Buying a connection. Private practice in public health care – the case of a Serbian maternity hospital

Ljiljana Pantovic, **University of Pittsburgh**

Abstract: Personal connections represent social capital usable to gain access to social provisions, such as public health care. This article deals with a shift in the ways these connections are attained. Drawing on a case study of a large maternity hospital in Serbia, in this article I show that some pregnant women in order to gain better maternal care and birthing experience in the public hospital resorted to paying for private prenatal care with the OB/GYNs who are simultaneously employed in both the maternity hospital and private prenatal care clinics. By paying additionally for private care, these women were able to establish alternative, institutionalized relationships with the same medical staff which allowed them to transfer those relationship into personal connections (veze) in the public maternity hospital setting.

Keywords: Privatization, Maternal health, informal relations and networks, Eastern Europe

Introduction

A few years ago, Nataša[1] was expecting her second child. Nataša and her husband are in their early thirties and working class citizens of Serbia's second largest city, Novi Sad, the capital of the Autonomous Province of Vojvodina. One day, Nataša and I were drinking coffee and talking about her pregnancy and prenatal check-ups. She was due to give birth in a couple of months in the only maternity hospital in the city, Betanija, the same institution where she had given birth to her son two years prior. This is a public, state-funded maternity hospital which should mean that her care is completely covered by the universal health care insurance provided by the Serbian state. And yet, she told me about the cash loans her husband and she had to take out in order to pay for all of the tests, check-ups and screenings she was doing within the private health care sector. She said: "I need a *veza* in Betanija, but the only way to get it is through private prenatal care, so I am doing everything private. Even though it is very expensive and it was hard for us to get that money."[2] When I asked her why she couldn't have similar prenatal care in the public health care system, she said she probably could. But her preferred OB/GYN has a private practice and this was a good way for her to make sure he will be there for her, as her *veza,* so everything goes well when she gives birth only maternity hospital in the city. This was important for her because of her previous birth experience during which she felt completely abandoned by the medical staff. She said: "I stopped believing in the devotion of the medical staff in Betanija". With her first child, she didn't seek out private prenatal care, which in hindsight she saw as big mistake--A mistake she wanted to avoid this time around.

Nataša's story sparked my interest in understanding the intersection of private health care practice with the public health care system and its peculiar linkage with the socialist concept of *veza* (plural *veze*), a form of informal relationship, similar to the Russian *blat*, studied widely across Eastern Europe (Wedel 1988, Ledeneva 1988, Kligman and Gal 2000,

Petryna 2003, Rivkin-Fish 2005, Ledeneva 2006, Brković 2012, Brković 2015). A *veza* can be defined as a set of personal relations and connections that a person pursues to realize various goals, mostly in regards to state institutions (Brković 2012, Brković 2015). But the relationship that Nataša called her *veza* was not a personal, informal relation but rather an institutionalized relationship between a health care provider and a patient.

In this article, I focus on the narratives and experiences of women who have given birth in the past three years in Betanija, the public maternity hospital in Novi Sad, Serbia. Building on the idea that in the Serbian context connections serve as social capital – a "set of actually usable resources and powers" (Bourdieu 1977, 114) – I investigated whether individuals utilized newly established private prenatal care practices to develop connections (*veze*) that would give them access to the better maternal care in public maternity hospitals. I asked the following questions: When it came to giving birth, are the market practices appropriating the resources of public care facilities for private gain, under the guise of connections (*veze*)? Why was it important for some women, like Nataša, to even take out loans to pay for prenatal care which was supposedly covered by state funded health insurance in the public sector? In this article, I argue that some women could transform their financial, economic capital into social capital (Bourdieu 1977) by establishing a patient-provider relationship with medical providers who worked simultaneously within the public and private health care sector. Through this process, they could circumvent their lack of traditional *veze*, personal, informal relations with the hospital staff and still establish a different type of connection that enabled them to receive better care during birth.

Maternal health care in Serbia

Since the collapse of socialist Yugoslavia, the Serbian health care system has undertaken a broad-scale privatization. According to the data gathered for a European Commission questionnaire that Serbia is currently filling out as a candidate for EU membership, since 2009 over 5000 various forms of private health care services have been registered in the country. Serbia has a universal health care framework which does not include private providers. 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 "guest" or "visiting" physicians. The fact that privatization of health care is emerging in Serbia makes it an important case study to understand the various implications this process has and will have on a previously exclusively public health care system.

Furthermore, reproductive health in general represents a socially and politically charged sector of health care (see also Martin 1987, Ginsburg and Rapp 1991, Inhorn 2003, Rivkin Fish 2005, Craven 2007, Browner and Sargent 2011). The nation-state has a vested interest in boosting birth rates as part of the larger pronatalist politics of the government (Greenhalgh and Winkler 2005, Kahn 2000, Kanaaneh 2002, Drezgic 2004, Gal and Kligman 2000). Maternal care in Serbia is a crucial case study for addressing this interface of private health care provision with the public health care system, not only because of the prolonged nature of care that requires multiple visits and check-ups over at least a one year period, but

also because prenatal care itself is extensively privatized. Yet there are only two privately operated maternity hospital s in the whole country, both located in the capital, Belgrade. This means that most women not living in the capital give birth in public maternity hospitals. Although they still have access to an ever-growing number of private prenatal health care practices and diagnostic laboratories.

The dismantling of socialist Yugoslavia and the subsequent civil wars had a great impact on the health care system. All the hospitals in Serbia lacked basic supplies, and medical staff experienced great delays in receiving their salaries (Tosić 1992). However, in 2000, after political changes, the World Health Organization (WHO) and the World Bank provided humanitarian aid to Serbian hospitals with special attention to the maternity hospitals (Becker 2009). It was expected that the government action and international help would improve the situation in the maternity hospitals. In recent years, the issue of the poor state of public maternity hospitals has been given extensive media and political coverage in Serbia, from the creation of a funding project called *Bitka za porodilišta* (Battle for the maternity hospitals) to the engagements of the First Lady and her foundation dedicated to improving maternal health and boosting fertility rates.

Although problems in the maternity hospitals were widely known, there exists an unwritten rule that women did not speak about their negative experiences in the maternity wards. To counter this silence, a grass root NGO *Majka Hrabrost* (Mother Courage) collected online surveys from mothers who delivered infants in Serbian public maternity wards in the period between 2000 and 2008. Mother Courage 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. Due partially to intense media scrutiny after these results came out, the state of the public maternity hospitals has become a hot-button issue in the country.

Interestingly, both the state and the civil sector completely disregard the emergence of alternative private prenatal and maternal health care services that occurred during the past decade. Civil sector initiatives focused on condemning and influencing state offered services without acknowledging the existence and intertwined nature of private and public services. To date there has been little to no interest by either the state or the civil sector in the importance of understanding interactions between the public maternity hospitals and the ever-growing number of private prenatal care practices. Below I argue that the possible reason these interactions are neglected is because patients, the informants of these online surveys, tend to label them under the same umbrella term of *veze* which does not adequately describe these institutionalized patient-provider interactions.

Not so informal alternative relations in maternal health care

"Dirty togetherness" was how in the 1980s Wedel's Polish informants described informal relationships (Wedel 1988). Wedel (1988) showed that people in Eastern Europe use these terms to describe groups with influence, those running things in the state. In her work on Poland, Wedel makes a general observation about the different approaches people have in relation to gaining access to social and welfare provisions in the West and East. According to

her: "Whereas the Western starting point is often What; the Eastern one tends to be Who. Who is connected to whom" (Wedel 1988, 3).

Čarna Brković (2012) studies the role of *veze* (connections) in attaining social provisions in a Bosnian border town and how people who provide connections can manage the ambiguities derived from neoliberal, flexible governance (Brković 2015). Brković warns against seeing favors and informal relations as by-products of deficient national democracies and markets because it prevents us from understanding the ways in which favors reflect contemporary globalized socio-economic processes (Brkovic 2015, 270). What she highlights is the importance of personal connections in gaining access to institutionalized care in Bosnia. She argues that the knowledge of "who to know" is used as a way of navigating through and with the state health care system (Brković 2012). Personal relations and connections play a key role in the political relations of citizens with the state apparatus (Brković 2015). The significance of personal connection in welfare provisions is a reflection of the ambiguity over public and personal responsibilities that was introduced by the neoliberalization of Bosnia (Brković 2015).

While Brković connects these emerging inequalities with the process of neolibealization, Michelle Rivkin-Fish (2005), in her work on women's health in post-soviet Russia, links inequalities more generally with the dismantling of communist health care. She argues that these inequalities are affecting doctors and patients alike (Rivkin-Fish 2005). In her ethnographic work in Saint Petersburg, Rivkin-Fish notes that some public maternity hospitals have private maternity wards within them which were reserved for women who could and wanted to pay for them. She goes as far as to argue that: "if economic forms of relationship become more acceptable a personal basis for relationships seems less necessary or desirable" (Rivkin Fish 2005:10). This may very well be the case in situations where a completely separate two-tier (public and private) system, but it does not fully encompass already-existing private enterprises that do not subsume public services but are symbiotic with them. Not all of these informal relations neatly line up in the binary model of personal connections – social capital – versus privatizing strategies – economic capital.

Giving flowers and chocolate to nurses and brandy and envelopes with money to the doctors as "thank you gifts," or mobilizing mutual acquaintances and personal relations to get preferential treatment in public health care and other social settings has been well documented in anthropological studies as forms of informal relations and networks (Wedel 1988, Ledeneva 1988, Kligman and Gal 2000, Petryna 2003, Rivkin-Fish 2005, Ledeneva 2006, Brkovic 2012, Brkovic 2015, Brotherton 2012). Unlike these informal relations, Nataša's case is a legitimate, institutionalized patient-provider relationship and thus cannot be treated as informal relations, even though they can occur in unison with informal relations. For example, one can establish a relationship with the doctor by paying for private prenatal health care services and still give them a bottle of brandy, as a thank you gift, after the baby is delivered.

What both Rivkin-Fish's ethnography on health care in Russia and Brković's on welfare provisions in Bosnia show is the importance of establishing relations and the creation of kind and warm relations in institutions generally perceived as cold and faceless by the patient. In this article, I suggest that it is also important not to disregard these not-so-informal, alternative institutionalized private patient-provider relations as alternative strategies for establishing a personalizing, closer human relation within the public health care sector.

Method

Fieldwork for this study was completed in 2014 at Betanija, the only maternity hospital in in Novi Sad. This maternity hospital was selected due to its reputation for having one of the highest numbers of medical providers that work both in the public maternity hospital and in private prenatal and gynecological clinics across the city. It is also infamous amongst pregnant women as having a very cold and unapproachable staff and providing an unpleasant birthing experience to those not having either personalizing or privatizing contacts within the hospital.

The study was completed in two phases. In the first phase a snowball sample of women who had given birth in Betanija in the past three years answered a questionnaire regarding their experiences. Based on these answers, I conducted follow up detailed structured and semi-structured interviews with some of these women and their partners in order to have a clear understanding of their experiences. Most of the women that were interviewed were either women who had given birth for the first time or women who had given birth their second or third time. The majority were in their mid-twenties and early thirties, living in Novi Sad and can be considered working class. All of them were more than open to talk about their experiences. In some cases, women themselves approached me to talk about their experiences when they heard what the study was about. Because of the open nature of conversation with my informants, the answers from the questionnaires along with these individual stories provide a stronger image of how often women who gave birth in Betanija used both public and private health care services.

The importance of having a connection in the maternity hospital

Seventy percent of women who answered my questionnaire stated that they sought private prenatal care prior to giving birth in Betanija. In all the cases, the OB/GYN they saw privately was also employed in this public maternity hospital. Even among the 30 percent that stated they did not seek prenatal care, 80 percent of those women did say they paid for some forms of tests privately, such as amniocentesis and other biochemical testing. Most of these tests are also available in the public health care sector but not all pregnant women are referred for such testing. This means that in actuality the majority of women who gave birth in the past three years at one point supplemented their prenatal care in the private sector.

To provide some context, I will describe an ideal type of this typically nine-month medicalized process occurring exclusively within the state, public health care system. The Serbian welfare system is linked with employment, which means that when an employed woman finds out she is pregnant in order to start her maternity leave has to start *vođenje trudnoće* (leading her pregnancy) in the primary public health care sector. In these primary health care institutions, called *domovi zdravlja* a pregnant woman is expected to come to at least four checkups (16th, 24th, 28th, and 32nd week) after confirming her pregnancy (National Good Practice Guidelines for Pregnancy Control 2006). These checkups should include an ultrasound as well as several laboratory tests, such as blood, urine, Rh factors and genetic and other testing if needed (National Good Practice Guidelines for Pregnancy Control 2006).

Aside from these checkups and tests the women are encouraged to attended *školica za trudnice* (schools for pregnant women) located in just one primary health care institution in the entire city. It is the OB/GYNs and medical staff that works in the primary health care sector that writes the referral note for admission of the pregnant women into the public maternity hospital that is the tertiary health care sector.

A problem that is quite common in post-socialist countries is that there is a lack of integration and continuity of care between the primary, secondary and tertiary health care sectors (Rivkin Fish 2005). Papers get lost. Waiting times tend to be long with typically one OB/GYN working in the entire primary care facility. CTGs and ultrasounds tend to stop working or breakdown. All these are contributing factors why the majority of women I spoke to opted to only go to a public primary care facility to request documentation for their maternity leave and do all of their prenatal checkups and test in one of the numerous private practice gynecological clinics across the city.

Cutting lines and newer equipment were important in women's decisions, but the most important factor all of them stressed was that by going privately for their prenatal care meant that they could establish a relationship with the medical staff working in Betanija. Something that is not available to them with they went to their primary care institutions. There is a lack of communication amongst the staff in the primary and tertiary health care sector which results in women coming to the hospital to give birth without having any prior contact with the medical staff in the hospital.

The experience of alienation, lack of trust and women's sense of complete disconnection form their birthing experience, especially in cases of C-sections, is well documented in anthropological literature (Davis-Floyd 1987, Martin 1988, Davis-Floyd, Barday, Tritten 2009). In this regard the medical practices in Betanija maternity hospital are no exception. The lack of trust and feelings of insecurity is only heightened in this setting. When a woman arrives to this hospital her partner or other family members are not allowed into the hospital. Having someone other than the medical staff present at birth is not allowed. For those few days prior and after giving birth the women, the patients are complete separated from their family. If their partner or family wish to see the newborn and mother prior to being discharged from the hospital they can only do so through video monitors and talking on their cell phones.

This complete separation from loved ones coupled with not knowing any of the medical staff in the hospital beforehand created a sense of isolation for most of the women I spoke with. It is this lack of possibilities for establishing a long-term care relationship with the same medical staff that contributes highly to the sense of impersonality and coldness that both my informants stressed and was pointed out in the surveys conducted by local women's NGOs (Mother Courage 2008 and Center for Moms 2014) as well as several public health scholars (Arsenijevic, Pavlova and Groot 2014). In most cases, women do not even know the names of the medical staff working in the maternity hospital (Center for Moms 2014), the staff does not introduce themselves to the women, nor do they wear name tags.
The OB/GYNs tend to be referred to by their last names (for example Dr. Jankovic, Dr. Ristic), while the midwives and other medical staff are called by their first names or nicknames accompanied by the term *sestra* (sister) or *brat* (brother), terms used to denote nurses. This went to the point where in the ledgers of the hospital, in which they kept track of

the births that occurred that day, if a midwife and not the doctor delivered the baby it would just say "delivered by *sestra* Irina" or just simply "Irina." The absence of a friendly, human relationship with the staff, coupled with poor infrastructure of the hospital left a lot of my informants disappointed with their birthing experience.

In order to have a better birthing experience women who were able sought out personal connections, *veze*, friends, or friends who knew people working in Betanija. As Brković (2012) and Rivkin-Fish (2005) pointed out, having a web of personal relations, friends and acquaintances with the "right people" can be used as a resource to navigate the impersonality inherent in the post-socialist health care system. These are usually relationships established outside of the institutionalized, patient-provider setting. For example, some of my informants mentioned that: "one midwife was a family friend, so she was nice to me while the others were not so nice." Having a nurse or doctor as a family friend means that certain women had enough actually usable social capital to help them circumvent the general dehumanizing character of medicalized birth. In some cases, their social capital was powerful enough even to bypass the strict no visitation policy of the hospital. Oliver, father of two, had such a connection when his first-born son and wife were admitted to Betanija.

> There are ways, channels to get in. I saw my son and wife in the elevator. The nurse smuggled me in. They were going down and she timed it so I was in the same elevator. We meet the nurse because our friend the accordion player, a famous accordion player in Serbia, knew some of the staff. He told me she is giving birth now, be there at that time and you can see them!

Oliver's experience exemplifies the power of social capital in bending strict institutional policies. Knowing someone, such as a famous musician was not in and of itself enough, what was important was the musician's connection to the hospital, his wife. Only in certain cases, according to my informants was being famous in and of itself enough to give someone a high social position that did not require knowing someone in the hospital. The strictest rule enforced in Betanija is that fathers are not allowed to witness and take part in the birth. The answer one mother gave sums up this perception: "Only if your husband is Janko Tipsarević (famous tennis player whose wife gave birth in Betanija). He can if he is famous, an athlete, politician or someone like that. Common folk are not welcome". She was alluding to a newspaper story that claimed the hospital made an exception for Janko and his wife. This story caused a lot commotion and was swiftly denied by the hospital administration stating that Janko, like every other father, was not allowed inside or present at the birth. Not everyone was fortunate enough to have family friends who knew someone in the hospital, or were famous politicians, musicians or tennis players but were fortunate enough to be able to take out loans or have enough financial and economic capital to pay for private prenatal care with some of the doctors working in the maternity hospital.

What is accomplished through going to private care is a shift from an economic capital of paying additionally for care into a social capital that can be used to navigate the women's stay in Betanija. This was most common for second and third births, after witnessing and experiencing the differences between having and not having someone in Betanija. To illustrate this I will present Maja's story which was quite similar to Nataša's experience when

she gave birth the first time. Maja is a mother of three (the second birth was with twins), she was in her early thirties when she gave birth for the first time. She was adamant that she would not give any money and did all her prenatal checkups in her primary public care institution. When it was time to give birth with her first child, she went to Betanija. When I asked her about her general impression she said it was very cold, she was not happy with the way she was treated:

> I shared a room with 5 other women and we shared one bathroom with another room. Ten of us for one bathroom! It was terrible. The roof was falling apart, the toilets were leaking, the nurses were at the far end of the corridor we couldn't call for them. When it was time for me to give birth the on call doctor was nowhere to be seen. Two nurses and two cleaning ladies carried me to the delivery room. They were the ones who actually delivered my baby. Dr. Petrović didn't even want to look at me! He told me then that his shift was over in ten minutes. I wasn't screaming or crying so he didn't think my labor started. When he left, the nurse came and saw that the baby's head was already out. That's when the two cleaning ladies grabbed my arms and the two nurses my legs and took me to the delivery table. I didn't even get to put my feet up the baby was already out. By the time the other doctor arrived the placenta was long out. I basically gave birth myself.

Because of her bad experience, with her second pregnancy--which was far riskier because she was carrying twins--Maja did all her prenatal care privately with the head OB/GYN who made sure he was there when she delivered the babies. The second time around, she had an *en suite* room which she shared with only one other woman. As she said: "Even the nurses and midwifes had to be nice to me and forced smiles when they knew whose patient I was." I have spoken with some of the midwives and other medical staff and they claim that they tend to leave the single and double bed rooms empty and move the women in the larger rooms whenever possible. According to them, no special treatment is given. But it is quite indicative that all the women who said they went private had *en suite* and shared a room with at most two other women.

Maja's story highlights the impact having or not having someone you know, have an established relationship during the birth itself. On the other hand, Jasmina said she went private because of the treatment she received in her local primary care *dom zdravlja*. Jasmina is a mother of two but when we met to talk. She wanted to tell me about the miscarriage she had a few years back. She talked about the problems in communication she had with her primary care OB/GYN, who didn't listen and take her seriously when she said something wasn't right. It was because of this horrible experience her other two pregnancies she went private. She said the treatment was very different. She could call the doctor any time, day or night and she had complete trust in him.

These two stories serve as ethnographic examples that highlight the importance of establishing personalizing connections within the maternity wards. These connections,

established through paid private prenatal health care can later utilized as social capital, clout within the public maternity wards, are not the same as having personal connections (Rivkin Fish 2005) and establishing informal relations within the public health care system.

Conclusion

Personal connections played an important role in the socialist favor economies and still have a significant role in most post-socialist contexts (Brkovic 2012, Brkovic 2015). Connections attained through privatization of care have goals that depend on the positionality of the actors involved. This relationship may be coded by the patients as a *veza*, using the long-established term for a personal, status-based connection but with different practical implications. The concept of personal connections is not adequate to define the practices of paying for personalized service and treatment within the public maternity wards, even though *veze* still play a contributing factor in the provision of health care in this region. The difference is that a personal connection denotes a previously established relationship that is not limited to the hospital setting, for example a family friend that the woman has seen outside of the patient-provider setting. In these connections, a patient-provider relationship established through payment for services in the private health care setting is assumed to transition into the public health care system as well, but not to continue outside of the medical context. Thus, the private visits and money given to the doctors is not seen as simply an economic transaction, but also has implications for solidifying social relations in the maternity hospital. The shift that is important to note is that money in this case does not equal impersonality, but on the contrary buffers against it. Private care thus became synonymous for safety, devotion and the personal contact within the public health care institution

Notes

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[1] To protect the privacy of my informants, I have used pseudonyms throughout the article.

[2] All translations into English are my own.

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