems. They claimed that many of these problems were not related only to their age, and what some called 'embarrassingly old bodies', but were aggravated by their impoverished lives and inability to 'take proper care of themselves' due to the pitifully small pensions they were receiving. Wanting to show they were doing everything they could to take care of themselves, many

made a point of how conscientiously they filled out diagnoses and prescriptions, offering printouts of diagnostic images and hospital discharge notices. They did this whether the medical establishment had pronounced them sick or well. Such heightened attention to health, though, did not extend only to parents and elderly people. My milieu in Belgrade was also one of younger people who casually but obsessively inspected and compared the level of their thrombocytes, red and white blood cell counts, protein profiles, haemoglobin and blood sugar levels, continually diagnosing each other, ascribing this or that condition, and discussing possibilities of therapy or remission. Women in their thirties and forties rarely lost an opportunity to discuss their levels of tyrosine and thyroid-stimulating hormone, exchanges that always saw me at a loss.

These conversations testified to an extraordinarily high level of specialised information among a section of the lay public. The situations in which I overheard the most apparently systematic 'knowledge' of healthcare dispensed were not (or not most usually) those of hospital waiting rooms, but were rather everyday interactions on public buses, in offices, between joggers or among the clientele of bars. The smart talk was all of the best aromatherapists and masseuses in the city. It was almost a mark of urban sophistication to be up to date on dietary supplements, restorative teas, melatonin intake, antioxidants, selenium, broccoli seeds, neem powder and various nutrition products – as if knowing these things was a sign of one's education, wealth and level of self-care. Indeed, the majority of my interviewees seemed constantly to bone up on newspaper articles on tips for a healthy life, reading books, consulting trusted doctors and on occasions becoming devotees of special teas and alternative treatments. Some utterly distressed people who were moneyed enough and open to alternative health practices saw their salvation in homoeopathy, apitherapy, aromatherapy, spiritual medicine, bioresonance therapy, quantum energy treatments[8] and many other healing methods. Those who could not pay for such treatments resorted to traditional and local herbal remedies made at home.

Pharmaceuticals and Humanitarianism

People's supposed knowledge of, and access to, healthcare tended to reflect their social status and aspirations. Their interest in monitoring the state of their health was most likely closely tied to their disillusionment with public healthcare and a sense that the envelope containing their pay cheque might never be fat enough to assure decent medical treatment. In consequence, it appears, many seem to have felt they have to educate themselves about their own conditions, populating the discomfort zone of illness with a host of reassuring health-indicator facts like hormonal and haemoglobin reports. More than disillusionment, however, was

8 Quantum energy treatments are known to many on account of their most famous practitioner – Dr Dragan Dabić, otherwise known as Radovan Karadžić.

involved in their desertion of the state system. Numerous people I had worked with simply seemed avidly fascinated with diagnostic laboratories.

Indeed, during the time the material for this research was collected (2004–2009), whether I thumbed through Belgrade's Yellow Pages or just walked through the city, I was astonished by the enormous number of private pharmacies and diagnostic and haematological laboratories, running into almost three figures, that together with scores of X-ray and ultrasound ambulances, systematically marked out the cityscape. These institutions sprang up in the 1990s with the collapse and isolation of the Yugoslav medicine market and state healthcare provision. The crisis in Serbia's 1990s, forced by United Nations Security Council sanctions, gave the go-ahead to a process of wild privatisation of healthcare and the public pharmaceutical sector, in which private companies were in some cases able to commandeer monopoly market positions and subdue the bargaining power of a highly educated class of chemists.[9] The government granted licences to pharmacies that had (as a sector) never been competently run or sufficiently well equipped. The argument went that a number of health-related laws formerly in force had to be cancelled, in order for the population to get access to medication. The founders of such pharmacies usually had good contacts abroad or were cash-rich enough to be able to buy in medicines from local pharmaceutical companies or drug wholesalers. Their drug stores were hard to differentiate from other aspirational shops, in stocking alongside medicine nutritional products, baby food, cosmetics, chocolates and perfume.

Pharmacies also prospered through their connection with international humanitarian help. During the wars and after, insulin, anaesthetics and medicine for treating infectious, endocrine and cardiovascular disease, psychosis, narcolepsy, kidney ailments and other organ failures were regularly shipped to Serbia and other ex-Yugoslav republics. Instead of ending up at branches of the Red Cross or local health institutes, some of those parcels were allegedly regularly diverted into the hands of those able to buy them for cash – that is, wealthy pharmacists or war profiteers.

Certain pharmacies, further, ran an endemically corrupt business. Public reports have alleged systematic over-prescription as a result of improper relationships between doctors and pharmacists, as well as cases of doctors' countermanding colleagues' diagnoses in order to push a particular line of medicaments with which they had some covert business relation. In this context, people's health increasingly depended on party or family connections, charitable help from humanitarian organisations, or access to the black market. During the war, smuggled drugs cost up to five times their normal price. Especially profitable were sales of Bensadine, Bromazepam and Diazepam, whose massive consumption suggested that the mental health of the population was parlous, with one in every two people in

9 The pharmaceutical industry in Serbia before the wars (with companies such as Hemofarm, Velefarm, Farmanova, Jugohemija, Farmalogist, Erma, Vetfarm, and so on) was small but nonetheless highly developed and profitable.

Serbia reliant on sedatives (Global IDP 2002). Further, according to some of my interviewees, some pharmacies sold a number of fake, unregistered and black-market drugs.

Despite health scandals and scares, for instance, over the degree to which parents had elbowed paediatricians aside in the care of their own children, and other 'portfolios of disasters' (Redfield 2006: 4) documenting patients' self-medication, people's concern to monitor their own health via various laboratory tests barely wavered. Those unable to afford regular check-ups from professionals would arm themselves with newspaper or internet research on trips to the chemist, often buying up antibiotics and other medicine in enormous quantities and an apparently hit-and-miss fashion.[10] Numerous people I spoke to voiced their scepticism about private healthcare's motives but would nevertheless regularly visit biochemical as well as DNA labs, some open 24/7, for self-diagnosis or simply to confirm doctors' examinations. Patients seemed to welcome this personalised approach to medicine and to labs' statistical representation of their health perhaps insofar as it has allowed them to develop their own 'aetiological vernacular'. The question put to Nikola's mother about the possible connection of his food allergy to his erythrocytes level in this sense conveys both care and some supposed, self-imputed medical knowledge. As a matter of fact, it often seemed to me that those particularly invested in healthcare were concerned to amass some sort of intellectual capital in, for example, recalling the provenance of medical equipment and drugs. Something of this can be seen in the pride with which Andrijana praised the Belgium medical technology of Dr Lidija's laboratory or in the manner her guests recommended a particular Swiss antihistamine. Within this framework, the pharmacies and diagnostic laboratories appeared to represent a sort of symbolic site of people's self-determination over their own health, and by extension over their lives.

Images of Medicine, Humanitarian Help and Europe

Although Serbia's health system was in the late 1990s and early 2000s almost entirely dependent on international help, this assistance was not always easy for Serbs to trust. After all, in the view of many NATO also intervened in the name of 'humanitarianism' in bombing Belgrade in 1999. Different international organisations thus faced the problem of how to foster trust in their medical provision. It is doubtless that these organisations have provided massive assistance to many internally displaced or otherwise affected by war. Along with

10 Contrary to the presumption that only wealthier social groups were able to enjoy the private health insurance options, research has shown that it was the middle-income class that used the private health sector most systematically. Nevertheless, private insurance coverage is still shown to be an exception rather than a common practice among the general population (see Marković 2010).

humanitarian health supplies, thousands of tonnes of food were distributed, with households benefiting from micro-credits, vocational training for young people and grants to buy tools, livestock and greenhouses. Government also directed international agencies to provide households with direct gifts of cash. The help, either routed through humanitarian agencies or through pharmacies and clinics, was much needed and therefore welcomed. But it was often also received as a cause for embarrassment among some sections of Serbian society. Western countries' public declarations of sympathy were almost always unanimously rejected. Especially those who denied that the country was at all at fault for the wars did not want a foot-up from 'the Americans'. People further turned against the presumptuousness of foreign largesse when they read local media reports that many medicines donated by humanitarian agencies had passed their sell-by date.[11] Humanitarian aid took over from private pharmacies in bearing the blame for importing and selling unregistered and knock-off medicine. The nation's Clinical Centre, for example, was vocal in complaining that the medicine it acquired in 1999 and 2000 from different humanitarian organisations was little better than some kind of pharmaceutical waste-product. These alleged 12 cubic metres of expired medicaments additionally burdened the hospital with disposal costs (see Derikonjić 2005).

This description of Serbia as the pharma-dump of Europe soured many Serbs against more obvious humanitarian interventions from the European Union and the West. For many, supposed humanitarian acts stank of hypocrisy. Something of this is suggested by the following conversation with a man in his 60s:

> Serbia is an autistic, pre-political, corrupt country, run by a kleptocracy. People respond to all sorts of fears and uncertainties, not in an educated way. Our problem was never the embargo or sanctions. Our problem is our own isolation. We have ruined all what we have had. Just look where we are now. Thirty years ago, Serbs were travelling all around the world. Our industry was good. Our kids were mouthing off that Belgrade was the first city in Eastern Europe to have opened a McDonald's. And where are we now? We're stealing from each other. We live in a corrupt country where people profiteer on each other's misery. One would maybe expect some corruption in the public finances, or in the police, in the customs, but it's the health sector that is most rotten here. [...] Do you know how much I paid for my granddaughter to be born [in 2002]? The tariff for a baby in Belgrade ranges from 300 to 500 EUR. I've heard that the price is calculated per weight – 100 EUR per kilo of a baby. For twins you get a discount. It's like they're selling you meat for grilling. Anaesthesiologists are particularly crazed for money ... . But I paid whatever they told me, and out of

11 Here are just two examples of numerous websites dedicated to fighting the corruption and mulfunctioning of the Serbian healthcare system: http://www.transparentnost.org.rs/ts_mediji/stampa/2005/11NOVEMBAR/18112005.html and http://www.forum-srbija.com/viewtopic.php?f=397&t=16138&start=80 (both accessed 21 July 2015).

> sheer happiness I got such a beauty, I even sent coffee and sweets to the doctor. I was such a fool. That way I allowed these criminals to go on governing us … . But don't believe for one moment that the West treats us any better. Nobody is kid-gloving us. In this country even the humanitarian agencies are corrupt. They nurture their egos imagining they are some sort of angel of the parish, whilst dumping old medicine on us and luring our people into shady clinical research trials. These clinical trials, I tell you, are catastrophic. Foreign pharmaceutical companies are literally abusing our people … . But Serbia is drowning, and it needs somebody's help. It needs someone to grip her by the hair and fish her out of the dirt and mire.

For a somewhat different view, consider the following excerpt from an interview with a 43-year-old publisher:

> Our society may indeed be gripped by apathy at the moment, but it is definitely not as fatalistic, pathological or corrupted as the media and foreign reports portray it. I actually feel safe here. My family and myself have always felt well cared for in the hospitals. I've lived for years in Austria and Belgium and have family all over Germany, and can tell you for sure that our doctors and nurses are far more devoted and kinder than theirs. Far more compassionate … . My aunt has just come out from a hospital [she had spent couple of weeks there due to severe pneumonia]. She is a bit difficult, you know, slightly hypochondriac, on about every conceivable concoction you could think of. Kind of a high-maintenance woman, with awfully high standards when it comes to her health. She's gone through a lot in her life … two wars, two divorces, all kind of bad experiences … . But she praised the doctors and the treatment she had received in the hospital. Sure, the hospital was not a Hilton hotel, but what do you expect … . To be honest she did pull a connection or two before checking in, but nothing too serious. She just wanted to make sure that she would be in good hands. One has to take good care of oneself … . Serbia is in many ways a decayed place. But it is also a good, caring, humane place. Some doctors might be stuck-up sometimes. But expertise and sympathy are never denied here. Never.

Importantly, a number of respondents suggested to me that even when patients seek to establish contacts with doctors through informal channels (that is, through personal familiarity or through family, friends', partners' or acquaintances' connections) this should not be taken as a token of corruption, but rather as a sign of intimacy and care. On numerous instances I have heard people eulogising their physicians, oncologists, drug rehabilitation or mental health experts. These people were respected for their professionalism and for the personal care they had shown to their patients – which had led to many weaning themselves off previously unhealthy and destructive habits. Equally important to note is the fact that numerous medical personnel were also praised for publicly contesting systemic corruption.

My respondents in Serbia are not unanimous in their attitude towards the Serbian health system, nor towards the West, nor about the country's post-war transition or relationship with the European Union (and its versions of democracy). Many will call out domestic corruption, bullying and inefficiency when they see it. At the same time, they refuse to be stigmatised as pathological, backward or unhealthy. Health plays a key role in these discursive struggles over self-evaluation and any remaining power of Serbian self-determination. One of the stronger sentiments that shape such reactions, I believe, is a feeling of humiliation enforced by the comparison of an implicitly (or explicitly) healthy socialist past and diseased post-conflict present. One man half-jokingly, half-acidly explained why he refused to go to the former Yugoslav republic of Slovenia, now part of the EU, for surgery:

> No, no I can't do that to myself. That would be like knowing that you are going to bump into an ex-girlfriend on the street. You know for sure that she still looks great, is toned, healthy, well kept ... obviously bourgeois. She would smile at your with her perfect teeth and ask you how you are whilst eyeing your bald patch, your beer belly, and grey complexion. What could you say? You would try to produce the most charming voice and say *I'm doing great, thanks*. But you would know that you have utterly embarrassed yourself!

Conclusion

In attending ethnographically to the pharmacies and biochemical and diagnostic labs flourishing across Belgrade, and to structural inequalities that have arisen in access to humanitarian medicine in the last 15 years or so, I have hoped to frame some theoretical terms for the analysis of a society both pervasively preoccupied with issues of bodily health and seen as needing psycho-social support. The chapter's aim has been critically to examine the psycho-social and cultural circumstances in which efforts are being made to establish a new political and physiological order in Serbia. My intention has not been to suggest a direct parallel between the health of Serbian citizens and the health (political and physical) of Serbian society. The sum of parts can often be different from the (presumed) whole. Neither have I proposed that those who recognise themselves as ill, or in need of medical assistance, are necessarily internalising the state of what is understood as a fractured society. Yet the ways in which the people I worked with narrate and practise their health concerns show that their bodies are often experienced as sites bearing palpable traces of the country's both conflictual and socialist past.

Moreover, the past (and the present) is often confronted through some form of bodily reckoning. This is not surprising, in that both the international community and local politics have focused on bodies and health as sites through which the past could be rectified. Both national and international agencies see bodily and healthcare interventions as able to ease social ills and re-knit social relations. Diverse actors impute different and heterogeneous assortments of ideas

and values to health. Some feel the need to account for their bodily health as an index of certain personal and social aspirations to move towards a healthy post-war polity, a concept inflected with ideas of democratisation, political settlement and political emotions including (conceivably) pride, guilt and remorse. Other people took up positions in relation to their health that struck me as a sort of strategic autism, like that of the patient refusing to travel to Slovenia, even when they were expressed in a rhetoric of indignation. Talking about health, people made clear the gap that existed between themselves and supposedly richer people, and expressed the desire to close that gap. Indeed, many people's experiences of structural inequality in healthcare provision in post-conflict Serbia become analytically accessible[12] and emotionally describable through their practices, as these work out different emotional and political responses. The majority of my respondents understand health as an explicitly political and politicised category and experience healthcare as a commodity. Supposing a conception of this kind, some resist Western humanitarian help as a route to an ultimately better, or more sophisticated, version of democracy. When doctors are medically interventionist in accessing humanitarian aid, some respondents see this not as healing, or to be taken neutrally, but as politically invasive. Being or appearing dependent on Western healthcare is sometimes understood as shameful.

In spite of the discourse that portrays the management of personal and societal health as an essential means for traversing post-conflict conditions,[13] it is important to stress two things. First, the majority of the people I worked with do not recognise their self-care practices as particularly Serbian. Secondly, they do not experience the post-conflict period as truly a time of healing. Not yet. And maybe they never will. Some even claim that physically they feel worse than they felt in the 1990s. Yet they also seem to want to hold onto an equation between their personhood and their health, even as they reject any amelioration of their health as proposed, in part, by the symbolically therapeutic projects of the international community. These, indeed, are often received as infantilising and hypocritical (Pupavac 2005). Many, further, refuse to be understood in terms of the past – either as guilty for the war or dealing with or recovering from this guilt afterwards.[14]

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12 Bearing in mind that all the 1990s conflicts took place outside of Serbia proper (except for the NATO bombing that destroyed a number of bridges, landmarks and public buildings inside the country), intervention for Serbians also served as an analytical framework to make sense of battles raging hundreds of kilometres away.

13 For rich and illuminating depictions of the moral landscapes of international humanitarianism, see Fassin 2011; Kennedy 2004; Redfield 2006. For analysis of similar struggles over narratives of modernity and backwardness in the vicinity of humanitarian interventions, see Fong 2007.

14 Some are visibly disgusted with what they understand as a situation where their right to healing is denied, because they are supposedly deemed undeserving. For an interesting discussion of the right to healing, see Petryna 2013.

Linked to these statements of personal independence, a number of my informants insist on their autonomy in taking care of their own body and health. They manage their conditions by excessively monitoring their health indicators and by naturalising their ailments through an assumption of (self-bestowed) authority in discussing them. Some project a particular sense of righteousness in criticising international humanitarianism on the one hand, while on the other embracing the potent language of haemoglobin level graphs and access to imported medical materials. The practices people describe of quasi-systematic self-monitoring and -measurement, using aetiological language and treating themselves, should not only be read as a form of healthcare in the last resort (as people lacking access to formal medicine) but also as forms of self-discipline and a particular form of contemporary culture of self-care in Serbia.[15]

Registering various tensions in health work, including forms of attention to the dead and ailing body in transitional Serbia, this chapter has argued that various practices of monitoring one's physiology mark the passing of time since the end of the wars. Some people I have described use their awareness of their health to 'pass through', or traverse, previous social and political identifications; this is often a matter of their insisting they are well (even when they are possibly not), and so making a claim to their autonomy, continued integrity or survival. The notion of good health translates into a range of different ideas: of entrenched inequalities among the population, of physical or social capital, of feelings of suspicion and indignation, and of other personal and social values and expectations. People both act on their expectations vis-à-vis and construct these as conceptual resources, since it is through the circulation of biomedical and political categories of health that people sometimes keep tabs on public modes of post-socialist and post-conflict temporality. Sometimes lacking healthcare, sometimes refusing it in the terms it is offered, people adopt a particular interpretive language of the body in such a way that it grants them authority over their bodies as knowable entities. Their aetiological language, compulsive checking of health indicators, naturalisation of ailments and general self-care are not only healthcare in extremis but may stand for a mode of self-discipline that aspires to record the nation's historical passage as this is irregularly inscribed on the body.

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15 These practices resisting or palliating medicalising conditions of the self, or the body, certainly recall the notion of 'biological citizenship' (Petryna 2002; Rose and Novas 2005). Yet people's eagerness to participate in social constructions of their own health is not always motivated by a desire to take part in 'global corporate or pharmaceutical citizenship' (see Dumit 2010; Ecks 2005; Hayden 2003; Van der Geest 1984a, 1984b).

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