2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Khashayar Beigi
PhD Candidate in Anthropology
University of California at Berkeley

Health and Illness in Cultural and Religious Contexts in Tajikistan

June 26, 2012 – December 20, 2013
Dushanbe, Tajikistan

Program for Research and Training on Eastern Europe and the Independent States of the Former Soviet Union (Title VIII)
Funded by the U.S. Department of State and administered by American Councils for International Education: ACTR/ACCELS

AMERICANCOUNCILS
FOR INTERNATIONAL EDUCATION ACTR ▲ ACCELS

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Research Abstract

The present research observes, follows, and reflects on questions of health and illness and their so called "cultural and religious" re-articulations in post-independence Tajikistan. The question of health was pursued in public health campaigns on HIV/AIDS prevention focused on migrant workers while the question of illness was explored through the emergence of palliative care medicine for terminal patients. The methodology included ethnography and participant observation. The theoretical lens used in the analysis of data was based on new debates and problematics in the field of medical anthropology. My overall attempt has been to distance my heuristic and analytical perspectives from "culturalizing" or localizing the studied phenomena and to bring back the question of social relations and dynamics not as answers but as global conditions for the production of questions.

Program for Research and Training on Eastern Europe and the Independent States of the Former Soviet Union (Title VIII)
Funded by the U.S. Department of State and administered by American Councils for International Education: ACTR/ACCELS

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Research Goals:

In my research project I observed and mapped the introduction and education of novel practices, concepts and aspects of Western or "modern" medicine into post-independence Tajikistan. Implementation of HIV/AIDS campaigns and palliative medicine are part of a larger globalization of medicine *enforced* by international and multi-national organizations such as WHO, UNICEF, the Global Fund, The Open Society, USAID and so on. While these organizations have their system-wide standards and procedures for needs assessment, monitoring and evaluation, it is only in participatory fields that policy and administrative procedures mediate and actualize "empirical" data and results. My goal however is not to re-evaluate or criticize the operations of such organizations and projects against the particularity of the local settings for example in terms of cultural competency of trainers or translatability of modern concepts of medicine into the cultural or religious frameworks of everyday life in Tajikistan.

In a reverse direction, I seek to understand if and how various problems, questions, and answers that emerge in the implementation of such medical modernization projects could throw light on some aspects of social life in Tajikistan. In this view the religious or the cultural are neither static categories opposed to nor are they dynamic phenomena produced in reaction to global forces of modernization and change. Rather, they are the very terms for the *continuation* of these forces as far as they *remain* questions of faith and doubt, suffering and relief, hope and despair, or basically life and death .

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Research Activities:

My research activities can be divided into two sections: my participation in training workshops, field visits, theatre performances and monitoring trips conducted by members of various NGOs and organization active in the prevention and education of HIV/AIDS. Most notably, the International Organization for Migration and its affiliated NGOs kindly agreed to let me accompany, observe and participate in their educational activities in Dushanbe, Vahdat and other regions of Tajikistan. Overall their activities were focused on teaching the public on various aspects of prevention of HIV with an emphasis on labor migration.

A large number of Tajiks, mostly men, choose to work in Russia in order to earn a higher income. The height of working season starts at the end of Spring and continues into the Fall as long as the weather permits in Russia. Therefore during year-along training activities, often the migrants themselves might be absent so the goal of trainings provided by local and national NGOs is to reach various members of community such as wives of migrant workers, medical and social workers, religious leaders, administrative leaders, local elders, and so on. So during the period of my scholarship, I started to observe and participate in training sessions provided by Imdod trainers in Dushanbe, Qerqontape, and Kulob. At the same time I accompanied their monitoring trips in various districts of the city of Dushanbe.

During these workshops, I observed the pedagogical process of teaching the public about the dangers and the ways HIV can (and cannot) spread as well as the preventative methods to

counter its spread. Most importantly, I listened and encouraged questions, comments and reactions from the audience in regards to the recommendations and instructions provided by the trainers or distributed to them via pamphlets, theatre performances, and discussion sessions. My goal was to understand how the seemingly objective information about medical aspects of HIV/AIDS are taught, discussed, and received by various actors including the trainers as well as the trainees in relation to other aspects of everyday life such as religion, economy, family and so on. For example how the question of using condoms are dealt from a religious point of view both by lay people and by clergies and religious leaders.

As the second part of my activities I observed and participated in the project of Palliative Care initiated by the Open Society organization in Tajikistan. Palliative care is a branch of medicine that deals with those medical conditions that are not treatable (such as malignant cancer) and may lead to the death of the patient eventually. Therefore the goal of palliative care is not to cure the patient but to alleviate her pain and suffering and to improve her quality of life from spiritual, social, and religious points of view. The main palliative care facility in Tajikistan is located in Dushanbe and is called Shafeqat Hospital. Through funding by the Open Society Tajikistan, Shafeqat Hospital started a mobile program to contact and admit palliative care patients for the first time in addition to renewing its wards and equipment and providing training for its medical staff. The mobile team comprised of a nurse, a social worker, a psychologist, a clergy, a driver and an oncologist. The oncologist in this case practiced medicine at Qarebola state hospital and thereby could also refer cancer patients to the palliative care program at Shafeqat.

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

The introduction of palliative care medicine into the health care system of Tajikistan happens at a particular time of transition not only for Tajikistan but also for global medicine. On the one hand, the new drugs and modes of therapies are increasing the survival change of cancer and other terminally-ill patients. Along with survival and postponement of death comes the question of quality of life and rehabilitation. These functions in today's progressive medical world necessitate a team of highly-specialized professionals working in collaboration with the primary care providers and the community. But on the other hand, the health care system in post-independence Tajikistan is wrestling with its own crisis. The collapse of the Soviet Union and its fully-subsidized medical system has left both the medical providers and the patients with less than standard procedures, shortage of modern equipment and high costs of treatment specially in the case of terminal and chronic conditions such as cancer. It is in the interstices of introduction of modern palliative medicine in Tajikistan and the crisis of socialized medicine that I tried to observe how physicians and patients interact via social, religious, and cultural frameworks to engage with questions of death, disability, suffering and pain. In this context I engage with the question of folk medicine and religious healing not just to map local systems of medicine made accessible to clients from various socioeconomic layers of the society but also to explore how illness and health give rise to contexts in which social dynamics of everyday life are re-articulated and expressed in capacity to make therapeutic choices and took medical risks and actions.

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Important Research Findings

In general terms, my findings point to the capacity of medical systems to carry the concerns of social actors, be it economical, spiritual, or moral, *within* their particular sets of medical practices, concepts, and reasoning. In a televised theatre, a Tajik family is shown at the bed of an elderly relative, who has been ill for a while. There is a heated debate on what should be the course of medical action: taking him to a private hospital can cost a fortune while tending to him at home is a burden particularly to the disgruntled daughter-in-law who could claim no credit whether the patient lives on in the vegetative state or dies. Finally an old family friend arrives for a visit and admonishes the family for being selfish and takes the patient to a medical facility. Similarly, many chronic and terminal patients admitted to Shafeghat hospital went through various phases of care provided by members of the family, folk and religious healers, private and public or even foreign clinics before being admitted in the palliative care hospital Shafeghat. Therefore in each phase or choice of therapy a different sets of forces or pull and push factors enter the scene. For example, in post-Soviet Tajikistan privatization without adequate oversight and professional regulations has led to a general sense of distrust in regards to the integrity and ethical practices of private clinics and doctors. There are many rumors or anecdotes about doctors who conducted unnecessary procedures just to maximize their compensation. In this context folk or religious healers carry the function of social and professional trust previously sustained through socialized medicine and later destroyed in the unruly process of privatization.

Their point of advantage over their modern rivals therefore is not just their lower fee but also their perception as running honest and ethical business.

Parallel to the question of social trust in the clinical context of palliative care I also studied the question of social trust in the public health campaigns of HIV/AIDS education. At first the similarities might not seem much: the task of educating the public on the danger, prevention, and treatment of HIV infection is considered a public campaign that has to be tuned to social, cultural and religious sensibilities of the target population. And not surprisingly, there are several booklets that are commissioned, published, and distributed by international organization in which the imperative to take preventative measures against HIV has been re-articulated and re-enforced by resorting to Qoranic verses and quotations by sages.

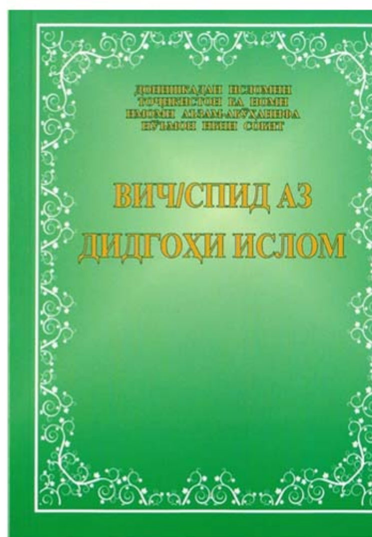
But in practice talking about prevention also means talking about responsibility, victimhood and moral values, which brings in categories of social actors, trajectories of (sexual) desires, and sanctioned marital bonds. For example, in a suburb neighborhood (or Mahalla in Tajiki) close to the city of Tursonzoda west of Dushanbe, the local NGO in partnership with IOM organized a question and answer session with active community members. In that session, while the locals did not deny that they all knew someone from the community working or having worked recently in Russia as a migrant laborer but still were not sure if the task of prevention of HIV could still be best addressed in terms of encouraging their fellow community members to undergo testing. In fact, someone suggested that maybe the government should round up all returning migrant workers at the airport and took their blood samples. Such a radical suggestion

may not be feasible due to violation of citizen's rights as well as the difficulty in following up on the test results. However, this also could imply that anonymous interaction with the public health system and the government is preferable to the direct involvement of the members of the community in each other's affairs, even if it is to the best of their interest. It is not hard to imagine the reasons behind such a suggestion. HIV carries a huge social stigma not only in Tajikistan but also in many modern and industrial countries. While in the West the privacy and rights of the patient is protected by various policies and laws, in Tajikistan there is a (perhaps unrealistic) expectation on behalf of internationally-funded public projects that the community or the neighborhood can or should be able to fill in for the range of administrative, legal and medical structures envisioned and implemented in other countries in this respect.

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

The above picture shows a scene from The Gift of Migration (Tuhfeyeh Muhajirat in Tajiki), a play written and directed by Shodi Soleh in Dushanbe about a returning migrant laborer who passes HIV infection to her pregnant wife.

The above picture shows two windows, the left for private and the right for public medical billing and services at a hospital in the city of Khujand.



Two samples of pedagogical material used in HIV public health campaigns: The drawing in the left depicts the predicament of a migrant laborer in pursuing his desires against marital life and thereby risking HIV infection. The right picture is the cover of an educational booklet entitled *HIV/AIDS from the View Point of Islam*. Both items are courtesy of International Organization of Migration (IOM) Tajikistan.

Policy Implications and Recommendations

In the absence or erosion of those modern programs of public health and medical services traditionally managed by the central administration in Tajikistan, international organizations have sought to find non-governmental allies to fill the gaps. These allies are often named after abstract and general entities such as “community members, “cultural facilitators”, “religious leaders”, NGOs and so on based in development studies. However, in addition to the dubious epistemological status of these categories in social sciences, there is even less attention and reflection on the part of these organizations and funders on how these terms emerge and function in the process of devising, implementing and evaluating medical modernization projects. More concretely, that which we call it *cultural* or *religious* aspects in for example HIV prevention educational campaigns may in fact have less to do with a specific culture or religion than with how certain questions (what to know, how to act, whom to ask) become objects of inquiry/learning. My findings show that this process of learning, however, never starts nor ends at the specific time, space and social settings designated by the intended pedagogical projects. In fact the questions continue to dissimulate and reverberate through socio-historical links. Each articulation of the question of for example death and suffering, be it in religious or cultural terms,

is in fact the continuation of the process of learning. Most often what transpires in such programs, beyond the objectives envisioned, is an *echoing* of the original problem in various names and voices. These voices, if not dismissed as noises, can bring back "the community", "the cultural", or "the religious" into the international development agendas without necessarily objectifying them as either allies or obstacles. Hence the questions should not be limited to how we can use Quranic versises as an *authority* to encourage HIV prevention or use a clergy to provide solace for palliate care patients. Rather, it should be asked how an strictly medical or public health project in the very terms it is conceptualized, operationalized and implemented *cannot* stop connecting to other problematizing forces of everyday life. It is only in seeing the public as equal in posing problems/questions and suggesting answers/solutions that we can boast of being "partners" in such projects.

Co-Curricular Activity

In the beginning, during and at the end of my fellowship activities I had numerous meetings with several officers in IOM Tajikistan, USAID, Shafeghat Hospital, National Migration Office and members of NGOs involved in the studied projects. At first, the common question or anxiety among most of my interlocutors was if I'd been sent to evaluate their performance or even to reduce their funding. When I explained that I'm interested in subjects other than the effectiveness of their programs or performance of their colleagues, they started to enter into conversations with me more openly and told me stories beyond the scope of program mandates and criteria.

In return I shared with them some of the critical debates in medical anthropology about the universality of definitions of health and illness or pain and pleasure. I encouraged them to look more at their job as not merely originating and ending in the funding agency but also in close connection to local histories beyond the limited life of a project.

Conclusions

Anthropology was born in its encounter with distant life-worlds during the colonial era and developed further by reflecting on and questioning the material and conceptual forces behind this encounter. While the terms of the encounter might have changed today under forces of globalization and international development projects, many insights, methodology and critical debates of anthropology still are relevant in shaping our understanding about the modern world and our role in it. The present study sought to emphasize those aspects of medical modernization projects in Tajikistan that were often neglected or considered superfluous in the process of designing, implementing, and assessing these programs. By emphasizing the participatory factor in these programs as a problematizing counter-part and not merely as a means-to-end relationship, I tried to bring back the question of "people" as agents of questioning, change and in brief life.

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Plans for Future Research Agenda/ Presentations and Publications

I'm planning to continue my PhD research both in Tajikistan and also in Russia, where most Tajik migrant laborers work and live before returning to their families. Meanwhile I'll also present my research and its results at various scientific and academic venues as well as at my home university UC Berkeley. I'm also working towards a draft of a book based on my research in Tajikistan.

Bibliography

Alexandrova, Anna. *Mobilizing Civil Society's Response to Stigma and Discrimination in Central Asia.* 2007.International Debate Education Association
Farmer, Paul. *AIDS And Accusation. Haiti and the Geography of Blame* 2006.
Jakubowski, Elke and Arnaudova ,Albena. *10 Health Questions about the Caucuses and Central Asia.* 2009.
Foucault, Mitchel. "The Birth of Biopolitics", in: *Michel Foucault, Ethics: Subjectivity and Truth*, ed. by Paul Rabinow, 1997. New York: The New Press.
Johnson, Erica Jane. Authoritarian regimes and nongovernmental organizations: Transitions in health care provision in Central Asia.2011 ProQuest, UMI Dissertation Publishing.
Keshavjee, Salmaan. Medicines and Transitions: The Political Economy of Health and Social Change in Badakhshan, post-Soviet Tajikistan.1998 Doctoral Dissertation. Harvard University.
Khodjamurodov G, Rechel B. Tajikistan: Health system review.
Health Systems in Transition, 2010, 12(2):1–154.
Klugman, Jeni; Scheiber, George; Heleniak, Timothy. *A Survey of Health Reform in Central Asia.* 1996. World Bank Publicaitons
McKee, Marting, Healy, Judith and Falkingham, Jane. *Health Care in Central Asia*. 2002
Michaels, Paula.*Curative Powers: Medicine And Empire In Stalin's Central Asia*. 2003. University of Pittsburgh Press; 1st edition..
Santosh Jatrana, Mika Toyota and Brenda S.A. Yeoh. *Migration and Health in Asia* 2005
Tobis, David. *Moving from Residential Institutions to Community-Based Social Services in Central and Eastern Europe and the Former Soviet Union*. 2000.World Bank Publications.

2012 -2013 TITLE VIII RESEARCH SCHOLAR PROGRAM
FINAL REPORT

Yusufbekov Yusuff, Babajanov Rustam and Kuntuvdiy Natalya. *Civil Society Development in Tajikistan*. 2007 Allavida.

Program for Research and Training on Eastern Europe and the Independent States of the Former Soviet Union (Title VIII)
Funded by the U.S. Department of State and administered by American Councils for International Education: ACTR/ACCELS