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OF FORMER YUGOSLAVIA / MEDICINSKA ANTROPOLOGIJA
Z OBMOČJA NEKDANJE JUGOSLAVIJE

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Medicinska antropologija

z območja nekdanje

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Osrednja tema prve letošnje številke je »Medicinska antropologija z območja nekdanje Jugoslavije«. Tematski sklop so uredile Uršula Lipovec Čebren, Jelena Kupšjak in Pia Krampl. Šest izvirnih znanstvenih člankov obravnava zgodovinske in sodobne dejavnike oblikovanja javnih zdravstvenih politik: socialistično dediščino in neoliberalno realnost zdravstvenih razmer ter sistemov, (ne)sodelovanje birokracije in skupnosti pri upravljanju javnega zdravstva v Srbiji ter na Hrvaškem, medkulturne komunikacijske prakse in razhajanja v Porodnišnici Ljubljana, dejavnike zdravja migrantov med pandemijo covid-19, tehnokratsko medikalizacijo poroda na Hrvaškem ter žalovanje in smrtnost diabetičnih bolnikov v Beogradu kot sestavni del etnografije. Tematski blok ponuja zastavek obsežnejše in dolgotrajnejše antropološke mreže za aplikativno preučevanje zdravja in zdravstvenih politik v tej evropski posocialistični in migracijski regiji.

V nadaljevanju revije objavljamo članek Vesne Petrič in Sare Sakač »Konstrukcije in trženje kulinarčne identitete na Solčavskem«. Avtorici predstavljata različne individualne in institucionalne dejavnike, ki vplivajo na turistično-gastronomsko ponudbo, ter odpirata vprašanja o predstavah tradicije, njenem obujanju in novih kulinarčnih pobudah na tem turističnem območju Slovenije.

Naša gostja v tej številki je Susan Levine, medicinska, politična in vizualna antropologinja, vodja interdisciplinarnega magistrskega programa Zdravstvene humanistike in umetnosti na Univerzi v Cape Townu. Njene raziskave segajo od aktivizma v zvezi s HIV/AIDS do multimodalne etnografije in umetniških praks. Susan Levine izpostavlja koncept debilitacije, ki vključuje procese trajnega poškodovanja teles in življenjskih svetov v sodobnih razmerjih moči – v vojnah, okoljskih katastrofah, rudnikih in ob sistemskih neenakostih. Z gostjo se je pogovarjala Nežka Struc.

Nena Židov predstavlja knjigo Irene Rožman *Babice na razpotju zgodovine: lik terenske babice od leta 1945 do poznih šestdesetih let*, ki je izšla pri Slovenskem etnološkem društvu (2025). Anuša Babuder opozarja na že drugo, predelano izdajo zbornika *Why the World Needs Anthropology*, ki sta jo uredila Dan Podjed in Carla Guerrón Montero (Routledge, 2025).

Natalia Rygovska nam je poslala poročilo s konference »Deagency« (2025), Tisa Kučan Lah pa z mednarodnega simpozija »Medicinska antropologija z območja nekdanje Jugoslavije« (2024). Jakob Stojanović je povzel pestro družabno dogajanje in razprave na »Etnološkem taboru treh dolin« (2025), Tajda Jerkič pa na simpoziju »Hand-on Ethnographies« (2025). Vse dogodke je (so)organiziral Oddelek za etnologijo in kulturno antropologijo Filozofske fakultete v Ljubljani.

Na koncu revije dodajamo novo rubriko, *Večnačinska antropologija*, ki sta jo zasnovala Matej Mali in Ana Svetel. Večnačinska antropologija je novost v raziskovanju in predstavljanju znanja z različnimi mediji, čutili in sodelovalnimi pristopi. Presega tradicionalne tekstualne in akademske forme ter odpira prostor za vizualne, zvočne, digitalne, eksperimentalne in (pol)literarne načine etnografskega izražanja, kot so fotoeseji, etnografski stripi in skice, avtoetnografije, podkasti, zvočne atmosfere ter druge ustvarjalne metode. Digitalna izdaja revije *Svetovi* spodbuja sodobno povezovanje in predstavljanje različnih avtorskih antropoloških modalnosti.

Novo rubriko odpirajo prispevki študentk in študentov pri predmetu Antropologija in pisanje, ki ga na ljubljanski univerzi vodi dr. Svetel. Sedem besedil nagovarja vprašanja pripadnosti, identitete in afektivnosti jezika ter segajo od večetničnosti Tržiča do terenskih jezikovnih vstopov v Tanzaniji. Besedila ne stremijo k znanstveni sistematičnosti, temveč k iskanju načinov, kako iz osebne izkušnje misliti širše družbene dimenzije jezika.

Pozdravljamo novega člana uredniškega odbora revije Mateja Malija in mu želimo uspešno urejanje rubrike. Bralke in bralce pa vabimo k sodelovanju.



Peter Simonič

1.20 Editorial
DOI 10.4312/svetovi.4.1.8-11

The central theme of this year's first issue is "Medical anthropology from the region of former Yugoslavia." The thematic section was edited by Uršula Lipovec Čebren, Jelena Kupšjak, and Pia Kramp. Six original scientific articles address historical and contemporary factors that shape public health policies in the region: the socialist heritage and the neoliberal reality of healthcare conditions and systems; the (non)cooperation between the bureaucracy and the communities in public health management in Serbia and Croatia; intercultural communication practices and divergences at the Ljubljana Maternity Hospital; health factors affecting migrants during the Covid-19 pandemic; the technocratic medicalisation of childbirth in Croatia; and mourning and mortality among diabetic patients in Belgrade as an integral part of ethnography. This thematic section serves as a flagship for a larger and more enduring anthropological network dedicated to the applied study of health and health policies in this post-socialist and migration region of Europe.

In the continuation of the journal, we publish an article by Vesna Petrič and Sara Sakač entitled "Konstrukcije in trženje kulinarične identitete na Solčavskem" (Constructions and Marketing of Culinary Identity in the Solčava Region). The authors present various individual and institutional agencies that influence the tourist and gastronomic offer and raise questions about the representations of tradition, its revival, and new culinary initiatives in this tourist area of Slovenia.

This issue also features an interview with Susan Levine, a medical, political, and visual anthropologist, head of the interdisciplinary master's programme in Health Humanities and Arts at the University of Cape Town. Her research ranges from HIV/AIDS activism to multimodal ethnography and artistic practices. Levine highlights the concept of debilitation, which involves the processes of permanent damage to bodies and life worlds in modern power relations – wars, environmental disasters, mining, and other system inequalities. She was interviewed by Nežka Struc.

Nena Židov presents Irena Rožman's book *Babice na razpotju zgodovine: lik terenske babice od leta 1945 do poznih šestdesetih let* (Midwives at the Crossroads of History:

The Figure of the Field Midwife from 1945 to the Late Sixties), published by the Slovenian Ethnological Society (2025). Anuša Babuder highlights the second, revised edition of the collection *Why the World Needs Anthropologists*, edited by Dan Podjed and Carla Guerrón Montero (Routledge, 2025).

Natalia Rygovska has sent us a report from the 2025 *Deagency* conference, and Tisa Kučan Lah report on the 2024 international symposium *Medical Anthropology From the Former Yugoslavia*. Jakob Stojanović summarises the various social events and discussions at the *Etnološki tabor treh dolin* (Ethnological Camp of the Three Valleys, 2025), and Tajda Jerkič recounts the *Hands-on Ethnographies* symposium (2025). All of these events were (co-)organised by the Department of Ethnology and Cultural Anthropology at the Faculty of Arts in Ljubljana.

At the end of this issue, we introduce a new section, Multimodal Anthropology, created by Matej Mali and Ana Svetel. Multimodal anthropology is a new approach to exploring and presenting knowledge through various media, senses, and collaborative methods. It goes beyond traditional textual and academic forms, creating space for visual, audio, digital, experimental, and (semi)literary modes of ethnographic expression, such as photo essays, ethnographic comics and sketches, autoethnography, podcasts, soundscapes, and other creative methods. This will enable the digital edition of *Worlds* to support authors exploring the contemporary integration and presentation of diverse anthropological modalities.

The new section opens with the contributions of students in the Anthropology and Writing course, led by Dr Svetel at the University of Ljubljana. The seven texts address issues of belonging, identity, and affectivity of language, ranging from the multi-ethnicity of Tržič to field linguistic entries in Tanzania. The texts do not strive for scientific systematicity, but to find ways to think about the broader social dimensions of language from personal experience.

We would also like to take this opportunity to welcome the newest member of the editorial board, Matej Mali, and wish him success with this new section. We invite our readers to participate and contribute to future issues.

Introduction to Medical Anthropology from the Region of former Yugoslavia



Uršula Lipovec Čebren, Jelena Kupsjak, Pia Krامل

1.20 Editorial
DOI 10.4312/svetovi.4.1.12-17

The special issue before you is a product of decades of fragmented yet deeply collaborative work among scholars across the ex-Yugoslav space, the Balkans, and beyond. The texts gathered here represent only a small glimpse into the exciting, diverse, and growing field of medical anthropology in the region, one that has long been shaped by the historical legacies of social medicine, post-socialist transformations, and the ongoing negotiation of local and global health paradigms.

This issue builds on the foundations laid by the international symposium *Medical Anthropology From the Region of the Former Yugoslavia*, held in Ljubljana on 28–29 November 2024, co-organised by the Departments of Ethnology and Cultural Anthropology at the University of Ljubljana and the University of Zagreb. The symposium brought together researchers from Slovenia, Croatia, Serbia, and Kosovo to reflect on the state of medical anthropology in the region and to explore its distinctive contribution to global debates on health, care, and social justice.

The symposium was conceived as a trilingual event, unfolding in Slovenian, Serbo-Croatian, and English, affirming our commitment to inclusivity, reflecting the linguistic and cultural diversity of the region and its shared anthropological space.

The symposium in Ljubljana has reaffirmed the importance of the region's intellectual and ethical heritage, rooted in the legacy of social medicine and the commitment to universal, accessible healthcare that characterised the socialist period. It also calls for the reintegration of these principles into contemporary anthropological and public health debates, especially as societies across the Balkans navigate neoliberal reforms, healthcare privatisation, and widening inequalities.

At the same time, we insist on decolonising medical anthropology by rejecting neo-colonial frameworks that render non-Western experiences marginal. Instead, we foreground region-specific approaches that highlight how histories of solidarity and public health cooperation can inform broader discussions on health equity and justice. Reflexivity, trans-/

inter-disciplinarity, and collaborative research, across anthropology, sociology, history, and public health, stand at the core of this effort.

We are also acutely aware that while this special issue and the symposium that inspired it focus on the region of the former Yugoslavia, they also have their limitations. The symposium, organised in a short span of time, lacked contributions from colleagues working in Bosnia and Herzegovina, North Macedonia, and Montenegro. This absence reflects not the lack of anthropological work or critical thinking in these contexts, but rather the haste with which we decided to organise this symposium. However, the initiative for this event is much older and is built upon more than two decades of efforts to build regional connections, first by Uršula Lipovec Čebren and Tanja Bukovčan, and later also by Jelena Kupsjak and Ljiljana Pantović.

Beyond the symposium and this publication, the meeting also marked the beginning of an informal network of medical anthropologists, FORMA (Forum for Medical Anthropology, accessible at: <https://med-anthro.org>), which now connects scholars in Slovenia, Croatia, Serbia, and beyond. FORMA aspires to grow into a wider Balkan platform, expanding to include colleagues from all corners of the region. Slowly but steadily, we hope to engage, inspire, and galvanise both medical anthropology in the region and its scholars. We invite all those interested to reach out and join us in this effort.

The Forum for Medical Anthropology (FORMA) emerges as both a network and a practice: a collaborative attempt to think from within the Balkans while remaining globally engaged. By doing so, it not only challenges dominant epistemologies but also illuminates how concepts such as vulnerability, care, and health equity are locally understood and lived. The Balkans' position, on the periphery of Europe yet central to contemporary migration routes, for example, renders it a particularly vital site for understanding global health challenges in context.

The articles that follow exemplify the scope and vitality of medical anthropology in the region. They span questions of embodiment, collaboration, institutional practice, and social justice, each reflecting a facet of the shared commitment to understanding health and care as social, cultural, and political processes. Together, they offer a grounded and reflexive view of what medical anthropology in the Balkans is, and what it might become.

The opening article, "At Home With Medical Anthropology in the Former Yugoslavia: Between Socialist Legacies and Neoliberal Realities" by Tanja Bukovčan and Uršula Lipovec Čebren, traces the development of medical anthropology across the region, highlighting how the discipline has evolved through the intertwined legacies of social medicine, socialist self-management, and post-socialist privatisation. The second contribution, "Between Bureaucracy and Community: Thinking With Public Health Collaboration in Serbia and Croatia" by Jelena Kupsjak and Ljiljana Pantović, addresses the question of collaboration that runs throughout the collection by reflecting on the Yugoslav legacy of social medicine and advocates for more reflexive, equitable, and community-oriented approaches to public health cooperation. Anja Marolt's "Communication Between Healthcare Professionals and Foreign Language Speaking Parents of Newborns at the

Neonatal Intensive Care Unit of the Maternity Hospital in Ljubljana” provides an intimate autoethnographic exploration of linguistic and cultural misunderstandings in one of the most emotionally charged medical environments. The fourth article, “People on the Move During the COVID-19 Pandemic: Health and Access to Healthcare” by Pia Krامل and Neža Vodopivec, addresses the intersection of migration, vulnerability, and health under the pressures of the pandemic. In the fifth article, Danijela Paska’s “The Medicalisation of Childbirth: The Technocratic Model of Birth in Public Hospitals in Croatia”, the author interrogates how biomedical power, social norms and expectations shape women’s reproductive experiences in Croatia. The final contribution, Jelisaveta Fotić’s “Echoes in the Field: Confronting the Unexpected Deaths of Interlocutors in Medical Anthropology Research”, offers a deeply reflexive exploration of the emotional and ethical dimensions of fieldwork when interlocutors pass away.

Together, these six contributions reflect the diversity and critical depth of medical anthropology in the region of the former Yugoslavia. Each engages with questions of embodiment, care, ethics, and power, yet they do so from distinct vantage points, across hospitals, communities, bureaucracies, and personal lives. What unites them is a shared commitment to grounded, engaged, and reflexive anthropology, one that does not merely document social realities but actively participates in reimagining them. In bringing these works into conversation, we hope to strengthen the foundations of a collaborative regional field that continues to learn from its socialist legacies while confronting the inequalities of the present, and that builds bridges of knowledge, care, and solidarity.

Uvod v Medicinsko antropologijo na območju nekdanje Jugoslavije



Uršula Lipovec Čebren, Jelena Kupsjak, Pia Krampf

1.20 Uvodnik
DOI 10.4312/svetovi.4.1.12-17

Posebna številka pred vami je rezultat desetletij razdrobljenega, vendar globoko prepletene-ga dela raziskovalk in raziskovalcev z območja nekdanje Jugoslavije, Balkana in širše. Zbrani prispevki dajejo le bežen vpogled v raznoliko, vznemirljivo in rastoče polje medicinske antropologije v regiji, polje, ki ga od začetka oblikujejo zapuščine socialne medicine, posocialistične preobrazbe ter neprestana soočanja lokalnih in globalnih zdravstvenih paradigem.

Pričujoča številka izhaja iz mednarodnega simpozija »Medicinska antropologija z območja nekdanje Jugoslavije«, ki je potekal 28. in 29. novembra 2024 v Ljubljani v soorganizaciji oddelkov za etnologijo in kulturno antropologijo Univerze v Ljubljani ter Univerze v Zagrebu. Na simpoziju so zbrani raziskovalci in raziskovalke iz Slovenije, Hrvaške, Srbije in s Kosova premišljevali o stanju medicinske antropologije v regiji ter pokazali na njene edinstvene prispevke h globalnim razpravam o zdravju, skrbi in socialni pravičnosti.

Simpozij je bil zasnovan kot trijezični dogodek, potekal je v slovenščini, srbohrvaščini in angleščini kot dokaz naše zavezanosti vključevalnosti ter kot izraz jezikovne ter kulturne razgibanosti regije in njenega skupnega antropološkega prostora.

Simpozij v Ljubljani je dokazal pomembnost intelektualne in etične dediščine območja, ukoreninjene v zapuščini socialne medicine ter zavezanosti univerzalnemu, dostopnemu zdravstvu, ki sta zaznamovala socialistično obdobje. Hkrati pa je pomenil svojevrsten poziv k ponovni integraciji teh načel v sodobne antropološke in javnozdravstvene razprave, še posebej v času, ko družbe po Balkanu krmarijo med neoliberalnimi reformami, privatizacijo zdravstva ter vse večjimi neenakostmi.

Sočasno pa smo na simpoziju z zavračanjem neokolonialnih okvirov, ki nezahodne izkušnje poskušajo zapečatiti kot marginalne, izpostavili pomen dekolonizacije medicinske antropologije. V ospredje smo postavili regionalno specifične pristope, ki izpostavljajo, kako lahko pretekle oblike solidarnosti ter sodelovanja na področju javnega zdravja napajajo širše diskusije o enakosti in pravičnosti v zdravju ter zdravstvu. Refleksivnost, trans-/interdisciplinarnost in sodelovalno raziskovanje na področju antropologije, sociologije, zgodovine ter javnim zdravjem so jedro teh prizadevanj.

Čeprav sta omenjen simpozij in posebna številka osredotočena na območje nekdanje Jugoslavije, se zavedamo njihovih omejitev. Na simpoziju, organiziranem v kratkem časovnem okviru, so umanjkali prispevki kolegic in kolegov, ki delujejo v Bosni in Hercegovini, Severni Makedoniji ter Črni gori. Ta odsotnost ni posledica pomanjkanja antropoloških raziskav ali kritičnega mišljenja v teh kontekstih, temveč bolj naglice, v kateri smo organizirali simpozij. Prvotna pobuda zanj pa je veliko starejša: temelji na več kot dveh desetletjih prizadevanj za vzpostavitev regionalnih povezav; sprva sta si zanje prizadevali Uršula Lipovec Čebren in Tanja Bukovčan, kasneje pa še Jelena Kupsjak in Ljiljana Pantović.

Srečanje je poleg simpozija in te publikacije prineslo tudi oblikovanje neformalne mreže medicinskih antropologinj in antropologov – FORMA (Forum medicinske antropologije, dostopno na: <https://med-anthro.org>), ki trenutno povezuje raziskovalke in raziskovalce iz Slovenije, Hrvaške, Srbije ter onkraj. Cilj FORME je prerasti v širšo balkansko platformo ter doseči kolege in kolegice z vseh koncev regije. Počasi, vendar vztrajno želimo vključiti, navdihniti in spodbuditi tako medicinsko antropologijo v regiji kot raziskovalce in raziskovalke s tega področja. Vse zainteresirane vabimo, da se nam pridružite na tej poti.

Forum medicinske antropologije (FORMA) obstaja hkrati kot mreža in kot praksa: je sodelovalni poskus misliti iz Balkana ter obenem ostati globalno vpet. S tem ne le izpodbija dominantne epistemologije, temveč tudi pokaže, kako so koncepti, kot so ranljivost, skrb in enakost v zdravju in zdravstvu, razumljeni ter živeti lokalno. Položaj Balkana na periferiji Evrope ter hkrati v središču današnjih migracijskih poti ga oblikuje v še posebej pomemben prostor za kontekstualno razumevanje izzivov globalnega zdravja.

Članki, ki sledijo, prikazujejo razsežnosti in pomembnost medicinske antropologije v regiji. Porajajo vprašanja utelešenja, sodelovanja, institucionalne prakse in socialne pravičnosti, pri čemer vsak od njih predstavlja svojo plat skupne zavezanosti razumevanju zdravja, zdravstva in nege kot socialnih, kulturnih in političnih procesov. Skupaj ponujajo utemeljen in refleksiven pogled na to, kaj medicinska antropologija na Balkanu je ter kaj bi lahko postala.

Uvodni članek, »Doma z medicinsko antropologijo v nekdanji Jugoslaviji: med socialistično dediščino in neoliberalno realnostjo« Tanje Bukovčan in Uršule Lipovec Čebren, sledi razvoju medicinske antropologije na območju nekdanje skupne države ter osvetljuje, kako se je disciplina oblikovala v prepletu zapuščin socialne medicine, socialističnega samoupravljanja in posocialistične privatizacije. Drugi prispevek, »Med birokracijo in skupnostjo: razmišljanje s sodelovanjem na področju javnega zdravja v Srbiji in na Hrvaškem« Jelene Kupsjak in Ljiljane Pantović, odpira vprašanje sodelovanja, ki preči vse tukaj objavljene članke, z reflektiranjem jugoslovanske zapuščine socialne medicine ter zagovarja bolj reflektivne, nepristranske in na skupnost osredotočene pristope k sodelovanju v javnem zdravju in zdravstvu. »Sporazumevanje med zdravstvenim osebjem ter tujejezičnimi starši novorojenčkov v Enoti intenzivne nege in terapije prezgodaj rojenih novorojencev Porodnišnice Ljubljana« Anje Marolt prinaša intimno avtoetnografsko raziskavo jezikovnih in kulturnih nesporazumov v enem najbolj čustveno nabitih medicinskih okolij. Četrty članek, »Ljudje na poti med pandemijo covid-19: zdravje in dostop do zdravstva« Pie Krampl in Neže

Vodopivec, se ukvarja s presečišči migracij, ranljivosti in zdravja pod pritiski pandemije. V petem prispevku, »Medikalizacija poroda: tehnokratski model rojstva v javnih bolnišnicah na Hrvaškem«, Danijela Paska proučuje, kako biomedicinska moč, družbene norme in pričakovanja krogijo reproduktivne izkušnje žensk na Hrvaškem. Zadnji prispevek, »Odmevi na terenu: soočanje z nepričakovanimi smrtmi sogovornikov v raziskavah medicinske antropologije« Jelisavete Fotić, pa ponuja globoko reflektivno raziskovanje čustvenih in etičnih razsežnosti terenskega dela v primeru smrti sogovornice oziroma sogovornika.

Teh šest prispevkov skupaj izkazuje raznolikost in kritičnost medicinske antropologije na območju nekdanje Jugoslavije. Vsak od njih se ukvarja z vprašanji utelešenja, skrbi, etike in moči, vendar z zelo različnih izhodišč – od bolnišnic, skupnosti, birokracije do zasebnih življenj. Druži pa jih zavezanost utemeljeni, angažirani in reflektivni antropologiji, taki, ki ne le dokumentira družbene realnosti, temveč dejavno sodeluje v njihovem zamišljanju. Upamo, da bomo s prispevki utrdile temelje regionalnega sodelovanja, takega, ki nenehno črpa iz svojih socialističnih zapuščin in se hkrati spopada z neenakostmi današnjega časa, ter takega, ki gradi mostove znanja, skrbi in solidarnosti.

At Home With Medical Anthropology in the Former Yugoslavia: Between Socialist Legacies and Neoliberal Realities



Doma z medicinsko antropologijo v nekdanji Jugoslaviji:
med socialistično dediščino in neoliberalno realnostjo

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ABSTRACT

The article traces the development of medical anthropology in the former Yugoslav region, highlighting how the discipline has evolved through the legacies of social medicine and socialist self-management and, in recent decades, as a response to neoliberal trends in healthcare. The authors understand this region as a site of epistemic resistance and creativity, where scholars respond to shifting healthcare landscapes by rethinking the boundaries between critique and care, theory and practice. Drawing on a wealth of regional references and field experiences, the article offers both a historical and conceptual grounding for this special issue of *Svetovi/Worlds*, framing medical anthropology in the Balkans as simultaneously local and transnational, reflexive and politically engaged.

KEYWORDS: medical anthropology, former Yugoslavia, social medicine, socialist self-management, neoliberalism

IZVLEČEK

Članek sledi razvoju medicinske antropologije na območju nekdanje Jugoslavije ter poudarja, da je ta disciplina zrasla iz dediščine socialne medicine in socialističnega samoupravljanja ter se v zadnjih desetletjih odziva na neoliberalne trende v zdravstvu. Avtorici območje nekdanje Jugoslavije razumeta kot prostor epistemološkega odpora in ustvarjalnosti, kjer se raziskovalci in raziskovalke odzivajo na spreminjajoče se razmere v zdravstvu z razmislekom o mejah med kritiko in oskrbo, teorijo in prakso. Članek, ki črpa iz bogatih regionalnih referenc in izkušenj s terena, ponuja tako zgodovinsko kot konceptualno pod-

lago za tematsko številko Svetov, obenem pa postavlja okvir medicinske antropologije na Balkanu, ki je sočasno lokalna in transnacionalna, reflektivna in politično angažirana.

KLJUČNE BESEDE: medicinska antropologija, nekdanja Jugoslavija, socialna medicina, socialistično samoupravljanje, neoliberalizem

The field of medical anthropology in the post-Yugoslav space developed through a unique set of historical and political trajectories that set it apart from the discipline's dominant paradigms as formed in the so-called Global North. While drawing on the broader anthropological canon, its epistemological foundations, empirical orientations, and ethical commitments have been deeply shaped by the region's legacy, the transition, and the fragmented and unequal landscape of post-socialist healthcare. The *Medical Anthropology from the Region of the Former Yugoslavia* symposium held in Ljubljana in November 2023,¹ and the articles in this special issue of *Svetovi/Worlds* – produced by scholars researching in ethnology, medical anthropology, public health, biomedicine, and adjacent fields – reflect this diverse and entangled inheritance, offering a critical and regionally grounded contribution to medical anthropology as both a local and transnational project.

The two key aspects through which medical anthropology in the former Yugoslav region (SFRY) can be most productively understood are the historical project of Yugoslav social medicine and the region's enduring articulation through the concept of periphery. Former Yugoslavia (1945–1991) was a federation of six republics and two autonomous provinces, based on a socialist system and established on the ideal of a classless society (Mihelj 2021). Yugoslavia was also one of the founders of the Non-Aligned Movement (NAM) in 1961, which sought to counterbalance the Cold War's bipolarisation with a "third way" based on the principles of peace, cooperation, and equality (Stubbs 2023). Guided by equality as a defining feature of the SFRY project, the state aimed to guarantee universal access to social rights, including social security and healthcare; this vision materialised most tangibly after 1970, when healthcare became universally accessible and health rights were extended to all citizens. As early as 1947, the former Yugoslavia had established compulsory health insurance for all employed citizens (Toth 2003: 442), later extending coverage to non-employed citizens and the broader population in 1962. A decisive transformation followed in the 1970s with the institutionalisation of the system of workers' self-management (*delavsko samoupravljanje*) and the growing autonomy of the individual republics, which enabled each to regulate its own healthcare system within a shared socialist framework. In Slovenia, for example, the new law enabled health insurance beneficiaries within the so-called health insurance community (*skupnosti zdravstvenega zavarovanja*) to determine their healthcare and provided other rights

1

This international scientific symposium was co-organised by the Departments of Ethnology and Cultural Anthropology at the Faculty of Arts, University of Ljubljana, and the University of Zagreb on 28 and 29 November 2024 in Ljubljana. Colleagues from the Zadar and the Beograd departments also joined representatives from the Ljubljana and the Zagreb departments in collaborating in the symposium's scientific committee.

(ibid.: 450–451). This law ensured cohesive healthcare organised on the principle of solidarity and a high level of social security (ibid.: 451). After 1974, health rights were further extended. The term “insured” was gradually abolished, and health insurance communities were replaced by self-governing communities of interest (*samoupravne interesne skupnosti – SIS*), where representatives of providers and workers decided on all healthcare issues and on the rights and obligations of insured persons – so that the level of healthcare contributions could be decided jointly (ibid.: 454, 462). This self-management model of healthcare brought about many positive changes (universally accessible health services, autonomous healthcare with opportunities for contributor co-determination, a very wide and well-functioning network of primary healthcare, etc.) but also severe drawbacks (fragmentation of the healthcare system, indebtedness due to investments beyond financial capacity, etc.), which are said to have contributed to the financial collapse of the Yugoslav healthcare system in the late 1980s (Albrecht 2010: 64).

However, this was not the first time in more recent European history that the idea of universal healthcare was a political issue. The ideology of social medicine emerged in the 19th century, shaped by thinkers like Rudolf Virchow, who argued that health is fundamentally determined by social conditions such as poverty, housing, and education. Rooted in the belief that medicine must address the structural causes of illness, social medicine called for state responsibility in ensuring health for all. This vision gained institutional traction in the 20th century, especially after World War II, and through movements like the World Health Organisation’s *Health for All by the Year 2000* campaign. Hence, health was not only a right but a collective good, enshrined in public policy and embedded in social imaginaries. Healthcare infrastructure was developed with particular attention to rural populations and underdeveloped regions, partly through programs of local public health networks and facilities. Health, in this framework, was not an individual asset but a shared obligation – care was not privatised, it was socialised. These legacies have left an enduring mark not just on healthcare institutions, but on how anthropologists in the region think about responsibility, justice, and the very object of health (Bilić 2012).

The post-1990s period saw not only war and state collapse in the region but also the introduction of the capitalist system with the rapid introduction of neoliberal reforms. The healthcare systems of the Yugoslav successor states were swiftly restructured through different – more or less successful – attempts at privatisation, decentralisation, and austerity (Stubbs and Zrinščak 2009). This created new inequalities and inequities in access and outcomes, leading anthropologists to investigate the intersections of health, class, gender, ethnicity, and geography in innovative and urgent ways. Anthropologists in the region have been particularly attuned to the contradictory realities of everyday health practices: the co-existence of public and private care, formal and informal economies, biomedical and traditional healing, as well as the intimate negotiations patients undertake to secure treatment and retain their dignity (e.g. Lipovec Čebren and Pistotnik 2018; Šimenc 2014; Žagar 2015; see also Balen 2017; Inhorn 2006; Lock and Nguyen 2010).

The former Yugoslavia, and the Balkans more broadly, have long been conceptualised by some authors as Europe’s semi-periphery – a zone of transition, pathology, and back-

wardness (Bakić-Hayden 1995; Todorova 1997). This orientation is shaped in part by the region's ongoing marginality in European and global imaginaries. However, the Balkans can be understood not only as a geographically, politically, and economically marginal area of Europe and/or the European Union, but also as a place where social relations and processes are “spatially, symbolically, discursively, and in other ways established in the contrast between the periphery and the center, and between different peripheries as well: internal and external, coming from within an area and from the surrounding areas (Kojanić 2020)” (Hameršak et al. 2025: 2). In this sense, the periphery can be understood as a relational category and as a “liminal area with its own dynamics – a stage for encounters, recognition, negotiations, and conflicts” (Majstorović 2021). As Ksenja Vidmar Horvat notes, it is also a space that disrupts “the global flow of history” (Vidmar Horvat 2018: 16). Medical anthropology in this space can thus be seen as a form of epistemic resistance: a refusal of imposed temporalities, geopolitical inferiority, and developmental teleologies. Anthropologists in the region often challenge marginalisation and reframe it as a site of epistemic productivity. In this sense, anthropology at home is not parochial but powerfully political (Kleinman 1995).

Working from and within the region, however, also demands a continuous reflection on positionality. The duality of being both insider and ethnographer poses distinct methodological and ethical challenges (Narayan 1993). Anthropology at home brings the promise of proximity, but also the burden of complicity. Our own experiences as users of healthcare systems, as researchers in post-socialist institutions, and as participants in wider political and moral economies inform – and at times unsettle – our analyses. Researchers usually embrace such reflexivity, not to paralyse but to reorient inquiry toward more situated, accountable, and dialogic forms of knowledge (Petrović 2018; Scheper-Hughes 1995).

In a broader context, medical anthropologists have, since the 1960s, worked as consultants for national and international health organisations and projects, as well as in hospitals and health centres in Western countries, Latin America, Africa, and Asia. By the 1970s, medical anthropology had become an established academic field, first within anthropology departments and later in medical schools and faculties of health sciences. Medical anthropology in the former Yugoslavia, as a result of the historical and epistemological developments discussed above, was institutionalised in ways that reflected its unique socio-political and disciplinary context, and the development of medical anthropology in the region proceeded more slowly, partly due to the dominance of social medicine, which already successfully addressed many issues that elsewhere fell under the field of medical anthropology. As late as the end of the 1980s, Slovenian anthropologist Borut Telban observed that “medical anthropology is practically non-existent in Slovenia” (Telban 1989: 153). However, from the late 1990s onwards, this began to change. As the region opened up to international academic exchange and disciplinary diversification, medical anthropology gradually took shape within departments of ethnology and cultural anthropology across the region, including Croatia, Serbia, and Slovenia. Over time, professional and personal connections among medical anthropologists in these departments began to take shape. Yet it is only in recent years that these initially fragmented networks have evolved into coordinated, collective initiatives uniting researchers in medical anthropol-

ogy from the former Yugoslavia and, more broadly, the wider Balkan region. As a result, the symposium *Medical Anthropology From the Region of the Former Yugoslavia* was organised in 2025, where the Founding Assembly of the FORMA – Forum of Medical Anthropology (<https://med-anthro.org/>) was established. Based on the contributions presented at the symposium, which brought together twenty researchers from across the former Yugoslavia, five key themes emerged that were common to all participants. We suggest that these shared concerns reflect both the enduring legacy of social medicine and post-socialist contexts, as well as the region's peripheral positioning within broader academic and geopolitical frameworks.

First, all the contributions reveal an enduring orientation toward the public: public healthcare, the public good, and public responsibility. Against the grain of global neoliberalism, which frames health as a matter of individual responsibility, the authors repeatedly return to the notion that health is collective (Bukovčan 2022; see also Baer, Singer and Susser 2003; Farmer 2013). Their ethnographies make visible the infrastructures of abandonment in remote areas, single households, and migrant lives, as well as the fragile solidarities that emerge in their wake. All the articles in this issue engage, to varying degrees, with public healthcare, a theme most centrally explored in *Between Bureaucracy and Community: Thinking With Public Health Collaboration in Serbia and Croatia* by Jelena Kupsjak and Ljiljana Pantović. The authors reflect on the erosion of the Yugoslav legacy of social medicine, which once emphasised equity, community participation, and decentralised care, and consider what remains of that model today. Drawing on a comparative ethnography of public health institutions and professionals in Belgrade, Novi Sad, Zagreb, and Rijeka, Kupsjak and Pantović analyse how bureaucratic, participatory, and transformative forms of collaboration emerge, coexist, and conflict within contemporary health systems. Their article conceptualises collaboration not as an unquestioned ideal, but as a complex and often fragile social practice, while advocating for more reflexive, equitable, and community-oriented approaches to public health cooperation. In this sense, the piece reflects on both the erosion and the enduring resonance of the Yugoslav legacy of social medicine and public healthcare.

Second, directly related to the first theme but focused more on the meta-language of (in)equity, the research in the region demonstrates that a shared conceptual and ethical vocabulary of equity persists across the region. This vocabulary is not simply a residue of socialism, but a living resource – albeit one under strain. Scholars continue to draw on ideas of justice, equity, and solidarity, not nostalgically, but pragmatically: as tools to analyse and critique current configurations of care and neglect (Petryna 2002). The former Yugoslav space, in this sense, remains a site of anthropological innovation – not because it is exceptional, but because it foregrounds increasingly global contradictions between privatisation and universality, policy and practice, scarcity and survival. This is specifically reflected in the articles where authors share the conviction that healthcare should be equally accessible to all residents and that the obstacles that reduce the principles of justice, equity, and solidarity must be identified, analysed, and eliminated. This line of thinking is most visible in Anja Marolj's *Communication Between Healthcare Professionals and Foreign Language Speaking Parents of Newborns in the Neonatal Intensive Care Unit of the Maternity Hospi-*

tal in Ljubljana. This one year-long autoethnographic exploration of linguistic and cultural misunderstandings in the Neonatal Intensive Care Unit, where the author works as a midwife, reveals many communication obstacles between healthcare professionals and foreign language speaking family members of newborns. Through several ethnographic examples, Marolt shows how the medical staff attempt to overcome communication barriers using a range of strategies that are often improvised and do not guarantee quality healthcare. In these multilingual contexts, where healthcare workers and family members are left to their own devices, the author calls for systemic support to address linguistic, cultural, and other barriers in order to ensure equitable healthcare.

Third, as the Balkans remain one of the key routes in Europe's migration pathways, medical anthropologists are also increasingly called upon to document, interpret, and intervene in the entanglements of mobility, legality, and care (Lipovec Čebtron 2025; Petrović-Šteger 2022; see also Ticktin 2011). Mainstream policies often erase or homogenise local experience; anthropology, in contrast, insists on specificity, on context, and on voices that too often remain unheard. The region, once a laboratory of socialist public health, is now a terrain of contested health futures. What role anthropology can – and should – play in shaping those futures is a question that cuts across the contributions of this thematic issue. In this sense, the experiences of the most marginalised – among whom people with migration backgrounds are often underrepresented – tend to foreshadow trends that the broader population may face later. This is clearly illustrated in the article *People on the Move During the COVID-19 Pandemic: Health and Access to Healthcare* by Pia Krampl and Neža Vodopivec. The authors show how inequities intensified during the health crisis and how the pandemic exacerbated existing forms of structural violence and structural vulnerability. Drawing on ethnographic research with migrants and refugees in precarious legal situations conducted as part of the Sonar-Global project, the article demonstrates how the intersection of legal status, precarious living conditions, and structural discrimination affect both health and access to healthcare – and how, in this context, migration can be understood as a social determinant of health. Moreover, by examining the intertwining of migration, vulnerability, health, and healthcare access during the Covid-19 pandemic in Slovenia, the authors reveal transformations in social structures that are likely to produce even more pronounced structural barriers to health and healthcare for many Slovene residents in the post-pandemic period.

Fourth, many of the contributions at the symposium were positioned between research and implementation, theory and application, “basic research” and “socially transformative activities”, showing the persistent discomfort concerning these divisions – ones that continue to structure much of contemporary academic knowledge production, especially under Western epistemological regimes (Janes 2016; Baer, Singer and Susser 2003). Medical anthropologists working in post-Yugoslav contexts – whether in public health programs or in academic institutions – rarely frame their work as exclusively theoretical or applied. Instead, they navigate and negotiate these registers simultaneously, seeing them not as antagonistic, but as mutually constitutive. Moreover, they do not follow the common idea of the hierarchicalisation of theoretical versus practical or engaged approach. Besides the in-depth

research and analysis, they try to answer the question in what way their research findings can contribute to social and especially to healthcare transformations (e.g. Huber et al. 2020; Lipovec Čebren and Pistotnik 2024). This is true for all the articles which employ theoretical apparatus and different methods to respond to one or more urgent social problems and do not hide their engaged or activist positioning. This is evident also in Danijela Paška's paper *The Medicalisation of Childbirth: A Technocratic Model of Birth in Public Hospitals in Croatia*, in which the author examines how biomedical power, regulatory forces, and social expectations shape experiences of childbirth in Croatian public hospitals. The author shows how the medicalisation of birth and the adoption of a technocratic model of care transform the female body into a reproductive machine, and childbirth becomes a site of control and objectification. By employing a Foucauldian perspective and cultural-anthropological concepts, Paška undertakes a discourse analysis of Croatian public policies in the field of reproductive health, as well as analyses the lived experiences of women that gave birth in public hospitals in Croatia. In doing so, the author demonstrates how different forms of obstetric violence reflect the disciplining of women's bodies, enforcing passivity and compliance, and serve as a tool to regulate pregnancy and childbirth. The author exposes obstetric violence as part of a continuum of patriarchal power relations, and she calls for a transformation of obstetric care that would be able to acknowledge women's needs, autonomy, and subjectivity.

Fifth, the hybrid positioning between engaged collaboration and conceptual critique has opened up space for what could be called a third mode of medical anthropology, one which simultaneously questions biomedical power and contributes to health practice (Farmer, 2004; Singer, 2004). In this regard, the region offers not just case studies, but methodological insights. As Byron Good (1994) once reflected, it was something of an embarrassment to be identified as a medical anthropologist during the 1960s: "Social theory was largely peripheral to this discipline, and given the splendid debates among structuralists, ethnoscientists, symbolic anthropologists, linguists, and ethnolinguists, all committed to rethinking cultural studies, medical anthropology seemed a kind of poor cousin" (1994: 4). Years later, as Paul Farmer and Arachu Castro (2007) argued, the discipline developed a "sophisticated theoretical discourse." Yet, in the post-Yugoslav region, this discourse gained a new inflection, one oriented not only toward critique but toward care, not only toward conceptual innovation but toward systemic repair (Langwick, 2011). In this context, this emerging model of engaged medical anthropology could prove to be especially urgent and relevant in today's context, where healthcare is increasingly commodified, and the ideals of equity and accessibility are under threat (Biehl and Petryna 2013; Fassin 2012).

In the articles written by the symposium participants, some of the most innovative insights arise from addressing unexpected themes and reflecting on researchers' positionalities, as demonstrated by Jelisaveta Fotić in the article *Echoes in the Field: Confronting the Unexpected Deaths of Interlocutors in Medical Anthropology Research*. This paper is based on her ethnographic research with elderly people living with diabetes in Belgrade, as well as on her own experience as both an anthropologist and a person living with diabetes. The author argues that grief and mortality are not disruptions to the research, but analytical

events integral to ethnography. Therefore, instead of ignoring and repressing the situations when interlocutors pass away, the author explores the emotional and ethical dimensions of these fieldwork events. Fotić shows that reframing loss in this way advances medical anthropology's engagement with chronicity and death, and contributes to innovative reflection on vulnerability and ethics in medical anthropology. The author concludes the paper with an engaged, activist reflection on the death of interlocutors in anthropological research and states: "Activist research can represent a 'good enough anthropology', which forces anthropologists to 'get down from their thrones of authority and pure research' (Huschke 2015: 64) and find meaningful ways to somehow help the people they study."

This special issue on medical anthropology in and of the former Yugoslavia's region represents both a continuation and a rupture. It extends a tradition of critical, empirically grounded, and socially engaged scholarship, yet it simultaneously breaks with earlier frameworks by confronting emergent and urgent challenges: migration, medical markets, privatisation, and the extraction of knowledge itself. What unites the contributors is a resolute refusal to remain neutral. For the authors featured here, medical anthropology is not a detached academic exercise; it is an ethical and political intervention. It refuses mere description, insisting instead on the responsibility to rethink, reshape, and reimagine the world – challenging entrenched hierarchies of power, knowledge, and care, and demanding that scholarship take a stand in the face of structural injustice.

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TANJA BUKOVČAN, URŠULA LIPOVEC ČEBRON
*At Home With Medical Anthropology
 in the Former Yugoslavia: Between
 Socialist Legacies and Neoliberal Realities*

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Prispevek prikazuje, kako se je področje medicinske antropologije v postjugoslovanskem okolju razvilo na podlagi edinstvenega niza zgodovinskih in političnih poti, kar jo razločuje od dominantnih paradigem discipline, ki so se oblikovale na tako imenovanem globalnem Severu. Avtorici opisujeta regijo nekdanje Jugoslavije kot prostor antropološke inovacije, ne zato, ker bi bila tako posebna, temveč ker v ospredje postavlja vse bolj globalne kontradikcije: med privatizacijo in univerzalnostjo, pravili in prakso ter pomanjkanjem in preživetjem. Nadalje dokazujeta, da je medicinsko antropologijo v tej regiji najproduktivneje razumevati v okviru dediščine jugoslovanske socialne medicine in artikulacije regije na podlagi koncepta periferije.

Simpozij »Medicinska antropologija z območja nekdanje Jugoslavije« ter članki v tej posebni številki odsevajo to pluralno in prepleteno dediščino ter ponujajo kritičen in regionalno utemeljen prispevek k medicinski antropologiji kot lokalnemu in obenem transnacionalnemu projektu. Avtorice pokažejo, kako je ta skupna dediščina zaznavna v številnih vidikih. Prvič, vsi prispevki razkrivajo še danes prisotno usmerjenost v javno: javno zdravstvo, javno dobro in javno odgovornost. Avtorice se vedno znova obračajo stran od globalnega neoliberalnega toka, ki uokvirja zdravstvo kot stvar individualne odgovornosti, k ideji, da je zdravstvo kolektivno. Drugič, raziskave v regiji kažejo, da se je skupni konceptualni in etični besednjak pravičnosti obdržal na celotnem območju. Besednjak ni le ostanek socializma, temveč živi vir – četudi pod stalnimi pritiski. Raziskovalke in raziskovalci še danes črpajo iz idej pravice, pravičnosti in solidarnosti, ne iz nostalgичnih, ampak iz pragmatičnih razlogov. Tretjič, ker Balkan ostaja ena ključnih evropskih migracijskih poti, je tudi vloga medicinskih antropologinj in antropologov z dokumentiranjem, interpretiranjem ter interveniranjem v prepletenih mobilnosti, iregularnosti in oskrbe vse pomembnejša. Regija, ki je bila nekoč laboratorij socialističnega javnega zdravstva, je danes teren nasprotujočih si prihodnosti zdravstva. Četrtoč, številni prispevki s simpozija se umeščajo med teorijo in uporabo, »temeljne raziskave« in »družbenotransformativne« dejavnosti, ter kažejo, kako pomembno je krmarjenje med tema registroma in njuno opredeljevanje, in sicer ne kot antagonistična, temveč kot vzajemno konstitutivna. Petič, hibridno umeščanje – med angažiranim sodelovanjem in konceptualno kritiko – je odprlo prostor za nekaj, kar bi lahko imenovali tretji pristop medicinske antropologije, ta, ki hkrati preizprašuje biomedicinsko moč in prispeva k zdravstveni praksi. V tem pogledu regija ne ponuja le študij primera, temveč omogoča metodološke vpoglede ter vse bolj angažirano medicinsko antropologijo, ki bi se lahko izkazala kot nujna in relevantna v sodobnem kontekstu, kjer je zdravstvo vse bolj poglobljeno, ideala pravičnosti in dostopnosti pa ogrožena.

Between Bureaucracy and Community: Thinking With Public Health Collaboration in Serbia and Croatia



Med birokracijo in skupnostjo: razmišljanje s sodelovan-
jem na področju javnega zdravja v Srbiji in na Hrvaškem

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ABSTRACT

This article explores how collaboration operates as both a concept and a practice in the post-socialist public health systems of Serbia and Croatia. Drawing on ethnographic research and expert interviews, it identifies diverse, often conflicting forms of collaboration. By tracing continuities and ruptures with Yugoslav social medicine, the article argues for reflexive, power-aware forms of partnership in contemporary health governance.

KEYWORDS: public health, collaboration, social medicine, post-socialist health systems, medical anthropology, epistemic partnership

IZVLEČEK

Prispevek proučuje, kako sodelovanje hkrati deluje kot koncept in kot praksa v postsocialističnih sistemih javnega zdravstva v Srbiji ter na Hrvaškem. Na podlagi etnografske raziskave ter intervjujev s strokovnjaki in strokovnjakinjami opredeljuje raznolike, pogosto nasprotujoče si oblike sodelovanja. Z ozirom na kontinuitete in prelome z jugoslovansko socialno medicino članek zagovarja refleksivne ter razmerja moči upoštevajoče oblike partnerstva v sodobnem upravljanju zdravja.

KLJUČNE BESEDE: javno zdravje, sodelovanje, socialna medicina, postsocialistični zdravstveni sistemi, medicinska antropologija, epistemična partnerstva

INTRODUCTION

This article emerges from our small collaborative ethnographic project.¹ As two medical anthropologists, one based in Croatia and the other in Serbia, we bring to this research not only our disciplinary training and field experience but also the shared frustrations, questions, and aspirations that led us to collaborate in the first place. Our interest in the history, present, and possible futures of public health and social medicine² in the former Yugoslavia has grown from a deep engagement with ethnographic fieldwork, teaching, institutional constraints, and conversations with practitioners, who describe their health systems as “ruined”, fractured, or simply exhausted.

Our research investigates collaboration in public health as both an object of inquiry and a methodological practice. Specifically, we examine how the changing institutional, political, and epistemological landscapes in Serbia and Croatia shape possibilities for collaboration among public health experts, and between those experts and anthropologists and various other interested parties and publics. We have used the notion of “epistemic partnership” (Holmes and Marcus, 2008, 2021) as an aspiring concept to explore how collaborative relations are formed, interrupted, and transformed in institutional public health settings, although we cannot claim that this type of relationship has been achieved. However, it is the work of Anna Tsing and her collaborators (2005, 2015, 2017, 2024) that deeply inspires our own thinking and requires to be noted here.

The main goals of our research are threefold. First, we aim to identify the current challenges facing public health systems in Serbia and Croatia from the perspectives of practitioners working within them. Second, we seek to explore what remains – discursively, institutionally, and practically – of the specific iteration of social medicine developed throughout the 20th century, which emphasized community participation, equity, and decentralisation. Third, we aim to establish relationships with experts who are open to future collaboration, especially in envisioning new interdisciplinary and transnational frameworks for health and care in post-socialist contexts. This article, however, does not strive to achieve any of these goals as much as it is guided by them in exploring the very concept of collaboration.

1

The project, entitled *In the Frictions of Social(ised) Medicine: A Collaborative Ethnography of Public Health Institutions in Croatia and Serbia*, was granted funding for junior post-doctoral scholars as part of the *A small but fertile field: Strengthening Southeast European Studies in Regensburg* initiative. We are deeply grateful for the funding that supported this research; without it, this work would not have been possible. Additionally, this paper was realised with the support of the Ministry of Science, Technological Development and Innovation of the Republic of Serbia, according to the Agreement on the Realisation and Financing of Scientific Research 451-03-136/2025-03/200025.

2

The distinction between public health and social medicine has long been a subject of debate. Public health is usually defined as the organised and interdisciplinary community effort to prevent disease, prolong life, and promote health in populations (Axelsson and Axelsson 2006). Social medicine, on the other hand, stems from the idea of medicine as a social science (Virchow, Grotjahn) and focuses on how social, economic, and environmental conditions shape the health of individuals and groups (Roemer 1993). Although different in their historical trajectories and emphases, the two approaches are today inextricably linked: public health cannot function without the insights of social medicine into the social determinants of health, while social medicine finds its practical application precisely through public health systems (see also Vukmanović 1972 on the Yugoslav model of integrated preventive and curative care).

Collaboration in public health is often invoked as an unquestioned good: an imperative for “better policy”, “stronger institutions”, or “efficient delivery”. Yet what exactly constitutes collaboration remains ambiguous, varied, and deeply contextual (Axelsson and Axelsson 2006; Bennett and Gadlin 2012). In our interviews with public health experts from institutions in Belgrade, Novi Sad, Zagreb, and Rijeka, we encountered a range of collaborative modalities, from bureaucratic and “coerced” forms tied to project funding, to charismatic and participatory engagements driven by individual initiative and informal networks. Drawing on these insights, we discuss possible models of collaboration on a spectrum between bureaucratic, rational-scientific, policy-oriented, charismatic, participatory, globalised, coerced, and aspirational.

These models are not mutually exclusive; rather, they coexist and clash in specific institutional settings marked by transitions (political, economical, social, health, technological, etc.), austerity, and the hollowing out of what was once known as social medicine. Echoing anthropological critiques of collaboration as both a discourse and a situated relation (Holmes and Marcus 2021; Tsing 2015), we approach collaboration not as a neutral tool but as a site of friction – contested, uneven, and sometimes deeply ambivalent.

In this paper, we reflect on our efforts to build collaborative relationships with public health professionals in key institutions historically linked to social medicine: the Andrija Štampar School of Public Health, a teaching branch of the School of Medicine, University of Zagreb (Škola narodnog zdravlja “Andrija Štampar”), the Institute for Social Medicine in Belgrade, Faculty of Medicine, University of Belgrade (Institut za socijalnu medicinu), the Institute for Public Health of Serbia “Dr. Milan Jovanović Batut” (Institut za javno zdravlje Srbije “dr. Milan Jovanović Batut”), the Teaching Institute for Public Health Dr. Andrija Štampar, a public health institution that covers the city of Zagreb and a teaching base of the Faculty of Medicine, University of Zagreb (Nastavni zavod za javno zdravstvo dr. Andrija Štampar), the Institute for Public Health of Vojvodina (Institut za javno zdravlje Vojvodine), and the Department of Social Medicine and Epidemiology, Faculty of Medicine, University of Rijeka (Katedra za socijalnu medicinu i epidemiologiju).

Through expert interviews and informal discussions, we trace how professional values, disciplinary boundaries, political entanglements, and institutional hierarchies shape the contours of public health work today. We also share the dilemmas we encountered as ethnographers seeking to engage not only with individuals but also with institutions whose capacity, and sometimes willingness, for collaboration is constrained by political shifts, lack of funding, and what our interlocutors often describe as a loss of autonomy.

Ultimately, this article is both a report on work-in-progress and a methodological meditation on what it means to collaborate ethnographically in the domain of public health in Southeast Europe. We argue that collaboration, if it is to be transformative rather than rhetorical, must be situated, reflexive, and attentive to power. It must recognise not only the possibilities of shared work but also its limits and failures. By thinking with collaboration, its bureaucratic constraints, its charismatic mobilisations, and its everyday frictions, we aim to contribute to broader debates in medical anthropology, social medicine, and public health governance in post-socialist contexts.

LEGACIES AND RUPTURES: SITUATING PUBLIC HEALTH
AND SOCIAL MEDICINE
IN YUGOSLAVIA, CROATIA, AND SERBIA

Our decision to explore collaboration in public health in Croatia and Serbia cannot be separated from the shared historical infrastructure of “public care”³ in socialist Yugoslavia. This history not only shaped the organisation of care, but also influenced how collaboration itself was understood, as a collective, interdisciplinary, and often intersectoral mode of working oriented toward population health and social equity. It is precisely this legacy that our research seeks to revisit, not nostalgically, but critically, asking what remains of social(ised)⁴ medicine today and how it continues to live, fracture, or be repurposed within current public health institutions.

During our early conversations, still on informal Zoom calls in the midst of the pandemic, we often returned to the figures of Andrija Štampar and Milan Jovanović Batut and the lore⁵ that surrounds them. For both of us, Štampar and Batut had been names occasionally mentioned in textbooks or at conferences, but rarely engaged with in depth. Yet, in the post-Covid-19 public discourse, their legacy seemed to resurface in Croatia (Štampar) and Serbia (Batut), often framed as a reminder of what public health once stood for: community outreach, prevention, and cross-sectoral collaboration. We began wondering if this was just symbolic revivalism or if there existed a deeper unease about what had been lost.

Yugoslav social medicine, especially in its Croatian and Serbian institutional forms,⁶ was more than an ideological project. It was a set of interlinked infrastructures that connected medical faculties, public health institutes, social work, education, and hygiene campaigns. It emphasized decentralisation, interprofessional collaboration, and the alignment of healthcare with broader social goals like housing, employment, and literacy (Dugac 2018, 2019; Parmelee 1992; Porter 2006; Silverstein 2021; Vukmanović 1972).

3

Without going into deep theoretical and practical discussions on these notions, how they intersect and are defined in different contexts, we use the term “public care” to cover public health, health care, welfare, education, and other public systems of care to acknowledge the often wider and more connected assemblages of social/public/state care that has historically been demarcated somewhat differently than in some more familiar state examples.

4

Like with public care, there is a need to acknowledge that there is a difference between social medicine as a field of medical science and socialised medicine as a system of universally organised and offered medicine, what can at times also be called a national healthcare system, universal health care, publicly funded healthcare, etc. Again, these terms do not sufficiently cover the practical meanings in which we use them to keep in mind that Yugoslavia had a functioning self-managing socialism for a few decades that to various degrees extended to public care systems. While this is not the focus of our article, we plan to address it in future publications, but it is of use to keep this “public care pluralism” in mind.

5

We use the term “lore” to emphasize that we are referring to collective knowledge and traditions within connected communities, knowledge that straddles the line between history and myth. When we invoke myth, we draw on its anthropological meaning: not as fiction but as a foundational narrative that explains the origins of social institutions. In this case, the “medical system” is understood as both grounded in historical fact and pliable to contemporary national uses.

6

There have always been significant differences between the Yugoslav republics, and it would be very hard for us to make claims beyond the two countries where we live and have done our research, but the assemblages of republics can't be ignored, nor be thought of as entities in the strict national countries sense they exist in today.

We are not historians, and understand that there is always a difference between how something was imagined and how something was brought to life, but we take this basis as a form of thinking with. The Institutes for Public Health in Zagreb and Belgrade, Štampar and Batut, were at the heart of these efforts. As state-building institutions, in the interwar period, they produced data, trained professionals, and coordinated mass campaigns in ways that made public health both technical and deeply political. The efforts of these institutions and the people who inhabited them have continued on these paths in various ways in the second half of the 20th century.

The 1990s marked a sharp rupture. With the collapse of Yugoslavia, wars across the territories and the rise of nationalist projects, the systems of care became caught in the cross-currents of war, austerity, and neoliberal restructuring. Concepts central to social medicine, like “participation”, “equity”, or “solidarity”, were either discarded or hollowed out, repackaged into project logics and measurable indicators dictated by international donors or simply the political whims of the time. In Croatia, the specialisation in social medicine was absorbed into public health in the early 2000s; in Serbia, it continued but became increasingly marginalised within the institutional hierarchy. In both cases, we heard from our interlocutors/collaborators that “social medicine no longer exists”, or more precisely, that it exists only as a memory, as something one might be “nostalgic for” but no longer operationalise. One of our interlocutors, a doctor attached to several public health and medical institutions in Croatia, noted that they might not have an accurate picture of the socialist/communist past, but that compared to today, what used to be the hallmarks of socialised medicine are lacking in the contemporary health care systems of both countries.

Healthcare under communism was more flexible, quicker to adapt, and more responsive to people’s needs. I realise this might sound like a cliché, especially since I can’t prove it as easily as I can demonstrate the current lack of prevention and evidence-based action in Croatian public health.

Still, that erasure is uneven and incomplete. As a professor of social medicine at the Medical Faculty at the University of Belgrade told us, “Even if social medicine is no longer a specialisation people want, the problems it addressed haven’t gone away. If anything, they’ve become more urgent.” What struck us in our interviews was how often people would pivot from describing bureaucratic inertia and burnout to invoking collaborative ideals rooted in older models: the need for intersectoral work, for deeper community engagement, and for autonomy in designing context-sensitive interventions.

In these moments, it became clear that the legacy of social medicine lives on, not only in archives or in professional genealogies but also in frustrations, memories, and unfulfilled desires for a more humane (public) health(care) system. What changed, however, was the ability to enact those visions. As a specialist of social medicine from the Institute of Public Health of Vojvodina put it, “Everything now is a project. When the project ends, everything ends. There is no continuity.” The move from embedded institutional planning to externally driven projectisation has created new hierarchies and dependencies, undermining the very idea of long-term, context-attuned public health work.

As we have noted above, we are not historians; however, for us, coming from medical anthropology, a field that itself grapples with tensions, this history raises both ethical and methodological questions. How do we account for our own positionalities when many of the people we talk to see themselves as surviving systems that no longer function as they should? And how do we even gauge what the content of this “was” and “should” is?

We do not seek to romanticise the Yugoslav model, which had its own exclusions, limitations, and blind spots. Nor do we presume that the concept of social medicine can simply be revived in its former form. But we are interested in the frictions produced by its partial erasure, in how its institutional ghosts continue to animate present-day struggles around collaboration, responsibility, and care. Understanding these frictions is essential to grasping the stakes of public health work today and to imagining what kinds of collaboration might still be possible, even in the ruins of transition.

FORMS AND FRICTIONS OF COLLABORATION

If collaboration in public health was once envisioned in Yugoslavia as a horizontal, interprofessional, and context-sensitive practice (even if it was never fully successful in that achievement), especially within the framework of social medicine (Roemer, 1993), what kinds of collaboration exist today? And just as importantly, how do the people working in public health systems experience, negotiate, or resist them?

Through our interviews and field visits, we encountered a wide range of collaborative formations, not only between institutions or sectors but also between individuals, disciplines, and professional cultures. As we tried to make sense of these variations, several recurring modes began to emerge. These are not rigid categories, nor are they mutually exclusive; they often overlap, blur, or transform over time. But they offer a heuristic for thinking about the landscape of collaboration in Croatia and Serbia today: bureaucratic, rational-scientific, charismatic, participatory, globalised, coerced, and aspirational. Each of these forms comes with its own promises, limits, and frictions.

(1) *Bureaucratic collaboration* would represent a sort of duty without dialogue. This is perhaps the most pervasive and simultaneously the most hollowed-out form of collaboration. Bureaucratic collaboration is mandated through formal hierarchies: institutes collaborate because they are told to, because a ministry orders it, or because an official memo requires a report.

Our interlocutors spoke of being summoned into task forces, advisory groups, or project boards without clarifications about goals or roles, or real decision-making power. For some, like our interlocutors from the Department of Social Medicine and Health Statistics with Informatics at the Institute for Public Health of Vojvodina, who met us as a group, this meant travelling to Belgrade for tedious meetings with no particular point:

We were regularly called into expert bodies, working groups, committees, advisory boards, whether at the city level or within the Ministry of Health. We'd spend years attending meetings, sometimes

every week, simply because it was expected of us. Most of this wasn't paid, and often, it wasn't even clear what we were really there to decide.

These arrangements often reproduce vertical structures: the ministry defines certain priorities, national institutes relay them to regional ones, and collaboration becomes a procedural checkbox rather than a meaningful exchange. A specialist of social medicine from Novi Sad noted wryly: "It's not collaboration, it's compliance."

Such enforced, hollow collaboration, marked by formal participation without genuine dialogue or decision-making, can have serious consequences, especially during crises like the Covid-19 pandemic. When collaboration becomes a performance rather than a space for debate, it fosters an environment of silence and conformity. Fearful of political repercussions, experts avoid open criticism, and necessary disagreements are pushed into private conversations. In these conditions, institutions prioritise activities that are politically safe over those that are evidence-based or effective. As a result, public health measures may appear active on paper but lack substance or impact, leaving systems poorly equipped to respond to emergencies. This type of collaboration erodes trust, limits innovation, and ultimately undermines the very goals it claims to serve. A doctor from the Teaching Institute of Public Health "Dr. Andrija Štampar" told us that raising concerns about failures in public health often carries the risk of being branded unpatriotic or disloyal:

There's a clear pattern: first, deny there's a problem, because admitting it would be seen as disloyal. Speaking openly about issues in public health is risky; it's easier to stay silent, and most do. Even during Covid, when I raised concerns in mass emails, no one responded publicly. Yet privately, people would message me saying they agreed but wouldn't say so aloud. It's a system where pretending everything is fine and performing activity [Croatian: *glumljenje aktivnosti*], launching superficial measures with no real impact, takes priority. The goal isn't actual prevention, but actions that won't upset anyone politically or economically. This kind of false activity leaves us with some of the worst health indicators in the EU, yet the system still pretends to function.

Closely related to bureaucratic collaborations are (2) *policy-oriented collaborations* that reflect a form of knowledge production that is deeply tied to policy processes but often remains outside academic or public scrutiny. Unlike purely research-driven collaborations, this model is focused on producing reports, recommendations, and technical documents intended to inform government decisions, legislation, or institutional strategies. We distinguish between bureaucratic and policy-oriented collaboration on the basis of power relations. Unlike bureaucratic collaboration, where little to no input is asked of collaborators, policy-oriented collaboration means professionals are actively engaged, often as experts tasked with producing evidence or shaping recommendations, but within predefined policy frameworks and timelines that limit broader reflection or long-term impact. While such collaborations are typically methodologically rigorous and often involve cross-institutional teams, they prioritise applicability and policy relevance over academic contribution.

Our interlocutors described how many public health projects in Serbia and Croatia are designed primarily to generate actionable recommendations for ministries or international organisations, rather than to produce academic publications that advance scientific

progress. Reports are written, presented to stakeholders, and sometimes discussed publicly, but they rarely enter the scientific literature. As a professor of social medicine explained, the process of turning these reports into journal articles demands additional time, resources, and often steep publication fees, which are difficult to justify when the research already fulfils its intended policy purpose. This creates a large body of “grey literature”, research that informs decisions but remains largely invisible to the academic community and disconnected from broader debates. She adds: “Turning them into academic articles takes extra effort, funding, and time, which we often don’t have or prioritise.”

(3) *Rational-scientific collaboration* would represent a sort of knowledge without context. Many professionals in public health come from clinical or scientific backgrounds, and interinstitutional collaboration often occurs around research projects, data-sharing, or knowledge production. This is the domain of what we term rational-scientific collaboration: efficient, goal-oriented, methodologically rigorous, but often abstract and removed from lived realities. While such collaborations can produce valuable insights, they can also marginalise experiential or qualitative knowledge. As a social medicine specialist from the Institute of Public Health of Vojvodina told us, “We get called to collaborate when there’s a need for numbers. But when we start to talk about the social side of health, poverty, stress, family violence, there’s no space for that.” In this model, disciplines like anthropology or social work are often sidelined unless they can produce policy-friendly outputs. The result is a narrowed understanding of collaboration, one that favours standardisation over adaptability and measurable outcomes over messy realities.

The fourth model we can extrapolate relates to (4) *charismatic collaboration*, where the focus is on specific people that can push forward topics and collaborations, not pre-imagined programs. In both Croatia and Serbia, some of the most vibrant collaborations we have encountered were rooted not in institutional mandates but in the personal energies, networks, and convictions of individual professionals. These we call charismatic collaborations as they are initiatives made possible through trust, long-term relationships, and shared commitment. What struck us was that even interlocutors who didn’t know each other often mentioned the same people, across both Croatia and Serbia, as key collaborators and drivers of change. These were individuals who seemed to carry public health initiatives forward not because of their official roles, but because of their personal energy, networks, and long-standing commitment to collaboration. In fact, nearly everyone we spoke to seemed to circle back to certain individuals, people we haven’t yet interviewed ourselves but who clearly play a central role in the region’s public health networks. It’s through these personal connections that projects get made, a professor of social medicine from the Medical Faculty in Belgrade tells us:

Recently, we’ve been involved in a few projects with colleagues from Croatia through the university, three of them, I think, but honestly, those collaborations are more about personal connections than formal partnerships.

However, this mode of collaboration is fragile. It relies on the time, labour, and affective investment of individuals, very often women, often underpaid and overworked, who

carry the burden of sustaining cooperation in their “free time”, outside project cycles or institutional recognition. When such individuals retire, move, or burn out, the collaborative structure often collapses. It is intensely meaningful, but rarely sustainable.

The next model is (5) *participatory collaboration*. Participatory collaboration, especially with communities or non-medical professionals, is often named in policy documents and international guidelines. In practice, however, it remains difficult to enact. Some practitioners spoke of sincere efforts to involve citizens in health promotion programs or needs assessments, only to encounter logistical, political, or methodological barriers. Others described participatory frameworks imposed by donors without regard for local trust networks, language barriers, or political sensitivities. Some, like our interlocutor from the Department of Social Medicine and Epidemiology, Faculty of Medicine, University of Rijeka, noted that there simply aren't enough medical practitioners to enact these changes:

One of the biggest challenges in making participation work in practice is the lack of healthcare workers, especially in rural areas and on islands. While policies might promote community-based care or citizen involvement, the reality is that many communities don't even have enough doctors or basic services, particularly in primary care. It's hard to engage communities meaningfully when basic needs aren't being met.

The sixth tentative model is (6) *globalised collaboration*. A sort of funding-with-strings, an increasingly common form of collaboration is that which occurs through international projects, regional networks, or externally funded initiatives. EU programs, WHO frameworks, and donor-funded public health campaigns enable forms of cross-border collaboration that bring new resources, visibility, and exchange. Some of the rare examples of cross-border collaboration we heard about were tied to IPA projects, EU-funded programs designed to support cooperation and development in candidate and neighbouring countries. However, even these collaborations were often described as highly technical and driven by external agendas, with little direct involvement from social medicine professionals.

An interlocutor from the Institute of Public Health of Vojvodina said that their institution had recently been involved in several IPA projects focusing on environmental health issues, such as mosquito control and microplastics in water, with partners from Hungary and Croatia. The mosquito project, for example, involved releasing modified mosquitoes to reduce disease risks, a project framed under the One Health model, which links human, animal, and environmental health. Yet despite its scale and technical complexity, said our interlocutor, the project had limited relevance to their everyday work:

We've had some IPA projects with partners from Croatia and Hungary, like one about microplastics in water with Baja and the Institute of Public Health in Sombor. But honestly, we aren't really involved beyond some minor roles, these projects are mostly handled by hygiene specialists, not us. They're very technical, focusing on things like reducing pollution at the source, recycling, or preventing synthetic fibres from reaching waterways. It's important work but not really connected to what we do in social medicine. In fact, we rarely participate in such projects because they require enormous administrative effort, extra staffing, paperwork, and time that we simply don't have. Our work schedules are already overloaded, and we don't have anyone who could take on that kind of project management.

Others noted how donor dependence creates a cycle of short-termism, where institutions chase grants not for content alignment but simply to stay afloat. As an epidemiologist from Belgrade summarised: “The project is over. The collaboration is over.”

Finally, we observed a mode of collaboration that was perhaps the most cynical and this is why we refer to it as (7) *coerced collaboration*. This describes arrangements where collaboration is mandated not to generate meaningful partnerships, but to perform institutional alignment, satisfy funding conditions, or avoid conflict. In some cases, public health professionals were included in working groups for projects whose content they fundamentally disagreed with but could not afford to refuse. In other cases, “interdisciplinary collaboration” was simulated for a report or an evaluation, only to be ignored in practice. This is another side of the collaboration discourse: a performance of unity masking deep epistemic or political divisions. A doctor and professor from the Medical Faculty, University of Belgrade, explained:

We have this mandatory collaboration with the Faculty of Organisational Sciences. Honestly, we are structured completely differently, and there are many misunderstandings, differences in sensitivity, research approaches, and ways of thinking. They are extremely pragmatic, focused on cost-benefit analysis, and often ignore our professional and scientific standards. It’s very frustrating. I haven’t worked with them much myself, but my colleagues often come back from meetings completely drained. At one point, I was asked to join their advisory board, but I refused, there’s just too much of a gap in understanding. They can also be very arrogant, even aggressive in their ignorance. Some of them have said things like, ‘I could easily give a lecture on surgery,’ which left everyone in shock. We still quote that as a prime example of their overconfidence.

Taken together, these seven tentative modes reflect a broader tension in the way collaboration is imagined and enacted in public health. On paper, collaboration is everywhere. In practice, it is often a site of contradiction, ambivalence, and exhaustion. And yet, within and between these forms, we also encountered moments of creativity, improvisation, and care, often hidden in the margins of institutions or nurtured within fragile interpersonal constellations.

Our own collaboration, as anthropologists navigating these systems, sits uneasily within this terrain. We rely on charismatic and participatory models but are often pulled into bureaucratic or project-based frames ourselves. This friction is productive: it reminds us that collaboration is never neutral. It is always shaped by histories, hierarchies, and the labour of those who choose to remain engaged, even when there is little recognition or reward.

INSTITUTIONAL ENCOUNTERS

As we moved from fieldwork research to conceptual mapping and back, the abstract forms of collaboration we had identified began to take on embodied, affective, and often contradictory shapes. Institutions, named, historical, and seemingly solid entities like the Institute for Public Health “Milan Jovanović Batut” in Belgrade, or the School for Public Health “Andrija Štampar”, at first appeared as static nodes. But what we found were not unified actors, but entangled assemblages of individuals, legacies, aspirations, and bureaucratic fatigue. These

were not simply “sites” of public health knowledge, they were spaces of encounter, negotiation, silence, and sometimes quiet refusal. We present here a series of situated vignettes drawn from our interviews and field visits, what we might call institutional voices, though they are often polyphonic and unsettled. These fragments do not aim to represent the institutions as wholes, but to open windows into the lived experiences of the public health professionals who inhabit them.

We go back to one of the most frequently repeated refrains in our fieldwork, the overwork of public institution employees and the absence of continuity. These are connected issues that come from the multiplicity of proscribed roles the experts in these institutions have and the project logic that needs to be satisfied in a timely manner. In a conversation at the Institute for Public Health in Vojvodina, a senior physician with over two decades of experience put it bluntly:

There is no continuity, let me tell you that right away. I've been in this field for over 25 years, and the biggest problem in our country is the lack of continuity within the Ministry of Health. Most initiatives are tied to project-based funding, and once the project ends, everything stops. Very little actually takes root. Those are the main problems.

This lack of continuity extended not only to programming and policy but to collaboration itself. Initiatives born out of urgent needs or shared crises, like Covid-19, disintegrated once the funding had run out. Collaborative efforts had to be maintained in the crevices of official working hours, sustained by goodwill and, quite literally, days off.

“Most colleagues will write their papers during holidays,” another doctor added, half-laughing. “It’s not funny.” Some recalled the days when public health education included fieldwork, community-based campaigns, and interdisciplinary cooperation. Others, particularly younger colleagues, had entered institutions already defined by audit culture, short-term grants, and shifting EU benchmarks. One of our interlocutors, a psychiatrist from Zagreb, paused before answering our question about the current state of public health:

What stands out here is the deliberate and continuous dismantling of the healthcare system, not just an effort to break with the communist legacy of public health, but an ongoing process of erosion. In Croatia, this really happened. In the 1990s, certain medical fields were intentionally discarded, treated as mere remnants of collectivist ideology, rather than recognised as essential parts of the healthcare system. Yet these fields had once been a strength, as shown during the 1972 epidemic⁷, which, despite its oppressive aspects, demonstrated how an organised state could effectively respond to a crisis. Today, we clearly see the consequences of losing that kind of institutional capacity.

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The reference is to the 1972 smallpox epidemic in Yugoslavia, the last major smallpox outbreak in Europe. The epidemic started in Kosovo and spread to other parts of the country, leading to a swift state response involving strict quarantines, mass vaccinations, and travel restrictions. While the measures were seen by some as repressive, the outbreak is often cited as an example of an effective, centralised public health intervention under Yugoslavia’s system of social medicine. For more on this topic, see Radina Vučetić (2022), *Nevidljivi neprijatelj: Variola vera 1972*.

This wasn't said with anger or resignation, but with a quiet sense of mourning. Later in the conversation, the same person pointed to the paradox that while public health discourse is ubiquitous, especially in crisis, its institutional foundations are eroding.

These institutional encounters were never neutral. Often, they mirrored broader patterns of fragmentation, precarity, and political exhaustion. Yet they also revealed the continued desire for something else: for "real" transformative collaboration, for mutual recognition, for spaces where public health could once again mean not just services and statistics, but care, prevention, and solidarity. What these voices make clear is that collaboration in public health is not only about institutional design or professional will. It is about power, positionality, and endurance. It is about who has the time to meet, who has the authority to speak, and who is allowed to act. Most importantly, it is about who still believes that something better is possible.

In our next section, we reflect on how these voices and experiences shaped our own research practice, and what it has meant to pursue "collaborative ethnography" in such a fractured institutional landscape.

BETWEEN ASPIRATION AND CONSTRAINT: RETHINKING COLLABORATION IN PRACTICE

As we moved through institutions and conversations, crossing administrative levels, disciplinary languages, and personal biographies, one thing became increasingly clear: collaboration is both deeply desired and structurally obstructed. The concept appears everywhere in public health discourse, in policy documents, mission statements, and grant calls. But its enactment, at least in the public health systems of Croatia and Serbia, is fraught with constraint. And yet, people try. They keep trying, often against their better judgment, often with full knowledge of the likely limits. This persistence, this refusal to fully give up on collaboration, is what we want to pause on here.

We began our project with an open question: What does collaboration mean in post-socialist public health institutions today? And how might anthropologists, not just as critics or observers, but as potential partners, contribute to its reimagination? These questions were never abstract for us. Our own research is collaborative in intention and in structure: it is the product of our mutual curiosity, our institutional affiliations, and our overlapping yet distinct ethnographic trajectories (Kupsjak 2022; Pantović 2022; Radovanović, Kupsjak and Pantović 2024). But this very collaboration has constantly required negotiation – with funders, with administrative systems, with disciplinary expectations, and with our own capacities and limits.

In many ways, our project is caught in the same binds as the public health professionals we spoke to. Like them, we work across institutional systems that reward individual achievement, not shared labour. Like them, we try to carve out time for dialogue and trust-building in systems that prioritise short-term deliverables. More often than we expected, we are, like them, writing grey literature and sitting in meetings with no goal or end in sight. And like

them, we find ourselves wondering: What counts as meaningful collaboration? What kinds of work are visible, valuable, and sustainable, and what kinds are quietly rendered invisible?

One recurring theme in our research is the emotional and temporal labour required for collaboration. “True collaboration,” as a doctor from Belgrade said, “takes time, energy, and vulnerability. But we don’t have the time anymore.” Many of the professionals described a desire for collective work across institutions, sectors, or disciplines, but pointed to time poverty, administrative overload, and lack of institutional support and funding as persistent obstacles. Collaboration is also risky. In hierarchical institutional cultures, inviting others in can mean losing control over projects, credit, or authority. Several people spoke of being burned by past experiences, excluded from publications, their contributions minimised, their expertise treated as secondary. This makes trust-building slow and sometimes painful, especially in contexts where professional mobility is limited and where “burnout” is no longer an exception but a normalised condition.

We also encountered what we might call (8) *aspirational collaboration*: partnerships imagined or planned but never fully realised. This includes memoranda of understanding between faculties, multi-stakeholder committees that rarely meet, or working groups whose work remains locked in unpublished reports. These moments were not failures in any simple sense; they often contained important conversations, flashes of mutual recognition, but they did not live on in practice. They are the ghosts of collaboration: real, remembered, but structurally foreclosed.

Throughout this project, we found ourselves repeatedly returning to a deceptively simple question: What counts as collaboration? Is it shared authorship? Co-writing a grant proposal? Organising a conference together? Having coffee every month to talk through work frustrations and ideas?

If we adopt an expansive, situated definition, one that includes informal networks, affective labour, care work, and knowledge exchange not formally recognised by institutions, then transformative collaboration is alive and well. But it is happening under the radar, in side rooms and WhatsApp and Viber groups, in conversations that are not transcribed or logged. One senior expert of social medicine from Serbia described this as “a different kind of system, one that isn’t rewarded, but that keeps us going.”

This “different system” often overlaps with what Tsing (2015) calls “contamination”: a mode of encounter in which divergent life worlds intersect, not seamlessly but generatively. Collaboration, in this view, is not necessarily harmonious or planned. It may be awkward, unfinished, and provisional. But it still matters.

When we presented ourselves to public health professionals as anthropologists conducting research on collaboration, we were sometimes met with confusion (“So you’re studying us?”), curiosity (“What exactly do anthropologists do again?”), or relief (“Finally, someone who wants to listen”). We were also frequently asked if we had concrete outputs or recommendations to offer, if our collaboration would be useful in the instrumental sense. Here, if we are fully truthful, we used our project funding as an external validation source. External both to us, but also to the region, thus relying on the symbolic geographies and imaginaries of Western

Europe and Germany (Pantović and Čeriman 2024). This is the double bind of collaborative ethnography in institutional settings: to be a good partner, one must be legible to the system, but legibility often requires surrendering the very critique and relationality that ethnography makes possible. The more we tried to “collaborate”, the more we encountered these frictions: between slowness and speed, between situated knowledge and standardised outcomes, between openness and expectation. In many cases, rather than securing access through formal institutional channels, we ultimately relied on what we term charismatic collaborations. Despite sending numerous official emails to institutional leaders to express our interest in establishing communication and conducting interviews, these formal approaches were often unsuccessful. Instead, access was frequently facilitated through personal networks, colleagues, friends, and friends of friends, who were able to open doors that official correspondence had left closed.

Rather than resolving this bind, we have come to see it as generative. Collaboration, in our experience, is less a stable method than a set of ongoing negotiations. It requires humility, attentiveness, and a willingness to be changed by the encounter (Tsing 2015). Sometimes this means showing up repeatedly with no clear outcome. Sometimes it means accepting that not everyone wants to collaborate or can afford to.

STAYING WITH THE TROUBLE:⁸ RETHINKING COLLABORATION FROM WITHIN THE FRICTIONS

The language of collaboration in public health is often technocratic, abstracted from the lived worlds of the people who are supposed to enact it. Our work, we hope, opens a space to rethink this language, to ask what collaboration looks like from below, in practice, and what it demands of those who engage in it. Between aspiration and constraint lies a wide terrain of improvisation, care, frustration, and quiet persistence. It is this terrain we seek to make visible, not to offer definitive answers, but to better understand what it means to work together when the structures around us are designed for separation.

In our conclusion, we turn to these structural dynamics and the political conditions under which collaboration can be reimagined not as a managerial buzzword but as a form of relational and epistemic commitment.

This article has emerged from our attempt to think and work collaboratively in a space where collaboration is both urgently needed and deeply constrained. Drawing on our research across public health institutions in Serbia and Croatia and grounded in our own cross-border, cross-institutional collaboration as anthropologists, we have tried to trace the complex terrain in which public health collaboration is imagined, practiced, desired, and resisted.

We began with the historical legacy of social medicine in Yugoslavia, not to idealise a lost system but to better understand the infrastructures and imaginaries that continue to shape public health today. From this legacy, we followed the institutional ruptures and

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Donna Haraway (2016) has also been an inspiration, even if we don't cite her directly, except in this heading.

policy realignments that have marked the post-socialist transition, especially the shift from sustained public investment to short-term, externally funded project logics. In doing so, we encountered professionals who continue to work under conditions of fragmentation, burn-out, and institutional inertia, yet who also carry with them visions of public health as an interdependent, care-based, and community-attuned practice.

By identifying eight provisional types of collaboration – bureaucratic, policy-oriented, rational-scientific, charismatic, participatory, globalised, coerced, and aspirational – we offer a heuristic for navigating the forms and frictions that characterise the current landscape. These modes are not fixed categories but points of tension where collaboration becomes visible as a lived relation, a risk, and at times, a form of quiet resistance. Across the interviews and institutional encounters we explored, collaboration was rarely what it claimed to be on paper. Instead, it was often improvised, informal, deeply personal, and at odds with institutional incentives. It required time people didn't have, energy they weren't paid for, and care that wasn't recognised. And yet, it happened. It happened over coffee during holiday time, in moments of solidarity between exhausted professionals who still believe in the value of their work.

We have argued that to understand collaboration in public health today, we must look beyond formal structures and institutional declarations. We must attend to the affective and temporal dimensions of collaboration: to how it is felt, sustained, and sometimes lost. We must consider the political conditions, both within institutions and across regional and global governance, that shape what forms of knowledge and partnership are possible, and for whom.

As anthropologists working within and alongside public health institutions, we do not claim neutrality. Our collaboration, this article included, is also part of the field we are trying to understand. We write not as observers from the outside but as participants entangled in the very constraints we analyse. Our hope is that by documenting these frictions and by refusing to reduce collaboration to a managerial buzzword, we can open space for a more reflexive and politically attentive understanding of what it means to work together.

Collaboration is a fragile achievement, sometimes hopeful, sometimes heartbreaking. But if we are to reimagine public health as something more than crisis response and fragmented programming, then we must start from these frictions. We must take seriously the everyday labour of those who, despite everything, still try to collaborate, not because they are told to, but because they believe something better is possible.

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Prispevek preiskuje pomene in načine sodelovanja v sistemih javnega zdravstva v Srbiji in na Hrvaškem, s poudarkom na tem, kako politični, institucionalni ter epistemološki obrati krojijo možnosti skupnega dela. Na podlagi sodelovalnega etnografskega projekta dveh medicinskih antropologinj raziskuje, kako sodelovanje hkrati deluje kot predmet proučevanja in metodološki izziv.

Z analizo gradiva, dobljenega s terenskim delom ter intervjuji s strokovnjaki in strokovnjakinjami, izvedenimi v osrednjih ustanovah v Beogradu, Novem Sadu, Zagrebu in na Reki, je bilo opredeljenih več oblik sodelovanja: birokratsko, javnopolitično usmerjeno, racionalno-znanstveno, karizmatično, participativno, globalizirano, prisilno ter aspiracijsko. Ti načini soobstajajo in trkajo eden ob drugega v razdrobljeni institucionalni krajini, ki jo zaznamujejo varčevalni ukrepi, projektizacija in politični pritiski. Prispevek sodelovanja ne obravnava kot inherentno pozitivno vrednoto, temveč ga razume kot situacijski, kočljiv in z močjo prežet proces, ki omogoča ter obenem ovira delo v javnem zdravstvu.

Z orisovanjem kontinuitet in prelomov z jugoslovansko socialnomedicinsko dediščino, ki je svoj čas poudarjala pravičnost, participativnost in decentralizirano nego, članek razkriva, kako se je ta dediščina obdržala v spominih, frustracijah ter profesionalnih idealih, četudi se institucionalne kapacitete razkrajajo. Sodelovanje, nekoč utemeljeno na kolektivni odgovornosti, postaja vse bolj birokratizirano, kratkotrajno in poganjano od zunaj. Kljub temu pa pristni trenutki partnerstva ne izginejo, po navadi se ohranjajo v neformalnih mrežah, z osebno predanostjo in afektivnim delom.

Avtorici s pomočjo refleksije lastnih poskusov vključevanja v javnozdravstvene institucije osvetlujeta trenja, asimetrije in čustveno delo, ki jih zajema sodelovalno raziskovanje. Trdita, da transformativno sodelovanje zahteva refleksivnost, čas in zavedanje razmerij moči. Prispevek zaključujeta s premislekom: da bi si bili zmožni na novo zamisliti javno zdravstvo, zunaj okvirov upravne retorike, moramo sodelovanje razumeti ne kot sledenje navodilom ali stvar učinkovitosti, temveč kot krhko in etično prakso deljene odgovornosti ter skrbi.

Sporazumevanje med zdravstvenim osebjem ter tujejezičnimi starši novorojenčkov v Enoti intenzivne nege in terapije prezgodaj rojenih novorojencev Porodnišnice Ljubljana



Communication Between Healthcare Professionals and Foreign Language Speaking Parents of Newborns at the Neonatal Intensive Care Unit of the Maternity Hospital in Ljubljana

Anja Marolt

1.01 Izvirni znanstveni članek
DOI 10.4312/svetovi.4.1.45-57

IZVLEČEK

Prispevek govori o jezikovnih nesporazumih med tujejezičnimi starši prezgodaj rojenih ali bolnih novorojencev ter zdravstvenim osebjem na Enoti intenzivne nege in terapije novorojencev v ljubljanski porodnišnici ter uporabi različnih komunikacijskih strategij za njihovo reševanje. Raziskovalna metoda enoletne raziskave je bila avtoetnografija, to je kvalitativna metoda dela, kjer raziskovalec uporabi lastno izkušnjo za opis in interpretacijo kulturnih izkušenj ter praks. Poseben pomen prispevka je v tem, da je okolje intenzivnih enot težko dostopno raziskovalcem, avtorica, ki je sama zaposlena v porodnišnici, pa lahko vsakodnevno opazovanje in svoja občutja poveže s teorijo. Raziskave kažejo, da se bo število migracij iz leta v leto povečevalo, kar pomeni še več stikov s tujejezičnimi pacienti in ob odsotnosti sistemske pomoči neenakih obravnava. V članku je predstavljenih nekaj reprezentativnih primerov jezikovnih nesporazumov na intenzivni enoti, opisov, kako jih zdravstveno osebje poskuša reševati in kako lahko pomanjkanje informacij vpliva na svojce.

KLJUČNE BESEDE: tujejezični pacienti, jezikovni nesporazumi, enota intenzivne nege in terapije novorojencev, avtoetnografija

ANJA MAROLT

Sporazumevanje med zdravstvenim osebjem ter tujejezičnimi starši novorojenčkov v Enoti intenzivne nege in terapije prezgodaj rojenih novorojencev Porodnišnice Ljubljana

ABSTRACT

The article addresses language-based misunderstandings between foreign language-speaking parents of preterm or ill newborns and medical staff at the Neonatal Intensive Care Unit of the maternity hospital in Ljubljana, as well as the use of various communication strategies to resolve them. The research method for this one-year study was autoethnography, a qualitative approach in which the researcher draws on personal experience to describe and interpret cultural experiences and practices. The significance of the article lies in the fact that intensive care environments are typically difficult for researchers to access; the author, who is employed at the maternity hospital, is able to combine daily observations and personal reflections with relevant theory. Research indicates that migration numbers are expected to increase year by year, leading to more frequent interactions with foreign language-speaking patients and, in the absence of systemic support, potentially unequal healthcare experiences. The article presents several representative cases of language-based misunderstandings in the intensive care unit, describing how medical staff attempt to resolve them and how any resulting lack of information can affect the relatives.

KEYWORDS: foreign language-speaking patients, language-based misunderstandings, neonatal intensive care unit, autoethnography

Porodnišnica Ljubljana je največja slovenska porodnišnica, v njej se namreč rodi približno tretjina vseh novorojencev. Je prizorišče srečanja med popolnimi neznanci, soustvarjajoč dogodke, ki si jih predvsem uporabniki zdravstvenih storitev zapomnijo za vse življenje. Največ je nekajdnevnih obiskov, kjer starša z novorojencem zapustita porodnišnico, ker pa je ljubljanska porodnišnica del Univerzitetnega kliničnega centra Ljubljana, ki je terciarni center in sprejema najtežje primere bolnikov iz večjega dela države, se občasno obporodni dogodki ne zaključijo po pričakovanjih. Na Enoto za intenzivno nego in terapijo prezgodaj rojenih otrok (v nadaljevanju EINT) so sprejeti prezgodaj rojeni novorojenci, nekateri tudi s težo pod 500 gramov (rojeni do 18 tednov prezgodaj, kar je le malo manj kot polovica trajanja nosečnosti). Zaradi nezrelosti se soočajo s posledicami nezrelih organskih sistemov, kot so možganske krvavitve, okužbe, poškodbe pljuč, oči, kože, nekateri potrebujejo tudi kirurško zdravljenje (predvsem črevesja, redkeje operacije srca). Poleg nedonošenih pa so lahko sprejeti tudi donošeni novorojenci, ti največkrat potrebujejo zdravljenje in diagnostiko zaradi dihalnih težav, okužb ter genetskih nepravilnosti. Zdravljenje in hospitalizacija nekaterih traja nekaj dni, tisti z najbolj nezrelimi organi pa lahko na EINT preživijo tudi do štiri mesece. To obdobje predstavlja čas velike negotovosti za starše in širšo družino, pogosto ima zaradi vsajčasne ločenosti matere od družine tudi logistične, čustvene ter socialne posledice. Zdravstvena obravnava ne vključuje le strokovnega vidika, ki je sicer najbolj v ospredju, ko govorimo o zdravstvenih storitvah. Zdravstveno osebje se vse bolj zaveda, kako pomemben je tudi primeren psihosocialni pristop. Starši so v primeru nepričakovane razpleta nosečnosti in zaključka poroda v nepredstavljenih stiskah, ki pa se še povečajo,

če ti z zdravstvenim osebjem ne delijo niti enega skupnega jezika. Prispevek se osredotoča na stiske tujejezičnih staršev in zdravstvenega osebja, ki se med seboj ne razumejo, ker ne govorijo nobenega skupnega jezika, ob rojstvu prezgodaj rojenih ali bolnih novorojencev v ljubljanski porodnišnici.

METODE DELA

Avtorica, diplomirana babica, zaposlena na EINT, sem z avtoetnografsko raziskavo med junijem 2023 in avgustom 2024 delala terenske zapiske o dogodkih, ki sem jim bila priča v svoji vsakodnevni praksi. Delo na tem oddelku opravljam od leta 2012 (zadnji dve leti tudi kot vodja izmene) in sem ena izmed približno petdeset zaposlenih diplomiranih medicinskih sester ter bobic. Vsakodnevno sodelujem z zdravniki pediatri (neonatologi), fizioterapevti in drugim osebjem, ki skrbi, da delo poteka nemoteno. Zaradi moje vpletenosti v vsakodnevno prakso se je zdela izbira metodologije precej logična. Avtoetnografijo Leon Anderson (po Pirman 2022: 22) opisuje kot kvalitativno raziskovalno metodo, kjer raziskovalec ali raziskovalka uporabi lastno izkušnjo za opis in interpretacijo kulturnih tekstov, izkušenj, prepričanj ter praks. Nadaljuje, da naj bi raziskovalec povsem pripadal raziskovani družbeni skupini že med raziskavo samo, poleg tega pa mora biti tudi v dialogu z drugimi sogovorniki, v svoje zapise vključevati še subjektivno izkušnjo, poskrbeti za analitično refleksivnost in opraviti analizo teorije (Pirman: 23). Carolyn Ellis (Ellis, Adams in Bochner 2011: 6) našteva več oblik avtoetnografije; najpogosteje uporabljam pripovedovalno, ki jo dopolnjujem z refleksivno. Raziskovanje z avtoetnografijo pa ni brez ovir; za najočitnejšo se je izkazala težko ločevanje med raziskovalko in zaposleno, pogosto so bile moje analize preveč čustvene in slabo podprte s teorijo, zaradi zakoreninjenosti v zdravstveni sistem pa občasno česa nisem prepoznala kot (večji) problem.

Med raziskovanjem sem opravila tudi nekaj nestrukturiranih intervjujev s petimi zaposlenimi iz drugih zdravstvenih institucij in s štirimi diplomiranimi bobicami iz drugih slovenskih porodnišnic, vsi so bili osebe, ki sem jih spoznala med študijem. Njihova mnenja so mi pomagala pri pridobivanju širše slike, ugotovila pa sem, da nismo vsi deležni enake systemske pomoči.

Paciente zaradi zagotavljanja anonimnosti opisujem samo toliko, da predstavim dogodek, tudi zdravstveni delavci so anonimizirani, vsi so predstavljeni v moški obliki. Za raziskovanje in pisanje sem pridobila soglasje Strokovnega kolegija zdravstvene in babiške nege ter oskrbe Ginekološke klinike.¹ Vlogo sem poslala tudi Etični komisiji Filozofske fakultete,² ki je ugotovila, da za raziskavo ne potrebujem pristanka etične komisije, saj gre za sekundarno analizo neidentificiranih podatkov.

1

Soglasje sta 13. 5. 2024 v Strokovnem kolegiju izdali svetovalka v zdravstveni negi za področje izobraževanja in glavna medicinska sestra Ginekološke klinike.

2

Odgovor je Komisija za etiko Filozofske fakultete podala maja 2024.

Svet se v zadnjih desetletjih spreminja s svetlobno hitrostjo, globalizacija se je razmahnila v nepredstavljive razsežnosti. Hkrati pa svet ostaja nemiren, poln konfliktov med državami, režimi, prepričanji. Po podatkih Združenih narodov (Vitorino 2022: xii) vedno več ljudi migrira v druge kraje in regije sveta, kjer iščejo miren kraj za življenje, trendi pa nakazujejo, da se to ne bo upočasnilo.

V sodobnem času postaja evropska populacija vedno bolj raznolika, ne le zaradi dolgotrajnih selitev, temveč tudi zaradi kratkotrajnih ali sezonskih migracij, saj se ljudje na splošno pogosteje premikajo (Lipovec Čebtron idr. 2019: 139). V današnjem svetu, polnem odmevnih dogodkov in migracijskih tokov ljudi, so spremembam podvrženi vsi družbeni sistemi, eden najbolj občutljivih pa je prav gotovo zdravstveni sektor. Nira Yuval-Davis (po Lipovec Čebtron idr. 2019: 140) piše, da se je znašel na točki, ko se »mora odzvati na mnogo-terost in raznolikost potreb posameznikov, ki so izražene z razlikami njihovega izvora, razreda, spola, starosti, jezika in drugih družbenih spremenljivk«. Pri tem se je treba zavedati, da je, kot opozarja Vojko Gorjanc (po Škraban in Lipovec Čebtron 2021: 9), struktura srečanja zdravnika in pacienta v kliničnem okolju osnovana na neenakih položajih moči udeležencev. Zaradi raznolikih družbenih spremenljivk lahko prihaja do nerazumevanja kot posledice različnega dojetja zdravja, bolezni in zdravljenja, še toliko večja pa je težava, ko v proces zdravljenja »vstopijo osebe, ki so se priselile iz drugih okolij in si z zdravstvenimi delavci ne delijo nobenega skupnega jezika« (prav tam). Komuniciranje je tako pogosto stvar improvizacije, razumevanje pacientovih težav pa je za uspešno zdravljenje ključnega pomena (Morel, Gorjanc in Kocijančič Pokorn 2012: 104).

Mnoge evropske države se že dlje časa srečujejo s stalnim dotokom migrantov, pišeta Mikolič Južnič in Kocijančič Pokorn (2021: 19). Med državami, kjer je priseljevanja vedno več, je zadnja leta tudi Slovenija, ki je bila zgodovinsko deležna predvsem priseljevanja iz sosednjih držav – republik, s katerimi je v preteklosti sestavljala skupno državo Jugoslavijo. V zadnjih dveh desetletjih pa se je demografska struktura priseljencev spremenila, vse več je migrantov in beguncev, ki v Slovenijo prihajajo iz bolj oddaljenih delov sveta in govorijo jezike, ki slovenščini niso podobni (prav tam). V Slovenijo se po letu 2020 še vedno priseljuje največ oseb iz Bosne in Hercegovine, sledijo pa jim državljani Kosova, drugi državljani EU, nekaj manj iz Srbije ter Severne Makedonije (Medvešek, Bešter in Pirc 2022: 40), v primerjavi s prejšnjimi dvajsetimi leti pa je opaziti več selitev iz drugih evropskih držav ter z drugih celin, predvsem iz Azije (Medvešek, Bešter in Pirc 2022: 41). Zdravstveno osebje, nevarno tako pogostih stikov s pacienti, ki jih ne razumejo, pogosto navaja občutke nemoči, nerazumevanja, vznemirjenja, ravnodušnosti in celo jeze, živčnosti (Marolt 2024: 22–23).

JEZIKOVNE DIMENZIJE ZDRAVSTVA V SLOVENIJI

Trenutno najbolj zgovorne podatke o naravi stikov med zdravstvenim osebjem in tujejezičnimi pacienti v Sloveniji daje vseslovenska raziskava, kjer je na vprašalnik, ki je bil posredovan

vsem članom Zdravniške zbornice Slovenije ter Zbornice zdravstvene in babiške nege Slovenije leta 2016, odgovorilo 564 zdravstvenih delavcev različnih profilov z različnih nivojev zdravstva in iz različnih slovenskih krajev (Mikolič Južnič 2019: 18). Kar 94 % se jih je pri svojem delu že srečalo z bolniki, ki ne razumejo in ne govorijo slovenskega jezika, z njimi pa se srečujejo na vseh nivojih zdravstvene dejavnosti (Mikolič Južnič 2019: 24). Odgovori iz te raziskave nakazujejo, pri katerih jezikih so imeli zdravstveni delavci najpogosteje težave s sporazumevanjem. Med najpogostejšimi so bili albanščina, nemščina, makedonščina, italijanščina in hrvaščina/srbščina/bosanščina/črnogorščina (Kocijančič Pokorn 2019: 100). Nekateri drugi, ki so bili navedeni kot redkejši, pa bodo zaradi globalnih sprememb v zadnjem desetletju, odkar je bila raziskava opravljena, morda v prihodnje tudi bolj izpostavljeni.

INTENZIVNE ENOTE ZA NOVOROJENCE IN TUJEJEZIČNE DRUŽINE

Zdravstvena dejavnost deluje na več ravneh, v mnogih raznolikih enotah in oblikah. V enotah, kjer skrbijo za bolne novorojence, poteka skrb po načelu zaupanja – to se nekoliko razlikuje od ambulantne dejavnosti ali hospitalizacije pacientov drugih starostnih skupin. Starši nimajo druge izbire, pišeta Nina Margrethe Kynø in Ingrid Hanssen (2022: 64), kot da prepustijo usodo svojega novorojenega otroka rokam zdravstvenih delavcev ter poskušajo zaupati, da bo deležen najboljšega možnega zdravljenja in oskrbe. Ta situacija starše postavlja v zelo odvisen in ranljiv položaj, saj je razkorak v znanju med njimi in zdravstvenimi delavci tako velik, da je običajno nemogoče oporekati njihovi profesionalni presoji (prav tam). Če pa obstajajo še jezikovne prepreke, lahko te skupaj z nepoznano strukturo in organizacijo zdravstvenega sistema vodijo starše še v večjo čustveno stisko ter negotovost, zato težje aktivno sodelujejo in se težje navežejo na otroka (Kynø in Hanssen 2022: 68). Na EINT v ljubljanski porodnišnici začnejo starši postopoma prevzemati skrb za otroke, ko ti tehtajo več kot 1500 gramov, do takrat pa večinoma le stojijo ob inkubatorjih, enkrat (včasih dvakrat) na dan dobijo otroka v naročje, informacije dobivajo redno, vendar večinoma za nazaj – torej, kaj vse je že bilo narejeno. Gre za zdravljenje izredno nezrelih novorojencev, za kar starši običajno nimajo dovolj znanja, ob sprejemu v porodnišnico le podpišejo, da se z zdravljenjem strinjajo. V tem vidiku se zdravljenje zelo nezrelih in bolnih novorojencev zelo razlikuje od zdravstva na primarni ravni, ki je bolj obširno raziskano področje v slovenskih raziskavah.

Pri razumevanju sporazumevanja med zdravstvenimi delavci in starši novorojencev pa ni pomemben le razkorak v ravni njihovega znanja, temveč tudi v izkušnjah, dostopu do zdravstvene oskrbe in informacijski preobremenjenosti (preveč informacij prek različnih informacijskih kanalov, ki so morda nekaterim tudi neznan). Priseljenci imajo pogosto težave z navigacijo v lokalnem zdravstvenem sistemu. Težave imajo s pomanjkanjem informacij, nepoznavanjem zakonov, ter sistemom, ki mora najprej zadostiti birokratskim zahtevam (Lipovec Čebren in Bombač 2018: 660; Ojeda, dos Santos in Damiani 2020: 7). Švedske raziskovalke Khadijah Kainat, Eeva-Liisa Eskola in Gunilla Widén (2021: 1131) s svojo kvalitativno raziskavo opozarjajo, da se migrantke (še posebej begunke) v državi prihoda s

ANJA MAROLT

Sporazumevanje med zdravstvenim osebjem ter tujejezičnimi starši novorojenčkov v Enoti intenzivne nege in terapije prezgodaj rojenih novorojencev Porodnišnice Ljubljana

tem pogosto srečujejo. Težave imajo zaradi nove in drugačne kulture sporazumevanja ter pomanjkanja ustreznih virov in socialnih mrež. To potrjuje tudi moje opazovanje odnosov med nekaterimi priseljenkami in zdravstvenim osebjem, tudi v pogovorih med zdravstvenim osebjem, ter je še posebej očitno, kadar je zdravstveno osebje v stiku z materami, ki niso v spremstvu partnerja, kar pa je med dalj časa trajajočo hospitalizacijo večino časa (možje so zaposleni in redkeje prihajajo na obiske) (Marolt 2024: 17). Ženske se lahko odzovejo s stresom, paniko, opuščanjem nalog, izgubljanjem časa in sprejemanjem napačnih odločitev, kar negativno vpliva na proces vključevanja v novo okolje (Kainat, Eskola in Widén 2021: 1131). Opazila sem, da takšno vedenje zdravstveni delavci lahko dojemajo kot lenobo, raztresenost, »nematerinskost«, nepozornost do otroka, nezadostno izkazovanje ljubezni, kot da »se imajo za nekaj več«, da ne sledijo navodilom, četudi so jim narisana in napisana, ter ne izkazujejo »osnovnega bontona« (Marolt 2024: 22, 58). V večini primerov gre verjetno zgolj za novo, tuje, drugače sistematizirano okolje, katerega pravil in načel ne razumejo, saj so do tedaj živele v drugih okoljih, z drugačnim zdravstvenim sistemom. Nerazumevanje okoliščin priseljencev in strukturnih ovir, s katerimi se soočajo, lahko dodatno vpliva na težave pri sporazumevanju in izogibanje komunikaciji med zaposlenimi in svojci otrok.

JEZIKOVNI NESPORAZUMI MED ZDRAVSTVENO OSKRBO

Do jezikovnih nesporazumov med zdravstveno oskrbo prihaja, kadar se zdravnik ali zdravstveni delavec in pacient med obravnavo ne razumeta (Škraban in Lipovec Čebtron 2021: 9). Ni težko sklepati, kot pišejo Rebecca J Schwei in sodelavci, da je takšna zdravstvena oskrba lahko manj kakovostna (po Štante, Mlinar Reljić in Donik 2018: 234).

V Sloveniji ta tematika ni nova, poleg že prej omenjene raziskave o tem pišejo antropologi, jezikoslovci in zdravstveni delavci (Božič in sodelavci 2022; Morel, Gorjanc in Kocijančič Pokorn 2012; Škraban in Lipovec Čebtron 2021). Izvaja se tudi program za usposabljanje medkulturnih mediatorjev, ki bi lahko priskočili na pomoč v obravnavanih situacijah, vendar so zahteve po sistemskih ureditvah zaenkrat prešibke oziroma pretihe, saj se v zadnjih letih kljub poslabševanju razmer in vse večjemu številu priseljencev v praksi stvari niso vidneje spremenile.

Za reševanje komunikacijskih problemov, ki nastanejo kot posledica rabe več kot enega jezika v pogovoru, se uporabljajo različne komunikacijske strategije. Zaposleni si lahko pomagajo s spletnimi prevajalniki (na primer Google Translate), sporazumevajo se tudi s pomočjo mimike, gestikulacije, risanja (Kocijančič Pokorn 2019: 41). Kot pogosto strategijo Nike Kocijančič Pokorn navaja tudi tolmačenje drugih oseb, ki so z uporabnikom prišle v zdravstveno ustanovo (prijatelji, sorodniki, znanci, sodelavci). Občasno tolmačijo kolegi, zdravstveni delavci, ki govorijo jezik pacienta. Tolmačijo pa lahko tudi drugi zaposleni, ki niso zdravstveni delavci, na primer administratorji, strežnice, varnostniki, kurirji. Še ena komunikacijska strategija je, da vsak govori v svojem jeziku, vendar je to smiselno le pri sorodnih jezikih. Manj pogosto pokličejo prevajalca (tolmača), pogosteje pa se uporablja

tudi tolmačenje drugih oseb po telefonu (Kocijančič Pokorn 2019: 35). Anika Božič, Anet Rožnik, Andrej Podlogar, Sabina Ličen in Mirko Prosen (2022: 207) s pomočjo svoje kvalitativne raziskave med medicinskimi sestrami kot eno izmed rešitev predlagajo tolmačenje na daljavo (z videokonferenco) za krajše pogovore. Nike Kocijančič Pokorn opozarja tudi, da je v praksi še vedno opaziti otroke v vlogi tolmačev, kar je ne le neprimerno, temveč celo sporno (2019: 41).

V nadaljevanju predstavljam nekaj primerov uporabe različnih komunikacijskih strategij. Ena izmed novejših je uporaba spletnih prevajalnikov. Google Translate, ki se najpogosteje uporablja v ta namen, sta s pomočjo prevajalcev proučila Sumanit Patil in Patrick Davies (2014: 2), ugotavljala pa sta, kako točni so prevodi na primeru desetih angleških medicinskih izrazov, ki so jih prevedli v 26 različnih jezikov. Kot uspešen se je izkazal le v 57,7 % primerov. Najbolje prevaja zahodnoevropske jezike, najslabše pa afriške, za svahili je bil prevod natančen le v 10 %. V resničnem življenju je zelo pomembno, da se zdravstveni delavci zavedajo, da lahko frazo »vaš otrok ima krče« prevede kot »vaš otrok je mrtev« (prav tam). V literaturi so pogosto te strategije predstavljene kot ločene, v svoji praksi pa opazam, da se med seboj, ravno zaradi slabe učinkovitosti, večinoma ves čas prepletajo, saj se pri popolnem nerazumevanju med sogovornikoma zdi, da nobena ne pomaga, zato zdravstveno osebo je kar se da inovativno preizkuša načine, ki bi omogočili razumevanje. To je predstavljeno v naslednjem primeru:

Bilo je poleti 2023, ko pridem v nočno službo, mi že popoldanski sodelavec pove, da mama ne govori slovensko. [...] Vidi se ji, da bi rada govorila z mano, me kaj vprašala, mi povedala. Z mimiko ji nakazujem, kaj želim, lahko mi vsaj malo pomaga, da se bo počutila bolj vključeno. Nekako se nama uspe sporazumeti in pomaga mi s podlaganjem svežih plenic, poskrbim za ostale stvari, ki jih ne more sama. Rada bi ji povedala, da je z otrokom vse v redu, da pa ima zaradi antibiotikov zelo vneto in rdečo ritko in da ga bom pustila vsaj nekaj ur golega, da se mu suši na zraku, kar pospeši celjenje kože. Najprej sem ji poskusila pojasniti s pomočjo Google Translate, čeprav me je ves čas skrbelo, kako bo prevajalnik prevedel besedno zvezo rdeča ritka. Moja taktika pri uporabi spletnega prevajalnika je taka, da ne vnašam celih odstavkov besedil, ampak le posamezne besede. Zdi se mi, da je tako večja verjetnost, da bo razumljivo prevedel. Ni se izšlo, ker me zmedeno gleda, zato razvijem otroka iz pleničke in kažem, kakšno ima kožo na ritki. Še vedno razlagam, da ga bom pustila golega, čeprav me ne razume. Že z oblečenim jo je tako skrbelo glede njegove telesne temperature, ves čas ga je pokrivala, jaz pa odkrivala. Potem sem ji pokazala na grelec nad posteljo, ga nastavila na večjo jakost, otroka obrnila na trebuh in ji kazala, da bo tako ostal, in ne, ne bo ga zeblo. Kažem vse možne znake za O. K. in v redu, ona mi kaže telefon, skrbi jo, da bi ga zeblo, jaz pa njej svoj termometer, ki ga postavim poleg otrokove glave. Temperaturo mu bom merila pogosto, upam, da razume. Ko odide iz sobe, me še enkrat ujame s pogledom in z znakom za molitev pokaže nanj. To sem razumela kot: prosim, pazi nanj. In sem. (terenski zapis, 14. 11. 2023)

Primer prikazuje poskuse komunikacije z albansko govorečo mamo preko spletnega prevajalnika, ki je najpogostejši način sporazumevanja s to jezikovno skupino pacientov. Zavedam se, da ni idealen, mnogi zdravstveni delavci pa ga ne želijo uporabljati, za kar imajo povsem legitimne razloge (napake pri prevodih, neosebnost komuniciranja, nepoznavanje tehnologije, težave z varovanjem podatkov). Kot je razvidno iz primera, uporaba spletnega

prevajalnika ni pomagala, na neki točki je vodila celo v zmedo in se je kot uspešnejši način izkazala neverbalna komunikacija. Takšnega kombiniranja različnih načinov je v praksi veliko. Ta izmenjava je potekala ob deveti uri zvečer, gospa verjetno niti ni pričakovala tolikšne izmenjave, če bi lahko prosila za pomoč vsaj kakšnega znanca. Stalna (ali vsaj rednejša) prisotnost medkulturnega mediatorja bi takšne, resnejše situacije omilila. V tem primeru ni šlo za nič ogrožajočega, vendar se podobno raztresene izmenjave dogajajo tudi v kočljivejših situacijah. Ali obstaja primerna neformalna komunikacijska strategija, kako nekomu, ki ne razume, pojasniti, da njegov otrok nujno potrebuje operacijo, bo slep, na invalidskem vozičku ali ima strukturno nepravilno ledvico?

Tolmači, ki jih srečujemo v vsakodnevni praksi, so najpogosteje neformalni. Če jih starši že pripeljejo s sabo, pa ne prihajajo dovolj pogosto, saj je težko zagotoviti njihovo prisotnost ves čas trajanja hospitalizacije, ki lahko traja tudi štiri mesece. Če pride do nenadnega poslabšanja stanja pri otroku, si starš želi informacij takoj, ker je težko čakati uro ali več. To bom prikazala s spodnjim primerom matere, ki je bila gluha. Takšni in podobni dogodki so zelo pogosti tudi pri tujejezičnih svojcih, s to razliko, da se zavedajo, da jim na pomoč zaradi neurejenosti področja ne bo prišel profesionalni tolmač.

Starša otroka sta bila gluha in jima po zakonu pripada, da za tolmačenje pride tolmačka. To je najbolj ustrezen način komunikacije in staršema je bil seveda omogočen. Eno dopoldne pa se je stanje otroka nenadoma zelo poslabšalo. Mama je prišla na obisk in bila vsa iz sebe, ko je videla, koliko ljudi se gnete okrog njenega majhnega dojenčka. Gluhi ljudje so še bolj pozorni na neverbalno komunikacijo, zelo hitro je opazila, da je nekaj zelo narobe. Vsi, ki smo opazovali od dlje, smo videli, v kakšni stiski je, bila je vsa iz sebe. Takoj je želela govoriti z zdravnikom, ki ji je bil pripravljen takoj pojasniti, kaj se dogaja, vendar je bila težava v tem, da tolmača tisti trenutek ni bilo na EINT. Zelo težko se opiše, kako je v takem trenutku, ko starš ne ve in ne razume, kaj se dogaja z otrokom, in bi rad vedel takoj, a je prisotna komunikacijska ovira. Mama je rekla, da lahko nekaj prebere z ustnic, vendar je takoj poklicala nekoga na telefon, ki ji je pretolmačil v znakovni jezik. Zdravnik je govoril, ona je gledala njega in na koncu dopolnila še s tistim, kar ji je oseba pokazala prek telefona (jasno, bil je videoklic). (terenski zapis, 24. 6. 2024)

Primer prikazuje stisko matere, ki so jo zdravstveni delavci želeli kar se da hitro rešiti skrbi. Pri tem je bilo uporabljeno tolmačenje znakovnega jezika po telefonu, ki ima na papirju veliko slabosti – slabost ozvočenja, povezave, težavno tolmačenje pogovorov, kjer sogovorniki istočasno govorijo, pomanjkanje kontekstualnih informacij (Cho 2023: 1038; Hadziabdic in Hjelm 2014: 6). Hitra pomoč je mater vseeno nekoliko pomirila, dokler ni bil na voljo boljši način za podajanje informacij, ko se je tudi situacija že malo umirila in otrok stabiliziral. V primeru tujejezičnih staršev je zelo odvisno, iz kakšnega okolja prihajajo. Nekateri imajo na voljo vsaj kakšno osebo za neformalno tolmačenje, nekateri znajo nekaj angleščine, včasih pa (sploh če je stanje otroka slabo in se iz obiska v obisk hitro spreminja) enostavno ne sledijo vsemu, se morda težko pogovarjajo z uradnimi osebami, se ne znajdejo v tem visokointenzivnem okolju ter samo tiho prihajajo na obiske in kimajo ob poskusih sporazumevanja zdravstvenih delavcev. Njim ni težko ugotoviti, da starša ne razumeta, kar jim govorijo. V praksi se pogosto izkaže za uporabno in priročno komunikacijsko strategijo medvrstniška pomoč med uporabniki, ki izhajajo iz istega okolja in delijo izkušnjo bivanja v bolnišnici.

Gospa, ki govori le albansko, je že kakšen mesec vsak dan na EINT, kjer obiskuje svojega otroka. Občasno si pri sporazumevanju in podajanju informacij pomagamo tako, da ona pokliče nekoga s svojega telefona, ki ad hoc tolmači, v nekem trenutku pa je bilo na oddelku več albanskih mamic, zato si lahko pomagamo s tistimi, ki razumejo slovensko. Običajno ni dovoljeno, da starši sploh gledajo druge paciente, kaj šele, da bi dobivali zanje informacije, saj je varovanje informacij pri delu v zdravstvu visoko na lestvici etičnih zahtev. [...] Staršem je bolj pomembno, da vedo, kaj se dogaja, kot pa to, da bi jih skrbelo, kdo ve, kaj je z njihovim otrokom narobe. Večinoma so to gospe, ki postanejo prijateljice, medtem ko skupaj bivajo v porodnišničnem apartmaju za doječe mame in si želijo pomagati med seboj. Večinoma tudi niso znanci, da bi jih skrbelo širjenje informacij izven porodnišnice, saj se pred tem sploh niso poznali. Tokrat je mamica, ki ni razumela, prihite-la z gospo iz sosednje sobe. Tudi sicer smo ju ves čas videvali skupaj, v apartmaju za mamice nedonošenčkov sta bivali v isti sobi in gotovo sta se dobro povezali. Osebno tolmačenje je za vse lažje in bolj kvalitetno. Gospa, ki je ta dan tolmačila, je bila slučajno prosta, ker so pri njenem otroku uvajali osrednji venski kateter. Ko smo jo odslovili, saj pri sterilnem posegu nihče ne sme biti v sobi, je bila vidno zaskrbljena. V tistem trenutku pa jo je gospa, ki ne razume slovensko, prosila če lahko pride k njej tolmačit. Z njenim otrokom ni bilo dosti težav, bil je večji in večinoma je tolmačila le dobre informacije. Rešitev se ti v tistem trenutku zdi skoraj idealna, vendar je bilo čutiti malo napetosti zaradi zaskrbljenosti matere tolmačke glede svojega otroka, ki je ravnokar prestajal poseg. (terenski zapis, 17. 10. 2023)

Primer kaže na uporabo medvrstniške pomoči v vsakodnevni praksi. Zdravstveni delavci se zavedajo, da je deljenje informacij drugim osebam nedovoljeno, vendar je bila v tem primeru narejena izjema, saj se je mati, ki ne razume slovenščine, s tem strinjala. Po besedah Uršule Lipovec Čebrovič gre »za hierarhično pravic, pri čemer se lahko eno povsem spregleda zavoljo pravice zdravstvenih delavcev in pacientov po medsebojnem razumevanju. Čeprav je pri ostalih pacientih potrebno spoštovati obe pravici, se tu ena umakne tisti, ki je za zdravstvene delavce bolj bistvena« (osebna komunikacija, 3. 7. 2024). V tujini (na primer v skandinavskih državah, ZDA, Avstraliji, Veliki Britaniji) so bolj odprti pri številu obiskovalcev in je dajanje informacij večjemu številu ljudi bolj sprejemljivo, sistem ni tako rigiden (Haslund-Thomsen 2024). Kakovostna izmenjava informacij je nujna za dober rezultat, starši se počutijo bolj vključene in manj jih skrbi. Starši si lahko brez pojasnil in informacij dogodke tudi po svoje (narobe) razlagajo – na primer alarme, neverbalno komunikacijo, drugo dogajanje. Tujejezični pacienti se tudi sami ne znajo ali ne morejo izraziti, zato njihove skrbi ostanejo neslišane in potlačene. Prav tako se pojavlja skrb, da je za osebo, ki tolmači in je sama v težki situaciji, to tudi prevelika obremenitev, še posebej če tolmači več različnim osebam ter so informacije negativne.

Še ena izmed slabosti takšnega načina tolmačenja, ki jo navajata Emina Hadziabdic in Katarina Hjelm (2014: 9), je v tem, da je sogovornikom lahko nerodno govoriti pred znanci (prijatelji, sodelavci, vrstniki, sorodniki) o nekaterih stvareh – predvsem v zvezi s telesom in njegovimi funkcijami. Medvrstniška pomoč pa ima tudi prednost v tem, da se matere med seboj večinoma dobro povežejo, družita jih skupna izkušnja in globoko razumevanje nastale situacije. Tudi če bi pacient imel pravico do izbiranja formalnega tolmača, je zelo pomembno, da je podobne starosti, istega spola, govori isto narečje in je istega političnega prepričanja (prav tam).

V slovenski kvalitativni raziskavi med medicinskimi sestrami je bila uporaba neverbalne komunikacije na pomembnem mestu (Božič idr. 2022: 205). Ker je pri tujejezičnih starših verbalno sporazumevanje oteženo ali onemogočeno, se pogosto še bolj osredotočajo na neverbalno komunikacijo. Z opazovanjem izrazov na obrazu zdravstvenega osebja in tonov njihovega glasu starši poskušajo dobiti občutek o tem, ali ima njihov otrok resne težave ali je vse v redu. Prijazen ton glasu presega jezikovne ovire ter pomaga sogovorniku, da se počuti sprejetega in varnega (Kynoe, Fugelseth in Hanssen 2020: 2228; Patriksson, Nilsson, Wigert 2019: 196). Treba pa se je zavedati, da je neverbalna komunikacija (bolj kot verbalna) kulturno specifična in lahko pomeni nekaj povsem drugega, kot je bilo prvotno mišljeno. Reakcije na neverbalna dejanja so pogosto še posebej nezavedne in globoko zakoreninjene (Alpres 2018: 320).

Pri komunikaciji s tujejezičnimi pacienti je potrebno več iznajdljivosti, če na voljo ni prisotnega tolmača. Že ob prvem stiku je težko pojasniti, kdaj sploh lahko pridejo, kje je vhod, kako naj se pripravijo za prihod. Če s starši nimam skupnega jezika, ju peljem do vhoda na oddelek, skozi filter, kjer nakažem, da slečeta dolge rokave in snameta ure in prstane ter kako si morata vsakič umiti roke do komolcev. Kasneje, ko starša pričneta sama rokovati z otrokom, je postopek enak, s tem da ne razumeta verbalnega dela postopka, čeprav mamam razlagam v slovenščini, gibe pa bolj poudarim, da bi razumele, kaj je bolj pomembno, in kasneje popravljam njihovo rokovanje. Čase obrokov in previjan napišem na listek papirja in zraven ur pokažem, da se takrat menja pleničke in hrani po steklenički. Upam, da starša razumeta, naj takrat prideta. Tudi pri hranjenju je potrebno malo več fizične pomoči in pri spodrseljajih je včasih nerodno, ker si želimo kaj povedati, ampak vidimo, da se ne razumemo, stvari pa obvisijo v zraku. (terenski zapis, 3. 4. 2024)

Katarina Patriksson, Marie Berg, Stefan Nilsson in Helena Wigert (2017: 250) so med intervjuvanjem šestdeset zdravstvenih delavcev v švedskih neonatalnih intenzivnih enotah opazili podobno, kot je razvidno iz zgornjega primera – da se zdravstveni delavci zavedajo frustrirajočega dejstva, da je prenos informacij v takšni izmenjavi nepopoln. Nesporazumi lahko povečujejo zaskrbljenost staršev, hkrati pa osebje čuti, da oskrba, ki jo ponujajo, ni v skladu z zakoni in predpisi – je nepopolna in neenaka. Ker starši ne morejo izraziti skrbi in volje v zvezi z oskrbo svojega otroka, imajo le omejene možnosti vpliva nanjo, pišejo švedski raziskovalci (prav tam). Opažajo, da med nego novorojenčkov, ko običajno starši prisostvujejo delu, ni mogoče klepetati z njimi, pri čemer se izgubita velik del navidezno manj pomembnih informacij ter možnost za dober odnos in komunikacijo. Pogosto se zdravstveni delavci vidijo kot učitelje jezika, saj se z dnevno komunikacijo z njimi ti starši tudi učijo jezika (prav tam). Te, na videz drobne informacije so za starše zelo pomembne, saj jih pomirjajo, hkrati pa so velika popotnica za življenje po bolnišnici, polne so namreč nasvetov glede dela z nedonošenimi otroki, ki jih težko dobijo kjerkoli drugje.

Podobno opažata Bengü Çetinkaya in Sibel Serap Ceylan v turški kvalitativni raziskavi (2023: 29). V okviru v »družino usmerjene oskrbe« pri tujejezičnih starših ne dosega optimalne oskrbe tujejezičnih staršev. Starše je treba podučiti o hranjenju, previjanju, rokovanju, ustreznih higieni rok in njenem pomenu. Vse te informacije so nepopolno prenesene in negovalno osebje pogosto skrbi, kako bodo starši doma zagotavljali ustrezno oskrbo svojemu nedonošenčku, ki se lahko pri težjih primerih zelo razlikuje od skrbi za zdravega, ob

roku rojenega otroka (prav tam). Prav tako opažata, da imajo zaradi nerazumevanja navodil ob odpustu in preračunavanja zdravil veliko ponovnih sprejemov. Ker ne razumejo navodil, tudi ne pripeljejo otrok na rutinske preglede, ki sledijo odpustu – sledenje teže, svetovanje glede prehrane, bazično cepljenje. Osebu zagotavljanje ustrezne nege ter podajanje informacij, pomembnih za odpust in nego doma, otežuje še nižja raven izobrazbe nekaterih tujcev, kar potrjujejo tudi rezultati drugih raziskav, ki jih navajata Çetinkaya in Ceylan (2023: 31).

ZAKLJUČEK

Migracije niso nov pojav, saj obstajajo, odkar obstaja človeštvo, vendar so se v zadnjih desetletjih razmahnile, zdravstvena dejavnost pa se temu zaradi svoje hierarhizirane rutine, zastarelosti zakonodaje in počasnega sledenja sistemskih sprememb zelo težko prilagaja, kar povzroča težave ne le pacientom, temveč tudi zaposlenim. V primeru jezikovnih nesporazumov so te težave, še posebej v intenzivnih enotah, kot je EINT, kjer so visoka zahtevnost zdravljenja, kočljivost situacij in težko zdravstveno stanje pacientov, še bolj očitne.

V zadnjih letih je bilo opravljenih več raziskav o jezikovnih ovirah v zdravstvu, podanih več pobud za izboljšanje razmer, vendar se tako velik sistem zelo počasi odziva. Obstaja več ravni zdravstvene dejavnosti, vsaka bi potrebovala malo drugačne rešitve, ki jih zakoni zaenkrat povsem izrecno ne predvidevajo. Nekatere zdravstvene ustanove že imajo na voljo medkulturne mediatorje, ki jim pomagajo pri oskrbi tujejezičnih pacientov, v večini pa se zdravstveni delavci še vedno zanašajo na svojo iznajdljivost, pri čemer zdravstveno osebje razvija ali pogloblja odpor do (nekaterih) tujcev (Marolt 2024: 22), ker je zaradi preobremenjenosti in nerazumevanja sporazumevanje z njimi bolj zamudno ter manj kakovostno.

Zdravstveno osebje si pri sporazumevanju s tujejezičnimi pacienti zaradi odsotnosti sistemske pomoči pomaga z različnimi komunikacijskimi strategijami, nekatere so v prispevku natančneje predstavljene in analizirane. Večina sporazumevanja na EINT poteka med negovalnim osebjem in materami, ki se, kadar gre za priseljenke, pogosto slabše znajdejo v slovenskem zdravstvenem sistemu ter slabše govorijo kak skupen jezik z osebjem ali pa ga sploh ne. Vse neformalne rešitve, ki jih zdravstveno osebje uporablja, imajo določene slabosti in vplivajo na to, da zdravstvena oskrba njihovih otrok ni povsem enakovredna: starši so slabše informirani, razvijejo lahko večjo stisko med hospitalizacijo ter se slabše naučijo nege nedonošenih otrok.

Zdravstveni delavci se zaradi vse pogostejših stikov s tujci med seboj vse pogosteje pogovarjajo o spremembah pri svojem delu in o delu s tujejezičnimi starši. Za nastale razmere (frustracije ob nerazumevanju, daljše obravnave, iskanje rešitev za doseganje minimalnega razumevanja) najpogosteje krivijo prav priseljence, kar le še pogloblja že tako prisoten neorasizem (glej Lipovec Čebren 2021; Marolt 2024: 22). Takega delovnega vzdušja in tovrstnih načinov reševanja jezikovnih nesporazumov zdravstveni delavci intenzivne enote, ki jih v času svojega študija, pred desetimi ali tridesetimi leti, niso mogli pričakovati: trenutne razmere v zdravstvu, položaj pacientov, ki ne razumejo in se težko sporazumevajo, ob zanje verjetno najpomembnejšem dogodku v življenju – rojstvu otroka.

IZJAVA: Članek je nastal na podlagi avtoričine magistrske naloge. IZJAVA O DOSTOPNOSTI PODATKOV: Članek temelji na etnografskem gradivu, ki ga ne opredeljuje kot zbirke raziskovalnih podatkov. Vse nadaljnje informacije o uporabljenem gradivu so na osnovi utemeljene prošnje dostopne pri avtorici.

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SUMMARY

The author of the article conducted an autoethnographic study exploring language-based misunderstandings between healthcare professionals and foreign language speaking parents of newborns admitted to the Neonatal Intensive Care Unit (NICU) of the maternity hospital in Ljubljana, where she works as a midwife (NICU nurse).

The modern world is characterised by a high flow of ideas and people, and research data indicates that migration will only continue to increase. The healthcare system is adapting very slowly to these changes, and legislation is not keeping pace. Specifically, it fails to clearly define the rights of foreign speaking patients regarding access to interpretation services.

When a child is born prematurely or becomes ill shortly after birth, parents suddenly find themselves in an intensive unit, an environment that is unfamiliar to them. In addition to concern for their child's well-being, foreign language speaking parents also face the burden of not understanding what is being communicated. Healthcare staff employ various communication strategies to assist with understanding, but these cannot fully replace proper interpretation. The information parents receive is often incomplete, especially when their children have multiple or more severe health issues.

The article presents real-life examples where staff have had to rely on their creativity and use alternative communication strategies, such as online translators, facial expressions, video calls, or even asking other parents for help. Each of these strategies has its strengths and weaknesses, but all are imperfect, informal, and unverifiable, since the staff cannot be certain what the parents have understood or how they have interpreted the provided information.

The experiences of those involved in such high-stress situations call for better regulation, especially at the systemic level, to ease the burden placed on healthcare workers, and not only reduce the psychological stress these parents are experiencing but also empower them to care for their children more effectively after discharge from the hospital.

ANJA MAROLT

Sporazumevanje med zdravstvenim osebjem ter tujejezičnimi starši novorojenčkov v Notri intenzivne nege in terapije prezgodaj rojenih novorojencev Porodnišnice Ljubljana

Ljudje na poti med pandemijo covid-19: zdravje in dostop do zdravstva



People on the Move During the Covid-19 Pandemic:
Health and Access to Healthcare

Pia Krامل, Neža Vodopivec

1.01. Izvirni znanstveni članek
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IZVLEČEK

Članek raziskuje povezavo migracij in zdravja ter dostopa do zdravstva ljudi na poti, med katerimi so osebe s statusom begunk_cev, prosilk_cev za azil in oseb z dovoljenjem za zadrževanje, med pandemijo covid-19 v Sloveniji. Analizira gradivo, ki je bilo leta 2021 zbrano v okviru mednarodnega projekta Sonar-Global, in sicer kot del etnografske raziskave v Ljubljani z imenom Covid-19: ocena ranljivosti in vključevanje skupnosti. Pokaže na dejavnike, ki presegajo formalni dostop do zdravstvenih storitev in vplivajo na zdravje ljudi na poti. KLJUČNE BESEDE: Pandemija, covid-19, migracija, zdravje, zdravstvo, ljudje na poti, begunci_ke

ABSTRACT

The paper examines the connection of migration, health, and access to healthcare during the covid-19 pandemic in Slovenia for people on the move, namely refugees, asylum seekers, and persons with permission to remain in the Republic of Slovenia. The paper is an analysis of the materials collected in 2021 in Ljubljana during the ethnographic study Covid-19: Vulnerability Assessment and Community Engagement, which was conducted as a part of the Sonar-Global project. The paper demonstrates some factors that go beyond the formal access to healthcare and influence the health of people on the move. KEYWORDS: pandemic, Covid-19, migration, health, healthcare, people on the move, refugees

Pandemija covid-19, ki jo je Svetovna zdravstvena organizacija razglasila 11. marca 2020 (WHO 2020), je tako v splošni javnosti kot v antropologiji sprožila razmisleke o (potencialnih) spremembah družbe med pandemijo in po njej. Rylan Higgins, Emily Martin in Maria D. Vesperi so se že v uvodniku revije *Anthropology Now* (*Antropologija zdaj*), ki je izšla aprila 2020, vprašali, ali bodo prepadi, ki so že na začetku pandemije začeli nastajati med ljudmi različnih etničnih pripadnosti, spola, starosti itn., končno »prisilili države, da se posvetijo globokim vzrokom takih neenakosti«, in pripeljali do spoznanja, da lahko antropologije »dragoceno prispevajo k osvetlitvi neštetih prepletov bioloških in družbenih kompleksnosti covid-19« (2020: 2). Čeprav ni opaziti, da je prišlo do večjih premikov glede ukvarjanja z neenakostjo in glede odnosa do antropologije, je pandemija posegla v vse vidike družbenega življenja ter od antropologije zahtevala tako njen angažma kot prilagoditev raziskovalnih metod (gl. Podjed in Muršič 2021).

V pričujočem članku bova predstavili raziskavo projekta Sonar-Global, ki je potekala med pandemijo covid-19, sledil ji bo del o raziskovanju zdravstva in zdravja v zvezi z ljudmi na poti med to pandemijo, nato pa bova podrobneje predstavili in analizirali dejavnike, ki so v tem obdobju vplivali na zdravje in dostop do zdravstva ljudi na poti.

Več avtoric_jev je pandemijo covid-19 prepoznalo kot totalno družbeno dejstvo (gl. npr. Ghahramani idr. 2021; Labora González in Fernández-Vilas 2024; Santos, Pontes in Coimbra ml. 2020), saj je vplivala na »vsa področja življenja« (Labora González in Fernández-Vilas 2024: 2): poleg javnega zdravja še na gospodarstvo, zakonske regulacije in politične odločitve, odnose med državami, družbene in kulturne vidike življenja, na psihološko stanje ljudi, verske prakse in srečanja, znanost in tehnologijo, izobraževanje in drugo (Labora González in Fernández-Vilas 2024: 4–5). Ti vidiki so med seboj povezani in vplivajo drug na drugega, hkrati pa razkrivajo razloge za to, da so bili v pandemiji covid-19 nesorazmerno prizadeti nekateri že tako marginalizirani deli prebivalstva, med drugim ljudje na poti (ibid), na katere se osredotoča pričujoči članek.

Podobno so razmišljali člani_ce konzorcija Sonar-Global, ki je prepoznal pomen in dolžnost raziskovalcev_k v družboslovju in humanistiki, da ob nastopu pandemije covid-19 vprežejo svoje metodološke pristope in znanstvene aparate. V ta namen so razširili projekt¹ ter pridobili dodatno financiranje za raziskovanje posledic pandemije v okviru raziskave Covid-19: ocena ranljivosti in vključevanje skupnosti (Lipovec Čebren 2023: 22).² Pomemben del gradiva, zbranega v raziskavi, je bil analiziran že v znanstveni monografiji *Kovidna krajina: ranljivosti v času pandemije* (Lipovec Čebren in Pistotnik 2023b), toda izkušnje

1

Polno ime projekta: SoNAR-Global – globalne mreže družboslovnih ved za nalezljive bolezni in protimikrobno odpornost (2019–2020) (Lipovec Čebren in Pistotnik 2023a: 15), v izvorniku SoNAR-Global: A Global Social Sciences Network for Infectious Threats and Antimicrobial Resistance. Projekt je nastal v okviru programa Evropske unije za raziskave in inovacije, imenovanega Obzorje 2020 (Horizon 2020) (Lipovec Čebren 2023: 22).

2

Kot raziskovalka je v njem sodelovala tudi Neža Vodopivec, ki je med drugim zbrala gradivo, ki ga je Pia Krامل analizirala v svoji magistrski nalogi (Krامل 2024), na kateri temelji pričujoči članek. O primerjalni raziskavi ranljivosti, ki je temeljila na vključevanju skupnosti (angl. *community engagement*), so pisale raziskovalke_ci projekta Sonar-Global (Geise idr. 2025).

ljudi na poti so bile vanjo vključene posredno.³ Ker njihove izkušnje na podlagi zbranega gradiva torej še niso bile analizirane, se v članku osredotočava na vprašanji, kakšen je bil dostop do zdravja in zdravstva v Sloveniji med pandemijo covid-19 ter kateri dejavniki⁴ so na to vplivali. Ti vprašanji nas morata zanimati, saj bi si kot družba morali prizadevati za spoštovanje pravic vseh ljudi, ne pa se sprizajzati s politikami in praksami, ki poglobljajo družbene neenakosti, na kar med drugim kaže tudi izpuščanje ljudi na poti iz zaščitnih ukrepov med pandemijo (Saifee, Franco-Paredes in Lowenstein 2021: 160). Poleg tega je proučevanje dostopa do zdravja in zdravstva ljudi na poti pomembno za celotno družbo, saj »hierarhizacija in selektivnost v dostopu do zdravstvenih pravic zadeva vse širši krog prebivalcev/-k, pri čemer je mogoče pri osebah z migrantsko izkušnjo, ki živijo v negotovih statusih, ovire le lažje zaznati, saj so običajno bolj intenzivne in številčnejše« (Fassin 2004: 204 po Lipovec Čebren 2017: 55).⁵

Odgovore na zastavljeni vprašanji bova iskali na osnovi analize polstrukturiranih intervjujev: leta 2021 jih je bilo v Ljubljani izvedenih 109, od tega osem z osebami, ki jih lahko umestimo med »ljudi na poti« (prosilce za mednarodno zaščito, osebe s statusom begunca ali subsidiarno zaščito), in dva z osebama, ki se pri svojem plačanem ali prostovoljnem delu ukvarjata z ljudmi na poti. Analiza gradiva je bila narejena s poglobljenim pregledom transkripcij polstrukturiranih intervjujev in terenskih povzetkov teh intervjujev (Lipovec Čebren 2023: 24). Četudi so bili nekateri od sogovornikov_c ranljivi zaradi več različnih dejavnikov, so bili v raziskavo vključeni na podlagi svoje begunske izkušnje. Intervjuji so potekali v slovenščini in angleščini, z občasnim preskakovanjem med jeziko-ma.⁶ Zaradi pandemičnih ukrepov, ki so ustavili skoraj vse vidike javnega življenja, je bilo težko priti v stik z ljudmi na poti, zato je bilo treba pri iskanju sogovornikov_c izhajati iz predhodno vzpostavljenih kontaktov in nato uporabiti tudi metodo snežne kepe. Do ljudi na poti, ki so bili v času opravljanja raziskave zaprti v Centru za tujce, dostop ni bil mogoč zaradi izrednih, s pandemijo povezanih ukrepov.

3

Jasmina Kuduzović (2023) je analizirala dostop do zdravstva študentk_ov z območja nekdanje Jugoslavije, izkušnje ljudi na poti pa so bile vključene tudi v prispevke o dostopnosti zdravstvene oskrbe v času pandemije (Pistotnik 2023) in o pandemiji v totalnih ustanovah (Škraban 2023).

4

Dejavnike (angl. *factors*) v članku razumeva predvsem v smislu strukturnih in družbeno-kulturnih dimenzij, ki lahko bolj ali manj neposredno vplivajo na dostop ljudi do zdravstvenih storitev ter na njihovo zmožnost ohranjanja zdravja. Omenjeni dejavniki seveda niso nespremenljiva kategorija in na sogovornike_ce ne delujejo le sami po sebi, temveč se lahko med seboj prepletajo, njihovi učinki pa se pri tem lahko krepijo. Čeprav so zaradi preglednosti nekateri dejavniki v članku obravnavani ločeno, bova hkrati opozorili tudi na njihovo spletnje in medsebojno vplivanje, da bi se s tem izognili poenostavljanju kompleksnih med seboj prepletenih družbeno-kulturnih dimenzij ter njihovemu napačnemu razumevanju kot »sekundarni[h] dejavnik[ov], ki so deležni manjše pozornosti v primerjavi z dejavniki okolja, psihološkimi ali genetskimi dejavniki« (Lipovec Čebren 2019: 39), kot se lahko zgodi v kontekstu javnozdravstvenega razumevanja družbenih in kulturnih vidikov bolezni (ibid.).

5

V pomoč nam je lahko »migrantizacija« državljanov, ki naj bi pomagala »uvideti povezave in podobnosti med formalnimi izključevanji nedržavljanov in pogostimi oblikami neformalnih izključevanj državljanov« (Anderson 2019 po Zavrtnik in Cukut Krilić 2021: 84).

6

Recimo pri lokalno specifičnem poimenovanju slovenskih organizacij in pojmov v zvezi z migracijo, statusom ali pravom.

Čeprav nobeno poimenovanje sogovornic_kov ne zaobjema popolnoma kompleksnosti in globine begunske ali širše, migracijske izkušnje, se je po pregledu bolj ali manj uveljavljenih možnosti »ljudje na poti« (*people on the move*) vendarle zdelo najprimernejše (gl. Kurnik 2019; Lunaček 2019; Zavrtnik in Cukut Krilić 2021). Poleg tega, da se z uporabo te besedne zveze izognemo binarnosti migrant/begunec (Hamlin 2021: 1), ki jo kot dihotomični kategoriji »definirajo oblastne strukture z namenom, da bi [...] vzpostavljale problematično ločnico med ‚begunci‘ in ‚ekonomskimi migranti‘« (Lipovec Čebtron 2017: 55), lahko besedna zveza zajame tudi njihove nelinearne izkušnje bivanja.⁷ Posameznice_ki so v prispevku omenjeni v povezavi s pravnimi statusi, ki so jih imeli v trenutku intervjujev, saj imajo ti pomembno vlogo pri razlikah v dostopu do zdravja in zdravstva.

RAZISKOVANJE ZDRAVJA LJUDI NA POTI

Svetovna zdravstvena organizacija je decembra leta 2020 »migrantke_e in begunke_ce« označila kot najbolj ranljive dele prebivalstva zaradi omejenega dostopa do informacij v jeziku, ki ga razumejo, bivanjskih okoliščin ter odrinjenosti v zdravstvenih, pravnih in drugih strukturah (Leung idr. 2023: 34). Od začetka pandemije covid-19 so bile na temo zdravja in dostopa do zdravstva ljudi na poti objavljene številne antropološke in druge raziskave, ki so pomembne za razumevanje položaja ljudi na poti med to zdravstveno krizo.⁸ K zbiranju podatkov o družbeno marginaliziranih ljudeh med pandemijo covid-19 prispevala tudi raziskava COVID-19: ocena ranljivosti in vključevanje skupnosti, v kateri je sodelovala tudi slovenska raziskovalna skupina in med svoje sogovornike_ce vključila ljudi na poti, ki zaradi različnih dejavnikov družbene odrinjenosti lahko izpadejo iz raziskav (Lipovec Čebtron 2023: 27).

Raziskava je upoštevala, da je ranljivost več kot »le tveganje za razvoj nekaterih boleznih ali zdravstvenih težav« (Lipovec Čebtron 2023: 21) ter da je relatiiven pojav in spremenljiv koncept, ki ga je treba razumeti »znotraj konteksta, v katerem se [ranljivosti] pojavljajo« (Lipovec Čebtron 2023: 22). Da bi razumela lokalne ranljivosti (in prakse odpornosti), ki so obstajale ali so se pojavile med pandemijo, slovenska raziskovalna skupina »ni vnaprej opredelila posebnih skupin, za katere bi domnevali, da so med pandemijo postale ranljivejše, temveč je uporabila lokalno utemeljeno razumevanje in skupnostne izkušnje pri opredelitvi ‚ranljivosti‘ in ‚odpornosti‘« (Giles-Vernick 2023: 12).

Ugotovitve raziskave v Sloveniji so pokazale, da je pandemija covid-19 razkrila bolj ali manj znane ranljivosti ljudi in šibkosti (vsaj deklarativno) socialnopodpornih ustanov in

7

Sogovornik s statusom begunca je recimo eno državo na svoji migracijski poti poskusil prečkati desetkrat (LJ-NV-R15). Stojčić Mitrović (2022) piše, da je po »zaprtju formaliziranega migrantskega koridorja leta 2016 [...] nelinearno, fragmentirano, pogosto krožno gibanje postalo prevladujoča značilnost migracijskih gibanj na Balkanu«. Poleg tega ni nujno, da se bodo vsi sogovorniki_ce v Sloveniji tudi stalno naselili ali da bodo obdržali oz. pridobili pravni status, ki bi jim to omogočal.

8

Bojorquez idr. 2024; Bužinkin in Šelo Šabić 2024; Di Meo in Bentivegna 2021; Elia in Fedele 2021; Leung idr. 2023; Mangrio, Zdravkovic in Strange 2022; Medact, Migrants organise in New Economics Foundation 2020; Ōcek idr. 2023; Saifee, Franco-Paredes in Lowenstein 2021; Zavrtnik in Cukut Krilić 2021.

sistemov (Škraban 2023: 95), nekatere ranljivosti ljudi pa poglobila, spremenila ali zmanjšala in tudi povzročila nove (Lipovec Čebren 2023: 30). Moč krize (kar je pandemija gotovo bila), da razgali ranljivosti, je kot odmev besed Oliverja-Smitha (1996: 304) o naravnih nesrečah, ki lahko delujejo kot »naravni 'laboratorij' ali kot kriza, ki razkriva, saj so temeljne značilnosti družbe in kulture jasno ter nazorno razgaljene, ko se prioritete zmanjšajo na osnovne družbene, kulturne in materialne potrebe«. Gradivo, zbrano v Ljubljani, razkriva tudi mnoge (pandemične) ranljivosti ljudi na poti, ki so predstavljene v nadaljevanju.

ZDRAVJE IN DOSTOP DO ZDRAVSTVA LJUDI NA POTI MED PANDEMIJO COVIDA-19 V SLOVENIJI

Izkušnje sogovornic_kov – ljudi na poti – kažejo na razumevanje zdravja kot prepleta fizičnega in duševnega počutja, možnosti za socializacijo ter finančne stabilnosti, pri čemer so dejavniki med sabo bolj ali manj povezani. Podobno večdimenzionalno razumevanje zdravja podaja Musso, po kateri je v antropologiji zdravje razumljeno kot odraz družbenih, ekonomskih, okoljskih, geopolitičnih in drugih dejavnikov, ki se poznajo na telesu (2017: 21). Naslednja podpoglavja bodo poskus prepoznavanja dejavnikov, ki vplivajo na dostop do zdravja in zdravstva ljudi na poti med pandemijo covid-19 v Sloveniji ter prek tega razumevanja migracije ne le kot ene izmed posledic drugih družbenih determinant, temveč kot posebne družbene determinante zdravja (Castañeda idr. 2015), saj vsi predstavljeni vidiki bolj ali manj neposredno vplivajo na zdravje posameznic_kov, hkrati pa so vsi vezani na migracijo teh posameznic_kov. V nasprotju s strukturnim okvirom razumevanja neenakosti v zdravstvu, ki se po mnenju Heide Castañeda in sodelavk_cev (2015) omejuje na dostopnost, razumevanje migracije kot družbene determinante zdravja vključuje tudi proučevanje vloge diskriminacije, recimo rasizma in predsodkov do ljudi na poti, stresa, nasilja in izključenosti iz dostopa do nekaterih virov, ki jih povzročata njihov pravni status, ter raziskovanje odpornosti (*resilience*) (Castañeda 2015: 382–384). Razumevanje migracije kot družbene determinante zdravja kaže, »kako družbeni in institucionalni konteksti oblikujejo življenja posameznic_kov ter kako so dejavniki, kot so zaposlitev, nastanitev in bivanjske razmere, dostop do hrane in socialnih storitev ter pravni status, pomembni za dobrobit« ljudi (Castañeda idr. 2015: 376). Migracija se torej ne kaže le kot okoliščina ljudi na poti, pač pa postane dejavnik, saj izkušnja migracije z vsem, kar ta lahko prinese (recimo nasilje, doživljanje predsodkov, revščina) v povezavi z drugimi dejavniki (kot so razni bolj ali manj negotovi pravni statusi in lokalne ter nacionalne migracijske, zaposlitvene, stanovanjske in druge politike), pomembno vpliva na zdravje posameznic_kov na poti. Ljudje na poti se lahko namreč zaradi strukturnih ovir in omenjenih izkušenj med migracijo srečujejo s težavami v fizičnem ali duševnem zdravju (Castañeda idr. 2015), hkrati pa z ovirami pri drugih dejavnikih, ki prav tako vplivajo na razširjeno razumevanje zdravja in dobrobiti, recimo pri finančni stabilnosti in možnosti podpore svoje družine.⁹

9

O tem nazorno pričajo izkušnje sogovornika, s katerim je potekal intervju pod šifro LJ-NV-R13.

Mnogi dejavniki, ki jih omenjajo Castañeda in soavtorji, so se za pomembne izkazali tudi pri raziskovanju izkušenj ljudi na poti v Sloveniji. Zaradi preglednosti bova nekatere obravnavali ločeno, hkrati pa bova opozorili na njihovo prepletanje in medsebojno vplivanje. V nadaljevanju se bova tako osredotočili na pravne statute, duševno zdravje, dostopnost informacij o covidu-19, diskriminacijo, ukrepe v totalnih ustanovah, nastanitev ter zaposlitve in prihodke ljudi na poti med pandemijo.

Pravni statusi in dostop do zdravstva

Med sogovornicami_ki v raziskavi so bile osebe z različnimi pravnimi statusi, iz katerih formalno izhajajo tudi različne pravice do zdravstvene oskrbe, med drugim pravica do nujnega zdravljenja za osebe z dovoljenjem za začasno zadrževanje oz. z dovolitvijo zadrževanja (ZTuj-2 2011) in za prosilke_ce za mednarodno zaščito (ZMZ-1 2016) ter obvezno zdravstveno zavarovanje za osebe z mednarodno zaščito (ZMZ-1 2016), od 1. 1. 2024 pa tudi kritje obveznega zdravstvenega prispevka za begunce (ZZZS 2024).¹⁰ Toda pravice do zdravstva na papirju ne ustrezajo nujno dejanskemu stanju (Pistotnik 2023). Pri opredelitvi nujnega zdravljenja za prosilke_ce za azil (ZMZ-1 2016) lahko recimo zaznamo manevrski prostor za odločitev zdravstvenega osebja glede tega, kaj šteje med stanja, ki zahtevajo nujno zdravljenje. Bolnice_ki pa morajo svoje stanje tudi predstaviti na način, da bi ga zdravstveno osebje ustrezno prepoznalo kot nujno. Oboje ustreza konceptu kandidature (angl. *candidacy*), ki ga poleg drugih uporabnih konceptov za razumevanje neenakosti v dostopu do zdravstva in zdravja (recimo strukturne ranljivosti, zaslužnosti in dostopnosti) podrobneje predstavlja Sara Pistotnik (2023). Koncept kandidature opisuje načine, na katere se posameznice_ki in predstavnice_ki zdravstvenih storitev pogajajo o upravičenosti oseb do zdravstvene obravnave (Dixon-Woods idr. 2006: 8; Pistotnik 2023: 70–72). Gre za »dinamičen in kontingenčen proces, ki je konstantno definiran in redefiniran v interakcijah med posameznicami_ki in profesionalkami_ci« (Dixon-Woods idr. 2006: 8). Ta proces zajema tudi nastop uporabnic_kov v zdravstvenih službah in razsojanje oz. odločanje zdravstvenega osebja o legitimnosti kandidature (Dixon-Woods idr. 2006). Pri tem lahko igra vlogo tudi koncept zaslužnosti (angl. *deservingness*), ki vpliva na to, kako bo zdravstveno osebje presoјalo o legitimnosti nastopa uporabnice_ka; zajema namreč pogosto neizrečene predpostavke o tem, kdo si zasluži določeno zdravstveno oskrbo in določeno kakovost zdravstvene oskrbe, ne glede na to, do česa je oseba upravičena glede na svoj pravni status (Holmes idr. 2021: 1).

Nujnost je hkrati »spremenljiv koncept, odvisen od konteksta« (Pistotnik 2023: 83), prav v kontekstu pandemije covid-19 pa so nastala nova razumevanja nujnosti na področju

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Za zdravstvene pravice glede na pravni status osebe in za izjeme gl. ZTuj-2 2011, ZMZ-1 2016, Zagorc 2023 in ZZZS 2024. Za mladoletne osebe (tako osebe z dovolitvijo zadrževanja kot za prosilke_ce za azil) recimo velja, da imajo po zakonih enake pravice do zdravstvenega varstva kot otroci, ki so obvezno zavarovani kot družinski člani (ZTuj-2 2011; ZMZ-1 2016). Za osebo, ki ima dovolitev za zadrževanje, Zakon o tujcih (PISRS 2011) določa, da »ima pravico do nujnega zdravstvenega varstva v skladu z zakonom, ki ureja zdravstveno varstvo in zdravstveno zavarovanje«, Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (ZZVZZ 1992) pa nujnega zdravstvenega varstva ne opredeljuje.

zdravja in zdravstvenega varstva, ki so jih ustvarjale tako zdravstvene ustanove kot ljudje (Pistotnik 2023: 83). Nujnost zdravstvene obravnave so namreč presojali glede na nevarnost okužbe z virusom SARS-CoV-2, na zmanjšano razpoložljivost zdravstvenega osebja zaradi premeščanja na druge oddelke ali zaradi okužbe z virusom SARS-CoV-2. Presojanje nujnosti glede na možnost okužbe z virusom SARS-CoV-2 kaže recimo primer sogovornika s statusom begunca in prekarno zaposlitvijo (tudi zaradi stikov z mnogimi ljudmi v službi dostavljavca se je dojemal kot ranljivega za okužbo), ki se je zaradi strahu pred okužbo med testiranjem nanjo izogibal zdravstveni ustanovi: »Včasih moram iti v bolnišnico na testiranje na covid, veš? Nek zdravnik pride ali mi reče, naj pridem noter, včasih, ko me pokliče, mi reče, pridi noter, jaz rečem ne, vi pridite ven. Zakaj bi jaz šel v bolnišnico?« (LJ-NV-R15).¹¹ Iz citata je razvidno, da bi se sogovornik raje izognil obisku notranjosti bolnišnice, da se ne bi okužil z razsajajočim virusom, čeprav ga je k vstopu spodbujalo zdravstveno osebje. Četudi je sogovornik prišel do zdravstvene ustanove, torej je prepoznal nujnost testiranja (je identificiral svojo kandidaturo), je presodil, da je zanj pomembneje ostati zunaj bolnišnice kot pa tvegati večje verjetnosti okužbe z virusom SARS-CoV-2.

Gradivo, zbrano v projektu Sonar-Global, je pokazalo tudi, da je o nujnosti razsojalo zdravstveno osebje. Po besedah sogovornika, zaposlenega v nevladni organizaciji za begunke_ce, je zdravnik v azilnem domu med pandemijo prosilke_ce za azil sicer napotil na zobozdravstvene storitve, vendar so ustanove »omejile dostop«:¹² zdravstveni delavec je bolnika kljub trajajoči in močni bolečini v zobu skušal odvrniti od obiska zdravstvene ustanove ter ga prepričati, da njegovo zdravstveno stanje ni dovolj nujno. Medtem ko je bil dostop do zdravstvene oskrbe omejen tudi za druge prebivalke_ce Slovenije, ki so se med pandemijo covid-19 prav tako soočali z dolgimi čakalnimi dobami za obravnavo, prestavljanjem terminov obravnave in nasploh omejenim dostopom do oskrbe (Pistotnik 2023: 74), pa so se ljudje na poti z različnimi statusi srečevali še s strukturnimi ovirami zaradi svojih statusov. Poleg tega so bili prepuščeni sodbam zdravstvenega osebja o nujnosti in o zaslužnosti zdravstvene obravnave, zaradi katerih so lahko bili pri dostopu do (oz. odvrčanju od) nje morda tudi diskriminirani.

Nacionalno poročilo o stanju slovenskega azilnega sistema za leto 2020, ki ga je pripravil Pravni center za varstvo človekovih pravic in okolja (PIC), navaja, da »[p]rosilci za azil niso bili vključeni v nacionalno strategijo cepljenja, saj so [bili] v strategijo vključeni le posamezniki z dovoljenjem za začasno ali stalno prebivanje« (PIC 2021: 65–66). Do sprememb za prosilke_ce za azil je formalno prišlo leta 2021, ko je bilo po poročilu iste organizacije »vsem prosilcem za mednarodno zaščito na voljo cepljenje proti covid-19. Poleg tega je bilo vsem prosilcem za mednarodno zaščito v Azilnem domu na voljo tudi brezplačno testiranje na covid-19« (PIC 2022: 16). Četudi so imele osebe s statusom begunca formal-

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»[S]ometime I take order for hospital for covid test, you know? Some doctor come or he tell me come inside, sometime, when he call me, he tell me, come inside, I say no, you come out. Why I come in hospital?« (LJ-NV-R15).

12

Intervju z oznako LJ-NV-R29.

no dostop do testiranja na okužbe z virusom SARS-CoV-2, je bil dejanski dostop do njega odvisen tudi od tega, ali je oseba imela osebno_ega zdravnico_ka in/ali dostop do ustreznih informacij npr. o možnostih (brezplačnega) testiranja na okužbo,¹³ se pravi zmožnost navigacije po zdravstvenem sistemu (gl. Dixon-Woods idr. 2006: 7).

Pravni status ljudi na poti med pandemijo covid-19 pa ni vplival le na njihovo formalno upravičenost do zdravstvene oskrbe. Ljudje na poti so morali bolj ali manj redno urejati tudi vrsto administrativnih zadev. Podaljšal se je postopek vloge prošnje za mednarodno zaščito, zaradi česar so nekateri ljudje dlje časa živeli v neprimernih bivanjskih razmerah (PIC 2021), po besedah sogovornic_kov pa prav tako čas odgovora nekaterih uradov, recimo upravnih enot in centrov za socialno delo, kar je botrovalo tudi negotovosti ter dodatnim finančnim pritiskom na ljudi na poti.¹⁴ Poleg težav s pravnim statusom in omejenim dostopom do zdravstvene oskrbe, ki jo ta prinaša, se ljudje na poti srečujejo še z duševnimi stiskami in težavami, ki so lahko prav tako vezane na njihov pravni status ali na druge dejavnike, povezane z njihovo negotovo situacijo.

Duševno zdravje

Duševnih stisk ljudi na poti (Burnett in Peel 2001)¹⁵ ne moremo vedno pripisati le sami migraciji, temveč jih lahko lajšajo ali poglobljajo pravni status, bivanjske in zaposlitvene razmere, dostopnost raznih virov ali družbena izolacija (Castañeda idr. 2006: 377). Tako recimo stresa, ki ga je sogovornik z dovoljenjem za zadrževanje doživljal v Centru za tujce v Postojni, ne gre pripisati le migraciji in njegovim preteklim izkušnjam. V prvi vrsti gre za posledico okoliščin, zaradi katerih je bil dlje časa zaprt v Centru za tujce, pritiskov zaposlenih, odrekanja zdravstvene oskrbe njemu in drugim, zaprtim v Centru, dejstva, da je bil priča hudim duševnim stiskam drugih oseb v Centru, in strahu pred deportacijo.¹⁶ Drug sogovornik s statusom begunca je celo izrazil strah pred spremembo zakonodaje, ki bi mu pridobljeni status nenadoma odvzela: »Ne počutim se zelo prijetno. Ker se lahko spremeni. Veš, ne vemo, kaj se dogaja z vlado.«¹⁷ K sogovornikovemu strahu je verjetno botrovalo politično napeto ozračje v Sloveniji v času pandemije;¹⁸ slovenska vlada je leta 2021 tudi sprejela nekatere spremembe Zakona o tujcih in Zakona o mednarodni zaščiti (ZMZ-1), ki

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LJ-NV-R17

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LJ-NV-R29

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Tudi eden izmed sogovornikov s statusom begunca se spopada s težavami s spanjem zaradi skrbi in preteklih izkušenj (LJ-NV-R15).

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LJ-NV-R20

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LJ-NV-R13: »I don't feel very comfortable. Because it might change. You know, we don't know what's going on with the government.«

18

Sočasno z izbruhom pandemije je nastopila nova slovenska vlada, ki jo je vodil Janez Janša, in proti kateri so od aprila 2020 do aprila 2022 potekali protesti proti restriktivnim politikam desno usmerjene vlade (MNSZS 2024).

naj bi nižale nivo zaščite prosilcev za mednarodno zaščito v postopkih mednarodne zaščite ter dopuščale zaprtje državnih meja v primeru nastanka »kompleksne krize« na področju migracij (PIC 2022: 14).

Med pandemijo covid-19 so se nekatere stiske, ki jih ljudje na poti doživljajo že sicer, še poglobile. Za otroke je bil recimo čas zaprtij šol in države težek tudi zaradi omejenih ali neobstojećih stikov s prijatelji_cami. To je sogovornici s statusom begunke povzročalo stres, zaradi katerega je tudi pridobila telesno maso:¹⁹ »Tudi za moja otroka me skrbi, ker zaključujeta šolo. [...] In nista dobila dovolj priprav, moj starejši si želi dobro opraviti, se več učiti, ampak nista imela šole doma. Težko je bilo za otroke. Tudi prijateljev niso videli, nikamor mogli iti.«²⁰ Njene besede ponazarjajo prepletenost fizičnega (prej omenjena pridobitev telesne mase) in duševnega zdravja, ki je povezano s skrbjo za družbeno, duševno in izobraževalno dobrobit njenih otrok. Hkrati kažejo na kompleksno prepletenost migracije in njihovega statusa begunk_cev, otrokovih želja za prihodnost, pomanjkanja odnosov z drugimi otroki ter okoliščin pandemije in zaščitnih ukrepov. Ljudje na poti z otroki so se v Sloveniji sicer soočali s podobnimi težavami kot preostali prebivalci_ke Slovenije, npr. z neenakim dostopom do spleta in tehnologij za šolanje na daljavo ter neprimernimi prostori za pouk na daljavo (Brunec 2023). Toda spoprijemali so se še z jezikovnimi in drugimi ovirami.²¹ Tako otrokom kot odraslim ljudem na poti je primanjkovalo druženja in socialnih mrež, ki so zanje lahko še posebej relevantne, saj so »vir informacij, ki mu posameznik najbolj zaupa in olajša včasih težavno privajanje na novo okolje« (Bofulin in Bešter 2010: 274). Pojavljal se je tudi strah pred prepuščenostjo samemu_i sebi v primeru težav: »Nisem z družino [...]. Na primer, če umrem [se nerodno zahahlja], nihče ne ve [...]. Ampak jaz, če se mi kaj zgodi, sem sam. Nič, ne morem narediti ničesar, ali če se ponesrečim ali kaj takega.«²² Pomanjkanje socialne mreže je v tem primeru vplivalo na sogovornikovo duševno zdravje. (Ne)obstoj socialnih mrež pa je za nekatere ljudi na poti pomenil tudi različno obveščeno o covidu-19 in zaščitnih ukrepih, ki jih je sprejemala slovenska vlada.

Dostopnost informacij o covidu-19 za ljudi na poti

Med pandemijo covid-19 je bila z več vidikov pomembna dostopnost informacij o pandemiji in o (zaščitnih) ukrepih. Ukrepi in priporočila naj bi bila namenjena zaščitni ljudi pred okužbo, širjenjem covid-19 in težjimi oblikami bolezni, poleg tega pa jih je bilo treba upo-

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LJ-NV-R52

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LJ-NV-R52: »Also I worry about my children, because they are finishing school. [...] And they did not get enough preparation, my older wants to do well, to study more, but they didn't get school at home. It was hard for kids. They also didn't see friends, cannot go anywhere.«

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LJ-NV-R16

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LJ-NV-R15: »I'm not with my family [...] for example, if me die [giggles awkwardly], nobody know [...]. But if me, something happen, I'm alone. Nothing, I can't make anything, or if me make accident or something.«

števat v izogib globam, ki bi osebe z nizkimi in prekarnimi prihodki lahko potisnile na rob preživetja.²³ Čeprav sogovorniki_ ce večinoma niso bili mnenja, da je primanjkovalo informacij o covidu-19 in ukrepih (»Mislim, da je na voljo več kot dovolj informacij za ljudi, ki se držijo ukrepov, in je bila maska in razkužite si roke«²⁴), te niso bile enako dostopne za vse. Nekateri (še) niso imeli zadostnega znanja slovenščine, da bi razumeli informacije o zaščitnih ukrepih v medijih, in so te pridobivali iz druge roke: »Od ljudi, ker ne govorim jezika. [...] Ne morem reči, da sem jih dobil iz medijev. Ne, od ljudi, recimo vprašamo prijatelje: kdaj so ponovno odprli?«²⁵ Po besedah delavca iz nevladne organizacije za begunke_ ce so bili ljudje na poti različno obveščeni o zaščitnih ukrepih, pri čemer jim je včasih primanjkovalo najnovejših lokalnih informacij, medtem ko so bili bolj obveščeni o globalnih pandemičnih novicah²⁶ (za podoben primer na Švedskem gl. Mangrio, Zdravkovic in Strange 2022: 10).

Da bi zagotovili večjo dostopnost informacij o covidu-19 in zaščitnih ukrepih v Sloveniji tudi za ljudi na poti, so v nevladni organizaciji za begunke_ ce ustvarili skupino na Facebooku, v kateri so objavljali informacije v slovenščini in v angleščini. To je nekaterim pomagalo pri večji obveščenosti o covidu-19 in zaščitnih ukrepih, vendar vsi družbenih omrežij ne uporabljajo redno.²⁷ Čeprav je bila pomoč nevladne organizacije gotovo dobrodošla, odgovornost za informiranje prebivalstva ne bi smela ostati le na plečih civilnega in nevladnega sektorja, omejenega na priložnostno nesistematično ustno informiranje ljudi ter obveščanje po družbenih omrežjih. Burnett in Peel sta že leta 2001 opozorila na nujnost dostopnosti informacij v zvezi z zdravstveno oskrbo »v relevantnih jezikih« (2001: 546), Svetovna zdravstvena organizacija pa je leta 2020 »migrantke_ e in begunke_ ce« za najbolj ranljive dele prebivalstva označila tudi zaradi omejenega dostopa do informacij v jeziku, ki ga razumejo (Leung idr. 2023: 34). Da bi zmanjšale neenakost pri dostopu do informacij in tudi pri dostopu do zdravstvene oskrbe, bi morale odgovorne institucije zagotoviti ažurne informacije v jezikih, ki jih govorijo prebivalci_ ke Slovenije.

Čeprav so bile med pandemijo covid-19 informacije o zaščitnih ukrepih in priporočilih na spletni strani slovenske vlade objavljene tudi v angleščini, vsi ljudje na poti nimajo (zadostnega) znanja angleščine za takšne informacije: »Slovenski jezik je zame zelo težek, ker tega jezika prej še nisem slišala. Takrat [ob prihodu v Slovenijo] sem znala zelo malo angleško.«²⁸ Če je namen zaščitnih ukrepov pred okužbo zaščititi vse prebivalstvo, je nespametno poza-

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LJ-NV-R15

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LJ-NV-R13: »I think more than enough information to people who are talking measurements and was mask and put the anti-septic on your hands.«

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LJ-NV-R13: »Through people because I don't speak the language. [...] So I cannot say that I got it through the media. No, through people like oh, what are we ask our friends like when they reopened?«

26

LJ-NV-R29

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LJ-NV-R15

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LJ-NV-R16

biti na prevajanje ukrepov v mnogo različnih jezikov in zapostaviti tujejezične dele prebivalstva, ki imajo prav tako pravico do zdravja, saj gre za eno temeljnih človekovih pravic.²⁹

Diskriminacija

Ljudje na poti so lahko zapostavljeni, spregledani ali (ne)namerno diskriminirani na različnih področjih (dostop do informacij o zdravju, zdravstvenem sistemu in zaščitnih ukrepih proti covidu-19, dostop do stanovanj ...). Mnogo raziskav povezuje rasizem in diskriminacijo ljudi na poti z njihovim zdravjem in dostopom do zdravstva (Bofulin in Bešter 2010; Castañeda idr. 2015; Di Meo in Bentivegna 2021; Holmes idr. 2021). Lipovec Čebtron ugotavlja, da ob težavah pri komunikaciji v zdravstveni obravnavi s tujejezičnimi migrantkami_i »[v] tej kulturi rasizma znanje slovenščine postane eden najpomembnejših kriterijev, ki ločijo zaslužne migrantke_e od nezaslužnih« (Lipovec Čebtron 2021: 13). Čeprav sogovornice_ki v raziskavi diskriminacije na podlagi jezika pri zdravstvenih obravnavah niso omenjali, v času izvajanja intervjujev vsi niso imeli osebnega zdravnika ali pa v Sloveniji zdravniške pomoči še niso iskali. Sogovornik s statusom begunca je ob težavah pri iskanju osebnega zdravnika najprej pomislil, da je za to kriv rasizem, sčasoma pa spoznal, da se s težavami pri iskanju osebnega zdravnika sooča veliko prebivalc_cev Slovenije.³⁰ Čeprav v tem primeru morda ni šlo za dejansko rasistično diskriminacijo, temveč bolj za zaznano diskriminacijo (Xiong in Johnson 2022), pa je sogovornik, zaposlen v nevladni organizaciji za begunke_ce, med pandemijo občutil, da zdravstveno osebe ni bilo naklonjeno obravnavi prosilk_cev za azil: »Zdravniki so pod tem nujno, ne-nujno, pa sploh, če imaš prosilca za azil – to pozabi! Res je, to kot sem ti rekel, ta občutek ‘ne pridet’.«³¹ Ljudje na poti so bili po njegovih besedah zaradi rasnega profiliranja in svojih družabnih navad (npr. druženje nekaterih v večjih skupinah) bolj izpostavljeni policijskemu nadlegovanju med pandemijo. V nevladni organizaciji so jih zato skušali informirati o zaščitnih ukrepih ter jih opozarjati tudi na večjo verjetnost, da jih ustavi (in kaznuje) policija. Kljub odsotnosti statističnih podatkov o pogostejšem kaznovanju ljudi na poti³² je sogovornik podal primer, ko se je policija

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Odgovorne institucije bi lahko pripravile informacije v jezikih, ki jih govori veliko število ljudi na poti, pri tem pa bi lahko k sodelovanju povabile nevladne organizacije, ki imajo na tem področju veliko znanja, ter upoštevale recimo morebitne evidencje jezikov prosilk_cev za azil in ljudi z mednarodno zaščito, da bi bile informacije karseda relevantne. Tudi slovenska raziskovalna skupina je na podlagi izsledkov raziskave *Covid-19: ocena ranljivosti in vključevanje skupnosti* podala priporočilo za boljše odzivanje na podobne krize, ki pravi, da bi morali biti »[v]si ključni ukrepi, pravila ter navodila v čas pandemije [...] dostopna ne le v slovenskem jeziku, temveč tudi v jezikih priseljencev in priseljenk« (Lipovec Čebtron 2023: 38).

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LJ-NV-R17

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LJ-NV-R29

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Iz Letnega poročila o delu policije 2020 je razvidno le, da je skupno število kršiteljev predpisov o javnem redu v letu 2020 30.042, od tega 24.172 ljudi s slovenskim državljanstvom, 1372 ljudi z državljanstvom drugih držav Evropske unije, 4417 oseb z državljanstvom t. i. »tretjih držav« in 81 ljudi z neznanim državljanstvom. Ti podatki sicer poleg kršitev Zakona o nalezljivih boleznih zajemajo še kršitve drugih zakonov, kot so Zakon o proizvodnji in prometu s prepovedanimi drogami, Zakon o osebni izkaznici, Zakon o prijavi prebivališča, Zakon o zaščiti živali ter Zakon o zasebnem varovanju (MNZ, Policija, Služba generalnega direktorja policije 2021: 116).

»spravil[a]« prav na človeka pred izpostavo azilnega doma v Ljubljani, četudi nista bila edina, ki očitno nista bila »iz istega gospodinjstva«; od drugih ju je očitno ločila le barva kože.³³ Na obstoj rasnega profiliranja ljudi na poti kažejo tudi besede sogovornika z dovoljenjem za zadrževanje, ki raje pešači kot kolesari, saj se boji nadlegovanja policije, ki ga 'prevečkrat ustavi'.³⁴

Ukrepi v totalnih ustanovah

Bivanje v t. i. totalnih ustanovah (Goffman 2019 po Škraban 2023) za ljudi na poti je tudi v času med pandemijo zanje pomenilo življenje, urejeno na specifičen način. O tem je pisal Juž Škraban (2023), ki je ugotovil, da so totalne ustanove v Sloveniji³⁵ med pandemijo ubrale dve nasprotni strategiji. Prva je bila izvajanje »*ad hoc* odpustov«, tudi iz Centra za tujce in Azilnega doma, pri čemer pa ni šlo za uvajanje (sicer s strani stroke zaželene) dezinstitutionalizacije, saj so bili ljudje izpuščeni brez potrebne formalne podpore, temveč za strategijo omejevanja okužb znotraj ustanove. Druga strategija je bila zapiranje, predvsem v domovih za starejše, posebnih socialnovarstvenih zavodih in drugih ustanovah, pri čemer so njihove_i prebivalci potrebovali več oskrbe. Zapiranje se je lahko kazalo celo kot zaklepanje v sobe ali pa so institucije omejevale stike z uvedbo dodatnih pravil (Škraban 2023: 97–102). Nenadni odpust so uporabili tudi v Azilnem domu, pri čemer so osebe izpustili vsaj navidezno brez razloga:³⁶ »[So] eno gospo iz Srbije, prosilka, so jo tudi tako dali ven. Niso jo odpeljali v Postojno, ne vem zakaj, al je bilo preveč ljudi tam, al se jim je zdelo, da ona kot nekakšna gospa ne sodi tja in so ji povedali 'pejt'.«³⁷ Prosilko za azil so iz Azilnega doma odpustili le z navodilom, naj odide (»*pejt*«), in jo pustili brez formalne podpore. Med pandemijo naj bi *ad hoc* odpuste izvajal tudi Center za tujce v Postojni, kot je povedal sogovornik z dovoljenjem za zadrževanje:

Ko so te izpustili, kje so te dali ven? V Ljubljani ali ...? LJ-NV-R20: Ne, Postojna! Samo ven. Rekli so [mi] – pojdi! Nimate vozovnice? To ni moj problem. [...] [Ker] nisem imel ničesar, sem prosil za vozovnico do Ljubljane, pa so rekli, to ni moj problem. Prosil sem prijatelja iz [ime države], naj mi da tri evre, in še en moški mi je dal [še] tri evre, ker je vlak do Ljubljane šest evrov.³⁸

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V Sloveniji so v Azilnem domu in njegovih izpostavah načeloma nastanjene_i prosilke_ci za azil, Center za tujce v Postojni pa je bil primarno namenjen ljudem v t. i. postopkih vračanja (PIC 2021: 72), večinoma tistim, ki jim je bila zavrnjena prošnja za mednarodno zaščito. Leta 2020 se je praksa pridržanja v nasprotju z Zakonom o mednarodni zaščiti spremenila in v Centru za tujce so ostali tudi ljudje, ki so izrazili namero za vložitev prošnje za azil (PIC 2021: 69). Poročilo baze podatkov AIDA (Asylum Information Database oz. Podatkovne zbirke informacij o azilu) za leto 2020 navaja, da je »[m]nogo pridržanih prosilcev za azil [...] trdilo, da so izrazili namero za vložitev prošnje za azil, ampak da niso imeli dostopa do azilnega postopka« (PIC 2021: 69–70).

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When they let you out, where did they let you out? In Ljubljana or ...? LJ-NV-R20: No, Postojna! Just out. They speak [to] me – go! You have no ticket? This is not my problem. [...] [As] I had nothing, I asked for a ticket to Ljubljana, they [said] it is not my problem. I asked my friend from [name of a country] to give me 3 euro, and another man gave me 3 [more] euro, because the train to Ljubljana is 6 eur.

Pri odpustu sogovornika iz Centra za tujce »ni šlo za načrtovano preselitev, temveč je z odpustom prenehal obstajati za ustanovo, ki ga je odpustila« (Škraban 2023: 99). Čim je izstopil iz Centra, se ustanova ni več čutila odgovorno za njegovo preživetje, niti za prevoz do glavnega mesta, kjer je zaradi ureditve migracijskega sistema v Sloveniji večja možnost, da bi bil deležen pomoči nevladnih organizacij; to je takrat očitno potreboval, saj ni imel lastnih sredstev niti za prevoz do Ljubljane, kaj šele za prenočitev. Odpustitev tega sogovornika ni bila osamljen primer.³⁹ Take *ad hoc* odpuste iz totalnih ustanov lahko razumemo kot še en izraz strukturnega nasilja (poleg tega, da so že sama zapiranja v totalne ustanove primer tega), saj ogrožajo človekovo zmožnost zadovoljevanja osnovnih življenjskih potreb, hkrati pa jih ustanova prikazuje kot nekaj neizogibnega, normalnega, objektivnega, pri tem pa za to ne določi neposredno odgovorne osebe⁴⁰ (gl. Galtung 1969 po Pistotnik 2023).

Iz sekundarnih virov in besed sogovornikov_kov izhaja, da Azilni dom v Ljubljani sicer ni bil popolnoma zaprt, vendar so bili njegovi prebivalci vseeno precej omejeni na bivanje v lastni sobi zaradi govoric in strahu pred zaprtjem doma ter zaradi nestalne odprtosti javnih prostorov, med drugim tudi nevladnih in drugih organizacij.⁴¹ Dom naj bi leta 2020 zapuščali »le po potrebi« (PIC 2021: 61), z letom 2021 je to priporočilo prenehalo veljati (PIC 2022: 74–75). Interna pravila oz. zaščitni ukrepi v Azilnem domu (PIC 2021), sprejeti med pandemijo, naj bi bili sicer namenjeni zaščititi ljudi pred okužbo z virusom SARS-CoV-2, nenadni odpusti iz Azilnega doma in Centra za tujce pa kažejo zelo dvoumno sliko skrbi teh ustanov za zdravje. Čeprav so bili ljudje zaradi odpusta morda olajšani in bi to lahko pozitivno vplivalo na njihovo duševno zdravje (tega iz zbranega gradiva sicer ni mogoče razbrati, zato je to zgolj hipoteza), so bili naenkrat prepuščeni sami sebi; odsotnosti formalne podpore po odpustu pa gotovo ne bi mogli označiti kot skrb za zdravje in dobrobit ljudi.

Nastanitev

Ljudje, ki so bili odpuščeni iz totalnih institucij, so se naenkrat znašli tudi brez nastanitve. O negativnem vplivu pomanjkanja primernih nastanitvev na zdravje ljudi na poti piše recimo Musso: zdravje se ljudem na poti pogosto poslabša, ko že nekaj let bivajo v določeni državi, in sicer zaradi »zdravstvenih determinant, povezanih z družbeno obravnavo migrantov in manjšin (nastanitev, delo ipd.)« (2017: 23). Med pandemijo covid-19 so odločitvi Svetovne zdravstvene organizacije, da »migrantke_e in begunke_ce« označi za najbolj ranljive dele prebivalstva, botrovale tudi bivanjske okoliščine ljudi na poti (Leung idr. 2023: 34). Večina sogovornic_kov – ljudi na poti je v času intervjuja živela v sobi v stanovanju ali hiši, ki so si jo delile_i še z drugimi osebami. S svojimi nastanitvami so bili ljudje

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zelo različno zadovoljni,⁴² bivanjske stiske ljudi pa so se med pandemijo še poglobile. To kažejo tudi izkušnje zaposlenega v nevladni organizaciji za begunce_ke:⁴³ ta organizacija je skupaj z drugimi ustanovami med pandemijo covid-19 skušala zagotoviti namestitve za ljudi, ki so bili *ad hoc* odpuščeni iz totalnih ustanov, veliko ljudi pa se je znašlo v stiski tudi zaradi izgube službe, ki jim je omogočala plačevanje najemnine.

Ob tem ne moremo govoriti o pozitivnem vplivu na zdravje ljudi; dostopnost varne nastanitve je tudi po mnenju Castañede in sodelavcev (2015: 383) namreč eden izmed mehanizmov migracije in pravnega statusa ljudi na poti, ki vpliva na zdravje ljudi, kot avtorice_ji prikazujejo s konceptom migracije kot družbene determinante zdravja. Tako kot za mnogo drugih prebivalk_cev Slovenije, ki so se med pandemijo covid-19 soočali z raznolikimi stanovanjskimi težavami (gl. Brunec 2023), je za ljudi na poti veljalo, da so ukrepi njihovo bivanjsko stisko večinoma še povečali, le da se je pri njih to pogosto povežalo še s težavami negotovega statusa, prekarne zaposlitve in slabega znanja ali neznanja slovenščine, kar je otežilo možnost popolne avtonomije v iskanju bivališča: »Recimo če lastnik reče ‚pojdi ven‘, bi bilo tako težko najti novo nastanitev, ker je brez slovenščine težko najti stanovanje.«⁴⁴ Zmožnost posameznic_kov, da lahko ohranijo dostop do te temeljne človekove pravice, kot jo razumejo npr. pri Kraljih ulice (2024)⁴⁵, pa je med drugim pogojena z njihovimi prihodki.

Zaposlitev in prihodki

Bivanjska situacija ljudi na poti in zmožnosti plačevanja najemnine je tesno prepletena tudi z njihovimi prihodki in zaposlitvijo, kot je izrazil sogovornik iz nevladne organizacije: »Veš, ful je folka izgubilo službe, več, lahko bi imeli večje število ljudi, ki se res ne morejo preživljati, ne morejo plačevati najemnine, posebej najemnine kakšne so.«⁴⁶ Nekateri ljudje na poti so bili zaradi izgube služb med pandemijo potisnjeni na rob preživetja.⁴⁷ Po besedah sogovornikov_ic jih je mnogo delalo v prekarjih delovnih razmerjih in v gospodarskih sektorjih, ki so bili med pandemijo zaradi zaščitnih ukrepov še posebej prizadeti, recimo v gostinstvu:⁴⁸ »Poznam veliko beguncev, ljudi s statusom, več, in veliko jih dela v kavarnah, restavracijah,

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Ocene stanovanj so se gibale od »zelo slabo« (LJ-NV-20) do »zelo dobro« (LJ-NV-R15).

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LJ-NV-R29

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LJ-NV-R13: »Like if I the owner will say 'go out' it would be so hard to find another place to live because it's hard without Slovenian searching for apartment.«

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Nevladna organizacija Društvo za pomoč in samopomoč brezdomcev Kralji ulice.

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LJ-NV-R29

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LJ-NV-R29

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O delu in zaposlovanju med pandemijo covid-19 v Sloveniji je v svojem magistrskem delu pisala Vanja Germ (2024).

v kuhinjah in ... Vse [so] izgubili.«⁴⁹ Zaradi različnih pravnih statusov so se sogovornice_ki tudi znašli v specifičnih položajih. Sogovornik s statusom begunca je med pandemijo dobil priložnost zaposlitve za šest mesecev, vendar je bila možnost podaljšanja zaradi nestabilnih virov financiranja organizacije izjemno negotova. Tako je med pandemijo prejel finančno podporo, ki je bila nižja od ponujene plače, vendar je bil zaradi prekarnosti zaposlitve in osebnih okoliščin, vezanih na migracijo družine, prisiljen pristati na nižje prihodke.⁵⁰

Po opažanjih Neže Vodopivec (2020) so protipandemični ukrepi zapiranja javnega življenja še posebej prizadeli nedokumentirane osebe, torej ljudi, ki so »zaradi zavrnjene prošnje za azil ali prekinitve azilnega postopka ostali brez dokumentov, ki bi jim omogočali bivanje na ozemlju Slovenije« (Vodopivec 2020: 10). Tudi nedokumentiranim osebam, ki ne morejo zapustiti Slovenije ali iz nje ne morejo biti »odstranjene«, pa se jim zato izda dovoljenje za zadrževanje, ni omogočena pridobitev delovnega dovoljenja, zato se ne morejo legalno zaposliti (Vodopivec 2020: 4). Sogovornik z dovoljenjem za zadrževanje se je zato zanašal na pomoč nevladne organizacije za begunke_ce in svojih prijateljic_ev.⁵¹ Prosilke_ci za azil, ki so po zakonu, veljavnem v času pandemije, delovno dovoljenje lahko pridobili po devetih mesecih (zdaj pa po treh) (Z. 2023), so sicer do dovoljenj lahko prišli, vendar je bilo izjemno težko najti zaposlitev.⁵² Ranljivost ljudi na poti se je med pandemijo kazala tudi v tem, da so nekateri službo še težje našli zaradi nezadostnega znanja slovensčine: »Iskal sem delo, ker je korona, zaprto, ni [v smehu pove] enostavno v tem času najti službe, veš? [...] Tudi mogoče neko službo, ampak je zelo težek zame [...] slovenski jezik.«⁵³ Poleg neposrednih vplivov prekarne, težaških ali pa neobstoječih zaposlitev na fizično in duševno zdravje ljudi na poti so bili ti med pandemijo lahko ranljivi še, če so izgubili zaposlitev in vmes niso bili upravičeni do zdravstvenega zavarovanja, kot se je to zgodilo sogovorniku s statusom begunca.⁵⁴ Zaposlitev oz. izguba prihodkov ima torej velik vpliv na dostop do zdravja in zdravstva ljudi na poti, sploh ko se poveže z drugimi dejavniki, kot sta njihov pravni status in dostojno bivališče.

SKLEP

Gradivo slovenske raziskave Sonar-Global ponuja pomembne uvide v to, kako prepleteni so med sabo razni pravni, administrativni, ekonomski in družbeno-kulturni dejavniki, ki

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LJ-NV-R16: »I know a lot of refugees that I know, people with status, you know, and a lot of them work in coffee shops, restaurants, in kitchens and ... Lost everything.«

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LJ-NV-R17

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LJ-NV-R20

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LJ-NV-R29

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LJ-NV-R15: »I searched to work, because it's Corona's close, it's not [says it with a laugh] easy to find this time job, you know? [...] Also, maybe some job, but it's very hard for me [...] the Slovenian language.«

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LJ-NV-R22

imajo v primeru ljudi na poti dve skupni točki: vsi so povezani z njihovim zdravjem in vsi so povezani z migracijo ali pa izhajajo iz nje. Koncepti strukturne ranljivosti (Carruth idr. 2021), zaslužnosti (Holmes idr. 2021), dostopnosti (Penchansky in Thomas 1981) in kandidate (Dixon-Woods idr. 2006) so vsekakor pomembni za oblikovanje našega razumevanja dostopa ljudi na poti do zdravja in zdravstva, prepletenost mnogih dejavnikov ter njihovo povezanost z migracijo pa povzema koncept migracije kot družbene determinante zdravja (Castañeda idr. 2015). Njihovi učinki se med sabo prepletajo in drug drugega krepijo, ob tem pa vplivajo na zdravje, zmožnost ohranjanja zdravja in dostop do zdravstva ljudi na poti. Ni dovolj skušati razumeti vsakega od dejavnikov migracije posebej (pravni status, občutki strahu in negotovosti, nastanitev, zaposlitev, diskriminacija ...), saj brez upoštevanja preostalih težko dobimo popolno sliko prepletenosti dejavnikov in njihovih učinkov, kar lahko vodi v manj celostno razumevanje zdravja ter dostopa do zdravstva.

Tako se je med pandemijo covid-19 v Sloveniji pokazalo, da so se prepletali razni dejavniki migracije, kot so stratifikacija pravnih statusov, administrativne in druge ovire pri uveljavljanju sicer formalno priznanih pravic, občutki tesnobe, nemoči in osamljenosti, prekarne zaposlitve, negotove ali prenatrpane nastanitve, diskriminacija in nezadostna dostopnost pomembnih informacij o pandemiji. Nekateri mehanizmi socialne države, kot so finančna pomoč za nekatere in dostop do osebne_ga zdravnice_ka za redke, so delno blažili njihove strukturne ranljivosti, večinoma pa so se pri ljudeh na poti pojavljale ali zaostrovale finančne, bivanjske, duševne in druge stiske. Zaradi obstoječih in hkrati spreminjajočih se družbenih struktur, ki so med pandemijo še bolj kot prej hierarhizirale družbo, pa so bili nekateri podvrženi izključevanju iz dostopa do zdravstvene obravnave, izobraževanja in zaposlitve. Najranljivejši so bili tisti ljudje na poti, pri katerih se je povežalo veliko mehanizmov migracije oz. so se znašli na presečiščih mnogih ranljivosti.

Pandemija covid-19 je razgalila marginaliziranost že tako zapostavljenih ljudi na poti in družbeno-kulturne dimenzije oz. dejavnike, ki imajo moč oblikovanja njihovega dostopa do zdravstva in zdravja, raziskava v okviru projekta Sonar-Global pa pomen vključevanja ljudi na poti v raziskave, iz katerih lahko sicer zaradi jezikovnih, informacijsko-tehnoloških in drugih preprek izpadejo. Izsledki so pomembni za naslavljanje neenakosti tako v kriznih kot v drugih časih, če taki še obstajajo, ter hkrati poudarjajo možnosti družboslovja in humanistike, da prispevata k proučevanju in razumevanju teh časov.

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SUMMARY

The article examines the connection of migration, health, and access to healthcare during the Covid-19 pandemic in Slovenia for people on the move (in the present research: refugees, asylum seekers, and persons with permission to remain in the Republic of Slovenia). The paper presents an analysis of the materials collected in 2021 in Ljubljana during the Covid-19: Vulnerability Assessment and Community Engagement study, which was conducted as a part of the Sonar-Global project. It demonstrates some factors that go beyond

formal and actual access to healthcare and, being connected to migration, influence the health and well-being of people on the move.

The research material offers important insights into how various legal, administrative, economic, and sociocultural factors are intertwined; they are all related to health, and they are all related to or stem from migration. The concepts of structural vulnerability (Carruth et al. 2021), deservingness (Holmes et al. 2021), access (Penchansky and Thomas 1981), and candidacy (Dixon-Woods et al. 2006) are certainly important in shaping our understanding of people's access to health and healthcare, but the intertwining of many factors and their connection to migration is summed up in the concept of migration as a social determinant of health (Castañeda et al. 2015). Their effects are intertwined and reinforce each other while also influencing the health, the ability to maintain health, and the access to healthcare of people on the move. When considering the impact of individual factors, it is important to understand how they influence each other.

During the Covid-19 pandemic in Slovenia, various migration factors were intertwined, such as the stratification of legal statuses, administrative and other barriers to formally recognised rights, feelings of anxiety, powerlessness, and loneliness, precarious employment, precarious or overcrowded accommodation, discrimination, and insufficient access to important information about the pandemic. People on the move mostly faced (exacerbated) financial, housing, mental, and other hardships. Due to existing and changing social structures, which further hierarchised society during the pandemic, some were excluded from access to healthcare, education, and employment. The most vulnerable were the people on the move who were affected by multiple mechanisms of migration or found themselves at the intersection of many vulnerabilities.

The Medicalisation of Childbirth: A Technocratic Model of Birth in Public Hospitals in Croatia



Medikalizacija poroda: tehnokratski model rojstva
v javnih bolnišnicah na Hrvaškem

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ABSTRACT

Beyond its biological functions, reproductive health represents a powerful discursive field. Women's reproductive health has been and continues to be regulated by societal norms, religious doctrines, and political policies. This article examines how regulatory forces manifest in the medical management of childbirth in Croatian public hospitals, particularly through the medicalisation of birth and the adoption of a technocratic model of care. In this technocratic paradigm, the female body is perceived as a reproductive machine, the woman is objectified, and medical personnel become alienated.

KEYWORDS: reproductive health, gender, public hospitals, biopower, medical care

IZVLEČEK

Poleg svojih bioloških funkcij reproduktivno zdravje predstavlja močno diskurzivno polje. Reproaktivno zdravje žensk je bilo in še vedno je podvrženo regulaciji družbenih norm, verskih doktrin ter politik. Članek proučuje, kako se te regulativne sile kažejo v medicinskem upravljanju poroda v hrvaških javnih bolnišnicah, zlasti z medikalizacijo poroda in sprejetjem tehnokratskega modela oskrbe. V tem tehnokratskem paradigmatskem okviru je žensko telo dojeto kot reproduktivni stroj, ženska je objektivizirana, medicinsko osebje pa postane odtujeno.

KLJUČNE BESEDE: reproduktivno zdravje, spol, javne bolnišnice, biomoč, zdravstvena oskrba

INTRODUCTION

The domain of women's health is shaped as a discursive field, framed by a diverse set of patriarchal knowledge systems and practices, religious and national values, and a socialist legacy, all of which are currently interwoven with neoliberal market logics. In Croatian society, both historically and in the present, the prevailing understanding of "women's health" is strongly linked to reproductive health, which predominantly concerns obstetrics and menstruation, that is, the female reproductive organs. This associates the ideal of womanhood with a naturalised role of motherhood (Galić 2006). To understand how such a conceptualisation emerged, the theoretical framework of the French philosopher Michel Foucault proves useful. Foucault posits that no knowledge or meaning about a social phenomenon, occurrence, or issue exists outside the discourse generated by the microphysics of power – power and control disseminated into all domains of human life (Foucault 1972, 1980). The population of citizens is shaped through an invisible form of governance, which Foucault defines as an activity that guides individuals throughout their lives (Foucault, as cited in Rose, O'Malley and Valverde 2006: 83).

The discursive construction of reproductive health and medical care in childbirth is analysed through the combined perspectives of public policy analysis and ethnographic study of lived experiences. Drawing on the anthropology of public policy, public policies are approached as instruments that construct social reality (Shore and Wright 1997) through norms, normalised practices, and representation, regardless of whether they pertain to public health, education, national security, or natality (Wedel et al. 2005: 7–8). According to Božić-Vrbančić (2010: 91), European public policies are shaped in a way that ostensibly seeks public support, while constructing what they propose with the aim of regulating society. This leads us to inquire into what and how certain aspects of women's health and reproduction are being regulated, and which forms of knowledge and practice are established as normative. From a Foucauldian perspective, the individual is born through *knowledge-power*, through disciplinary and regulatory processes most often tied to institutions such as schools, hospitals, prisons, and bureaucracies. Citizens are subject to a range of discourses, interpellated into a web of normalised knowledge about social phenomena, including reproduction, women's health, childbirth, and abortion, which circulate daily through mechanisms of domination, ultimately normalising such practices and forms of knowledge as so-called objective truths (Foucault 1972). Drawing on a Foucauldian perspective, this paper examines how the female body is positioned within the contemporary Croatian public health system during childbirth as a effect of dominant discourses.

Methodologically, starting from discourse as a representational system of knowledge and truth about social phenomena, this paper problematises the medicalisation of women's childbirth experiences in Croatian public hospitals, drawing on both real-life narratives collected through interviews and an analysis of Croatian public policies in terms of reproductive health. To be more precise, a discourse analysis was undertaken by examining public policies and their representations of women's reproductive health, alongside the material-

isation and effects of such representations. This analysis included regulatory frameworks such as laws and declarations on reproductive health, patient treatment, human rights, and pro-natalist policy in Croatian society, as well as statements from medical experts in Croatia and documents from international entities, including the United Nations, the European Union, and the World Health Organisation. The analysis is grounded in the lived experiences and narratives of 25 women who gave birth in public hospitals in Croatia between 2003 and 2023. Thus, the study is situated within an analytical lens that conceptualises public policies as instruments which produce and shape social reality. Within this framework, the analysis explores how forms of knowledge, practices, norms, and truths concerning medical care, hospital conditions, human rights, childbirth, and the position and rights of birthing women are constructed and normalised, thereby exercising control over citizens and materialising in the lived experiences of women giving birth in Croatian public hospitals.

Situating women's childbirth experiences within the context of biomedicine and the public health system in a neoliberal society, medicalisation is articulated as an immanent technique of governance and control. Anthropology teaches us that the medical system is itself a cultural system (Kleinman 1981) and that biomedicine functions as an apparatus of governance and regulation over individuals (Foucault 1980). In this case, the medicalisation of health, specifically women's reproductive health, denotes the expansion of biomedicine (biopower) into areas of life previously considered social rather than medical. It signifies the encroachment of medical authority into human life, sometimes to the extent that medicine assumes control and decision-making power that supersedes human rights (Pool and Geissler 2005: 39). Reproduction thereby becomes the central domain of governance across society, politics, and the economy (Roberts 2015). Analysing how contemporary public reproductive health policies represent this issue, the role of the World Health Organisation appears to be relevant in this global discourse, constructing societal mechanisms throughout its definition of reproductive health. According to the WHO, reproductive health "implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when and how often to do so" (WHO 2018). In this context, the representation of reproductive health is critically examined through a biomedical lens, which, via "cosmopolitical obstetrics" and medicalisation, imposes a particular distribution of power (Jordan 1993: 196).

THE PATRIARCHAL STRUCTURE OF REALITY: THE WOMAN'S BODY AS THE BODY OF THE NATION

The question of women's healthcare within the representation of public policy is articulated through phrases such as "a women's issue", which derive their effects from historical and cultural definitions of gender, sexuality, and identity categories. These categories have been constructed through patriarchal, national, religious, and market-based value systems. Similar to other Western societies, Croatian society contains certain governance practices that produce dominant knowledge discourses (Foucault 1972). In Croatia, these social practices

fundamentally arise from a patriarchal structure of power. In other words, all contemporary political regimes, including the Croatian one, are structurally patriarchal (Galić 2006). Understanding the epistemology of women's health and medicalisation thus requires the analysis of the broader societal context and the constructed nature of social reality.

The patriarchal structure of society rests on heteronormativity, which instils in citizens a moral upbringing centred on family life and reproduction, within which the male is assigned a superior position, and the woman is defined by her naturalised role as mother-birther, a role to which she is systemically subordinated (Berlant 1997; Walby 1990). Patriarchy in Croatia, inherited from both egalitarian and truly patriarchal socialist times, has become further entrenched in Croatian society through a wartime paradigm (Koludrović-Tomić 1996: 335), one that relies on the construction and prosperity of the Croatian nation. This process is further reinforced through the development of public policies aimed at national prosperity, in which the postwar formation of the Croatian nation prioritises the family and pronatal policies as central mechanisms for shaping and consolidating national identity. According to Lauren Berlant (1997), this occurs due to the national fixation on the future. Put differently, the only thing the nation can provide for its prosperity is the past, presented as collective memory in the present, to preserve the future. Given Croatia's wartime past and its history as part of the Socialist Federal Republic of Yugoslavia, national identity becomes a traumatic zone in need of political therapy – a therapy that envisions salvation through natality, that is, through the female body as a reproductive machine. The dominant paradigm – what Berlant (1997) refers to as “national pedagogy” – places the family as the primary authority and social value that all citizens must aspire to (Brown 2019). A series of regulatory documents and declarations of the Republic of Croatia, most notably the National Population Policy adopted by the Croatian Parliament in 2006, emphasise the promotion of what is described as a “positive climate towards family, marriage, and children.” This policy orientation not only reflects the prevailing social atmosphere but also exemplifies the construction of a dominant discourse in Croatia, wherein public policies consistently reinforce the family as a fundamental moral, social, and national value. Within this discursive framework, the family is framed not merely as an ideal but also as an imperative and a measure of personal fulfilment that citizens are expected to attain. This understanding of constructed social reality, informed by Shore and Wright's anthropology of policy and Foucault's concepts of discourse and governmentality, is brought into dialogue with Berlant's notion of national pedagogy to strengthen the analysis of how this dominant paradigm is produced through public policies and sustained within discourse. For this reason, family values, heteronormativity, and reproduction are presented as crucial political issues (Berlant 1997: 56). The family, along with reproduction, is established as the primary vehicle that drives the Croatian nation and enforces the self-discipline of its citizens (*ibid.*), creating subjects as national bodies.

In creating such a national pedagogy, the female body becomes what is known as “the body of the nation”. A woman's fertility and body become the core of her health and the knowledge represented about it (Berlant 1997). In other words, the female body becomes a

burden of the Croatian nation and of general well-being, with the woman perceived as both the object and the national category upon which citizenship and national survival depend (Berlant 1997: 98). An analysis of public policy reveals how Croatia's patriarchal structure reproduces an archetype of motherhood, placing reproduction, seen as the only source of value, power, and status for women in their civic role, at the centre (Berlant 1997). The social value of a woman is defined through motherhood, as the pregnant woman represents the principal legitimate space in which the category of "woman" and "femininity" is transformed into a national category (Berlant 1997: 98). This conversion of gender into nationality renders the woman as a public object and political body of the nation, making the body – specifically the pregnant woman – a national fetish (Berlant 1997: 95). The fetishisation of women's bodies, particularly those of pregnant women, as a national body is further evident through the civil pro-life movement, which holds significant influence in Croatian society. The civil pro-life movement, by promoting women's reproductive roles while fetishising both the fetus and the pregnant body, constitutes a key component of the dominant discourse on women's reproductive health. In this vein, by positioning the discourse of women's reproductive health within an androcentric, patriarchal social structure as the Croatian one, the following analysis will focus on the medicalisation of women's childbirth experiences within the contemporary public health system, analysing what is normalised as medical care during childbirth. The medicalisation of women's experiences, particularly through the development of gynaecology and obstetrics, finds its foundation precisely in the patriarchal conceptualisation of the female body, aiming to exert control over female citizens.

MEDICALISATION OF WOMEN'S HEALTH

One of the foundational theses of this paper is the understanding of the medical system as a cultural system, which can only be interpreted within the broader culture of which it is a part (Kleinman 1981, cited in Pool and Geissler 2005: 77). This makes it essential to analyse the complex relationship between the affective-emotional lived experiences of female patients and the broader discursive representations embedded in public policy. Changes in the understanding of the female body, reproduction, and childbirth have not been solely the result of scientific discoveries, but also changes in social power, discipline, and control. These medical branches, focused on women's health and the birth process, provide a rich field for research from Foucault's perspective (1972, 1980), whose analysis of biopolitics and power relations within biomedical practices has contributed significantly to understanding the development of medical disciplines.

Today, health is primarily associated with the system of biomedicine and public healthcare, whereby biomedical classifications are based as much on cultural beliefs and social norms as they are on objective facts (López 1998). In Foucauldian terms, the cultural element of biopower enables a critical analysis of the medicalisation of human life (Foucault 1972), which perpetuates gender inequality in access to and the provision of healthcare (Wilkinson and Kitzinger 1993). To be more precise, biopolitics governs the biological

aspects of human existence, including health, reproduction, and mortality. The state, aiming to enhance productivity and fertility, intervenes in human life through public policies, medical discourses, and pronatalist initiatives. Medicine thus functions as an instrument of power, developing techniques to observe, examine, and regulate bodies, enabling physicians not only to treat but also to objectify and control populations. This process produces medicalisation, in which individuals become subjects of surveillance and their bodies sites of exercised power. With this in mind, this paper addresses the following research question: How do women perceive the medicalisation of childbirth in Croatian public hospitals?

To answer this question, the analysis draws on the work of Robbie Davis-Floyd, one of the most important theorists of the anthropology of birth, who provides the theoretical concept of the technocratic model of medical care during childbirth. Robbie Davis-Floyd (2022) defines technocracy as a society that is capitalist, hierarchical, burdened with institutions, (still) patriarchal at its core, based on the overvaluation of (certain types of) science, and the progressive development of high technologies (Davis-Floyd 2022: 64). Namely, during pregnancy and childbirth, because of the unusual demands placed on it, the female body is treated as a machine at risk of serious malfunction or complete failure (Davis-Floyd 2022: 61). Therefore, the technocratic model of medical care articulates the human body as a type of machine and doctors as mechanics. Anthropologist Emily Martin argues that obstetricians are both supervisors and mechanics, although they act more like supervisors, since their primary role in hospital births is the active management of labour (Martin 1987: 57, cited in Davis-Floyd 2022). Among these core values, in both medicine and the wider society, technology reigns supreme. As has been clear for over twenty years, most routine obstetrical procedures have little or no scientific evidence to justify them. They are routinely performed not because they make scientific sense but because they make cultural sense (Davis-Floyd 1992).

The shift from treating diseases to managing bodies as objects of study is crucial to the growth of the medical profession as an authoritative institution, and is enabled by the technocratic model of medical care that dominates within the (Western) medical system. This technocratic model of medical care manifests in real life through twelve tenets: 1. mind/body separation; 2. the body as machine; 3. the patient as object; 4. alienation of the practitioner from the patient; 5. diagnosis and treatment from the outside in (curing disease, repairing dysfunction); 6. hierarchical organisation and standardisation of care; 7. authority and responsibility are inherent in the practitioner, not the patient; 8. supervaluation of science and technology; 9. aggressive intervention with emphasis on short-term results; 10. death as defeat; 11. a profit-driven system; and 12. intolerance of other modalities (Davis-Floyd, 2022: 70).

Based on the experiences shared by women who have experienced childbirth in the narrative interviews, the most noticeable principles in medical care during childbirth in Croatian hospitals are the first three principles: the body as a machine, the patient as an object, and the alienation of medical staff from the patient. Technocratic medicine divides a person into constituent parts, as well as the process and experience of childbirth from the course of life. But above all, it separates the human body from the human mind, described below in the narrative of one of the women who experienced childbirth in Croatian public hospitals:

They don't deal with the upper body, only the lower body. It's yours to spread your legs, they look at it and leave. So they don't expect the upper body to talk, to have questions and rights. (S2, 14.10.2022)

The objectification of women as patients during childbirth is articulated as a dominant practice of medical care in Croatian public hospitals, as it was encountered by every woman interviewed. This type of objectification is recognised in practices related to the lack of communication between the medical staff and the woman in labour, the lack of information about medical interventions, the unempathetic approach of the medical staff, the lack of privacy, and control of the escort (partner, close friend or family member) of the woman in labour. This type of objectification and viewing the woman in labour as a number or clinical case is additionally perpetuated through the principle of alienation of medical staff, which is set as a learning system in Croatian medical schools. This principle is set as the basis of their system of knowledge and learning practices internalised during socialisation and within their medical discourse (Orešković 1990). Medical staff become emotionally distant or indifferent, and they are taught to view patients as objects or clinical cases. The women's narratives confirm this:

They literally ignored me as a living person in the room. They didn't listen, didn't ask anything, didn't introduce themselves. I was just an object to them, a number. They didn't acknowledge me; they saw me as a task. (S6, 21.10.2022)

They treat you like a factory, a machine that produces people. (S25, 10.02.2023)

These quotes reflect the objectification of women, whose identities are reduced to reproductive machines focused solely on their reproductive organs. While most of the women emphasised that their child's well-being was their top priority, they also expressed how the lack of empathy and communication from the medical staff during childbirth constituted a deep sense of disrespect for them as a human. Objectification was coupled with poor communication, and every intervention was justified by the staff with the phrase: "It's all for the good of your child." Although the women experienced this objectification as a form of violence and disrespect, many consoled themselves with the healthy outcome for their baby and simply moved on from the experience:

In that moment, all you want is for it to end and for your baby to be alive. You feel so helpless that you don't think about your expectations or the lack of information. Women often don't even realise what happened to them; they stay silent because they're just happy to be alive. (S9, 25.10.2022)

This treatment of women during childbirth reflects the previously discussed patriarchal structure of social reality. The national fantasy is driven by the idea of preserving the nation through reproduction. Hence, the foetus and newborn child become central to representations of citizenship (Berlant 1997). They are framed as legal subjects – both medically and juridically – positioned as the solution to human existence. This idealised form of citizenship is accompanied by the archetype of motherhood, rendering the woman within

public health and policy frameworks a reproductive machine carrying the burden of the nation's future (Berlant 1997).

Patriarchal culture has normalised women's otherness and gender-based violence, rendering certain childbirth practices socially acceptable. This is why the social reality and the dominant discourse in Croatia are constructed in a way that limits knowledge about reproductive health and reproductive rights, makes it taboo and stigmatises it as a "women's problem". That is why most women are not informed about their rights as patients and as women in labour, and do not know what is a legally permissible medical intervention and what is not. In this way, doctors are positioned as authorities and great experts.

The problem is that you know nothing, no information is available, no one talks about it, so you don't know what to expect or how to act. I think I went through it normally. (S9, 25.10.2022)

Due to the discursive control over knowledge about their reproductive health and reproductive rights, many women are unaware that certain procedures and medical interventions are not intrinsic to childbirth but indicate dehumanising medicalisation. Consequently, they defer to medical staff, don't articulate pain or discomfort, and assume that "this is how it's supposed to be". This objectification is further reinforced by a culture of silence, a product of the discursive representation of women's reproductive health. Most women do not speak openly about their childbirth experiences, sharing them only with close confidants. The lack of postnatal care also affirms their objectification and the perception of motherhood as a naturalised role:

After giving birth, no one asks how you are, how the birth was. They ask how the baby is and how your husband handled it. For them, it's normal that you gave birth. They treat childbirth like an assembly line. (S2, 14.10.2022)

Because of the dominant perception of motherhood as a naturalised female role, it is considered normal for a woman to give birth, rendering her pain and bodily suffering invisible or negligible.

Furthermore, when discussing specific medical interventions, the interviewees emphasised practices that are normalised within Croatia's public healthcare system yet are prohibited in other European contexts, and which can be interpreted as forms of obstetric violence. These included episiotomies, the intentional rupture of membranes by the medical staff, abdominal expressions (manual pressure on the abdomen to accelerate labour), and other labour-accelerating methods performed despite the patient's desire for a natural birth. Instrumental intervention via CTG monitoring (cardiotocography) was central to their experience of medicalisation, illustrated by this quote:

They have to make sure we're under CTG monitoring in case something goes wrong [...]. I was screaming in pain, and the nurse told me, "Why are you yelling if the CTG is calm?" (S1, 14.10.2022)

CTG monitoring often led to medical personnel expressing mistrust toward women who reported intense and painful contractions or other complications. Several women re-

counted how this mistrust placed them in life-threatening situations because the staff prioritised CTG readouts over the patients' verbal accounts of pain. This experience was particularly common among first-time mothers, where the discourse of reproductive health reinforces stereotypes about "first-timer hysteria", shaping the way these women were treated in hospitals.

Technological interventions were frequently accompanied by the administration of drugs and labour-inducing agents, often without explanation or consent:

They injected something into my vein without telling me what it was or asking for permission. Before that, they gave me a cocktail of medications that left me dazed and unable to say anything. (S2, 14.10.2022)

This normalised practice of medical care – including disregarding the women's interpretations of pain, the strict adherence to CTG monitoring, the objectification of patients, and the failure to provide information or obtain informed consent for medical interventions (such as treatments, drugs, or modes of labour) – can be understood as a form of violence and as a manifestation of dehumanised and disrespectful medical care.

Additionally, the women noted that each hospital appeared to have its own set of unspoken rules and informal practices, representing a form of institutional discipline in Foucault's terms, where domination and the power of medical personnel control the patient, leading to women's alienation (Foucault 1980). This discipline is evident from the moment a woman enters the hospital: she parts from her companion, gives her personal data, and her movement becomes restricted. Even the hospital's architecture – from the waiting room to the delivery room – manifests this medicalised control. The unwritten hospital rules often stipulated that the partner could only be present during the final stages of labour. Additional restrictions included immobility, being forced to lie down, prohibition of food and drink, and minimal communication or information from the medical staff. The women described this treatment as subjugation and neglect, as illustrated in the following quotes:

That's just how it is. Nobody gives you any information, no one introduces themselves or gives you a choice about what they'll do [...]. The whole system is designed to meet their needs, not ours as patients. (S6, 21.10.2022)

Your preparation and birth plan mean nothing because no one listens to what you want. There's no: "Do you want this?" They decide instead of you. (S7, 21.10.2022)

As for their attitude toward me as a woman, as a human being, zero. I felt like I was talking to criminals; they had no empathy, no feelings at all. I understand that their situation is difficult, that there are few of them, but I believe empathy is the most basic quality one should have, especially when working with vulnerable women. (S15, 6.11.2022)

Among the women, the hidden knowledge of "that's how it is in Croatian hospitals" and the narrative of "if they all survived, I will survive too" are rampant, so that sometimes in the narratives of their experiences, the concept of luck appears as an important factor in the experience of childbirth. In other words, women's narratives of childbirth frequently empha-

sis the central role of luck in shaping their experiences. This sense of luck is particularly tied to the chance of encountering supportive and competent medical staff upon arrival at the hospital. Consequently, the quality of care during childbirth is often framed not as guaranteed, but as contingent on fortune, with Sunday frequently cited as the least favourable day to give birth. In conclusion, the medicalisation of childbirth is intrinsically linked to the objectification of women, not only as patients but also as individuals, citizens, and mothers.

CONCLUSION

Within the framework of Croatian national culture, a patriarchal lens constructs and fetishises the archetype of motherhood, reinforced by heteronormative politics and underpinned by conservative traditional and religious values. The national pedagogy of Croatian society reinforces the ideal of the family as an indivisible social authority. Within the context of such societal values, women's reproductive health becomes subject to control and politicisation. Within the public healthcare system, women are exposed to specific forms of medicalisation and objectification, accompanied by normalised practices shaped by the discursive effects of knowledge and truth. In this discourse, the physician's knowledge, based on technology and procedural protocols, is crucial: without his or her team, the birth cannot proceed even if the woman is ready to give birth to her child. The competing types of knowledge possessed by the woman and others involved in the event are suppressed and managed. What her body says, what she knows (and shows) based on her bodily experience, makes no difference in this environment.

Being confined to a hospital bed, giving birth in a supine position, being attached to a CTG machine – often trusted more than a woman's own interpretation of her pain – the administration of medications and labour-inducing substances without prior information and/or patient consent, as well as practices such as the intentional rupture of membranes, episiotomy, and abdominal expression are recognised as common practices of medical care during childbirth in Croatian public hospitals, which confirms the dominance of the technocratic model of medical care. The institutional discipline of hospitals alienates and restricts the woman as a patient. This form of medicalisation is marked by a profound objectification of the woman as a machine and object – a reproductive machine – thereby absolving medical personnel of any responsibility for the patient's mind and spirit. Thus, within the framework of normalised and routine medical care, elements of obstetric violence can be identified. Thus, the medicalisation of women's reproductive health entails the expansion of biomedicine, at times to the extent that medical authority assumes control and decision-making powers that override human rights.

Therefore, the medicalisation of women's reproductive health must be viewed not only as a response by the state to a perceived public health crisis and to pronatalist concerns about the national well-being, but also as an expansion of diffuse forms of governance and control. The experience of medicalisation thus highlights gender-based inequality in access to and provision of healthcare services. Based on the real experiences of women, it becomes evident that medical care functions as a mechanism of governance, revealing structural

and often invisible forms of violence that reproduce social inequalities. Obstetric violence reflects the disciplining of women's bodies, enforcing passivity and compliance, and serves as a tool to regulate pregnancy and childbirth. Normalised care in these settings thus operates within a continuum of patriarchal power relations.

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POVZETEK

Poleg bioloških funkcij predstavlja reproduktivno zdravje diskurzivno polje, ki ga močno oblikujejo družbeni, kulturni in politični konstrukti. Tako v preteklosti kot tudi danes je žensko reproduktivno zdravje področje, ki je podvrženo regulaciji in na katero posegajo družbene norme ter verska in politična prepričanja, ki opredeljujejo, kaj šteje za sprejemljivo ali moralno vedenje. V članku sta predstavljena kritičen pogled na te regulativne sile in njihov izraz v medicinskem vodenju poroda v hrvaških javnih bolnišnicah, zlasti pri medikalizaciji poroda in na tehnokratskem modelu oskrbe. Raziskava, ki se naslanja na Foucaulta, proučuje izkušnje žensk, ki so rodile, ter ugotavlja, kako bolnišnice kot institucije moči standardizirajo znanje in medikalizirajo naravni proces poroda. V tem tehnokratskem paradigmatem okviru postane žensko telo reproduktivni stroj, porodnica je objektivizirana, medicinsko osebje pa je odtujeno od pacientke. Ta model je postal prevladujoči način oskrbe pri porodu. Analiza se v veliki meri opira na teoretične perspektive antropologinje Robbie Davis-Floyd (1992, 2022), ki je zastavila dvanajst temeljnih načel tehnokratskega modela poroda, ki vključujejo ločevanje uma in telesa, objektivizacijo, odtujenost, hierarhično organizacijo ter avtoriteto zdravnikov. V kontekstu hrvaških javnih bolnišnic se ta model kaže v rutinskih praksah, kot so stalno elektronsko spremljanje ploda, uporaba epiduralne analgezije, pomanjkanje komunikacije, dehumaniziran pristop in visok odstotek carskih rezov. Takšni posegi so včasih medicinsko potrebni, vendar pa so postali normalizirani do te mere, da zasenčijo individualizirano, na žensko osredotočeno oskrbo. Članek v središče postavlja življenjske izkušnje žensk, na podlagi katerih pokaže, kako ustaljeni pristopi hrvaških javnih bolnišnic utrjujejo nadzor nad porodom in normalizirajo zdravniško poseganje. Zdravstveni sistem je tako treba proučevati kot kulturno institucijo, ki jo oblikujejo družbene vrednote. Članek prinaša kritično analizo obstoječih praks, ki kažejo na dehumanizacijo in nasilje, ter izpostavlja potrebo po preoblikovanju porodniške oskrbe v model, ki spoštuje avtonomijo, subjektivnost in individualne potrebe žensk.

Echoes in the Field: Confronting the Unexpected Deaths of Interlocutors in Medical Anthropology Research



Odmevi na terenu: soočanje z nepričakovanimi smrtmi
sogovornikov v raziskavah medicinske antropologije

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ABSTRACT

This article examines the deaths of elderly interlocutors after ethnographic research on diabetes in Belgrade. From the author's dual position as an anthropologist and a person with diabetes, it argues that grief and mortality are not disruptions but analytical events integral to ethnography. Reframing loss in this way advances medical anthropology's engagement with chronicity and death, while exposing the structural neglect embedded in biomedical individualism.

KEYWORDS: medical anthropology, interlocutor death, diabetes, reflexivity, emotional labour, grief, engaged anthropology

IZVLEČEK

Članek obravnava smrti starejših sogovornikov po etnografskih raziskavah diabetesa v Beogradu. Z dvojnega položaja avtorice kot antropologinje in osebe s sladkorno boleznijo zagovarja tezo, da žalovanje ter smrtnost nista motnji, temveč analitična dogodka, ki sta sestavni del etnografije. Takšno preokvirjanje izgube krepi obravnavo kroničnosti in smrti v medicinski antropologiji ter razkriva strukturno zanemarjanje, vtkano v biomedicinski individualizem.

KLJUČNE BESEDE: medicinska antropologija, smrt sogovornikov, sladkorna bolezen, reflektivnost, čustveno delo, žalovanje, angažirana antropologija

INTRODUCTION

In August 2023, I conducted semi-structured interviews with elderly people with diabetes in Belgrade, with the purpose of writing a paper for a PhD course at my university. We had meaningful conversations about their lives, diagnoses, health-related opinions, etc. Since no research had been done on the quality of life of elderly people with diabetes in Belgrade (or Serbia) that I could find, the course professor suggested I try to publish it. Had the paper not been published (Fotić 2023a), perhaps I would not have written this reflection at all, as my interlocutors¹ would have remained completely hidden from the world, and I would not feel this responsibility towards them and towards the stories of those who live “through” the Serbian healthcare system.

In April 2024, a few months after the paper was published, one of my interlocutors died. In July 2024, a second interlocutor died and in January 2025, a third. When the first interlocutor died, I felt sad, but I had already known she was unwell and had been hospitalised for two months prior to passing away in an intensive care unit. When the third interlocutor died, I thought: Is everyone I interviewed going to die very soon? Why do I feel this guilt, and is it even possible for me to change things for the better? Should I have seen the signs that they would be unwell, and could I have predicted that from our conversations? I was never trained for these situations, nor were many other researchers. Unprepared for this outcome, the experience sparked deep reflection on the emotional labour and empathy of anthropologists, the double insider position, and the responsibilities inherent in qualitative research, especially when studying groups on the margins. In this paper, I examine how my research and point of view – as a researcher with long-term experience of living with type 1 diabetes – have been impacted and changed by these events.

The primary focus of this paper is the unexpected experience of the death of my interlocutors and the personal and analytical implications of this situation for a researcher and their future perspectives. Firstly, I offer a short review of the anthropology of death and focus on the few existing papers regarding the death of interlocutors. Secondly, I shift my focus to the topic of diabetes in my previous paper and in medical anthropology and biomedicine in general, and reflect on my newly formed interpretations of the topic of research and my approach to it. Thirdly, I move onto the analytical and personal shifts in my reflection and their scholastic contribution to the topic of the death of informants. Lastly, I conclude the article with an activist (engaged) contribution to the topic of the death of informants in anthropological research.

1

I do not use informants and interlocutors as synonyms. In my opinion, informants are those who I talk to often, form a stronger relationship with, and frequently check facts with since they are better *informed*. Informants are also gatekeepers on some occasions. Interlocutors are people I “have a dialogue with” and infrequently talk to again on the same topic.

DEATH IN (MEDICAL) ANTHROPOLOGY AND THE DEATH OF INFORMANTS

Death and dying have been the topics of anthropological research since the field's onset; however, they were initially explored as part of the topic of religion and religious practices in small-scale societies, with attention to rituals, customs, funerals, emotions, liminality, etc. Death is explored in the works of Tylor, Fraser, Boas, Durkheim, Malinowski, and Radcliffe-Brown, among others (Kaufman 2004). Despite their valuable insights, their ethnographies always focused on the ritualistic part of death, rather than bereavement (Rosaldo 2004). They also did not focus on the universal problem of human existence, which resulted in the "abandonment of transcendental and universal conceptualizations of the problem and failure to formulate a theoretical plan by means of which the discipline would take on the challenge of death" (Čapo Žmegač 2009: 149). As Roberto Rosaldo wrote: "Ritual itself is defined by its formality and routine; under such descriptions, it more nearly resembles [...] a fixed program [...] than an open-ended human process. Ethnographies that in this manner eliminate intense emotions not only distort their descriptions but also remove potentially key variables from their explanations" (Rosaldo 2004: 172). In other words, rituals were equalised with mourning and emotions, and death was only studied in relation to ritualistic events. However, since the last decade of the 20th century, anthropological interest in death and dying has changed and broadened immensely. Death in (medical) anthropology is presently researched from the point of view of Michel Foucault's biopower, biopolitics, and medical gaze (Foucault 1977, 1980, 2003), body commodification and biotechnology (Franklin and Lock 2003; Jensen 2011; Scheper-Hughes 2000), foetal and newborn death (Anspach 2019; Bleyen 2012; Heinsen 2023; Komaromy 2012; Rapp 1999), and a rethinking of the culture/nature and human/non-human dichotomies. It is also studied as the political economy of epidemics, and the culture of risk mainly inspired by AIDS/HIV, where the focus is on the social inequality of disease distribution and death, with race, gender and class as factors of health and access to healthcare (e.g. Biehl 2005, 2007; Biehl and Petryna 2013; Farmer 1992, 1999; Saussy 2010; Žikić 2006, 2013). Additionally, the anthropology of violence, war, and terror explores ways in which death is "lived" in memory, illness, the body, and in everyday practices, where ethnographic work focuses on riots, gangs, warfare, tribal genocide, rape, torture, and mass death (Kaufman 2004).

Locally, Aleksandra Pavićević has written a meta-analysis of how death has been studied in Serbian ethnology (Pavićević 2008). Her paper contributes to the anthropology of death by showing how Serbian ethnology moved from ritual description to symbolic and political interpretation. From the 1950s to the 1970s, Serbian ethnology was mostly descriptive, with a focus on rituals, omens of death, and graveyards. Thanks to the translations of the works of Louis-Vincent Thomas (*Anthropology of Death*, 1980) and Edgar Morin (*Man and Death*, 1981) in the 1980s, Serbian ethnology experienced a turning point – symbolism got to be interpreted and death was read instead of described (Čolović 1983). Between the 1990s and 2000s, death became politicised. The deaths of Josip Broz Tito, war "heroes",

and national figures (e.g. Željko Ražnatović, Zoran Đinđić, Slobodan Milošević) created a “political thanatology”, where mourning was collective, mythologised, and tied to nationhood (Pavićević 2008). Serbian anthropology began to recognise death as a site of ideology and power, linking it to state rituals, nationalism, and the politics of memory.

Contrastively, what happens when death is not researched *per se*, but experienced when informants die?

Before the beginning of this millennium, no attention had been given to the experiences of researchers studying death or experiencing the death of informants (Burles 2017). Whether after or during fieldwork, the death of informants has been the topic of only two relatively recent articles (Burles 2017; Jakoubek 2019) due to a bitter and simple reason: “it’s difficult to write about it” (Jakoubek 2019: 208).

Burles and Holtslander were studying the everyday lived experiences of women with ovarian cancer (Burles and Holtslander 2013) when, upon learning of some of their informants’ deaths, Burles realised that she needed to do more with her research. She started reflexive journaling, writing about her reactions and feelings upon learning of the informants’ deaths, and published an article on the topic a few years later, highlighting that little attention is given to the experiences of researchers who study death, dying, illness or bereavement, and that proper preparation and support are needed for researchers studying these topics. She also channelled her emotions into her research, writing a draft paper faster than originally planned, so that her remaining informants could read it as soon as possible and feel represented and understood (Burles 2017).

Jakoubek (2019), on the other hand, although focusing on the theory of ethnicity, came upon death as a decisive point in his research. He was conducting long-term (1999–2016) fieldwork in the only Czech village in Bulgaria, which had been founded in 1900 and remigrated in the 1950s, and where his ideal population of informants was around seventy years of age at the beginning of his research and, naturally, died out over the years. He experienced the death of his informants many times throughout this research project and in 2015, his last informant died, meaning “the death of the community as a whole, which ceased to exist” (Jakoubek 2019: 209). Jakoubek’s exceptional experience, however, made him an informant for younger generations of (ex)Voyvodovo descendants, who had migrated to the Czech Republic and lost their roots. Having no more living older relatives, they came to Jakoubek in search of their communal memories, and the satisfaction of helping younger generations see archival, photographic and other materials of their ancestors helped him deal with the death of informants more easily.

REFLECTION I: A FEW NOTES ON DIABETES
AND THE QUALITY OF LIFE OF ELDERLY PEOPLE
WITH DIABETES IN BELGRADE

In order to delve into the topic of the quality of life of elderly people with diabetes more deeply, a blend of biomedical and anthropological descriptions of diabetes is needed. The

Institute of Public Health of Serbia estimates that approximately 700,000 people or 12.2% of the adult population in Serbia have diabetes. Overall, of the three main types of diabetes – type 1, type 2, and gestational diabetes – type 2 is by far the most prevalent (95%). Moreover and more importantly, 36% of the total number of people with type 2 diabetes do not have a diagnosis and are unaware of their condition. The prevalence of diabetes increases with age, and it is estimated that almost half of those affected are older than 65, making it “the geriatric disease” (Rakočević, Miljuš and Božić 2022). With this in mind, it is no wonder my interlocutors saw their diagnoses as part of the natural course of ageing (Fotić 2023a). Generally, type 2 diabetes is detected relatively late, when numerous cardiovascular complications are already present.

Although genetics play a role, the emergence and spread of type 2 diabetes is the result of social and cultural processes related to changes in lifestyle, food quality and the amount of energy consumed, economic conditions, the environment, etc. Instead of taking cultural factors into account, in biomedicine, the main understanding of type 2 diabetes is that of a disease of personal responsibility. Namely, people with type 2 diabetes are often considered “bad patients” who “don’t listen” to medical staff (Carruth et al. 2019: 121). For example, data from the WHO report for 2016 states that obesity is strongly associated with diabetes (cited in Thorsen 2023: 9–10). However, examining the numbers in the report shows that the regions with the highest and lowest prevalence rates of diabetes and obesity do not match. The Southeast Asian region, for example, has the second highest prevalence rate of diabetes but the lowest prevalence rate of obesity, while the European region has the second highest prevalence of obesity but is second to last in diabetes prevalence (Thorsen 2023: 9–10). Why is it then that diabetes is so easily associated with obesity, and why is the combination of these two terms (*diabesity*) constantly emphasized in the medical literature?

This is where medical anthropology steps in: the answer lies in the fact that some factors are more in line with neoliberal ideology than others. Namely, the neoliberal and biomedical understanding of type 2 diabetes has led to the prioritisation of risk factors such as obesity over other known risk factors related to, for example, structural and political issues (Ferzacca 2012; Thorsen 2023). Health promotion discourse as a form of social regulation, an “imperative of health”, acts as a moral obligation for individuals to manage their bodies responsibly and visibly in line with social norms. A healthy subject is a responsible, moral member of society who avoids risk, consumes health-related information, and demonstrates self-control. Ill health, conversely, becomes associated with irresponsibility, lack of discipline, or moral failure (Lupton 1995).

In the paper I wrote about elderly people with diabetes in Belgrade (Fotić 2023a), I mapped out their quality of life using objective (housing, occupation, employment in retirement, pension level and the relation of these indicators to the finances necessary to buy medicine) and subjective indicators (the mental impact of a diabetes diagnosis, physical health, relationship with healthcare professionals, availability of information, and views on the types of help provided by the state/healthcare system that would positively affect their quality of life). When I started exploring the topic, I had no direct contact with people with this condi-

tion, since all of the informants included in my previous PhD project had type 1 diabetes. My only point of contact with type 2 was either through literature or volunteering (I measured blood sugar at a health festival, where elderly people with type 2 diabetes would approach me and ask for advice). I was broadly familiar with the fact that this group is often poorly educated upon diagnosis and needs advice more often than the regular check-ups at the hospital allow.

Therefore, my approach to their quality of life was exploratory, as I wished to find out what their everyday lives looked like. The research included five interlocutors, two women and three men, while four family members provided additional or more precise information. The criteria for selecting the interlocutors were age (men over 65 and women over 63), entitlement to a pension (age-based or disability), and a diagnosis of diabetes. The interlocutors' age ranged from 66 to 77 at the time of the interviews. All of them had type 2 diabetes, which consequently directed the focus of the study. The interviews were conducted in Serbian, partly in person (at their homes) and partly by telephone (due to the extreme heat waves in Belgrade in August 2023). The biographical method was used due to the need to collect information about the subjective experience, with a brief focus on the period before the diagnosis of diabetes, and up to the present. Although one interlocutor is sufficient for the biographical method (Vučinić-Nešković 2013: 43), five were included, together with their family members, in order to complete the PhD course requirements. Institutional approval was given by my department for all PhD-related research. The interlocutors were anonymised and their identities were hidden with aliases and the exclusion of any identifying information. Oral consent was given upon first contact as well as at the beginning of each interview. Due to the health conditions and comorbidities of all the interlocutors, I tried to limit the semi-structured interviews to less than an hour, except in one case, when the interview with a woman who did not leave her apartment and therefore rarely had the opportunity to talk to new people lasted longer. I reached my interlocutors via snowball sampling (through friends and family members), and therefore always had a mediator who could recommend me and instil trust in the person I was speaking with. At the beginning of each conversation, I explained what my paper was about and that I myself had been living with diabetes for more than twenty years, which I believe had a positive effect on the interlocutors. For example, they felt free to comment on their blood sugar levels with me without needing to explain the complexities of diabetes. In Serbian anthropology, there is no codified protocol on posthumous data, but the prevailing practice is that data remains usable if consent was obtained during life. Out of the five interlocutors, three died during the following year.

As for the research results, I was aware that normally the amount of pension and salary affect the attitude towards medicines and out-of-pocket payments, but I was also familiar with the fact that my interlocutors had good pensions, i.e. better than a large number of pensioners in Serbia, and that their daily lives would certainly be very different if their circumstances were worse. The most interesting finding for me was their understanding of the diagnosis of diabetes – which until then I had known almost nothing about. I learned that they perceive it as part of the normal course of life, as a factor that is not a biographical disorder (Bury 1982), but something that naturally comes with age and with which one

lives. In contrast, when I was researching the diagnosis of type 1 diabetes in people who were diagnosed as children, it was perceived as a serious biographical disorder affecting the whole family (Fotić 2023b). I also found it interesting that my elderly interlocutors were resisting diets, which I understood as resisting, among other factors, neoliberal ideology and therefore the cultural norms that place the blame for type 2 diabetes on individuals instead of on socio-economic living conditions. However, my earlier interests changed drastically upon learning that three of my interlocutors had died.

When the first interlocutor, Gorica, died, I was not completely surprised since she had been hospitalised for two months and was mostly unconscious as a result of a stroke. Nevertheless, I was puzzled because she had previously been healthy and had no complications. When Radoslav died three months later, I started looking for a culprit, someone to blame, especially since even the doctors themselves did not know the cause of his death. As an anthropologist, I naturally look for the culprit in wider trends and not in individuals, and when the third interlocutor, Dragomir, died, I found the culprit in the state, in its extended hand, the state-funded healthcare system they were all depending on and neglected by.

This is what changed my research findings, or better yet, my perspective. The subjective and objective indicators of the quality of life that had previously interested me now became completely irrelevant. I re-read our interviews, trying to find between the lines the connections related to how the system had failed them and potentially killed them. This is the main prism through which I now see the topic I was researching, and it is a shift in the critical approach towards the study. Now, for example, I find their opinions about the state and the state-funded healthcare system and its potential improvement crucial, whereas before it was only one of several factors in my analysis. I look for what I might have missed, what I might have misunderstood or misinterpreted. In other words, “death after fieldwork” as an analytical event has changed how I read, approach, and understand data, and how I interpret it.

I am aware that I cannot tell if the interlocutors actually passed away due to complications from diabetes, because diabetes-related death is a very grey area and presents a very serious problem. In the previous paper (Fotić 2023a), I never mentioned the numbers regarding diabetes-related mortality, since I was completely oblivious of the situation I would find myself in a couple of months later. In fact, diabetes is the third leading cause of death in Serbia. In 2023, 2,794 people (1,282 men and 1,512 women) died from it. In the period from 2014 to 2023, the mortality rates from diabetes increased by 19.9% (Miljuš 2024: 64). It should be borne in mind that the number of diabetes-related deaths is much higher than is cited due to errors in coding the cause of death.² In other words, when a person dies from a diabetes-related complication, it is the complication that will often be put down as the cause of death, not diabetes itself. This is especially the case with heart attacks, strokes, and chronic renal failure. Two interlocutors with mild or no diabetes-related complications, respectively, had strokes

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This has been recognised in the national strategy and guideline papers (Republička stručna komisija za izradu i implementaciju vodiča dobre kliničke prakse 2012: 11; Rakočević, Miljuš and Božić 2022: 6).

which resulted in their deaths. Only two interlocutors had no complications (Slavoljub and his wife, Gorica, who was the first one to pass away). Ljiljana has polyneuropathy, has survived breast cancer and receives a disability pension due to hepatobiliary echinococcus.³ Radoslav had polyneuropathy and led a very active life until his passing, and Dragomir had polyneuropathy and retinopathy, but was also on a disability pension due to heart attacks (Fotić 2023a). Gorica either did not have any complications or if she did, they were not diagnosed in time, while Radoslav and Dragomir both had polyneuropathy, which together with retinopathy should not have led to a deadly outcome.

REFLECTION II: EMOTIONAL WORK, EMPATHY, AND POSITIONALITY

Because I agree with the reflexive turn in anthropology, which argues that ethnography is highly subjective and depends on factors such as the researcher and their characteristics, as well as their life-history and connection to the groups they study (Ivanović 2005; Rosaldo 2004), I find it normal that in some circumstances, a significant part of the work done in the field is emotional. Consequently, the researcher is seldom left untouched when their interlocutors die.

Entering the field, making first contact, establishing rapport, doing participant observation, interviewing, and overcoming cultural shocks have all been at the centre of the ethnographic spotlight since the very beginning of anthropological research. However, “the situation of ending this relationship and situation in which it is the informant who leaves the researcher (by dying) has practically never been thematized” (Jakoubek 2019: 216). Hence, Jakoubek (2019) believes that the topic of the death of informants should be taught in students’ fieldwork training, where more attention should be given to the importance of integrating reflexivity and emotional preparedness into fieldwork training. Although reflexivity has been normalised for quite some time (Ivanović 2005), the practice of emotional preparedness and learning about the possible death of informants does not merely honour the legacy of those who may pass, but also contributes to a more compassionate methodological framework *for* the researcher and their well-being. In other words, there needs to be greater acknowledgement and support for researchers grappling with the emotional toll of informant death, which might best be achieved through psychological support and peer/group meetings.

A researcher can experience over-identification with informants, feel distress because of an informant’s health condition (or other life circumstance) and because they do not have the power to help (Benoot and Bilsen 2016). Burles (2017) writes that the emotions of a researcher and their openness help informants open up and feel safe. Emotions also mean that the relationship between a researcher and an informant should not be merely one-sided

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A parasitic disease caused by a small tapeworm in the human stomach, travelling to organs such as the liver and creating cysts. It requires an operation and is life-threatening. For more information see Bhutani and Kajal (2018).

or instrumental but may include feeling and reciprocity. Some anthropologists, such as Jean Briggs, Waud Kracke, and Peter Black, have emphasized deep emotional involvement and personal resonance as essential for establishing trust and achieving meaningful understanding. Their field experiences show that anthropologists' own emotional states – from grief to compassion – shape not only their relationships with interlocutors but also their interpretive insights (Black 1985; Briggs 1970; Kracke 1981). The emotional experiences of anthropologists are not peripheral, they are central to the ethnographic endeavour. Empathy is revealed as both a method and a personal, situated emotional process that is deeply entangled with how anthropologists come to understand others – and themselves (Ilić 2019). In other words, the ethnographic journey of an anthropologist might potentially affect them deeply due to the time spent with the community and the depth of the very methodological tool they are using. It can affect them more seriously when they identify with their informants.

As a proponent of the reflexive turn, I also argue that a researcher's position may depend on their specific research field, and that feelings can be amplified when the researcher is, in a way, a part of the community they are studying. In anthropology at home, "home" can have multiple meanings: it can refer to a specific country, continent, Western societies, culture, institution, activity, disease, etc. (Van Dongen and Fainzing 1998). Some researchers may feel at home if they share the same condition with the interlocutors, as is the case in my research. The over-identification is already there and the distress of not helping or even seeing any signs that help could be needed can be completely overwhelming.

As horrible as it sounds, by experiencing death as an echo of the fieldwork, I have gained a new perspective and interpretation: what was once interesting has now become irrelevant, and what was once not analysed deeply has become significant. Ilić reminds us of Rosaldo's "positioned subject", where the anthropologist's own life experiences become gateways for deeper empathy and comprehension. Rosaldo famously argued that only after experiencing the devastating loss of his wife could he truly grasp the Ilongot's⁴ expressions of grief and rage, illustrating how personal suffering can reframe ethnographic understanding⁵ (cited in Ilić 2019: 635). This, however, does not mean that it is in the researcher's best interest to have the experience Rosaldo, Burles, Jakoubek and probably many others who have not written about it publicly have had, in order to gain new insights. Just as Burles understood that making terminally ill women feel seen, represented, and understood by writing her paper at a fast pace is an anthropological contribution, so did Jakoubek's exposure bring about him advocating for making the experience of death in the field a mandatory part of university curricula. Should death be experienced every time a researcher goes into the field in order

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Indigenous peoples of Luzon, an island in the Philippines, who used to be headhunters. Rosaldo and his wife, Michelle Zimbalist Rosaldo, were doing ethnography with the Ilongot when Michelle tragically died in 1981.

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Although I agree that empathy and shared experiences can impact the researcher's understanding of the people they are studying, I also agree that this cannot be implemented all the time. Leavitt, for example, insists that anthropologists' emotions should not be erased, but neither should they dominate the interpretation. Rather, emotions become part of the dialogical and narrative process of ethnographic meaning-making (Leavitt 1996).

to have an altered perspective? The answer, again, is no. The contribution lies in the fact that future researchers do not have to experience death in the field for an altered, broader perspective, but can read from the authors who have experienced it and written about it before. This should also help them, as it has helped me as well, to feel less lonely and more understood.

Rosaldo's notion of the "positioned subject" invites an inversion of the trauma-informed approach to qualitative research. While trauma-informed methodologies typically emphasize the need to protect participants – particularly marginalised groups with histories of personal, structural, or historical trauma (Alessi and Kahn 2022) – a similar lens can be applied to researchers themselves. Anthropologists, especially those working in medical anthropology, often bring their own embodied histories of illness, stigma, or trauma into the field.⁶ For researchers working with elderly, chronically ill, or otherwise vulnerable interlocutors, preparation must include recognising that death may occur during fieldwork. This entails reflecting in advance on how such an event may be experienced emotionally, developing strategies for handling data ethically (e.g. stricter anonymisation), and cultivating an acceptance of mortality that allows rapport and compassion without assuming the role of caretaker. During interviews, if death arises as a theme, it should be acknowledged rather than avoided, with the encounter reframed as an opportunity for participants to articulate legacy. When loss occurs, researchers must also navigate their own grief. This may involve recognising avoidance behaviours, pausing research activities, or ritualising closure through personal acts such as attending funerals or writing private reflections. Reflexivity is central: documenting the experience, engaging with support networks, and validating the legitimacy of grief can transform loss into an analytic resource. In this way, the pain of participant death can deepen the anthropological understanding of vulnerability, chronicity, and mortality in the communities under study.

Could I have had these new insights if I had not experienced death in the field or read about them? I think not. However, this new knowledge will not evaporate into thin air but will stay with me in my future anthropological endeavours. If other anthropologists unfortunately experience death in a similar way, I encourage them to write about their experience, not only for their own sake but for the sake of other researchers as well, since a plethora of papers on this topic might lead to new insights and new conclusions, which might create a new methodological pattern of studying and experiencing death in the field.

ENGAGING CONCLUSIONS – OR A "GOOD ENOUGH ANTHROPOLOGY"

The experience of death changes people, so when it occurred to me to research other groups of people with diabetes, I started questioning the emotional impact it could have on me.

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Candice Bradley (1997) wrote about her experience of having type 1 diabetes during her fieldwork in Kenya in 1986, contributing to defining anthropological fieldwork as a "high-risk occupation". Diet and episodes of hypoglycemia significantly shaped her allocation of time, course of interviews, and field diary writing. When revisiting her diary entries, she realised there were entire hours and interviews of which she had no recollection as a result of low blood sugar (Bradley 1997).

Certainly, it is less likely that younger people or children with type 1 diabetes would die during or shortly after an ethnographic endeavour, but researching those groups has its own emotional challenges, especially when the researcher is also a person with diabetes, dealing with their own trauma-inducing and life-threatening situations. For example, talking to the parents of a child with diabetes is almost always burdening, especially if they seek help from you or blame you for the way the healthcare system is set up because they perceive you as a health activist.⁷ As much as the double position of a researcher and a person with diabetes has its positive aspects, the negative ones can sometimes have a greater impact and leave psychological marks. However, the experience of elderly interlocutors passing away has not turned me away from the topic, but has made me even more interested in studying groups on the margins⁸ as a specific sub-group in the healthcare system.

How do we cope with the death of informants and how do we give back to the people who are no longer with us?

I learned a great lesson reading Mark Nichter, who believes that simply observing other people's diseases and problems without interfering by trying to find ways to help and change their situation represents "capitalizing on the suffering of others" (Nichter 2006: 344). Nichter calls himself an "engaged" anthropologist because this title always reminds him to ask himself important questions such as: "Whom do I hope to engage through this research and writing? What kind of engagement am I trying to foster? What stage in the multistage process of problem solving does this research inform? What needs to be considered next; what stakeholders are being addressed by the research and who is being neglected?" (Nichter 2006: 345).

If nothing is done about the suffering of others, the anthropologist capitalises on it. Nichter's questions have helped me identify some of the possibilities of engagement in finding ways to help – if not those who have already passed, then those who belong to the same group. Due to my double position as a person with diabetes and a researcher, I am trying to engage in advocacy in the context of type 2 diabetes and the elderly, and against the discourse of health promotion which, among other factors, attributes individual blame for the disease. Although diabetes is a major health issue in Serbia, little effort is put into preventing diabetes or its complications in the state-funded healthcare system. Instead, public health policy papers in Serbia, like in the UN and WHO, determine individual behavioural factors as the only ones prone to change (Glasgow and Schreker 2015), using biomedical individualism that

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A few years ago, when I wrote a semi-academic book on stigma and diabetes in Serbia, I would often meet people in person and hand them the book. One mother of a child with diabetes kept me in the cold outside my place of work and shouted about the fact that a dentist would not remove her son's tooth because he had diabetes. I tried to give her the numbers of doctors I went to when I was a child, but she did not take them. She needed to vent, and I was the channel for that. These situations can be very tricky because we try to help people, and at the same time, they behave aggressively towards us, but we have to keep it together. I was very emotional after that encounter and deleted all of her contacts and social media and was afraid that she would come to my place of work in the future.

8

Generally speaking, Serbian anthropology perceives the elderly as a marginalised population (Radulović 2022). Elderly people with diabetes, regardless of their pension, are a marginalised population.

primarily focuses on the biological characteristics and personal behaviour of individuals. This is in close relation to market-oriented political ideologies that emphasize personal responsibility over collective rights and tend to produce policies that focus on personal responsibility for behaviour change (Baum et al. 2009). The highest possible goal I could achieve with this paper and my research would be to influence public health policy regarding diabetes to shift the course of action towards socio-economic factors instead of individual ones, and to highlight the importance of prevention instead of treating complications after they arise, which carries tremendous costs both for the state as well as the citizens. On the other hand, institutional review boards or ethics committees should produce protocols that address researcher wellbeing (including grief management and support systems) and reflexive practices that acknowledge mortality while ensuring that the participants' narratives are honoured.

Activist research can represent a "good enough anthropology", which forces anthropologists to "get down from their thrones of authority and pure research" (Huschke 2015: 64) and find meaningful ways to somehow help the people they study. Researchers used to search for otherness outside of their own geographical and cultural surroundings (Ivanović 2005); however, Naumović writes that the ethnologists who belong to the group they study and share its language, traditions, and values (Naumović 1998), identify themselves with the object of study. They can also advocate for the group, and if they perceive their group as "being threatened, deprived or oppressed by other groups, then we can expect the specialist to engage in the production of ideologised discourses in order to influence the change of his group's position, regardless of [...] the fact that he is engaged in the practice of 'ethnology' or 'anthropology'" (Naumović 1998: 115).

I have read ethnographies about terminally ill people in the past, but it never occurred to me that by doing medical anthropology in general, I am more likely to experience death than, say, a researcher involved in the anthropology of games (although I can currently see death as part of all anthropologies).

The experience of the death of my interlocutors has affected the way I understand an interlocutor's life in general, but more specifically, the life of an interlocutor with a chronic condition such as diabetes. Since I had not previously known anyone who had died because of it, I only saw diabetes-related death as a slow killer of my own body through complications. In researching the elderly with type 2 diabetes, their death is no longer just a number – a prevalence or a mortality rate – but an experience with very specific contextual factors that depend on the healthcare system and many other indicators.

As I wrote in the beginning, many deaths from diabetes go unregistered or are registered under different causes of death because of the complexity of diabetes-related complications and the often unknown existing complications that are due to the low-levels of type 2 diabetes prevention in the Serbian state-funded healthcare system. In other words, if type 2 diabetes related check-ups were done once a year, especially among older people, a diagnosis could be made before any complications arose. Metaphorically "going into the field" for the second time, through my notes and interview scripts, has allowed me to look at the research differently and notice some aspects that were not as relevant earlier. "Death after fieldwork"

deepened my understanding of the fragility of human life and the importance social and cultural factors have when it comes to the marginalised members of a community. The interlocutors' death moved and changed me, as a researcher and an activist alike. Reading the works of other authors on the death of informants has helped me grapple with the situation, feel less lonely and more understood.

In research with elderly or chronically ill interlocutors, the likelihood of encountering death during fieldwork is significant. Such losses may resonate with the researcher's own experiences of illness and mortality, thereby intensifying the affective impact of fieldwork. Developing a trauma-informed protocol for the researcher is therefore essential: it provides tools to safeguard one's own wellbeing while also honouring the deceased. In doing so, it ensures that participants' narratives continue to form part of the collective record without overwhelming the anthropologist tasked with carrying them forward.

By reframing interlocutor death as part of the ethnographic record, this case pushes medical anthropology toward new methodological ground, where grief and loss are recognised as data that reshape interpretation rather than as disruptions to it. This case advances medical anthropology by showing that attending to the deaths of interlocutors is not only an ethical obligation but also a form of care that ensures their lives and narratives remain embedded within the collective memory of research. Hopefully, this paper is a useful contribution to examining the ongoing struggles anthropologists face during and after their fieldwork, as it was nourishing to my soul to write about the analytical and personal reflections of my own experience.

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POVZETEK

Članek je refleksija nepričakovane smrti treh starejših sogovornikov, ki so sodelovali v raziskavi o kakovosti življenja s sladkorno boleznijo tipa 2 v Beogradu. Avtorica na podlagi svoje dvojne vloge – kot antropologinja in kot oseba, ki živi s sladkorno boleznijo tipa 1 – raziskuje, kako so žalovanje, krivda in kritika sistema vplivali na njeno interpretacijo podatkov, kot tudi na etično držo, ki jo izraža v raziskavi. V antropologiji je smrt že dolgo

časa predmet proučevanja, vendar pa je smrt sogovornikov med terenskim delom ali po njem premalo teoretizirana. Avtorica smrti sogovornikov ne obravnava kot prekinitve, temveč kot analitične dogodke, ki zahtevajo refleksijo in čustveno pripravljenost raziskovalca ter prepoznavanje s strani institucij.

Z umeščanjem smrti sogovornika v širši kontekst kritike biomedicinskega individualizma in neoliberalnega uokvirjanja sladkorne bolezni avtorica poudarja strukturno zanemarjanje, ki je značilno za bolezni in umrljivost med starejšimi. S tem ko smrti sogovornika ne opredeli kot motnje v etnografskem zapisu, ampak kot del tega zapisa, nadalje razvija nove načine ukvarjanja s smrtjo, žalovanjem in kroničnostjo v medicinski antropologiji, saj pokaže, kako lahko ranljivost odpira nove metodološke ter etične razsežnosti.

V članku zagovarja stališče, da antropologi ne morejo ostati nevtralni opazovalci, ko se soočajo s sistemskimi napakami, ki pospešujejo trpljenje in smrt. Izkazovanje spoštovanja do sogovornikov ne zahteva le refleksivnosti in sočutja, temveč tudi zavezanost angažirani, aktivistični antropologiji, ki se zoperstavlja družbenim ter političnim razmeram, v katerih poteka življenje – in smrt.

Konstrukcija in trženje kulinarične identitete na Solčavskem



Construction and Marketing
of the Solčavsko Culinary Identity

Vesna Petrič in Sara Sakač

1.03 Drugi znanstveni članek
DOI 10.4312/UCNH6082

IZVLEČEK

Članek obravnava procese ustvarjanja in trženja regionalne kulinarične identitete na Solčavskem. Osredinja se na akterje, ki so vpleteni v turistično-gastronomsko ponudbo območja na različnih ravneh: od individualnih nosilcev ponudbe do občine ter vmesnih institucionalnih teles, ki delujejo predvsem v obliki zvez in društev. Na podlagi zbranega etnografskega gradiva odpira vprašanja o predstavah tradicije in njenega domnevnega obujanja ter o novih kulinaričnih pobudah na proučevanem območju.

KLJUČNE BESEDE: okus, gastronomija, kmečki turizem, Zgornja Savinjska dolina, alpska kuhinja

ABSTRACT

This article explores the processes of constructing and marketing regional culinary identity in the Solčava region. It examines various actors involved in the area's tourism and gastronomic landscape, operating at different levels – from individual providers to the municipality and intermediary institutional bodies, often organized as associations and societies. Drawing on ethnographic material, the study highlights notions of tradition and its purported revitalization, as well as the emergence of new culinary initiatives in the region.

KEYWORDS: flavour, gastronomy, agritourism, Upper Savinja Valley, Alpine cuisine

Solčavsko je prostor, ki ga med drugim oblikujejo naravna krajina in kulturna dediščina ter številni režimi njenega varovanja, kot tudi lokalno gospodarjenje, povezano zlasti s kmetijstvom, gozdarstvom in turizmom. Pomembno mesto na preseku omenjenih komponent življena zaseda kulinarika, ki ne nastopa le kot del turistične ponudbe, temveč tudi kot dinamičen kulturni izraz in način oblikovanja lokalne identitete.

V prispevku se bova ukvarjali z vprašanjem, kako se oblikuje in vzdržuje ideja »solčavskih okusov« ter kako je povezana s percepcijami odročnosti prostora, samozadostnosti, kakovosti, lokalnosti, tradicije in avtentičnosti, pa tudi, kako jo sooblikujejo tehnološke spremembe ter turistična pričakovanja. Pozornost bova namenili institucijam in lokalnim akterjem, ki sooblikujejo gastronomsko identiteto kraja – denimo s spodbujanjem kratkih dobavnih verig, vključevanjem hrane v turistično ponudbo, promocijo lokalne dediščine – ter ohranjajo in prenašajo »tradicionalna znanja«. Pomembno vlogo igrajo tako občina in zavod Center Rinka kot tudi posamezne turistične kmetije ter zaposleni v gostinstvu in drugi nosilci lokalne kulinarične ponudbe, ki hrano umeščajo v širšo naracijo o Solčavskem kot o posebnem, drugačnem, izjemnem prostoru.

Prispevek temelji na etnografskem raziskovalnem delu: glavnino etnografske raziskave sva izvedli v okviru Etnološkega tabora treh dolin septembra 2022. Opirava se na gradivo, zbrano z opazovanjem z udeležbo ter polstrukturiranimi intervjuji s sogovornicami, ki živijo ali delajo na Solčavskem ter so na različne načine vključene v turistične in kulinarične dejavnosti. Njihove izkušnje in pripovedi osvetljujejo, kako se lokalna kulinarika oblikuje na presečišču idej o tradiciji, inovaciji ter strateškem umeščanju v širši turistični razvoj. V prvem delu prispevka se ukvarjava z vprašanjem »solčavskih okusov« in odročnosti, nadaljujeva z analizo etnografskih primerov, nazadnje pa se posvetiva še kulinarični identiteti v kontekstu vprašanja avtentičnosti.

KAKŠNI SO OKUSI SOLČAVSKEGA?

Hrana je v družbenem življenju ljudi izjemnega pomena; z njeno pomočjo se ljudje spominjajo, prenašajo vrednote in navade skupnosti, ohranjajo tradicije, gojijo individualne in kolektivne občutke ter čustva, vzpostavljajo medsebojna razmerja (Godina Golija 2014: 64), nenazadnje pa se tudi razločujejo, tako družbeno-kulturno kot geografsko. Z geografskim označevanjem hrane so začeli v Franciji, kjer so že na začetku 19. stoletja pri vinu zagotavljali podatke o poreklu in specifični lokaciji, od koder izvira. Tam je nastal pojem *terroir*, ki je najprej opisoval tehnične podatke o terenu, geologiji, prsti, mikroklimi, rastišču itn., ki naj bi ustvarjali značilne okuse določenega živila. Danes *terroir* zajema tudi ljudi, vključene v proces pridelave, ter veščine in znanja, ki so potrebni za obdelovanje določene krajine (Berris 2019: 61–75, Pratt 2007: 285–300). Opisani pojem izpostavlja predvsem povezanost ljudi, ki pridelujejo in predelujejo določena živila, s krajino, iz katere ta živila »izhajajo«. Tudi na Solčavskem hitro naletimo na predpostavko, da naj bi bila prehrana tesno povezana z geo-

grafskimi značilnostmi prostora: »Način življenja, ki ga je pogojevala predvsem geografska lega Solčave, je izoblikoval človeka ter prispeval k razvoju nekaterih prehranskih posebnosti in 'solčavskih' jedi« (Brlec Suhodolnik 2015: 8). Eden izmed vzrokov, da je na Solčavskem povezava med geografijo, ljudmi in hrano tako tesno stkana, je po mnenju lokalnih akterjev odročnost. S tem merijo na specifično korelacijo geografskega konteksta in fizičnih lastnosti prostora, pa tudi na procese, transformacije ter delovanja »na polju političnega, zgodovinskega in materialnega« (glej Germ, Krampfl in Krašovic 2022: 30). Predstave o odročnosti in samozadostnosti, ki opredeljujejo prostor ter načine bivanja (prav tam), se kažejo tudi v »tipičnih« solčavskih jedeh in v razumevanju njihove specifičnosti.

»Hrana je bila preprosta. Tisto, kar si doma imel, tisto si ponucal,« je poudarila ena izmed sogovornic (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022). Za »tradicionalno« solčavsko kuhinjo (Brlec Suhodolnik 2015) so značilni krepki in obilni obroki, v ospredju katerih so mlečni izdelki (npr. *zmetki* – pinjenec, *masunk* – prevreta smetana ali maslo z moko, *sirnek* – zorjena skuta, *sirnica* – juha s sirnekom), žitarice (*putrtobi* – sladki hlebčki iz pšenične moke, *ajdnek* – ajdova potica, *ovsenak* – ovseni kruh, *drkung* – pšenični drobljenec kot polnilo na primer krvavic) in mesnine (*savinjski želoc*). Naštete elemente lahko obravnavamo kot zapuščino visokogorske pašne živinoreje (prav tam), saj gre pri omenjenih jedeh za lokalne različice jedi, ki jih najdemo tudi v drugih alpskih prostorih, kjer so na voljo podobne sestavine in kjer so zaradi okoljskih ter klimatskih dejavnikov podobne razmere za kmetijstvo.

Vsakdanji jedilnik se je sicer zaradi različnih dejavnikov korenito spreminjal, kljub temu pa vodilo o preprostosti in lokalni dostopnosti hrane velja tudi danes. Opažava, da sogovornice v ospredje postavljajo svoj odnos do prostora in lokalne (kulinarične) zapuščine. »Poskusimo skrcit na to, kar dejansko imamo,« zaključuje sogovornica Marjana (Marjana Vršnik, intervju, Robanov kot, 20. 9. 2022). Tako za lastne potrebe kakor za potrebe turizma sogovornice najraje posežejo po lokalno pridelani hrani:

V Solčavi se mi zdi, da smo ponudniki, pa tudi [...] proizvajalci določenih stvari, od peke, mleka do mesa, kar fejest povezani. [...] Če bi karkoli jemali, je nam pomembno, da je tisti, od katerega jemljemo [lokalni pridelovalec], da gre po istih stopinjah, da ima iste kriterije kot mi. [...] Nikoli si nismo konkurenti, ampak smo bolj sodelavci. Se mi zdi, da sam ne moreš, pa tudi zakaj pa bi. (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022)

V besedah sogovornice lahko zaslutimo povezanost, o kakršni v kontekstu odročnosti pišeta Martin Saxer in Ruben Andersson (2019: 143). Ugotavljata namreč, da je odročnost »proces odmikanja in hkratnega selektivnega ustvarjanja novih vezi«. Z zavračanjem interpretacije odročnih prostorov kot marginalnih (prim. Harms in Hussain 2014: 361–367) o njih razmišljata s pomočjo ideje poti (pathways) (glej tudi Ingold 2015), torej povezav, pogojenih tudi s topografijo in krajino. O poteh je po Harmsu in Hussainu (2014) produktivno razmišljati tudi zato, ker omogočajo, da v ospredje pridejo srečevanje, premikanje in izmenjevanje. Tako so lahko etnografsko izhodišče povezave in razmerja, ki se vršijo v specifičnem prostoru.



Fotografija 1: Savinjski želodec v Logarskem kotu (Vir: Center Rinka 2025a).

Prav te povezave so ključne, da lahko govorimo o kulinarčni identiteti Solčavskega. Hrana ima osrednji pomen za občutek skupinske pripadnosti, zato lahko o njej govorimo tudi kot o eni pomembnejših identitetnih sidrišč (glej Ule 2000). Maja Povrzanović Frykman (2009: 108) trdi, da se verjetno nekatere »homogene skupnosti oblikujejo na podlagi skupnih praks, in ne v smislu skupnosti glede na izvor ali etnijo«, čeprav lahko skupnosti naknadno svoj obstoj utemeljujejo prav v skupnem izvoru, kot velja tudi na Solčavskem (Bajič 2023).

Skupne prakse, povezane s hrano, pa so povezane tudi z okusom, ki je v kontekstu najine raziskave prav tako osrednjega pomena. Okus in okušanje sta habituirana praksa, ki je plod plastenja preteklih izkušenj ter je tesno povezana s spominom (Bourdieu 1984). Govorimo lahko o »kultivaciji« okusa v kontekstu proučevane družbe oziroma o družbenosti okušanja. Pri tem posameznik ni le pasivni sprejemnik zaznav, temveč jih nenehno upomenja, zato sta okušanje in družbenost v soodvisnem razmerju – družbenost vpliva na proces okušanja, kakor tudi obratno (seveda lahko podobno trdimo tudi za preostale čute). Tako lahko predpostavimo, da »kultivacija« okusov v kontekstu specifičnega načina bivanja v določenem geografskem okolju ustvarja (ohranja in preoblikuje) kulinarčno identiteto prostora.

Toda Bojan Baskar (2025) opozarja, da je prostor treh alpskih dolin premajhen, da bi lahko v tem kontekstu govorili o solčavskem okusu kot o »sistematičnem pojavu«, ki »bi predpostavljal obstoj kompleksne in unikatne solčavske kuhinje«. V okviru komparativne jezikovne analize okusa in okušanja ter obravnave »flavorologije«, ki se je razvila kot »produkt moderne kemične znanosti«, poudarja, da terminologija lokalnih okusov nastaja v odvisnosti od jezikovnih prostorov in njihovih koncepcij okusov ter specifičnega registra (turistične) industrije. Baskar s tem problematizira termin »solčavski okus« kot turistično invencijo geografsko zamejenega okolja, ki se želi postaviti na mednarodni (ali vsaj avstrijski) gastronomski zemljevid s prevodom *Geschmack von Solčava-Gebiet*. Hkrati poudarja,

da solčavski okus (oziroma okus Solčavskega) kot tak ne obstaja, saj v svojih določujočih lastnostih ni dovolj distinktiven ali poseben, da bi po »gustativno-olfaktoričnih načelih« (tipične sestavine, ustaljene kombinacije jedi, začimb, načini priprave itn.) izstopal kot regionalna posebnost (Baskar 2025).

TRADICIJA: OHRANJANJE, OBUJANJE IN EKSPERIMENTIRANJE

Kljub kulinaričnim sorodnostim z drugimi območji v Sloveniji in širše v alpskem prostoru kulinarični turizem na Solčavskem temelji na p(r)odajanju celovite in edinstvene izkušnje regije ter njene tradicije. Tovrstna gastronomska nišna ponudba je kombinacija izkustvene ekonomije in intimnostnega turističnega modela (Sidali, Kastenholz in Bianchi 2013) ter meri na turiste, ki iščejo okolju prijazne, trajnostne počitnice in nove izkušnje. Prav gastronomska ponudba pa je tista, ki lahko razmeroma enostavno utelesi omenjene predstave in ideale. Svojo identiteto zato gradi na izumljeni tradicionalnosti in ohranjanju zapuščine, kamor lahko prištevamo tako kuharska znanja in recepture kot tudi sestavine ter seveda same jedi. Toda, da so »lokalni okusi« lahko pripoznani v širšem, potencialno globalnem prostoru, ponudniki težijo k predstavljanju »posebnosti« na način, da bodo te po okusu zamišljenega, idealnega turista. Prijem, ki ga v ta namen pogosto uporabljajo, je podeljevanje certifikatov in nagrad ter umeščanje na sezname, ki potrjujejo izvor, način proizvodnje oziroma priprave ter domnevno tradicijskost sestavin in jedi. Tudi na videz nezaznamovana živila, kot je denimo mleko, so lahko predmet tovrstne certifikacije. Več manjših kmetij na Solčavskem je v preteklosti zaradi nerentabilnosti sicer opustilo domačo predelavo mleka, vendar so, ko je Aktiv kmečkih žena Solčava organiziral serijo praktičnih izobraževanj o predelavi mleka, dejavnost obudile. »Je bilo kar veliko zanimanja in tisti, ki se je želel v to podat, je šel naprej in je to [razvil]. In je zdaj po dolini iz teh tečajev kar nekaj ljudi prešlo na to, da so odprli doma dejavnost za predelavo mleka,« je povedala sogovornica (Jožica Bezovnik, intervju, Logarski kot, 19. 9. 2022). Nekatere kmetije, ki so prej mleko oddajale mlekarnam, so ga sedaj zadržale in ga predelovale za lastne potrebe, večina pa je tudi prepoznala in izkoristila obujanje mlekarstva kot priložnost za razširitve svoje turistične ponudbe.

Kot rečeno, obenem mnogi iščejo novosti, s katerimi bi tradicionalne kulinarične in prehranske prakse ter znanja preobrazili v nove izdelke ali doživetja. Tak primer so različne oblike degustacij ali ponudba piknika v naravi (Center Rinka 2025b). Sem bi lahko prišleli tudi nekatere sire, katerih recepturo prilagajajo ter spreminjajo na primer z dodajanjem zelišč in začimb. »Del te dopolnilne dejavnosti za predelavo mleka imajo po večini bolj mlade družine. In so začeli na drugačen način malo improvizirati, poskušati,« je povedala sogovornica (Jožica Bezovnik, intervju, Logarski kot, 19. 9. 2022). Natalija Ramšak, ki vodi Eko turistično kmetijo Ramšak v Podolševi, pa je opisala primer lastne inovacije, tesno povezane s potrebami turizma:

Na primer imeli smo [...], je nam pač mleko ostajalo. In smo začeli na primer delat take sirove kroglice v olivnem olju. Tu, na primer v Solčavi oziroma v Savinjski [dolini], tega, da bi jaz vedela,

še ni bilo. Delali smo z različnimi okusi. In se je zdelo zanimivo jim [obiskovalcem]. Na primer to je bila taka stvar, kar se je tudi domačinom zdelo zanimivo in se je kar fejšt prodajalo. Bilo je nekaj tega, ko še noben tule ne dela. [...] Ker če je kriza v prodaji, da je preveč ponudbe, pol si lahko tudi ne vem kako dober, ampak ti stvari ostajajo, ampak moraš nekaj na novo izumit, bom rekla, da je ljudem zanimivo, da porabiš tista svoja živila, ki jih imaš na tak način. (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022)



Fotografija 2: Siri z različnimi okusi Matkove kmetije (Vir: Center Rinka 2025c).

Poleg mlečnopredelovalne dejavnosti so se nekatere kmetije usmerile v prodajo domačih čajev, peko peciva, izdelavo sladoleđov iz kozjega mleka ipd. Te iniciative posameznikov in skupnostnih akterjev (npr. Društvo kmetov Zgornje Savinjske doline, Združenje kmečkih sirarjev Slovenije, Aktiv kmečkih žena Solčava), ki povezujejo določena agrarna in prehrabna znanja ter veščine, sooblikujejo strategije, ki predstavljajo kulturno dediščino v turizmu (Bessiere 1998: 29–30). Na Solčavskem so razvili več praks, ki turističnim ponudnikom zagotavljajo večjo stopnjo finančne varnosti in nenazadnje tudi možnost poslovnega razvoja. Svoje izdelke lahko tako prodajajo v temu namenjenih avtomatih z mlečnimi in suhomesnimi izdelki, ki so postavljeni na bolj obiskanih mestih (npr. v središču Solčave, pod slapom Rinka, na Solčavski panoramski cesti). Obiskovalcem so na voljo ob katerikoli uri dneva. Ko se spraznijo, jih ponudniki zopet napolnijo. S tem se kmetom ne le olajša prodaja, temveč, kot poudarjajo sogovorniki, tudi razširi njihov prodajni doseg.

PROMOCIJA, PROMOCIJA, PROMOCIJA

Turistične kmetije, ki jih smatrava za najpomembnejše nosilce gastronomske ponudbe v regiji, samostojno oglašujejo predvsem nastanitve, kulinarčna ponudba pa je »dodatek«, ki skupaj s prodajo domačih izdelkov (npr. volneni in leseni izdelki, čaji) tvori celostno ponudbo bivanja na kmetiji. Za (samo)promocijo in trženje skrbijo večinoma same, kar pome-

ni, da turistična (in gastronomska) reprezentacija postane neke vrste podaljšek domačega gospodarjenja. Toda tovrstno domače gospodarjenje se nadaljuje v sodelovanju z občino, pa tudi povezovanju na nacionalni in mednarodni ravni. V nadaljevanju zato izpostavlja nekaj pobud in projektov, ki potekajo v sodelovanju med individualnimi ponudniki ter institucijami, bodisi Občino Solčava bodisi Centrom Rinka, ki sodeluje s Slovensko turistično organizacijo. Pobude za tovrstne iniciative prihajajo z obeh strani – od zgoraj navzdol in obratno. Mateja Brlec Suhodolnik, višja svetovalka na občini, sicer pa tudi avtorica *Kubinje naših babic* (2015), poudarja, da sta vzajemno sodelovanje in ustvarjanje dobre turistične ponudbe preprosto nujna.

Tiste pobude so po navadi iz strani nas [občine]. Ali pa včasih je tako, da kakšna ideja pade s terena, pa zori, pa potem tukaj vidimo priložnost mogoče kakšnega projekta, pa se skupaj zložimo pa malo zmenimo, pa spet gre eno z drugim. Obojestransko, no. Inštitucija ali pa mi, ki delamo tukaj, brez posameznikov, občanov, periferije, nimamo kaj za delati tukaj. [...] Vzročno posledično. Brez tega, da bi institucionalno spodbujali, delali, ne bi imeli toliko nosilcev znakov. Spet, nosilci znaka ne morejo brez nas oziroma mi brez njih smo [nič]. (Mateja Brlec Suhodolnik, intervju, Solčava, 20. 9. 2022)

Na ravni celotne občine je ena pomembnejših pobud *Solčavska panoramska cesta*. Območje Podolševe s številnimi razpršenimi kmetijami je z vzpostavitvijo Solčavske panoramske ceste povezano v strnjeno turistično podobo. Solčavska panoramska cesta ali *Pot najlepših razgledov* obiskovalce prostorsko usmerja ter jim predstavi različne tematske, sprehajalne in planinske poti in petnajst kulinarčnih postojank – visokogorskih kmetij. Solčavska panoramska cesta je izjemnega pomena, ker obiskovalca usmerja in vodi do ponudnika, tudi če je ta oddaljen od njegove začetne točke.

Kmetje se lahko s svojimi produkti predstavijo in jih prodajajo na različnih lokalnih prireditvah in sejmi, na festivalu Bicka, dnevih kulinarike, ki so se začeli v sklopu projekta »Iz narave na krožnik«, ter na poletni »Solčavski ižini« (ižina v solčavskem govoru označuje kosilo). Slednja je primer vzpostavitvečasne restavracije s pogostitvijo na prostem, ki je razbremenila kmetovalce v obdobju sezonskega navala turistov v juliju in avgustu, vendar jim hkrati še vedno zagotovila dobiček od kuhe, ki jim je v tem obdobju ni treba zagotavljati doma, temveč v vasi Solčava. Idejo za »Solčavsko ižino« nama je Mateja Brlec Suhodolnik razložila takole:

Ker smo opazili, da ljudje odhajajo od nas lačni, da je večji obisk kot ponudba. Predvsem obiskovalci. Ker v času sezone so pri nas ponudniki 100 % zasedeni. [...] Za vikende, praznike je ogromno dnevnega obiska, takrat vse poka po šivih in ni dovolj [kulinarčne ponudbe]. (Mateja Brlec Suhodolnik, intervju, Solčava, 20. 9. 2022)

Zunaj občinskega okvira, na nacionalni in mednarodni ravni, se solčavska hrana postavlja na kulinarčni zemljevid kot del večjega (alpskega) turističnega imaginarija tudi s pomočjo certifikatov in označb. Slednji so povezani predvsem s trajnostnim turizmom. Solčavska regija je nosilec več nazivov Zelene sheme slovenskega turizma: Slovenia Green

Destination Gold (Logarska dolina), Slovenia Green Park in nagrada CIPRA (Mednarodna komisija za varstvo Alp) za najbolje upravljano zavarovano območje v Alpah (Krajinski park Logarska dolina). Od Evropske komisije je regija dobila naziv Evropska destinacija odličnosti (EDEN oziroma European Destinations of Excellence), uvrščena je bila med sto najboljših trajnostnih destinacij na svetu, Solčavsko pa na seznam Best tourism villages Svetovne turistične organizacije (UN Tourism). Omenjene označbe utrjujejo prepoznavnost destinacij Solčava in Logarska dolina ter ju na sebi lasten, standardizirajoč način razlikujejo od množice drugih turističnih destinacij. Posledično pa tovrstna pripoznanja privabljajo turiste tudi v sosednji dve dolini – v Robanov in Matkov kot.

Poleg tega ne smemo zanemariti promocije s pomočjo geografske označbe porekla, ki jo ima zgornjesavinjski želodec. Ker obstaja interes, da bi z označbo zaščitili tudi sirnek, si nekateri akterji želijo začeti s procesom standardizacije proizvodnje (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022). Z uvajanjem protokola izdelave in označevanjem pa se doseže tudi standardizacija okusa, ki se lahko oglašuje z načrtovano vizualno podobo in narativno strategijo (Grasseni 2005: 84). Proces trženja dediščine se tako začne z ustvarjanjem ustaljene recepture in zgodbe, ki bo podpirala izdelek ali jed, hkrati pa tudi z določenim poenotenjem in homogenizacijo sicer različnih načinov pridelave in predelave, kar seveda proizvaja nekatere paradoksalne učinke trženja »lokalnosti«.

Zgodba o lokalnemu produktu, sploh če pridobi geografsko označbo porekla, »oza-veščnemu« potrošniku omogoča premostitev razdalje med njim in proizvajalcem (Bessiere 1998: 25). Z njim vzpostavi vez, bodisi neposredno z nakupom pri kmetu ali posredno prek vizualne podobe oziroma embalaže v trgovini. Tovrstna označba torej ne zagotavlja zgolj užitenosti hrane, temveč naj bi jamčila tudi zgodovino in identiteto, ki sta povezani z določenim živlom oziroma nujni zanj. Certifikati obljublajo kakovost, hkrati pa tudi kulturno doživetje danega okolja in apropiacije lokalne identitete (Bessiere 1998). Bessiere se naslanja na Fischlerjevo teorijo (Fischler 1993 po Bessiere 1998), ki pravi, da kulinarčni turist z zaužitjem integrira kulturne karakteristike hrane in tako »postane del kulture«. To počne v želji, da bi doživel idealizirano ponudbo, nasprotno urbaniziranemu svetu, iz katerega želi pobegniti »nazaj v naravo«. Ravno ta »pobeg v solčavsko naravo« nastopa kot kurirana naracija proučevane lokacije tudi v drugih, ne zgolj kulinarčnih kontekstih.

Označba geografskega porekla naj bi potrošniku zagotavljala pristnost, stik z »doma-čim in avtentičnim« (Bessiere 1998). Vseeno pa lahko za tistega, ki proizvaja živila z geograf-sko označbo porekla ali z drugimi označbami, slednje – kljub številnim prednostim, ki jih s tem dobi – predstavljajo breme. Za nekatere, denimo male kmete, je že sama pridobitev označb zelo zahtevna, včasih praktično nemogoča.

Je pa problem pri teh zaščitah živil. Ker zaščite živil niso poceni. To je res izredno velik strošek, ki si ga takole čisto iskreno povedano taka majhna kmetija, kot smo mi, s samo prodajo sirneka, samo promocijo sirneka ne moreš privoščiti. [...] Naša velika želja je, da bi se zaščitil sirnek. Ampak vsako leto investirat praktično ne moreš. [...] Od same izvedbe, papirologije do samega procesa postopka, kontrole ... je težko eno kmetijo s tem obremeniti. (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022)

Če se proizvajalci držijo postopka priprave, toda nimajo omenjenega certifikata kakovosti, so pogosto prisiljeni tudi v nižanje cene izdelka. Zaradi pravne zavezanosti ga morajo prodajati pod drugim imenom. Rešitev za to težavo je lahko sponzorsko podjetje ali kolektivna organizacija zainteresiranih kmečkih ponudnikov. Oziroma, kot je izpostavila Natalija Ramšak:

Iskreno povedano, zgornjesavinski želodec je zaščiten. Ampak pri njih, na primer, jim to financira neko podjetje. Kar je svetoven plus. In bi bilo na primer tudi v našem primeru res nekaj najboljšega, da bi se nek sponzor našel, da bi to naredil. (Natalija Ramšak, intervju, Podolševa, 21. 9. 2022)

»NA VAŠE ŠTRUKLE SMO PRIŠL, TAKO SO DOBR, TAKO SO DOBR«¹

Kulinarična identiteta je zamišljena celota, katere drobce skušajo turistične kmetije, restavracije, institucije in posamezniki prikazati obiskovalcem treh dolin. Skozi jedi in živilske produkte želijo domačini posredovati spoštovanje do prehranske dediščine ter tradicije:

Danes še ohranjene jedi znova spoznavamo, okušamo, čislamo, ponujamo in uživamo ob njih. Te jedi so naša vrednota, po njih smo prepoznavni. Ravno zaradi teh naših še ohranjenih jedi in še mnogih drugih, ki jih znamo odlično pripraviti, so pa ne le solčavska, temveč vseslovenska kulinarična dediščina v številnih različicah, imamo z razlogom motiv za ohranjanje znanja in spomina, za razvijanje samih sebe in svojih družin z izvrstnimi zdravimi jedmi ter za razvijanje pomembnega turističnega produkta. (Brlec Suhodolnik 2015: 7)

Hrana je pomemben gradnik turizma, saj naj bi odražala kulturo prostora in določene lastnosti lokalnega okolja. Po Richardu Wilku je turizem tisti, ki »ustvarja potrebo po občutku lokalnosti in zavedanju različnosti, unikatnosti in pomembnosti« (Wilk po Long 2018: 4). Turist tako prepozna lokalno hrano in prakse, povezane z njo, pri čemer še posebej vrednoti izstopajoče karakteristike in posebnosti v želji po »pristni izkušnji«. Jacinthe Bessiere (1998: 23) piše, da lahko na željo po gastronomski turistični izkušnji gledamo kot na turistovo »integracijo v novo kulturno okolje skozi prehranjevanje, tako s psihološkega kot s fiziološkega vidika«. S svojo gostinsko podobo se turistični ponudniki v tekmovanju z drugimi turističnimi destinacijami opirajo na lastne posebnosti in razlikovanje od drugih prostorov, pri čemer hrana postane močno orodje diferenciacije. Daša Ličen (2015: 130) piše, da »[h]rana, eden temeljev identitete, na eni strani skupine povezuje, na drugi pa krepko ločuje«. Na Solčavskem naj bi izstopali po tem, da »živila sami pridelujemo, jedi poznamo, spoštujemo, ohranjamo, razvijamo in ob njih uživamo« (Brlec Suhodolnik 2015: 7). V lokalnih zamišljanjih »tipične« solčavske hrane se srečamo s pojmi lokalnega, tradicionalnega in kakovostnega, katerih presek predstavlja koncept avtentičnosti (primerjaj Pratt 2007: 293).

Avtentičnost je po Jeffu Prattu konceptualna povezava med proizvodnjo in potrošnjo ter je v središču razprav o hrani in kakovosti (prav tam). Gre za hrano, ki je lokacijsko specifična in je rezultat razvoja obrtniškega procesa, veččin, spretnosti – najine sogovornice

1

Jožica Bezovnik, intervju, Logarska dolina, 19. 9. 2022.

to povezujejo z idejo domačega. Sogovornica Štefanija, potomka sester Logar, ki so v prvi polovici 20. stoletja vodile hotel v Logarski dolini, pravi:

Vse je bilo pa domače. Vse je bilo doma pridelano. Vrt so imele. Tudi same so imele tudi prašiče od začetka. Pa dve kravi so imele, tako da so imele vse, kar je bilo od mleka, in vse, kar je bilo od mesa, vse je bilo domače. (Štefanija Logar, intervju, Logarska dolina, 19. 9. 2022)



Fotografija 3: Zajtrk na turistični kmetiji Lenar² (Vir: Instagram 2025).

Pojem avtentičnosti se povezuje tudi z idejo kakovosti; to naj bi zagotavljali znana («naravna») lokacija, vsaj določene surovine (npr. mlečnine, mesnine, rastline), procesi pridelave in predelave ter ljudje, ki so v te procese vključeni. Sogovornice lokalnosti pripisujejo velik pomen: »Lokalno gospodarstvo, to se mi zdi zelo pomembno. Tudi, ne samo v kulinariki, tudi v drugih stvareh. [...] V bistvu več ali manj vse [kupujemo] tu. To, kar nimamo sami« (Urška Lenar, intervju, Logarska dolina, 19. 9. 2022). Hkrati se avtentičnost

2

V opisu objave je zapisano: »Zajtrk na turistični kmetiji Lenar v Logarski dolini je prava poslastica, ki je ne gre zamuditi. Kot certificirana ekološka kmetija pri zajtrku ponujamo izključno domače ali lokalno pridelane izdelke. Med bivanjem lahko uživate v našem domačem bezgovem soku, sadnih marmeladah, pecivu ter regionalnih suhih mesninah (npr. savinjski želodec), sirih, medu in jajcih. Ob predhodnem obvestilu z veseljem prilagodimo ponudbo vašim prehranskim omejitvam (prosimo, sporočite nam vnaprej)« (Lenarfarmstay 2025).

opira tudi na idejo trajnosti (Svetel in Zavratnik 2025) in tradicije ter njene celovitosti. Pri slednjem se odpira vprašanje prenosa specifičnih kuharskih tehnik in veščin. Bojan Baskar piše o testeninah oziroma »pašti«, ko pri razvoju jedi izpostavlja tehnike:

[V] duhu francoske etnološke tradicije kulturne tehnologije veliko pozornost posvečajo tehnikam oziroma tehničnim postopkom, kamor sodijo poleg drugih tudi tehnike priprave in obdelave testa, tehnike oblikovanja testa, tehnike kuhanja, tehnike serviranja, tehnike zaužitja hrane itn. Izhajajo namreč iz teoretske podmene, da vse tehnike v okviru skupne kulture sestavljajo tehnični sistem, kar pomeni, da so medsebojno odvisne, koordinirane, analogne itn. (Baskar 2021: 146)

Ena izmed sogovornic je povedala, da se na Solčavskem kuharsko znanje in tehnike prenašajo iz generacije v generacijo ter nadalje v turistično ponudbo: »Kar je stara mama kuhala, sta obe stari mami kuhali, še vedno kuhava z mamo. [...] Seveda so tudi nove [jedi], pa nove sestavine, osnova pa mislim, da kar ostaja, ja« (Marjana Vršnik, intervju, Robanov kot, 20. 9. 2022). Hrana je produkt kontinuiranega in kolektivnega truda, iz katerega izhaja tudi njena vrednost:

Bistvo tega je, da so [predniki] hrano, ki so jo pridelali, prodali na kmetiji. Na tak način so največ takrat iztržili iz tega. Pri nas se ta tradicija nadaljuje, da še vedno pridelujemo hrano, še vedno imamo kmetijo. In še vedno to hrano prodamo in vse porabimo na kmetiji. [...] Večino kuhamo in porabimo. Se pa še vedno pripravlja na tradicionalni način. Lahko vidita, da zakurimo štedilnik in pripravljamo reči. Seveda si pomagamo tudi z drugimi [napravami, tehnikami], ampak to je nam najljubše. Ker se potem fajn kuha in je tudi okusno. (Marjana Vršnik, intervju, Robanov kot, 20. 9. 2022)

Zvestoba tradiciji se po sogovorničinem mnenju kaže v okusu hrane, kar opazijo tudi obiskovalci: »Vsaka ima nek tisti svoj okus in so [gostje] navdušeni, da so to pravi okusi, kot jih več ne poznajo. Opazijo to« (prav tam). Po besedah sogovornice obiskovalci na podlagi lastnega okusa – torej izhajajoč iz osebnih preferenc, pogojenih s habitusom – ocenjujejo okus lokalne solčavske hrane kot »pravi«, kot okus, za oblikovanje katerega so bili potrebni specifično znanje in tehnike ter je povezan s specifičnim krajem in časom (glej Ličen 2015: 127).

Po Prattu potrošnik oziroma turist poskuša vzpostaviti razmerje z avtentičnim s kupovanjem stvari, ki jih vrednoti glede na njihovo povezavo s proizvodnjo. Avtentičnost tako ni povezava s preteklostjo, temveč z ekonomijo; gre za blago, za nekaj, kar ima menjalno vrednost. Paradoksalno skuša turist spoznati vrednost nečesa, kar se postavlja v nasprotje denarne ekonomije, tako, da troši denar (Pratt 2007: 295–297). Kar želijo turistični ponudniki na Solčavskem posredovati v polje turizma, so predvsem pripisane vrednote, ki naj bi jih živeli tudi sami – spoštovanje do okolja, hrane in dediščine. Turist to domnevno prepozna kot avtentično, zato naj bi ideja o doživljanju »pristnega« vodila njegovo izkušanje lokacije, ki jo je obiskal:

Včasih se tudi sprašujemo, malo se pogovarjamo – mi v družini – če bi kaj spremenili. Če bi šli na kaj bolj moderen nivo; tudi na način serviranja ali priprave, da bi zmanjšali porcije [...]. Samo gosti rečejo, da [naj] ne. Da naj kar ostanemo pri tem, ker je to čar neke domače hrane [...], ki jo iščejo, ja. (Marjana Vršnik, intervju, Robanov kot, 20. 9. 2022)

Druga sogovornica, ki na svoji kmetiji prav tako ponuja obroke za obiskovalce, pa izpostavlja, da je vseeno nujno sprejemati številne prilagoditve in kompromise:

Kot nastanitev se moraš gostom prilagoditi. Se tudi prilagajamo s hrano gostom. Se pravi, za te sredozemske, če imamo goste iz sredozemskih držav, damo več sadja, zelenjave, več peciva, sladkega, recimo. Za te bolj severno gor malo več narezka, odvisno, no. V bistvu tisto, kar jim je všeč, tistega, se malo vidi, ne, ali malo veš, ali vidiš, kaj jejo, tistega pol več ponudiš. [...] Ja saj v bistvu imam tudi na zalogi recimo, če kaj prosijo, ali po naročilu tudi kaj naredimo. Pomembno je, da se gostje najejo, da niso lačni, tak da ja, se prilagajamo, no. [...] So pač neke dietarne zahteve nove, mogoče to, no. Ali brez glutena ali vegansko. [...] V bistvu tudi, če treba, pripravim tudi košer. (Urška Lenar, intervju, Logarska dolina, 19. 9. 2022)

Ponudniki se torej s svojo ponudbo praviloma ne prilagajajo sodobnim kulinaricnim smernicam ali trendom, toda če in ko je to potrebno, jih, vsaj nekatere, pri njihovem »odstopanju od tradicije« vodijo želje in zahteve gostov. Sogovornica je povedala, da je to po eni strani preprosto, saj so nekatere jedi že brez prilagoditve primerne za ljudi z dietnimi restrikcijami (»ajdovi žganci so brezglutenski, razne kaše so brezglutenske, tudi veganske ...«), po drugi pa prilagajanje zahteva poseben trud in čas, ki včasih s strani gostov ni poplačan:

Ne, kar je takega posebnega, še rajši rečemo, da sami prinesejo. Tudi večinoma [pripravimo], če so brezglutenski večinoma – mislim, če nam povejo v naprej – ampak to so tako; tisti, ki so zares bolni ali občutljivi, itak oni so na to pripravljeni in prinesejo tudi kaj zraven. Če je pa kar moderno, tisti pa ne povejo v naprej. Da se to grejo kar zaradi mode, pač potem naj se pa izmišljujejo, kot želijo. Včasih smo pa žalostni, če kateri zakomplicira in na koncu reče, da bo pojedel neko sladico. To se zgodi. Smo že imeli, ko se itak trudiš, da pikice ne pride kaj zraven in vse posebej pripraviš za njega in na koncu on pa pove, da to [mu ni všeč] ... To pa je težko. To je v bistvu nesramno, ker toliko enega truda notri vložiš, je le bolj zahtevno. Pač kuhaš in to in potem ti rečejo ... (Marjana Vršnik, intervju, Robanov kot, 20. 9. 2022)

Ne glede na to, kako kritično (ali ne) razumemo koncept avtentičnosti (glej Muršič 2013), se v turizmu prodaja predstava avtentičnosti, z njim se trži in znamči tudi celotna destinacija, pri čemer pa je, čeprav vpeta v skupne družbene in kulturne okvire, resničnost izkušnje lastna vsakemu posamezniku – tako domačinu kot turistu. Pri tem nastajajoča razmerja so lahko v več pogledih produktivna za udeležene.

ZAKLJUČEK

Kot sva pokazali v prispevku, je odročnost Solčavskega na eni strani dejavnik omejenosti (geografske, kulinaricne), na drugi pa izhodišče za povezovanje, sodelovanje in kolektivno krepitev celostne kulinaricne ponudbe. Ravno skozi te povezave se utrjujejo prakse skupnostne poslovne podpore, lokalnih iniciativ, prenašanja tradicijskega znanja. Hrana tako postane eno ključnih identitetnih sidrišč območja, saj vpenja preteklost(i) v sedanost z jasno usmerjenim pogledom v prihodnost. Hkrati se kulinaricna identiteta Solčavskega ne gradi zgolj na obujanju zamišljene kulinaricne zapuščine, temveč tudi na njenem reinterpre-

tiranju in inovacijah, ki izhajajo iz sodobnih potreb – tako lokalne skupnosti kot turistov, ki iščejo avtentične okuse obravnavane alpske regije. Kulinarčna identiteta Solčavskega je torej ne le družbeno konstruirana, temveč tudi spremenljiva, nastajajoča in nikoli fiksna kategorija – je rezultat nenehnih pogajanj med tradicijo in sodobnostjo, lokalnimi potrebami in globalnimi pričakovanji, pa tudi med koncepti domačega, avtentičnega, tradicionalnega ter trajnostnega. Prav v tej plastičnosti ideje kulinarčne identitete pa se skriva njen pomen za lokalne akterje – najsi bodo to turistične kmetije, gostinski ponudniki ali večje institucije. Omogoča namreč tako ohranjanje in prenašanje znanj ter večšin kot ustvarjanje novih možnosti za reprezentacije in trženje »solčavskih okusov«, ne glede na to, ali so z analitičnega antropološkega vidika sploh mogoči.

IZJAVA O DOSTOPNOSTI PODATKOV: Članek temelji na etnografskem gradivu, ki ga ne opredeljujeva kot zbirke raziskovalnih podatkov. Vse nadaljnje informacije o uporabljenem gradivu so na osnovi utemeljene prošnje dostopne pri avtoricah.

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SUMMARY

This paper examines the intersections of culinary identity and tourism in the Solčavsko region, a geographically and symbolically distinct alpine area of northern Slovenia. The authors focus on identifying the constitutive elements of the local culinary identity – referred to as the “Solčava flavour” – and analyze how these elements are socially and institutionally produced, maintained, and mobilized within the context of tourism development.

In the first part, the analysis explores how the region's physical and social characteristics shape its culinary identity. Particular emphasis is placed on the role of remoteness as a spatial condition that influences food-related practices. Rather than being a marginalizing factor, remoteness is shown to function as a productive force in the construction of perceived authenticity.

Subsequent sections explore how this identity is embedded in the region's tourist offer, showing how authenticity is articulated and leveraged within tourism discourse and practice. The authors investigate how culinary knowledge – especially that which is associated with traditional dishes – is transmitted, preserved, and valued by the local population, not only as a resource for tourism but also as an element of communal heritage.

The study further considers the roles of institutions and individuals in shaping and supporting local culinary identity, including mechanisms for integrating food into broader tourism strategies. These include the actions of local tourism organizations, the activities of tourist farms, and the everyday work of women involved in cooking and hospitality, many of whom act as cultural intermediaries between local tradition and visitor expectations.

The research draws on participant observation and semi-structured interviews with women living or working in Solčavsko, engaged in culinary and/or tourism activities. Their narratives illustrate how culinary practices function both as expressions of local identity and as active components in negotiating place within the tourism economy.

Irene Rožman Pišek



*Babice na razpotju zgodovine:
lik terenske babice od leta 1945
do poznih šestdesetih let, 2025*

Nena Židov

1.19 Recenzija
DOI 10.4312/svetovi.4.1.120-121

Znanstvena monografija je izšla kot 58. publikacija v okviru knjižne zbirke *Knjižnica Glasnika Slovenskega etnološkega društva*. Nastala je izpod peresa etnologinje in sociologinje dr. Irene Rožman Pišek, ki je velik del svojega raziskovanja posvetila zgodovini rodnosti in babištva na Slovenskem. Poleg monografije *Peč se je podrla! Kultura rojstva na slovenskem podeželju v 20. stoletju* (2004) je omenjeno tematiko obravnavala tudi v številnih znanstvenih in drugih člankih.

V knjigi je predstavljeno delovanje terenskih babic v povojnem obdobju med letoma 1945–1960, za katero so bile značilne velike družbene spremembe, med katere je sodilo tudi izboljšanje zdravstvene skrbi za nosečnice in otroke.

Glavnina knjige temelji na narečnih ustnih pričevanjih zadnjih generacij terenskih babic, upoštevni pa so tudi viri, povezani z zakonodajo, uredbe, pravilniki, učbeniki, priročniki, časopisni in strokovni članki ter statistični podatki. Da je lahko upoštevala različne demografske, zdravstvene in gospodarske razmere, je avtorica 65 polstrukturiranih intervjujev z babcami

opravila na različnih območjih Slovenije. Knjigi je dodanih še 22 izbranih pripovedi, k razumevanju pa pripomore tudi zemljevid v raziskavi zajetih območij delovanja terenskih babic.

Knjiga nas popelje od razlogov žensk za odločitev za poklic babice do njihovega izobraževanja, zaposlovanja in do najrazličnejših vidikov njihovega vsakdanjega dela v različnih lokalnih okoljih. Po končanem šolanju so jih razposlali na različne konce Slovenije, v nepoznane kraje, kjer so delale z ženskami, ki so bile bolj vajene starih, slabše izobraženih babic in mazačk.

Ob patronažnih obiskih na domu so spoznavale življenjsko okolje nosečnic in jih pripravljale na porod. Babice so se morale znajti v primerih, ko porodnica ni imela pripravljene vsega potrebnega, ko se je porod začel prehitro ali prostori niso bili primerni za rojevanje. Če rojevanje doma ni bilo varno, so poskrbele za prevoz nosečnic v porodnišnico.

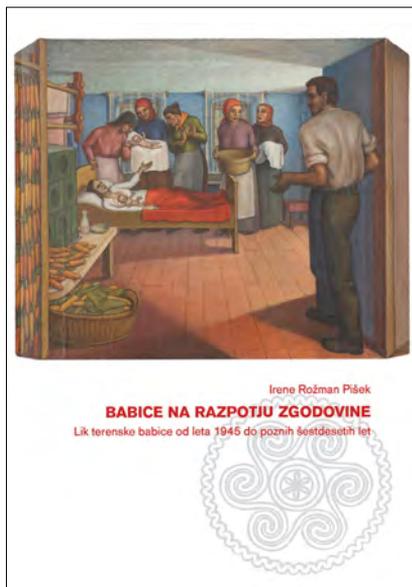
Terenske babice so spodbujale nosečnice k obiskovanju posvetovalnic za nosečnice in otroke, k rednim pregledom in k

rojevanju v porodnišnici. Zaradi pomanjkanja medicinskih sester so ponekod vodile dispanzerje za žene, sodelovale pri ustanavljanju ginekoloških dispanzerjev in delale v porodnišnicah. Na patronažnih obiskih na domu po rojstvu otroka so babice izvedle marsikaj o stanju v družini ter stanju matere in novorojenca. Porodnicam so dajale nasvete o dojenju, prehranjevanju in negi otrok.

V nekaterih težko dostopnih in od porodnišnic zelo oddaljenih krajih so ženske nekoliko pozneje še vedno rojevale doma, tudi s pomočjo mazačk. V začetku šestdesetih let preteklega stoletja so doma rojevale predvsem tiste, ki jih je porod prehitel ali so odklanjale porodnišnice, tako npr. kmečke ženske, ki so že večkrat rodile doma, oviro za rojevanje v porodnišnici pa je za nezavarovane kmečke ženske predstavljalo tudi plačilo participacije. Zaradi dela na kmetiji in skrbi za otroke niso mogle biti več dni odsotne od doma. Ponekod pa so bile domače razmere tako slabe, da je bila porodnišnica rešitev (družinsko nasilje, alkohol, nesoglasja).

V primerih zapletov pri porodu je bilo tudi za babice bolje, da so ženske rojevale v porodnišnicah, saj so morale biti sicer ves čas v pripravljenosti. Z vse več porodi v porodnišnicah se je začel oblikovati nov poklic medicinska sestra – babica. V šestdesetih in sedemdesetih letih je vse več kmečkih žensk rojevalo v porodnišnici. V sedemdesetih letih je večina Ljubljančank in okoli 90 % vseh žensk rodilo v porodnišnici.

Knjiga *Babice na razpotju zgodovine: lik terenske babice od leta 1945 do poznih šestdesetih let* je pomemben prispevek k razumevanju kulture rojstva ter vloge babic v obdobju po drugi svetovni vojni, ko so s svojim delom pomembno vplivale na izboljšanje reproduktivnega zdravja žensk in zdravja otrok.



Podjed, Dan, Carla Guerrón

Montero (eds.) *Why the World Needs Anthropologists*
(2nd edition), 2025



Anuša Babuder

1.19 Review
DOI 10.4312/svetovi.4.1.122-123

Why the World Needs Anthropologists is a product of the Applied Anthropology Network's annual conference of the same name. The goal of the first edition was to show that anthropology has outgrown its stereotypical public image. The second edition endeavours to make sense of how anthropology and its practitioners can engage with a world shaped by the Covid pandemic, new and ongoing wars, the climate crisis, and the spread of generative AI.

It features a new introduction and conclusion by Dan Podjed and Carla Guerrón Montero. With nine updated and two new chapters, it answers the question what anthropology in practice looks like today and how it is relevant to the global and local issues people face in their daily life. The sentiment of the refreshed chapters is, among other things, that anthropology was never about studying the world of the other, "but multiplying our own," paraphrasing Viveiros de Castro and Skatfish (*Cannibal Metaphysics*, 2014).

Each chapter includes an (auto)biography of the author, which helps to illustrate

message of each essay by presenting practical lessons from their life and career. These include candid examples of both successful and unsuccessful projects, offering useful guidance to anyone working in the applied sector. In the first edition, each author provided five tips on what to "DO". The second edition expands on this with five additional "DON'Ts". These range from personal ("DON'T lose trust in life." and "DO come back to the field.") to career-oriented ("DO develop a public voice." and "DON'T be discouraged by your working conditions, if you work freelance."), providing a variety of advice for the reader.

The second edition is thematically divided into two parts: "New answers to old questions" and "How to keep optimism in a troubled future". Thomas Hylland Eriksen begins by presenting how the Covid pandemic affected anthropological methodologies and fieldwork, changing what it means "to be there". Authors such as Joana Breidenbach, Lorena Bohren, and Daniel Miller discuss which anthropological skills and methods are relevant for different interdiscipli-

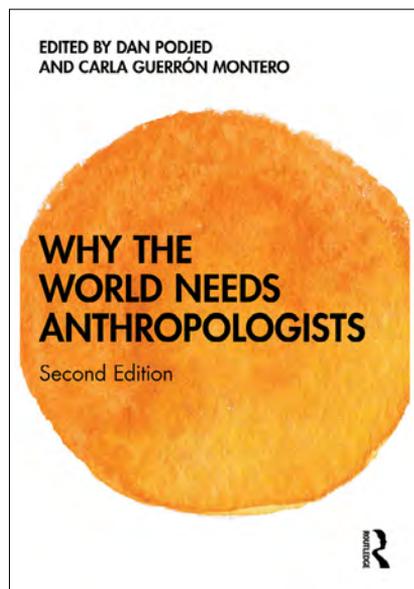
nary projects. This is supported by a strong focus on multiperspectivity – the ability to understand the many different ways humans relate to the world, each with its own logic – which enables anthropologists to work with multiple perspectives simultaneously, integrating them into their work. This is crucial for resolving challenges in multicultural, complex environments. Shifting the focus from the present to the future, Sarah Pink introduces “futures anthropology”, emphasizing the discipline’s need to prepare for a world permeated with artificial intelligence, particularly by collaborating in teams with other sciences. In the final chapter, Elizabeth Briody examines anthropology from a career and employment perspective, presenting resources and techniques to advocate for anthropological skills in the job market.

Each in their own way, the authors demonstrate the relevance of anthropological thinking in applied projects addressing current dilemmas. Contact between culturally different groups is increasing more than ever, creating a need for understanding, mediation, and communication to inform policy adjustments. Eriksen emphasizes that it is precisely anthropology that excels at making the invisible visible, explaining many aspects of human experience that are complex, are not measurable, and cannot be studied through quantification.

As expected for a book focused on practice, its content excels in illustrating practical experiences of collaborative projects aimed at solving specific problems. Throughout the book, collaboration is positioned as central to the future of the discipline. One reason for this is the global state of “polycrisis”. As described by the editors, this term refers to the situation where vari-

ous global crises have become so intertwined that none can be addressed without tackling the others. Although this concept is only briefly discussed in the conclusion, it encapsulates what the authors advocate in multiple chapters: the need for interdisciplinarity and collaboration.

The book successfully positions anthropological knowledge and skills within policy creation, problem solving, and product development. Although some chapters focus more on how anthropologists could theoretically become more relevant in the future, the publication otherwise clearly demonstrates how anthropological knowledge and methodologies are already contributing to change. In the conclusion, the editors also encourage the discipline to adapt the ethnographic method to the “different circumstances in which anthropology” operates today, at last developing beyond long-term in-person field work as the main integral way of achieving anthropological insight.



“We Don't Have to Look Very Far to See Who's Being Maimed and Injured”



Interview with Susan Levine About How the Medical Humanities Are Framing Large Questions of Deep Politics

Nežka Struc

1.22 Interview
DOI 10.4312/svetovi.4.1.124-128

Susan Levine's work is positioned at the intersection of medical, political, and visual anthropology. She is the convenor of the Health Humanities and the Arts interdisciplinary master's program at the University of Cape Town. Her interests span a variety of subfields in anthropology, including political economy, youth and childhood studies, ethnographic film, and medical anthropology.

We met in Ljubljana, where she was participating in an Erasmus exchange for academic staff and the conference that was part of the *Days of Cooperation with African Universities*. Like many of our colleagues from African universities, Susan Levine contributed decolonial perspectives and methodologies to our discussions, particularly in the field of medical anthropology. That's why we invited her to share more about her work with us in this interview, where we talked about how she became involved in the medical humanities, the connection between medical and visual anthropology, and why debilitation (Mohamed 2023, Puar 2017) as a concept is so important these days.

I wanted to begin this interview with your amazing story of how you became a medical anthropologist. How did that journey unfold for you?

I think there were multiple routes to becoming a medical anthropologist. And the most striking is really my early experience. My father was a pathologist at Stanford University and was on a team of researchers who identified a cancer called Burkitt's lymphoma that has a viral component. In his early 20s, my dad contracted this virus during his research, but he didn't know that until he



Susan Levine (Author: Coco Van Oppens)

was in his late 30s. He had become a leading pathologist on tumours of the thymus and a much loved teacher. He died when he was 42. But before he died, because he'd been a mountain climber and a marathon runner, he had a very, very strong heart. And the cancer affected everything except his heart. When he died, it was catastrophic for me and our family. But I think as heartbreaking as his dying was, it was his suffering and the inability to find an easy way to bring a peaceful end to his life in a more caring death. All those big existential questions (Why me? Why now?) that medical anthropologists ask – about bioethics and disease, that are bound up with thinking about bodies and embodiment, healthcare systems, and the legality of it – converged later in my life when I came upon medical anthropology, and it really made sense that some of those questions had been planted in me quite early.

A second route towards medical anthropology was the start of my career at the University of Cape Town, which coincided with catastrophic HIV/AIDS affliction and the rise of AIDS denialism in South Africa. The deadly combination of the State President Thabo Mbeki's refusal to accept HIV/AIDS science and the Minister of Health's rejection of antiretroviral treatment required urgent political and intellectual response. These historical figures desired African solutions to what they considered an African problem and very forcefully rejected Western science. Millions of people were infected and died, with international and national alarm that our state was advocating a combination of lemon juice, garlic, and the African potato to cure AIDS. Having grown up in California and witnessed the AIDS activism of the 1980s, where people were pushing

back against intense homophobia and framing AIDS as GRID (gay-related immune deficiency), it was very peculiar to come to South Africa. It was almost like an echo chamber.

At that time it didn't really matter if one was a physicist or a poet. We fought for antiretrovirals and were trying to get the government to acknowledge the relationship between HIV and AIDS. In those early years, I also got involved in a documentary film project, doing the advocacy work and (peer) education, just because the government was not doing that work. It had to come out of the grassroots protest movements and NGO initiatives. This was my initiation into the field of medical anthropology, which I hadn't really known before.

And then a third thread of how I started to be involved with medical anthropology was by chance. While taking several gap years from study, I came back to Cape Town on a holiday to visit my mum, and I ended up on a camping trip in the Cederberg mountains with an anthropologist named Nancy Scheper-Hughes, who I didn't know at that time. She told me about her work in Brazil, and it sounded really fascinating. At the time she was doing research around community justice, and she asked if I wanted to be her assistant. It was only a few years later that I returned to graduate school and went to the American Anthropological Association meetings and realised what a rock star and super famous person Nancy was. But she had been so humble and so kind in a way, not trying to really let me know, like who she was fully. After that I became a big Nancy Scheper-Hughes fan, and I started teaching her work. It was through meeting her and the works of medical anthropologists such as Paul Farmer, Arthur Kleinman,

Lawrence Cohen, and Veena Das that the field of medical anthropology began to take shape for me. And then I was able to go back and reread some of Marx's own work on health, factories, and children's health.

All this developed a thread in my own research, which was invested in thinking about health at the cusp of capital, power, domination, race, gender, and class. And so somehow medical anthropology was entwined from the start with my work in political economy. Medical anthropology is a way of framing very large questions of deep politics, of war, famine, genocide, and entitlement, about who has the right to maim other people's bodies, or who has the power to wield a genocide, whether it's in Sudan, Gaza, Yugoslavia or Rwanda.

In your previous answer, you mentioned that one of the threads through which you became involved in medical anthropology is also visual anthropology. How have medical anthropology and visual anthropology intersected through ethnography in your work?

While I remain an anthropologist, I'm pretty convinced that working across disciplines is the way to go. I like the idea of working in and out of disciplines, but never losing my anthropological training or insight, and at the same time stepping out of the discipline to regard the epistemological frameworks of other disciplines. I am very interested in medicine, but also in art production, storytelling, and filmmaking.

For my senior thesis at Bard College, I documented a play called *You Strike a Woman, You Strike a Rock*, which was an

incredible piece of theatre directed by Phyllis Klotz. This play was an improvisational story, a play about three women who had moved from the Eastern Cape in South Africa to Cape Town to try to find their husbands, sons, and brothers. It was banned in South Africa, but they performed it in churches or wherever they could, and I attended it many times. At the same time, I was telling a similar story through the life histories of two women, who were the first people to set up an informal community called Crossroads in 1976.

Between 1976 and 1986, Crossroads became a vibrant township. Women activists and community leaders demanded legal status, water rights, and electricity, and the apartheid state became very concerned about their activism. In June of 1986, the state armed a group of people in the township with guns, and they effectively orchestrated what they called "black on black violence". The state was basically leveraging and creating conflict within the community. People at Crossroads were pretty much bulldozed to the ground and were resettled. After apartheid came to an "end", the story of Crossroads was a scar in South Africa's history. People were speaking about the damages, loss of family, homes, and lives. My research happened literally while this was happening.

Another thing, as said before, in 1999, I got a job at the University of Cape Town and was soon also asked by a film-making company called Day Zero Productions to come along with them and analyse the impact of a series of documentary films that they had produced called *Steps for the Future* about HIV/AIDS. Over a period of five years, we travelled with a mobile cinema

unit and 35 films through Lesotho, Mozambique, and South Africa. We showed films to local communities in places where there wasn't formal media reach. There was a wave in which medical anthropology around HIV/AIDS joined sides with visual anthropology in terms of advocacy, public health interventions, and peer education. In that sense I developed a course in ethnographic film and visual anthropology at the University of Cape Town. Now we've shifted the course from visual anthropology to multimodal ethnography, which is one of the core elective courses in our interdisciplinary master's program called Health Humanities and the Arts.

Can you tell us a little bit more about how you are integrating different visual art based approaches into the medical humanities and look at them as both research methods and forms of presenting data in this student program? One of the examples is probably also body mapping?

The body mapping started in an HIV context with Jonathan Morgan's book *Long Life*, in which he worked with women who were HIV positive and used body maps as a way for them to reflect on their stories, to reflect on their bodies, to produce a kind of an archive for their own children. We use body mapping in our classes to open students' awareness of their own experiences of health. We invite professional body mappers because it can open some deep traumas. We work with Jade Gibson, who's an artist and specialises in leading workshops on body mapping. Once the students know how a body mapping workshop feels, they can use

it in their own research to generate their own body maps, though we always say to do it very carefully.

There are so many different things that are pulling the medical and the visual together. For example, the hospital design should be occupied by medical anthropologists who've thought carefully about the relationship between space and wellness. That alien sense, especially in these big biomedical hospitals, is pretty awful. In this context, we had one experience that was frustrating. We were invited by the Department of Health to help them think through nine waiting rooms in the Western Cape. It was a huge opportunity for the students, and they put all their ideas forward. They had great suggestions based on ethnographic work, like building chairs with backs instead of benches, incorporating power stations so people could charge their phones while waiting, and many other structural things that would have made the waiting time more bearable. But at the end of the day, the Department of Health just put in some TVs, even if patients didn't feel the need for them.

But then there's other spaces where we have excellent relations, like the Red Cross Children's Hospital in Cape Town. This unique medical setting includes artwork for the children to enjoy, music, an in-house radio station where kids who are staying long term can make their own radio programs, and they also do regular performances around honouring the dead through music before autopsy. In South Africa, it is interesting to think about the ways in which music has always been a part of the healing, whether it's Khoisan, Hausa, or Zulu. The nurses sing to their patients, they sing in the hallway, it's a way to pass the time, and it is

part of their healing. The medical humanities in Africa have always been here.

My last question is about the concepts you work with. When you talk about the medical humanities, are there particular concepts, like debilitation, that you would like to say something about?

Debilitation (Mohamed 2023; Puar 2017) is emerging as one of the most important concepts of our time. And the reason why I think it's so important is that if you think about the genocide in Gaza and Sudan, people think about genocide in terms of death. If you think about disasters in the gold mines or the diamond mines in South Africa, the emphasis is on death. If you think about Covid, one worries about death. Within the world now, death is kind of everywhere. But in fact, for the dead, there's no experience there, right? You're dead. If one shifts from death to debilitation, you get a very different set of questions. Then you can focus on amputations, on people who live on debilitated landscapes, on dead animals, on the earth that has been scorched by bombs, on starvation and grief worlds. Debilitation is permanent maiming, permanent injury, permanent grief, permanent loss of loved ones. Similarly with gold mining, the antithesis of death is debilitation. And you live with the consequences of toxic exposures, of miner's injuries, things falling on your head, concussions, missing limbs, broken bones, and other forms of debilitation, like eating food that's been sprayed with toxic pesticides. We don't die from it, but we will eventually die of cancer from it. But while we are living, we live in forms of debilitation and injury.

And so that's why I think Jasbir Puar's book *The Right to Maim* and Kharnita Mohamed's work on disability and debilitation are so important, because it shifts our focus from death to debility. What debility does as a concept is it sits together with older models of exploitation, alienation, and Marxist social theory, but it extends it profoundly by asking us to really reckon with brokenness and power. It asks how race, class, gender, and power create debilitated bodies and lives along those axes. We're still looking at the same trajectories of privilege and underprivileged. Kharnita makes the point that a very tiny percentage of people on the planet are born with disabilities and that most disabilities are produced in very violent societies through war, rape, injury, and harm. Her basic argument is that we need to rethink what it is to be disabled from a political and historical perspective, that it's not a natural category, and that it replicates most of the political economies of the inequality in the world. And we only have to look to Uganda, Gaza, the Democratic Republic of Congo, Sudan, Ukraine, Russia. We don't have to look very far to see who's being maimed and injured.

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Thoughts on the DEAGENCY Conference 2025



Nataliia Rygovska

1.25 Other component parts
DOI 10.4312/svetovi.4.1.129-131

Last summer, the second conference of the European Research Council Project DEAGENCY was held in Ljubljana. From 2 to 4 July 2025, the Faculty of Arts at the University of Ljubljana hosted the event. The DEAGENCY research project examines four post-socialist countries: Slovenia, Hungary, Slovakia, and Bosnia and Herzegovina. It focuses on the role of the dead in three areas of social and cultural change and challenges faced during the post-socialist period: the political past, particularly regarding mass graves; the religious landscape; and social life in rural communities. The aim of DEAGENCY is to provide a comprehensive understanding of how the agency of the dead influences individuals' lives. This perspective shifts from viewing the dead merely as part of "folk belief" to recognising their agency, which impacts individuals' bodies, ideas, and actions.

The conference brought together participants from four continents and more than twenty countries, including Belgium, Bosnia and Herzegovina, Canada, Denmark, Estonia, Finland, Greece, Hungary, Iceland, India, Italy, Lithuania, the Netherlands, Norway, Poland, Slovakia, Slovenia,

South Africa, Spain, the United Kingdom, and the United States of America.

The variety of the academic disciplines that the presenters work in was impressive: cultural, media, and social anthropology, gender studies, mythology, folklore, religion, history, ethnology, sociology, nursing, religious and death studies, media and communication, language, sociology of death and dying, thanatology, as well as cross-disciplinary scholars, such as interdisciplinary researchers of trauma, grief, and remembrance after political violence.

This year's topic was "The Agency of the Dead in the Lives of Individuals: Reasons, Triggers, and Contexts". The conference aimed to explore how the agency of the dead manifests and is experienced by the living. It investigated the reasons, triggers, and contexts behind this interaction. Traditional cultures often view violations of social norms and cultural values as reasons for the dead's influence. One of the central questions of the conference was whether these conventional contexts still hold significance or if new triggers have emerged.

The event had two keynote speakers. Terry Gunnell, professor emeritus at

the University of Iceland, opened the conference with a presentation entitled “The Revenge of the Rejected: The Rise, Fall and Background Context of Icelandic Beliefs in Family Ghosts”. Due to the short life of Icelandic buildings, the ghosts prefer to connect not to the house but to the families. Gunnell discussed the topic of family-attached spirits called *mo ra* and *skotta* in his talk. One cannot find entities like this in neighbouring countries, though legends concerning them are worth wider attention.

In the other keynote, Francisco José Ferrándiz, a professor at the Spanish National Research Council (CSIC), presented “Cuelgamuros: The Decline of a Dictatorial Funerary Project”. Creating the term “toxic monuments”, Ferrándiz elaborated on the conflicts that have arisen around the Valley of Cuelgamuros, the leading memorial site for Spanish fascists. This presentation also covered the process of discovering and exhuming numerous mass graves from the Civil War times and the debates around this sensitive topic in Spanish society.



Photo 1: Francisco José Ferrándiz (Author: Nataliia Rygovska, 3 July 2025).

The conference had 11 thematic sections, which explored the agency of the dead

from multiple perspectives and through the lens of the different disciplines. There were presentations of the personal experience, such as Felicity Wood’s story of her close friends’ murder, Jonathan Laszlo Mark’s report on grief after organ transplantation based on his and his peers’ life experience, and Ülo Valk’s talk about his students’ first-hand experience of the supernatural. Other speakers reported on their decades of research material, including both of the keynote speakers as well as Kirsten Marie Raahauge with her haunting studies in contemporary Denmark.



Photo 2: Laszlo Mark Jonathan (Author: Nataliia Rygovska, 4 July 2025).

Kaarina Koski and Lina Būgienė shared their perspectives on dreams concerning death. Meanwhile, the aspect of materiality arose in numerous presentations. Simona Kuntarič Zupanc talked about the physical space dedicated to the dead, both in the home and at the cemeteries, Ágnes Hesz concentrated on heritage and the belongings of the deceased, Jennifer Amy Riley shared her research on grave goods, Evy Johanne Håland talked about Greek women’s food traditions, and Nihad Dostović offered a historical overview of endowments for the salvation of the soul.



Photo 3: Yseult de Blécourt and Ágnes Hesz
(Author: Nataliia Rygovska, 4 July 2025).

In the context of broader historical changes, Mirjam Mencej's study examined the shift in social and moral spheres of rural Bosnian Muslim society. Modern topics such as new spirituality, hospice work, terrorism and migration victims, and Covid were also present at the conference.



Photo 4: Mirjam Mencej (Author: Nataliia Rygovska, 4 July 2025).

Two presenters covered the gender perspective on death-related topics. Asli Zengin shared her observations on the conflict between the transgender identity of the dead and the strictly gendered traditional Turkish funeral ritual, and Charles Oscar Warner

III talked about the ideas of masculinity and patriarchy in the "proper" representation of a soldier in the post-Yugoslav area. Petra Hammer's and Jaka Repič's presentations addressed the topic of war and mass graves.

On the fifth of July, after the academic part of the conference had concluded, the participants were invited to several excursions. In the morning, they joined a guided tour of the Žale Cemetery, one of Europe's most picturesque necropolises. The tour offered not only an introduction to the history of the graveyard and its architectural gems but also a visit to the crematorium, where the participants learned about its technical operation. In the afternoon, the group explored the city's historical centre. Despite the extreme heat, the participants actively engaged in both tours and left feeling inspired, already looking forward to next year's gathering.



Photo 5: Žale cemetery (Author: Nataliia Rygovska, 5 July 2025).

Poročilo z mednarodnega simpozija *Medicinska antropologija z območja nekdanje Jugoslavije* 2024



Tisa Kučan Lah

1.25 Drugi sestavni deli
DOI 10.4312/svetovi.4.1.132-133

Med 28. in 29. 11. 2024 je na Oddelku za etnologijo in kulturno antropologijo FF UL potekal mednarodni simpozij *Medicinska antropologija z območja nekdanje Jugoslavije* v soorganizaciji ljubljanske, zadrške, zagrebške in beograjske univerze. Posebnost simpozija so bile predstavitve v raziskovalcem lastnih maternih jezikih, torej jezikih, ki se govorijo na območju nekdanje Jugoslavije. Poudarek pa je bil na specifičnosti medicinske antropologije v regiji.

Simpozij sta otvorili Tanja Bukovčan in Uršula Lipovec Čebren s premislekom o posebnosti discipline na območju nekdanje Jugoslavije. V prvem sklopu so sledile še predstavitve Barbare Hrovatin o razumevanju celostnega zdravljenja v biomedicini, Atila Lukića o analizi javnih politik invalidnosti na Hrvaškem, Juša Škrabana o izkušnji uporabnikov varovanega oddelka socialnovarstvenega zavoda in Mateje Habinc o antro-

poloških pogledih na izgorelost. V drugem delu simpozija se je zvrstilo pet predavanj, vezanih na javno zdravje in javno zdravstvo. Jelena Kupsjak in Ljiljana Pantović sta predstavili svoje namere vzpostavitve »epistemskih partnerstev« med raziskovalci javnega zdravja na Hrvaškem in v Srbiji. Sara Pistotnik je razmišljala o ranljivih skupinah oziroma posameznikov in nedostopnosti zdravstvenih storitev. Jelisaveta Fotić je predstavila izkušnjo starejših prebivalcev Beograda z diagnozo diabetesa. Zoran Milosavljević je v svojem predavanju predstavil diskurz tehnoseksualnosti med moškimi, ki imajo spolne odnose z moškimi. V zaključku drugega sklopa pa se je Vesna Trifunović posvetila cepivom in cepljenjem. Naslednji dan je simpozij začel sklop predavanj, vezanih na porod, poporodno oskrbo in komunikacijo v zdravstvenih ustanovah. Danijela Paska je razmišljala o tehnomedicinski dimenziji

skrbi v javnih bolnišnicah na Hrvaškem. Neža Zore, Anja Marolt in Besjana Rrahmani pa so v svojih predavanjih razmišljale o jezikovnih in kulturnih ovirah pri komunikaciji tujejezičnih staršev z zdravstvenim osebjem. Neža Zore in Anja Marolt sta o tem govorili na podlagi lastnih izkušenj dela v babištvu, Besjana Rrahmani pa kot predstavnica kosovske manjšine v Sloveniji.

Simpozij je zaključil sklop predavanj o družbenih dimenzijah pandemije covid-19. Vanja Germ je razmišljala o vplivu pandemije na delo in zaposlovanje, Jasmina Kuduzović o (ne)dostopnosti zdravstvenega zavarovanja in težavah s prehajanjem meja, Tisa Kučan Lah pa o vplivu pandemije na duševno zdravje mladih odraslih. Simpozij je omogočil povezovanje raziskovalcev in predstavitev aktualnih medicinskoantropoloških tem območja nekdanje Jugoslavije.

Poročilo z Etnološkega tabora treh dolin 2025



Jakob Stojanović

1.25 Drugi sestavni deli
DOI 10.4312/svetovi.4.1.134-135

Od 22. do 27. septembra 2025 je Solčavsko že šestič gostilo nadobudne študente na *Etnološkem taboru treh dolin*. Logarski kot je postal začasna raziskovalna baza mladih etnologov in kulturnih antropologov, ki so letos raziskovali medvrstne odnose med ljudmi ter nečloveškimi bitji.

V prvih dveh dneh je v Centru Rinka potekal raziskovalni seminar, v sklopu katerega so študentje pridobili osnovno znanje o medvrstni etnografiji. Znanje so jim osvetlili različni predavatelji, med katerimi so bili trije nekdanji obiskovalci tabora. Žiga Zwitter je pojasnjeval odnose med ljudmi in



Jakob Stojanović, Matkov Kot, 26. 9. 2025, Študentke in sogovornica med sprehodom po posestvu.

alpskimi travniki, sledilo je predavanje Elizabete Vršnik, v katerem je prikazala kompleksnost medvrstnih odnosov na planini Grohot. Ana Svetel je razkrivala, kako so življenja Islandcev pogojena z življenjem ptic in drobnice, Miha Kozorog, Sandi Abram ter Žiga Korber pa so se vsak na svoj način spoprijeli s kompleksnostjo odnosa med lovci in divjadjo. V predstavitvi Gašperja Raušla je bil prikazan zapleten in večplasten odnos dunajskih konjev ter kočijažev, ki je odlično orisal glavna načela večvrstne antropologije. Po predavanjih se je vsak večer razvila debata, ki je trajala do večera.

Osrednji del tabora je bil namenjen študentskemu raziskovanju medvrstnih odnosov v lokalni skupnosti na Solčavskem. Letošnja novost so bili še-ne-bruci, ki so se lahko udeležili tabora, še preden so sploh začeli s študijem, kar je bila odlična priložnost za prvi spopad z etnografskim raziskovanjem. Organizatorji so pred prvim raziskovalnim dnevom v ta namen pripravili strnjen uvod v etnografijo oz. *Ethnography 101*, med katerim so prevetrili znanje tudi starejšim študentom. Ekipa ni bila razgibana le po izkušnosti, temveč tudi po narodnosti; med nami je bila doktorska študentka Liling Yan iz Južne Afrike, ki v sklopu študija raziskuje pohodnice, in francoski študent Mathieu Lanthelme, ki se na magistrskemu programu Kreol ukvarja z ekološkimi kmetijami.

Naslednje jutro je bil čas za razvrščanje v skupine po zanimanju. Tako so se formirale tri skupine; prva je raziskovala zeliščarstvo, druga odnos med kmetom in živaljo, tretjo sta pa sestavljala študenta iz tujine. Organizatorji so jim priskrbeli stike ljudi, ki bi lahko bili relevantni za pogovor o raziskovalni temi, in študentje so se hitro lotili kontaktiranja. Čez teden so izvedli več daljših

polstrukturiranih pogovorov in sprehodov s kmeti ali zeliščarkami po kmetijah, travnikih ter vrtovih. Poleg raziskovanja so se udeležili digitalnega sprehoda po Logarski dolini, ki je potekal v sklopu projekta *Evropska noč raziskovalcev oz. Humanistika – to si ti*. Ob večerih so sledili pogovor z mentorji, diskusija in priprava za naslednji dan, ki pa jo je pogosto spremljala tudi kitara.

Zadnji dan je bil namenjen dogodku v Centru Rinka, na katerem so študentje kratkopredstavili svoje preliminarne ugotovitve poslušalcem, med katerimi so bili tudi domačini. Prva skupina je poskušala predstaviti vpliv zeliščarstva na lokalno ustno izročilo ter spremembe in pomen ljudskega zdravilstva v luči turistifikacije, napredka v medicini in boljše povezanosti doline z večjimi upravnimi središči. Z analizo ustnega izročila so na primeru Vida Strgarja - Fide predstavili pomen posameznikov ki so v preteklosti zdravili domačine in jim svetovali. Druga skupina je predstavila odnos med kmeti ter delovnimi živalmi in ljubljenci. Študentje so odkrili, da odnosi z delovnimi živalmi pogosto presegajo zgolj praktične potrebe, saj mnogi razvijejo čustvene vezi kljub primarno gospodarskemu razlogu za odnos. Liling je v svojem predavanju predstavila dotedanje izsledke doktorske raziskave, ki jih je aktualizirala s primeri s Solčavskega.

Tabor je bil izpeljan odlično, saj je študentkam in študentom omogočil, da so se prvič bolj poglobljeno srečali z etnografsko metodo na terenu, spoznali Solčavsko ter stkali trdne kolegialne vezi. Raziskovanje je bilo letos izjemno vključujoče, saj so poleg ljudi dobili glas še krave, psi in zeli. Krave so mukale, psi lajali, zelišča pa so bila precej tiho. Ampak saj veste, kaj pravijo; tišina kdaj pove več kot besede.

A Report on the International Symposium *Hands-on Ethno- graphies: The Production and Meaning of (Contemporary) Handicrafts 2025*



1.25 Other component parts
DOI 10.4312/svetovi.4.1.136-137

Tajda Jerkič



Presentation by Linn Sigrid Bratland at the symposium. Photograph Jana Rajh Plohl

On 23 May 2025, the Department of Ethnology and Cultural Anthropology at the Faculty of Arts, University of Ljubljana, hosted an international symposium entitled *Hands-on Ethnographies: The Production and Meaning in (Contemporary) Handicrafts*. For this occasion, the organisers – Veronika Zavrtnik, Mateja Habinc, Tajda Jerkič, and Jana Rajh Plohl – invited four guest speakers from abroad and four Slovenian contributors to explore the political, legal, economic, social, and technological aspects of handicrafts. The event also aligned with the Faculty of Arts' 2025 theme year, the Year of Heritage.

The symposium built upon two previous events dedicated to the same topic,

held in 2021 and 2023. These events focused on professional practices, institutions, and projects related to handicrafts. This time, the concept aimed to highlight ethnographically rooted research, offering a more reflective perspective and fostering stronger international connections in this field.

Seven papers, which were presented by eight speakers, were divided into two sessions. In the first, "Representations", Saša Poljak Istenič guided the discussion through four presentations. Blaž Bajič critically examined the economic commodification of supposedly transformative or activist contemporary handicrafts. Nicolette Makovicky presented her paper on gendered craft practices in the



Accompanying handicraft fair with the artisans. Photograph Jana Rajh Plohl

production and distribution of lace thongs in a Polish city via Zoom. She approached this topic using the concept of commoning. Ewa Klekot discussed the role and position of designer-makers within the New Craft Movement in Poland, contrasting it with the longer-standing but politically burdened folk craft tradition. The final presentation in this section was given by Martin Frideriksson, who explored questions related to the construction and legal protection of traditional cultural expressions.

The second session, “Practices”, was moderated by Špela Ledinek Lozej and focused on the ethnographic perspective. Linn Sigrid Bratland analysed the driving forces behind the adoption of technology in silversmithing. Tajda Jerkič and Veronika Zavrtnik then presented the contemporary motivations and digital influences among young craftspeople in Ljubljana. Finally, Jasna Fakin Bajec demonstrated how handicraft heritage can foster intergenerational learning with a local applied project. The symposium provided a valuable opportunity to network and gain insight into the fascinating and engaging topic of contemporary approaches to handicrafts.

In addition to the symposium, two related events took place. One day earlier, on

22 May, a round table entitled “What Happens in the Brain When You Pick Up a Needle, Thread, or Piece of Wood?” was held at Plečnik House. It was conducted in the Slovenian language and was intended for the general public. The discussion, moderated by science journalist Renata Dacinger, brought together experts from five different disciplines: neurologist Zvezdan Pirtošek, psychologist Grega Repovš, andragogue Nives Ličen, occupational therapist Alenka Oven, and anthropologist Veronika Zavrtnik. Each offered interesting insights from their own field and practice on the cognitive and social benefits of crafting, reflecting on its importance for society as well as for the functioning of the body and mind, apart from the heritage and conservation discourses.

During the symposium, the organisers also sought to provide a tangible experience by setting up a handicraft fair, which was held in the main hall. The four stations featured craftspeople and institutions that presented their work and invited visitors to try their hand at various skills. They included the Anselma sewing workshop, Jana Koteska with macramé, the Repair Café Knjižnica reči, and the Smetumet association, which upcycles discarded materials into new contemporary products.

Rečnacijska
antropologija

Multimodal
Anthropology

Predstavitev rubrike

Večnačinska antropologija

in uvodnik k tematskemu

bloku *Plovba med jeziki*



Matej Mali, Ana Svetel

1.20 Uvodnik
DOI 10.4312/svetovi.4.1.139-144

VEČNAČINSKA ANTROPOLOGIJA: IDEJNA ZASNOVA NOVE RUBRIKE

Da se v zadnjih letih krepí premislek o množstvu načinov raziskovanj in (re)prezentacij na polju etnologije ter socialne in kulturne antropologije, pravzaprav ni presenetljivo. Gre namreč za vedo, ki je tako v epistemološkem kot vsebinskem smislu zavezana prožnosti. Da je disciplina, katere osnovni gradnik je človeška izkušnja, nujno vsaj do določene mere spremenljiva in prilagodljiva, je zato domala neizpodbitno, kar nakazujejo tudi tendence po nenehnem preizpraševanju njenih temeljnih epistemoloških predpostavk, učinkov in načinov predstavljanja raziskovalnih uvidov. Večnačinskost soudeležencu v interpretaciji ali produkciji raziskave pogosto ponudi manj konvencionalno pot in drugačno izkušnjo. Znanjenje kot proces pridobivanja in oblikovanja znanja lahko v večnačinski antropologiji zamenja klasične in preizkušene tirnice ter ponudi nove spoznavne, interpretacijske in izkustvene možnosti – morebiti pa celo premošča vrzeli, ki jih klasično antropološko udejstvovanje, raziskovanje in reprezentiranje včasih (nenamerno ali namerno) vzdržujejo ali celo ustvarjajo.

Večnačinski pristopi in reprezentacije vabijo k premisleku, ali lahko svoje raziskovalne uvide predstavimo (tudi) onkraj ustaljenih načel znanstvenega pisanja. V tem smislu se večnačinska antropologija v veliki meri naslanja na dediščino vizualne antropologije, vendar skuša polje etnografskih raziskav in reprezentacij odpirati tudi na področjih digitalnega, čutnega in novih medijev, ter umetniških in eksperimentalnih pristopov tako k vizualnim kot besedilnim prispevkom. Uporaba participativnih oz. sodelovalnih, avtoetnografskih,

senzoričnih, elicitacijskih, zvočnih, eksperimentalnih in drugih, pogosto interdisciplinarnih metod omogoča izstop iz konvencionalnega oblikovanja ter reproduciranja znanja. (Antro)poezija in druge (pol)literarne oblike, podkasti, zvočne atmosfere, risanje, kodiranje in izdelovanje iger odpirajo drugačen ter v nekaterih primerih celo primernejši način za prenos znanja ali za njegovo prevpraševanje. Večnačinski pristopi lahko delujejo kot vznemirljivi ponudki ali oprimki za raziskovanje in artikulacijo afekta, atmosfere, intime ali telesnih praks, kajti človeško življenje in njegova izkušnja včasih presegata repertoar klasičnega akademskega jezika (in seveda jezika vobče).

V zadnjih letih so številne antropološke raziskovalne in izobraževalne institucije v svoje programe začele intenzivneje vpeljevati večnačinske pristope. Široko uveljavljen magistrski program vizualne antropologije na Arktični univerzi v Tromsu na Norveškem se je tako denimo v preteklem letu združil z magistrskim programom socialne antropologije ter preimenoval v magistrski program vizualne in večnačinske antropologije. Podobno se je že leta 2017 rubrika *Visual Anthropology* (Vizualna antropologija) v periodični publikaciji *American Anthropologist* (Ameriški antropolog) preimenovala v *Multimodal Anthropologies* (Večnačinske antropologije). V filmu *Where can I get lost? oz. Kje se lahko izgubim?* (2024) avtor, vizualni antropolog, Mattijs van de Port na avtoetnografski način razmišlja o koprodukciji in reinterpretaciji tistega, česar ni mogoče posneti s kamero. Andrew Causey v monografiji *Drawn to See: Drawing as an Ethnographic Method* oz. Videti z risanjem: risanje kot etnografska metoda (2017; glej tudi Kuschnir 2016) razmišlja o pomenu in vrednosti risanja kot antropološke raziskovalne ter prezentacijske prakse. Zbornik *Crumpled Paper Boat: Experiments in Ethnographic Writing* oz. Pomečkana papirnata ladja: poskusi v etnografskem pisanju (2017), ki sta ga uredila Anand Pandian in Stuart J. McLean, se poigrava z manj ustaljenimi in eksperimentalnimi načini antropološkega pisanja ter preslikava (pol)literarne oblike v epistemološko bogate načine raziskovalne prisotnosti. Zbornik *Gender Futurity, Intersectional Autoethnography: Embodied Theorizing from the Margins* oz. Prihodnjenje spola, interseksijska avtoetnografija: utelešeno teoretiziranje z obrobij (2020), ki sta ga uredila Amber L. Johnson in Benny LeMaster, pa predstavlja večnačinskost kot del avtoetnografskih pristopov. Z večnačinskostjo se, vsaj posredno, ukvarjajo številni antropologi in antropologinje tudi na področju čutov in zaznavanja (glej npr. Howes 2003; Laplantine 2015; Pink 2015) ter institucije, kot sta Sensory Ethnography Lab na Harvardu in ReCNTR Lab Univerze v Leidnu. Seveda pa je seznam raziskovalcev in raziskovalk, pomembnih del ter raziskovalnih centrov, ki uveljavljajo ali širijo polje večnačinskih raziskav in reprezentacij v antropologiji, bistveno daljši in bolj razvejan – ter daleč presega okvire tega uvodnika.

Večnačinska antropologija se uveljavlja tudi pri nas, četudi doslej zlasti posredno. Rajko Muršič in Dan Podjed v članku *Biti ali ne biti tam: etnografija na daljavo med krizo in onkraj nje* (2021) razmišljata o nuji predruženja raziskovalnega postopanja, kar od nas zahteva spremenljivi svet – v njunem primeru epidemija covid-19. Številni domači raziskovalci in raziskovalke vključujejo večnačinske pristope tudi v raziskovanje okoljskih odnosov, telesnosti in gibanja, denimo znotraj projektov Sonar Cities, Sensotra, DigiFREN in Biogra-

fije istrskih poti. Pomemben prispevek novih, eksperimentalnih in ustvarjalnih pristopov k etnografskemu pisanju je tudi zbornik *Hodopisi: zbirka etnografskih esejev z metodološkimi premisleki o hoji in pisanju* (2023), ki sta ga uredili Nataša Rogelja Caf in Špela Ledinek Lozej. V njem Rogelja Caf razmišlja:

Pri »prehajanju isker« med žanri, ohranjanju in vadenju pisanja različnih tekstov, razmisleku ob pisanju lastnega terenskega dnevnika, občutku nezadovoljstva ob (zgolj) znanstvenem zapisu pa ne gre samo za drobna vsebinska etnografska spoznanja, za prepoznavanja relevantnih tem ali za vzpostavljanje novih nepričakovanih povezav, temveč gre tudi ali predvsem za kompleksnejše premisleke o dekolonizaciji pisanja, o sestopu z avtoritativnega piedestala vsevedne znanosti in predvsem za pripustitev dvoma v naše zaključke. Dvom namreč pospeši naš korak, eksperimentalno, nedokončano, vmesno, hibridno, meandrirajoče, morda lahko rečemo celo antropološko pisanje pa se pri tem zdi dober medij preizpraševanja samoumevnosti, nekakšen liminalni teritorij, kjer je vse mogoče in nič gotovo. (Rogelja Caf 2023: 53–54)

Večnačinski antropologiji bo posvečena prihajajoča tematska številka revije *Traditiones*, ki jo urejata Manca Filak in Ana Svetel ter bo deloma izhajala iz projekta slovensko-norveškega mednarodnega sodelovanja Naslavljanje odnosov med ljudmi in okoljem s pomočjo multimodalne etnografije, ki ga financira ARIS. *Glasnik Slovenskega etnološkega društva* pa z letom 2026 uvaja možnost objave fotoeseja, kar prav tako lahko razumemo kot odpiranje vrat večnačinskosti. O večnačinskosti nenazadnje intenzivno razmišljajo (naj)mlajše generacije antropologov in antropologinj, na kar je med drugimi pokazala samoorganizirana študentska delovna skupina *Re_fract* na Dunaju, ki se je oblikovala z namenom preizpraševanja znanstvene forme. Podobna pobuda se vzpostavlja tudi v Ljubljani s Skorjo, študentsko skupino za multimodalno in eksperimentalno antropologijo. Do določene mere pa pri nas ta vprašanja mlajši kolegi in kolegice odpirajo v novoustanovljeni študentski reviji *Šreka*.

Večnačinska antropologija med drugim teži k preizpraševanju znanstvenega procesa ter v iskanju alternativnih oblik raziskovanja in (re)prezentiranja znanja vidi nove možnosti za izražanje raznovrstnosti človeške izkušnje. Sprašuje se o medsebojnem sodelovanju, interin transdisciplinarnosti, znanstveni preciznosti, izkustvenosti ter morebiti v svojih obronkih ponuja celo izhod iz akademske hermetičnosti. Z vpeljavo rubrike Večnačinska antropologija v *Svetovih* odpiramo vrata antropološkim, etnološkim, folklorističnim in drugim prispevkom, ki ne sledijo konvencijam znanstvenega pisanja niti se ne uvrščajo med strokovna besedila, temveč preizkušajo oziroma ustvarjajo nove (pol)literarne oblike, eksperimentalne predstavitve ali kombinirajo vizualne, besedilne, digitalne in druge načine. Ki, skratka, ne nadomeščajo uveljavljenih in prevladujočih načinov podajanja znanstvenoraziskovalnih izsledkov, temveč obstajajo ob njih. Naj pretočnost, s katero odpiramo to rubriko, spremlja večnačinske plobe tudi v bodoče.

»ČEMU SO SPLOH NAMENJENA TA BESEDILA?«
O OZADJU PLOVBE MED JEZIKI

Svet se nenehno vrti okoli jezikov. To gibanje zapopasti celostno je skoraj nemogoče, tako kot je nemogoče ujeti vso mrgoljavo raznovrstnih rib v Tihem oceanu. Sprva sem poskušala ribje jate poloviti v mreže iz ključnih besed »migrantska«, »čezmejna«, »kreolska«, »manjšinska«, »prevodna« in še drugačna »literatura«. Iz tega ali onega razloga se mi ni posrečilo. Pa sem se pridružila ribam in zaplavala od morja do morja. In opazila sem, da lahko tako bolje dojamem in ujamem tisto, o čemer bi rada pisala. Tako pisanje bolj ustreza mojemu popotnemu življenju. Mesta, ki jih običajno zasedajo abstraktni samostalniki, so zato zapolnila imena krajev. Kot riba se najlaže po ribje spreplavam med morji in prek lusk zaznavam jezikovno stanje blizu in daleč. (Tawada 2024: 7)

S temi vrsticami nas nemška in japonska pisateljica Yoko Tawada povabi v esejistično zbirko *Eksofonija ali poti iz materinščine*. V prvem delu knjige so eseji izrazito geografsko intonirani, saj vsakega že z naslovom umešča v določeni prostor. Vendar ne gre za potopisno literaturo. Avtorici prostorsko (in jezikovno) umeščeni dogodki služijo zgolj kot izhodišča za razmisleke o identiteti in migrantstvu, ki ju vidi tudi v kontekstih (po)kolonializma. Predvsem pa v esejih raziskuje, kako pisca ali pisko opredeljuje in zamejuje materinščina. V izogib pisanju o izseljenski, migrantski ali kreolski književnosti se opira na pojem eksofonije, ki naj bi pomenil izstop iz materinščine v širšem smislu. »Pisci, ki pišejo v tujem jeziku, niso nujno le migranti in njihov jezik ni nujno kreolščina – svet je veliko zapletenejši,« poudarja (2024: 11).

S teh izhodišč in ob branju njenih esejev smo v študijskem letu 2024/25 pri predmetu Antropologija in pisanje razmišljali o svojih lastnih eksofonijah – in koncept prilagodili individualnim »jezikovnim plovbam« študenta in študentke. Na podlagi branja izbranih esejev in skupinske diskusije o prebranem ter naratološke analize prvega eseja (Dakar – *Praktična eksofonija*), ki smo jo izvedli skupaj z asistentko Tino Krašovic, so študent in študentke nato zasnovali lastne eseje. V njih so obravnavali svoja soočanja tako z materinščino kot z jeziki, v katere so pozneje vstopali in iz katerih so izstopali, ki so jih zaznamovali, jim približali neznano ali jih oddaljili od primarnih okolij. Na podlagi odzivov, ki so jih dobili na prve različice, so svoja besedila strukturno in slogovno obrusili, nekateri so naknadno izostrili fokus, drugi so zelo specifične spominske in anekdotične drobce razširili ter kontekstualizirali, tretji so iskali način, kako razrahljati strogo akademski način pisanja, v katerem so kot drugostopenjski študenti etnologije in kulturne antropologije sicer že dodobra izurjeni. Sedem esejev se na svojstvene načine loteva vprašanj osebnih eksofonij, pri čemer prepletajo literarne, esejistične in avtoetnografske prvine. Hibridna, zvrstno težko opredeljiva in raznolika besedila zato brez eksplicitnega omenjanja odpirajo vrsto vprašanj, na primer kaj pomeni biti socializiran v določenem jezikovnem okolju, kakšne svetove odpira učenje tujih jezikov, kako lahko narečne nianse signalizirajo drobne (ne)pripadnosti, kakšne etnično-identitetne dileme lahko sproži mimogrede navržena opazka neznanca in kako antropološko »splavati« v povsem nepoznanem jeziku.

V eseju *Lingvistične sledi kljukuš: kartografija izgube in vračanja* Hana Uma Zagmajster osvetljuje kompleksen odnos do rodnega Tržiča ter njegove večetnične skupnosti.

Katarina Bezjak pa v besedilu »*Jaz bi te rad čüja gučate*« na primeru razlik med različnimi panonskimi narečji razmišlja o subtilnih znakih, ki nas simbolno povezujejo s krajem, v katerem bivamo, ali nas od njega oddaljujejo. Neža Jakšič v eseju »*Reče se fotografirati, ne vzeti fotografijo*« niza spominske drobce odraščanja na Nizozemskem in razmišlja o svoji večjezikovni preteklosti. V otroštvo sega tudi Sebastjan Brumat, ki v eseju *Italijanščina v obmejnih zidovih in mostovih* razpira razmisleke o odnosih in razpetostih obmejnega goriškega prostora. Vesna Petrič v najobsežnejšem besedilu v tematskem bloku o sebi razmišlja kot o lingvistični kameleonki in bralca popelje od svojega prvega jezika – *dolinščine* do poznejših, z izobraževalno potjo zaznamovanih jezikovnih (zlasti španskih) epizod. Lara Davidović v eseju *Nema Trsta bez tri prsta – tranzitna kontemplacija* izhaja iz drobne opazke sprevoznika na avtobusu iz Trsta v Ljubljano, ki je v avtorici sprožila niz premislekov in asociacij, kar posrečeno imenuje »miselna uganka«. Zaključni esej nas geografsko popelje najdlje, tematsko pa vrača v znane antropološke tirnice. Gaja Basaj namreč v besedilu *Hatujui* odstira svoja mnogotera, toda krhka jezikovna oprijemališča, ki jih je ustvarila med terenskimi bivanjem v Tanzaniji.

Besedila niso znanstvena in zato ne gradijo na sistematični argumentaciji, teoretskih zastavkih ter etnografsko zbranih gradivih. Namesto tega meandrirajo po tokovih avtobiografskega in avtoetnografskega, refleksivnega in izkustvenega pisanja ter namesto analitičnih zaključkov ponujajo možnosti, kako pisati o jeziku iz resda zelo osebne izkušnje, vendar jo misliti družbeno: vsaka lastna »jezikovna plovba« je sorodstveno, institucionalno, razredno, prostorsko ali kako drugače pogojena. Zato ni presenetljivo, da se jezik v vseh esejih izrisuje kot izrazito afektiven: povezan je z občutki sramu, vrednosti, (ne)pripadnosti, domačnosti in tujosti. Proizvaja tako nove povezave in stike kot tišine, obžalovanja, premolke. Občutja mnogoterih eksofonij, vstopov v jezike, narečja, govornice ter izstopov iz njih avtorice in avtor ubesedujejo z veliko mero antropološke občutljivosti. To pa aplicirajo na vsebine, ki so preveč intimne, fragmentirane ali ustvarjalno predelane, da bi jih lahko prištevali med konvencionalna (avto)etnografska »gradiva«. Vsi preigravajo težko ubesedljive nianse lastnih izkušenj, vzdušja, ki vedno vznikajo onkraj jezika, ter spomine, zasidrane nekje med občutenjem in dejstvi. Jezika se ne lotevajo kot samoumevnega sredstva sporazumevanja, temveč kot vstopne točke za kompleksna vprašanja o sebi in svetu. Kako nas oblikujejo jeziki, ki smo jih izgubili ali nikoli povsem osvojili? Kaj pomeni pripadati jeziku – in kdo sploh lahko ali sme pripadati? Kako institucije, meje in zgodovine vstopajo v naš vsakdanji govor? Kako lahko o jeziku pišemo z vidika njegove spremenljivosti, napak, nedoslednosti, krhkosti, ne njegovega domnevnega reda ali nedvoumnosti? Eksperimentalni tematski blok *Plovba med jeziki* nadaljuje morsko metaforo iz uvodnega sestavka Yoko Tawade¹ in je hkrati povabilo etnologom in etnologinjam, folkloristom in folkloristkam ter kulturnim antropologom in antropologinjam k preizkušanju novih plovnih poti, ki jih odpira rubrika Večnačinske antropologije.

1

In se s tem navezuje tudi na simboliko zbornika *Crumpled Paper Boat* (2017) oz. Pomečkana papirnata ladjica.

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Lingvistične sledi kljukuše: kartografija izgube in vračanja



Hana Uma Zagmajster

1.23 Umetniški sestavek
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Ko premišlujem o jeziku, njegovih možnostih in omejitvah, me niti spomina vedno znova vodijo v domači kraj – v malo gorenjsko mesto Tržič, nekoč znano po cvetoči industriji, kjer sem dolga leta tistih prvobitnih, naivnih in nedolžnih osnovnošolskih dogodivščin preživela s takratno najboljšo prijateljico Jasmino, hčerko priseljencev iz Hrvaške in Bosne.

Slikovito se spominjam njene mame Azre, ki mi je vsakič, ko sem jih obiskala, z odprtim srcem ponudila kos slastne, mastne sirnice ali kljukuše in me – tako kot svojo hčerko – zadovoljno opazovala pri hlastanju hrane, medtem ko me je klicala *sine*. Kadar smo si med obedom izmenjevale besede, je Azra govorila v svojem, srbohrvaškem jeziku – in vendar sva se brez težav razumeli, čeprav je občasno kakšna beseda poletela v prazno. Podobno je potekala tudi komunikacija v medvrstniških odnosih na ulici, v šoli, na igriščih in v vrtcu, kjer so se številni otroci priseljencev še pred vstopom v šolo spontano in igrivo priučili slovenskega jezika.

Jezik se nam torej razodeva kot prostor spomina, kjer se zgoščajo čustva, zven časa in odnosi, ki nas oblikujejo, hkrati pa kot posledica in vzrok političnih, ekonomskih in socialnih procesov, kot so mednarodne selitve. V mojem primeru ta kraj spomina zato nikakor ni vezan zgolj na gorenjsko narečje, ki smo ga govorili doma, temveč tudi na druge južnoslovenske jezike, ustaljene v Tržiču. Šele ko sem se z osemnajstimi leti preselila v Ljubljano in začela pogosteje potovati po Zahodni Evropi, sem se vse pogosteje zatekala k angleščini – čeprav je bil moj prvi tuji jezik pravzaprav srbohrvaščina. Kot otrok je sicer nisem govorila tekoče, vendar se je očitno vtisnila v moj zvočni spomin – tako kot pozneje angleščina in ljubljan-

ščina. To sem spoznala šele v zadnjih treh letih na potovanjih po Balkanu, ko sem spontano začela preklapljati iz angleščine v jezik, ki ga nikoli nisem zares »znala«, pa vendar sem ga razumela in se ga hitro priučila – ker sem ga, očitno, že dolgo nosila v sebi.

Šele po nekaj letih študentskega življenja v Ljubljani sem se začela aktivno zavedati, da sem skoraj povsem izgubila stik z gorenjskim narečjem, s srbohrvaščino ter s specifičnimi frazami, šalami in zvenom, ki so mi bili nekoč samoumevni. Postopoma je iz mojega besednega repertoarja izpuhtel izraz »majkemi«, besedo »žehta« je zamenjalo knjižno pravilno »perilo«, »ceker« je postal »košara«, »č'pine« so se prelevile v »umazano posodo«, »talar« v »krožnik«, »kwa« v »kaj«, »ne me basat« v »ne morem verjet«. Skupaj z njimi pa so neke v kotih moje zavesti ležali zaprašeni spomini, vezani na otroštvo in domači kraj. Jezik torej ni le razkrivalec spomina, temveč tudi nosilec pozabe.

To spoznanje me je spodbudilo, da sem se želela poglobiti v razloge za jezikovne spremembe. Zanimalo me je, kdaj oziroma kako hitro je do njih prišlo, v kolikšni meri sem jim sama botrovala in koliko je bilo to preprosto logična posledica samodejnega prilagajanja govoric okolja – govoric, ki se v naše sluhovode vtihotaplja kot nekakšna zajedavska popevka. Tista, ki si je – morda – samoiniciativno nikoli ne bi zavrteli, vendar jo znova in znova zalotimo, da domuje v naši glavi.

To nezavedno prilagajanje sem še posebej močno občutila po študijski izmenjavi na Nizozemskem, ko sem še mesece po vrnitvi v Slovenijo mislila – in celo sanjala – v angleščini, čeprav se v vsakdanjem življenju pogosto izogibam njeni uporabi, kadar ta ni nujna. Vendar pa v primeru prevzemanja ljubljansčine in knjižnega jezika verjetno ni šlo za povsem enak proces. V srednješolskih letih, ko sem obiskovala srednjo šolo za oblikovanje, ki je v mojem takratnem simbolnem svetu predstavljala nekakšno gnezdo »frikov«, ki so uspešno pobegnili iz sveta »civilov«, me je očitno prežemala ideja Ljubljane kot odrešitvene prestolnice kulture – kot protiutež tistemu majhnemu odročnemu kraju, kjer lahko izbiraš le med barom Cokla in barom Jaslice, kjer sonce zaradi hribovite stene, ki obdaja tržiško kotlino, vzide šele opoldne in kjer – kot pravijo – »še duhov ni več«, saj starejši ljudje odhajajo naravno, mlajši pa načrtno – v »mesta priložnosti«, kakršno Tržič že desetletja ni več.

Zaradi takšnih stereotipov, pomešanih z realnimi ekonomskimi težavami, naše alpsko mestece še danes nosi slab sloves, strnjen v frazo, da »v Tržiču še veter ni dober«. Moja sprememba v govoricu je bila torej deloma zavestna odločitev, povezana z željo po spremembi atmosfere – atmosfere, ki se je šele z zamikom izkazala kot nekakšna prevara ali celo zamenjava ene iluzije z drugo. V skrajnosti bi lahko rekla, da sem bila na neki točki tujka tako v Ljubljani kot doma. V Ljubljani so me vsi začudeno gledali, ko sem namesto »ni problema« rekla »navadn'«, hkrati pa se spominjam situacije, ko se je brat doma pošalil na moj račun zaradi pogoste uporabe ljubljanskega mašila »ne« na koncu stavkov in besede »dejansko«, ki mu je zvenela preveč intelektualno in vzvišeno. Kot Tržičanka bi seveda lahko rekla »tko, pa čist n'č drgač«. Ob poslušanju in rabi takšnih fraz danes čutim prijetno toplino, ki me vrne v neki lahkotnejši čas in prostor – tja, kjer, četudi nimaš veliko, imaš vse, kar je v ključnih trenutkih morda »dovolj«; kjer pripadaš, ne glede na to, kaj študiraš, kakšno glasbo poslušаш, kdo so tvoji starši ali iz katere države bivše Jugoslavije prihajaš.

O pripadnosti, jezikovni vzvišenosti in identiteti pa priča tudi anekdota, ki mi jo je pred časom povedala Jasmina. Njena mama je z možem, Jasmininim očetom, tedaj že živila v Tesliću, majhnem mestu v Bosni, o katerem sta v času življenja v Tržiču vsak dan sanjala, da se tja preselita v pokoju. V telefonskem klicu pa je oče Jasmini povedal, da je mama »poludila«, saj je začela na javnih mestih, kot so trgovine, nenadoma govoriti v slovenščini – jeziku, ki ga v Tržiču kot nekakšni Jugoslaviji v malem, kjer vendarle ne manjka zapriseženih Slovencev –, na njej značilen prikupni in hudomušni način namerno skoraj nikoli ni uporabljala. Ko jo je Jasmina vprašala, zakaj to počne – zakaj zdaj, ko je končno »med svojimi«, kjer se od nje ne pričakuje, da govori jezik, ki ni njen materni –, ji je mama v resno šaljivem tonu odgovorila: »Naj vejo, da sem iz Slovenije.«

Ta anekdota me je hkrati pretresla in nasmejala. Ne le zaradi svoje obratne logike v primerjavi z mojo izkušnjo, temveč tudi zato, ker razkriva kompleksnost jezikovne identitete kot prostora med intimnimi in razrednimi svetovi ter nacionalnimi fantazijami, ki v končni fazi – na lokalnih ravneh in v človeških odnosih – lahko popolnoma izgubijo svojo veljavo. Jezik tako ni nikoli zgolj sredstvo sporazumevanja – je prostorska koordinata, časovni stroj, točka ponovne obuditve in sredstvo igre, najsibo v obliki poezije ali humorja. Zato izguba ni nujno izbris, temveč je lahko tudi preobrazba. Jezik, ki se mu oddaljimo, nas morda ne zapusti, temveč se preseli v globlje plasti spomina, kjer preživi kot šum, intonacija, kot občutek doma – tudi v tuji besedi.

In morda prav v tem izmikanju, v tem neprestanem gibanju med jeziki, naglasi in tistim, kar izbiramo izreči – vznikne novo zavedanje pripadnosti, vezano na vse prostore, kjer smo se kdaj počutili razumljene. Zato grem dandanes z enakim veseljem kot v ljubljansko Kinoteko tudi v bar Jaslice, kjer imajo enkrat na mesec domači golaž »za male pare« – pa četudi bom morala poslušati kakšno trapasto popevko, v najboljšem primeru pa že v nešteto slišati *Durđevdan*.

»Jaz bi te rad čüja gučate«



Katarina Bezjak

1.23 Umetniški sestavek
DOI 10.4312/svetovi.4.1.148-149

Navadno je mojim sogovornikom že po nekaj besedah jasno, da prihajam iz Štajerske, nekoliko težje pa je morda slišati, da prihajam z obrobja Prlekije. Čeprav sem rojena v Veliki Nedelji oziroma *Vejki Nedli*, vasi v občini Ormož, je marsikdo presenečen nad mankom močnega naglasa, ki se skozi majhne podrobnosti spreminja od vasi do vasi in tako natančno določa človekov izvor. Moj materni jezik je bliže ptujski govoric, z nujnimi velikonedeljskimi vložki, ki so bolj rezultat zavednega truda in želje po govorni pripadnosti.

Pred kratkim me je nekdo iz bližnje vasi prekinil po le nekaj izgovorjenih besedah in z začudenjem vprašal: »Te pa ti *govoriš*?« In s tonom glasu moje govorjenje označil za nekoliko manj vredno od domačega *guča*. Nenaklonjenost knjižnemu pogovornemu jeziku me ni niti malo presenetila. Čutiti jo je bilo mogoče že v osnovnošolskih letih, ko so morala dekleta na prehodu v srednjo šolo, po navadi na Ptuj ali v Maribor, svojim mlajšim prijateljicam obljubljeni, da ne bodo začela *govoriti*, s čimer naj bi se vrednostno oddaljila od deklet, ki so ostala na vasi. Strah pred spremembo naglasa je s seboj nosil mnoge druge konotacije in bil dejansko le redko povezan z jezikom. Moje govorjenje je bilo zaradi svoje »avtentičnosti« do neke mere opravičeno, zato me očitki spremembe osebnosti, kroga prijateljev in življenjskega nazora, bojda na podlagi spremembe naglasa, niso doleteli. V šoli je bila moja govorica še posebej dobro sprejeta med učiteljicami in profesoricami slovenščine, saj so lahko na oder postavile nekoga, ki je besedila večine šolskih proslav samozavestno prebral že na prvih vajah.

Razmišljam, kaj je pravzaprav najbolj vplivalo na moje narečje. Mama me je v lokalno knjižnico včlanila pri enajstih mesecih, do konca osnovne šole pa sem predelala vse otroške, mladinske in del odraslih polic s knjigami, ki jih imam rada še danes. Oče si je vsak večer izmislil novo epizodo zgodbe za lahko noč ter mi prek glavnih likov več let podajal bistroumne šale in življenjske nasvete. Tako sta rastle moj besednjak in domišljija, ki sta mi skupaj s pridobljenim splošnim znanjem zelo olajšala zgodnja leta šolanja. Rada sem brala in še raje govorila. Pa vendar v svoj govor nisem mogla spustiti govorice prijateljev in okolice.

Afiniteta do domačega kraja je v meni rastle počasi in se razrastla šele, ko sem opustila pričakovanja vseh, ki so mojo govornico, odmik od narečja, hvalili kot dosežek. Govorila sem, kot govori moja mama. Enako kot moji prijatelji govorijo narečja svojih staršev, pa zaradi tega niso bili deležni posebne obravnave. Čeprav sem bila zaradi govorne nadarjenosti in veselja do nastopanja pogosto ravno jaz izbrana, da predstavljam in zastopam kraj, svoj kraj, sem se nemalokdaj počutila kot tujka. Še vedno me nekoliko zbode vprašanje, če sem se od kod priselila.

Danes narečje poznam in ga lahko govorim, vendar to iz mene ne pride spontano, temveč kot neki na pol tuji jezik, ki zveni v moji glavi veliko bolje kot po tem, ko zapusti mojo ustno votlino. Morda kaj več niti ne bi smela pričakovati. Navsezadnje sta se starša vsak iz svojega konca skupaj preselila v kraj, ki je postal moj dom, kot prva generacija v novem kraju pa sem bila govorno oziroma narečno razpeta med materinščino in lokalno govornico, ki z njo ni sovpadala. Kar nekaj časa sem doma *govorila*, zunaj doma pa *gučala*, dokler ni nastal neki skupek besed, ki je ustrezal vsem. Zdaj moj jezik niha, se nezavedno prilagaja različnim družbam in je glede na situacijo bolj ali manj narečen. In glede naslova tega eseja? Želja. Ne več toliko moja, ne več taka, da bi se nanjo čutila dolžna odzvati. Ne morem zanikati prednosti tega, da mi je bila knjižna slovenščina vedno domača, toda v tej nekoliko pozni introspekciji ugotavljam, da je bilo pomanjkanje bolj osebne narave, od iskanja svojega mesta do občutka nepripadnosti, ki se, čeprav redkeje, na moja ramena prikrade še danes. Vedno sem mislila, da je znanje tujih jezikov merilo vrednosti človeka, z leti pa ugotavljam, da je prava vrednost, vsaj zame, v domačem narečju, ki ga ne bom nikoli za res osvojila, v dediščini mojega kraja, ki ne bo nikoli zares moja.

» Reče se fotografirati, ne 'vzeti fotografijo' «



Neža Jakšič

1.23 Umetniški sestavek
DOI 10.4312/svetovi.4.1.150-152

Zjutraj me pobere šolski taksi. Jutro je megleno in oblačno, zdi se, da bo vsak trenutek začelo deževati. Naša hiša je prva postaja na njegovi poti. Ustaviti se moramo še pri petih drugih hišah. Moja sestra je že dovolj stara, da lahko sama kolesari v šolo, jaz pa sem šele začela z osnovno šolo. Sedem na zadnji sedež. Med vožnjo od hiše do hiše poslušamo nizozemsko radijsko postajo Sky Radio 101FM – glasba je v angleščini, novice in oglasi pa v nizozemščini.

Ko sem bila stara šest let, smo se preselili v Alkmaar, mesto na severozahodnem delu Nizozemske. Razumela sem samo slovenščino, vendar še nisem znala brati ali pisati. Starša sta me vpisala v zasebno mednarodno šolo European School of Bergen (Evropska šola v Bergnu). Moji sošolci so prihajali z vseh koncev sveta – iz Južne Afrike, Koreje, Velike Britanije, Španije, Francije, Singapurja itd. Pouk je potekal v angleščini, ki je bila zame sprva popolna neznanca. Toda nisem bila edina nova učenka, saj sem vsak dan imela dodatne ure angleščine skupaj s Tereso, sošolko iz Španije. Teresa se je v tem času, ko še ni znala angleško, vseeno lahko sporazumevala z drugimi špansko govorečimi učenci in učitelji. Ker sva bili s sestro edini Slovenki na šoli, je bilo znanje angleščine zame ključno, saj se brez nje nisem mogla sporazumevati z nikomer. Na začetku sem bila nema v novem mednarodnem okolju, vendar je bila šola k sreči navajena takšnih učencev in sem se hitro udomačila. V manj kot pol leta sem se naučila tekoče govoriti angleško.

S procesom prilagajanja na novo mednarodno okolje sem izgubila stik s svojim materinim jezikom. Lažje sem se izražala v angleščini kot v slovenščini, saj se doma nismo pogosto pogovarjali. Moja starejša sestra je večino časa preživela v svoji sobi, mama s starejšim bratom, oče pa je bil pogosto odsoten. Tako sem veliko časa preživela sama – na trampolinu ali v vrtnih labirintih naše soseske – največkrat v pogovoru s seboj, in to najpogosteje v angleščini.

Poleg angleščine sem osvojila še nekaj nizozemščine. Ko se nisem potikala po vrtnih labirintih naše soseske, sem največkrat sedela pred televizijo in gledala sinhronizirane risanke v nizozemščini. Pasivno sem osvojila nekaj ključnih besed, čeprav se v tem jeziku nisem z nikomer aktivno pogovarjala.

Z mamo sva se vračali iz moje najljubše živilske trgovine, Albert Heijn. Na parkirišču sva našli naš rdeči avto in se odpeljali domov. Živimo v vrstni hiši, po celi dolžini opečnate tlakovane ulice stojijo hiše, ena ob drugi, ki so videti skorajda enake. Ista okna, ista temno rjava opeka. Hiše lahko razlikuješ le po barvi vrat in urejenosti sprednjega vrtička. Mami parkira avto zraven naše hiše, ki ima rdeča vrata in dokaj neurejen sprednji vrt. Za trenutek pogledam k našim desnim sosedom in vidim nekaj znanega v njihovem sprednjem oknu. Na njihovi okenski polici sedi naš maček Šef in naju z mami zdolgočaseno gleda. Meni se zdi to nedopustno, našega Šefa so nam ukradli! Odkorakam do sosedovih temno modrih vrat in pozvonim. Mami mojega izginotja ne opazi, saj zлага hrano iz prtljažnika. Ko se sosedova temno modra vrata odprejo, okregam žensko kar v nizozemščini: »Dajte mi našega mačka nazaj.« Sosega me začudeno gleda. Ko vidi, da kažem na Šefa, ki še vedno sedi na njihovi okenski polici, dojamem in mi ga prinese v naročje.

Po treh letih prebivanja na Nizozemskem sem tekoče brala in pisala v angleščini ter znala nekaj besed v nizozemščini, vendar še vedno nisem zares znala brati ali pisati v slovenščini. Moj vsakdanji govor je bil mešanica slovenščine in angleščine. Moja mami se spomni, kako sem jo enkrat vprašala: »Mami, kje imamo kakšen *rope*?« ali pa rekla, da sem »vzela fotografijo«, namesto da bi rekla, da sem fotografirala. Po teh treh letih se je očetu iztekla službena pogodba in preselili smo se nazaj v Slovenijo. Nisem zares razumela, da to pomeni, da ne bom več videla svojih mednarodnih sošolcev: Becce Emme, Myrte, Terese, Jacoba ... Prav tako si nisem predstavljala, kako bo moje življenje potekalo izključno v slovenščini.

Mami me je vpisala v waldorfsko šolo v Ljubljani, ker je menila, da bom imela tukaj lažji prehod v slovenski pouk kot na državni šoli. Tako sem vstopila v četrti razred in bila ponovno »ta nova«. Vsi sošolci so se med seboj dobro poznali, saj so skupaj preživeli že tri leta. Zdela sem se jim eksotična, ker sem prispela iz tujine in sem se večinoma pogovarjala v angleščini.

Danes imamo uro slovenščine. Ne maram slovenščine, ker je ne razumem. Ne vem, kaj so glagoli, samostalniki, pridevniki ... Ne razlikujem jih med sabo, nič mi ni jasno. Učitelj me popravlja, ker ne znam uporabljati dvojine, tako da se je kar izogibam. Danes moramo na glas brati pesmi pred celim razredom. Učitelj za vsako kitico nekoga pokliče, da jo na glas prebere. To najbolj sovražim. Mislím si: »What will my schoolmates think, ker potrebujem tok dolgo časa, da preberem štiri vrstice? I'll look so stupid in front of everyone!¹ Kaj če se ne bodo hoteli več družiti z mano?« Učitelj pokliče Anjo za prvo kitico, vendar je ne poslušam, ker se trudim dešifrirati naslednjo kitico za primer, da me pokliče. Ne pridem niti do sredine druge vrstice druge kitice, in Anja je že končala. Poskusim se skriti za sošolcem, ki sedi v klopi pred mano. Če me učitelj ne vidi, upam, da se me ne bo spomnil poklicati. Pokliče Davida, da prebere drugo kitico.

1

Kaj si bodo mislili sošolci, ker potrebujem tako dolgo, da preberem štiri vrstice? Izpada bom tako neumna!

Samo enkrat se mi zatakne. Učitelj nato izreče stavek, ki ga res nisem želela slišati: »Neža, prosim, preberi tretjo kitico.« Mine nekaj trenutkov, da najdem, kje na strani se nahaja tretja kitica, saj sem zaradi treme nehal slediti. Najdem jo in preberem prvi dve besedi. Pri tretji se mi zatakne do te mere, da mi mora učitelj pomagati. Skupaj bereva zlog za zlogom. Pred celim razredom. Vsi me gledajo. Vsi me čakajo. Z učiteljevo pomočjo preberem prvi dve vrstici kitice, le še dve sta mi ostali. Na koncu tretje vrstice obupam in utihnem. Po glavi mi začnejo vibrati misli: »I want to hide, I don't want to be here anymore. I'm so embarrassed. I'm so stupid. I just want to be as smart as everyone else who can read v slovenščini.«² Začne me stiskati v prsnem košu, ampak nočem jokati pred celim razredom, ker bi se tako samo še bolj osramotila. Učitelj namesto mene konča zadnjo vrstico kitice in nato pokliče Floro, da prebere naslednjo.

Za razliko od European School of Bergen me waldorfska šola ni vključila v dodatne učne urice. Znala sem govoriti slovensko, brati pa se bom že sproti naučila. Tako se je začela moja dolga bitka osvajanja slovenskega jezika. Izogibala sem se mu, kjerkoli sem le lahko. Nisem marala brati, najmanj pa v slovenščini. Ko sem brala, sem raje brala v angleščini, ker sem jo znala bolje. V osnovni šoli sem prepisovala odgovore iz sošolkinega delovnega zvezka za slovenščino, ona pa je prepisovala iz mojih delovnih zvezkov za angleščino. Z najboljšo prijateljico sva se večino časa pogovarjali v angleščini, ker sva obe radi gledali YouTube posnetke v tem jeziku. V angleščini sem se izražala lažje kot v slovenščini.

V prvem letniku gimnazije mi nikakor ni uspelo napisati eseja za več kot *cvek*. Profesorica mi je povedala, da ni težava v vsebini mojih esejev, ampak da sta moja slovnica in slog stavkov katastrofalna. Grozil mi je popravni izpit iz slovenščine. Oče mi je organiziral inštruktorico, ki mi je razložila, kako se v slovenščini sestavljajo stavki. Povedala mi je, da stavke oblikujem po angleškem vzorcu, le da uporabljam slovenske besede. V nekaj mesecih sem se naučila napisati esej za pozitivno oceno.

Vse od selitve v Slovenijo sem čutila močan odpor do slovenščine, saj sem verjela, da mi bo angleščina v prihodnosti bolj koristila kot slovenščina. Do konca srednje šole sem se zato borila proti njej. Šele zdaj, krepko po svojem vstopu v odraslost, se zavedam, da ima znanje slovenščine smisel. Občudujem posameznike, ki so večji mojega maternega jezika. Rada bi se izpopolnila v večini pisanja in izražanja v slovenščini. V nasprotju s stališčem, ki sem ga imela v mladosti, sedaj menim, da mi bo slovenščina koristila veliko bolj kot angleščina, saj si ne predstavljam, da bi se ponovno odselila – stran od družine, predvsem babice in dedka, stran od svojih prijateljev, stran od svojega resnično domačega okolja.

2

Želim se skriti, nočem več biti tukaj. Tako me je sram. Tako sem neumna. Želim biti tako pametna kot vsi drugi, ki znajo brati v slovenščini.

Italijanščina v obmejnih zidovih in mostovih



Sebastjan Brumat

1.23 Umetniški sestavek
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Z diskurzi, ki preizprašujejo uporabo italijanskega jezika v obmejnem prostoru, se srečujem že vse življenje. Razni obmejni narativi, ki izhajajo iz številnih izkušenj prebivalcev in prebivalk tega prostora, so zlasti v mojih zgodnjih letih oblikovali moj odnos do italijanščine. Tekom življenja pa se je moje mnenje zaradi osebnih izkušenj močno spremenilo.

Kot otrok se zaradi okolja, v katerem sem odrasčal, nisem pretirano navduševal nad učenjem tujih jezikov. Babica mi je pogosto pripovedovala, kako se je morala v svojem otroštvu, medtem ko je bila Primorska 25 let okupirana pod Italijo, prisilno učiti in uporabljati italijanski jezik; zato je dojemala učenje italijanščine kot podrejanje tuji oblasti. V takratnem času je bilo zavračanje uporabe italijanskega jezika oblika upora proti okupatorju. Njen odnos do italijanščine je vplival name, zato sem tudi sam razvil rahlo odklonilen odnos do italijanskega jezika.

Kljub temu sem z babico in preostalo družino večino časa gledal italijanske televizijske kanale, ker so bili tam večinoma zanimivejši filmi in risanke kot na slovenskih kanalih. Z gledanjem televizije sem se nevede naučil italijanskega jezika in ga postopoma vzljubil, kar mi je odprlo vrata k postopnemu zblíževanju z italijanskim jezikom in kulturo.

Gledanje italijanskih programov je številne generacije zblížalo z italijanščino, jezik pa je postal orodje za ustvarjanje čezmejnih vezi. Moja generacija je bila ena izmed zadnjih, ki so se z gledanjem televizije naučile italijanščine. Pozneje so v večini obmejnih krajev priklopili kablensko televizijo z raznoraznimi tujimi kanali, ki so pritegnili več pozornosti kakor italijanski. S tem se je med mladimi znižala raven znanja italijanščine. Kljub temu se je številni učijo v osnovnih in srednjih šolah, kar pripomore k ohranjanju osnovnega nivoja znanja, ki omogoča čezmejno povezovanje.

Prav tuji jezik na drugi strani državne meje ustvarja proces drugačenja in daje občutek tujosti, ko srečamo sosednje Italijane in Italijanke; obenem pa ravno znanje italijanskega jezika omogoča povezovanje in vzpostavljanje novih vezi z njimi. Večina obmejnega prebivalstva govori italijansko, kadar se znajde v situacijah, ko jo mora uporabiti. Najpogosteje takrat, ko gremo v Italijo po nakupih ali na kratke čezmejne izlete, kjer preživljamo prosti čas v barih ali restavracijah. Stiki z italijansko govorečim prebivalstvom se večinoma dogajajo spontano med opravki, kjer se tvorijo kratkotrajne vezi, ki se vzpostavijo in nato izginejo.

Sam najbolj občutim prisotnost meje s tem, da nimam na drugi strani nobenih poznanstev in prijateljev. Tudi številni prijatelji nimajo prijateljev iz Italije, zato si mnogi želimo, da bi bili obmejni kraji bolj povezani. Sam vidim vzrok v pomankanju dogodkov in prostorov, kamor bi zahajali eni in drugi, ali pa ovira mogoče tiči v sodobnem načinu življenja, kjer spoznavamo nove ljudi večinoma prek že obstoječih poznanstev.

Včasih, ko grem na enodneвне izlete ali pa po nakupih v sosednjo Italijo, imam občutek, kot da so stare zamere zaceljene in se italijanščina uporablja brez zadržkov. Kljub temu pa pogosto slišim godrnjanje čez uporabo italijanščine, češ da je to ena izmed oblik podrejanja. Od vojne je minilo že več kot 80 let in nekateri še vedno nejevoljno uporabljajo italijanščino ter se pri tem počutijo v manjvrednem ali celo ponižujočem položaju. Obenem pa slišimo, da je za Italijane in Italijanke slovenščina zahtevnejši jezik kot italijanščina za Slovence in Slovenke ter da je slovenščina za številne tuje govorce zaradi majhnosti in perifernega položaja v Evropi nezanimiva. Zaradi takšnih in podobnih očitkov se meja med državama še naprej izraža in nas ločuje.

Številni akterji, še posebej politični in lokalni veljaki, si prizadevajo z različnimi projekti in govori zakrpati stare zamere ter obmejne prostore ponovno povezati. Povezovanje mest »od zgoraj navzdol« doseže kratkotrajne učinke ali pa zaobjame le določene družbene skupine, ki so bolj nagnjene k obiskovanju kulturnih dogodkov. Do medetničnega povezovanja pa lahko pride le s spontanimi srečevanji in z ustvarjanjem novih prostorov za stike.

Negativen odnos do italijanskega jezika zagotovo ne ustvarja priložnosti za čezmejno povezovanje, temveč krepi obmejne nacionalizme. Pozitiven odnos do uporabe dvojezičnosti pa lahko v obmejnem pasu deluje antinacionalistično in pripomore h glajenju medetničnih trenj, kar nadalje omogoča grajenje čezmejnih povezav.

Lingvistična kameleonka



Vesna Petrič

1.23 Umetniški sestavek
DOI 10.4312/svetovi.4.1.155-160

Od malega so mi odrasli očitali, da sem jezikava. S tem so predvsem želeli povedati, kako jim gre na živce moje postavljanje zase in oporekanje vélikim krivicam, ki se dogajajo majhnim otrokom. Toda na neki način so imeli prav: rada sem se ukvarjala z besedami, jih formirala v čete in pošiljala v boj, če je bilo treba. Majhna in bojazljiva, kot sem bila, nisem imela veliko drugih orožij, in kmalu je beseda postala moja najboljša prijateljica. In z njo ... jezik.

Moja jezična pot se je pričela v majhnem stanovanju, kjer se je govorila *dolinščina*, ki spada med dolenjska narečja, čeprav je del notranjske regije. Ta pa je bolj kot ne le slovenski Božiček, v katerega nekateri verjamejo, drugi ne. Takrat sem samo sebe klicala Nesi in o sebi govorila v tretji osebi. Rada sem imela slikanice, zato sem se, še nepismena, pretvarjala, da berem. Svet besed je kot magična knjiga brbotal, čakal, da odprem platnico in skočim vanj. To se je zgodilo z mojim prihodom v osnovno šolo, kjer sem spoznala zategnjeno sestro svoje materinščine – knjižno slovenščino. Bila mi je všeč, zvenela je modro in učeno. Veliko sem jo srečevala in »človek se tega kar navadi«. V osnovni šoli je bila naša dolinščina prepovedana. Učiteljice so kakršno koli zavijanje, daljšanje in pokvečanje samoglasnikov ter premikanje j-jev zatirale v kali, vsakršna intervencija med poukom je morala biti v zborni slovenščini. Kdor je to pravilo kršil, se je moral prevesti. Učili smo se, kako zveneti pametni in učeni, kot radijski napovedovalci, takoj ko pa je zazvonil odmor, smo se »drli kot jesiharji« in tulili kot krave po hodnikih vsak v narečju svoje vasi. Kontrast bi bil zunanjemu opazovalcu nadvse bizaren, toda nam se je preklapljanje med jezikovnimi kodi vžgalo v podzavest in postalo normalno. Nekateri so te dobronamerne standarde učiteljic čutili kot zatiranje, jaz pa sem jih oboževala. Osvajanje visoke ravni jezika, obvladovanje slovničnih pravil in poznavanje izjem so bile kategorije nove jezične igre, v kateri sem želela nenehno napredovati vse do cilja – popolnosti.

Polnost pa se meri s petkami. Ocenjevanje znanja je to igro spodbujalo, vendar jo hkrati tudi polnilo s paniko. Kaj pa, če mi ne uspe? Kaj, če ne bom poznala pravilnega odgovora, ko me učiteljica vpraša pred celim razredom? Kaj, če ne bom znala določiti sklanjatve ali spregati glagola? Kaj, če se mi bodo smejali? Kaj, če bodo mislili, da sem neumna? Občutek, da morda ne poznam do potankosti jezika, v katerem mi je mama brala in oče prepeval, se je zasadil v meni in rasel kot plevel skozi razpoko betona. Tako se je dvom v lastno znanje razširil tudi na druge jezike, ki sem jih govorila in se jih učila. Moje jezikovno polje je prepreždal strah pred napakami in osramotitvijo – do neke mere ga še vedno. Postala sem mojstrica v zaznavanju potencialno napačnih struktur in se jim začela slalomsko umikati. Tako kot človek, ki noče neposredno naslavlјati sogovorca, ker ne ve, ali naj ga vika ali tika. Tako se skozi jezike premikam že celo življenje: tipaje in postopajoče.

Moj sindrom prevarantke, kot bi to poimenovali psihologi, se je občutno nadgradil v srednješolskih letih, ko sem stopila v popolnoma novo okolje. Tedensko sem več ur namenila učenju tujih jezikov. Vpisala sem se v »ruski razred«, sedela pri izbirni španščini in obiskovala tečaj arabščine. Angleščino sem nadgrajevala do mere, da mi je postajala že bolj domača kot slovenščina. Vsi jeziki so s svojimi znaki in pravili čebneli v moji glavi in naseljevali najrazličnejše kotičke mojih možganov v upu, da bodo tam ostali čim dlje in da jih bom kmalu zopet priklicala na ustnice ali na papir. Toda tukaj na hodnikih nihče ni kričal kot »ževau«, za malico se nikomur ni pilo »mlajku« ali pa jedel »kräh«. Na ljubljanski gimnaziji ni bilo preklapljanja med formalnim in neformalnim jezikom, kot tudi ne med formalnim in neformalnim odnosom. Pri pouku je večina dijakov in profesorjev govorila v ljubljanskem slengu, v prepričanju, da je to zborna slovenščina. V učilnicah sem naenkrat začela izstopati zaradi svojega »zavijanja« in »petja«. Vsakič, ko sem poskušala sodelovati pri pouku, so me prosili, naj se ponavljam, s čimer so v resnici prosili, naj se prevedem. Pogosto je to razred zabavalo. Bila sem dolenski paradni konj. Ta lingvistični cirkus je sčasoma privedel do mojega »peglanja« naglasa in ustvarjanja neke vrste slovenščine »s pridihom notranjščine«. Hkrati pa tudi do mojega nesodelovanja in strahu pred oglašanjem. Na poljskih hodnikih, ki so zaudarjali po elitizmu, sem se počutila nevidna in neslišna, toda obenem preveč slišana.

Bolj ko se je po eni strani večal moj odpor do izobraževalne institucije, intelektualne superiornosti ter formalnega in rigidnega učenja jezikov, bolj sem se po drugi navduševala nad ostalimi eksotičnimi naglasi. V dijaškem domu sem se prvič srečala s polno narečno pestrostjo, ki jo premore Slovenija. Med sabo se nismo razumeli in to nas je nadvse zabavalo. »Kako vi rečete« in »pri nas pa to pomeni nekaj drugega« so bili lahki nastavki za začetek pogovora ter spoznavanje novih ljudi. Svet se mi je odprl. Ker iz mojega konca ni bilo veliko predstavnikov, sem se družila z vsemi, še posebno veliko pa z govorniki rovtarskega narečja oziroma *Cerklani*. Tkanje prijateljskih odnosov z njimi je privedlo do jezikovnih stikov, ki so zaznamovali mojo govorico z najbolj vsakdanjimi frazami, ki so se pojavljale v naših prenatrpanih sobah. Tako se ujamem, da še vedno kdaj rečem »zapri luč« ali pa za spodnjo majico prej najdem besedo *kanetera*.

Kmalu sem se podala tudi »na teren«. V tretjem letniku smo odšli na Slovaško, ker nam v Rusijo niso dovolili. Naše znanje ruščine je bilo naravnost klavrno, zato smo vsi posegli

po angleščini, ki smo jo obvladali. Na drugi strani smo se srečali z vrstniki, ki se jim je zgodilo ravno obratno. Bili smo presenečeni nad njihovo nizko ravno angleščine – saj to je vendar mednarodni jezik. Pa še tako lahek, za povrhu. Šele pozneje sem se zavedela političnega ozadja lingvistične spretnosti naših prijateljev. Njihov nabor znanj je bil odvisen od tega, kaj je država želela, da se naučijo. Prvič sem pomislila, da poznavanje jezikov selektivno odpira vrata različnih svetov ter da ni samoumevno ali naključno, da se v mojih zvezkih kopiči toliko različnih sklonov, konjugacij in zaimkov. Leta pozneje se je zgodba ponovila, ko smo s kolegi etnologi odšli v Anglijo. V projektu so sodelovali še Litvanci in Španci. Oboji kar nespretni v angleščini. Jaz sem kot hispanistka premoščala naše razlike s Špankami, kolega rusist pa je navezal stik z Litvanci. Medtem ko so se drugi na predavanjih in delavnicah lomili ter se izražali na nivoju četrtošolčkov in smo le slovenski študenti suvereno delili svoje refleksije, so se v večernih urah njihovi jeziki razvezali in kaj kmalu smo se pobratili. Prvotne zadrege ob njihovem neznanju *lingue france* ne bi nikoli premostili, če ne bi znali tudi drugih jezikov in imeli razumevanja, zakaj je tako. Litvanci so nam zaupali, da si niso upali povedati, da je njihov prvi tuji jezik ruščina, saj je bila ukrajinska vojna v polnem razmahu.

Tako se mi je čedalje bolj izrisovalo vprašanje avtoritete in nadzora nad učenjem jezikov ter regulacijo izražanja. Doživljala sem pritiske, ki so me spodbujali k spremembi izražanja v različnih jezikih, tako formalnih kot osebnih, kar je vplivalo tudi na moj način razmišljanja, dojemanja sveta in same sebe. Skozi spremembo govora (*parole*) sem se spreminjala kot oseba – bodisi z učenjem novih jezikov (*langue*), narečij ali jezikovnih registrov. Včasih rečem, da sem lingvistična kameleonka. Z leti sem pravzaprav tako zdrgnila svojo luščinasto kožo, da je postala neprepoznavna. Ali pa se ta lahko prepozna tako, kot je najbolj varno in uporabno zanje – zlije se z okolico, da je kdo ne napade in da se lažje vključi. Velik del življenja sem posvetila študiju besednega in nebesednega. Intertekstualnosti in citiranju. Fiktivnemu in faktu in ter fiktivnemu znotraj faktu in obratno. Antropološkemu opazovanju kulturnih razlik na eni strani in njihovemu premoščanju s prevajanjem na drugi. Še danes razmišljam, kakšna oseba bi bila, če ne bi zapustila doma pri štirinajstih letih. Prav gotovo bi vsak dan šla v pekarno po *kræb* in *dejlala u fabrka*. Do kakšne mere besede, ki jih slišimo v materinem trebuhu, zaznamujejo naše življenje? Kako globoko seže narečje našega otroštva? V kakšen vrstni red zloga besede priučeni šolski glasek, ki posnema naše predavateljce? Katere misli tlačimo, ker niso primerne za dano okolico?

Odsotnost takih pritiskov sem opazila v španski kulturi, ki je jezikovno nekako samozadostna. Prvič sem to opazila, ko sem se po maturi odpravila v Seviljo, kjer sem opravljala delo *au pair* v štiričlanski družini. Starši so utopično mislili, da bom z otrokoma govorila angleško, kar je sicer pogosta praksa. Tujejezične varuške naj bi bile neke vrste intenzivna poglobitev v tuji jezik, pri Špancih najpogosteje angleški. Otroka sta milo rečeno protestirala in z mano govorila zgolj špansko, zato nisem imela druge izbire, kot da tudi jaz treniram. Na trenutke sem se počutila popolnoma bosa. V šoli smo se naučili raznolikega besedišča, ki sem ga obvladala, vendar »na terenu« nisem znala poimenovati vsakdanjih predmetov, da bi lahko povedala, s čim želim počistiti tla ali kaj želim za kosilo. Besede so postopoma kapljale v moj besednjak, toda vsakodnevno prevajanje me je fizično popolnoma utrudilo in

ob večerih sem padala v posteljo »kot klada«. Takrat sem spoznala, kaj pravzaprav pomeni tekoče govoriti jezik – to je v njem misliti. Moje misli so bile v Sevilli najprej slovenske, nato so hitro skočile v angleščino, od koder so se nekako vlekly ter preslikavale v španščino, pogosto z določeno mero improvizacije in ugibanja. Domačini so mi govorili: »Pa ti se tukaj ne boš naučila špansko. Naučila se boš andaluzijsko!« Družini je po drugi strani postalo jasno, da se njihovi otroci (niti starša) ne bodo tako zlahka priučili tujega jezika, če se ga na vse načine otepaajo. Ko smo skupaj gledali filme, sem se čudila sinhronizacijam in jim poskušala dopovedati, da je ogled v izvirniku vendar izjemna prilžnost za učenje angleščine, vendar se jim je to zdelo popolnoma bizarno in nemogoče. Moje presenečenje je bilo še večje, ko sem ugotovila, da ne gre zgolj za otroške filme, ampak da ob večerih starša gledata *Breaking Bad* (v slovenskem prevodu *Kriva pota*) z glasom nekega Juana ali Raula.

Kljub temu sem vztrajala, da smo se angleščine učili na bolj formalen način – za mizo, z vajami iz slovnice in konverzacije ter slušnega razumevanja. S tem sem poustvarjala »vtis šole« med poletnimi počitnicami. Za otroka sem postala »represivni organ poletja«, »angleška avtoriteta v hiši«, obupana nad neformalnim učenjem z igro in vsakodnevno improvizacijo. To je bil začetek moje pedagoške kariere. S španščino sem se še naprej ukvarjala, ko sem nadaljevala študij na fakulteti. Tu smo bili vsakodnevno potopljani v morje akademske kastiljščine, ki smo jo počasi osvojili, vendar se nato soočili z enakim problemom, ko smo hodili v Španijo za počitnice ali na študijske izmenjave. Dobri smo bili pri pisanju in poslušanju, nikoli pa zares v govoru, kaj šele v slengu in narečjih.

Ko sem pet mesecev živela v Barceloni, sem se povsod pogovarjala v kastiljščini. Včasih sem s tem nehote užalila Katalonce, ki so mi nazaj odrezavo odgovarjali v katalonščini. Počutila sem se, kot da sem s posedovanjem lingvističnega koda, ki sem si ga tako močno prizadevala osvojiti v daljni Sloveniji, na določenem (napačnem) ozemlju postala okupator in kolonizator. Hkrati sem se veliko družila z migranti in begunci iz Latinske Amerike, ki so mi včasih očitali ali zavidali »evropejskost«, ki je sama nisem nikoli niti čutila niti prepoznavala. Njihova španščina je bila drugačna, hitrejša, imela je specifične besede, ki jih nisem poznala. Moje presenečenje se je ponovilo in nadgradilo, ko sem izvedela, da se celo latinskoameriške televizijske vsebine sinhronizirajo v špansko španščino in obratno. Največ preglavic mi je delala argentinsščina. Ko sem se znašla v skupini z dvajsetimi Argentinci, ki so vsi vpili eden čez drugega, sem utihnila kot malo jagnje, paralizirana od nesposobnosti, da bi dosegla to hitrost jezika (iz katerega sem, za božjo voljo, diplomirala). Ko so me kaj vprašali, sem iz sebe stiskala stavke počasi in z veliko napora, medtem ko so vsi prekinili svoje žvrgolenje in se zagledali vame. Počutila sem se kot otrok, ki izreka svoje prve besede. Osramočena sem se zatekla k angleščini, stari psi, ki me je pridna čakala v kotu. Ves moj trud za doseganje popolne stopnje jezika se je zdel zaman. Vsekakor bi bilo bolje govoriti slabo in počasi kot sploh ne govoriti. Mar ne? Kljub temu sem vseskozi čutila pritisk, da mora biti moja španščina brezhibna in hitra kot Speedy Gonzales. Kar koli manj bo vendar pomenilo umazan pečat, ne le na moji lingvistični karieri, temveč na ugledu Univerze v Ljubljani. Medtem so bili vsi Španci prepričani, da je Slovenija poleg Latvije, Argentinci pa so Evropo tako ali tako videli kot eno samo državo, manjšo od svoje.

Svoje nepopolno znanje jezikov sem tako občasno dajala v nič. Svojo uspešnost sem merila, kot da je šlo za test DELE.¹ Ob tem sem popolnoma zanemarila svetove, ki mi jih je moje znanje odpiralo. Tega sem se zavedela šele ob pogovoru z umetnikom Frankom Rosalyjem. Ta s svojo partnerko Ibelisse Guardia Ferragutti ustvarja glasbo, ki črpa iz tem kolektivnega in individualnega kulturnega spomina prednikov. Čeprav imata oba korenine iz Latinske Amerike, le Ibelisse govori špansko. »Nikoli se nisem naučil špansko, ker mi starši niso dovolili. Meni in bratu so prepovedali, da bi govorila v španščini. Bila sta migranta prve generacije. Živeli smo v Arizoni, ki je bila zelo rasistična. Nista želela, da bi najina angleščina imela naglas. Želela sta naju zaščititi. Tako se nikoli nisem spravil k učenju. Že vrsto let čutim, da je to velik del, ki mojemu ustvarjanju manjka,« mi je zaupal. V tistem trenutku me je zaščemelo v nosu in orosile so se mi oči. Začutila sem val empatije do malega Franka, ki sta mu starša morala onemogočiti dostop do tako temeljnega gradnika identitete. Spraševala sem se, kako sta imela dovolj moči, da sta ga za to prikrajšala. Sama tega ne bi bila zmožna. V jezikih sem se nekako »razkomotila«, z njimi sem lahko vstopala v različne prostore (in case) ter prevzemala različne vloge. In to je privilegij. In sreča. In trdo delo.

Trdo delo pa ni zgolj učenje, temveč tudi poučevanje. Ko sem sama začela poučevati španščino, sem zaznala, da imam odpor do ocenjevanja, primerjanja in izpostavljanja napak. S standardnimi preverjanji znanja bi namreč prej ocenila njihovo razpoloženje, naspanost, živčnost, mentalno odsotnost, skrbi doma, tisto eno pozabljeno domačo nalogo in tako naprej. Njihova znanja so se razlikovala, vendar jih nisem videla razporejenih na linearno premico ali stopničke do španskega raja. Videla sem, da otrok, ki ima motnjo pozornosti, skoraj nikoli ne ve, kaj delamo, toda je edini, ki zapiše in izgovarja besede brez napake. Slišala sem, kako tečajnik, ki doma snovi ne ponavlja in vedno sprega glagole narobe, intuitivno uporablja prihodnjik, ker ga pobere od špansko govoreče žene. Da druga tečajnica razume veliko več kot ostali, vendar se v vsak njen stavek prikradejo italijanske besede. Da si eni zapisujejo, ker jih zanima, in drugi, ker jim jaz tako naročim. V svoji praksi sem si za vodilo zadala slavljenje heterogenih poti in hitrosti učenja. Spodbujanje napredka in izogibanje sramotenja učecih. V svoje ure vstopam z močno željo, da lahko ljudem nekaj predam, tudi če je nepopolno ter na trenutke zmotno, na način, ki bo zanje koristen in razumljiv.

Tako sem po mnogih letih samokritike ter mestoma sovraštva do sebe in svojega znanja spoznala, da našega jezikovnega sistema ni mogoče izolirati od nosilca – govorca – nas. Ocenjevanje znanja prek tečajev, certifikatov in podobno je prav gotovo plodno za teoretsko učenje jezika. Toda govoriti v učilnici, ko si obkrožen s profesorico in sošolci, ki jih poznaš, je nekaj popolnoma drugega kot govoriti z neznancem na ulici, ki momlja čez dolge brke in ima poleg tega močen naglas, ki ga ne znaš umestiti. Moj govor in negovor imata oba izjemno sporočilnost. Ob ljudeh, ki v meni zbujejo varen občutek in me pozorno poslušajo, veliko bolje govorim. Prav tako prilagodim svojo raven jezika in besedišče, ki ga uporabljam. S starejšimi ljudmi ne uporabljam uveljavljenih angleških tujk, z otroki, ki jih poučujem, ne govorim akademske španščine, s tujci, ki govorijo le osnovno angleščino, govorim s prepro-

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Certifikat o znanju španščine kot tujega jezika.

stejšim besednjakom. Inertna želja po tem, da si razumljen in da razumeš drugega, govorca samodejno potiska k prilagoditvi njegove komunikacije – bodisi spremembi jezika, narečja, hitrosti govora ali kompleksnosti jezika. In za antropologa je prav to ena od ključnih veščin, ki jih mora posedovati. Kajti dober pogovor sega mnogo dlje od postavljanja »pravih« vprašanj ob pravem času. Sega tudi v polje puščanja in čutenja tišine, spodbujanja sogovornika s »toplimi« mašili, parafraziranja, preverjanja lastnega razumevanja, zaznavanja čustev, ki se skrivajo med vrsticami, in težkih pomenov, ki čepijo za preprostimi besedami.

Prav tako okolje zaznamuje jezik, njegovo rabo in nerabo, ki ima lahko politične, razredne, regionalne ter druge konotacije in specifikke. Prav to pa ustvarja izjemno partikularnost in lepoto, ki jo pravzaprav nadvse obožujem. Zato se počutim domače, ko slišim seviljsko požiranje končnic besed ali cerkljansko pretvarjanje samoglasnikov v i-je v spremljavi goriških h-jev. Kako govorce z osebnimi posebnostmi plujemo čez različna morja in navigiramo jezikovne čeri, izostruje naše sposobnosti in nas bogati.

Nema Trsta bez tri prsta¹ – tranzitna kontemplacija



Lara Davidović

1.23 Umetniški sestavek
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Zdi se mi, da se je narava mojih notranjih monologov, ki me včasih vodijo do razumevanja določenih vsakodnevnih situacij, precej spremenila, odkar sem se zaradi nadaljevanja študija preselila v Slovenijo. Prejšnji konec tedna sem preživela na poti, tik zunaj te države – ali bi bila morda beseda *izlet* ustrežnejši izraz za moje sobotne aktivnosti? Tako kot večina Balkancev, ki živijo na obrobjih nekdanje Jugoslavije in težko iznajdejo inovativne načrte za netičen ali vsaj manj dolgočasen konec tedna, sem dan preživela v Trstu. V Trstu sem se imela približno tako, kot sem pričakovala, toda ko sem se vkrcala na svoj *double-decker* Flixbus za povratek v Ljubljano, svoje trenutno prebivališče, sem doživela nenavadno situacijo, ki se je izkazala za ustrezno snov za hkrati komičen in ilustrativen razmislek.

Ko sva se z mojim fantom namreč znašla pred avtobusom, ki naj bi naju odpeljal nazaj v Ljubljano, sva morala poleg validacije vozovnic konduktarju in sovozniku, ki je bil zadolžen za sprejem potnikov, pokazati veljaven potni list ali vizo. Vsi najini sopotniki, ki so se vkrcavali pred in za nama, so morali storiti enako, vendar sem svojo situacijo neformalne validacije potnega lista doživela nekoliko drugače. Zadeva je bila videti takole: moj fant, kot vsi potniki pred njim, konduktarju izroči bosansko-hercegovski potni list, odprt na prvi strani; ta ga mimogrede pregleda in ga brez besed vrne; nato pridem na vrsto jaz, s srbskim potnim listom – konduktar ga vzame, gleda morda sekundo dlje kot prejšnjega, zapre knjižico, pogleda med platnice, privzdigne obrvi in, ne preveč glasno, ne ravno zanesljivo, izgovori »*Serbija*«, mi ga vrne in se obrne. Nisem bila prepričana, kako naj interpretiram njegovo

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Naslov eseja je oblikovan kot besedna igra na podlagi popularne fraze »*nema krsta bez tri prsta*« (slo. *ni križa brez treh prstov*), ki se nanaša na srbski pozdrav s tremi prsti in implicira pravoslavno vero večine srbskega prebivalstva.

izjavo. Je želel reči »*Serbija!*«, »*Serbija?*« ali »*Serbija ...*«, kjer bi klicaj morda pomenil navdušenje, vprašaj zmedo ali presenečenje, tri pike pa neodobranje? Med vožnjo sem poskušala ne preveč razmišljati o tem nenavadnem vzkluku, toda bilo je skoraj nemogoče, tako da sem o njegovih možnih pomenih razmišljala celo popoldansko vožnjo do Ljubljane.

Moje interpretacije nejasnega vzkluka »*Serbija*« so se nizale hitro. Bile so si precej različne. Glede na to, da imam bolj ali manj svežo izkušnjo selitve iz Srbije v Slovenijo, torej v Evropsko unijo, je moje vsakdanje življenje večinoma zaznamovano z neko obliko birokratskega etiketiranja. Ker so me različni birokratski postopki precej okupirali, pogosto svojo prisotnost v novem okolju enačim z oznakami, kot so tujka, študentka migrantka, oseba z začasnim prebivališčem v Sloveniji. Zame je nenehno ukvarjanje z birokracijo in umeščanjem svojega bivanja v novi državi v veljavne administrativne okvire hitro postalo vzrok skrbi in anksioznosti, zato sem najprej pomislila, da je bil konduker presenečen nad mojim srbskim potnim listom, ker je morda v preteklosti imel težave s srbskimi potniki – morda so potovali brez vize ali pa so postopki potne kontrole trajali dlje, če na avtobusu niso bili zgolj državljani EU, saj italijanska vojska pogosto nadzoruje italijansko-slovensko mejo, ne glede na to, da formalne meje ni več. Kakorkoli, in verjetno povsem brez razloga, sem se najprej počutila *interpelirano* kot kakšen birokratski subjekt – migrantka ali tujka v tranzitu.

Zatem sem prišla do druge misli – konduker ni rekel »*Srbija*«, ampak »*Serbija*«, in je govoril, kolikor sem lahko razbrala, italijansko, kar sem razumela kot znak, da verjetno ni državljan katere od bivših jugoslovanskih držav, torej ne *Balkanec* ali kakorkoli bi to želeli poimenovati – zato sem iz arzenala možnih razlogov za dano situacijo izključila določene predsodke, tipične za postjugoslovanske prepire. Pomislila sem, da je morda za tem tonom stal kakšen povsem osebni razlog: nekdanja ljubezen ali pa eno samo neugodno druženje s Srbi, ki se mu je vtisnilo v spomin, bolj kot bi želel. Zelo možno je, da pretiravam. Na tej točki svoje devetdesetminutne analize dvoumnega trenutka sem se zdržnila iz svoje komične premise, da namreč nevarnost in neodobranje vedno pretita Srbom, ter začela iskati odgovor na svojo uganko na bolj veseli strani – morda konduker spremlja dogajanja v zvezi z napeto politično situacijo in študentskimi blokadami, ki v Srbiji potekajo od konca prejšnjega leta, in ga je moj potni list le spomnil na ta dogajanja. Mogoče je tudi, da je bil seznanjen s študentsko kolesarsko turo do Strasbourg, ki je bila v času, ko sem bila v Trstu, še vedno aktualna.

Presenetilo me je, kako se prvič po 23 letih svojega življenja nedvoumno in pozitivno poistovetim z bojem v svoji rojstni državi, jo prepoznavam kot svoj dom in se z njo, pa tudi z njenimi ljudmi, istovetim na način, ki ga pred selitvijo nisem poznala. To me je hkrati navdušilo in vznemirilo. Že prej sem se v svoji diplomi ukvarjala z vprašanjem, kako izkušnje notranje migracije vplivajo na načine, kako srbski študenti v Beogradu doživljajo koncept doma, in katere dejavnosti izvajajo, da bi si občutek doma ustvarili v začasnem življenjskem prostoru. Ugotovila sem, da so za študente migrante glavni viri za ustvarjanje doma materialni predmeti, medosebni odnosi in vsakdanje navade. Danes pa, v kontekstu lastne migracije, ta seznam lahko dopolnim – moj odnos do idej o domu, pripadnosti in migraciji so oblikovali birokracija, aktualna politična dogajanja, celo notranja prisvojitve samozadovoljnih idej, in, resnično, tudi materialna kultura – vendar ne tista, ki bi jo instinktivno povezala s

tem procesom. Ko sem živela v Beogradu, so me k razmišljanju o domu največkrat spodbujali prenosljivi, ljubi predmeti – darila, knjige, spomini iz otroštva; danes pa sta predmeta moje osebne materialne kulture, ki me brez dvoma najbolj spodbujata k razmišljanju o naravi koncepta doma, prav moj potni list in dovoljenje za začasno prebivanje – predmeta, ki sem ju pred selitvijo dojemala kot zgolj formalna, danes pa ju vidim kot izrazito evokativna.

Ko se približujem zaključku te miselne uganke, se moram še enkrat vrniti k misterioznemu vzkliku »*Serbija*«. Prepričana sem, da je oblikovanje različnih, napol zavednih načinov jezikovnih prilagajanj nekaj, s čimer se srečuje vsak, ki se vsakodnevno giba v prostoru, kjer se ne uporablja njegova materinščina – in zdi se mi, da moje jezikovne navade po prihodu v Slovenijo vsaj delno pojasnjujejo razmere, v katerih se je rodila trenutna tranzitna kontemplacija. Opazila sem, da sem po selitvi in potopitvi v učenje novega jezika začela v mislih vstavljati ločila v tuji govor – predvsem v izjave ljudi, s katerimi se pogovarjam iz oči v oči. Tako kot jasno pokaže izjava, ki tvori jedro tega besedila, lahko rečem, da sem v zadnjem času skoraj vsaki ne dovolj jasno izrečeni izjavi v glavi pripisala vprašaj, klicaj ali tri pike. Kot da mi ta tihi, notranji akt dopolnjevanja izrečenega, ki mi ga zaradi omejenega razumevanja še ne uspe v celoti zajeti, pomaga zapolniti razpoke v pomenu ter me približa temu, kar ni neposredno povedano, pa vseeno obstaja v ozadju: v slengu, v intonaciji, v širšem družbenem kontekstu, ki se mi še vedno izmika.

Ko razmišljam o tej drugi plati učenja in spoznavanja jezika – tisti, ki ni obremenjena le s slovnico in pravopisom, pač pa je prav tako (če ne še bolj) zaznamovana z omejenimi možnostmi komunikacije, ki jih prinaša življenje v neznanem jezikovnem okolju – se tudi spomnim, kako me je ena od mojih najbližjih prijateljic in kolegic, ko me je prvič obiskala v Ljubljani, vprašala: »*Od kod zdaj toliko gestikuliraš med govorjenjem? A je to slovenska stvar?*« Takrat se še nisem zavedala, da se je moj način govora sploh spremenil – da je postal manj monoton in bolj animiran, kot da bi besede iskale pomoč telesa, da bi bile stvari dovolj jasne. Odgovorila sem: »*Ne, ravno obratno – mislim, da mi veliko bolj mahamo z rokami.*« Potem sem se spomnila na še nekaj slovenskih kolegic, ki so mi omenile določene geste, ki jih uporabljam, ko se trudim razložiti stvari v jeziku, ki ga poznam le na pol, in jih razumele kot simpatične. Jaz pa na drugi strani nisem bila prepričana, kako naj se ob tem trenutku prepoznanosti v resnici počutim. Kakorkoli že, tako sem nenamerno prepoznala še dva artefakta svoje jezikovne »izmeščenosti«: gestikulacijo in ločila kot *ad hoc* pripomočke za učenje jezika onkraj besed in črk ter za približevanje pomenom onkraj semantike brez družbenega konteksta.

Birokratski artefakti, sveža izkušnja migracije in nove jezikovne navade so nedvomno odigrali pomembno vlogo v tej zgodbi, ki se je razpletla na način, ki ga v svojih premišljevanjih vendarle nisem predvidela. Ko sem prispela v Ljubljano in se spustila z zgornjega nadstropja Flixbusovega *double-deckerja*, sem med vrvežem izstopajočih potnikov zaslišala radio v srbsčini in napovedovalca, ki je kot naslednjo pesem v oddaji napovedal pesem Bajce Malega Knindže, kontroverznega izvajalca srbske krajiške domoljubne glasbe. Izkazalo se je, da je bila stvar več kot preprosta – in predvsem smešna. Glavni voznik avtobusa, kolega konduktorja, je bil (verjetno) iz Srbije, kar je nato tudi spodbudilo vzklik »*Serbija!*« – zaključen z mojim naknadno in morda optimistično dodeljenim klicajem.

Hatujui



Gaja Basaj

1.23 Umetniški sestavek
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V vročem majskem večeru se prebijamo čez polne ulice in v gručah prečkamo kaotične ceste. Na njih mrgolijo avtomobili, tovornjaki, *bodabode* in *bajaji*, ki kljub vsej zmedi uspešno navigirajo s pomočjo hupanja. Ljudje nas radovedno opazujejo in ogovarjajo. Zdi se zelo odprti. Želim jim odgovoriti, vendar ne prepoznam pomena njihove govornice, iz mešanice zvokov ne razločim niti posameznih besed. Zato se jim lahko samo zmedeno nasmiham.

Ko pridemo do tržnice, postanejo občutki še intenzivnejši. Sprehajamo se med tisočerimi pari čevljev, kavbojk, stojnicami, polnimi oblek in nakita, ločenimi z ozkimi prehodi. Naučim se prvih besed v tujem jeziku: »*No, asante sana – ne, najlepša hvala,*« ki postanejo moj ščit pred prodajalci, ki me obkrožajo na vsakem koraku. V vsej zmešnjavi mi ne uspe zares razmišljati o tem, da mi je neprijetno uporabljati svahilijske besede, da se počutim, kot da ne spadam v ta jezik. Saj je vendar očitno, da sem tujka: »*mzungu – belka*« kličejo za menoj. Odrinem te misli in se opomnim, da je poskus prilagoditve okolju, v katerem se človek nahaja, vendarle univerzalen znak spoštovanja.

Celotna izkušnja neznanega okolja bi bila zame verjetno precej drugačna, če mi ne bi ob prihodu v Dar es Salaam družbe delala prijateljica iz Slovenije, ki je tam živela že nekaj mesecev. Zame je bila mediatorka kulturnih pomenov, razložila mi je tudi pomen osnovnih fraz: »*Mambo pomeni nekaj v smislu 'kako si.' Odgovori jim s 'poa', to pomeni 'v redu.'*« Opremljena z novim znanjem sem se počutila bolj suvereno in sproščeno. Opazovala sem prizore iz vsakdanjega življenja, ženske, ki so hodile po ulicah s košarami sadja na glavi ali pa prodajale hrano na stojnicah, otroke, ki so mi veselo mahali, občasno je mimo prikorakala kakšna koza.

Večino potovanja sem preživela v Mbeyi, ki sem jo spoznavała v družbi prijatelja Lawrencea. Ker sem mu zastavljala veliko vprašanj o položaju žensk v družbi, je poklical eno izmed svojih nekdanjih učenk, ki je bila pripravljena spregovoriti o tem. Dogovorili smo se, da se z Nalo srečamo v kavarni Maua, povsem upravičeno poimenovani po cvetju, saj je v najrazličnejših barvah in oblikah krasilo teraso.

Naročili smo mangov sok in se spustili v pogovor. Nala je pripovedovala o *unyagu*, tradicionalnem obredu prehoda žensk v odraslost, njegovih sodobnih oblikah, odraščanju in odnosu moških do žensk. Njena odkritost me je presenetila in pomirila, saj me je pred pogovorom skrbelo, da bi bil moj način komunikacije, s katerim sem želela nežno pristopati k težjim vprašanjem, napačno razumljen kot vsiljiv. Vseeno se sprašujem, ali Nala o teh zadevah z enako sproščenostjo govori s svojimi vrstnicami in sorodnicami. Kaj pa z moškimi? Morda se odgovor skriva v dejstvu, da smo se pogovarjali v jeziku, ki za nikogar od nas ni materni. Je angleščina omogočala dovolj čustvene razdalje, da smo se počutili varne govoriti o intimnih temah?

Jezikovna razlika je tudi sicer pomembno vplivala na komunikacijo. Vsi Tanzanijci namreč niso večji angleščine, ki je poleg svahilija uradni jezik. Posledično sem se z večino pogovarjala v nekakšni poenostavljeni govorici: zanemarili smo glagolske čase, predloge in vsa preostala slovnična pravila, sama sem se prenehala truditi za pravilno izgovorjavo glasov. V tem načinu sporazumevanja sem začutila udobje in sproščenost, jezik je postal nekaj živega in gnetljivega.

Vsakdanje interakcije in nakupovanje niso bili zapleteni, težji so bili poskusi antropoloških raziskovanj. Sporočila, izmenjana s pomočjo spletnega prevajalnika, so bila skopa in rigidna, zato mi je na pomoč priskočil Lawrence. Ob obisku starejšega gospoda, ki me je naučil izdelati žlico iz bananinega lista, sem želela izvesti še krajši pogovor, vendar sem ugotovila, da je stvar zelo zapletena. Kako naj bom pozorna na vzdušje, občutke, način, kako je povedal stvari, torej vse tisto onkraj besed, če pa še teh nisem razumela? Lahko sem izhajala zgolj iz lastnih predpostavk, ki so bile v tem okolju morda povsem zgrešene. Lawrence je sicer tolmačil njegove besede, vendar je bil njegov prevod selektiven, informacije pa okrnjene. Vsi neuspeli poskusi in napačne interpretacije so me nekoliko frustrirale, vendar sem pri sebi vedno ponavljala besede prijatelja Jeremiaha: »*We are patience.*«

Njegove besede so mi odzvanjale v glavi tudi ob obisku šole, ko so me učitelji povabili, naj kósim z njimi. Postregli so mi *pilau*, jed iz riža in zelenjave, vendar brez pribora, saj je v Tanzaniji običajnejše prehranjevanje z rokami. Opazovala sem hitre in elegantne gibe učiteljev, ki so bili povsem drugačni od mojih nerodnih poskusov stiskanja riža v kepice s pomočjo dlani. Ti so med učitelji sprožali valove smeha. Nisem bila prepričana, kaj točno pomeni njihov smeh, vendar sem upala, da gre za topel, ne posmehljiv ton. Ponovno je šlo za kulturno razliko, ki jo je treba razumeti in prevesti skozi različne kontekste, šele takrat jo lahko v celoti razumemo.

Moje razmišljanje prekine trobljenje *bodabode*, motorja, ki je priljubljeno prevozno sredstvo in tudi vir prihodka za mnogo moških. Za tisoč tanzanijskih šilingov me odpelje k Jeremiahu, pri katerem prebivam. Potolaži me, ko prizna, da je imel tudi on težave z uporabo

pribora, ko je potoval po Evropi. Hišo, ki jo oddaja popotnikom, je opremil z mislijo na to, da bodo v njej bivali tujci. V njej sta kavč in ogromna televizija, kuhinjsko pohištvo je prelepil z nalepko, ki imitira marmor, na posestvu biva tudi psička Gina – udomačevanje psov v Tanzaniji sicer ni tako pogosto. Postane mi jasno, da Jeremiah ve veliko več o moji kulturi kot jaz o njegovi, tudi on je predstavljal presečišče dveh svetov.

Z njim sem se vedno pogovarjala v angleščini, nekoč pa me je popolnoma presenetil, ko je v svoj govor vključil slovensko frazo »*Ne vemo*«. Spomin me je odnesel na prvi dan v Tanzaniji, ko sem prijateljico iz Slovenije slišala suvereno narekovati pot vozniku v svahiliju: »*Kaka, kushoto! – Brat, zavij levo!*« Občutek je nenavaden, nekakšna mešanica tujstva in bližine – nekaj, kar sem pravzaprav čutila ves čas.

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