work shows how patients and medical providers, in different but mutually congruent ways, leverage the emerging private medical sector as brokering strategies with and within the public health institutions.

List of Figures

Dedication/Posveta

Ova disertacija je posvećena mom ocu, Branku Pantović.

This dissertation is dedicated to my father, Branko Pantović.

Acknowledgments

At the core, this research showed the importance of trust, and I could not have written this dissertation without the trust of so many people. I am grateful for the support and confidence of various institutions, from the health care institutions in Serbia (maternity hospital, *dom zdravlja*, and the private maternal care institutions), to my academic home institution, the University of Pittsburgh (the Dietrich School of Arts and Sciences, UCIS European Studies Center and the Department of Anthropology).

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I will forever be grateful to Dr. Robert M. Hayden for not only teaching me academic rigor and writing with confidence but for his support and guidance throughout this six-year endeavor. I am likewise grateful to my informal advisor, Dr. Tomas Matza for his patience and guidance. I would also like to thank Dr. Kathleen Musante for teaching me to become a good ethnographer, Dr. Gabriella Lukacs for asking the tough questions, and Dr. Martha Terry for her help in the final

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Defending my dissertation on International Women’s Day and becoming the first woman in my family with a doctorate was such a grounding experience. I am always inspired by the women closest to me, Maja, Jovana, Nevena, and Taca, the courage and strength they radiate. I want to thank my women, *moje žene*, for their love and friendship. Especially Nevena for the dissertation poster that was the best defense poster in the history of the Anthropology department. I am so grateful to Jovana for introducing me to Nemanja Manojlović, my love, and my partner. He flew over oceans for me and always makes me smile.

Finally, words cannot express my endless love for my family– Vera Pantović, Branko Pantović, and Aleksandra Pantović. You are my compass, my anchor.

Volim vas najviše.

A Note on Names and Translation

In this dissertation, all of the names of my interlocutors are pseudonyms. To protect anonymity, I also use composite characters based on interactions with multiple people. The names of private practices and institutions have also been altered or discuss in generic terms (example: "the maternity hospital," "the primary care center").

In constructing the pseudonyms, I reproduced the naming structures that were used in practice. For example, the new mother's I spoke with I was on a first name basis. In regards to the hierarchies within the health care institutions, I wanted to reproduce the unequal naming system as it is used in practice among the medical practitioners. Nurses, nurse-midwives, residents are called by their first names (Darko, Vera, Mira), while staff physicians and specialists are referred to by their title and last names (example: Dr. Ivanović or Professor Jovanovic).

All of the translations from Serbian to English are my own. I have used letters with diacritical signs for the names of people and places throughout the dissertation. The Serbian language is phonetical; each letter of the alphabet represents one sound.

Forward

> **"To negotiate, n**." according to the Oxford dictionary, is a verb with several meanings including:
>
> 1. to obtain or bring about by discussion.
>
> 2. to find a way over or through (an obstacle or difficult path).

I find that the verb to *negotiate*, in both meanings noted above, truly encapsulates the goal of this project to present the various strategies, micro level, daily negotiations used by patients and medical service providers to try to obtain their desired goals. It also applies to my case, in which the desired goal is a Ph.D. in anthropology. In the case of my interlocutors, the goal was to be treated as more than a birthing body or an impersonal medical expert, but rather as a social person, who both *is* and *has* someone.

This dissertation itself is a product of much negotiating: with my adviser, with various Internal Review Boards (IRB), and with the dissertation committee. I also had to negotiate my positionality as a native anthropologist, as a researcher conducting participant observation in a medical institution, specifically a maternity hospital, and the one where over thirty years ago I myself was born. I had to negotiate the trust of my informants whose own personalities varied within these medical institutions. However, out of all of these, the most important forms of negotiations that this dissertation deals with are those going on every day in the second-floor delivery ward of the maternity hospital in Novi Sad.

1.0 Introduction

1.1 **Aleksandra's negotiating strategies**

The summer after completing my first year in the graduate program at the University of Pittsburgh, I was in Novi Sad having coffee with my long-time friend Aleksandra, who was expecting her second child. She and her husband were in their late twenties, university-educated and both from Novi Sad. Aleksandra had just gotten back from her first pregnancy class. Classes that are offered free of charge to all pregnant women in the city so that they can be better prepared both physically and psychologically for giving birth and taking care of a newborn baby. In Serbia, access to free maternal care is a constitutional right. Every pregnant woman in Serbia regardless of her insurance status is guaranteed completely covered care through the public health care system. This coverage included the classes Aleksandra started attending that day.

She was telling me about the class, the women she met there and about her previous and current pregnancies. She was due to give birth in less than two months in the only maternity hospital in the city. This was the same place both of us were born and the same institution where she had given birth to her son two years earlier.

This is a public maternity hospital, which should mean that her care was covered entirely by the universal health care insurance provided by the Serbian state. Moreover, she was telling me about the loans and additional jobs she and her husband had to take out to pay for all of the tests, check-ups, and screenings she was doing within the private health care sector. She kept telling me, "I need a *veza*," a connection and informal way to help her find a way through her next birthing experience.

Informal relations were nothing new or extraordinary in the Serbian context (Stanojević, Gundogan, and Babović 2016) and eastern Europe. Nor are informal economies present only in this part of the world or in post-socialist settings (Haller and Shore 2005, Tong 2014, Nuijten 2003, Duarte 2006). We can broadly define these strategies as the invisible and unwritten rules and practices of "getting things done" (Ledeneva 2008, 120). Specifically discussing the Serbian concept of *veza*, we can note its literal meaning of 'connection,' but in its common wider meaning referring to the use of informal contacts to obtain access to opportunities that are not available through formal channels (Stanojević, Gundogan, and Babović 2016, Cvejić 2016).

I asked Aleksandra what she meant by finding a connection and why she thought she needed one in the first place. What she meant was finding a way of managing her prenatal care simultaneously in the public institutions for free and paying out of pocket for services from a private institution. Aleksandra kept telling me, "I am doing everything private (*privatno*). Even though it is costly and it was hard for us to get that money."

When I asked her why she could not get adequate prenatal care in the public health care system, Aleksandra paused and said she probably could, but her gynecologist in the maternity hospital also works in private practice in the city. Seeing him at his second place of work was, she felt, the only way for her to make sure he would "be there" for her and serve as her *veza*, her connection with and within the hospital. This was important for her because during her previous birth experience she felt completely abandoned by the medical staff. With her firstborn, she did not seek out private prenatal care, or a connection of any kind. Speaking in hindsight, she saw that as a big mistake on her part, one that she wanted to avoid this time around. She said: "I have stopped believing in the devotion of the medical staff."

Aleksandra's story sparked my interest in understanding this intersection of private health care practice with the public health care system, and to investigate Aleksandra's phrasing this juncture using the well-established local concept of informal relations, *veza* (plural *veze*). Contrary to the general assumptions inherent in this term, the relationship Aleksandra described as her veza was not an informal relation but rather an institutionalized relationship between a health care provider and patient.

Michele Rivkin-Fish (2005b)'s work on women's health care in Russia served as both a theoretical springboard for this dissertation and a guide on how to navigate my own experiences within the maternal care setting. Women in Russia were, like Aleksandra, attempting to find flexible pathways to desired childbirth experiences in public maternity hospitals.

Rivkin-Fish (2005b) distinguishes two seemingly opposite paths to achieve this outcome – personalizing strategies and privatizing strategies. A personalizing strategy is a Russian equivalent to *veza*; it is an informal relation to recognize and place certain persons within the hospital as part of one's kinship and friendship network. A relationship of trust and reciprocity is thus established between those women and the medical providers, they consider themselves as belonging to each other (Rivkin-Fish 2005b). Rivkin-Fish describes the privatization of formerly public services and the consumer-patient model as distinct and separate from this type of strategy: "the key difference is that personalizing strategies draw on the emotional and moral element of personal relations (*svoi*), whereas in privatizing strategies, the element of business/monetary exchange is overt and legitimate" (Rivkin-Fish 2005b, 10).

Aleksandra's description of why she was doing everything double, in the private and public sectors, seemed to be bringing these two strategies together rather than separating them thus blurring the boundaries between illegitimate and legitimate. Rather than placing a boundary and

making categories between the two strategies for my dissertation research, I wanted to look at how these strategies are enacted and negotiated in practice, and in what larger political, economic, historical power configurations are they taking place (Stan 2012).

1.2 **The negotiating strategies of young gynecological residents**

Write this down in that research of yours, so it is known![1]

This fieldwork would not have happened if it were not for my informal relationships and connections in the city. Knowing the right people, going to the same high school with some of them and just simply being from the same town allowed me to gain access into places previously unattainable to social science researchers of maternal care. I was a part of their world; they could place me, my friends, and family within their social networks (Brković 2017a). The new patients or medical providers whom I would meet would try to locate me within their existing social network. This contributed a great deal to my negotiation process of getting access to my desired field sites.

I was the first anthropologist to conduct fieldwork inside any maternity hospital in the country. Previous research on maternal care relied exclusively on interviews and questionnaires, all of which took place well outside the delivery wards of hospitals (Arsenijevic, Pavlova, and Groot 2014, Sekulić 2016, Stankovic 2017b, Stanković 2017). The opportunity to conduct ethnographic research within and with all of the actors involved in maternal health care provision

[1] Klara, second year volunteer resident in the maternity hospital.

allowed me to have a greater understanding everyday obstacle that prevents health care workers from providing the kind of care both they and their patients sought after.

I had the opportunity during my fieldwork, to meet so many incredibly kind and dedicated medical professionals. The people that stood out the most and with whom I related the most were the young residents and interning nurse-midwives. We shared a common experience; we were all there in these institutions of maternal care to learn. I learned a lot from these young people and excellent caregivers. We would talk about how hard their work was and how much they loved it nonetheless. On more than one occasion, I was told to write something they said down in my little fieldnote book "so it is known."

I spent time with the gynecological residents while they were writing up medical case histories and discharge papers of patients. The case histories were usually written on old typewriters moved around throughout the maternity hospital. On the baby-friendly wards[2], in the back of an exam room was where most of this typing would take place. They would jokingly call that space their little dingy hovel (*ćumez*) and would sneak in fruits, coffee, and snacks to keep them going while they type. The residents spent so much time typing that the nursing staff would behind their backs call them the "typists" (*kucači*). These were mostly young women in their mid-twenties. They all completed their M.D.s and were now on track to becoming specialists in obstetrics and gynecology. Most of them were also in graduate school working towards a Ph.D. in medicine. For the gynecological residents, it was mandatory to spend at least a year in the maternity hospital.

[2] This means that the babies were rooming in with their mothers after delivery.

Most hoped that they would be asked to stay on in the hospital after residency. Even getting a position as a resident was hard as the Ministry of Health sets out the quotas for each sector of medicine for a given year. Some residents I met did not want to become gynecologists, but this was the only residency that they liked from the limited options provided. Klara, one of the third-year residents, told me: “It was either this or orthopedics. I do not have the real straight for that. Mostly men chose that one!” I met Klara for the first time in one of the private “pregnancy” schools that offered classes similar to the one Aleksandra was taking in the public sector. These schools were similar. The women had to pay for the classes and this private practice, and they were taught by the residents working in the maternity hospital. When I asked Klara why she was working two jobs, she laughed: “I am paying the state to work for them! I have been volunteering for two years. I work for a smile”.

In 2014, in an attempt to curb the growing national debt, the Serbian government passed two harsh laws. One “temporarily” cut the salaries of employees in the public sector and monthly pensions of all pensioner. The other placed a temporary ban on new permanent hires in the public sector. The law on salaries and pensions was partially lifted in 2018, but the law banning employment in the public sector was extended until the end of 2019.

The ban on new hires means that it is increasingly difficult for young residents to get even short-term contracts with the hospital. Some like Klara were paying for their residency[3] by moonlighting as a lecturer, and some managed to get contracts with primary care centers and general hospital in other towns with the obligation of working there after residency. Some had

[3] A year of residency costs roughly 1 500 dollars, the average Serbian monthly salary is less than 400 dollars.

contracts with private gynecological practices. Darko, a tall dark-haired resident, whose residency was through a private practice, said:

> *My paperwork is through a private practice, but I am paying for it on my own. It is paperwork only because when I wanted to apply for residency, there was no gynecology residency option. I am still working part-time at this private. It is not legally completely solved, but we found a way (snašli smo se).*

Darko was describing his path of negotiating, finding a way through obstacles to obtain his goal of a gynecological residency. Darko's strategy also included the intersection of the public with the private health care sector. He then told me that that was how things work, "we all work two jobs it is horrible. Not just us residents, the specialists too. We all work in the private sector and the public." Darko and many others were working two jobs and getting half of a paycheck.

> *Volunteer residency means you pay to work. I knew I wanted to do this work. In the meantime, you realize there are things in your control and so many things that are not. I did have people tell me that I was no one (niko) and that you will never get this residency. So, I found a way to get it through private practice.*

Darko was expressing the need for negotiating his position in the public hospital through private practice. He was glad that he could use the private sector as a strategy to get his desired residency in the maternity hospital, but he was not in favor of the privatization of public health care: "There has to be a balance, not everything can be on the market. The story is that when everything is on the market, everything will be better it will not." And in the writing of most liberal public health policymakers that is the narrative (Arsenijevic, Pavlova, and Groot 2014,

2015a, Buch Mejsner and Eklund Karlsson 2017a, Buch Mejsner and Eklund Karlsson 2017b, Dickov 2012, Kornai 2008, Kornai and Eggleston 2001, Kornai, Rose-Ackerman, and Collegium 2004, Perišić 2014).

The introduction of market practices into health care would curtail the need for informality in Serbia. Sabina Stan's work on the ambiguity of gifts and commodities questions this assertion in much the same way as Darko: "allowing doctors to practice in both public and private settings opened new spaces for informal exchanges, as doctors designed new schemes for shuffling patients between the two sectors" (Stan 2012, 78). Stan sees the private practice as a predatory practice for most patients (Stan 2012). I agree with Stan in that the entangling of private and public opens new spaces for informality. However, I caution about labeling all interactions of doctors with patients who are moving between the private and public sector as a predatory act that undermines any possibility for establishing a personal relationship between patients and providers. "By undermining the possibility of developing personal relations, predation lays bare the stark inequalities of power between patient and health care personnel" (Stan 2012, 79). The market-based health care interventions into the public health care system have indeed intensified the existing unequal power structures not just between doctors and patients.

The ability to serve as a connection for someone is in itself a position of power (Brković 2017b). Through discussions with people like Darko and Aleksandra, I came to question the assumption that privatizing strategies undermine the possibility of developing personal relations in a public hospital. For some medical providers, the flexibility to move between the two sectors not was a sign of power, but a path for being seen as trusted and respected experts. I asked Darko if he agrees with Aleksandra that paying for prenatal care was a strategy to obtain a veza in the hospital:

I that a veza? I mean when you want to get your bike fixed you have your bike guy. It is the same with the doctors, and you want to go to the person who is qualified. A veza for better treatment? I doubt it. We treat all the same, but a veza to feel more secure? That does exist. However, I think that is normal. You feel secure, even though we all have the same knowledge it is a matter of personal relations (ličnih odnosa).

1.3 **Private within the public**

This dissertation is an ethnographic account of negotiating strategies in a health care system that can best be described as combining private and public sectors. In order to explain the contested and hybrid nature of the Serbian health care system, I analyze three key and mutually connected categories of actors: the patients, the health care providers and the state. For example, Aleksandra, as a patient, and Darko, as a health care provider, both use the private sector as a brokering strategy to personalize their interactions with and within the public health institutions (Alexander 2002). Existing theoretical frameworks of unreformed health care systems see such relations as "plagued" with informality, as corruption and poor governance (Batory 2012, Buch Mejsner and Eklund Karlsson 2017a, Del Vecchio, Fenech, and Prenestini 2015, Grigorakis et al. 2017, Habibov and Cheung 2017, Moldovan and Van de Walle 2013, Morris and Polese 2015, Radin 2013, Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015). This presumption, though, results from a superficial reading of what both Darko and Aleksandra meant by *veza*, literally "connection." For them, a connection referred to the use of medical services in the private sector to establish a personal relation within the state health care system. Their strategies and strategies of others like them are

often framed as examples of "clientelism," with examples given of informal cash payments in envelopes, that undermine the trust between patients and health care providers.

Such framing does a great disservice to the disenfranchised medical providers, working in demanding jobs and searching out ways to maintain a semblance of social and economic status. It also does not present a suitably complete picture of the use of market practices as patients' strategies to better navigate through the public health care sector, actions that are contributing to reshaping the health care landscape.

Still, most studies of welfare and health care systems have presumed the adequacy and accuracy of models with the central characteristic being the presence or absence of market practices (Esping-Andersen 1990, Sidel and Sidel 1977). Based on this distinction, most scholars adopted Esping-Andersen (1990)'s three models of health care and welfare. The *socialist model* is seen as based on the principles of universalism, where health care is a right. Examples of this model of health care are former socialist states in Europe, Cuba and a growing number of Central and South American countries. In these systems, access to benefits and services is based on citizenship, separate from market forces. The *capitalist model*, in contrast, is based on the principle of subsidiarity, which means that the focus should be on the local or medium level,l rather than on centralized solutions. In this model, the dominance of social insurance offers a medium level of decommodification, meaning there is social stratification of access amongst citizens. This second model is usually ascribed to countries of Western Europe, most notably Germany. Finally, the *liberal model* is based on market principles and private provisions with little to no state intervention, an example being the United States of America.

While ideal types are useful to think with and use as starting tools, the problem with these models is that they tend to presume their general comparability, and implicit hierarchy, based on

the presence or absence of market practices. These are static frameworks that structure discussions via opposing binaries of putatively "unreformed" and "reformed" systems, with the assumption also being that a higher presence of market practices leads to efficiency and effective health care provisioning. In contrast, I situate my intervention into this field by focusing on the importance of understanding health care systems as sites of negotiations and contestation, rather than through measurement according to static models. The literature on health care systems in Eastern Europe has mostly relied on such fixed models, and especially on distinctions between reformed and unreformed health care systems.

Approaches to studies of health care systems (Del Vecchio, Fenech, and Prenestini 2015, Edwards and Glover 2001, Grigorakis et al. 2017, Habibov and Cheung 2017, Kaitelidou et al. 2013, Sidel and Sidel 1977), especially those in Eastern Europe, can be categorized into two general types, culturalist or interactional. Both operate under unquestioned assumptions about the role of marketization on health care, and in both the issue of agency is central. General studies of corruption and clientelism, not only in health care, focus on the public sector (Haller and Shore 2005), and in most public health studies, the solutions tend to be placed on the transition to the market, as of yet still incomplete (Kornai and Eggleston 2001).

In the public health literature on Eastern Europe, however, culturalist approaches are common (Arsenijevic, Pavlova, and Groot 2013, 2014, 2015b, a, Baji et al. 2017, Buch Mejsner and Eklund Karlsson 2017b, Buch Mejsner and Eklund Karlsson 2017a, Dickov 2012, Dill 2014, Hyde 2016, Kornai and Eggleston 2001, Miteniece et al. 2017, Perišić 2014, Radin 2009, Stambolovic 2003, Stankovic 2017b, Stepurko, Pavlova, et al. 2015a). In a culturalist approach, health care systems in Eastern Europe tend to be characterized by pathologizing terms, such as "illness" (Radin 2009) or "disease" (Dickov 2012, Hyde 2016). Through such pathologizing

narratives, the presumed flaws in a system are presented as naturalized, ingrained in the culture (Baji et al. 2017, Buch Mejsner and Eklund Karlsson 2017b, Buch Mejsner and Eklund Karlsson 2017a, Kornai and Eggleston 2001, Stambolovic 2003). From a culturalist perspective, eastern European health care is presented as the backward and deficient "Other" of an idealized western health care system. An example is the writing of Eggleston and Kornai (2001) that describes citizens of *western* Europe learning about good governance, the costs of health care delivery and efficiency "along with mother's milk." The assumption is that the medical providers and patients in *eastern* Europe lack the necessary cultural knowledge to understand that their health care system is "deficient." Considering specifically the Serbian health care system, public health scholars Buch Mejsner and Eklund Karlsson (2017b) conducted a pilot study on primary care. They argued that there is endemic corruption, but that the patients and providers were ill-equipped to recognize it, seeing "a perception among [their] respondents that corruption was given too much attention in the media and that the real problem in healthcare was not corruption" (Buch Mejsner and Eklund Karlsson 2017b, 13). The assumption in public health literature may stem from a lack of knowledge about informal payments and gift giving in healthcare. Providers in Serbia may, therefore, not be held properly accountable for accepting informal payments" (Buch Mejsner and Eklund Karlsson 2017b, 10).

This quote sums up the critical concern with the culturalist approach, which is to presume a total lack of agency of patients, assuming that individuals have no choice but to pursue favors, either due to the specific historical and cultural context or due to the "system." This approach explicitly dismisses what the researchers' informants are saying. In that same pilot study, the researchers quote a doctor as telling them: "Bigger corruption is with politicians, not with the

doctors. Believe me." (Buch Mejsner and Eklund Karlsson 2017b, 13). However, they not only do not believe him; they ignore him.

On the other hand, an interactional approach emphasizes individual agency but does not critique the underlining assumption that the health care system is unreformed and backward. From this perspective, individual strategies are ways of "filling in the gaps" within the existing health care system (Brotherton 2012). Instead of arguing that actors are not aware, or lack knowledge about favors and informality, utilizing this knowledge is read as acting morally in the face of general immorality, and of mistrust in the system. Ledeneva (2006) argues that Russians sought after informal relations, *blat*, because of a general mistrust in the Russian state, and thus needed to establish personal trust in order to get things done within the public system. The issue of trust, or rather its lack, is central to this approach and is another way of positing the distinction between reformed and unreformed systems. The unaddressed underlying assumption in this model is that market practices, as supposedly transparent and clearly defined sets of prices and services, should automatically generate trust. Humphrey (2012) and Rivkin-Fish (2005b) go a step further to argue that informal cash payments, and *blat* relations in general, are the preferred path for obtaining a goal in the public health care system in Russia. Exercising agency by patients is thereby seen as positive since it is subversive of a flawed system. Again, the approach to health care systems is the presumption that personalizing strategies such as *veze* or *blat* show systemic flaws, but that such strategies will end once market practices take over.

Newer scholarship on health care and welfare more broadly are providing a much-needed critique to models unquestioned in the previous approaches, and instead of tracing agency as subversive, looking at how people conform to the system (Brković 2017b). Instead of looking at ruptures and gaps, there is a shift towards studies of connectedness (Alexander 2002) and

articulations (Matza 2018). Most such scholarship has focused on studies of informality (Brković 2017a, Brković 2017b, Stan 2012) or on the engagements of the civil sector in alternative strategies to health care distribution (Dill 2014, Dill, Zrinščak, and Coury 2012, Hemment 2009, 2012, Leutloff-Grandits, Peleikis, and Thelen 2009, Matza 2012, Stubbs 2012, 2013).

Privatization is a blind spot in most studies of health care systems. A few studies coming out of South America deal with issues of privatization, and those have focused on questions surrounding medical pluralism (Chamberlin 2018, Chary and Rohloff 2015). Rather than being the solution needed to end personalization of the provision of services in the public health care system, privatization is seen as a new form of personalizing public institutions. Looking at health care systems as sites of negotiation rather than as closed models allows us not only to focus on agency, but to understand how actors' agencies are shaped, and also shape the system.

Brković (2017b) shows that agency is key in understanding why and how people pursue *veze/štele* (favors) in Bosnia but does not agree that using these resources is viewed by informants as a positive characteristic of resistance to the system. On the contrary, she sees the pursuit of favors as a way of conforming, of being seen by and within the system. The Serbian term *veze*, typically used to denote informal relations or personalizing strategies, actually literally means "connections." *Veze* does not have to be informal, nor are they a unique feature of post-socialism. Persons are socially constituted by connections (Alexander 2002): kinship, friendship, business connections all shape social personhood. Cathrine Alexander in her ethnography of Turkish sugar factories shows that farmers, bureaucrats, and engineers not only construct their personhood through various forms of connectedness but personalize the state as well. Knowing someone or being someone who has worked or works in the public sector provides those actors with the agency and ability to personalize bureaucracy.

Jenine Wedel describes actors who can straddle the private and public sectors as *flexians*, players who "live symbiotically within the system, quietly evading and stretching its rules as they help mediate its transformation" (Wedel 2011, 15). Both Alexandre and Wedel make the point that the actions and agency of certain people are not only responses to structural conditions within a given system, but also, in turn, shape the system (Bourdieu 1977). Wedel (2011) points out that when people flex or move between different roles, they thus blur boundaries.

In the case of the Serbian medical system, the boundary between a service provided to a customer in the private sector and a favor offered in the public sector is blurred. The power to move between these two sectors, private and public, is not afforded to all actors within the health care sector. Thus, rather than trying to fit the actions of people like Darko and Aleksandra into standard categories of informality, and readings of the Serbian health care system as unreformed, through an ethnographic account of their strategic movements between the private and public sector, we can understand how the actually existing health care system is working, as private actions within the public system.

1.4 **Chapter outline**

2.0. Negotiating theory

The main aim of this chapter is to engage and untangle some key theoretical strands used in previous discussions of Eastern Europe and Eastern European health care systems. I start with the overarching theoretical discussion of the dissertation, which is to untangle the various articulations of private/public. My main strategy is to focus on the relationship of these two concepts rather than presenting them as fixed, clearly defined analytical categories. Building on the analysis of the private within the public is then a discussion of the theoretical conundrum of

how best to frame the region Serbia belongs to, Eastern Europe. The typical framing of Eastern European health care, especially in the public health literature, has been one of corruption and mistrust. In this chapter, I outline and provide commentary on the main lines of argumentation of supposedly generalized mistrust and corruption by placing them in conversation with the anthropological scholarship of informality and, oddly enough, ethnographies of agriculture.

3.0 Negotiating methods

This chapter provides a brief overview of how the research was conducted, focusing on the importance of several levels of negotiation. The first focus is on the negotiations inherent in being a native anthropologist conducting fieldwork in my hometown and in the hospital in which I was born. Second, I describe the need for rethinking and adjusting the classic anthropological method of participant observation in a clinical setting, where even a native anthropologist can become a complete and visible outsider. I draw on Gita Wind's (Wind, 2008) reconceptualization of the classic participant observation method and the importance of thinking and negotiating my positionality in the clinical setting ahead of time.

4.0 State (of) Health care

The first part of this chapter aims to provide historical context and a clear description of the state health care system in Serbia. I start with outlining the differences and similarities of the unique Yugoslavian approach to socialism and socialist health care systems from the more frequently studied Soviet-style systems (Ledeneva 2013, Rivkin-Fish 2010, Rivkin-Fish 2005b, a). I end this part of the chapter with a detailed outline of the infrastructure of the public health care system with a specific focus on the provision of maternal health. This historical-institutional

analysis enables us to understand the continuities and ruptures in health care provisioning after Yugoslavia's specific form of socialism.

The second part of this chapter focuses on the *of* the Serbian health care. In this part of the chapter, I take a closer look at the current, nationalist government discourse of public health care and the introduction of the private sector as both potential hindrance and also a solution for the growing problems of "our system" (*naš sistem*). From these official discourses on the public and private health care system, I draw attention to the ambiguous treatment of medical providers and their relation to the state. In the final section, I focus specifically on maternal care and the paternalistic and nationalistic state discourses on reproduction.

5.0 Paper Pushers, Doctors and Entrepreneurs

In this chapter, I describe the various factors governing the ability or inability of medical providers, specifically gynecologists, and nurse-midwives, to move between the private and public sectors, or to work in only one of them. I address theoretical understandings of private and public, trust and mistrust, and provide a critique of the assumption that adoption of a market economy in place of a state monopoly on the provision of medical services will render informal economies obsolete. Rather than rendering informal relations obsolete, the emergence of private practice provides a new avenue for patients to establish a personalized connection with physicians also working within the public sector. At the same time, through the private sector, medical providers are granted a flexible path for establishing individual authority and power. Through supplemental work in the private sector, gynecologists can draw on the considerable authority of the state institutions and channel that authority to gain personal power and influence, and facilitate personal

entrepreneurship. However, not all gynecologists working in the public sector can transform the generalized authority of the public institution to individual power.

6.0 From having no one to having someone

In this chapter, the focus is on mapping out strategies available to women as they navigate through the maternal health care system. The experiences of women mirror the doctors' stories described above. Women seek out individual strategies of personalizing the public hospital, so they are seen as individuals rather than only as birthing bodies during childbirth. Success in this endeavor transforms a pregnant woman from "having no one" to "having someone," whereas, in hospital settings, women must give birth not only without the support of their families or partners but in strict isolation from them.

"Having no one" (*nemati nikog*) means obtaining access to maternal care only through the fragmented public health care system and not knowing anyone in the hospital staff when coming to give birth. "Having someone" (*imati nekog*) means establishing a personalized (if also commercialized) relationship with the medical staff of the hospital, bringing them into ones' network of known people, and more importantly, a network of people who know them as individuals. "Having someone meant" thus meant that a woman had established a personalized and trusting relationship with at least one of the doctors, and through that connection, with the hospital's other staff.

This finding adds to current understandings of connections as a strategy of personalizing state institutions. Personalizing strategies have been understood generally as seeking to establish "informal relations" (friendships, acquaintances, fictive kinships), and unlike strategies established through market practices, essentially as customers. What the stories of women from the second

floor of this Serbian maternity hospital show are that these two strategies are not necessarily separate but rather interconnected. The knowledge gained from observing how maternal care is provided in practice enables a new perspective for drawing larger conclusions about the political economy of (universal) health care and the supposed roles of informality as a problem, and of the flaws in market-based solutions to that supposed problem.

7.0 Concluding Remarks

In this final chapter, I summarize the main points and observations made throughout the dissertation. I point to the importance of looking at patterns of individual social negotiating strategies in the study of the political economy of (mixed) health care systems, not just in post-socialist countries but also in places such as Brazil or Greece, and even in countries without universal health care, like the United States.

The ethnographic research reported here enables me to critique ways in which liberal scholars have lumped informality with corruption and placed those concepts as separate from privatization and system efficiency. Instead of seeing informality and privatization as opposites through ethnographic observations I argue that they are articulated with each other in a shifting context-dependent nature. Finally, I discuss possible avenues for future research, specifically the need for more studies on the positionality and importance of nurse-midwives within the maternal care system. I argue that they are actors who have been overlooked by both the state and women-patients, and yet are among the key figures on which the very unstable but still functioning public health care system rests.

2.0 Negotiating Theory

In this chapter, I present the key conceptual frameworks of this dissertation to bring about a new avenue of inquiry in the literature on informality and public health in Eastern Europe. I will discuss when need in greater depth theoretical discussions on reproductive politics (Ginsburg and Rapp 1995, Chalmers 1997, Greenhalgh and Winckler 2005, Davis-Floyd and Sargent 1997, Drezgic 2008, Ehrenreich and English 2010, Martin 1987, Ginsburg and Rapp 1991) and with the larger body of biomedical anthropology literature (Lock and Nguyen 2018, Good 2001, Sharp 2011, Petryna 2013, Conrad 2007, Bae 2012).

My intention is not to ground my ethnographic data in what Gibson-Graham describes as "strong theory" - the powerful discourses that want to organize events into understandable and seemingly predictable trajectories (Gibson-Graham 2014, 147). The main reason for this is that the everyday interactions and negotiations of maternal health care in Serbia do not fit into predictable trajectories. Negotiating is central to my argument as I am not attempting to fit my ethnography into existing theoretical frameworks neatly. I am interested in understanding how these central strands of post-socialist theories and key, usually presented as binary concepts, can be re-conceptualized, placed into dialog with each other and thus negotiated in order to yield new knowledge.

I will start untangling the various articulations of private/public. My main goal with these two categories (private and public) is to focus on their relationship rather than presenting them as fixed, clearly defined analytical categories. I will unpack various meanings of these "shifting categories of activity"(Gal and Kligman 2000, 51) in both emic and etic contexts. My aim is to focus on how these categories are "articulated" together (Matza 2012, 2009) in a given

ethnographic context. Rather than using a strong theoretical framework to describe and interpret the negotiations happening on the second floor of the maternity hospital, I will do the inverse.

Like the seemingly clear binary between private and public, scholars have either reinforced or fought against creating distinctions between framing the region Eastern European as post-socialist (Sampson 2002, Burawoy and Verdery , Ghodsee 2011, Ledeneva 2006) or as neoliberal (Stubbs 2013, Stan and Erne 2013, Stan 2012, Mikuš 2016, Kalb 2012, Bockman 2011). Building on the discussion around private within/and public, what follows is a discussion of the theoretical conundrum of how best to frame the region Serbia belongs to, Eastern Europe. A typical framing of Eastern European health care, especially in public health literature (Arsenijevic, Pavlova, and Groot 2013, 2014, 2015a, b, Buch Mejsner and Eklund Karlsson 2017a, Buch Mejsner and Eklund Karlsson 2017b, Dickov 2012, Radin 2009, Radin 2013, Stambolovic 2003, Stepurko, Pavlova, et al. 2015a, b, Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015, Stepurko, Pavlova, Levenets, et al. 2013), has been one of corruption and mistrust. In this chapter, I will outline and provide commentary on the main lines of argumentation by placing them in conversation with an anthropological scholarship of informality and (oddly enough) ethnographies of agriculture.

2.1 **Negotiating between different understandings of private and public**

Generally, two main strands define what is meant by the terms private and public. One focuses on the issue of ownership, in a very materialist sense (Walter and Howie 2003, Chary and Rohloff 2015, Read and Thelen 2007, Loewenstein 2015, Graham 1998, Engels and Leacock 1972), The other focuses more on discursive practice (Collier, Yanagisako, and Bloch 1987, Ginsburg and Rapp 1995, Martin 1987, Browner and Sargent 2011). I am drawing on both strands to describe how maternal care is provided in Serbia. My aim is to question the private/public

binaries and avoid creating new ones. In order to attempt to place these seemingly different strands into the dialog, I have created a table of different meanings of the terms private and public, or "domains" (Collier, Yanagisako, and Bloch 1987). Rather, I used the distinction between etic and etic as a writing tool. Dichotomies present below should be questioned and explained rather than taken for granted.

The concept of the public is taken to be a general term referring to the state, the market, and in general male-dominated spaces, while the private is associated with domestic, intimate spaces. Rosaldo (1974) argues that what is understood as public or private varies, that this division is not universal. The origins of this conceptualization are grounded in the liberal political theory of a gendered division of space, whereas the home, the domestic sphere had been associated with the role of women.

Within the framework of liberal political theory, the public domain is a sphere that is regulated by the state to preserve individuals' freedoms, the public, on the other hand, conceptualized as either family or as private enterprise should be outside of the domain of the state. Feminist theory from the onset has critiqued this general view of private/public (Collier, Yanagisako, and Bloch 1987). The implicit argument in this generalizing view of private and public is that it naturalized and reinforced other dichotomies: private or domestic as more akin to nature, and thus, more female and public as more akin to culture and thus male. These assumed universal dichotomies have long been dismantled by feminist scholars (Landes 1998, Rosaldo, Lamphere, and Bamberger 1974, Collier, Yanagisako, and Bloch 1987). Feminist scholars have highlighted the ideological construction of this division by showing that there is no such thing as a clear separation of private and public. The public permeates actions and domains seemingly coded as domestic(Collier, Yanagisako, and Bloch 1987, Weeks 2011). Scholars have drawn

attention to how domestic violence tends to naturalized and imbued in assumptions around male dominance (Brush 2011), how caretaking and domestic work are naturalized as female even when it is intersecting with other problematic issues such as colonialism and racism (Chan 2018, Constable 2014).

In scholarship on socialism and post-socialism, the dichotomy of private and public has highlighted the changing configurations and fractalization of these domains during and after socialism. During socialism, women were encouraged to "step out of the home" into the workforce, while at the same time being solely responsible for the care work within the family. Susan Woodward (1995) for example argued that it would be too simplistic to see gender equality as magically occurring because of socialism: "it appears that once particular functions are labeled as private and female, there is still little pressure to redefine them as public" (Woodward 1995, 229). Industrialization has brought both sexes into the sphere of productive work, but the double shift is still there.

Despite working outside the home, women are primarily responsible for housework. Neither education, occupation, urbanization, nor participation in the informal economy had a significant effect in reducing this. By the late 1960 women were excluded from the labor market systematically. Legislative commissions turned their attention to family policy, passing a law on contraception in 1969, excluding women from a wide range of activities to "protect" maternity in the associated labor act of 1976, and 1978 creating extensive maternity benefits (Woodward 1995, 245).

In Eastern European socialism, women were seen as "unreliable" by the state (Fodor 2002) because of their supposed "backwardness" as not being loyal political subjects to the party because of their role as mothers. The fact that women were the ones raising the children, as Fodor shows,

was seen as a potential threat to women's devotion and allegiance to the Party. "Women's primary allegiance was to their offspring"(Fodor 2002, 224), in the eyes of the Party and this was potentially dangerous, and thus women could not be trusted as fully as men to take positions of political power.

The private or domestic is thus anything but not political. Notions around gender roles and motherhood interact with and impact directly political and economic concerns of socialist states. Feminist scholars of socialism and beyond point out that the problem lies in the unquestioning of the notion of worker itself (Fodor 2002, Weeks 2011, Lukacs 2013, Fodor and Kispeter 2014, Glass and Fodor 2018). The notion of worker is itself a gendered term and what is expected of women is to comply with the male standard and definition of worker and not to question the gender biases behind it. In turn, this provides another challenge to the supposed universality and clear boundary distinction between private (family) and public (the state). There is a constant negotiation of the family as a political institution between the actual family and agents of the state in a way that "ever-changing boundaries between public and private were most often signaled implicitly and invoked indexically within interactions. Thus, fleeting, inhabitable roles (us/them) came to seem like immutable, bounded social groups, and shifting categories of activity (public/private) came to seem solid and distinct" (Gal and Kligman 2000, 51). In other words, even though the distinction and boundary between private and the public seems concrete, it is not. Feminist scholarship, in anthropology especially, has done a good job dismantling the assumption of universality and solidity of the public/private binary. The problem is that this dismantling has largely remained in the discursive, etic realm.

While studies have questioned and blurred the boundaries between private and public in the discourse sense when it comes to the materialist perspective, the assumptions of liberal political

theory have remained almost unchallenged. Rofel (2015) points out that we tend not to question the division of private and public when it comes to capitalism. In her work in China, Rofel put this division into question by looking at the intersections of the public-private enterprises in textile. Rofel'(Rofel 2015)s ethnography shows that it is difficult to discern a clear difference between private enterprise and the state. Moreover, from the emic perspective, her interlocutors benefit from blurring this boundary.

In a materialist sense, what is understood as public or the public sector refers to institutions and practices that are governed and usually are owned by the state. The private sector, on the other hand, is not owned by the state. Private thus can also mean private property, a notion that is seen as different and separate from state property or in the case of socialist Yugoslavia, social property (elaborated further in chapter 3). In this instance the notion of ownership is central. Another articulation focuses more on employment. In Serbia, people distinguish two types of employment sectors, "*privatni posao"* (private job) or "*državni posao*" (state job). My interlocutors refer to public and private as a marker of job value and job security. Private practice is associated with instability, working for a private employer as a negative experience (Naumović 2013, Trifunović 2015, 2016b, a). On the other hand, the process of getting a job in the public sector, while seen as corrupt - you need to have strong informal connections to get the job, once hired working in the public sector is secure and stable.

The usage of these term public and private, thus, comes from an emic rather than an etic perspective, as my informants refer to the private health care sector as "*privatna praksa*" (private practice) or simply "*privatno*" (private) in opposition to *državna praksa* (state practice), *javno zdravlje* (public health) and *državno (*public/state). Thus, the term private is understood about economic notions of privatization.

Scholarship on the privatization of public health care has mostly focused on the role of the civil sector, “NGO-ization of the health care sector”(Chary and Rohloff 2015) and in the welfare sector more broadly (Adams 2013, Muehlebach 2012). There is scholarship on the “commoditization of care”(Chary and Rohloff 2015) that does look at market-based health care in universal health care systems in Central and South America(Chamberlin 2018). This scholarship deals with market practices that are emerging in aspects of health care not available in the public sector. Typically the focus is about understanding the internal variations within biomedicine (Kleinman 1995). Most of these studies are on health care landscapes in Central and South America and South East Asia and have traditionally dealt with questions of medical pluralism (Bridges 2017, Koss-Chioino, Leatherman, and Greenway 2003, Harvey 2011, Harrison and Cosminsky 1976) and more recently of biomedical pluralism (Chamberlin 2018, Chary and Rohloff 2015). This is not the case with maternal care in Serbia. Instead of seeking out medical care that is unavailable through the public sector, what is being sought through the private sector is a connection within the public sector.

While there are civil society institutions engaging in health care provisions (Dill, Zrinščak, and Coury 2012, Dill 2014, Mikuš 2018) in the broader sense and broader post-Yugoslav region, in the case of providing perinatal care this is done through either the public biomedical institutions or medical institutions in the private for-fee biomedical institutions. Nor is this a case study about biomedical or medical pluralism. Medical pluralism implies that patients seek out an alternative form of healing traditions in their quest for health (Wiley and Allen 2009, 28), this can included different approaches to biomedicine.

In the case of maternal health care in Serbia, whether in the private or public medical institution the medical tradition provided is almost exclusively a technocratic model of birth

(Pincus 2013, Stankovic 2017b, Stanković 2017, Sekulić 2016, Sekulic 2014, Davis-Floyd 2003, Davis-Floyd 1994). It is the labor of the biomedical provider that has been privatized. Medical providers, in this case, gynecologists, are moving between the two health care sectors. I am interested in mapping out the continuities of care that are negotiated daily by patients and providers through the interconnections of private and public health care. While ownership can be the dividing category between private and public, care and establishing care and trust is a central uniting thread not only in my research, and not only in research on former socialist countries.

Closer to my research, Hromadžić (2017) looks at the role of private nursing homes in postwar Bosnia. She points out nicely that care (*briga)* in the local vernacular has a double meaning - to care for and to worry. Her main topic of interest is the affective labor of the private entrepreneurs or "*privatnici*" who have opened up nursing homes in post-war Bihać. *Privatnik* (entrepreneur) has in the vernacular the notion of private in a sense associated with liberal political theory (Hromadžić 2017). Hromadžić (2017) points out how in the case of private nursing homes this conceptualization of private embeds and challenges both understandings of the term. This ethnography shows how these two domains or readings of private become intersected and embodied in the lives of the (usually women) who run these nursing homes.

In her work on private nursing homes, Hromadžić (2017) traces the changes in perception of care and responsibility practices in Bosnia. She frames her understanding of private through the lens of post-war/post-socialist issues. The "compassionate *privatnik*" in Hromadzić's perspective is a response to the crisis of care due to postwar migration of youth especially and the falling apart of the zadruga style care within the family unit (Erlich 1966) and due to an absent state (Hromadžić 2017). While I agree that the local context is important, I would rather side with authors who look at this issue from a larger global economic lens. Daly (Daly 2001) point out more broadly that

there is a general move away from the state as a provider of care towards the family and voluntary sector. Muehlebach (2012) in her work on neoliberal shifts in welfare and care in Italy looks at this move in greater detail. Her main argument is that the state is trying to mediate the effects of its withdrawal by mobilizing the youth and elderly into voluntary care labor. Both Hromadžić and Muehlebach provide a much-needed corrective to the monolithic impression of neoliberalism as producing exclusively cold and calculated subjects. Instead, their research, along with the research of scholars like Adams (2013) and Cabot (2016), point to the importance of sociality and compassion in the face of precarity and exclusion.

2.2 **Negotiating between post and neo**

One key issue of anthropological engagement with Eastern Europe, beginning about a decade after the European communist regimes collapsed, has been whether or not it is still fruitful for anthropologists to talk about socialism and post-socialism (Burawoy and Verdery , Cullen Dunn and Verdery 2011, Thelen 2012, Gilbert et al. 2008, Yurchak 2003, Boyer and Yurchak 2008). Some have even gone as far as proposing a framework of post-post socialism (Sampson 2002) when studying former socialist states. What these debates about "the post" have in common is that they revolve around questions of theoretical knowledge has emerged from anthropological engagements with this region. Nearly three decades after 1989 and the fall of the Berlin wall, can we still analyze former socialist countries as post? Boyer and Yurchak (2008) think that postsocialist studies are becoming a "vanishing object," that is, that the notion of post-socialism becomes less and less relevant for the study of this geographic area. The new buzzword has become neoliberalism.

Anthropological writings that try to address neoliberalism are accustomed to using adjectives such as "slippery," "hazy," "contentious," and "a rascal concept," thus obscuring and presenting neoliberalism as some (un) a certain thing. Neoliberalism is not a thing; it is a process that needs to be understood as historically contingent (Bockman 2012, Goldstein 2012, Jessop 2013, Kalb 2012, Peck and Theodore 2012, Wacquant 2012). There is no single definition of neoliberalism, especially within anthropology. Some would argue (Ganti 2014) that the reason for this is the very localized ethnographic approach taken up within the discipline. Anthropologists concerned with neoliberalism, tend to “focus on specific effects of, resistance to, neoliberalism, not on the phenomena itself” (Hoffman, DeHart, and Collier 2006, 9).

One of the most common assumptions, especially in political economy studies, about neoliberalism is that it requires the withdrawal of the state and the shift of previously public services over to private enterprise (Kornai 2008, Jones 2012, Kornai and Eggleston 2001, Kornai, Rose-Ackerman, and Collegium 2004). There are several ethnographic examples from post-socialist countries challenge this notion. Julie Hemment, for example, in her article "Soviet-Style Neoliberalism?" (Hemment 2009), she critiques the notion of neoliberalism as a coherent hegemonic project rather than an uneven and contradictory process.

Gilbert, Greenberg, Helms, and Jansen (2008) find several anthropological strands emerging out of studies of post-socialist states, most notably from former Yugoslavia. They wonder "how many glasses of Milton Friedman's Kool-Aid” did the rest of the social sciences have to drink when they claimed that Central and Eastern Europe had transitioned, and highlight as well that there is much about socialism that remains analytically relevant (Gilbert et al. 2008). Twenty years have passed since Sampson claimed that the transition was over and that the people living in

central and Eastern Europe are “becoming consumers, are angry and depressed, or just plain tired” (Sampson, 2008:298).

In this dissertation, ethnographic research shows that Sampson(Sampson 2002)’s depiction of life is valid, with the difference that instead of using the transitional term “becoming.” We can state that the people working for or trying to obtain health care in Serbia are tired, most are angry and depressed and in more and more cases, patients are treated as consumers. So either we should start calling this period post-post-postsocialism (Sampson 2002) or acknowledge that what we are seeing are practices revolving around realities and understandings of realities that have little or maybe even nothing to do with socialism. The majority of the women with whom I spoke during this research were themselves born not in socialism but rather in post-socialism, in the late 1980s and early 1990s. Some new mothers were even born after the breakup of Yugoslavia in 1991. Some of the senior medical staff did remember what it was like growing up under socialism, but most of them, too, talked about the start of their professional careers from the 1990s onward.

Before conducting research, I assumed that the notion of “Yugonostalgia” (Jansen 2005, Kojanic 2017, Jansen 2009) would be a central theme in my interlocutors understanding of their everyday lives. I was surprised to find that it was not. This is not to say it was completely absent[4], but that it did not figure so prominently at least not as much as it had in the 1990s and early 2000s, the immediate post or post-postsocialist context[5]. All of these are of course anthropological concepts, but they also arose and corresponded to historical conditions(Humphrey 2002). "If the

[4] Using NVivo software, the code “Yugonostalgia” was referenced only eleven times and in a total of five sources.

[5] Another possible reason why this code was not as common could have to do with the age of my main sample – new mothers (most born between 1988-1997).

people themselves reject the category, we as anthropologists should not cling to it, but pay attention to whatever framework of analysis arises from within these countries themselves" (Humphrey 2002, 14).

In this dissertation, I critique the notion of imposing conceptual frameworks such as socialism, post-socialism or even neoliberalism as if they were monolithic and all-encompassing explanations of the lived realities of the people I spoke to and spent time with. Thelen (Thelen 2011)calls this type of approach a theoretical dead end (Thelen 2011), arguing that by creating a binary opposition model of socialist: capitalist/buyers vs. seller's markets/shortage vs. abundance, socialism became the Other to capitalism and thus foreclosed many possibilities of fruitful anthropological engagement. She argues that the dead end is due to the ambivalent construction of the socialist Other as defined by an economic analysis of socialism in the late 1980s (Thelen 2011). Using an economic theory that presumed the inefficiency of socialist institutions implicitly replicated the Cold War prism, resulting in a theoretical dead end (Thelen 2011).

The frequent use of static analytical concepts has brought about one of the critical misconceptions I want to address in this dissertation. I demonstrate why the label of corruption is not useful for understanding and describing the practices of negotiations between patients and providers taking place on the maternity hospitals and delivery wards, and the health care sectors in Serbia specifically, and probably more widely across Eastern Europe. The notion of corruption as something dangerous, and backward stems from an orthodox, even dogmatic treatment of shifting binaries (public/private, socialist/capitalist) as solid and concrete. In that logic, any transgression of binary lines is corrupt. The problem with this dogmatic view is that it genuinely does foreclose any possibility of anthropological engagement. Both doctors and patient transgress these binaries on a daily, weekly, monthly basis. Using the umbrella of corruption (Buch Mejsner

and Eklund Karlsson 2017a, Kornai 2000, Kornai and Eggleston 2001, Radin 2013, Hyde 2016, Vasiljevic-Prodanovic 2015, Jancsics 2013, Batory 2012, Radin 2009, 2016, Stepurko, Pavlova, Gryga, et al. 2013) does a great disservice to both theory and more importantly to the lived realities of patients and providers.

Thus, health care providers negotiate their positions both as (post)socialist extensions of the state and as neoliberal entrepreneurs. Many of the women who are giving birth in the maternity hospitals are also trying to negotiate their positions from being just one of the (un)educated patients, reproducers of the nation, to being, as one gynecologist phrased it, "*faking stranka*" (the fucking client). It would not do justice to any of them to box their experiences into any one of those categories. Informal relations(Ledeneva 1998, Rivkin-Fish 2005b, a, Brković 2017a, Stan 2012, Wedel 1992), such as connections (*veze, blat, spaga*) and gift-giving still exist. However, these should not be understood as relics or survivals from a socialist past, but instead as strategies and mechanisms for dealing with a capitalist (neoliberal) present (Brković 2017a, Rivkin-Fish 2005b, Stan 2012). In that sense, I take a cue from Yurchak and Boyer (2008) and use anthropological studies of informality in order to confront the dominant social scientific understanding of the contemporary state of health care in Eastern Europe as corrupt and backward.

2.3 **Questioning the diagnosis of corruption**

One can frequently read descriptions of Eastern European health care as “ill” (Radin 2009), or as having a “mixed diagnosis” (Hyde 2016), and of informal payments as symptoms of deficiency in governance (Arsenijevic, Pavlova, and Groot 2013, 2015b, Buch Mejsner and Eklund Karlsson 2017b, Dickov 2012, Stambolovic 2003, Vasiljevic-Prodanovic 2015). Usually, the prescribed cure for this illness of socialism is the magic bullet of the free market (Buch Mejsner

and Eklund Karlsson 2017a, Jancsics 2013, Kornai 2000, Radin 2013). The dominant literature on the subject of Eastern European health care has not been anthropological or sociological but tends to come from economic, public health, and public policy perspectives – and include the unquestioned presumptions of those fields. There are two significant problems with policy solutions/recommendations regarding health care. The first is the problematic concept of “basic needs”/” needy” and the second is implicit orientalism.

A typical example of this type of approach to studies of health care reforms in Eastern Europe is Kornai and Eggleston's (2001) “Welfare, choice, and solidarity in transition: Reforming the health care sector in Eastern Europe.” Kornai, an economist whose work has mostly revolved around understanding socialism and postsocialism in Hungary, and Eggleston, a public health scholar, argue that in order for Eastern European health care to recover from its illness of socialism, a “middle ground” between state welfare and the market must be found (Kornai and Eggleston 2001). They do not argue or claim that complete privatization of the health care system is feasible or desirable. What they propose is that public financing should be limited to only "basic health care needs" (Kornai and Eggleston 2001) and that the rest of the health care sector should be opened to the market. However, the question then becomes what is considered a "basic need" and who decides?

For these authors, the analysis must fit into two categories: what is medically necessary (Kornai and Eggleston 2001) and what is the most cost-effective (Kornai and Eggleston 2001, 220). In their view, basic need should be reserved solely for those who genuinely need it, those who cannot provide for themselves: "The needy must be helped mainly by giving them the opportunities to work and skills to better their circumstances in life" (Kornai and Eggleston 2001, 22).

On the other hand, Linda Haney (2002) tries to understand how shifts in welfare policy affect the actual lives of three women in one Hungarian household. She provides a historical account of the transformation of welfare regimes in Hungary, and how each regime constructed the notion of "truly needy." Hayne provides an ethnographic vignette of the drastically different experiences with welfare in three generations of women within one family, regarding maternity care. Haney's case study provides important ethnographic insights into the ways Hungarians experienced these changes. Her account makes clear that the loss of social recognition was equally as traumatizing as the loss of material benefits. Based on the differences between these women's lives, she points out that the Hungarian welfare system has become increasingly specialized, segmented and punitive (Haney 2002). Haynes's ethnography shows what other scholars have also pointed out, that by creating a very narrow category of those that the states define as "in need of care" or "needy" excludes a large number of the population. The individual is presumed to be informed and actively responsible in regards to their health.

What Kornai and others are referencing and suggesting Eastern European health care should emulate is precisely this type of notion of identity, which they place squarely as having Western origins. In the presumed context of western states, the critical features of patienthood (Rose 2007) are informed consent, active participation and the possibility of choice and flexibility when managing risk. In this sense, "responsible patient" becomes an immutable mobile object (Ong and Collier 2005) that is the same regardless of the local context, meaning that patient identity should be inseparable from consumer identity.

Kornai and Eggleston claim that: "even if the state or insurer covers most of the cost of a good or service, recipients should make co-payments, so that they appreciate that good or service is not free" (Kornai and Eggleston 2001, 29). A key point that keeps getting referenced in public

health, public policy recommendations and by government representatives in Eastern Europe is the notion that citizens need to forget the idea that health care is free. What is interesting is this implicit logic that responsibility is somehow inextricably linked to money. In order to be seen as a responsible individual, you have to be a consumer. This is a Foucauldian type of definition as it draws attention to how individual bodies and populations are made into governable, self-disciplined, entrepreneurial citizens. The key difference from previous modes of governance is that it is done through calculations and incentives, giving the governed subjects the notion that they made choices independently. In this sense, it is also very similar to Harvey's understanding of neoliberalism as a political rather than an economic project, to restore or reinforce the power and dominance of the economic elites (Harvey 2005).

Policy and public health reform proponents claim that individual choice and responsibility should be at the heart of Eastern European health care. According to them, the issue with the socialist health care model is that citizens relied on the state to "think for them" and take responsibility for them, "they have to quit the habit of allowing a paternalistic state to do all the thinking for them" (Kornai and Eggleston 2001, 16). On the other hand, according to these authors, the notion of taking responsibility for one's health care is embedded along with "mothers milk" (Kornai and Eggleston 2001, 16) to Western Europeans. This is a clear example of Orientalism, where citizens of Eastern European countries are presented as children incapable of making rational choices without the help of the paternalistic state. Because they are irrational, rather than opting for transparent market practices when it comes to attaining health care, individuals in Eastern Europe settle for informality and corruption.

2.4 **(In)formal relations**

This brings me to the second problem. Corruption frequently tends to be presented as the exclusive characteristic of the Other (Haller and Shore 2005). There is a common assumption that corruption will happen only in so-called weak or failed states (cf.Woodward 2017). Buch Mejsner and Eklund Karlsson when describing the health care system in Serbia, state that: "informal payments are symptoms of poor management, underfunding, poor control in health care, lack of accountability, and deficits in the rule of law, that is, poor governance" (2017b, 10). Heller and Shore point out: "actually informal personal networks may be complementary and necessary arrangements in maintaining stability" (Haller and Shore 2005, 11). The problem with this logic lies in seeing social practices coming out of socialism as deficient or failed, and more broadly presenting socialism as lacking, in opposition to neoliberalism. In this logic, the informal networks were a way of making up for the deficits and shortages in health care and welfare provisions during socialism. However, since socialism is over, the assumption was that after socialism there would decrease the need for informality. This did not happen.

What anthropologists point out is the importance of looking at how these exchanges occur in practice, how they are performed, and in what broader political, economic, historical power configurations are they taking place (Brković 2017a, Brković 2017b, Brotherton 2012, Haller and Shore 2005, Hann 2002, Jansen, Brković, and Čelebičić 2017, Ledeneva 2008, Ledeneva 1998, Rivkin-Fish 2005b, a, Stan 2012, Wedel 1986, Wedel 2011). Anthropologists who studied socialism and post-socialism have shown that in everyday practice, individuals have used various forms of social connections and social networks to establish access to health provisions (Brković 2017b, Brotherton 2012, Raikhel 2016, Rivkin-Fish 2005b, a, Stan 2012). Such works show that informal relations are neither simply legacies of a socialist past nor pathologies, but political

strategies used by patients and health care providers alike to navigate transforming political and economic landscapes (Brković 2017b, Rivkin-Fish 2005b, Stan 2012). Informal exchanges are individual responses to ever increasing inequalities that are only exacerbated by the ongoing neoliberal transformations of the states after socialism (Stan 2012). They are strategies for navigating and even managing ambiguities prevalent in the current socio-political landscape of Eastern Europe (Brković 2017b, Brković 2017a).

When I initially set out to do this dissertation, my original hypothesis was that the local concept for informal relations, *veza* (connections), was being co-opted by market processes. Having a *veza* or finding ways to obtain one was an integral part of socialist "favor economies" (Ledeneva 1998). "*Can you get good health care without veze? Honestly, no. You cannot*!" was the observation of a Serbian cardiologist that made headline news in Serbia in late December 2014. The response also highlights that universal health care was only an ideal during socialism. In reality, citizenship did (and still does) not guarantee one's right to adequate health care. Instead, connections, who you are and whom you know, determine who has access to high-quality health care throughout the former Yugoslavia.

My initial question was whether, when it comes to giving birth in Serbia, market practices are appropriating the resources of public reproductive care facilities for private gain, under the guise of connections (*veze*). This would not have been a completely surprising discovery. Ledeneva in her work on post-soviet Russia tried to understand why she had assumed that after socialism there would be a lesser need for informality (Ledeneva 1998, 2006, 2013). This did not happen. However, she does claim that after 1990s blat became monetized, and remained linked to the notion of shortage, this time of money. Was a similar phenomenon happening in Serbia?

Pre-fieldwork hypotheses and post-fieldwork realities are two different things. The first reason, of course, is that the reality on the ground is much more complex than simply transforming what was once seen as social capital into a new form of economic capital. The main flaw of my initial hypothesis is that I too drank a little too much of the Milton Friedman Koolaid (Gilbert et al. 2008). It would have been naive to argue that *veze* have simply transitioned into a new, neoliberal framework without questioning the binary logic behind such a hypothesis. This would mean that my interlocutors were not aware that they had become consumers, and I would have fallen guilty of the same orientalizing logic. I critique public health scholars in the region for doing. Greenberg, Helms, and Jansen (2008) call for thinking about new frameworks, that encompass both entrenched practices (here, *veze*) and the emergent ones (private practice in health care), and understand how they are interwoven with each other. Rather than trying to fit in the practices, behaviors, experiences, and stories of the people who gave birth in the hospital and the doctors and nurses who work there into the existing theoretical frameworks, I found that I need to challenge those frameworks.

2.5 **Negotiating (mis)trust/What can agriculture teach us about health care in Eastern Europe?**

There is almost no literature dealing with the emergence of the private health care sector in Eastern Europe after socialism. The private health care sector seems to present as more of the end goal of transition rather than a reality on the ground (Arsenijevic, Pavlova, and Groot 2014). The logic is that what is missing is a completely independent private sector, working on market principles that require "responsible patients" who know the cost of health care and are free as consumers to shop for services available to them in their price range.

The problem with this logic is that it assumes a clear-cut transition into a capitalist market system completely devoid of personal connections or ties. The idea of impersonality or atomization was disproved under socialism, so why would it be valid under capitalism? The private health care sector is not an idea but a reality in Eastern Europe, where private practices have been (re)emerging since the 1980s. Across Eastern and Central Europe doctors employed in the state public systems are working second shifts in the private sector. The key to understanding these social practices, I argue, is that most of these private practices are not completely severed from the existing public sectors but rather that they are all interdependent.

Anthropologists (cf. Haller and Shore 2005) have shown that reliance on personal connections is not just a postsocialist phenomenon. Giordano and Kostova go even farther and provide ethnographic data which show that indeed individual and social prosperity can be established through personal connections/personal trust even in societies classified as low trust, or as they call them societies of mistrust (Giordano and Kostova 2002, Giordano and Kostova 2013). Ledeneva (2006), makes a similar distinction between personalized and generalized/institutionalized trust. In her work on post-soviet Russia, she clearly illustrates that informality is both an impediment and a resource, thus both subversive and supportive of market transformations (Ledeneva 2006). At the core of this seemingly paradoxical state of informality is, according to her, the different notion of trust - "informal practices work on personalized trust, but they weaken generalized trust" (Ledeneva 2006, 191).

Personalized trust can be defined as trust in specific people, kinship, and familial ties, while generalized trust is the notion of trust in the state or state institutions. This is a common distinctive marker in most studies of (post)socialism. Hayden (1989) on the case-study of enforcement of the seatbelt laws in Yugoslavia and Illinois, shows that people in Serbia

(Yugoslavia) also resorted to going to extraordinary lengths to pretend to comply with the law rather than simply buckle their seatbelts because there was a general mistrust in the socialist government.

From my ethnographic research, this distinction of personal trust and institutional (mis)trust is both very evident but is also put into question. If there is complete mistrust in state-run health care institutions, why are we not seeing a bigger shift of those who have economic capital completely "lifting off" (Sampson 2002) into the private system? One concern I have with an unquestioning usage of the term "societies of mistrust" (Giordano and Kostova 2002, Giordano and Kostova 2013) or general mistrust in the state is that it can easily lead to (self)exoticization of the Balkans, which would bring us back to the narrative of weak and deficient states that breed corruption and mistrust. My ethnographic data puts any monolithic view of complete distrust in the state into question. Thelen and Read (2007) point out that instead of a priori assuming withdrawal, we should take a closer look at the full range in which state bodies, actors, and institutions shape social life in the region.

Studies of agriculture entrepreneurship in socialist Eastern Europe (Halpern and Kideckel 1983, Kideckel 1993) provide insights for understanding entrepreneurship after socialism (Kideckel 2008, Lampland 2002, Naumović 2013, Thelen 2001). Scholars of socialism and postsocialism have pointed out the importance of understanding how farm workers actually collaborated and the values they held during and after socialism to gain insight into why certain entrepreneurial projects failed while others succeeded.

In her research on de-collectivization in Hungary, Lampland showed that "the combination of social ties, expert knowledge, and extensive experience gave socialist agrarian elites a disproportionate advantage in the transition" (Lampland 2002, 47). The central feature of these

relationships was and is trust. Trust mitigates, or as Brković (2017b) states, manages insecurity and precarity of the market economy. According to Martha Lampland (2002), it is this trust that gives agrarian elites their advantage.

In a different approach, Klaus Roth (2015) claims that during socialism there was no separation between work and personal time and that it was this linkage between work and personal that fostered the emergence of informality. Such personal/work activities produced the first private businesses in Bulgaria (Roth 2015). Most were family run, demonstrating again what Lampland (2002) had noted, the importance of kinship and other personal ties in the market venture. The majority of the initial private enterprises in Eastern Europe emerged out of former socialist collectives (Thelen 2001, 2012), thus among people who knew each other.

The studies of Serbian agriculture also note the importance of personal/work activities and connections established during socialism. Agriculture entrepreneurs drew on their family and connections from the socialist period to establish their private business. Two types of pathways emerge, unsuccessful or successful.

Naumović (2013) describes an unsuccessful entrepreneurial attempt of Milutin in the agro-business trade in Serbia. Using social and cultural resources to sustain the entrepreneurial effort, Milutin relied heavily on his family and on connections established while still working in the public sector (Naumović 2013). Sadly, Milutin's story is one of failure because his social resources, pulled mostly from his family and connection established abroad rather than with local public networks meant that he lacked the resources to negotiate the structural constraints posed on entrepreneurs within the Serbian market. Milutin story is a common one in the country, without adequate social ties to the state, public institutions it is increasingly difficult to establish entrepreneurial success.

The Serbian state does not create a positive framework for small entrepreneurship (Rajković 2018). The Serbian legal and regulatory frameworks create constraints; that is, the regimes of distribution (Collier and Way 2004) are far from equal for all. Thus, while Milutin (Naumović 2013) did not succeed, but Goran, another small agriculture entrepreneur in Central Serbia, has had entrepreneurial success, successfully navigating the uneven nature of capitalist development in Serbia (Thiemann 2014). The central distinction between Goran's entrepreneurial story and Milutin's lies in their abilities to draw on social resources acquired during their previous employment in the public sector(Thiemann 2014).

The ability to capitalize on these resources is a central characteristic of "flexing"(Wedel 2011). According to Wedel (2011), a mode of operating in which actors and organizations can shift back and forth between various social roles depending on the context can be called flexing, and it is not an exclusively post-socialist phenomenon as she shows in her more recent work on the US administration. For example, the same person can in one context, say a business meeting, represent the Russian state, and at another meeting represent the foreign aid agency hired to administer aid to the Russian state. Flexians can personalize bureaucracy, privatize information while broadening convictions, juggle roles and representations in order to maximize their influence, and finally can bend or relax rules and boundaries as it suits them (Wedel 2011). Flexians draw on their expertise and experience acquired over time, their network of social relations to establish trust with their clients and to achieve their individual goals. To conclude, the literature on agriculture in former socialist states provide an understanding of how not only entrepreneurialism is established in actually existing neoliberalism in Eastern Europe but also points towards strategies of establishing trust in the current economic and political precarity.

3.0 Negotiating Methods in a Clinical Setting

Previous approaches to understanding patient-provider relationships tended to focus on informal relationships, seeing them as markers of corruption and hindrances to health care reform. My research was aimed at understanding how various configurations of private practice impact publicly provided maternal care in Novi Sad. Specifically, I focused on how patients and providers move between, negotiate and navigate relations from private into the public health care sector, and why they do so. My analysis is based on a year of ethnographic fieldwork conducted during 2016-17 in Novi Sad, the second largest city in Serbia.

During the research year, I conducted semi-structured interviews with gynecologists and with women who had given birth during that year; and unstructured interviews with midwives, residents, nurses, lactation specialists, as well as owners and non-medical staff of privately-owned institutions centered on maternal care (birthing schools and biobanks). I attended several fairs and conferences dealing with questions of health care and maternal care. At those events, I got a chance to hear and talk to key actors from the Ministry of Health. From all of these different people, I wanted to hear and understand their perspectives on health care provision in Serbia, specifically on how maternal care is provided in practice.

3.1 **Research sites**

Novi Sad was chosen as the primary research site, in part because it is the second largest city in the country but not the capital. Belgrade, the capital, is the exception rather than the norm when it comes to access to health care in general, and maternal care specifically. In the capital city,

with over two million inhabitants, there are two public maternity hospitals and three other hospitals with maternity wards. This means that the citizens of Belgrade have several choices in the public system when it comes to giving birth. Aside from the public institutions, Belgrade is the only city in which women can give birth in one of three private health care institutions. Novi Sad, on the other hand, like all cities in Serbia other than Belgrade, has only one public state-funded medical institution in which women can give birth. To conduct qualitative, long-term participant observation research, a city with just one maternity ward was representative of how maternal care is provided in the whole country.

The decision on site selection was based on exploratory research conducted during the summers of 2014 and 2015, as well as on some initial interviews with women from Belgrade, Novi Sad and Valjevo[6]. These interviews showed more similarities of experiences being pregnant in Novi Sad and Valjevo than in Belgrade. This means that Novi Sad, although a large city, provides a more typical case study of how maternal care is provided in the country than would Belgrade, while still having a fairly large number of individual childbirths.

My focus was on maternal health care as a system of care. Most studies tend to focus only on the birth event itself and the two to four days the women spend in the hospital (Rivkin-Fish 2005b, Arsenijevic, Pavlova, and Groot 2014, Baji et al. 2017, Chalmers 1997, Davis-Floyd 2003, 2009, Davis-Floyd and Sargent 1997, Pincus 2013, Sekulić 2016, Stankovic 2017b, a, Stepurko, Pavlova, Levenets, et al. 2013, Stanković 2017). I wanted to analyze the entire experience of being pregnant, as well as those involved in giving birth, in the Serbian health care system. This meant that I had to focus on two separate levels of health care provisioning – primary and tertiary.

[6] Valjevo is a medium size city in Central Serbia.

Spatially this research was conducted in three spaces: the public primary care center and maternity hospital and the private spaces of homes and private medical practices.

3.1.1 **Birthing classes - primary care**

Before the birthing process and delivery in the maternity wards or maternity hospital, women interact with various medical and non-medical institutions during their prenatal stages. They have regular gynecological check-ups in the public primary care setting, and many also in private gynecological practices. Women are encouraged by the public health care system, and in many cases by their families, to attend birthing classes when they enter their 28th week of pregnancy, in order to psychologically and physically prepare for labor.

In Novi Sad, there is only one state-run *Škola za trudnice* (literally "School for pregnant women" or birthing school), offered in the primary care center two blocks away from the maternity hospital. Nurse-midwives run this school, and there are between 15 and 20 pregnant women per group. These classes are completely free and are covered through state health insurance. That said, as with the prenatal check-ups, women also have two private options available to them when it comes to these types of classes, two private schools both associated and financially supported by international biobanks.

I attended the entire birthing course in all three schools, though my not being pregnant caused comments. The private school classes were once a week and lasted approximately a month and a half, while the public-school class met three times a week and lasted around three months. In total, I spent four and a half months learning about birthing and being pregnant, in the company of future mothers in both private and public institutions.

3.1.2 **The maternity hospital - tertiary care**

I spent four months in the Novi Sad maternity hospital, the only women's hospital in the entire Province of Vojvodina and the only hospital with a delivery ward in the city. Yearly, the institution delivers over 6800 births, and doctors conduct over 3000 surgeries, all with minimal staff. This hospital is part of the Clinical Center of the Province and is also affiliated with the University of Novi Sad as a teaching and research hospital. I shadowed various doctors, mostly residents, three to four times a week to learn what their typical work day was like. I was there to give a supportive smile to the women during delivery, to help out the nurses when they made gauze and other materials. I took the first pictures of newborns so their mothers could share them with their families and partners, I made and drank coffee with the medical staff, and in general, I spend time observing the daily routines in the delivery ward.

3.1.3 **Home settings and private practices**

After birth, women in Serbia are entitled to several post-birth visits from nurse midwives in their homes. Usually, these check-ups last until the baby's umbilical cord scar heals, and in the case of women who had a C-section birth until their stitches are healed. The information gathered for this part of maternal care is based on interviews with women a few months after and from two semi-structured interviews with two nurses in the public sector who are in charge of this portion of care, and three nanostructured interviews with nurses who offer their post-natal care services to mothers for a fee. I also conducted interviews with a gynecologist who work in the private sector in their places of business. These private practices are located in private apartments in residential buildings across the city.

hour trip to Belgrade to give birth in a private maternity hospital there. Aside from these women, I conducted semi-structured interviews with 14 gynecologists, who were working (n = 10) or have worked (n = 4) in both the public and private health care sector. I also interviewed two nurse-midwives whose primary job is postnatal care of the mother and newborn. During the interviews, all interlocutors were asked to sign consent forms and given similar conversation prompts to increase the chances that all topics were similarly covered in each interview. The women were asked to talk about their interactions with medical providers during pregnancy, birthing experience, and postnatal care. The gynecologists and nurses were given prompts to discuss their career paths, impressions about the public and private health care system and their approach to patients.

The transcribed interviews and researcher's field notes were entered into qualitative research Nvivo software for managing, analyzing, and interpreting the data.

3.2.2 **Participant observation**

Anthropology as a discipline has a long tradition of studying the "Other," of the anthropologist going off to a distant place different from their upbringing to spend a year or more in the field. The central method of anthropology has, thus, been participant observation, actively taking part in the daily activities and lives of people in a social, economic, political and cultural context different than their own.

In most textbooks and guides to participant observation, a section is always dedicated to the discussion of culture shock and the "feeling of always being on" (DeWalt and DeWalt 2011) and how to deal with it. At the University of Pittsburgh (Pitt), before I had completed my comprehensive exams and could officially go into the field, we held a workshop on sharing

experiences from the field. One older American graduate student, just back from the field in Vanuatu, gave the following advice on how to deal with the pressures of the field: "When you want to distance yourself from the research and the field, take a weekend off, book a room in the nice hotel, take a nice hot shower and watch Netflix". Both the discussion at this workshop and the books on participant observation provide tips and guidance for dealing with feelings of loneliness, homesickness while in the field - "culture shock is a virtually universal experience for investigators pursuing the method of participant observation" (DeWalt and DeWalt 2011, 73).

As an international graduate student in the United States, I experienced culture shock far more during the four years at Pitt than I did during that one year in the field. The explanation is quite simple: I could not feel lonely or homesick in the field when the field was my home. So, if I did not experience culture shock, was I then genuinely using the method of participant observation? What happens when you not only research your own country, in the city you grew up in but even more so in the hospital, in which you were born?

Bernard (2014) makes a distinction between an observing-participant, an insider who observes and records aspects of life, and a participant observer, an outsider participating in some aspects of life. I would claim that during my research I was both. It was because I was an observing participant that privatization and maternal care became a topic of research interest for me. The lack of a larger cultural and language barrier meant that I could gain access that might not have been possible for a non-native anthropologist. Thus, some of the background information presented in this thesis does come from news reports and official statements of the government. On a macro-level, it can be said that my role and method of collecting data included an observing participant positionality. On the other hand, even though I am a Serbian native, I was a very market outsider

on the micro-level of my fieldwork - the maternal health institutions in Serbia. My position on the level of those specific institutions was that of a participating observer, an outsider.

3.2.2.1 **Negotiating participant observation**

The main purpose of participant observation is to allow the researcher a window into the insider perspective. According to Musante and De Walt (2011) there are seven key elements of participant observation: "living in the context for an extended period of time learning and using the local language and dialect; actively participating in a wide range of daily, routine, and extraordinary activities with people who are full participants in the context; using everyday conversation as an interview technique; informally observing during leisure activities (hanging out); recording observations in field notes; using both tacit and explicit information in analysis and writing" (Musante and DeWalt 2011, 5).

While on a macro-level of my fieldwork experience, I employed all of the seven elements listed; their application on the micro level of the public primary care center and maternity hospital required re-conceptualization. For this reason, I would argue that it would not be enough to simply state that I conducted participant observation in a maternity hospital in Novi Sad and proceeded with presenting my ethnographic vignettes and quotes from the fieldwork. What does it mean to participate in a "wide range of daily, routine, and extraordinary activities" in a delivery ward? If the main point of participant observation is to gain insight into the insider perspective, what roles were available to me as an anthropologist in a clinical setting?

The hospitals, even though public institutions, are not easily accessible spaces. Foucault (1975) points out that clinics and medical institutions, in general, are exclusionary and exclusive highly structured and regimented spaces. Access into those types of spaces cannot be taken for

granted, and it took me over half a year to obtain approval from the ethics review boards on both local and provincial levels.

Danish anthropologist Gita Wind (2008) has proposed a reconceptualization of the classic participant observation method. In most ethnographic fieldwork the roles that the anthropologist takes on do not have to be so strictly defined, they can be fluid and dependent on the specific circumstances of the given context (Bernard and Gravlee 2014). Fluidity and shifting roles become more challenging to achieve in a setting where individuals have assigned strict roles that are made visible by the clothing they wear or do not wear. Doctors wear white uniforms and green scrubs when in the operating rooms, OB nurses and nurse midwives wear white with green rims on the collar, and PEDs nurses wear pink uniforms, medical students wear yellow uniforms.

Central to understanding how fieldwork can be negotiated in a clinical setting is understanding what kinds of roles the anthropologist can take up in those spaces, and what the implications are for each of those roles (Wind 2008). Wind (2008) offers four possible roles that an anthropologist can take up in a hospital setting: patient, visitor/family member, health care provider, or student/researcher. This research was not auto-ethnographic; at that point in my life, I was not nor have ever been pregnant. Thus, the role of the patient was not a role I could embody. The role of a visitor or family member would have been problematic. The maternity hospital I researched it was categorized as a tertiary medical institution. This categorization meant that visitations or presence of family members was not allowed. When labor starts, women are usually escorted by their family and partners to the entrance of the hospital. After that they are separated from their family, change their clothes into a nightgown and escorted upstairs to the delivery ward by a nurse midwife. The entirety of their stay in the hospital the woman does not have visitors. The first time the partner and the family have physical contact with the mother and infant is upon

discharge from the hospital, two or even more days after the birth. Having all this in mind, it was clear that that particular role would not only grant me very limited access to the workings of the hospital itself, but it would also have been a highly sensitive moment to approach new mothers and establish rapport with them.

In order to gain more access than a visitor, I had to provide lab results that testify that I am healthy. I had to take these tests, as part of obtaining a sanitation card (*sanitarna knjizica*). These cards are official documents required of all providers of health, food preparation and beauty services, in order to work in those sectors[7]. These lab tests included a nasal swab. I had decided that it would take far too long for me to complete the lab test and wait for the results from the public labs, so I paid for the test in a private lab. When I went in and asked them what is needed for those tests, the lab tech at the front desk asked me the following question: "Are you a colleague?“. What she was asking was if I was a medical professional. I told her the truth, and I was a medical anthropologist intending to research a hospital setting. I assumed the term medical was enough to guarantee that I was colleague enough. "You can pass the test even if you have a cold, just put some *'Chloramphenicol'*[8], and the test will come back clean," she told me. I was lucky not to have needed the tip, but the exchange was indicative of the access and rapport I would gain if I were able to assume the role of some medical professional.

[7] Zakon o zaštiti stanovništva od zaraznih bolesti, 2016; Pravilnik o obaveznim zdravstvenim pregledima određenih kategorija zaposlenih lica u objektima pod sanitarnim nadzorom, obaveznim i preporučenim zdravstvenim pregledima kojima podležu određene kategorije stanovništva, 2017

[8] Chloramphenicol is an antibiotic used for the treatment of many bacterial infections, including conjunctivitis.

As in other regions, the white coat or white cotton uniform is the marker of the authority of doctors in the Serbian health care landscape. Wearing a white coat and assuming the role of a medical provider would afford a researcher more or less unrestricted access within biomedical institutions (Wind 2008). If I put on the white coat, it would grantee me access, but it would alter the rapport I could establish with the women in the hospital. Doctors have a status of medical authority, especially in the tertiary institutions where many doctors are specialists, many of whom are also academics with PhDs and teaching positions in the University of Novi Sad. Their interactions with patients are strictly ritualized. After the delivery, when women are in the baby-friendly rooms, the doctors visit them during scheduled rounds. Women are instructed to sit up and to clean themselves and their belongings before the doctor's visit. These are moments of stress for women. Wearing white would give the impression that I am one of the actors in the relationship I want to understand better, that I was a doctor.

After obtaining all of the necessary documentation from the ethics committee of the hospital and presenting them with satisfactory lab results, I had an interview with Ivanka, the head resident whom I was to shadow during my time in the hospital. I had asked her if there were any other options for me other than white. The nurse-midwives wore white as well; the pediatrics nurses wore pink. "How about yellow?" Ivanka asked. "Those are the scrubs that medical students have to wear when they come to the hospital to for their practicum exams" she informed me. This color and role suited my research needs best; it allowed for both women and doctors to position me and see me as a student, someone who is there to learn from them, which was exactly the role I was in. The student who is there to ask questions, observe and learn through interactions. The role of a student is not unprecedented in anthropological studies. This role allowed me to enter

into the delivery ward without too many questions about what I was doing there. I was there to learn.

I do agree with Wind (2008), though, that such roles in medical settings require constant interactive negotiation. Clifford Gertz (1973) famously wrote about him and his wife running from the police after cockfight in Bali as a turning point in establishing trust with his interlocutors. In my case, the events that signified trust and established rapport were not as dramatic, but important to note. With the women, my presence during their deliveries was crucial in establishing a connection. I was not like the doctors there to see them at specific times or there to give them instructions. I sat with them in the latent stages of delivery, talked with them, handed them ice chips and offered an encouraging smile. I was there to take the first pictures of some of the newborns on their phones so that they can send them to their families. I was present at crucial moments in their lives. I deliberately decided not to interview them on the day of the birth or the next day, but on the second day or the day of discharge.

Establishing trust with the medical staff required more than an encouraging smile. The routine of an anthropologist in the field is far from the regimented and structured routine of medical providers and medical students (Wind 2008). Over time, most of the staff got accustomed to the lone student in yellow, following residents, talking to patients and writing things down in a little black notebook; but two key moments marked the establishment of trust with the doctors. The first was when I was offered coffee by the specialist on duty one afternoon in the doctor's lounge. The other was a joke about me assisting in a C-section. "You have been here long enough, you should scrub in and assist," said Miloš, a resident in the hospital. Joking and invitations to join in during times of leisure are central for participant observation in any setting, clinical settings included.

4.0 The State (of) Health Care

This chapter is divided into two parts. The first part of the chapter aims to provide a historical context and a clear description of the public (state) health care system in Serbia. I will first outline the history of how the now Serbian, formerly Yugoslavian, the health care system was imagined and how it looked in practice during and after socialism. It is essential to outline the differences and similarities of the Yugoslav approach to socialism and socialist health care systems from the more frequently studied Soviet system so that we can understand the continuities and ruptures in health care provisioning after Yugoslavia, after socialism.

Despite political and economic changes, the public health care infrastructure has remained the same since Yugoslavia. While I mentioned that for my informants Yugonostalgia was not a topic of conversation when it came to their experiences in and of maternal care, there are clear connections to the Yugoslavian times in the system in which health care is provided by both the public and the newly emerging private sector. For example, the primary care centers established during Socialist Yugoslavia were called *Domovi zdravlja* the literal translation being homes or homes of health. The newly emerging private sector, especially in Belgrade also has a parallel in primary care provisioning, and those spaces are also called *domovi zdravlja*. In the following chapter on private medical providers, I will also address the connotations of the notion of *dom* or home in the opening of individual private medical practices.

After a description of the Yugoslav health care system, I then provide a brief political and economic context of Serbian health care after the overthrowing of Milošević and the impact of IMF restrictions on public health care.

The second part of this chapter focuses on the official government discourse on the state of public health care and the introduction of the private sector as a potential problem and solution to the growing problems of "our system" (*naš sistem*). From the official discourses on the public and private health care system, I draw attention to the ambiguous treatment of medical providers and their relation to the state. In the final section, I focus specifically on maternal care and the problematic, paternalistic and nationalistic state discourse on reproduction.

4.1 **Part I: State health care**

4.1.1 **Yugoslav health care system: building a health care system from scratch**

"*Everyone shall be entitled to health care.*[9]"

"*Mothers and children shall enjoy special social care.*[10]"

Health care in Yugoslavia before 1945 has been described as "largely miserable" (Stambolieva 2015). During the inter-war period (1918-1939), medical practitioners were quite rare—one physician to 3000 patients—most of the population, had no health insurance whatsoever (Parmelee 1985, 1992, Parmelee, Henderson, and Cohen 1982). It is only after the Second World War, when Yugoslavia changed from being a monarchy to a socialist republic, that we can trace the nascence of a health care system.

[9] Article 186, The Constitution of The Socialist Federative Republic of Yugoslavia, 1974

[10] Article 188, The Constitution of The Socialist Federative Republic of Yugoslavia, 1974

The Yugoslav welfare model was not a typical socialist model. In a world divided between East and West, the Yugoslavian government tried to negotiate its existence. One way this negotiation took place was through imagining a different approach to socialism that resulted in two connected concepts: socialist self-management and social property. In most parts of the Eastern Bloc and especially in the Soviet Union, health care, like all other aspects of economic activity, was controlled, planned and delivered through a centralized system. This meant that medical providers felt powerless and disenfranchised (Rivkin-Fish 2010, Rivkin-Fish 2005b). In the Soviet Union according to Rivkin-Fish, "physicians were disenfranchised from political and economic power while at the same time promoted as authorities with disciplinary power" (Rivkin-Fish, 2005b, p.73). This meant that they had little or no control or even say on hiring processes, on their salaries, or on what was seen as necessary medical supplies for that particular clinic or hospital. Similarly, medical supply needs and staff allocation were matters of centralized planning in most socialist states (Verdery 1996). However, unlike the situation in the USSR, Yugoslavian health care, as indeed the entire social, economic and political system, was organized differently, through the decentralized model of workers' socialist self-management.

Socialist self-management was a pillar of Yugoslav socialism, and it signified the separation of Yugoslavia from the Soviet Bloc. Socialist self-management became the legal framework for the county in the early 1970s, with the new constitution in 1974 and laws, such as the Associated Labor Act in 1976. The key traits of self-management were decentralization and the withering away of the state. Understanding this specificity is essential not only for further historical and theoretical discussions of socialism but for studies of contemporary, post-socialist contexts. From the onset, the Yugoslavian government stated that they needed "a maximum degree of initiative, self-organization and independent assumption of responsibility" (Kardelj 1984,

104),[11] the main traits required of a self-manager. This is a different image of agency than what existed in the Soviet Union. Workers' self-management was seen as a socialist alternative to centralized state socialism in the Soviet Union. Self-management was practiced through the establishment of "organizations of associated labor" (*organizacije udruženog rada—OUR*). Every factory, every hospital, every clinic—every form of both economic and non-economic institution was legally an organization of associated labor. There were even workers courts that dealt with legal and organizational violations within these organizations of associated labor (Hayden 1990).

The most plastic way to explain the difference between this organization and the ideal type of centralized socialist planning is to compare it to the example given by Verdery (1996) to describe the difference between a capitalist and socialist economy. In a centralized socialist economy, all the shoe factories in the country had to make the same type and the same number of shoes regardless of buyers' demand. The centralized planning meant that the Soviet economy was a seller, not a buyer's economy. There was a central plan that defined what type and how many shoes were to be made, and these shoes were the property of the state.

In the Yugoslav case, each shoe factory was self-managed as an organization of associated labor. The workers in that shoe factory decided what type and how many shoes were to be produced. Most important, the shoes were not the property of the state, but rather social property. The idea was that social property was to cultivate the socialist consciousness and empower the workers that they feel like they are the owners of their labor. Unlike the Soviet Union, where private property was completely banned, and all property was nationalized, Yugoslavia made distinctions between state property, social property, and to a certain extent allowed private

[11] Member of the Presidency of Yugoslavia for SR Slovenia

property. For example, private property did remain in agriculture, but not in health care. In agriculture, some small private farmers cooperated on a contractual basis with other cooperatives or with OURs. While private property, in agriculture, was allowed it did not mean it was favored. Industry, which was organized through associated labor and self-management, was favored. Health care highlighted this preference very clear.

Health care workers were not employees of the state but workers in organizations of associated labor. Each clinic was an organization in and of itself, deciding how funds were allocated and how medical providers were hired and fired. They did have a large level of independence from the republics and the League of Communists, but that autonomy was not as complete as in other sectors. The reason for this was that health care was considered an activity of special social concern (Associated Labor Law 1976, 403): activities of organizations of associated labor or self-managing communities of interest (*samoupravne interesne zajednice*) which are "essential for the normal life of citizens," such as health care.

In order to ensure that these organizations were working in the interest of all citizens, aside from the workers in the clinic, the users (patients) were also included in the decision-making process. This was the aim, but in reality, patients had barely any say in the decision-making process (Stambolieva 2016). Even though membership in these communities of interest should have been open to all members of that community, in reality, these delegate positions were taken by white collar, higher educated men (Parmelee 1992).

After the war, health care was funded by the government, the insurance contributions of workers, and direct payments. Decentralization, a key feature of the self-management model, meant that the brunt of the costs got shifted to the local administration. By 1960s, the municipality covered 54% of the expenditure (Parmelee 1992), while the rest was covered from insurance and

direct payments. By 1985 over 98% of the population was insured (Parmelee 1992) but this did not mean that access to health care was equal for all citizens of Yugoslavia. Stambolieva (2016) argues that the health care system is only as good as the economy. If there is economic growth, the welfare system will be stable. The Yugoslav system was thus described as a "generous system of social rights" (Stambolieva 2016), but it was a fragile system. This decentralized model of funding highlighted the stark inequalities among the republics.

Yugoslavia had envisioned an "ambitious package of health insurance benefits" (Parmelee 1992, 320) - ambitious even for more affluent countries, let alone a country struggling with, and subsequently drowning in, debt and low GDP. While there was money, the socialist state invested in educating medical workers, so by the mid-1980s, there were 12 medical schools in the country, and over 57% of the practitioners were specialists (Letica 1989, Parmelee 1985, 1992, Stambolieva 2016) However, the 1980s were not a great decade for the Yugoslav economy, and the economic recession had a major impact on the health care system.

The impact of the crisis is most visible in the overall allocation of the social product of the country. The health care allocation declined from 6.2 percent in 1979 to 4.2. percent in 1986 (Letica 1989). There was an overall shortage of pharmaceuticals, a growing number of overcrowded waiting rooms in big cities. Medical personnel were poorly distributed between rural and urban areas

There were massive migrations from rural areas to cities (Denich 1976, Woodward 1995). From the 1980s and onward, scholars mark an increase in reliance on "veze" (connections) and bribes to access health care (Ćirić 1987, Letica 1987) in larger cities and the capitals of the republics. The self-managing communities of interest (samoupravne interesne zajednice), which were supposed to foster mutual trust between users and medical providers working in the interest

of everyone, were seen as corrupt and untrustworthy. As each clinic, each primary care center, and each hospital had independent planning and funding; inequality became starkly visible. Since most of the funding came from the taxes collected of the workers in that community, the bigger cities with more workers had more funds than rural, underpopulated areas. Wealthier communities had better funding and infrastructure. Doctors, as they were not employees of the state but could choose where they wanted to work, chose to work in urban areas and capital cities resulting in their disproportionate representation in these areas (Parmelee, Henderson, and Cohen 1982). People preferred to work in the industry at the expense of over agriculture because the health care benefits were far better in factories than in fields. Maternal care was a key example. If you were a young woman working in agriculture, chances you were not even officially recognized as a worker but as a household helper and thus not eligible for receiving maternity leave and cash compensation for it. On the other hand, if peasant women moved from the villages to cities to be factory workers, they were eligible for higher health care benefits. Denich (1976) argues that industrialization and gender equality were linked as women too were seen as workers.

Urban employment meant direct access to means of support for women but during the 1980s unemployment became a serious concern in Yugoslavia (Woodward 1995). As Susan Woodward points out, in the 1980s Yugoslavia had the highest rate of registered unemployment in Europe. She draws attention to not only the ideological paradox of socialist unemployment—given the proclaimed disappearance of unemployment in socialist ideology—but, more important, to the stigma around unemployment in socialism. She states that “to be unemployed (in socialist Yugoslavia) was to be excluded from full membership in a society” (Woodward 1995, 4). With a growing number of students graduating from medical schools, in the most prestigious and better-funded institutions there simply were no jobs for them.

The logic of self-management meant the atomization of health care institutions. Some scholars even referred to the status of health care as "feudalized" (Parmelee 1992). The institutions were thus not in collaboration with one another. This atomization, made coordinating activities difficult when patient care required such collaboration—as in the case of maternal care, which required interactions with general practitioners and stayed in hospitals. This feudalized characteristic of Yugoslavian health-care has continued to create problems in the present, as I will elaborate towards the end of this chapter. The ideal of self-management, collaboration, and democracy in health care was falling apart by the end of the 1980s.

Policymakers scrambled to fix the new health care system begun. Should they revert to complete centralization, following the Soviet model? Alternatively, should they completely open health care to the market and let the citizens with their insurance fend for themselves as they have done in the United States? Not opting for either of the extremes, policy and lawmakers attempted to "tinker around the edges of the existing organizational and financial arrangements" (Parmelee 1992, 331).

It is in this period that we can trace the re-emergence of private practice. During this time, scholars of Yugoslav health care were very skeptical about the privatization of health care. Privatization was seen as going against socialist ideology, and it was thought that it would "likely encounter stiff resistance from the public which has come to accept the promise if not always enjoying the reality of a right to health care" (Parmelee 1992, 311). The legal prohibition of private practice lasted until 1986 (Perišić 2014, 2016) when Serbia began debating the re-introduction of private dental practice. Two years later having a private practice became a legal possibility again, and not just for dentistry (Perišić 2014, 2016). The re-introduction of private, market-based health care practice at this time can be seen as complementary to what Rusinow was pointing out about

the “compromise model” (Rusinow 1977) of the Yugoslav economy more generally: state wanted to introduce capitalist flexibility into an existing robust system of state-provided care. The government saw the introduction of private practice as a short-term solution. They did not know that their short term would become more permanent without ever resolving conflicting characteristics of capitalist entrepreneurs with self-managing medical providers. However, private medical practice did not begin to flourish until the complete dissolution of Yugoslavia, and the end of state socialism—and specifically of self-management and its fundamental institution of social property.

The main characteristic of the Yugoslav economy was its (workers’) self-management approach to socialism. The collapse of Yugoslav self-management does not fit theoretically in Verdery’s (1996) interpretation of why socialism failed. According to her, one of the main contributions to the failure of socialism was in its economy of shortage, which produced an “etatization of time” that did not merge well with the post-Fordist just-in-time economy when socialist states began opening up to the market (Verdery 1996).

The studies of socialist Yugoslavia allow for a reframing of the study of socialism and post-socialism. Johanna Bockman (2011) for example is one of the scholars who refuted the idea that Soviet-style state socialism was the only socialism out there. When discussing Yugoslav self-management, she argues that current theories of how neoliberal reforms are taking place in this region need to either be rethought or at least more nuanced (Bockman 2011). She says that instead of using a binary opposition model to describe neoliberalism (state vs. market, capitalism vs. socialism) we need a different approach focused on the intersections and the networks that existed (Bockman 2011). For this reason, an understanding of Yugoslav self-management decenters the

binary model of socialist state/capitalist market, which helps us understand how the intersections of public health care and private practice play out in present-day Serbia,

4.1.2 **Serbian health-care system**

After the declared independence of Slovenia, Croatia, Bosnia and Herzegovina, and Macedonia, the two remaining republics, Serbia and Montenegro, formed a new federation still called Yugoslavia (the Federal Republic of Yugoslavia instead of the Socialist Federative Republic of Yugoslavia).

Along with the name, the country also inherited the Yugoslav health care system. However, as Stambolieva pointed out, the success of the health care systems was dependent on the economic conditions in the country (Stambolieva 2016). It would be an understatement to say that the economic status of the "new" Yugoslavia was not good.

During the 1990s, Serbia was under international isolation, which had severe repercussions. The wars and international sanctions left the previously "generous" health care sector of Yugoslavia in severe crisis (Perišić, 2011). The Milošević regime tried to maintain the illusion of the status quo, but in reality, the country's infrastructure was deteriorating (Perišić, 2011). All of the hospitals in Serbia lacked basic supplies, and medical staff experienced significant delays in receiving their salaries (Tosic, 1992).

One of the gynecologists I spoke to remembers working in a large maternity hospital during the sanctions and the 1999 NATO bombing:

> *During the sanctions, it became increasingly difficult to work. There were no medications, no resources. During the bombing, it was the worst. We*

would frequently lose electricity. Imagine doing a C-section under candlelight!

No one did this except us! We worked, without water or power but we worked.

It is this period—with the public infrastructure in crisis—that some authors point to as the "flourishing" of the private sector in the shadows of the public one (Perišić 2014). Milošević's regime led the country into sanctions and "had taken Serbia from the largest republic in the internationally respected and cosmopolitan Socialist Federal Republic of Yugoslavia to a pariah country plagued by nationalism, haunted by war crimes, and devastated by economic insecurity" (Greenberg 2014, 2). The government's insistence on maintaining the status quo also meant finding ways to keep doctors working, even though they, like all other state employees, were significantly underpaid. Allowing doctors to work part-time in the private sector became another way of maintaining the status quo. Since the private sector is wholly financed out-of-pocket, the services provided in this sector were unattainable to most people during the 1990s, except the newly forming wealthy elite, which made Serbia one of the countries with pronounced income inequality.

People stormed the nation's capital of Belgrade. They on October 5th, 2000ousted Milošević and established the democratic government of the new Yugoslavia, comprised of now two countries – Serbia and Montenegro. A year later the Serbian government was led by the prime minister Zoran Đinđić, - a man who only three years later would be assassinated in the same city (Greenberg 2014). Even though hopes that were high right after the revolution grew into disappointment after it, changes had been put in motion. The new post-Milošević government slowly managed to lift the international sanctions and started negotiations of their own with the International Monetary Fund (IMF).

The goal of the post-Milošević government was to "create a real market economy" (Perišić and Vuković 2012), emphasizing market and economic stability. When it came to reforms in health

care, this government also tried to maintain at least the perception of universal health care coverage. The government sought help from various international aid organizations to re-build essential health care infrastructure. Most notably, the World Health Organization (WHO) and the World Bank provided humanitarian aid to Serbian hospitals, with special attention to the maternity wards (Becker 2009).

The International Monetary Fund imposed reforms that had a severe impact on health care provisioning (Perišić 2014, 2016, Stambolovic 2003). Every one of these reforms hurt health care provisioning for the majority of the population. IMF suggested further containing public health care spending and imposing a cap on the duration of sick leave benefits, increasing the level of copayments, and downsizing the number of medical and nonmedical staff in public health care, as well as speeding up reforms of public enterprises and the privatization process (IMF 2013). These reforms included severe cuts in public health care funding and when the current right-wing government led by then Prime Minister, now President Aleksandar Vučić imposed a ban on new hires within the public sector the situation only got worse. While there are no official reports as to how many public health care providers have immigrated to Western European country, the public and media narrative describes the current state of the Serbian health care system as on the brink of collapse. In order to understand the current state of health care and how those medical providers that have decided to stay, navigate and negotiate through it, I provide a detailed explanation of how the state or public health care system is envisioned to function.

4.1.3 **The structure of public health care provisions in Serbia**

According to official state statistics, around 93% of the Serbian population is covered through the national health insurance fund and thus has (at least nominally) access to public health

care. The remaining 7% are people who do not have state identification cards (IDs) and are mostly Roma[12], or, as researchers have shown (Sekulić 2016, Stankovic 2017b), are elderly and live in remote rural areas of the country.

There are three central governing institutions: The Ministry of Health (*Ministarstvo zdravlja*), the Institute for Public Health, named after the founder of the Serbian public health care, Milan Jovanović Batut (*Zavod za javno zdravlje Batut*), and the National Health Insurance fund (*Republički fond za zdravstveno osiguranje*). The Ministry is in charge of planning, policy, laws, and oversight of the entire system. The Institute is in charge of research on various topics in public health; it also provides guidance and support to the Ministry. The National Health Insurance Fund (NHIF) is, as its name implies, in charge of collecting and managing the funds needed for the working of the health care system. NHIF collects funds directly from employed citizens via taxes. The citizens are taxed by their incomes, and the national insurance fund distributes health insurance cards (*zdravstvene knjižice*) to all legal citizens of Serbia regardless of employment status.

NHIF is the main auditor of the entire system, in charge of finances. If a doctor wants to prescribe a medication, for example, their prescription (*recept*) needs to be validated and paid through the NHIF. Patients can pick up prescriptions in either state or private pharmacies. In the state pharmacies, if the medication is covered through the fund, there generally are no additional costs to the patient. For example, the same logic applies if the doctor wants to send the patient for

[12] The Romani population is a racialized ethnicity in most parts of Europe. Roma people, especially Roma women, are subjected to various forms of structural and institutional racism throughout Europe. https://www.reproductiverights.org/press-room/romani-women-subject-to-forced-sterilization-in-slovakia

an ultrasound. The doctor writes a referral (*uput*) that, just like the prescription, has to be validated and paid through the fund. In general, public health care is provided to insured citizens on three levels: primary, secondary and tertiary.

Primary care institutions are the first place people are told to go to when they need medical care and for preventive care, annual checkups, and similar concerns. Primary care, in general, is provided and financed at the municipal level. The main type of primary care institutions in Serbia is the *Domovi zdravlja* (homes of health), which offer a varied array of out-patient care. There is a total of 158 primary care centers in the country.

The primary care centers provide patients with access to general practitioners, gynecologists, pediatricians, and dentists. In the primary care level patients have to select their chosen physician, or primary care provider (PCP) in the previously mentioned medical areas and accordance with their health insurance benefits package. To see these physicians, a patient needs to have a valid health insurance card and preferably a scheduled appointment through the call center or the new mobile phone application. Unless it is an emergency that requires immediate hospitalization, thus requiring direct admittance to the ER, the system requires patients first to seek out care in the Primary care centers.

According to the pamphlet printed by the Ministry of Health (2010): "Your chosen primary care provider is in charge of all segments of your health, they know you, they know your medical history. The chosen primary care provider is dedicated to their patients and is always on hand (*pri ruci*) when you need medical help. If the PCP decides they are not equipped to treat the patient, they write a referral (*uput*) to the secondary or tertiary level of care.

The secondary level of care is general hospitals (77 in Serbia), where medical specialists offer patients in-patient care. If the patient's situation requires more advanced technical resources

national strategies, and guidelines made women's health care during pregnancy, delivery, and the first nursing year a priority of the public health care system.

Prenatal care is provided in primary care centers. According to the Serbian National Program for the Health of Women and Youth (2009b), one gynecologist and one gynecological nurse are in charge of women's health care in the primary sector for 6,500 women older than 15 in the primary care sector. In 2007, 542 doctors and 883 nurses were in charge of women's' health care provisioning (Ministry of Health 2009b). This means that pregnant women have to follow the same bureaucratic procedure as all other patients in the public sector. They need a referral from their chosen PCP to give birth in the closest hospital to them. Places more than 30 km away from the nearest maternity ward in general hospitals can form small maternity wards in the primary centers (maximum of ten beds). There were 13 of these small maternity wards in 2006, but these numbers decreased to 12 in 2014. Small maternity wards in the primary care centers were the first to be cut due to austerity measures and lack of funding from the NHIF.

In these primary health care institutions, usually the ones nearest to their place of residence, the pregnant women are expected to come to at least four checkups after confirming their pregnancy (Ministry of Health 2009b). These checkups are supposed to include an ultrasound as well as several laboratory tests. Aside from these checkups and tests, the women are encouraged to attend pregnancy and birthing classes (*školica za trudnice*), located in the primary health care institution. The medical staff who work in the primary health care sector write referral notes for admission of the pregnant women into the public maternity hospital, i.e., the tertiary health care sector, or to the maternity ward in a general hospital in the secondary level. The difference between the two depends on two things: the individual diagnosis and where they live. Novi Sad does not have a maternity ward in its general hospital. Thus, the only place where women can give birth is

in the maternity hospital. However, if a woman who lives in a neighboring town, which has a maternity ward, she will probably give birth there; if her pregnancy is “risky” or there are medical complications, she will be referred to the maternity hospital in Novi Sad.

Upon admission into the hospital, pregnant women are separated from their partners and families. Cell phones are prohibited, as well as the possibility of bringing in external food. The women go through obligatory admission procedures, which include shaving and enemas. There are no visitations for the pregnant woman—she is a patient until her and the baby’s discharge. In recent years the ward has installed monitors in the babies’ rooms so that family members can see them in the discharge waiting areas after the birth. The birth itself is completely medicalized. Only the staff along with medical students occasionally are allowed to be present at the birth. If the pregnancy goes well, the mother and infant are sent home after two days, but if complications arise the stay can be prolonged.

After mother and newborn are discharged from the hospital, they are provided with post-birth care at their homes. The nurse (*patronažna sestra*), previously nurse midwife, comes for house checkups until the newborn's umbilical cord scar has healed. This usually means between four to seven home visits.

This was a description of how the public maternal health care system is designed to function. Maternal care in its design requires women to move between the levels of care, primary and secondary/tertiary. We can trace a continuity in the structuring of the health care system not only from socialism but specifically from Yugoslav self-managing socialism. The infrastructure and the organizational structure of the current Serbian system were inherited from the Yugoslav self-management period. Socialist self-management, unlike state socialism, gave power and authority to each medical institution. The connecting thread between these autonomous institutions

also to blame when for stagnation. Rivkin Fish points to similar examples in Russian maternity hospitals, and argues that through this distancing from the state, from "the system," the providers are placing themselves in the role of the victims of state power and of the constraints it imposes on their professional and personal lives (Rivkin Fish, 2005:29). The providers tend to misrecognize (Bourdieu, 1977) themselves as representatives of the state while shifting state authority and constraints onto people employed in the Ministry of Health.

An example of this shifting blame happened during my fieldwork in the maternity hospital in Novi Sad. One morning the fire alarm went off in the maternity hospital. I was sure it was not due to an actual fire because I saw some maintenance workers tinkering with the fire alarm system as I was walking in. I was struck that no one paid any attention to the horrific noise coming from the alarm system. What was the fire alarm protocol for this hospital? I realized that I was never told, and I had never thought to ask. In the United States, medical personnel is trained what to do in the event of a fire. I mentioned this observation to Dr. Gorunović during his coffee break that day. Dr. Gorunović laughed and said, "well, they [the United States] have a system. We do not. The United States has a system; we do not. We do not know what to do for lesser protocols let alone something like that. Those types of things are not resolved here (*nisu rešene*). No one knows what they are supposed to do (*niko ne zna ko šta radi*)." Dr. Gorunović's response to why there is no protocol on what to do in the case of a fire is an indication of disassociation from the hospital as an institution. He then blamed the state (*država*): "the problem is that the ones who decide about these things, the ones that make the laws, the politicians do not care. They are so alienated from our problems."

Dr. Gorunović and other medical providers understood the constraints placed on them by the Ministry of Health. I was shadowing Vera, a resident at the maternity hospital one morning

while she was helping Dr. Gorunović set up for an ultrasound exam. The gloves that Vera was supposed to use were too big for her. We all laughed, and Gorunović noted that the lack of smaller size gloves was a real-life example of the miscommunication and disconnect between how the state health care is supposed to function and how it works. He told us:

> *I have a friend who works in the administration. It is like we are not speaking the same language. She was here a few years back for our accreditation and said it is all good a here! All good? My dear, we only have gloves size eight! How is that good? We do not understand each other. The administration and us.*

The division of the Serbian health care system into primary, secondary, and tertiary levels means that the only connecting thread between them is the administrative referral aspect of the centralized insurance coverage and the policies and laws of the Ministry. The focus, especially in the secondary and tertiary level, is not on continuity of care, but rather on specialization. This means that the responsibility for the patients does not lie with the doctor but in the institution, especially at the tertiary level such as maternity hospitals. Not only is there no continuity when it comes to patient care, but is no communication and continuity within the different levels of care. I attended pregnancy classes in the primary care center in Novi Sad, which is located a block away from the maternity hospital. During one of the lectures, Olivera the instructor-midwife advised the pregnant women not to ask for an epidural during pregnancy. I initially suspected that the reason she advised them against it was that she was against any form of medicalization during birth. What I instead learned from Olivera was that the reason was more to do with a lack of communication with the hospital.

Our biggest problem is the system. We do not communicate with each other [meaning the different health care sectors]. The clinic, for example, they do not inform us of the changes they make most of the times I hear something is different from the women who have already given birth once and are back in school again with their second pregnancy. However, it is not just here. In Serbia, the system does not work. The issue is that I am an individual, not the whole institution. I cannot do anything. The women do not know where to get the right information anymore and when the clinic does not keep us in the loop than I do not know what to tell them and in return, they lose faith in not just me but the school. The epidural is a good example: they keep promising the women they will have an epidural, and I know they will not, that is why I discourage them from asking.

One of the factors that Dr. Gorunović and Olivera did not mention is the funding cuts to the health care system and the accompanying strains placed on the feasibility of the entire system.

4.2.2 **What is the cost of "free health care"? making the private sector the problem and the solution**

The State Secretary of Health, in a TV interview in March 2016, pointed out that that the Insurance Fund allocated around 260 euros per person for health care and that that is barely enough to cover the costs of one ultrasound appointment. He estimated the current public health care debt

to be around four billion dinars (around 40 million USD). I met the State Secretary at a large public panel on health care prosperity in Novi Sad. In his view, Serbian medical practice is still highly regarded, and Serbian universities are top notch, but it is undeniable that the current situation in health care is dire. It was at this event that I heard a public official speak about the private sector about health care problems in Serbia. He proposed that the right thing to do is to contract out services to the private sector:

> *We are doing the best we can with the funds available to us. The whole point is to finally instill some order into the health care sector and establish what is understood as the basic health care package. The private sector needs to be part of the solution, not the problem.*

The idea of including the private sector in the national health insurance coverage is not new and has been recommended by several social and public policy and health scholars(Arsenijevic, Pavlova, and Groot 2014, Arsenijevic, Pavlova, and Groot 2015c, Arsenijevic, Pavlova, and Groot 2015a, Perišić 2014, 2016). This is part of the complete transition to market logic rhetoric. They assume that if the private sector was covered within the national health insurance fund that this would lead to the complete eradication of corruption in the health care sector (Perišić, 2014).

After the panel ended, I asked the State Secretary what he meant when he said that the private sector was part of the problem. He said that the private sector is the breeding ground for corruption and *veze*. He said he had no intention of completely privatizing health care because privatization is damaging for the medical practice: “Some medical employees are not worthy of the white coats they wear.” This last statement reflects a larger narrative of distrust towards the encroachment of the private sector in previously exclusively public institutions. For example, there

is a public distrust towards private universities. The belief is that people buy degrees in private systems of higher education (cf. Bacevic 2014). Within these overarching narratives—complete distrust in the private sector and the narrative of numbers, costs of health care, and the need to establish how much basic health care provisioning costs—government officials are directly taking aim at the expanding private sector. The official government narrative is calling into question the integrity of the doctors who work both for the state and for private practice. The Minister of Health stated on national television that he did not see it as a problem "if someone wants to work in the afternoon in the private practice (*kod privatnika*), but we need to centralize the payments." On the other hand, the Ministry of Health offered no solutions for the very meager pay of the public medical providers, but rather argued the need for more transparency in their finances.

> *It cannot happen that someone goes to the private doctor (privatnik) and pays 5000 dinars for a check-up and that 2500 dinars end up in the doctors' pockets without any record. That cannot happen. We have to solve that problem and quickly.*

The Minister is not questioning whether the second labor of the doctors would lead to burning out or even questioning why most providers, especially specialists, tend to supplement their state salary by moonlighting in the private sector. State representatives tend to view both the patients and the providers through a lens of cost and benefit, an economic lens of health care as a matter of cost rather than a matter of right or entitlement (Kornai and Eggleston 2001). What is evident from the official government narrative is, interestingly, a step back from the paternalistic image of the state that is there to think for its citizens. The Minister of Health went on to say that:

As Vučić said, there is no free health care. Health care is expensive. We have to make a price list, make a price list of service. These have to be real costs and prices. Citizens need to know how much things cost.

In this view, the patients need to stop being socialist subjects and become rational actors, aware of how much their health care costs; and the providers need to take responsibility for their additional work if they choose to perform it - unless the patient is a pregnant woman and the provider is a gynecologist. Maternal care is provided for every citizen regardless of previous insurance status. In the case of maternal care, the Minister of Health had the opposite rational to his general stance of the patients knowing the price of health care.

The NHIF before 2016 considered epidural anesthesia a "nonstandard medical treatment" during childbirth and hospitals charged women for epidurals. The cost and inaccessibility for pain-free childbirth became the lens through which women's NGOs in Serbia view the larger problems of state maternity hospitals and the treatment of women during childbirth. Although problems in maternity hospitals were widely known, there exists an unwritten rule that women should not speak about them in public. To counter this silence, a grassroots NGO called *Majka Hrabrost* (Mother Courage) collected online surveys from mothers who had delivered infants in one of the maternity hospitals in Serbia in the period 2000–2008. After 657 questionnaires were collected on the website of Mother Courage, they named three main problems in Serbian maternity care: poor communication, corruption, and outdated medical protocols that are still in use, such as mandatory enemas upon admission. All of these problems were condensed to the issue of access to the epidural. Instead of solving the questions of understaffed hospitals, broken and outdated infrastructure and most importantly the treatment of women during childbirth, the solution the Minister of Health provided was making epidurals a standard treatment and thus covered by NHIF.

This was the opposite of what he generally claimed was the solution to the problems of the health care system. As a mock response to the 2017 Ministry of Health public search for a slogan for projects intended to boost fertility in Serbia, one submission summed up the problem: “You will get an epidural only you have a strong veza.” Making the epidural, a standard treatment did not include an increase in the number of anesthesiologists who could administer this treatment to every woman during childbirth. Instead of fostering better communication and curtailing corruption the ad hoc introduction of “free” epidurals only bolstered the notion that women need to find a *veza,* a connection in the hospital.

4.3 **Conclusion**

This chapter addressed the role and notion of the state in Serbian health care. We cannot fully understand the health care system in Serbia without addressing the role and perception of both the current state and the Yugoslav socialist state, the larger historical, economic and political contexts that shaped the current state of Serbian health care.

The specificity of Yugoslav self-management highlights the problems of treating “socialism” as a monolithic category, and the importance of fully comprehending the differing states of actually existing socialism. During Yugoslav socialism, health care institutions were social property, to be managed by workers, not directly by the state. Each health care institution was thus the property of the community which it served. The health care institutions were funded through health insurance collected from the community, and it was the role of these “communities of interest” to decide how best to spend the money. This logic, in turn, led to “the atomization and feudalization” (Parmelee 1985, 727) of the health care system that has continued over into the current Serbian health care system. The issue is not that the health care system is divided into

sectors. The atomized and feudalized logic refers to the lack of communication between the institutions – hence Olivera's remark that she relies on her patients to tell her about the protocol changes in the maternity hospital.

The Yugoslav wars, economic sanctions, and overall political turmoil damaged the Serbian health care system, and yet care was and is still provided daily, and for specific categories of citizens and health issues, it is completely covered through the insurance fund. In the last decades of Yugoslavia due to both internal and external political, social and economic factors, private health care was introduced as a stop-gap measure for the growing number of unemployed medical providers.

The re-introduction of private medical practice was not planned to be a permanent fixture of the health care system. In public discourse, the private sector overall is perceived as less valued that the state public sector. Ambivalence towards the private medical sector is present in the official state discourse, as best reflected in the narratives of government officials. The uniting thread in addressing both the public and private health care institutions is the concept that together they comprise "our system" (*naš sistem).* The next chapter looks at how medical providers negotiate their place in the medical system.

5.0 Paper-pushers, Doctors and Medical Entrepreneurs

How many gynecologists are also working in private practice? All of them.[14]

This was a short response one doctor gave me when I told him I was interested in understanding the relationship between the public maternal health care system and private health care practices. According to Dr. Milić, who has his private practice, every gynecologist in Serbia is working in the private sector, either exclusively or part-time. While there are no statistical data to support his claim[15], in this chapter I address the following questions:

1. Why were gynecologists working in the public sector moonlighting in the private sector, thus choosing to work 16 hours or more in a day?

2. Why are there so many small private practices but only two private maternity hospitals?

3. Why are we only seeing doctors and not midwives in the private sector?

In order to answer these questions, the chapter is divided into two main sections. The first section tracks the authority and trust of the medical provider during pregnancy in public and private

[14] Dr. Milić - owner of private medical practice

[15] There are no accurate data on how many medical providers are working in the private sector overall. The Association of Private Medical providers estimates that 4223 doctors in total are working exclusively in the private sector. The association also estimates that over 7000 state employed doctors work part time in the private sector. This is the general estimate for all doctors. There is no estimate based of specialization. We can infer from the data on state employed gynecologists (1114 gynecologists) that there is a high probability that the majority of them (over 80%) could be working in the state and private sectors. In order to confirm this claim, further data has to be collected.

sectors at the levels of primary care. The second is centered around institutions in which women can give birth—public maternity hospitals and private hospitals in Belgrade. This chapter contributes to the current theoretical view (Giordano and Kostova 2002, Giordano and Kostova 2013, Ledeneva 1998, 2006) that a general institutional mistrust in the public health care system drives patients to seek out alternative ways of achieving their rights to care. The main argument is that people resort to corruption, bribery, connections and other arrangements of the informal economy because the system is flawed and has gaps that need to be filled. A crucial example of this perspective is the conclusion that Buch Mejsner and Eklund Karlsson (2017b, 7) give: "informal payments are symptoms of poor management, underfunding, poor control in health care, lack of accountability, and deficits in the rule of law, that is, poor governance."

The issue is that systems, especially the health care system, tend to be compared with others instead of looking at them on their terms. This chapter looks at how medical providers negotiate their place in the medical system. In that sense, the understanding that there is a difference in perception of institutional (mis)trust between the primary, secondary and tertiary levels of health care is essential. This is why, again, maternal care proves to be an excellent ethnographic case study.

The maternity hospital in Novi Sad has employees 60 gynecologists working in one of several wards, not all related to pregnancy. The work day for the medical staff starts at 7:30 am with meetings and lasts officially until 2 pm, with the end-of-the-day meeting. Little of this time is spent sitting at a desk. It is a very active and demanding eight-hour day with up to 15 deliveries and several surgeries, all before 2 pm. Of course, in most cases, people, especially junior staff, have to stay later than that to follow up with a patient or catch up on paperwork. Some gynecologists with whom I spoke would have to get up at 5 am because they lived several hours

outside of the city where they worked. The hospital has a rotation schedule for the staff, so that most of the medical providers work in the hospital between 16 and 24 hours at least twice a month, the so-called "*dežurstva*" or evening and night shift. According to the State Institute of Public Health's yearly work satisfaction survey, the medical providers working in the hospital were not overly satisfied with their working environment, least of all their income. Most of the doctors I met would sometimes after working two days straight due to night shifts, spend another five or six hours working additionally as consultants in private gynecological practices in the afternoon hours after working in the hospital. Some would moonlight in the private sector once or twice a week, others far more often. If the only incentive was to bolster their income, why not just move entirely into the private sector? Why risk being perceived as corrupt?

I will not assume to provide a definitive answer to any of these questions. Instead, in this chapter, I describe the ability and inability of medical providers, both gynecologists, and nurse-midwives, to move between private and public sectors. Through a thick description of how maternal care is provided in practice, I want to contribute to the current theoretical understandings of private and public, trust, and mistrust, and provide a critique of the assumption that market economy would render informal economies obsolete.

Rather than rendering informal relations obsolete, the emergence of private practice provides a new avenue for establishing a personalized connection for patients within the public sector. At the same time, through the private sector, medical providers are granted a flexible path of establishing individual authority and power. Through supplemental work in the private sector, the gynecologists can draw on the authority of the institution and channel that authority to gain personal power and influence. The gynecologists working in public hospitals can transform and capitalize on the generalized authority of the public institution for personal entrepreneurship. The

gynecologists who work in the public maternity hospital make use of the generalized trust in the hospital to establish personalized trust and authority with "their" (*njihovim*) patient-clients in the private sector. This is contrary to the current theoretical view that personalized trust in state institutions weakens general trust in those public institutions (Arsenijevic, Pavlova, and Groot 2014, Baji et al. 2017, Buch Mejsner and Eklund Karlsson 2017a, Buch Mejsner and Eklund Karlsson 2017b, Dickov 2012, Hyde 2016, Jancsics 2013, Kornai and Eggleston 2001, Kornai 2000, Kornai, Rose-Ackerman, and Collegium 2004, Ledeneva 2006, 2013, Perišić 2016, Radin 2013, Stepurko, Pavlova, et al. 2015a, Vasiljevic-Prodanovic 2015).

Not all gynecologists working in the public sector can transform the generalized authority of the public institution to individual power. The main reason for this is that not all public institutions of health care have the same power and patients' trust. Through the description of the authority and trust of providers in primary and tertiary levels of public and private health care, it is possible to map out the fractal notion of general or institutional trust and mistrust. In this chapter, I describe the difference in patient trust between gynecologists who work the primary care sector, who are deemed as untrustworthy paper-pushers, and the institutional trust in the public hospitals, where the gynecologists are deemed as the best experts in the country. Small private practice, as will be described here, is predominantly focused on filling in the untrustworthy section of public care, providing trust and expertise for patients who can pay. Private hospitals with maternity wards cannot compete with the institutionalized trust of the state maternity hospitals. Pregnant women do not trust private hospitals like they trust public hospitals. If the private sector was generally more trusted than the public institutions, it does not explain why the majority of gynecologists are still working in public hospitals and why the majority of women give birth in the public sector.

Gynecologists who work in the public hospital and small private practices are the only ones who can establish continuity of care and continuity of trust with the patients. Gynecologists who work exclusively in the private sector do not have authority. The state curtails their medical authority through the rigid system of referrals that will be described in this chapter. The role of the state is central to understanding how power and authority play out in practice within the health care system. The assumption that the private sector is separate from the regulation of the state is questioned with a deeper understanding of the importance of fractalized trust and mistrust in public and private institutions. Further, the state provides legitimacy to the entrepreneurial ventures of doctors, allowing some of them to establish personalized power and authority through moving between the two sectors while denying the same flexibility to other medical providers in the hospital—midwives.

5.1 **Part I: Primary care**

5.1.1 **The power of referral - primary care providers as the gatekeepers**

You have to go to primary care. You need the doctor for the referral to the hospital, to open maternity leave.[16]

From its inception, the then Yugoslav and now Serbian health care system has been separated and fragmented into three levels—primary, secondary, and tertiary care. In its design, it resembles a pyramid, with the primary sector as the basis for all the other layers of care. Primary care institutions are envisioned to be homes of health (*domovi zdravlja*) and the medical provider

[16] Nataša, new mother.

in those houses should be the first person you contact when you seek out medical care. These should be patients' chosen doctors. The medical provider in primary care should be the person the patient trusts and knows best.

The primary care providers are also the gatekeepers of the other levels of medical care. The doctors in primary care decide if a patient needs to move up the pyramid of health care and seek out specialized care or if the patient can be treated on the level they are currently at. They are the gatekeepers of access to other benefits provided by the state, like paid maternity leave, to specific categories of citizens. The mechanism through which primary care providers grant or deny patients movement within the health care system and access to state-provided benefits is by writing an *uput* (referral). The *uput* is used to communicate among the fragmented sectors. The medical providers in primary care refer their patients to the other institutions, not to other medical providers. Through the referral system, the primary care sector communicated with the upper levels of care. Maternal care in that regard is an excellent example to understand why the referral system that is supposed to glue the sectors of care together is drawing them apart.

Public health care is designed in such a way that it is provided by institutions, not individual providers. Women cannot manage their pregnancy in the maternity hospital, as it is the highest level of care. The same can be said for the secondary level, the general hospital. Maternity and general hospitals are in-patient institutions. Prenatal care, in most cases, is out-patient care. It would be impossible and far too costly to admit every pregnant woman for each checkup during pregnancy. Prenatal care is under the jurisdiction of primary care providers. Women can move up through the health care system only after the approval of and referral from the primary care center.

The general idea behind this framework was not intended to be malicious or constraining. The assumption was that the gynecologist working in the primary care center is the leading

specialist in charge of a woman's reproductive health beginning at the age of 15, and that the patient and the provider have an established long-term relationship over the course of the woman's reproductive life, with mutual respect and trust built through such a relationship. This model is very similar to the model of family doctors in Cuba (Brotherton 2012) and highlights the ideal of long-term treatment and prevention that should be at the heart of primary care (Buch Mejsner and Eklund Karlsson 2017b).

While some women with whom I spoke to had established such long-term relationships with their primary care gynecologists in the public sector, the majority of women had not. For many women, like Nataša who is quoted above, visits to the gynecologists working in the primary care center were more of a bureaucratic hassle than a medical concern. For Nataša, the generalized trust in the institutions of primary care is missing, but due to the referral system, she cannot avoid this institution. Even if they gave birth in the private hospital, they still could not avoid the encounter with the *dom zdravlja*. If they want to receive maternity leave and other benefits from the state, they need approval from the public primary care sector.

The *uput* is not only a characteristic of the primary level of care. It is the exclusive privilege of the public sector. The referral is used to communicate within the public sector, and in turn to exclude the private practice. The referral in all cases except two (IVF and cataract operations) cannot be used to access private hospitals. The reverse also applies. The private primary care practitioner cannot write referrals to public hospitals. The reason for this is that the state insurance system takes care of its budget through referrals. With limited funds available for the yearly health treatments of each citizen, the role of the referral becomes more a barrier to accessing upper levels of care than the key to unlocking more advanced treatment.

5.1.2 *Dom zdravlja*: a place just for paperwork, not an actual place of medicine

The primary care centers, established during socialist Yugoslavia were envisioned to be the homes of health (dom zdravlja) for the community. The reference to home and family was supposed to symbolize the trust and connection between the medical providers and the community that they served. The gynecologist working in the primary care center should be the person with whom women were living in that community already have an established relationship. This should be the person they have been talking to about reproductive health since puberty. “My prenatal care gynecologist was also my mother’s doctor. I trust her" said one of the women I spoke to after giving birth in the maternity hospital. “I managed my pregnancy in my hometown with the doctor I see regularly. I chose my gynecologist in the primary care and had been going for my annual checkup for years", another woman said when I asked about her prenatal care. Some women had a long term and trusting relationship with their primary care gynecologist. However, the women who go to annual checkups are the minority. In reality, every fifth woman in Serbia goes for annual gynecological checkups[17]. Buch and Mejsner connect the fact that few women go for annual check-ups and preventative care with the view of primary care providers as obsolete and incapable of providing sufficient care to patients (Buch Mejsner and Eklund Karlsson 2017b, 7). Women talked about feeling rushed and enduring vaginal exams that they saw as unnecessary. They talked about doctors who would not listen to them or give information about their pregnancy. A common concern was the outdated technology in primary care centers. Manja, a German teacher in her late twenties, compared her first ultrasound experience to one of her sister who lives in the Czech

[17] https://www.b92.net/zdravlje/vesti.php?yyyy=2013&mm=04&dd=24&nav_id=708209

Republic. Her sister, a mother of two, has framed ultrasound print outs from both pregnancies. Manja was expecting the same when she was pregnant and went to her primary care provider:

> *She did the ultrasound for the first time, and I had to take a picture of the screen with my phone! They were out of paper for the printer. She did not tell me anything about what she saw on the ultrasound, just that it was fine.*

This was not a description of a trusting relationship. Not only do the women perceive the primary care centers and the medical providers working there as a bureaucratic hassle, but most of them also do not trust them as medical providers as well. They are viewed as gatekeepers to the specialists (Buch Mejsner and Eklund Karlsson 2017b)who work in the secondary and tertiary sector. They are also the gatekeepers for maternity leave for women who are employed.

"I went to the primary care so she can open my leave early. I was bleeding during pregnancy. I was supposed to rest. He would not write it", one woman told me, frustrated. The person who had told her she was supposed to go on bed rest was the doctor she was paying to see in the private sector. This doctor could not give her the documentation she needed to take leave from work. Only the public sector primary care doctor had that power. This power is not medical power, but bureaucratic power.

The gynecologist in primary care became not a person of trust, but an obstacle woman had to overcome. Framed as a bureaucratic obstacle of the rigid public health care, women sought out an individual, flexible path to health care services. These paths were obtained through favors or connections with these gynecologists. Favors were a way of establishing a personal relationship with public health care providers (Brković 2017b, Brotherton 2012, Rivkin-Fish 2005b, Stan 2012). Public health literature, unlike anthropological literature, claims that the lack of trust is one of the main reasons why patients resort to favors. In a study conducted in 2017, "general

practitioners were believed to be obsolete and incapable of providing sufficient care to patients" (Buch Mejsner and Eklund Karlsson 2017b, 7). How was this distrust viewed and experienced by medical providers in the primary care centers?

Most general practitioners in Serbia, including gynecologists in primary care, felt that primary care is not given enough attention from the state and that the providers feel there is a lack of incentives to work (Buch Mejsner and Eklund Karlsson 2017b). They feel that there is a disconnect between them and the specialists and that the specialists are treated better and are more respected. Some of the young residents whom I met at the maternity hospital were employed in primary care centers. One day as I was shadowing Vera, a young resident, she remarked on the way primary care providers are treated today.

> *The general reputation of health care is deteriorated in Serbia. I do not understand how we can still call it free health care. It is not. It has not been for a while. The people are overworked and unappreciated. Our reputation is also terrible now. We get no respect from our patients.*

In primary care centers, one gynecologist takes care of the health care needs of 6.500 women older than 15 per year (Ministry of Health 2009a). This roughly translates to seeing and treating 18 to 20 women during one seven-hour work day, or 20 minutes per patient. In reality, the numbers are much higher and the time dedicated to each patient is more in the realm of 10 to 15 minutes. This means that Vera will have less than 10 minutes to complete an ultrasound, write up her patient's paperwork and provide further advice on prenatal care to her patient. According to the doctors I spoke to this is barely enough time to complete an exam and not enough time for the patient and doctor to establish any relationship of trust and mutual understanding. But unlike the assumption made by this and other public health studies that this lack of trust would lead to an

increase in favors (Arsenijevic, Pavlova, and Groot 2014, 2015a, Baji et al. 2017, Buch Mejsner and Eklund Karlsson 2017a, Buch Mejsner and Eklund Karlsson 2017b, Kornai 2000, Stepurko, Pavlova, Gryga, et al. 2013, Stepurko, Pavlova, et al. 2015a, Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015, Stepurko, Pavlova, Levenets, et al. 2013). Vera did not see the items given to her by patients as attempts to establish a personalized, trusting relationship with her.

> *Today, patients are rude. They come in and bring me a brlja[18] and an envelope with twenty euros, and want to buy us! Those are bribes! There was a time when patients would dress up to visit the doctor, shave, smell nice, and treat us with respect and give you something as a gift, not as a bribe.*

Buch Mejsner and Eklund Karlsson (2017b) claim that medical providers, such as Vera, lack the knowledge do not distinguish bribes from gifts. This is a paternalistic assumption. It is due to the lack of possibility of establishing relationships of trust that may explain why there is a lack of appreciation for primary care providers. From Vera's response, it is the lack of trust and appreciation from the patients that is important. It is in this lack of sociality, mutual respect, and understanding that Vera sees the distinction that makes rakija a gift, rather than a bribe.

Marcell Mauss (1967), in his study on the practice of gift exchange, pointed out that what distinguishes gifts from other forms of economic transactions is the establishing of social relations marked by gifts and their accompanying obligations on the recipient. It is the social relationship that was missing in Vera's story. In order for the rakija and the envelope to be considered gifts from patients which the providers see "as legitimate compensation for their knowledge, skills and

[18] rakija, a form of brandy, usually home-made

the gift of health" (Stan 2012, 71). For Vera and other public primary care providers, this is a bribe because it is not read as a compensation for her knowledge and skills as a doctor but her role as a gatekeeper. Vera summed it up best: "*Dom zdravlja* has now become a place just for paperwork, not an actual place of medicine." It is an obstacle in the patients' path to reaching those who deserve gifts (Stan 2012)—the experts in the higher levels of care. These feelings of under-appreciation and constrained agency played a crucial role in making decisions to leave the country or start working in the private sector.

Gynecologists and other medical providers working in primary care, and nurse-midwives who taught pregnancy classes, were expressing feeling under-appreciated in comparison to their colleagues working in the maternity hospital. The rigid referral system, coupled with the cuts in staff and equipment, transformed them into paper-pushers in the eyes of their patients. This low status and perception of primary care providers as lacking essential knowledge and skills in providing care were only further exacerbated by the evident lack of contact and collaboration with their colleagues in the maternity hospitals, and upper levels of care more broadly.

"We do not communicate amongst each other [i.e., the different health care sectors]," said Branka. She was the nurse-midwife whose pregnancy classes I attended for several months. One of the main purposes of attending the maternity classes, shadowing doctors in the maternity hospital, and conducting interviews with nurses who provide post-natal care was to piece together the fragmented nature of the Serbian maternal health care. On the other hand, the doctors working in the school would also complain that the school was not providing the women with adequate information. Instead of having an official channel to communicate this problem, I was once asked by a resident to send a message back to the school: "Tell them to stop telling women to bring

catheters! We have those!" The primary care center where the public classes take place is located two blocks away from the maternity hospital in Novi Sad.

Instead of continuity, the key trait of public maternal care is separation. In this fractured system of care, both patients and providers seek their strategies to overcome these constraints; these strategies span from legal to illegal, formal to informal.

This is the situation that most public health and health policy scholars claim can best be resolved with the introduction of market practices. These practices would transform providers into sellers of a particular type of sound—health care—and patients into consumers, who would, supposedly, be empowered to speak up and to choose the kind of care that best suits them and their financial status. Reformers such as Kornai and Eggleston (2001) argued that the market would increase responsibility and that profit would motivate both providers and clients to be more responsible and build mutual trust. In the following section, I focus on those providers who have moved into the private sector to understand why the magic bullet of the market has not been the best treatment for Serbian health care.

5.1.3 **Entrepreneurial acrobatics - the private medical sector in Serbia**

One of the founders of the Association of Private Care providers called the everyday obstacles that private care physicians faced a form of *privatničke akrobatike* (entrepreneurial acrobatics) when she was giving a talk at a conference of Private Medical Practitioners in 2016. It is a good way of describing the daily navigation and negotiation that are required from medical providers in the private sector. The lack of regulation by of the state would appear to be in line with the central tenets of neoliberalism—deregulation, decentralization, and privatization—but it does not explain why many medical providers "choose" to work in both sectors rather than just the

private sector. Rather than viewing neoliberalism as a contained package that is supposed to replace the existing system, the emergence of private health care practice in Serbia allows for seeing neoliberalism as a set of partial measures taken over time that are unbundling the public system. The term unbundling comes from business terminology. The AMA Dictionary of Business and Management defines unbundling as the "separation of business into its constituent parts, to sell off some of them" (Kurian 2013, 229).

The Serbian public health care system is bundled together through a single health insurance provider—the state. This bundling is enacted through the movement of papers such as referrals (*uput*). I describe it as bundled because production, distribution, and price setting was all connected. Collier (2011) notes that this is a key trait of institutions and infrastructures originating from the mid-19 through much of the 20th century, and notes a similar variation of this bundling within "Soviet Modernity." Bundling was not just a characteristic of health care but other infrastructural processes as well, from roads to heating pipes (Collier 2011).

By the late 1980s, it was legal again to open private medical practices in Serbia and the "selective intervention" (Collier 2011) of market practices. The first splinter was dentistry; by 1989 most of the primary dental care was provided in parallel for a fee in the private sector. This was the beginning of the unbundling of the previously tightly bundled health care system. The state is still mostly in charge of both the founding of health care institutions and the education of health care providers. The state health care system thus distributes these institutions and providers to its citizens and sets a unified rate charged through the national health insurance. If bundling includes the production, distribution, and rate setting, the distribution of health care was the first thing to become unbundled.

The health care system in Serbia is not completely unbundled. The state has not dismantled the public health care system or privatized and marketized every segment of social health care and welfare provisioning. Collier (2011) notes a similar process in Russia with the unbundling of the Soviet heating system. A complete dismantling of a previously bundled infrastructure such as health care would go against the social welfare goals, both of the Russian states, in Collier's study, and health care provisioning in Serbia in my research. Through selective intervening, as a "micro-economic device"(Collier 2011, 207), the bundled framework is not dismantled but altered. It is altered so that it still retains the ideal that, similar to heat, health care is "an essential need, and […] its provision has, at the end of the day, to be guaranteed by the government" (Collier 2011, 207). I would argue that in order to still be able to maintain the essential provision of health care, the government has very selectively unbundled health care provisioning, which does not allow providers to disassociate themselves from the bundle of public health care completely.

Rivkin-Fish observed that maternity hospitals in Saint Petersburg physically sectioned off parts of their maternity wards into paying wards (Rivkin-Fish 2005b). This was not the case in Serbia. With the re-introduction of private practices, the providers were allowed to distribute their product—health care—outside of the public health care bundle. They could provide care for a fee, but they had to find their infrastructure for that purpose. Most of the doctors who opened private practices did so by converting apartments into doctors' offices. In essence, these private medical care providers were taking the socialist naming of the primary care infrastructure, as homes of health, quite literally into their homes.

In Novi Sad on my daily route between the maternity hospital and the primary care center where pregnancy classes took place, I would pass by several signs perched on balconies of apartment buildings with the words: *Ginekologija* (Gynecology).

disadvantage when it comes to providing care. From the perspective of the state, they are entrepreneurs whose status depends on how well their practices do in the market, which is heavily constrained and inflexible when it comes to health.

Many women mentioned Dr. Manojlović to me when talking about not just their prenatal care but their reproductive health care in general. They mentioned having gone to see him for years and just continuing to do so when they became pregnant. Dr. Manojlović can be considered a successful entrepreneur with his private practice. I spoke to Dr. Manojlović about how he dealt with the entrepreneurial acrobatics of opening his private practice.

> *I am lumped in that category of privatnik (entrepreneur). Me and the shoemaker and the baker—we are all entrepreneurs. I think that is the wrong way to go about it and, yes, it is more than a technical issue. For example, when I went to the bank to ask for a loan to buy some equipment, they told me that it would have been easier for me to lease a new car than new medical equipment. Because for the car, in the case I default, they can always find a new buyer, but for medical equipment, which is specialized, it is hard, and even the loaning system is not well equipped to deal with it. All this is nothing new; it has been like this for twenty years, so no change has happened.*

The physicians who work exclusively in the private sector face many constraints. They are not able to provide referrals, write prescriptions, or provide valid medical documentation for their client-patients when they need to open medical leave from their jobs, or, as was the case for my research, provide pregnancy leave for employed pregnant women. Mainly, the state did not view the medical providers working in the private sector as health care providers and denied them all of

the privileges and authority that came with that role. For Dr. Manojlović, a prenatal care gynecologist, the lack of ability to write referrals was the main problem.

> *You cannot from your private practice write a referral directly to the institution that you think the patient should go. No, instead it has to be verified by someone else in the public sector, usually by someone who is much less educated than that person. We cannot open sick leave, maternity leave, pregnancy leave for our patients. Moreover, I can tell you from talking to my friends in the primary care sector how much of an administrative burden that is for them.*

The administrative burden placed upon his friends in the public system; this was not the reason he decided to work in the private sector. Dr. Manojlović never worked in the public sector. He started his career working for another doctor's private practice, but not because he did not want to work in the public sector. He volunteered for years in the maternity hospital, as he put it: "I was working for years [in exchange] for a smile." After completing his residency, he was not able to obtain a job in the hospital. "The main reason was I [pause] did not have the right pedigree to work in the clinic. [laugh] It all depends on your pot. If you are going to blossom as a big flower, you need a big pot (veliku saksiju). My pot was not as big as some other pots". The vivid metaphor of the potted plant that needs space to set roots was an excellent one to describe the importance of social personhood in "getting things done"(Brković 2017b, Brković 2017a, Ledeneva 1998). This was a euphemism for having or not having a connection (veza) to get the job in the public hospital. His social network was not big enough, not powerful enough to let him flourish in the public sector. Looking back on this time, Dr. Manojlović now sees this small pot as a blessing in disguise.

In the early two thousand, they banned those who worked in the private sector from working in the public sector as well. That was an interesting moment. It was a short time. This worked out well for me because most private clinics depended on the work of the public sector consultants and they could not work without them. I was unemployed, so I took that opportunity. I started in the private sector as a young gynecologist, without anyone to have my back, without a name, which is very important in the private sector. This was seventeen years ago. I have been working private this whole time. When I look back on it now, I am glad. It turned out well.

He indeed was doing well. He now has his own practice and has dedicated his time to his growth as a health care provider. It is not a big practice, but it is located in the city center, on the fifth floor of a beautiful residential building. The interior was painted in soothing pastel colors. His practice focused on a more psychological approach to pregnancy and delivery, which was entirely different from the medicalized approach of the public sector. He encouraged his patients to take on an active role during their pregnancy and delivery and worked with them on meditation and breathing. This method, called NLP (neuro-linguistic programming), was initially made for the business sector and has been adapted to medicine. The main idea is that women can alter their experience during pregnancy through their thoughts and by working on themselves. In Dr. Manojlović's view, it would be ideal if the hospital itself would work hard to switch the focus from a medicalized birth centered around the doctors, to a birth focused on the woman. "But if we cannot change the system, I can at least help the women come prepared, believe in themselves and have a good birthing experience. My job is to make sure that women enjoy their pregnancy".

While the question remains whether this strategy does indeed help women feel empowered during their pregnancy and delivery, incorporation of this method is a way of standing out for Dr. Manojlović. Sadly, good thoughts cannot help his patients bypass the administration of the public sector. However, even though Dr. Manojlović cannot write referrals for his patients, women did not stop coming to him for care. For various reasons women either do not regularly go for gynecological checkups or choose to pay for their reproductive care in the private sector. One potential explanation as to why women who can afford it are going to private practice is related, again, to the issue of trust and establishing a relationship with their provider.

> *People are unhappy with the public system, and you can see that. At the core, the issue is trust. There are doctors in the public system who do not have the trust of their patients. A pregnant woman will see me every time.*

Dr. Manojlović established trust with his patients by being more available to his patients. He is not constrained by an allotted quota of patients he has to have. He can devote as little or as more time to his patients as he chooses. In other words, he is the owner of his work.

> *The fact that I am a solo privatnik (independent entrepreneur), I am the owner of everything. It gives me the ability to decide how I will approach my patients in that financial aspect. I have that option of not charging. Many of my patients do not pay for certain things, like check-ups. I do not charge when we discover extreme anomalies in the fetus that result in abortions. I do not think I should be charging people for their grief. These are things that private practice grants me.*

This act of choosing who can pay them, and how much, at the same time recognizes the precarious state his patients are in financially and a re-affirms his authority and power over patient-clients. His office is decorated merely with his diplomas and specialization certificates that demonstrate, to the patients waiting to see him, that he is an expert. The addition of focusing not only on their physical state but also their psychological state is another reason why he has garnered trust. In his view, this trust is enough for women.

> *If she trusts me, she is not bothered by the administrative stuff, for her getting the paper for maternity leave is a technical matter. She will endure waiting in lines, the verbal abuse from the nurses and the doctors. Usually, the comments are: Why did you come here now? Don't you have your doctor? Why don't you go privately now instead of coming here? Moreover, all of them also work as consultants somewhere privately. So those who treat women badly, usually what they mean by it is, why did you go to that private practice and not my own. They will endure all of that and will not deter them from coming to see me.*

The doctors working in the private sector do not have the authority to write referrals or prescriptions for their patients. This means that to receive the needed referral for the maternity hospital or for working women to get the necessary documentation for parental leave, they have to "endure it all" in the public sector, at least once. These sporadic encounters between the pregnant patient and the gynecologist working in the public sector, solely for documentation and not actual care, could be the reason why most public primary care providers stated that they felt like they were not doing medicine but paperwork.

While the doctors working in the private sector alone have harsh words for their peers in the public sector, they are aware that the structural constraints, which label them as entrepreneurs, do not afford them the ability to provide complete maternal care to their clients. If they do not work or have never worked, in the public sector, their small pot is limiting not only them but also their potential clients; the doctors' small pot affects their patients' experience when they have to go back into the public sector.

Dr. Manojlović is aware of this and has worked hard to cultivate friendships with his colleagues in the primary care center. "How women will fare usually depends on the goodwill of the doctor in *dom zdravlja*. I have a few colleagues who will help out, and I help their patients out. I see them for free here in the clinic. There has to be collegiality". Even though he volunteered in the maternity hospital, he could not say the same type of collegiality was present with the doctors there.

> *When I send women to give birth, it is a nightmare. God forbid I have to call and ask for a favor, maybe there is a complication with the birth. Sadly, I sometimes fall on deaf ears. Why did you go there, why didn't you see me? I would have solved this for you.*

"God forbid, I have to ask for a favor"—this sentence highlights the importance of sociality not only for the patients but in the interpersonal relationship between medical providers. There is a power inequality between various categories of medical providers. Selective interventions of the market into health care are brought into stark relief if we untangle the practice of using the private sector to establish a connection in the public-health-care sector from both informality and corruption.

The legal possibility of creating a framework for the re-emergence of the private sector in Yugoslavia in the late 1980s was seen as a solution for combating high unemployment numbers among medical specialists. However, this inclusion was by no means complete; patients and providers were left to seek out their ways of navigating these constraints. The same legislative framework governs private medical practices as all other private entrepreneurs; hence, my interlocutor's comparison with shoemakers and bakers. This lumping of medical providers with other small private businesses points to a sense of loss of social status more broadly. Aside from the more psychological aspects, this constraining normative framework means that they are faced with everyday obstacles in running their businesses.

The referral system coupled with the selective unbundling only of the distribution aspects of the bundled public health care infrastructure has left doctors like Vera and dr. Manojlović in precarious situations. While the referral system excludes private medical providers, it paradoxically forces their patients to include the public primary care doctor in their health care pathway. Dr. Manojlović's patients have to go into the public system; they cannot pass it by entirely. Instead of referring his patients to the maternity hospital, he has to ask favors of his peers. At the same time, the doctors in private prenatal care practice are the ones who can to dedicate more time and be personally available to their patients. They establish trust, but they are *privatnici* (entrepreneurs). The doctors in primary public care cannot devote as much time to their patients or provide them with more personalized treatment. They are seen as paper-pushers. Mostly, neither of them has a pot that is big enough to let them have both trust and the authority to grant continuity of care to their patients.

5.2 **Part II: Tertiary Fare**

5.2.1 **(Mis)Trust in higher levels of health care**

In the previous sections, I have outlined the constraints visible in both the public and the private sector for the gynecologists who provide prenatal care. From Vera and Dr. Manojlović we learn how the selective interventions of market practices and austerity measures affect their perception of their relationship with patients and their jobs. The doctors in the public primary care centers have lost the trust of their patients, who do not regard them as medical providers but rather state bureaucrats. This observation supports the claims that there is generalized, institutionalized mistrust (Giordano 2010, Giordano and Kostova 2002, Giordano and Kostova 2013, Ledeneva 2006, 2013) in public health care institutions. Moreover, due to this institutional mistrust in the care provided in the public *dom zdravlja,* patients not only resort to the informal economy but those who can afford it choose to pay for that same care in within the private sector.

The observation that most women would choose to pay for prenatal care with her trusted *privatnik* thus supports Rivkin-Fish (2005b)'s predictions that privatizing strategies (paying for care) will take over personalizing strategies (giving gifts). The doctors in the private sector can establish trust with their patients. On the other hand, it is their lack of bureaucratic power—the ability to write referrals—that chips away at the private prenatal care providers sense of medical authority. The health insurance system does not encompass the private providers, and they are categorized more as entrepreneurs (*privatnici*) than as doctors.

The health care system in Serbia is fragmented and is slowly being unbundled and opened up to market practices. I would argue that the notion of institutionalized (mis)trust has to be treated as fragmented as well. The fragmentation of the health care system complicates monolithic

theories about the state and trajectory of post-socialist health care. Neoliberalized health care is not a bundled structure that will take over or stand parallel to the existing system. Practices that can be understood as neoliberal are intervening and interacting in a patchy manner. They are sometimes filling in the gaps of the existing system but, because of the rigid nature of the referral, a system the public sector is also filling in the gaps in the emerging private system.

This is a different image than, for example, the ethnography on the two-tier health care system in Cuba (Brotherton 2012), where those who can afford it can "lift off"(Sampson 2002) from the public health care system into the private sector. What is meant by "lifting off" is the ability of some economic classes to completely bypass the state health care system and seek out for-fee care in the private sector(Sampson 2002)? This brings me to the questions from the start of this chapter: Why were gynecologists working in the public sector moonlighting in the private sector, thus choosing to have 16-hour work days or more? Why are there so many small private practices but only two private maternity hospitals?

For the majority of Serbian citizens, the ability to lift off in this manner is unattainable. The obvious issue is financial: not being able to afford completely switching to care in the private sector. Even if they can afford it, they cannot avoid interacting with the public system; they need someone like Vera to write them sick leave from work. If they are employed, they pay into the state health insurance, regardless of their potential supplemental health insurance. There are some emerging practices of additional or private health insurances offered by foreign insurance companies, but these are not widely known about or used by citizens of Serbia outside of Belgrade. The other issue is geographical: even if someone has the means to afford to lift off or has the knowledge and takes advantage of private health insurance, their choices are limited. Only one city in Serbia has not only out-patient private care but also large private hospitals, which would

serve as equivalents to the state secondary levels of care. This means that the nature of Serbian health care, both public and private, remains fragmented for the majority of citizens not living in Belgrade. This being said, it does not explain why are doctors opting to remain in the public health care system? Why don't they transition into the private sector completely? What is the incentive for them to remain when the salary in the private sector is potentially far higher than the one in the public system?

In the case of prenatal care, trust is located with the personal medical knowledge of the private doctor, but this personalized trust does not imply that the private health care sector, as an abstract institution, is generally trusted. It is the opposite. If there was a complete institutional mistrust in the health care system, why do even women who can afford to opt out prefer to seek care in the public tertiary system rather than bypass it altogether in the private sector?

The most straightforward answer, I was usually given is: "If something goes wrong, God forbid, all the best experts are in the state hospitals." The public discourse is that in the event of any medical complication in the private hospitals in Belgrade are transferred into the public hospital in case of emergency. The implicit argument behind this statement is that the best, most qualified specialists do not work exclusively in the private sector; they work in the highest level of the state-provided health care system. If you work in the tertiary sector, the assumption is that you have achieved the highest possible status when it comes to your medical education and expertise. When the then prime minister, now president, talked about how the Serbian state has good doctors, even great doctors, he was referring to those in the higher levels of care. While other government officials have stated that most of the medical providers working in the private sector are "not worthy of the white coats they wear." This may not be a reality, but it feeds into a narrative of big and small pots.

The generalized impression of not enough institutional trust in the private hospital shows two things. First, it shows us the need to rethink the notion of general mistrust in the public system. More important, it highlights that the privatization of health care is not uniform and independent of the existing public infrastructure. The doctors who are working in the large private maternity hospitals used to work in public hospitals. Some of them were even in charge of entire maternity wards at one point or another.

5.2.2 **I am not an institution - transitioning into the private hospital**

"I have completely left the state system, and I do not regret that," Dr. Surla told me as we were having coffee and cake in the restaurant of the private hospital in Belgrade. Dr. Surla, after more than twenty years of work in a large general hospital, along with supplemental work in one private practice, decided to move completely into the private sector and become a member of a large private hospital in Belgrade. I went to talk to her at her new place of work in a very nice, affluent residential area. What struck me most was that the place looked more like a hotel than a hospital. It was a new building, but its design, as well as all of the furniture and the entire interior, was baroque: large gold-plated mirrors in the hallways, classical music playing in the background. The cleaning staff was dressed in maids' uniforms, and in general, the impression was that most of the non-medical staff were very young and all spoke English. This was not surprising, as the handful of people I saw waiting in the hallways were speaking English as the hospital mostly catered to international patients.

When I arrived, I was instructed to talk to the concierge of the hospital, a young woman standing behind a counter with multiple credit card machines in front of her. This signaled that the treatment provided here was to be paid for out of pocket or through international insurance.

The concierge told me that the doctor was waiting for me in the hospital's restaurant and gave me directions to the garden located within the building.

The doctor with whom I was going to speak was heralded by many women's NGO activists as a shining example of a doctor who is on the side of the pregnant woman. During her time as chief of the maternity ward in the public hospital, she had made drastic changes in hospital protocol, such as allowing women to sit on swiss-balls, walk around, and have their partners present during birth. Thus, it was a shock to everyone when she decided to move into the private sector entirely. When we started talking, I asked her what the main differences between working for the state and in the private practice were. From her perspective, there was a clear distinction between the approach of the state and the approach of the big private health care providers in Belgrade.

> *The main difference between the private and state [health care sector] is that we have come to the point that in the state-run practice the only answer to any question you have is no and it cannot be done. In the private sector, in answer to the same question [can something be done], the answer is always yes. People put in the effort. It is not a farce; they are trying to help.*

Dr. Surla spoke at length about her almost twenty years of work in the general public hospital within its maternity ward. During her tenure as chief, that ward became known as one of the best maternity hospitals in the country. The hospital where she worked, like the maternity hospital in Novi Sad, was the only one in the city. It was the only choice women had, and it was not a great one.

At the time our maternity ward was like the rest of them. Our windows were bolted shut. Visitations were not possible. The hospital was so closed off that we did not even allow food from outside. This was in the 1990s. Imagine in those unfortunate times we had to throw out food that was smuggled into the ward. This was heresy for the time. People barely scrounged together something to bring to the pregnant woman and then you throw it out because it is forbidden and they dared to break the rules.

Dr. Surla was one of the first medical providers to speak up on behalf of birthing women and question the overmedicalized approach to birth. She proudly pointed out to me that she is the only doctor in the country who offers her patients the option of a birthing chair rather than the gynecological bed. She worked hard to make changes that would benefit women during her tenure as chief of the maternity ward.

I used the be the head of a public maternity ward, and the moment I started to implement changes and do something different, like let the women walk while in labor instead of being chained to the bed, they started tearing me down. This was a slow process, but by 2009 we were voted as the best maternity ward in the country. I did think I made changes in the system, I truly believed I was changing the system, but within a month of leaving everything fell apart and nothing that we made remained.

This is what she was referring to when she said that, in her opinion, the public system's answer to any idea or change is negative. She felt like she was not supported by her peers in the hospital. In her view, her role as an obstetrician was not to manage women's birth but follow it and only intervene in case something goes wrong. Her colleagues did not share her view.

In theory, all the people I used to work with were all for these changes. This was the way to go. However, the second theory became a reality there was pushback. You see, natural birth requires time and more time is spent with a patient. This brings us to an absurd situation that some things are implemented only when I am around. It came to the point where colleagues would tell me they do not want to do it, that I should do it for them.

During our conversation, Dr. Surla provided a fascinating picture of the workings of public maternity wards. She presented the public institutions as a rigid system that was hard, if not impossible, to change. That change could only happen on the level of the individual practitioner and that this was far from enough. She would tell me; I am not an institution. I cannot support this idea on my own; the institution has to do that. Dr. Surla's observation also points to the question of the power and authority of the doctors within the public health care institution. She did exert a certain level of power within the hospital that allowed her to make these changes. Her story points out that the power of the chief only makes an impact on how things are done in the hospital while they are in charge. When another doctor takes over the position of power that impact disappears as well.

When I became chief of staff, I asked the former chief, who had set in place all these constraining protocols on women, on what legal grounds they were made. He told me: Good god, what protocol and legal grounds, you are the boss (gazda). I never saw myself a boss; all I wanted to do was find a solution for the common good. You have individuals that stand out and are trying to drag this big boat along with them, but the boat won't budge. That is how I see things.

This notion of the state-run reforms failing due to the doctors' unwillingness to relinquish power and change the status quo is echoed in statements made by Dr. Stambolovic, who also extensively writes about and advocates for the right of women to choose how they want to give birth. "Health care experts, as engineers of reforms, are striving to change the health care systems without changing the status quo. They want to improve efficiency, effectiveness, and equity but at the same time, they are reluctant to challenge the fundamentals so that they can protect those dominant interests that made health care systems the way they are" (Stambolovic 2003, 78). He points to an asymmetry of information between the providers and the patients, as well as the structural relationship between them because the provider has more influence than the patient in decision-making processes. "The much-vaunted right of patients to choose whom they will see is illusory" (Stambolovic 2003, 79). In general, he argues that the reforms do not question the dominant values of the system, they reinforce the status quo and do so for the profit of certain actors, the *gazde* as dr Surla called them.

However, unlike Dr. Stambolovic, who is very skeptical about the role market logic and private practice can and should have in health care, Dr. Surla sees the private sector as the solution. Alternatively, at least, the type of private sector that is available in Belgrade. Primarily, she sees the state as immovable and rigid—a big boat that will not budge—and the private sector which in her view as the complete opposite. Her description of the public health care resonates with an observation made by the Comaroffs on neoliberalism: "individual citizens, many of them marooned by a rudderless ship of state, attempt to clamber aboard the good ship Enterprise"(Comaroff and Comaroff 2012, 159). Dr. Surla gladly jumped ship of state after decades of work trying to steer it.

Within this private health care system, things are less rigid, and this makes it easier to achieve what Serbia, in general, should strive to do—give women the freedom of choice to give birth how they want. This private hospital puts the accent on patient relations. The patient is always in the center, even if it is sometimes to the detriment of the worker, for example, against certain aspects of labor laws. You have to find a solution. The answer cannot be that there is no solution. I like the flexibility of this system, especially when it comes to finding solutions and working in the best interest of the birthing mothers.

From this perspective, the best interest of pregnant women and for health care seekers in Serbia more broadly is to allow market logic to take control. However, as the Comaroffs show, there are concerns and problems related to the "good ship Enterprise" that Dr. Surla recognizes, at least to some extent. These large private hospitals are now slowly building their network of providers and are offering, in collaboration with large life insurance companies, forms of additional, or even alternative, health insurance for those who can afford it and who live in Belgrade. Even this doctor and other medical practitioners who have previously worked both in the private and public sector and who have completely moved into the private sector, state that they are aware that the care in the private sector is not available to everyone.

I have completely left the state system, and I do not regret that. I just regret that I do not have the same chances of helping as many women as I did before. Simply the number of patients I have now is far smaller—this is a select group of women. Care here is available only to those who have the financial means, or are savvy enough, to use the little resources that they have to enable themselves a birth in the private sector through additional health insurance.

However, sadly, this is not widely known outside of Belgrade, and even here less than 20% of people seek out these options. The moment you leave Belgrade that percentage drops dramatically.

Dr. Surla is saying she only regrets not being able to help women is an important commentary on how she perceives the difference between the patients in public and those in the private sector. The women-patients in the public sector are helpless and left to the whims and wills of the careless institutions. On the other hand, the women who can afford to pay and give birth in a private hospital are savvy. There is a class divide that evident in this dichotomy, another doctor, Dr. Gorunović, described that class divide even more bluntly:

The patients are, I am sorry, but the fucking client (faking stranka). They will give the last cents from their pocket to come to see me. We should not be fooling anyone you have to pay for that. It is segregation but what can you do. Segregation is Gucci and penthouse.

His career path is in many ways similar to Dr. Surla's, except he is still working in the public maternity hospital. He shared this view of patients as clients when I came to see him in "his"[19] private clinics. What these different classifications of patients show is the stratification of care embedded in the current transformed, unbundled, and marketized health care system. The introduction of private for-fee practice highlighted, even more, the uneven nature of health care provisioning in Serbia. In that sense, taking a close look at the career pathways of medical

[19] I place this in quotation marks, because while the practice bears his name on paper it is owned by another doctor.

providers, especially those with authority and in positions of power brings to light the changing patient-provider relationship.

5.2.3 **"I trust the institution" - trust in public maternity hospitals**

The lack of access and ambivalent public and government perceptions of the medical expertise of private hospitals puts into question any notion of a clear dichotomy between the public as not trusted and private as trusted. The reality is not as clear cut. I assumed that the main reason why I was not seeing more women of economic means transitioning into the private hospitals was lack of availability. The hospitals in Belgrade were simply too far, and it would be easier to "find someone," obtain a connection, in the maternity hospital in Novi Sad. I also assumed that not all doctors were like Dr. Surla and felt inclined to uproot and move to Belgrade. When I started fieldwork in the maternity hospital, I was expecting to hear a similar narrative to the one I heard in the primary care centers. I was expecting to hear about mistrust and lack of medical authority. What I heard from the women-patients was:

> *I trust the institution. I trust the maternity hospital. I do not think that the fact that it is a public (državno) makes it automatically wrong. If I had to have an operation or some medical intervention, I would instead go public.*

This was not the response I expected to hear, and it confirmed the public and government narratives about the lack of trust in the private hospitals. The young residents with whom I spent most of my day voiced similar opinions about being grateful that they are here, in this hospital, because the best professors work here. The residents, like Darko, who worked in the hospital had

high aspirations of remaining in the hospital afterward. Even those, like Vera, whose residency was paid for by the primary care center hoped that she could find a way to stay on and not go back. In that sense, this is even similar to the aspirations of their predecessors during socialism. In the socialist period, doctors were unevenly dispersed in Yugoslavia with most of them gravitating towards big cities and big tertiary institutions. Why would you be a paper-pusher if you could be a medical expert? "The difference between the primary care centers (dom zdravlja) and the tertiary clinics is that the latter are specialists," I was told frequently by both women and residents. "How can a general practitioner be considered an expert?" The residents also did not see themselves as moving, like Dr. Manojlović had, into the private sector after their residencies either, even though for some of them, the private practices were paying for their residency in the hospital. As much as they did not want to become paper-pushers, few aspired to become just *privatnici* (entrepreneurs).

When the women spoke about trusting the hospital, they did not say that they trusted the hospital because a certain doctor or doctors work there. They trust the hospital because if the doctor works there, it means that they are regarded as experts. The majority of the gynecologists working in the maternity hospital were not only doctors but academics, teaching at the Faculty of Medicine. It was so common that even the women-patients would call some of them "Professor Jovanović" and not just "Dr. Jovanović." The medical authority of the doctors working in the hospital was rarely put into question.

Institutionalized trust does not mean that there was no need for personalized trust, as Ledeneva (2006) concluded; these two forms of trust do not cancel each other out. Even if there is generalized trust, it does not disregard the need for personal trust. Women-patients may trust in the medical authority of all the doctors, but that trust does not negate the need for personal trust. Studies conducted by women's' NGOs and sociologists show that in most cases women do not

even know the names of the medical staff working in the maternity hospital (Center for Moms). In her large quantitative study on women's' perceptions of maternal care in Serbia, Stanković (2017) points out that medical care is provided in a distant and impersonal manner. Since maternity hospitals are tertiary institutions, women give birth without the support of their families. The only emotional support system available to the women is the support of the medical staff, and that support was lacking (Stankovic 2017b).

> *What we are paying for is the human relationship (ljudske odnose). It is not like a hotel here, but they at least look you in the eyes and have patients for you, I know it is not easy for them, but they can at least introduce themselves. They can ask how we are feeling. Sometimes a single word means a lot, a single smile. We are paying for kindness.*

These were the words women would utter when talking about why they paid for private prenatal care with the same doctors who worked in the hospital. None of them felt that they would not be given adequate medical care; they had faith in the medical authority and expertise of all of the doctors. However, kindness and "human relationship" are not covered under the institutional trust and nor by the state maternal health insurance.

If all the doctors in the maternity hospital are the best experts in the country, then they are all interchangeable. In public health care institutions, both patients and medical providers are generalized categories, not individuals. In order to be seen as a social person within the maternity hospital, both doctors and patients need to establish personalized trust. This trust can be established through kinship and friendship ties, but more often it is established through the supplemental labor of the maternity hospital medical staff in the private sector. For the women, this is a pathway for

being treated with kindness and for the medical providers this is a way of establishing individual respect, power, and authority.

5.2.4 **Medical entrepreneurs - flexing between private and public**

Legally, a physician cannot be fully employed in both the private and public sector. To get around this legal constraint, private practices are usually on paper owned and operated by retired physicians, while physicians employed in the public health care sector are classified as "consultants" or "visiting" physicians working an additional 30% per week in private practice. A typical example is the private gynecological practice were Dr. Gorunović works, the private clinic named after him— "*Dr. Gorunović*." During my fieldwork in the maternity hospital, I did not even have to ask some of the women if and where they went for prenatal care. They all carried their test results, documents they acquired during their pregnancy, in a bright purple folder with the "Dr. Gorunović" logo.

Dr. Gorunović was not the only one working as a consultant for this private clinic. The website of this private practice, which is dedicated exclusively to obstetrics and gynecology, boasts that they not only have the most modern ultrasound technology, they also have highly educated experts in the field of obstetrics and gynecology. In total there are twelve very impressive and detailed biographies with pictures of their gynecological team. Only three out of those twelve specialists are not employed full time in the public tertiary sector, in the maternity hospital. Out of those three, only one had retired from the public sector, and another held a high position in government.

In contrast to the private clinic's web page, the website of the maternity hospital provides almost no information about the medical providers working there, not even including the fact that

it is a teaching hospital and that a patient might be asked to be examined by a student. It states that the hospital has 70 specialists in gynecology, but no biographical information is provided as to who those 70 people are, what they look like, and what are their areas of expertise. This demonstrates that generalized trust is placed in the institution rather than in the individual practitioners. If a pregnant woman wants to find out more information about the individual credentials of a specific doctor, she can find that information on the website of the private practices they work in—usually, on more than one website.

For example, those nine doctors, including Dr. Gorunović, supplement their work in at least three other private clinics in the city. This would mean that they are there in private practice two days a week, usually in the afternoon hours. However, in practice, most of my interlocutors state they spend more time than what is legally permitted. This is a widely known secret among medical providers. When I interviewed Dr. Zorić, in her office in the maternity hospital, I asked her when she started supplementing her work in the hospital within the private sector.

> *I did not start working before my children got a little bigger. When they started getting bigger, I needed a financial boost in the household. I started working once a week, in the afternoons. I think you should not overdo it. I know people who work [in private clinics] every day. I do not think that is a good idea. You cannot be everywhere. Something has to give somewhere. I would never completely transfer to the private sector because that would mean I would have to quit working for the University and I love teaching.*

Dr. Zorić acknowledges that her paycheck in the state maternity hospital would not be enough for her to support her growing family. She had previously told me about various opportunities she had had to leave the country altogether, but that she had decided to stay. The

ability to supplement her income in the private sector allowed her to choose not to emigrate. During our interview, she also told me about colleagues who started working privately the moment it became possible.

> *My colleagues started working privately in the 1980s, and this was becoming more and more of a trend. I think we have a wrong image or rather a wrong habit of seeing that type of work and saying: "Oh he was resourceful (snašao se)"*

If we look closer rather than simply labeling these practices as potentially corrupt, we can understand how physicians are acting as flexible, responsible agents with the goal of (re)establishing their social and economic position through this double labor. I would argue that the practices of this gynecologist are best understood using the term coined by Jenine Wedel (2011)—"flexians." According to her, flexians are players who "live symbiotically within the system, quietly evading and stretching its rules as they help mediate its transformation. The new system they help fashion blurs the boundaries between state and private sectors, bureaucratic and market practice" (Wedel 2011, 15).

Gynecologists, too, are trying to manage their own precarious underpaid and underappreciated status as faceless state employees by taking advantage of their ambiguous position as both (state) medical practitioners and private entrepreneurs to regain influence, authority, and power.

Flexing is not available to all medical providers; it is a different and less informal type of "sociality with a purpose" (Brković 2017b) that reproduces power relations. More specifically this practice is building on the existing practice of people personalizing their interactions with the state by forming informal relations with the officials, clerks, and so on Wedel argues that flexians are

not the same as blat relations since she sees blat as being the predecessor of flexing. She goes on to say that: "today they not only personalize bureaucracy through one-time transactions of survival, but they also organize their interrelations between state and private, bureaucracy and market, to allocate state resources for their benefit which, of course, flexians and flex nets do so well." (Wedel 2011, 61). It allows them to re-establish more power than they would have if they worked exclusively in the hospital and opens new avenues for establishing social personhood.

A doctor who works in both sectors can use his dual labor to become the veza or connection for the women who were their patient-clients in the private practice in the public and very bureaucratic state institution, the hospital. This private-public intersection resulted in the emergence of new kinds of sociality (Brković 2017b, Collier 2011, Collier and Way 2004, Matza 2012, Matza 2018, Stan 2012), including the flexian sociality of these medical flexians/entrepreneurs.

It is quite common for the doctors to whom I have spoken to tell me that they estimate the economic status of the patients that see them privately. If they determine that the woman and her family cannot afford to do all of their prenatal testings in their private clinics, they want to help them out (*izađu u susret*). They use their existing professional networks and their positions, as specialists in the public sector, to schedule those tests in the public hospitals, where they would be covered by the national health insurance. The doctors would speak of their examples of this type of transfer of patients from the private into the public sector, but they were all quick to state that they have never done the reverse.

> *In my life, I have never transferred a patient from the public into my private practice. I have sent them from the private to state. However, the other way never.*

For example, amniocentesis is a prenatal test that checks for genetic anomalies in the fetus. This is an invasive procedure that is usually done after other noninvasive tests have come back inconclusive (such as the double test that screens for Down Syndrome). This test can only be performed until the 14th week of gestation, but many women complain that when they try to schedule the test through regular channels, calling the scheduling hotline, they are told the waiting period can be as long as a few months. Ana, a woman in her late thirties, told me that she had called to schedule her "amnio," and was told that there was a slot open in March; her baby was due in February. She knew that this procedure is available in the private prenatal practices but can cost up to 400 euros whereas it is completely covered through the state health insurance in the public maternity hospital.

Using their connections and networks of professional relations, medical entrepreneurs can mediate women's experiences in the public hospital. They would schedule "their patients" (*svoje pacijente*) from the private sector into the time slots they would have while working in the public hospitals, or they would ask a colleague of their to pencil them in as a favor to them. This personal relationship forged through the flexing capability of the physician opens an avenue for morality within the constraints of both the for-fee private system and the impersonal public system. Dr. Zorić, as a flexian herself, explains her reasoning as a question of Balkan mentality.

> *It is in our mentality. If someone you know calls you and asks you to see someone ahead of the waitlist (preko reda) you do it. I had a colleague in Japan, a world-renowned breast cancer specialist who is booked for years in advance, tell me that she would not schedule her sister to see her ahead of the line. She has to wait like anyone else. I was shocked. I told her, it is your sister; she is in pain; she has a fever—you would not see her? No, she has to make an*

appointment; she will not see anyone without an appointment. I am an old-fashion doctor; if someone calls me and says their neighbor's ovaries hurt, I will tell them to bring her over immediately. Here in the hospital or the private practice, it does not matter. We will treat her immediately. It is the human thing to do.

In these examples, we can see how the term *usluga*, and the uncertainty of whether it referred to favor or service that is provided, helps in building social status and power positions of the doctors. By the blurring between service and favor, they are presenting themselves not only as capable medical experts but as caring and moral entrepreneurs (Hromadžić 2017, Muehlebach 2012). Through this practice, they are regaining power and agency, which typically constrained if they did not negotiate between the private and public sector. By blurring the lines between paid service and favor, they are re-balancing their overall position (Stan 2012) in the mixed private-public health care system of Serbia. This allows them to negotiate between two positions, personal and entrepreneurial.

It is the importance of establishing a trusting relationship, the notion of being heard and taken care of, that women found most important when deciding which doctor to go to for their prenatal care (Pantović 2018). These women thus become a part of their circle of known people—their people (Rivkin-Fish 2005b), part of their world (Brković 2017b)—instead of being just a client or just a patient. The introduction of private practice and the ability to work in both sectors has expanded the previously exclusively informal strategies of navigating and personalizing state health care. I would argue that at least in the case of maternal care in Serbia currently, that personalizing has consumed the privatizing strategies (Pantović 2018). Many women told me that they would change private prenatal providers a month before giving birth to doctors who worked

simultaneously in maternity hospitals. Thus, it could be said that these women were making informed choices about their medical treatment, but these choices had more to do with the social connections these medical practitioners could provide in the public health care than with their capabilities as physicians.

I do not mean to say that their medical expertise was not a crucial factor but that the possibility of navigating their stay in the maternal hospital more successfully was something that would tip the scales in favor of one doctor over another. This meant that when they would eventually come into the maternity wards, they would be treated as "someone's patient" and thus would be viewed and treated differently than the women who had no connections in the maternity hospital (Pantovic 2016). The question that remains to be addressed is whether the power of these flexians is enough to transform the system?

Wedel notes that an important characteristic of flexians is not only that they "live symbiotically within the system, quietly evading and stretching its rules" they should also "help mediate its transformation" (Wedel 2011, 9). Both Dr. Surla and Dr. Zorić, as I have shown in this section, would argue that they had tried to transform the system but failed to do so. I am not certain that, even though they consider it a failure, their flexing is not a part of this "predatory neoliberalism" (Stan 2012), i.e., that they misrecognize (Bourdieu 1977) their roles in the creation of this ambiguity and interdependence between the two systems. Even though their career pathways in the private sector are different, they both benefited, and still benefit, from their period of flexing between the two sectors.

5.2.5 **What about the nurse-midwives?**

Up to this point, I have presented the micro-negotiations and social interactions happening in maternal care as if there were only two types of actors involved: the pregnant woman and her public-private gynecologist. Arguably, the woman's partner also plays a central role, but he is excluded from virtually all interactions within medical spaces during pregnancy and completely excluded during childbirth. In the public primary care centers, women would mostly go alone for their prenatal care checkups. It was usually women who went to the primary care providers even if they were there to pick up the document they needed. The only exceptions were in cases when the women had to be admitted into the maternity hospital ahead of time. Only in those instances did the woman's partner go to the primary care centers to pick up her referral for the hospital she was already admitted into. In the private prenatal checkups, there was more flexibility, but even then, they would usually wait outside, in the waiting areas, while the checkup took place.

The pregnancy classes were also women-only spaces. In both types of schools that I attended there was only one day in the entire course dedicated to the fathers. In the public primary care center classes, the day the fathers came for lecture women were told explicitly that they could not attend. While disheartening that these future fathers were being left out of the entire process, this was not unexpected. It would be a fruitful area for future study to look at the exclusion of men in these spaces.

However, another crucial agent in the entire process of providing maternal care is the nurse-midwife, whose negotiations and positionality are often overlooked. The official name of their profession is a gynecological-obstetric nurse, but more commonly they are known by the vernacular term *babica* (midwife). The authority of midwives within the biomedical spaces is usually negated (Becker 2009, Chalmers 1997, Davis-Floyd 2003, Davis-Floyd and Johnson 2006,

Davis-Floyd and Sargent 1997, Davis-Floyd 1994, Ehrenreich and English 2010, Pincus 2013). In Serbia, descriptions of their profession also negate their medical training, calling them the "fairy godmothers of childbirth"[20] (*dobre vile porođaja*); there are even websites that compare their profession to practices observed in bonobo apes,[21] thus reaffirming the image of the naturalness of their work.

There is nothing innate and natural about becoming a gynecological-obstetric nurse. This job is learned through four years of vocational high school in Serbia. During those four years, the pupils are required to have practical knowledge by volunteering in all levels and aspects of maternal care. The final exam before they complete schooling is to observe birth and in detail explain the entire procedure to their committee. I witnessed several young; bright eighteen-year-old girls fearfully go over questions about the necessary position of the episiotomy scissors on the tray table or where to place the placenta after birth. They would impatiently walk around the delivery ward waiting for women to be in their final stages of labor so they can take their exams. Once finished, they could choose to seek out employment right away or continue schooling to become senior nurse-midwives with the hope of a slightly higher paycheck and a job in the tertiary care level. In general, they had three options: work with the doctors in the primary care centers (prenatal care) and possibly also run pregnancy and childbirth classes, work in maternity wards and hospitals and deliver babies, or work in postnatal care visiting mothers and their newborns in their homes several times after birth. Just like the entire health care system, the care provided by nurse-midwives is also segmented and divided.

[20] http://www.bebacstartup.com/zasto-je-vazna-saradnja-sa-babicama-na-porodaju/

[21] https://naukakrozprice.rs/babice-najstarije-zanimanje/

The nurses working in primary care centers are seen as the least desirable jobs. If the doctors in domovi zdravlja felt like paper-pushers, the nurses felt more like receptionists and secretaries. In a slightly better position were the nurse-midwives who taught the pregnancy classes, the nurse-midwife educators. As was the case in the public health care system as a whole, there was little to no communication among the institutions. In some instances, there was open distrust among nurse-midwives. Frequently the nurses who worked in the maternity hospital would voice their disapproval of the classes in the primary care centers as useless. Zorana, a senior nurse-midwife at the maternity hospital was very vocal in her disapproval of the primary care nurse-midwives and the classes they teach. According to Zorana, "all they do is propaganda to sell women stuff they do not need."

There was a disconnect between the institutions of care. The least respected by the other nurse-midwives were the nurses whose job was to visit women after giving birth—*patronažne sestre*. The disapproval is mostly linked to the fact that this work in not actually done by midwives. The job of the postnatal care midwife used to be limited to the care of the infant and mother. Due to budgetary cuts and restructuring, their job description now includes the care of the entire household (elderly care primarily). Their job description increased but not their salary or staff. In the city, most of the post-birth nurses walk or use the bus to reach their patients, as the department only has three cars for the entire city with a population of over 300,000 inhabitants.

When I was doing fieldwork, there was a government ban on hiring new staff in the entire public sector, including health care. Even before the ban, indicators show that between 2007 and 2011, there was an increase in the number of new gynecological hires in hospitals by 10% and then a decrease of nurse-midwife hires in the same percentage (Stanković 2017). Hiring new staff during the ban was not easy, but it was not impossible either. The head of the maternity hospital

would hire them on a fixed-term contract, but the trend in hiring preferences remained. There were far fewer midwives in the maternity hospital than there were doctors. It is no surprise then to hear that many of the nurse-midwives decide to leave the country after volunteering in search of a better job.

One day in the delivery ward I asked two of the pupils volunteering what their plans were after they finished school. Their answers were not what type of maternal care they were interested in. Instead, their answers were related to geographical locations. "Germany," said Ana; "Switzerland," said Maja. For them, Serbia is not the place where they saw their future employment. Ana said, "I mean, I would stay and work here if I had a decent job, but the chances of that happening are slim.“ Maja then chimed in: "I am not even considering it, my cousin lives in Geneva. I am learning German now and heading there when I finish my schooling". To Maja’s mention of Germany, Ana just stated, as a matter of fact, that: "You know that they do the shift changes in some German hospitals in Serbian. That is how many of us are there! "

The nurse-midwives along with the residents were the people I spent the most time within the hospital. The midwives have their room within the delivery ward. Most of the midwives were middle-aged women, and all of them can best be described as women who take no nonsense. I used to sit with them in their room more frequently than in the doctors’ room. The conversations in the room were always very lively and jovial. They would usually make coffee for each other and share a breakfast of *burek*[22] or some other pastry from the bakery or canned sardines. While making herself a cup of coffee, Milana, a serious woman with short blond hair, started talking about her feelings about her work.

[22] A type of meat (or cheese) pie.

It is a hard job, but I love it. The only thing I can complain about is the fact that they cut down our off days. We work 12-hour shifts, plus night shifts twice a month (24h shift) and we used to have three days off; now we have two. That is barely enough for you to get some sleep not nearly enough time if you have a family as well.

They are all very unhappy with their status. I asked Nena, another senior midwife, to compare, in her view, their situation during socialism and now: "Sure the technology is better now, but our paycheck is not. It is challenging to make ends meet let alone think about things like holidays. Those are luxuries for us". Milena smirked at that comment and added: "I am surprised we do not make more mistakes along the way! Its because we are tired! Tired, overworked and severely underpaid".

The lack of communication and respect from the patients was a common theme in the lounge, especially from the senior midwives. They complained that the women seem more detached than ever, that they cannot wait to deliver the baby and get their phones back. They feel like the women tend to write bad things about them on the Internet and present them as the boogie women of the maternity hospital. This became such a common theme that they even made jokes about it. Senior nurses had customized mugs with their names and epithets such as kind, and always smiling midwife. I commented on that to Zorana, and she just said: „Haha, yes unkind, heartless and never smiling midwives that's how the women tend to describe us.“ I asked her why she thought that was so.

Because they, these younger generations are spoiled (razmažene) and egocentric (egocentrične) they think the world revolves around them and god

forbid you to tell them they have to push because otherwise, they are hurting the babies' chances. Spoiled, that is what they are (razmažene su).

The description of women-patients as disinterested in their birth can be understood as an attempt to regain authority. It was more common that midwives would then establish expert authority by yelling and berating the women, demanding compliance during delivery. This type of "crude expert authority" (Bourdieu 1977, 189-190) tends to disregard social inequalities among women. Not all midwives employed these cruel strategies. Sanja, a now-retired midwife, lamented to me over coffee the current position of midwives and their treatment of birthing women.

I was mistreated during my delivery. I was very young, twenty-two years old. I realized then that I would not allow my profession to be like that. The key thing during delivery is empathy; there has to be a connection with the midwife. We are there to support women, to encourage them, to counsel them. Most of the women who are giving birth nowadays could be our children. We have to be like mothers to them.

The central mechanism for asserting authority then becomes not medical expert authority but the generational and familial authority of the wise mother, wise older woman. This type of familial authority is less valued within the setting of a medicalized birth where the more violent and crude assertion of medical authority over the birthing woman becomes favored.

The Zorana and Milana would frequently discuss the fact that women paid for prenatal care with a specific doctor in the hospital and assume that it also meant a special treatment from them. What that meant was that during pregnancy the position and role of the midwife were not of central concern for the women. The women sought out the doctors for their medical authority and power in the hospital even though in physiological births, the person delivering the baby is not the doctor

but the midwife. The problem is that the nurse-midwives do not have the power to speak up. One morning after a difficult childbirth Ana, the nurse in training, told me that:

> *Honestly, the women are not treated as best as they could be. If I tried, I would be scolded; it is not my place. Even though realistically, we the nurses do most of the work here*.

One day, one of the Milana, a senior midwife, told a story of how she addressed this inequality during a delivery. Milana was delivering a baby, and somewhere towards the end the doctor came in and told the women she was doing a great job and that he will deliver the baby shortly. Milana was very upset that the doctor wanted to take all the credit for the delivery that she was doing. Milana said she started slowly taking her gloves off and giving them to that doctor while says: “Okay then, you deliver the baby and I will stitch her up after.”

For the midwives within the public maternity hospital, it is difficult but not impossible to maintain medical authority, but their abilities to capitalize and convert this authority to entrepreneurialism is far more difficult. Unlike the doctors, nurse-midwives, cannot establish a continuity of care with their patients through the private sector. They are not recognized by the state as potential entrepreneurs. This does not mean that these women do not exhibit entrepreneurial traits, nor find ways of establishing trust and authority with the patients. The midwives relied on informality and personalizing strategies with certain women before they entered the delivery ward to establish authority.

The key difference is that the flexing capability of the nurse-midwives are not only more limiting but also seen as less legitimate, more in the gray zones than the gynecologists’(Pine 2015). The personalizing strategies available to midwives thus do not allow for privatization. Midwives, unlike the doctors, are not left with an avenue to manage their already precarious job positions.

They are more susceptible to the label of corruption, and under-the-table payments than the doctors. Frequently the women I had spoken to, who had stated that they wanted to make sure they had a midwife they trusted present, either spoke of finding connections (*vezu*) for that midwife, while others knew the number and going rate for a particular midwife who was rumored to be good and trustworthy.

The only legal strategy for the midwives from the hospital is to guest lecture at one of the two private schools. The owners of the two schools even advertise these lectures as a chance to put a face to the faceless institution and meet the women who will be in the hospital when they give birth. This type of self-promotion gives certain midwives an avenue to establish themselves as individual experts, but to a far lesser extent than the ability afforded to the medical providers who consult in the private practices.

The midwives who teach in the public school resort to the Internet to establish individualized authority, by opening Facebook groups and using social media to communicate with women and offer them advice during pregnancy and after birth. Since they do not work in the maternity hospital, these midwives offer their services for an under-the-table fee after birth. Even though this too is part of the public maternal health care framework, some women do pay for extra private or rather personalized care from these midwives.

The practices we can trace in the midwives' strategies for negotiating their status and role within the health care system belong under the umbrella of informality far more so than the practices afforded to the doctors. The crucial difference between the two is not the practices themselves but rather the legitimacy, although constrained still afforded to the doctors, specialist more than others, and not to other medical providers. This brings us back to the discussion of legitimacy and (mis)trust in the state institution. I argue that it is because of the fractured nature

of mistrust and trust—mistrust in the system, but with a certain level of trust in the specialized levels of health care open up pathways for some and closed for other medical practitioners.

5.3 **Conclusion**

By introducing Vera, Dr. Manojlović, Dr. Surla, Dr. Zorić, and the nurse-midwives, I addressed for the following questions: Why were gynecologists working in the public sector moonlighting in the private sector, thus choosing to have 16-hour work days or more? Why are there so many small private practices but only two private maternity hospitals? Finally, why are we only seeing doctors and not midwives in the private sector?

The chapter began with Vera telling me what was in her view the symbolic difference between classifying the same alcoholic drink, rakija, as a gift (*poklon*) or as a bribe (*brlja*). The difference was not in the quality of the alcohol but in the quality of the relationship that the liquid symbolized. Vera spoke about the constraints under which doctors in the primary care centers work, low salaries, broken or outdated technology, and the increasing demand to see more patients in an ever shorter time-frame. The ideal of the primary care doctor is the personal doctor to the patients in their community becomes strained. The lack of communication between the levels of care in the public sector and the austerity measures that cut health care expenditure mean that Vera's job has transformed from care provider to gatekeeper. The primary care sector thus becomes not a place of medicine but a place of bureaucracy and therefore not a place of institutionalized or personalized trust. In order to regain at least personal trust with their patients, other gynecologists work in the private sector. This was the case of Dr. Manojlović.

Some like Dr. Manojlović see themselves as a "compassionate privatnik" (Hromadžić 2017) who blurs the lines between payments and gifts in acknowledgment of the state of financial

precarity of some of her clients. The ability to decide whom he will or will not charge is a strategy of maintaining power, a form of keeping while giving (Weiner 1992, Brković 2017b). The problem with working within the private sector exclusively is that this power of blurring between a service and a favor is limited to their practice. The p*rivatnik*'s exclusion from the referral system and the public health care infrastructure means that they also have to rely on favors from other medical providers in order to maintain the trust of their patients.

'Entrepreneurial acrobatics' shows that existing processes of neoliberalization are not the same throughout the world and are not monolithic (infra)structures that will take the place of the slowly unbundling public health care. The legalization of medical practices, a stopgap measure during the 1980s, became the strategy for keeping medical doctors from leaving the country and complying with the IMF proposed austerity measures. However, the complete separation of the emerging private sector from the public is neither feasible nor desirable for the state. The centralized and mandatory public health insurance system and its referral politics maintain the supremacy of the public health care system and the image that health care is still a right of all citizens. Moreover, it reinforces the notion that only those who are the best medical experts work in the state tertiary institutions and that those working only in the private sector are not the best. The exclusion from the referral system means that doctors, like Dr. Manojlović, are categorized as *privatnici* (entrepreneurs) and not as health care workers. Only a select few have access to a complete private infrastructure that can, to some extent, parallel the public infrastructure that Dr. Manojlović is allowed to interject partially.

One of those select few is Dr. Surla. She used to work in public hospitals. She has maintained personal contacts within the public system even after leaving it. She now works in one of the two private maternity wards in the country, but before that, she was head of a public

maternity ward. At the core of her comparison of the two sectors was the problematic role of the individual within the public system. The notion of the head of the maternity ward as the *gazda* (boss) can potentially be linked to the logic of the socialist self-management of each institution but shows the unstable nature of policy and protocol establishment within the hospital. If change, positive or negative, only happens when the boss is around, then it is not permanent. Dr. Surla, after years of being *gazda*, decided to give up that power and still retain her medical authority. The lack of institutional trust and the monopoly of the state health insurance systems means that no one can question Dr. Surla's medical authority. However, while Surla can establish trust and continuity of care with her patients, the patients who have access to her are limited. She cannot claim to be a compassionate *privatnik* (Hromadžić 2017). Dr. Manojlovićcan blurs his relationship with his patients-clients, through maintaining the ambiguity between payments and favor. In the case of the private hospitals, the patient is quite evidently the client and client belong to a specific upper-class category of citizens. Dr. Surla's story sheds a bright light on the inequalities embedded in the system of health care provisioning that relies exclusively on the market.

The official government discourse does not support a complete transition into a market system and supports the narrative that the best experts in the state, the pinnacle of medical authority, reside in the highest levels of public health care. The maternity hospitals, as tertiary institutions, are trusted institutions. The issue is that individual medical authority is not visible and the atomized nature of health care distribution does not allow for continuity of care. Dr. Zorić, like Dr. Gorunović and others, shows how the private sector has enabled a new individualized strategy of obtaining personal trust within the public health care system. Their stories can be understood as health care parallels to agricultural businessmen and the anthropological studies of socialist and post-socialist agriculture (Halpern and Kideckel 1983, Kideckel 1993, 1995, Stan and Erne 2013,

Thelen 2001, 2012). The successful agro-businessmen were the individuals who took advantage of their status as socialist managers and the power of their social networks for their entrepreneurial interests.

Personalized trust does not emerge only in cases of institutional mistrust; rather personal trust emerges even when institutional trust is present. This supports the larger theoretical turn in studies of informality that connections and favors are not only present when the official route fails (Brković 2017a, Humphrey 2002). Personalizing strategies offer ways of establishing social personhood (Brković 2017b), and this is why we see so many doctors working two jobs. Dr. Zorić wants to establish herself as an individual medical authority, as a person of trust within an institution that fosters impersonal and generalized trust. Secondly, the legalization of private practices does not mean that the personalizing strategies, like connection, have disappeared. The private practice becomes a state-sanctioned strategy of personalizing public institutions. Rather than the private sector co-opting connections, the private sector becomes a new pathway of establishing connections. Dr. Zorić is a key example of a petty, small-scale flexian (Wedel 2011) using her personal authority gained in the private sector within the general authority of the public to be both a caring and compassionate, not just *privatnik* but medical provider—a medical entrepreneur.

I end this chapter with the question about the role of medical providers whose work is crucial and invisible. The position of the nurse-midwives is arguably more precarious than that of the gynecologist. The authority of the nurse-midwives is questioned by the state and other medical providers, and, as I will show in the following chapter, she is forgotten by the women-patients. Unlike the doctors, the nurse-midwives cannot legally become *privatnici* (entrepreneurs). Their individual negotiating strategies for establishing authority and social personhood lie squarely in

the grey zones (Pine 2015). For the nurse-midwives, the opportunities for establishing social personhood are less legitimate and less visible. As I will show in the following chapter, being seen and being somebody is a crucial concern for the women-patients in the maternity hospital.

6.0 From Having Someone to Not Having Someone

I feel so bad for those women that suffer, that have no one to take care of them. That is not fair![23]

Nataša's observation because it identifies a key concern among middle- and working-class women in Serbia when they prepare for childbirth: How do I make sure I do not suffer? How do I make sure I have someone (*imam nekog*) who will take care of me? To understand why these questions are critical to the women I met during my fieldwork, it is essential first to sketch out a broad description of what childbirth in maternity hospitals looks like in Serbia.

It is no surprise that childbirth is highly medicalized, institutionalized and pathologized, just as in other western parts of the world (Misago et al. 2013). Feminist scholars have written extensively about the adverse effects of a medicalized or technocratic model of birth (Behruzi et al. 2013, Davis-Floyd 1994, Lazarus 1994, Lyerly 2006, Misago et al. 2013, Pincus 2013, Stankovic 2014b). The technocratic model of birth fosters a separation of women's sense of self from their bodies. In this model, women's bodies are perceived as productive machinery governed by a hierarchical system of controls. Birth is seen as the control of laborers (women) and their machines (their uterus) by managers (doctors), often using other machines to help (Martin 1987). The question of women's resistance or acceptance of the technocratic model is shaped by their subject position within larger power structures. The problem with the classic literature (Davis-

[23] Nataša, new mother

Floyd 1994) is that nonsubversive agency of women is not taken into account. How do women themselves describe and understand their experience during childbirth?

Biljana Stankovic (2017b) states that women's' bodily experiences during childbirth depend on how they perceive their treatment by the medical staff. (Stanković, 2017:19-20). She and a team of scholars in Belgrade recently conducted a large scale quantitative study on women's reproductive health and life more broadly in Serbia (Stanković 2017). The study sample was comprised of a thousand four hundred and sixty women who had given birth in the past 50 years. I collaborated in this study as a consultant. This study concluded that more than half of the women were satisfied with their birthing experience.

Similarly, a government led a study a few years prior also concluded that overall women were satisfied with their birthing experience in Serbia (Matejić et al. 2014). Unlike the previous study, however, the new survey also showed that this satisfaction depended on how they were treated by the medical staff (Stanković 2017). These data indicate that there is a difference in how women are treated or perceive they are treated in public hospitals alternatively, as Nataša saw it the difference between having someone or having no one.

More than half of the new study's sample (56%) felt the staff were kind and helpful, while 34 percent described the staff to be cold and distant, with 10% describing the staffs' treatment towards them as rough and uncomfortable (Stanković 2017) This study also revealed that almost half of all the sampled women (44%) reported having a *veza* (connection) in the hospital (Stanković 2017). Based on my pilot research (Pantovic 2016), Stanković and the other researchers asked a follow-up question on how many women paid for private prenatal care with the doctor they considered their *veza*. Among the women who said they had a connection in the hospital, 64.5% managed their prenatal care in the private practice with a provider that worked in

both sectors (Stanković 2017). The majority of the women who stated in this study that they had a *veza*, just like my friend Aleksandra, may have been describing a privatizing relationship with what I define as medical entrepreneurs. The women who stated they managed their pregnancy with medical entrepreneurs felt they were active participants in their birth and reported being satisfied with their birthing experience (Stanković 2017).

The fact that 44 percent of women seek out a connection in the maternity hospital thus points to a different reading of *veze* (Stanković 2017). Having someone, a personal connection in the hospital provides women "a flexible path to state services and resources" (Brković 2017b, 106). It is a negotiating strategy, a mechanism of attempting to construct and maintain social personhood in an environment that is structured to strip women of any sense of self. Having no one also means obtaining access to maternal care through the fragmented public health care system and not knowing anyone in the hospital staff when coming to give birth. Women who described having no one were unable to establish a personalized relationship, and yet, not all of them reported rough or unsatisfactory treatment (Stanković 2017). Moreover, the birthing experiences of Serbian women provide a crucial understanding of how healthcare works and how class and ethnicity impact access to healthcare. The knowledge gained from observing how maternal care is provided in practice may grant a new perspective to draw broader conclusions (Lazarus 1994).

This chapter is divided into two parts. The first part describes the procedures and rituals associated with entering the maternity hospital in Novi Sad. My ethnographic account of what a technocratic birth looks like in Novi sad is amplified with the connections gained from the larger nationwide survey on the management and medical interventions of birth in Serbia (Stanković 2017). In the first part of the chapter, I describe a "generic" woman-patient as she moves and is moved through the halls and wards of the maternity hospital. Moreover, the generic women-patient

is transformed into a birthing body through the rituals of a technocratic model of birth (Davis-Floyd 1994, Davis-Floyd and Sargent 1997, Misago et al. 2013, Pincus 2013).

In the second part of the chapter, I show how women's social, economic and ethnic identity, shape their treatment and experience in this institution. The stories of the women in this chapter highlight the flexible and unstable strategies actual women use to navigate and negotiate their birthing experience. As I address in this chapter, it is problematic to ascribe the success or failure to the strategy's women used to navigate and negotiate their birthing experience. Firstly, for the women, I spoke to all of them considered their childbirth as a success just because both the baby and they are healthy and well. Secondly, the assumption of successful or failed strategies re-inscribes again the binary logic. Instead, with the introduction of the private sector, we can view the strategies available to women on a spectrum between two poles, public patient and private consumer. The question articulation between these two poles, patient and consumer, provides more insight into sociality in the current health care system than an opposition between success and failure.

6.1 **Part I: moving through the maternity hospital**

6.1.1 **"Atomized maternal care" – rites of passage in a maternity hospital**

From socialist times to the present, the healthcare system is described as atomized (Parmelee 1992, Perišić 2014, 2016, Stambolieva 2016). As I have shown in the previous chapter, medical providers point out that there is little to no communication between the primary and higher sectors of care and that there are a power and trust hierarchy between them. The maternity hospital is an institution of trust. I argue that the reason why there is instructional trust is linked to the more

considerable trust in biomedicine and technology (Davis-Floyd 1994, Good 2001, Lock and Nguyen 2018). The providers who work in the maternity hospital are the ones who can flex successful between the public and the private sector. They can do this precisely because of the authority and power given to them by working in this building that has come to embody the values of biomedical authority.

The maternity hospital is a large three-story building. Its central feature is a glass window, a half-dome shape that protrudes from the main rectangular base of the building. The central sections of the maternity hospital are contained within that half-dome portion of the building. The third floor houses a large conference room with enough seating for all the medical staff of the hospital. This room is where the day usually starts and ends for the medical staff, having both morning and afternoon meetings there.

The building itself structures care in a way that allows us in part to read the way it shapes people's experiences. For pregnant patients, their experience in the hospital begins at the ground level, with births eventually taking place in the room just below the conference room on the second floor. While the doctors and I could freely move around the building, the movement of these women was strictly monitored and constrained. For gynecologists, entering and working in this building provide the opportunity to regain their sense of authority and individual expert power. It is the space where doctors can establish themselves as medical entrepreneurs. Working in the hospital clouts gynecologists to negotiate their status as impersonal, nameless workers for the state to persons with authority and respect. For women, when they enter the maternity hospital, it is nearly the opposite that happens. Women are transformed from private persons, individuals with names and lives, into public bodies, birthing bodies, when they step into the maternity hospital. This transformation can even be described as a type of rite of passage (Turner 1967, Davis-Floyd

2003); as women move through the floors of the hospital, they move through the three stages of a rite of passage – separation, liminal, and re-aggregation.

The separation stage for pregnant patients begins as they enter the building. The central admissions area on the ground floor is where women, with their suitcase ready and packed, have to say goodbye to their partners and family. The large admissions room in the main entrance is divided into two sections split by a large dividing wall, with the main hall containing seating for the family on one side and several exam rooms and another set of waiting room chairs on the other. Once a woman passes through the door of this dividing wall into a second waiting room, she becomes a patient. She is instructed to sit in the second waiting hall, while her family either leaves or waits on the other side of the wall. From this point, women are separated from their family, or at least their male family members. Security guards who patrol the hallway enforce this gender division, as shown in the following vignette.

During my fieldwork days in the hospital, spent some time sitting in the waiting room seats on the non-family side of the wall. On this side, it was quite common to see not just the women waiting but medical students, who used this hall as a gathering place. While the women's family could not be present at the examination the students would fill the exam rooms observing the entrance procedures the women had to go through upon admission. While the husbands and partners had to wait behind the wall, male students could pass through - if they wore their uniforms. One morning, two male international students forgot to put on their yellow scrubs and came dressed in their regular clothes to the hospital. When the security guard saw them, he thought they were visitors and wanted to escort them to the other side of the wall promptly. The gender division became even more apparent when I noticed that on another occasion the guard said nothing about

a mother and pregnant daughter sitting together in the waiting room, while very sharply addressing the husband of another woman to move to the other waiting area.

Women come to the hospital in various stages of labor, from no contraction pains to women in the near-final stages of labor. All of them had to pass through the admission protocol and an admission exam before progressing to the first or second floor of the maternity hospital. There are always at least one doctor and one midwife conducting these admission exams, which include taking pelvic measurements, weight, blood and pressure, and a gynecological exam. A general observation I made is that this, in most cases, became routine and that not much was said, let alone explained, to the women who had come to the hospital to give birth. After the exam women are sent on to one of three usual routes; first, if the woman is deemed to still be in the very early stages of labor, she is told to go home and come back in a few hours. The second option is that she is taken up to the first floor - day hospital. She can remain on this floor for several hours, sometimes the whole day as her labor progresses. Moreover, finally, the third option, is that a woman's labor has already progressed enough that she has to be taken directly up to the second floor, the delivery ward.

Fragmentation and separation are the central characteristics of the entire public health care sector, and they are visible in the architecture of the maternity hospital. This layout and the protocol that follows it leads to a sense of separation and solitude for the women-patients. The separation that occurs in the hospital is thus a final culmination of the larger atomization of health care. Women's experience in maternal care is fragmented between separate medical providers and institutions for prenatal care, childbirth, and postnatal care. However, it is within the hospital itself that this separation reaches the physical level (Rose 2007). Women are cut off from their social and family networks, encountering people they have never seen before and entering a space (if it

is their first pregnancy) they have never been in. One set of medical providers examine the women downstairs on the admissions floor, another set is in the ward in the pathology-day hospital overseeing the treatment of women deemed to be in early stages of labor, and finally, there is a set of medical providers within the delivery ward itself. At each level, a different set of medical and non-medical staff is in charge of their care and their movement.

Like the broader separation between primary, secondary and tertiary care, these departments rarely communicate with each other. There is a lack of communication within the hospital. On the other hand, there is no communication with the auxiliary institutions outside the hospital, like the pregnancy and birthing classes in the primary care center. There is no communication, even though the classes are held in the *dom zdravlja* less than two blocks away from the hospital. There were days when I would spend the morning in the hospital and walk less than ten minutes to attend the class. The fact that the anthropologist had to informally send information between the two levels of maternal care highlights the fragmented nature of public healthcare provision. Telephone game could leave pregnant women in unfavorable situations as they attempt to negotiate their maternal care. The epicenter of negotiations takes place on the second floor, the delivery ward.

6.1.2 **The panopticon - the delivery ward on the second floor of the maternity hospital**

"No need to be afraid, when you are with us you are all the time on the CTGs[24]. We monitor you all the time," Dr. Gorunović told a room full of pregnant women during a free lecture

[24] Cardio cartography machines used to monitor babies heart rate.

sponsored by one of the international umbilical cord stem cell biobanks operating in the country. Machines, such as CTGs, were used as a proxy for human interaction in the delivery ward. CTGs, feminists' theorists have argued (Davis-Floyd 2003, Davis-Floyd and Sargent 1997, Davis-Floyd 1994, Ginsburg and Rapp 1995, Good 2007, Martin 1987, Sekulić 2016, Stankovic 2014b, 2017b, a) are one of the critical machines used to keep women in a biotechnical embrace (Good 2001, 2007)). The biotechnical embrace refers to the imaginative and affective dimensions of biomedicine, hope, and trust in technology and technological development. I was fascinated to see that all of the twenty or so women in the audience nodded and seemed reassured by this fact that they will be monitored with CTG machines. The second floor of the maternity ward thus presents a dilemma: Women feel alienated from their bodies, feel alone and yet are always watched.

A description of the floor plan of the delivery ward might shed some light on this dilemma. The ward, along with the conference room, is located in the half-dome section of the building. The space and structure of this ward are vital for understanding the perception, fragmented, alienating and medicalized nature of birth in the maternity hospital. For all of these reasons, I include my sketch (see Figure 2) of the second-floor delivery ward of the hospital. The drawing illustrates that the spatial arrangement of the delivery ward represents an accurate diagram or replica of Bentham's panopticon. Space itself fosters unequal power relations and alienation. Foucault (1995) argues that the panopticon is the prime example of disciplinary power over a large number of bodies most efficiently and cost-effectively. All of the bodies in this ward and this hospital are subjected to disciplinary power and categorized according to norms and protocols where there is little room for an individual sense of self. This is true for both the medical staff and strikingly so for the women-patients.

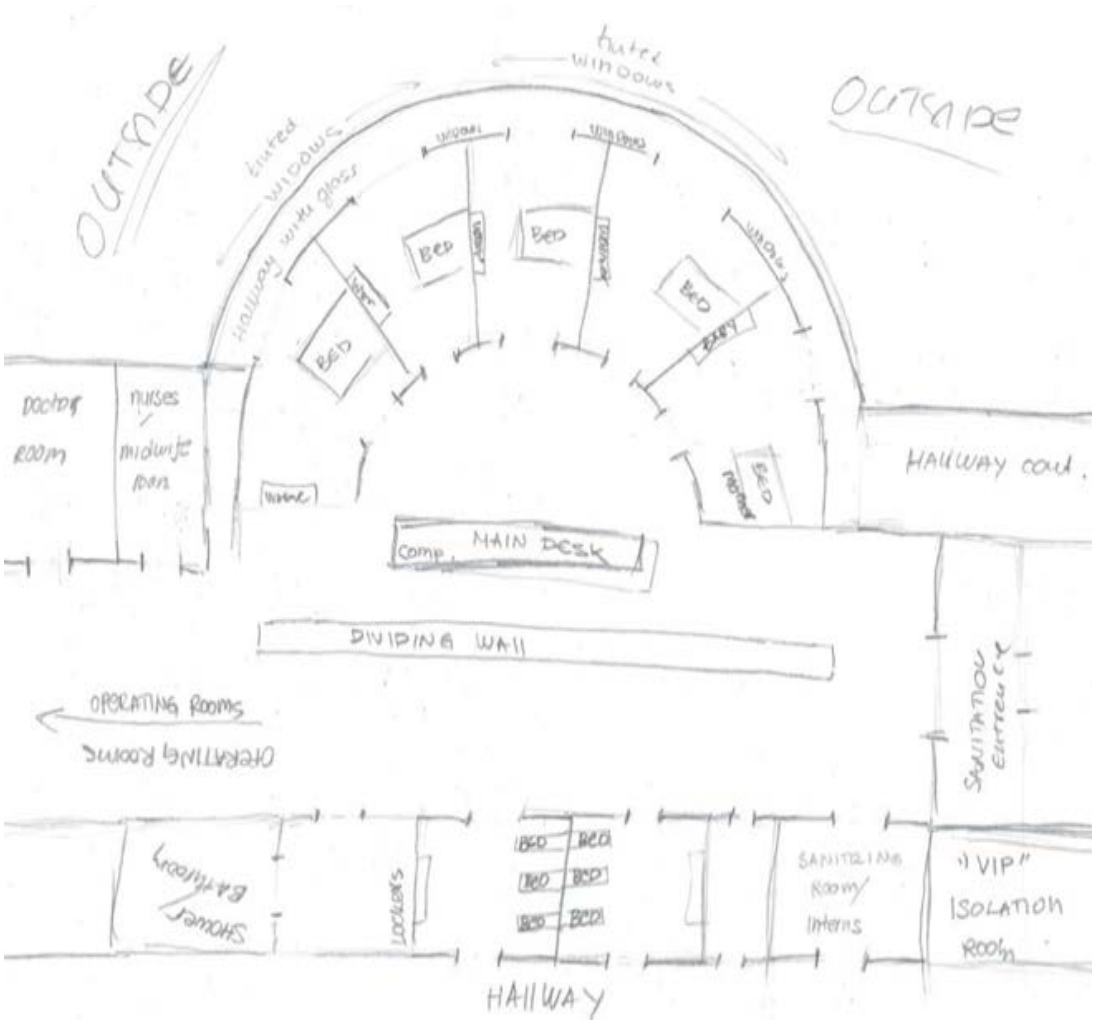

Figure 2 Drawing by author

Almost wholly encased in glass, the women cannot see each other while they are in labor, but they can all be seen from the vantage point of the warden's tower or in this case the main desk. I sat at that desk. I can now understand how women become transformed from persons into bodies. I caught myself sometimes forgetting that there are women giving birth steps away from me while I was busy helping the residents google in secrecy a question their attending-mentor asked them to answer. I had only spoken to some of the women who had given birth during my fieldwork in the hospital, but I had witnessed the labor of many more who even for me had become a number and whose stories and experiences I know nothing about.

After being admitted and coming either directly from the ground floor or the first-floor day hospital, women are escorted by a midwife or nurse-intern to the shower rooms and locker rooms in the delivery ward via the long hallway that connects the ward and the rest of the floor. This hallway is used for patients and staff that have not been sanitized, passed the proper protocols to enter into the main sanitary sections of the delivery ward. Unless their labor has progressed to the final active stage, they are instructed to change into their nightgown (if they were not in them already) with no underwear underneath.

Women who had not shaved were shaved and given mandatory enemas by the nurse-interns. The routinized practice of shaving and enemas has been well documented and critiqued in both Serbian and international feminist literature (Arsenijevic, Pavlova, and Groot 2014, Davis-Floyd 2003, Davis-Floyd 1994, Sekulić 2016, Stankovic 2014b, 2017b, a, Stanković 2017). Thus, these two practices serve a ritual purpose of separation from the outside world and a transformation of the women into patient bodies (Davis-Floyd 2003). These were also the final ritualistic acts of the separation stage before women are told to lie down, signifying the start of the liminal stage.

The shower/locker room is the last chance for the women to send a quick text message to their partners and family before they are asked to turn off their phone and leave it in their locker along with all of their belongings. Once they have been shaved, evacuated their bowels and taken a shower woman are not allowed to move in the delivery ward. Despite their now "clean-state," women are not allowed to walk freely around the sanitary part of the delivery ward. The inability to move freely during labor is a common state in all Serbian maternity hospitals, the majority of their birthing experience in the hospital is spent on their backs (Stanković 2017). The little amount of time they are allowed to walk is under direct supervision.

After the shower, the women are escorted to one of the beds in the two rooms they had passed previously on their way through the hallway to the shower-locker room. These rooms are called "*Prvo porođajno doba*" (first stages of labor). Two rooms are right next to each other, each with three beds. Every bed has a little nightstand in which the interns place the women's lip balm, sanitary napkin and key to their locker. These are the only items women have with them. Next to each bed is a cardiocartography machine (CTG machine) that monitors fetal heart rates. The CTG machines are connected to a central computer on the other side of the dividing wall between the rooms for inactive stages of labor and the five delivery rooms - as they call them boxes. While the main desk looks directly at the boxes, the women who are in latent stages of labor are monitored on this computer, along with the rounds done every two hours — usually accompanied by students and residents. In a small room with three beds, it can get very crowded during that time.

The doctors say hello to the women, occasionally providing words of encouragement but the majority of the conversation was attendants dictating to the resident sitting at a desk on the opposite side of the room taking progress notes for the woman's medical chart. It is obvious that the women's privacy is jeopardized not only by the frequent change of medical staff but also due to exposure of their intimate body parts in the delivery ward. In the latent stages of labor, all the women can do is lie in the beds, wait out their contractions, breathe, and listen to the soft music playing on the radio in the background and the sound of the CTG machine.

The nurse or intern insert an IV cannula needle into the women's hands while they are in those rooms. Since hospital protocol does not allow women to eat or drink anything while in the delivery ward, the IV keeps them hydrated while simultaneously providing various medications. More than once, I had seen women ask the nurse or midwife what they were being given. Occasionally, the midwife would take the time to explain that they were given a sedative, saline

and frequently syntocin (oxytocin) and why. More often they would list the medications, and seldom some would only respond that they were given medicine.

My observations support the data from Stanković (2017)s qualitative study, that women are usually not told or poorly informed about medical interventions on their bodies during labor. This study also showed that two-thirds of births in Serbia were induced with medications such as syntocin and or by manual dilatation by medical staff (Stanković 2017). Induced labor left women feeling disoriented, threatened and neglected by the medical staff (Stanković 2017).

I asked Doctor Gorunović about inducing labor one morning while we were sitting at the main desk. “The conditions here are such that it becomes a necessity. It is not ideal” he told me. By conditions, he did not only mean medical conditions of assessed for particular labor, but he was also referring to non-medical conditions.

> *It is all dictated by the speed, so it does not get too crowded here. If it does, it gets clogged up. However, this is a slow month, in our high peak, it gets very hectic. I know what they say. That we do not pay attention to them, it is not true we are doing our best with the limited resources we have. There are rounds at 8 am, and 11 am in the other wards, and here we do rounds every two hours. It is not that we do not want to be there with them all the time; it is that we do not have that time. That is why we induce, for the speed. In the night shift, it is rare. It is more relaxed in that shift.*

The midwives tend to check up on women more often than the doctors. Once a woman’s labor progresses into active stages, meaning the baby is ready to be born, she is disconnected from the CTG machine and asked to walk from the so-called *meki krevet* (soft bed) she had been in to

the delivery box and the *tvrdi krevet* (hard bed), gynecological bed with stirrups. This is the final stretch of the liminal stage when the women become completely immobile bodies.

The woman's' legs are fixed with restraints (87.3% of women reported their legs were fixed during labor (Stanković 2017), and she is asked to cooperate, breath, and push. The moment she enters the box, a clock is started in the delivery box above her head. Most women in Serbia (68.5%) deliver without an epidural or state the lack of any type of painkiller (Stanković 2017). While epidural anesthesia is rare, episiotomy is very common; 75.5% of women reported having an episiotomy (Stanković 2017).

When the baby is born, it is "not like in Hollywood movies," as one mother described, where you hear crying instantly. The seconds you wait before the newborn takes its first breath feel like hours. "Do not worry, baby needs a moment to get their bearings" the nurse midwife would tell the mother as they suction the baby's nose so they can start breathing and swiftly and with such dexterity cut and tie the umbilical cord. Those seconds feel like hours, while the time baby spends on the mother's chest, between one and three minutes, passes in a heartbeat.

"Congratulations! Here is your baby. Look all here, ten fingers and ten toes. What is the baby's name?" the midwife asks as she hands the baby over to the mother. "Can you please repeat to me the number on your wristband?", The nurse midwife asks the new mother. This is done so that there is no mistake in identity when the baby and mother are separated. The woman repeats the number on her hand while taking her first look at the child. "Is that the same number as the number we just gave the baby? Can you tell us that number?" In no more than three minutes the baby is taken from the mothers' arms, weighed and measured, and put under the heater on the table next to the far wall of the cubicle in which the women just gave birth.

This marks the aggregation stage. The new mother has to stay on the delivery bed and rest on the bed, but at this point, she regains the possibility to contact her family. She is given her cell phone back so she can call her partner and family to tell them the birth went well. Most of the time the newborns cry while under the lights until they tire themselves out. Mother and baby stay like this, in the same space but far apart, for another hour to two hours. Waiting for the placenta to be delivered, inspected by the doctor and mother's episiotomy (if she had one), to be sewed up and have her blood pressure measured every thirty minutes. After those two hours pass, the baby is finally returned to the mothers' arms. In a wheel bed, they are taken downstairs to the "*bejbifrendli*" (baby friendly) ward on the first floor of the hospital (cf.Becker 2009). There they will room with at least one, but as many as three more babies and mothers. Moreover, from that point on, mother and baby are never more than an arm's length apart during the remainder of their stay which is usually at least two to three more days after delivery.

Women undergo humiliating practices and their contacts with outside visitors are limited while moving and being moved through the maternity hospital. They become birthing bodies. The loss of autonomy and the fragmentation of the self is a trait of medicalized birth (Arsenijevic, Pavlova, and Groot 2014, Becker 2009, Behruzi et al. 2013, Chalmers 1997, Davis-Floyd 2003, Davis-Floyd and Sargent 1997, Davis-Floyd 1994, Landes 1998, Martin 1987, Rivkin-Fish 2005b, Sekulic 2016, Sharp 2011, Stankovic 2014b, 2017b, a, Stanković 2017)It is not a unique characteristic of Serbian maternal care, post-socialist care, or even unique to the universal healthcare system. That said, the fragmented nature of post-socialist healthcare systems and the complete lack of privacy and the institutionalized isolation present in care in the tertiary sector exacerbate the conditions of medicalization. The women who did not pay for prenatal care and the

women who did not have informal connections, *veze*, with the medical staff will not be able to negotiate the impersonal and bureaucratic treatment.

6.2 **Part II: Delivery Ward Strategies**

6.2.1 **"Opšte narodna" - having no one in the hospital delivery wards**

That morning started relatively slowly for this busy hospital. I decided to spend the whole day on the second floor of the hospital, the delivery ward (see the drawing of space by the author). Three women were in the latent stages of labor, laying in beds next to each other, hooked up to CTGs. All three beds were identical; all three machines were working the same. All three women were in this maternity hospital because it is the only place in the entire city where they can give birth. The beds were numbered one to three. Even though the doctors and other medical staff always tried to address each woman by her name, when talking amongst themselves they used the shorthand: bed one, bed two, and bed three. At this point in the early morning, the four nurse-midwives were about to start their shift and were asking the night shift nurses to fill them in.

Nurse Ana: "All right, who have we got now?"

Nurse Bojana: "One is Dr.Gorunović's, three is Dr.Ivanović's, and the one in bed two is of the people (*opšte narodna*)"

"Of the people? (*Opšte narodna*)" - I ask.

Nurse Bojana: "Yeah, she belongs to all of us. The economic situation causes problems. For example, a few years back when the epidural was nonstandard,[25] the differences were visible

[25] Meaning you had to pay for it out of pocket.

between the women here between who could afford an epidural and who could not. I always try to be there for the ones that do not have anybody (*koje nemaju nikoga ovde*). The ones that have someone or can pay they are fine. I take care of the majority that cannot. However, this is the problem of our system (*naš system*)."

The woman in bed two is named Angela. This was her first pregnancy; she was from a neighboring small town that no longer had their maternity ward. Angela was a Romani. She was in her mid-twenties and living in a rural area. All of this meant that her chances of establishing a social bond either through personalizing or privatizing strategies were very little. It was apparent she was in pain while she was lying in the soft beds, in the latent stages of labor. She arrived in the hospital late last night and was induced and taken upstairs to the delivery ward this morning. She was offered an epidural by the staff anesthesiologist, which she had declined. Angela later told me that she was not sure if the epidural was safe; she had heard rumors about negative side effects. The anesthesiologist did not take the time to explain the procedure or what it would entail.

Bojana comes to check on her during this time. She encouraged Angela to relax and breathe. Bojana proceeded to check her chart once more and then leave the room. I lag taking notes. "Please do not leave me alone," Angela tells me. I tell her that I can stay with her a little while if she wants. She smiles at me: "Yes, please stay. I know I should not be so loud but it hurts, and I am weak". I stayed with her, but we do not talk much. While I did introduce myself and told her that I am not medical personnel but an anthropologist conducting research, I still worried about saying anything that could have been seen as giving her any advice that might be construed as medical. I had spent time with other women like this in their latent stages of labor. I would mostly smile at them, pass them a damp gauze to wet their lips. Most of the time, the simple act of smiling would be all the women could respond with, as they were heavily focused on their breathing and

contractions. Occasionally, some women would engage in small talk with me about the music on the radio, life in the United States and other topics. Only after, these women would tell me that they were glad that I had been there with them.

I sat by Angela's side a little while before I was called off by one of the residents for an interview, we had scheduled a few days before. When I came back, Angela was the only one left in the room. The other two women had given birth already. I asked Vera about Angela who tells me that she has not been checked on in a while. The rounds were coming up, so someone would take a look at her son, was her reply. Angela was vomiting due to the induction she had been given around 11 am to speed up her delivery which was estimated as too slow. They had eight scheduled inductions for tomorrow morning, I was told by one of the nurses. "It is because the pathology ward and the day hospital are too full and "needs to be cleared up" (*da se rasčisti*)" the nurse stated. As she said this, she glanced over to Angela who was fidgeting in the bed and commented on her making a mess. After the rounds, the doctors confirmed that she could be moved to the delivery box.

No one spoke to Angela through this process. All that happened was that they deemed she could be moved to the hard table, and Bojana did so promptly. She was moved to the boxes, and Ana and I watched the birth from the hall. It was painful to watch. At this point, Angela was beyond tired and drained. She was kept being told to push, her stomach was pressed, and she was cut. When they cut her, she screamed so loudly that tears came to my eyes. The baby was delivered, a baby girl. No congratulations this time, I did my best to smile reassuringly at her and tell her how brave she was. Ana who was standing next to me just commented one thing that summed up the entire experience: "This is how it is when you do not have someone" (*Ovako je kad nemas nikoga*).

Having someone who is yours (*imati nekog svog*) was a common concern that women had when their delivery due date approached. Angela's experience and experiences of women of similar ethnic and economic backgrounds were are often used as cautionary tales to women who attended the birthing schools, both private and public. These included stories of Roma women refusing to get stitches after the episiotomy, women who did not take proper care of their hygiene and the hygiene of their newborns who got fungal mouth infections. "This [the infection] will not happen to you; you are orderly (*uredne*) women. Roma women think this is normal," women were told during the classes in the primary center. Roma women experience both direct and structural violence in various medical settings across Europe. In 2014, an NGO report showed that in Slovakia doctors would after C-sections, without consent, sterilize Roma women[26].

There were no Roma women attending the free classes either in the primary centers or in the free lectures sponsored by the biobanks. The women who attended these classes were mostly urban, working class and with a higher degree of education. The majority Serbian and most of them with the financial abilities to pay for private prenatal care. Roma women not only did not attend the classes in public schools, but they were also not encouraged to attend, and their birthing experiences were used as cautionary disciplining tales. Roma women are presented as the negative other, the uneducated pregnant women, the bad patients who did not fare well during birth and after. These were the women "of the people" (*opšte narodne*), their ability to negotiate their birthing experience severely limited by their position in the larger structures of society. Their experience was deeply affected by institutionalized racism and structural violence.

[26] https://www.reproductiverights.org/press-room/romani-women-subject-to-forced-sterilization-in-slovakia

Women's subject positionality within larger structures of power not only severely limits their ability to resist but their ability even to question the existing social order, let alone imagine the possibilities for an alternative. Lazarus (1994) argued that while there may be class differences in how women later re-interpret their birthing experience, there is a near-universal resentment to a rushed and impersonal treatment. All women want to be treated with dignity(Lazarus 1994).

Drawing a larger parallel Angela's story is the mirrors the lack of agency of the gynecologist, like Vera, working in the primary care sector. The medical providers working in *dom zdravlja* (primary care centers) are seen as paper-pushers, faceless and sometimes heartless bureaucrats. Most importantly as persons who could not establish trust with their patients.

6.2.2 **"I was told I was spoiled": giving birth in the private sector**

> *My friends told me I was spoiled. That I was supposed to endure (istrpim), to fight in order to get some kindness in the hospital. I did not have the energy for that kind of fight.*[27]

Angela's positionality did not grant her the chance or rather the choice to take action against the impersonal treatment in the public system. Sanja's story I share next did. If Angela's story mirrors the experience of providers in primary care, like Vera, Sanja's story is best understood in relation with the experiences of doctors like, doctor Jovanović, whose "pot was not big enough" to work in both public and private sectors. Doctor Jovanović cannot write referrals (*upute*) for her patients. She is treated more as an entrepreneur (*privatnik*) than a medical provider

[27] Sanja, new mother.

and does not have well-established personal and professional relationships with colleagues within the public hospital to make sure that her patients are not given an impersonal treatment. “God forbid I have to call and ask for a favor. Sometimes (those requests) fall on death ears” Dr. Jovanović summed up the fragile and tentative nature of her authority and reach of power in the public hospital. How does dr. Jovanović’s fragile authority affect her patients? Is their experience different from the women who also had no connections to the staff in the maternity hospital, women like Angela?

Short answer, yes, it is different. It is different because Sanja’s positionality is different. Sanja is one of those privileged few who could “lift-off” (Sampson 2002) from the public maternity hospital. Sanja is a young 25-year-old woman, with a dazzling smile and sunny disposition. Both she and her husband are freelancers, who worked hard to save money for the birth of their son.

> *We had to work hard to afford this for us. We had to work like crazy. My husband had two jobs; I had three. We do not have fixed paychecks; our earnings depend on how much we work. We worked to the bone. I know that other people work this hard and do not earn. We had the opportunity to work and save up. This was a crucial factor that allowed us to decide to go private.*

Sanja was able to afford giving birth in the private hospital. She was able to travel from Novi Sad to Belgrade to give birth in one of the two private maternity wards in the country. She was able to do this, but by making this choice, her friends and her community called her “*razmažena*,” spoiled.

A key question her story raises is the question of choice. Sanja’s story is one about a romanticized view of choice. Her ability to choose a private hospital rather than the public one did not give her a choice to avoid medical interventions she did not want. She did not want to have a

C-section; she had one. She wanted to feed the baby right after birth; she could not. She knew what a "good birth" meant for her, but not the power to make that a reality. She had the power to buy out of impersonality, to have a private birth and her partner present. This was more than Angela had.

However, Sanja's consumer choice, of paying for birth, also did not seclude her from the broader social discourse about women who care more about their happiness than the risk for their baby's health. As was mentioned in previous chapters, private hospitals are not seen as trustworthy, unlike public maternity hospitals. The narrative of distrust towards the private sector was best summed up by the words of one state official: "some medical employees are not worthy of the white coats they wear." Supposedly, they are not as good doctors as the ones in the public sector. The other side of that narrative is that women should thus endure (*istrpe*) the impersonal treatment because it is best for the baby.

Women "learn" that this is what they are supposed to do while attending the birthing classes. Within the state-funded maternal care package, women are offered the possibility to attended classes that are supposed to prepare them psychologically and physically for birth, as well as breastfeeding and early infant care. These classes should take place within their primary care centers, where the women are supposed to come monthly for their prenatal checkups. In Novi Sad, even though there are several primary care centers across the city, only one offers these preparatory classes. Just like with giving birth, within the public sector in the city there is no alternative. The classes were attended mostly by the working class and middle-class women, the majority of first-time mothers (prima gravidas) - just like Sanja. These classes were a space where women met each other, forged new friendships. Some women even saw each other in the maternity hospital and continued being friends well after birth. It was a space where they could share their

experiences, stories of doctors and previous births. It was also an opportunity to "get the list" of things they would need to bring with them to the hospital, as well as get information on what paperwork they would need to complete to receive benefits from the province and state after birth. It was also space where women learned how to become good pregnant women, good patients.

The first class the nurse-midwife would single out the women who had given birth before and had attended the classes during their first birth as well. She would then ask those women to tell the group about their birthing experience in the maternity hospital. Once they finished, the nurse-midwife would say: "and this is how an educated pregnant woman talks about birth!". This, along with breastfeeding, changing babies' diapers and getting the needed documents for benefits, was a key theme of the classes. These women will be educated, well informed and most importantly they will learn how to listen to the medical staff in the maternity hospital. They will learn how to behave "properly," as good patients and they will endure (*izdržati*) the discomfort. The nurse-midwife would tell the class:

> *The hospital does not have the capabilities to provide you with comfort. It is not a five-star hotel. It is not the Hilton. This is how it is in our system (našem sistemu). The nurses are overworked; that is why you have to listen to them. You know why you are there, endure (izdržite).*

Women were repeatedly advised by the nurse-midwife to wait out their contractions at home "if you want your childbirth to be less traumatic, not to have your labor induced" women should come to the hospital "only when you can no longer stand your husbands touch." The women are told comfort was something they can expect from a hotel, like the Hilton, not from a state hospital, not from *naš sistem* (our system). They were told to have understanding for the medical staff, by invoking the rhetoric of *naš sistem* they wished to explain away the women's

lack of agency. The *sistem* is a way of negating women their rights as patients, such as the right to be informed about medical procedures, the right to know their healthcare providers name (Sekulić 2016, Stankovic 2014b, 2017a, Stanković 2017). These rights, women were told were luxuries, and the women who wanted luxury were spoiled. While I did not meet Sanja in the schools, she did tell me she also attended the classes, and it was what she learned there that confirmed and solidified her choice not to give birth in the public maternity hospital.

> *The lectures in public school were the tipping point for me. It was horrific in my opinion. They tell you there that women are spoiled. The lecturer told us point blank that she had never given birth. If she did, she told us that she would not care what happened to her, as long as the baby was all right. She said she would be all right with being butchered (iskasape) if the baby were all right. She was around 35 years old, a midwife. When she told us that I was horrified, I mean if it came to that, of course, I would rather that the baby is well and not me. However, that should not be a startling thought. This scared me so much.*

The notion of the mother who is willing to sacrifice herself is an internalized social norm (Blagojević Hjuson 2014). Women would not complain against mistreatment during pregnancy and birth in order not to appear selfish and ungrateful (Stankovic 2017b). Women are generally pressured to be satisfied with their birth and to place the health and needs of the baby ahead of their own (Davis-Floyd 2003, Davis-Floyd and Sargent 1997, Stankovic 2014b, 2017b).

Sanja did not agree with this norm. In her opinion, if she were happy her baby would also be happy. She did not see her needs as different from the needs of her future child. As a first-time mother, she feared being left alone or worse to be mistreated in the maternity hospital. Sanja did not have a doctor who could use her connections with other colleagues to help her with her

paperwork, let alone help her out in getting a connection with the hospital staff. She also did not want to bribe the medical staff.

> *I was uncertain what to do at this point. I knew that it would cost me less to bribe someone in the hospital according to rumors that would get you better care. I just could not get over the idea of giving someone 500 euros (600 dollars) in an envelope to take care of you. That is their job! I know they are overworked and need the motivation to pay attention to you. I found that horrible; I did not want to get into that.*

Sanja's acknowledgment that the doctors in the public sector are overworked was not enough to justify bribery in her view. This is contrary to the observations made by Humphrey and Rivkin-Fish in post-Soviet Russia, where favors and blat were seen as moral acts and were thus preferable. "Many people prefer the "favor mode" - in other words, they will do things this way even if it is entirely feasible to adopt the official route (Humphrey 2012, 23). Unlike their observations, paying for bribes, seeking our connections with providers working in the hospital was nothing to brag about, nothing anyone wants to admit, but it is done in order to conform with the system, in order to survive(Brković 2017b).

In that sense, Sanja did not want to conform. The fact that she had opted out of the public health care system to give birth did not include the possibility of opting out of a medicalized birth. It meant that it also became a very explicit question of consumption. She was asked if she would prefer a C-section or not. She did not want a C-section but was told she would have to have one regardless. Her impression was that her doctor seemed keen on C-section births.

I was frustrated when I was admitted. They gave me an enema. There was much staff. They were focused more on attending to the doctors rather than me. The doctor did not even explain to me that I will feel the pressure of the water breaking. They did not give us the baby after birth, we asked for it, and they completely ignored it. We wanted to do skin to skin. This was a little bit frustrating.

She also had the impression of being a customer rather than a patient the moment she entered the hospital. “The doctor and the nurses were superficial, all very nice and pretending to be nice. That I did not like as a patient”, said Sanja This was only heightened by the existence of a hospital concierge.

I felt like a customer with the concierge because why would the hospital have that? I wanted to avoid feeling the sense of entitlement because for some reason, mentally, I did not want to be one of those people who go like: Oh we are paying for it now we are entitled to shit you know! I did not want to ask anything that is above and beyond what we are supposed to do.

The experience of women like Sanja echoed back the comment that Dr. Manojlović made when I asked him what happens to the patient in the private sector - they are “faking stranka” - fucking client. Her story highlights that in either exclusive option, public or private women cannot negotiate the cold, impersonal and alienating birthing experience — the difference being in the presence or absence of a partner and the price tag. At either end of the spectrum without establishing a personal relationship with the medical providers, it is hard to transform bureaucratic characters of health care.

Sanja's story is thus a contradictory example to Rivkin-Fish (2005b)'s prediction that privatization will replace, become less desirable the need for seeking out personalizing strategies in health care. Thus, distrust and impersonality are not excursively linked to public health care. Becoming a consumer-patient did not include a guarantee against the dehumanizing nature of medicalization such as the routine administration of enemas, ignoring the mothers' desire for the skin to skin contact after birth, and the increase in C-section deliveries. The core concerns that feminist scholars raised about how birth is treated had not changed, but it is billed as a service rather than a healthcare right. Patients were constructed as buyers entitled to receive quality services, but not active participants in decision-making concerning their birth process (Rivkin-Fish 2005b). Introduction of a consumer model of childbirth has effectively displaced, rather than solved, critical concerns about the need to de-medicalize birth.

6.2.3 **Veze - having someone in the hospital**

> *In Serbia it is normal, even though not everyone wants to admit it, to have a veza (connection). I looked into finding someone (da nekog nađem) to take care of me.* [28]

Some scholars have picked up on the normalized and matter of fact nature patients in Serbia talk about the need for informality in accessing healthcare (Arsenijevic, Pavlova, and Groot 2014, Buch Mejsner and Eklund Karlsson 2017b). Just because informal practices are normalized does not mean that they are also perceived as moral acts. Caroline Humphrey's research in Mongolia

[28] Nataša, new mother.

showed that informal practices were seen as the preferable way of getting things done. Informal, strategies were just and moral acts because the larger socio-political structure was unjust and immoral (Arsenijevic, Pavlova, and Groot 2015b, Humphrey 2012). Both patients and providers I spoke to in Serbia also felt they were treated unjustly by "naš sistem" (our system). After Dr. Gorunović's lecture in the private school, one woman said she understood the precarious position of the doctors and wanted to justify why they were not as attentive towards their patients.

> *He openly told us that they do not have enough staff for all of the patients. If I remember correctly, he told us they have the capacities for 3000 births, and they have 6 000. That means that daily these need twice as many people as they have. I understand that. I know they are not malicious; it is the conditions in which they work.*

Nataša's observation puts into question Humphrey (2012) remark that informal practices of getting things done are preferable to the official way of accessing public services. It is normalized, but it is not seen as morally acceptable. Brković (2017b, 6), on the other hand, shows that: "People do not need to like the social strings that shape them in order to be shaped by them." The majority of women I spoke to thought it was unfair that they had to pay for private prenatal care but also thought of it as a necessity for making sure their pregnancy and birth went well.

Informal exchanges are individual responses to ever increasing inequalities (Stan 2012), they may not be moral actions, but they are practices that aim to establish a sense of social belonging (Brković 2017b). The attempt to personalize public institution, like a hospital, through establishing a personal relationship with a public employee, like a doctor. The goal behind paying for prenatal care with a doctor who also works in the maternity hospital is to create a bond with this doctor, to belong to them in the public hospital. The notion of belonging to someone shows

the unequal power dynamic in the patient/client and provider relationship. Through keeping the relationship with the pregnant women ambiguous - whether they are doing them a favor or providing them a service - doctors reconfirm their authority and superior status (Rivkin-Fish 2005a, b).

Women, middle-class women specifically are more likely to accept and even seek out the authoritative knowledge of biomedical technology and doctors far more than working-class women (Davis-Floyd and Sargent 1997). Moreover, theorists of birth argue that women conform their perception of birth and birthing choices to larger societal values (Davis-Floyd and Johnson 2006). Birthing theorists were referring to the values of technology.

In the case of Serbia, we can extend that to internalized gender norms that label women who do not conform as "spoiled." Within this context, it becomes clear why so many women report seeking a connection in the maternity hospital and take advantage of the private sector to establish this connection. Nataša's story fits into this description as an attempt to establish a personalized relationship within the public sector. She relied on the private sector, used a privatizing strategy (Rivkin-Fish 2005b) to establish this relationship in the public sector. However, Nataša's story is not how every attempt at establishing a connection through the private sector works out. Stan (2012) makes a good point that informal relations should be understood as practices, not as things, thus not static and do not always guarantee enduring relationships. In that sense, the interjection of private prenatal care does not guarantee a mutually satisfactory relationship in the public hospital. Sandra's story highlights this insecurity, as she was not as satisfied with her birth like Nataša.

6.2.4 **Women who sacrifice - paying for private for care within the public**

Nataša and her husband were in their early thirties, university educated and working in a large state-owned company. Nataša is not from Novi Sad but Vrbas, a town half an hour's drive from the city. She had a maternity ward in her hometown. I had conducted pilot research in this maternity ward in the summer of 2015. The ward was much smaller, half the size of the second floor of the maternity hospital that was almost exclusively dedicated to delivery. The Vrbas maternity hospital had only two beds for vaginal delivery and far fewer medical staff than the hospital in Novi Sad. Vrbas did lack both space and medical staff but had a greater grasp of humanized birth practices. For a fee of 50 dollars, women could have their partner or family member with them during childbirth. The space of the delivery section of the ward was not set up like a panopticon and thus allowed for more privacy by placing curtains and a dividing wall. Nataša knew that the Vrbas general hospital offered the option of having her partner present, but the stories of other women and the rumors about the hospital outweighed the notion of humanized birth.

> *We did not even think of giving birth there. My husband would not even consider it. He also heard just the worst stories about that general hospital. They are not competent there! In Vrbas, women are cut regardless of the babies' size. My friend was cut, and her baby weighed two point four kilos! My husband and I both have much trust in the maternity hospital.*

Nataša trusted the hospital as an institution even before she started researching what doctor to seek out for private prenatal care. She wanted to make sure to avoid an episiotomy if she could. When I met her, this was one of her main fears during childbirth. Upon recommendations of her friends, she had managed her prenatal care in the private practice with Dr. Gorunović. She chose

Dr. Gorunović precisely because he worked in the maternity hospital and would provide her with continuity in care. She consulted her friends' network to find the best fit. "All of my friends went private (*privatno*) and based on their experiences I did the same. It matters that he works in the maternity hospital, it makes you feel safer because you trust this person for nine months, they know you," Nataša told me.

The fact that she would instead choose to give birth in a closed institution, with no family with her, then give birth in smaller general hospital points towards the fragmentation of trust in the public healthcare system. Mistrust in the public sector is not a monolithic category. Like the doctors working in the primary care centers, Nataša regarded the medical providers working in her home town to be less competent than the staff working in the highest levels of care - tertiary sector. Her choice, thus, reflects the larger belief that the best doctors work in the public system, specifically in the tertiary level of the public system. The fact that someone works in the maternity hospital is read as being the best of the best. If the doctor does not work in the tertiary level but in primary or secondary care they are viewed as paper-pusher and less competent. It is even worse if they work just in the private sector, then they are not even deemed to, as one government official told me, worthy of the white coats they wear. I asked Nataša why not just give birth in the private hospital, and she looked at me with a puzzled and even a little offended face. "I would never pay to deliver in a private hospital," was her short response. It was not a matter of payment in her view but the question of what she would obtain through her payment.

Nataša's decision not to even consider private practice was a response to her social context. Sanja, who decided to go to Belgrade and give birth in the private hospital, became a topic of gossip and negative stories from her neighbors and friends. Nataša did not want to be seen by her friends and peers as spoiled. She also did not want to have a birth experience that Angela had

either. She attended all the classes. Nataša heard the cautionary tales from the nurse-midwives. She saw herself as belonging to the category of "*uredne ženice*" (orderly women) and "*obrazovane trudnice*" (educated pregnant women). As part of that education, she knew: it was crucial to getting prenatal care with a doctor working in the maternity hospital. It mattered that she established continuity of care and a trusting relationship within the public hospital. It was important that her doctor could flex. Nataša told me:

> *It mattered that the doctor who managed my pregnancy would see me through to the end. It matters that he works in the maternity hospital, it makes you feel safer because you trust this person for nine months; they know you. When I got into week 36, he told me I do not have to come to the private practice anymore. I could do my checkups in the hospital during his shift.*

Nataša did not establish her connection with Dr. Gorunović through personalizing strategies (*veze*) or through bribes. Sociality was established through a patient-provider relationship in the private sector. It was through the doctor's positionality as flexians, that allowed her to have check-ups in the maternity hospital. The relationship between her and doctor Gorunović was at that point more than a paid client and service provider relationship. It became less clear that the checkup in the maternity hospital was a part of the service she had paid or a favor Dr. Gorunović was extending to her.

What is clear is that through this ambiguity between favors and service an unequal power relationship is formed between the patient and provider. Stan (2012) noted a similar ambiguity between gifts and bribes in the Romanian healthcare sector. She argued that the deliberate murkiness of those two concepts allowed patients to "re-balance the books" in the public sector in their favor (Stan 2012). The unclear distinction between gifts and bribes allowed patients to

"symbolically place themselves in the position of gift-givers rather than payers of services"(Stan 2012, 73). On the other hand, my ethnography presents the same reciprocity loop from the providers perspective. A Through the ambiguity of favor/service, a personal relation is formed, as it leaves uncertain if the doctor would extend the same practice - checkups in the public hospital, to all of their clients or just to those considered trustworthy. Stan (2012, 77) states that: "Personal relations give more leeway to both patients and doctors than do completely commoditized relations."

Nataša knew it would be a significant expense for their household budget and that both she and her husband would have to make sacrifices in order to afford the prenatal care with Dr. Gorunović, whose prices were higher than other private prenatal care providers. Dr. Gorunović can charge higher prices because of his position within the maternity hospital. He is one of the heads of the delivery ward. Nataša knew and stated: "I do not think we wasted the money. I asked how much it would cost and sacrifice. I did not go out, buy new clothes, makeup. My entire pregnancy I was reclusive", Nataša confessed. She saw herself as sacrificing for her child. She did not consider paying for prenatal care as a luxury.

If you think about it, it is not that expensive to go private. I mean when I hear that from women that have their nails professionally done, new haircuts. They tell me they have no money for health care but for the hairdresser they do?

Her answer points towards two implicit perceptions. The first is that healthcare is no longer seen as a right but rather a service that has to be paid for. Second is the perception that only women who do not prioritize their maternal care, the care for the unborn child, who pay for personal cosmetic treatments do not pay for private prenatal care. This is a new dimension to the existing social norm of the mother who sacrifices for her children and thus for her nation (Drezgic 2008,

Stankovic 2014a, b, 2017a, Stanković 2017). The idea of the woman who will sacrifice her haircare for paid maternal care stems is echoed even within official government discourse. Vučić, former Prime Minister, the current president on various public occasions implored (ethnically) Serbian women to have more children, to have an understanding for the needs of the country. While addressing these "good women-mother" who have three or more children not to listen to those "spoiled" (*razmažene*) women that "ostracize them from society because they do not have time for expensive parties, handbags, shoes and who knows what else," the president of Serbia told the media. In the pregnancy classes, Nataša and other women were disciplined to behave as good patients and more broadly through sacrificing their own social lives to pay for prenatal care, going on pregnancy leave from work so they can attend the classes during working hours, produced them as good Serbian mothers.

The day Nataša gave birth, I was also there. Nataša was one of three women whose birth I had witnessed one Monday morning. The midwives knew that Nataša was dr. Gorunović's patient and that knowledge affected how she was treated on the second floor of the maternity hospital. Nataša wanted to negotiate her experience and worked on cultivating a relationship, a veza, with the medical providers. The sociality established by paying for private prenatal care had the purpose of transforming her from a bed number to being someones (*nečija*). Not just someone, but Dr. Gorunović's and in turn his sociality, the position of power and influence transferred on to Nataša as well.

Even though the power afforded to her through her connection to dr Gorunović did not mean she could have her husband with her; it did mean that she could transgress other protocols. She was allowed to walk around a little, take off the CTG machines for a while. She had wanted to give birth vaginally, so her doctor requested that Ana, one of the senior midwives takes special

care of her. Dr. Gorunović and Ana's seniority allowed them to bend protocols for Nataša. Ana sat next to her bed while she was in latent labor. Held her hand and voiced words of encouragement. When it came time to move to the "hard bed" in the delivery boxes, Ana was the one who delivered the baby and not Dr. Gorunović. He was there encouraging her to listen to Ana. Nataša did not have an episiotomy. Ana gave her the baby in her arms.

Ana: "Look at your new baby boy isn't he great! And you were not even cut! Great job!"

Nataša: "If I were in Vrbas they would have cut me for sure."

Ana: "Some of the other midwives here would have cut you too."

Dr. Gorunović stepped into the hall immediately to call Nataša's husband. While the baby was with her, Ana carefully delivered the placenta. Usually, the mother's hold the baby for a few seconds before they are placed under a heater. This was the longest I had seen a new mother hold her baby in the delivery ward. I wrote down the time: 50 seconds. Not long but compared to other women giving birth at the same time it was. Afterward, Nataša only told me that she "thanked" (*zahvalila*) and treated (*častila*) both Ana and dr. Gorunović.

Nataša's story is the best possible outcome of negotiations within the rigid structure of maternal healthcare. If I had not spoken to Nataša after her birth, and asked her about her prenatal care, focusing only on her treatment and interaction within the hospital, it would be hard to distinguish it from the treatment that women who had a classic veza, informal relation with the medical staff.

There were women, like Maria for example, who knew the entire staff because she worked in the infertility ward. Her colleagues would come in and check on her while she was in labor — other women whose family members or friends knew someone working in the hospital. My intention is not to state that Nataša's experience was somehow completely different from Maria or

other women who had through personalizing strategies (Rivkin-Fish 2005b) carved out a more flexible path within public health care services and resources (Brković 2017b). During her fieldwork in maternity hospitals in Saint Petersburg, Rivkin-Fish observed similar strategies: "Patients sought to transcend the bureaucratic framework of doctor-patient relations that worked on the basis of anonymity and fragmented care by personalizing it, transforming the health care setting into an extension of one's personal relations"(Rivkin-Fish 2005b, 154).

Nataša's story highlights that the essential factor is not that these relationships are necessarily informal instead that they allow for flexibility and establishing a personal relationship. The strategy for establishing a personal relationship with the staff that would, as a result, allow for more flexibility can also be attained through privatizing strategies. Nataša did not know Dr. Gorunović privately or informal, in the sense that they are friends or family members. Their relationship remained formal but was established and maintained in private, for fee health care sector.

The relationship established between Nataša and Dr. Gorunović cannot be understood as a remnant of socialism. They did not use or reference socialism or post-socialism to describe the reasons for their strategies. Nataša's birthing experience shows us that theoretical frameworks cannot neatly align with ethnographic realities. Nataša's story points towards a broader imperative, the importance of establishing social personhood (Brković 2017b). Through paying for private care, all three central actors within this story were acknowledged as social beings in a setting that is structured around fragmentation, alienation of both women patients and medical providers. Thus, managing her pregnancy with Dr. Gorunović in the private sector is a mechanism for constructing social personhood for both of them. As social persons it allowed them to grapple with the impersonality and even to an extent the medicalization of maternal care.

6.2.5 **I wish I had a midwife instead**

How Nataša negotiated her experience in the maternity hospital is one of the various strategies' women use to establish a social bond with the medical providers. These are strategies of exclusion and privilege, not available to every woman. Some strategies are more successful than others. What women could expect are "mixed results at best"(Rivkin-Fish 2005b, 177) regardless of the strategy women used to negotiate.

Nataša even though she managed to avoid some forms of routinized medicalization but not all of the procedures and protocols. She could not walk when she wanted to but when Ana told her she could. Her story illuminated the very confusing statement Ana's colleague made during her lecture: you can do whatever you want in the delivery ward, but when I tell you so. ". In other cases, women's social bonds with the medical staff through private prenatal care meant that they could bypass the delivery ward and schedule a C-section birth, thus relinquishing any chance of agency. Best case scenarios, it gave legitimacy to the biomedical power; this points towards the impossibility of overcoming structural factors of tertiary institutions.

The hope that formal patient-provider relationships in the private sector would be more stable showed to be false. Sociality, established through personalizing or privatizing strategies, does not always guarantee nor override the systemic constraints on patients' rights. Sandra's story shows how unstable this strategy is in practice.

In many aspects, Sandra's story was very similar to Nataša's. Sandra also through recommendations of her friends and acquaintances. This was her second birth; she decided to continue with Doctor Ivanović because she was satisfied with their relationship with her first birth. Sandra was very picky with regards to whom she wanted to manage her prenatal care.

First, I wanted it to be a man. Second, he should not be too old so that he is too jaded to work or too young to be full of himself. I want a golden middle. Ivanović was just that, and it helped he also went abroad to specialize in obstetrics, that he is an expert and most importantly that he works in the maternity hospital. I did not want someone to manage my pregnancy and another person to deliver the baby. I did not want a stranger to deliver the baby. In the middle of all that chaos and fear around the birth, I wanted to have a familiar face. These were my main criteria, and I had full support from my husband. He was charming, but he never had too much time for me during the exams. I know I may have had more questions than others, but still. I was paying him he should have taken the time.

Even though she felt that he did not take as much time as she would like she continued to see him in the private sector with the hope that he will be there for her again during her second birth. Sandra's experience with her second birth highlights how unstable this strategy actually can be. Dr. Ivanović did not like Dr. Gorunović request from the midwives also to take care of Sandra. His position of power in the maternity hospital structure had a boomerang effect on Sandra. The staff knew that she was his patient. "No one asked me anything in the hospital. They probably saw in my paperwork that I was his patient", Sandra told me. When the head started crowning, the midwives called for Dr. Ivanović, but he could not be reached. No one dared to make a decision about her delivery without him present.

Sandra wanted to negotiate a social bond with a provider who not only worked in the hospital but was also in a position of power and authority. Too much authority that no one wanted to act without his approval. At the moment when Sandra counted on him the most, not to have a

stranger in the delivery box with her, he had to dash into the operating room for an emergency C-section. Without leaving express instructions to the rest of the staff, a midwife Sandra did not know helped her deliver her baby. Dr. Ivanović came in an hour later in his green scrubs to congratulate Sandra. "I chose him for my pregnancy because I thought he would be here for me, but honestly I wish I had also found a connection (veza) for a midwife. I might not have been cut then", Sandra told me a few weeks later. Sandra was not happy with the strategy she chooses to negotiate her birth and thought that it might have been better had she tried to establish an informal relationship, a connection or maybe even bribe the midwife.

Sandra and Nataša, like all of the women who through personalizing or privatizing strategies wanted to negotiate their experience in the maternity ward, did not question the medical authority. They did not openly resist to being treated as a patient during birth, even though neither of them had medical complications that would warrant certain medical procedure, such as enemas, not being allowed to eat or drink water. They internalized the biomedical treatment of birth.

6.2.6 **You are pregnant. You did not have to pay**

When I first met Ceca, she as in the half-intensive care ward of the hospital. She shared a room with two other women. I came into the room to talk to her, as we had met two days before, during her delivery when I told her I wanted to talk to her about her pregnancy. Ceca is thirty years old; she wore glasses and was employed as a teacher in one of the cities public schools. It was because of her eyesight that Doctor Gorunović, with whom she did her private prenatal care was able to justify her wish to have a c-section birth. In general, the conversation I had with Ceca about why she chose to pay for private prenatal care was the same as the ones I had had with other women who had done the same. What made this particular conversation interesting was not Ceca's story

but her roommates' responses to her story. Namely, Ceca was sharing a room with two Roma women, both of whom had delivered babies once before in this same hospital.

As Ceca was telling me, she does not trust the care in *dom zdravlja*, that the lines are impossibly long and that you wait far too long to be seen by the doctor in the primary care sector. Jelena, the Roma woman to her left, interjected: "But dear, you are pregnant! You should have said something; you have priority. I would just come up to the nurse with my health insurance card, tell her I am pregnant, and they saw me right away. You did not have to pay." The other woman nodded in agreement and added she "did" everything public. Jelena agreed as well but then quickly added to Ceca: "Well, I mean I did a lab test privately, I paid 1000 dinars for that. I do not have a doctor here; I did not pursue any favors (*preko veze*). The doctor in the primary care center managed my pregnancy. When I got here, I knew I would get whomever I get (*ko mi zapadne*). Everything was fine. They are all normal and good. I did not notice that the women who went to see them privately were treated any better than me who had no one and did not pay them."

Not all acts of resistance were as visible. For some women, the strategy of resistance through delay was never a possibility, such as in the case of women who had complications during their pregnancy and have had C-section births. Mahmood's research on the politics of piety and the submissive agency of Muslim women in agency helped illuminate some ethnographic encounters in the maternity hospital (Mahmood 2005). Mahmood critiqued the western-centric, liberal notion of freedom and resistance as always subversive and active (Mahmood 2005). Through her ethnographic works, she showed that passivity, docility, and submission do not automatically result in a complete lack of agency (Mahmood 2005). This is important to highlight in studies of women's birthing experiences because without this critique we run the risk of completely disregarding women voices within existing and lived structures of power. If we only

give voice to women whose resistance, we consider visible, we not only silence the agency of others but also fail to fully grasp the importance of broader societal structures on women's lived experiences.

Feminists activist and scholars in Serbia are usually baffled when quantitative studies and surveys show that overall women were satisfied with their birthing experience in public maternity hospitals. While in some of these studies it is easier to question this high satisfaction rate because the study was administered by representatives of the state (midwives) in their homes. This unequal power dynamic could have skewed those results, but even in more recent studies, 56% of their sample stated that the staff was kind and helpful (Stanković 2017). This correlates with the findings of the government survey. Moreover, it is something I too have heard from almost all of the women I had spoken to about their birth in the maternity hospital.

The problem with taking these findings at face value is that state officials tend to see it as encouragement for not changing the existing status quo and that all that needs to be done is more investment in the infrastructure of the hospitals themselves. This type of explanation I heard multiple times from the medical staff in the hospital, and it shows that the concern of for better understanding the interpersonal relations between patients and providers is left unquestioned. On the other hand, the feminist activist also takes these numbers as a sign of the complete lack of agency of women. In an way activist like the medical providers take away or disregard women's agency in the maternity hospitals. The task of fitting lived experiences to theoretical frameworks may be easier, but it does no justice to one's interlocutors. Mahmood states that agency can be understood from within, within the discourses and structures of subordination that create the conditions of its enactment" (Mahmood 2005, 14-15). From this perspective, it becomes clear that for some women agency within the public healthcare system can be found through negotiations

within the private sector, for others through personalizing strategies but for some, it can be found through navigation within the existing structural boundaries of the public sector.

6.3 **Conclusion**

This chapter can be seen as a mirror of the previous chapter on medical providers. In this chapter by presenting the birthing experiences of Angela, Sanja, Nataša, Sandra and Ceca, I wanted to present and provide clarification for the following questions: Why are most women paying for prenatal care and doing everything double when maternal care is completely covered for all women in Serbia? Why if they are already paying for private prenatal care don't more women pay for birth in the private hospital as well? Finally, is it always worth it?

A key conclusion can be drawn from all of the birthing stories is the unquestioning hegemony of the biotechnical embrace of biomedical knowledge (Good 2001, 2007). This is best exemplified by the sight of reassurance heard from the pregnant women when Dr. Gorunović told them about being monitored by CTG machines. Feminist scholars have pointed out that women's' bodily experience during childbirth is influenced by how they were treated by the medical staff (Lazarus 1994). If they were treated like a birthing body without any social ties to anchor her to the medical staff that treatment impacted their birth, this was the situation with Angela whose positionality left her with little to no abilities to attempt to personalize the maternity hospital. For the medical staff, she was just another women "of the people" (*opšte narodna*), and to her, they were just employees of the state institution.

On the other hand, Sanja's social network considered her "spoiled" for seeking out and paying for birth in the private hospital. If Angela were the generic patient, Sanja would be the generic client. In Sanja's story she wanted to pay for humanized birth, something promised but not

fulfilled by the state. Her desire for a humanized birth was not granted in the private setting either. Instead of a humanized model of birth, she received a consumer model of birth.

Most women I spoke to have internalized the norms of the patriarchal society, in the case of Serbia this is the image of a sacrificing mother. Nataša embodied these norms in her view of how a good birthing experience should be like and what sacrifices she had to make. Her notion of sacrifice might be different from Angela or Sanja's, for her, this meant paying for private prenatal care with Dr. Gorunović. She managed to negotiate her birthing experience by becoming someone's patient. For a brief 50 seconds, she even had a semblance of what the state promised as a humanized birth.

Nataša's personalizing path may be the most common, but that does not mean that it will always provide the same outcome for all the women who attempt to do the same. Sandra's story provides a counter to Nataša's experience. Comparing these two experiences sheds more light on the importance of not only establishing a connection with the doctor. The social bond between the woman-patient and the flexing doctor needs to extend to the entire medical staff. In Nataša's story even though she thanked Dr. Gorunović the invisible somebody that delivered her child was the nurse-midwife. In that sense, Dr. Gorunović served as a broker between Nataša and the nurse-midwife. Sandra's doctor did not broker on her behalf with the midwives. The midwives are overlooked, but central figures in the entire maternal care system and certainly require further research.

The final story of this chapter focused on the unexpected discussion between Ceca and her roommates. This conversation I think best sums up the ambiguity and dilemmas of unbundling of the public healthcare system and the selective intervening of private practices. Privatizing strategies did not erase the need for personalizing strategies but have merged them. Moreover, the

fact that Jelena added that she did pay for private lab tests means that while privatizing-personalizing strategies are seen as acceptable and preferable strategies for negotiating within the public healthcare system. All of the women I spoke to internalized the biomedical approach to their bodies. What this encounter in the C-section recovery room shows is the importance of not taking away their agency because of this internalization.

In conclusion, a binary model of successful/failed strategy does not do justice to the agency of these women. Instead of a binary model, these strategies are best understood on a spectrum between public (*opšte narodna*) and private(*razmažena*) with actual strategies of all the women from Angela to Sanja fitting best in the spaces in-between.

7.0 Concluding Remarks

> *"Hey Ljilja, how are you? I wanted to ask if you were still in touch with anyone from the maternity hospital? If you still have someone you know (neko tvoj) can you tell me so they can be there for me? So, I can have someone (imam nekog), case. Of course, I plan on gifting them (častim)*

This was a text message I received from my childhood friend Maja a full year after I had returned to Pittsburgh and started writing this dissertation. Maja at the time was nine months pregnant and knew that I had previously researched the only maternity hospital in our city. I looked at the screen of my mobile phone puzzled for a few minutes, wondering how best to reply to Maja. More pointedly, I wondered what her reaching out to me said about my research topic. For Maja, I had become one of her connections (veze) with the maternity hospital -- I had become a part of Maja's back-up plan. She told me she had already been seeing Dr. Gorunović in his private practice but wanted to ask me for someone of mine (neko moj) "just in case". This "just in case" that she was referencing, I thought, had to do with a concern that Dr. Gorunović was going to extend his social network and authority to engage the rest of the staff in the delivery ward. Maja was concerned about whether he was going to make it clear to everyone in the ward that day that she was not "of the people," belonging to no one. She wanted to make sure that they knew she shared social ties with them, that she belonged to someone. In this case, she wanted them to know that she was connected with me. In Maja's mind, I became a person who could be her veza.

While the focus of my dissertation was not in tracing the types of connections, this encounter shows that there is no one route of informality and that we need to broaden our

understandings of why and how people attempt to "get things" done within state institutions. The broad definition used in this dissertation to explain the notion of "getting things done," or favors, is "a flexible path to state services and resources" (Brković 2017b, 106). Other studies, most notably Michele Rivkin-Fish's work on maternal care in Russia (Rivkin-Fish 2005b), have also mapped out various strategies' women turn to attempt to inspire personal concern within the hospital, and which have increased women's trust that the best would be done for them. For this reason, my starting point in this dissertation was the concept of "negotiating," as a signal for looking at the practices and intersections of seemingly fixed dimensions, such as private and public, formal and informal, trust and mistrust; and how through the unbundling of these binaries we gain insight into how (health care) systems work.

As stated in Chapter 1, I did not intend to provide a strong theory out of my dissertation research but rather to provide a thick description of how a nominally universal health care system is enacted differentially through the everyday negotiations between patients, medical providers, and state officials. That said, I do think this dissertation offers a strong contribution to studies of political economies of various health care systems and the methodology of ethnographic fieldwork in hospital settings.

Throughout my year-long fieldwork, and especially during the eight months spent observing the daily interactions in the maternity hospital and pregnancy/birthing classes, I too became a part in these everyday negotiations of how to get things done. I became a connection between the public primary care center pregnancy/birthing classes and the maternity ward, relaying messages back and forth on whether or not women should bring their catheters with them to the hospital. I was the principal intermediary for the first connection between the newborns and their mother with their families outside the hospital walls, by taking the first picture in the delivery box.

I also had to negotiate my position as a native anthropologist, and working within a clinical setting with a rigid system of protocols and procedures while not fitting entirely into any of the usual roles envisioned in that system. I am also a native anthropologist whose private life has intersected with the public life of my dissertation research on multiple occasions and invisible ways, as illustrated by my sudden need to think how best to respond to a text from a friend like Maja. Finally, I too sought out connections in my social networks, to help speed up the IRB process or to get in touch with the "right" person to whom to send my research documentation. All of these small and dispersed negotiations were crucial to the formulation of this dissertation.

When I set out to conduct this research, my working hypothesis was that the local notion of favors - *veze* - was co-opted by market practices. The dominant narrative in the public health literature and to an extent some post-socialist anthropological literature was that favors would become less desirable strategies as market logic and privatization take a stronger hold on the former socialist Eastern European states. Public health literature described Eastern European health care as "ill" (Radin 2009) and as proof of these assessments point towards informality as a symptom of a deficiency in governance, stemming from the socialist past (Buch Mejsner and Eklund Karlsson 2017b). These forms of presumptive corruption were framed as individual responses to a failing and inefficient mode of governance that is struggling to weed out informality as a legacy of socialism (Kornai 2008, Kornai and Eggleston 2001). The central claim of this strand of literature was that people seek out personalized strategies because there is a generalized mistrust in society as a whole (Giordano 2010, Giordano and Kostova 2002, Giordano and Kostova 2013, Kornai 2008, Kornai and Eggleston 2001, Kornai, Rose-Ackerman, and Collegium 2004). This argument rests on the presumption that people seek out connections – *veze* - because they cannot obtain access to care through formal channels (Stanojević, Gundogan, and Babović 2016).

Specifically, the assumption that the state is no longer able to provide a particular health care service, and that instead of individuals have no other option but to bribe the doctors if they want to receive care. The prescribed "cure" for this illness of socialism is the magic bullet of the free market (Arsenijevic, Pavlova, and Groot 2014). There is a severe flaw in such diagnosis and prescription. Market-based health care exists in Eastern Europe and has exacerbated rather than cured the need for informality (Brković 2017b, Brković 2017a, Pantović 2018, Stan 2012).

In this dissertation, I took a step further from the broad definition of informality, or informal relations as the invisible and unwritten rules and practices of "getting things done" usually within public institutions, such as hospitals. The rationale for this step was that various and diverging practices tend to be bundled up under this ubiquitous term. I drew on anthropological studies of informality (Brković 2017a, Brković 2017b, Haller and Shore 2005, Humphrey 2012, Ledeneva 2008, Pine 2015, Rivkin-Fish 2005b, a, Stan 2012, Wedel 1986, Wedel 2011, Alexander 2002) to argue against the dominant social scientific understanding of the contemporary state of health care in Eastern Europe as corrupt and backward because of the culturally embedded informalities in the system (Arsenijevic, Pavlova, and Groot 2013, 2014, 2015b, a, Arsenijevic et al. 2016, Baji et al. 2017, Buch Mejsner and Eklund Karlsson 2017a, Buch Mejsner and Eklund Karlsson 2017b, Del Vecchio, Fenech, and Prenestini 2015, Dickov 2012, Grigorakis et al. 2017, Hyde 2016, Kornai and Eggleston 2001, Kornai 2000, Radin 2009, Radin 2013, Stepurko, Pavlova, Gryga, et al. 2013, Stepurko, Pavlova, et al. 2015b, a, Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015, Stepurko, Pavlova, Levenets, et al. 2013) .

The problem with the dominant narrative was that it shifted the focus away from analyzing the current, actually existing neoliberal practices. Neither neoliberalism nor post-socialism, or even private and universal public health care systems is discrete and separate models. Insisting on

a binary framework of unreformed and reformed, corrupt and uncorrupted health care regimes thus prevents conceptualizing other frameworks that can provide a better understanding of how health care is provided in practice. Aside from preventing alternative theoretical frameworks, more importantly, it does a great disservice to the already disenfranchised medical providers working in demanding jobs and searching out ways to maintain a semblance of social and economic status.

As I have shown in this dissertation, a binary framework also does not present the complete picture of the strategies used by patients to better navigate through the public-health-care sector. Not everyone "gets things done" through bribery, favors and personal friendship or kin relations. In this dissertation, I looked at the sector that was hailed as the „cure „for socialist legacies of connections – the private medical sector. Instead of a cure for informality, patients and providers alike establish trusting personal relations (*veze*) in the public-health-care sector through ties forged in the private sector. It is not just a matter of filling in the missing gaps of the state, nor is it a socialist or rather post-socialist exclusive phenomenon it is a mechanism of negotiating and personalizing individual's interactions with public health care institutions. The private medical sector has thus far been an invisible avenue in the studies of informality.

One of the central conclusions of this dissertation is that attempts to personalize the public health care institutions do not have to be „informal. ". Rivkin-Fish (2005b) distinguishes between two strategies of achieving care, as privatizing through the interventions of market practices and personalizing through individual interventions with the informal economy. She predicted that in the future, "these privatizing strategies may increasingly subsume personalizing strategies among some groups if economic forms of the relationship become more acceptable and a personal basis for relationships seems less necessary or desirable" (Rivkin-Fish 2005b, 10). However, rather than seeing these two strategies as separate and opposing to each other, what became visible in my

ethnographic case study is that personalization of the system is achieved through privatizing strategies. Thus, to the women in this system, private services are personal, and potentially more reliable than the kinds of personal contacts formerly envisioned as „connections. “

Having corruption as the dominant narrative, however, makes medical providers', and especially nurse-midwives,' demands recognition and respect in both the private and public sectors an uphill battle, fostering distrust among patients. My intention is not to deny the existence and persistence of corruption, especially petty corruption, in countries such as Serbia; instead it is to shed light on the problems of using the narrative of corruption as a cultural syndrome, and a socialist legacy. This framing does a great disservice to the already disenfranchised medical providers working in demanding jobs and searching out ways to maintain a semblance of social and economic status. It also does not represent a full depiction of the strategies used by patients to better navigate through the public-health-care sector. This private-within-the-public system is a response to the increasing inequalities, systemic cuts, and restructuring in the health care sector in Eastern Europe, which leaves both patients and doctors little alternative but to seek out their strategies of gaining access to care on the one hand, and social and economic security on the other.

Another key conclusion of this dissertation concerns the question of institutionalized mistrust (Giordano and Kostova 2002, Ledeneva 2006) as being the cause of the need for privatizing-personalizing strategies, and that seeking out personal forms of trust occurs because of lack of trust in the institutions themselves. This is a central point in the flawed- system argument used most commonly to describe post-socialist Eastern Europe. Instead of comparing health care systems by such stereotypes, I have sought to understand the Serbian health care system in its terms. Through a look back at the original blueprints on which the current state of Serbian health care rests, we gain insight into the fragmentation and atomization of its institutions. The thread

that holds together the atomized public health care infrastructure is the mandatory public health insurance system and its centralized referral system. At the same time, coupled with austerity measures and the current ban on hiring new employees, this same thread is exacerbating the difference between authority and trust among the three levels of public health care. The primary care centers are at the lowest end of the totem pole of authority and trust, while tertiary institutions are regarded as the pinnacle of trust and authority. My conclusion is that we cannot talk about a general institutional mistrust in the health care system because the system itself is fragmented. Mistrust is placed on the primary levels of care, while institutional trust can be found in the highest levels of public care. A plausible explanation for this is the general trust in and hegemony of bio-technical medical authority (Davis-Floyd and Sargent 1997, Davis-Floyd 1994, Good 2001, 2007).

In this dissertation, I argued that maternal care was *the* case study for understanding how the previously exclusively public health care system is slowly unbundling along the seams of the different levels of care and thus opening new avenues for interventions by the private sector. The reason for this is in most cases women have to move through almost the entire health care infrastructure. The majority of women with whom I spoke in Novi Sad, and over half of the sample of the large quantitative study of maternal care in Serbia, stated that they used private prenatal care practices as a strategy to secure better treatment in the hospital (Stanković 2017). Women like Sandra, Nataša, and Ceca each had two gynecologists who managed their pregnancies simultaneously. The gynecologists in the public primary care center who managed their paperwork did not have their trust, while they did have faith in the gynecologists working in the private sector. Ironically, legalizing the private medical practice in the late 1980s after being banned during most of the socialist period of Yugoslavia, was done to be a short-term solution for the growing problems of the declining conditions in the Yugoslavian health care system, along with larger

political and economic troubles. The intention of legalization being a temporary solution is felt to this day. While the seams of the public health care might be losing their tightness (if they ever were tight in the first place), that they still hold together is thanks mainly to the thread of the referral system. This thread is also a central contributing factor why medical providers working in the private sector feel and are treated more as "*privatnici*" - entrepreneurs -- than as health care providers.

Medical providers who work only in the private sector do not have the same authority and power as their peers in public maternity hospitals. While there is trust in the maternal hospital as an institution, that trust does not allow for the establishment of personal authority and power of specific providers. Only by navigating and flexing between these two sectors can doctors establish personalized authority. The public sector gives them access to a large pool of patients and provides them with legitimate medical authority, to the point of presenting them as representatives of the highest medical authority in the country. What working in the public maternity does not afford, though, aside from financial stability, are an individual authority, personal respect, and trust from their patients. The private sector, on the other hand, grants them individual flexible authority and the opportunity to establish long term relationships with their patients. This relationship is not one of the equals. Through their flexing positionality doctors, who are at the same time medical providers and entrepreneurs, have the power to blur the distinctions between favors and services. It is this power that women seek to capitalize on when they wish to transfer their client relationship in the private sector to their treatment as patients in the public hospital. Thus, rather than private market-based strategies replacing favors and personalizing strategies, they are constantly being negotiated and interconnected through the interactions of medical entrepreneurs and patient/clients.

The perceptions of what a successful medical provider was not the only change that occurred with the selective intervention of private practices. We may look at the reconfiguration and re-affirmation of the social norm of a sacrificing mother (Ramet 1999, Sekulic 2014, Sekulić 2016), who will endure childbirth in the public hospitals because "love and the baby" is all that she needs. This notion of sacrifice for the good of the child has been selectively reconfigured to include the notion that health care is not completely free and that paying for parental care is not a luxury but a necessity. In this framework, by not paying for prenatal care women risk being treated as no(bodies) within the hospital. If they opt to pay for private care and give birth in the private sector, they run the risk of being labeled as egocentric, spoiled and thus bad mothers. Middle-class Serbian women learn to embody this reconfigured ideal of a sacrificing mother through the pregnancy classes in both private and public settings. The middle class and higher educated women are inclined to accept and trust the technological model of childbirth (Chalmers 1997, Davis-Floyd 2009, Davis-Floyd and Johnson 2006, Davis-Floyd and Sargent 1997, Davis-Floyd 1994, Martin 1987, Pincus 2013, Stankovic 2014b, 2017b, a) and do have generalized trust in the institutions that offer this model. However, generalized trust does not protect them from impersonal treatment that negatively impacts every women's birthing experience regardless of class (Lazarus 1994). Having someone (*imati nekog*) and being someone's (*biti nečiji*) in the hospital is thus the flexible and unstable path for women to navigate to establishinging social personhood and personalizing the hospital. Again, the notion of connections (*veze*) is the specific informal strategy that has been present since the days of socialism in Serbia.

The selective interventions of privatization of health care have not rendered connections and informality undesirable, nor do they arise solely when the official system does not work. Connections persist "because they shape who people are socially" (Brković 2017b, 73). With the

emergence of private medical practices, what has also emerged are new pathways for shaping sociality of people that serve as mechanisms for negotiating increasing insecurities and ambiguities and reproducing relations of power. Specific strategies of establishing personal connections have become legitimized by the state - the connections established in private prenatal care with flexian gynecologists who also work in the public maternity hospital. On the other hand, the privatizing strategies of nurse-midwives remain invisible and illegal.

Though this topic is not explored in depth in this dissertation, it is an important direction for future research as this disparity sheds light on social practices of maintaining social personhood and establishing authority within the health care system that remain unseen. Even though the work of the nurse-midwives is instrumental in every level of maternal care, and they also supplement their labor by working "privatno," their entrepreneurial endeavors thus far remain in the grey areas of „informality." I spoke to many women like Svetlana who later regretted not trying to establish contact with the nurse-midwife instead of the doctor, because the doctor did not extend his/her power over the way the midwives treated her during birth. Other women, like Nataša, whose doctor's authority and influence extended to her and she was happy with how she was treated by her nurse-midwife, had one thing in common with women like Svetlana. They all knew and wanted to know about the credentials and medical knowledge and expertise of their chosen flexian doctors, but at the end of the day women that were there to deliver their babies remained a nameless midwife. Their work is left out of selective interventions of the private sector, and their labor is deemed far less valuable than that of the doctors. The nurse-midwives in the current state of maternal care are the nobodies who are key somebodies for every woman with a physiological birth, every day on that second floor of the cities only maternity hospital.

My ethnographic account, of the slow unbundling of public maternal care and the selective interventions of private prenatal care, contributes to the growing literature on the emergence of new kinds of sociality (Alexander 2002, Brković 2017b, Collier 2011, Matza 2012, Matza 2018). This dissertation thus contributes to studies of political economies of health care systems, by cautioning against broad-scale comparisons that reaffirm the presumed validity of postsocialist/neoliberal, east/west, corrupt/not corrupt binaries, and instead of studying health care systems in their terms. Rather than accepting the existing binaries and trying to fit the ethnographic realities into theoretical categories, I looked at the sites of negotiations to understand the importance of sociality and social personhood within health care systems thus demonstrating that while the public health care system is being disarticulated in segments, neoliberal reforms are not replacing them but reconfiguring them. While specific to Serbia, my work on the interjections of private medical care within public health care systems is not just of relevance to former socialist health care systems. Similar studies should be done within other universal health care systems, such as Brazil and Greece.

Moreover, this dissertation can serve as a sounding board for studies on the market-based health care system as well. At the start of the 2020 presidential candidate for the democratic party, Kamala Harris made a bold claim the United States should eliminate private health insurance and transfer to a single health insurance provider. I do not think the US health care system is or should be comparable to the Serbian case. What we can grasp from looking at how birth is negotiated in Serbia, is the benefits of looking at the connection between shifting categories of private and public (health care).

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