RADICAL HEALTH

Doing Medicine, Health Care, and Anthropology of the Good

Aragón, Beatriz; Servicio madrileño de salud Madrid & **Kehr, Janina**; University of Vienna; **“Screening and Roundtable “New Forms of Social Medicine in Spain”**

Social Medicine started as a political utopia, a medical promise and a social urge in the 19th century. When Rudolf Virchow famously proclaimed that “medicine is a social science, and politics is nothing but medicine at a larger scale”, he not only conceived of health care as a responsibility of the state. He also pictured medicine as a vital supplement to state’s failing health and social policies. To Virchow, health and disease were closely linked to the successes and failures of state politics. Improving health and combatting disease meant therefore also combatting social inequalities and fighting for political change.
In Spain, a setting our roundtable proposes to focus on, social medicine has always been a promise as well as an incomplete realization of the post-Francoist national health system. In addition, neoliberal policies like public private partnerships have been gradually transforming public health infrastructures into marketized systems with high economic stakes. Moreover, after the 2008 economic crisis, austerity measures have profoundly cut back the national health service. In this context of economization, precarity and austerity, moral and political demands for social medicine newly thrive. But what does social medicine actually mean in Spain today? And which conceptions of health, politics and the good does it convey?
Our Roundtable proposes to bring together representatives of several social medicine initiatives that are currently taking place in Spain in order to discuss the following questions: Where and by whom are projects of social medicine experimented with and why? What is their virtue? Which material infrastructures, communities and social relations do they built, foster or transform? After the Roundtable discussion, we will propose a film screening of the documentary “Los Cuidados”, which talks about community health care in a working-class barrio in Madrid. The screening will be followed by a Q&A session with participants of the documentary film.

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Baer, Roberta & Wilson, Jason; University of South Florida, Tampa, FL; **“Fostering 'good' medicine by shifting the clinical gaze: Improving patient centered care by integrating medical anthropology into physician training and clinical spaces”**

Through a partnership between a medical anthropologist (RDB) and an Emergency Department physician (JWW), we have created an ongoing, multi-part project that incorporates medical anthropological theory and methods into physician training and also inserts medical anthropologists into clinical spaces. Our goal is to both shift the clinical gaze of physicians by integrating medical anthropological theory and methods into premedical education and medical training and also to integrate anthropologists into direct patient care and healthcare teams to build patient-centered care pathways in partnership with physicians.
By hardwiring a patient experience approach into early physician training, we aim to prevent later physician burnout from frustration arising secondary to a current mismatch in physician skill set and patient expectations. Trainees learn medical anthropology, but the key part of the training involves what we have termed, “patient shadowing,” which parallels the standard medical training activity of physician shadowing. However, we structure the “patient shadowing” to be anthropological participant observation and reflection. We currently offer courses for pre-medical students, medical anthropology graduate students, as well as training for medical students and second year residents and emphasize patient experience, differences between disease and illness, as well as methods for addressing social determinants of health.

Baumann, Julia Nina; HU Berlin; **“The fear to feel, the shame to share: Wellbeing in neoliberal academic emotion regimes and the values of peers support and ‘‘academic activism’”activism’”**

Academic work, research, and thinking has evolved into a practice in European academic culture in which most emotions are perceived as opposing or obstructing and are therefore often rejected, tabooed or silenced. At the same time, there have been an increasing number of findings in recent years that prove the high mental strain of researchers at their workplaces. At neoliberal European universities, that see themselves more and more as "companies", these problems are often translated into a context of "efficiency and function enhancement". Social and Cultural Anthropology (SCA) is no exception to these developments.

I will draw on initial findings and data from my ethnographic research on emotional experiences of ethnographers in academic work environments as well as my engagement as an ‘academic activist` as a basis to formulate suggestions for a “healthy future” of SCA through the lens of an emotional positioning in academic peer groups.

Benton, Prof. Adia; Northwestern University, Evanston, Illinois; **“Good for what: radical health in the midst of an epidemic”**

"In this keynote, I ask how we might think carefully about what constitutes 'the good' in anthropology of health and medicine, and the potential for naming and unsettling 'the bad' in the practice of public health and medicine (and in anthropological critique of it)."

Blome, Rebecca; FU Berlin; **“Biomedical and biotechnological approximations towards radical health”**

Many traditional biomedical distinctions between physical sufferings and mental sufferings are increasingly questioned through biotechnological progress, whereby radical novel ways emerge to understand and promote health and healing. Findings of recent studies concerning the impact of biological, psychological and psychosocial factors in the onset and progression of conditions — such as depression, cardiovascular diseases, cancer or autoimmune conditions — give a clear picture of the mutual influence between these factors. This paper explores distinct biomedical and biotechnological approaches to human health beyond the rigid mind-body-dualism. Psychoneuroimmunology is a recent research area of psychosomatics, which faces the challenge of operating on the border of the two medical paradigms of biomedicine and biopsychosocial medicine. Psychoneuroimmunology inquires not only the interactions of the central nervous system, the hormone system, the immune system and the mind, but also the *relational dynamics* between psychosocial aspects and physical systems. Integrative medicine and functional medicine systematically *unify* conventional biomedical diagnostics and treatment practices with the aspiration to treat the human in its complexity as a psychosocial being. Whereas the universal healing method developed by extreme athlete Wim Hof, nearly barrier-free, offers the ability to *wilfully* regulate certain immunological processes by breathing and meditation practice combined with cold exposure. The approaches differ substantially with regard to the role of the individual and its biology within the healing process, or in the importance given to the social and ecological factors. Also, phenomenological methods and psychotherapeutic interventions for recovery are valued differently. Nevertheless, they share the *radical potential* to shift dominant biomedical ontological and epistemological boundaries, by recourse to empirical findings, which are based on biological reductionism. Likewise, they are contributing to the establishment of more *radical* health and person-centred biomedical treatment cultures for empowered patients.

Bugbee, Mary; Storrs; University of Connecticut; **“Contesting neoliberal health policy in Mexico: The case of Seguro Popular”**

In 2003, a health system referred to colloquially as “Seguro Popular” was passed into law in Mexico. This reform, based in the hegemonic and neoliberal model of universal health “coverage,” contained the explicit goal of restructuring the health system to introduce so-called “market-style” discipline and allow for greater private sector participation in the health sector. Yet, these goals were never fully realized. In the years that followed, this new insurance expanded health coverage to millions of Mexicans but failed to transform the public health sector as its architects had planned. The historic 2018 presidential election saw Mexicans elect Andrés Manuel López Obrador, a leftist candidate wielding promises to challenge the neoliberal status quo and bring change to Mexico. Included in such promises was an end to Seguro Popular. Since his presidential term began, his administration has used the discourse of human rights in proposing and implementing health system reform that includes the disappearance of Seguro Popular, in name, and its incorporation into a more integrated public health system model. I draw on ethnographic interviews conducted with medical professionals, administrators, and academics in the city and state of San Luis Potosí and in Mexico City, alongside critical discourse analysis during this time of major political transition, to propose why Seguro Popular’s privatization features never fully materialized, and to illuminate the ways in which the neoliberal project to privatize Mexico’s health system, although ongoing, has been and is being deeply contested among both supporters and critics of Seguro Popular.

Buhl, Andrea & **Staudacher, Sandra**; University of Basel; **“World Café: Radical Health in Professional Care”**

Globally, higher life expectancies, altered family structures and an increase in (chronic) health problems lead to a higher demand of long-term, old-age and palliative care. Daily levels of healthcare requirements for elderly people/patients are rising due to worsening chronic illnesses, multi- morbidities, acute illnesses, deterioration of mental health or people dealing with a palliative situation. Demographic developments combined with altered lifestyle and economic limitations change expectations and requirements of how professional care should be and how these ideas can be translated into practice. For example, the increased necessity of institutional long-term residential care in later life, like nursing homes and care homes, is countered with attempts from nursing professionals to foster person-centred organisational structure. Quality of care - and subsequently quality of (end of) life – play an increasingly important role. But additionally, the changing professional care needs produce high expenses and human resources for the health care system, which will further rise in the future.
New approaches to meet these enhanced demands are fostered by public and private agencies: inter- professional teams in health care services are providing person-centred and coordinated care, and are allegedly cost-effective. But are these innovative approaches leading towards ‘better’ care?
We invite conference participants with an interest in (professional) care to provide empirical insights as well as theoretical ideas about new approaches in this field. The aim of this world café is to reflect on what these developments mean for the cared for individuals as well as for their personal networks and professional caregivers.

Bůžek, Richard; Dzudzek, Iris; Hübl, Susanne; University of Münster; **Exner, Andreas**; University of Graz; **Franke, Bettina**; Poliklinik Leipzig; **Strüver, Anke**; University of Graz; **Tsapas, Vasilis**; Social Solidarity Clinic Thessaloniki; **“Roundtable: Health as Right to the City”**

Health is unequally distributed within cities. The life expectancy among rich and poor people differs in Germany by ten years. Contemporary mainstream neoliberal discourse explains these differences individually.
In contrast to such individualizing approaches, *Health as a Right to the City* can be defined as absence of systematic disparities in health or in the major social determinants of health, between social groups who have different positions in a social hierarchy. Thus, it is not limited to physical, mental and social wellbeing of individuals. Instead, it approaches the social roots of illness, inequality and health with critical geographical and social theories. Drawing on Henri Lefebvre, Margit Mayer and others we understand the *Right to the City* as “far more than a right of individual or group access to there sources that the city embodies” that is “the exercise of a collective power over the processes of urbanization” (Harvey 2012:4). The urban opens a political arena for communities of affected people, health professionals and other urban activists to collectivize seemingly individual illnesses and to organize health care, health infrastructure and health environments democratically for everyone.

In this light, our round table brings together urban activists, health movements and academics such as *Poliklinik Veddel* (Hamburg), Berlin-based *Care-Streik Charité*, *Frauengesundheitszentrum Berlin*,
Solidarisch G'sund (Austria), *Verein demokratischer Ärztinnen und Ärzte*, *Social Clinics of Solidarity* in Greece, and *Solidarity City Berlin* in order to discuss the following questions: How can we realize health as a right to city? Which urban networks allow to build community-based health initiatives as 'real health utopias' in order to "change and reinvent the city more after our hearts' desire" (ibid.)? How can we empower movements for health justice in the city, forging alliances with other urban struggles as promising steps towards lived healthy futures?

Cabezas Pino, Angélica; University of Manchester; **"This is my face" (Chile, 2019)**

In Chile, people living with HIV fear stigma, and often conceal their condition and remain silent about what they are going through. This is My Face explores what happens when a range of men living with the virus open up about the illness that changed their life trajectories. It follows a creative process whereby they produce photographic portraits that represent their memories and feelings, a process which helps them challenge years of silence, shame, and misrepresentation. A lesson in the power of collaborative storytelling.

https://vimeo.com/282154916

https://www.youtube.com/watch?v=ZVYbOafY4v4

Casartelli, Sara; University of Amsterdam; **"Moving bodies: Drowning and creative infrastructures for identification"**

This article empirically analyses how the unknown bodies of migrants who died in the attempt to reach Europe are managed and potentially identified. Shifting attention away from the border, the paper provides a new angle to the crisis unfolding in the Mediterranean, investigating the practices to know and attend to the dead migrant's body. Exploring the existing initiatives of identification in Italy, the article presents an ethnographic account of the emergent forensic infrastructure. It does so by looking at movement. The movement of bodies towards identification. Attending to the very fact that a dead body cannot be left where it is found, but necessarily must be moved to be identified or only to be buried, I engage with the circulation of bodies and bodily material to explore how the forensic infrastructure to manage and study them emerges. The pursuit is informed by Science and Technology Studies (STS); the focus is on material practices aimed at the eventual identification of unknown bodies. My argument will be developed in two steps. Firstly, foregrounding the movement of the body in the journey towards identification, the paper demonstrates the forensic infrastructure is enacted through the circulation of body and bodily material. Secondly, I argue that while caring for the dead allows them to be identified as persons, it also produces relationships that go beyond formal citizenship. Following the circulation of bodies in the infrastructure whose purpose is identification, in my analysis I show that this process involves constant tinkering and experimenting with the forensic care work and argue that caring for the dead requires caring for the forensic infrastructure.

Clarke, Kris; University of Helsinki; **"Decolonizing Finnish social work education: Radical implications"**

Social work is a scientific discipline and profession based on the value of diversity, relationships, and social justice. However, it is also a practice often performed through state institutions to implement colonizing neoliberal policies that do not serve the health and wellbeing of the general population.
Although social work claims justice as one of its core pillars, it rarely has invoked decolonization as a legitimate social work approach or as an antidote to the injustices of colonialism (Waziyatawin & Yellow Bird, 2012). Moreover, settler colonialism is another term that is rarely uttered in social work theory, practice, or education.
Decolonization is a major academic framework in Native American/American Indian and Indigenous Peoples Studies. It refers to undoing and overcoming the myriad, negative, and disabling effects of colonialism. Colonialism celebrates the ideas, stories, history, beliefs, and values of the colonizer (the oppressor); at the same time it trivializes, ignores, and subjugates those of the colonized (the oppressed, Indigenous Peoples). Decolonization is not a metaphor but is intended to "bring about the

repatriation of Indigenous land and life, and is “distinct from other civil and human rights-based social projects” (Tuck & Yang, 2012).

This paper considers decolonizing theories could contribute to a radical conception of health and wellbeing in social work by examining the context of Finland. Contemporary social work education is analyzed through a scoping analysis of prevailing theories and curricula to assess how settler colonial normative structures of social identities and interventions are constructed. The paper then explores how the main themes of community activism around climate crisis and anti-racism and their relation to local social work. It concludes with considering how decolonizing theories could inform possibilities for collaboration between social work and community activism to challenge neoliberal social welfare interventions.

Contentin el Masri, Caroline; FU Berlin; **“Mamacura Workshops. Circulating health knowledge among the neighborhood mothers”**

The ethnographic analysis of my M.A. was on the cognitive, phenomenological and praxeological processes of change in the representation of "healthy eating" through activity in the project Stadtteilmütter in Neukölln (En: “neighborhood mothers in Neukölln”). District mothers with migrational experience are trained for five months on ten topics concerning pre-school development, bilingual education and health care. They enrich the content with their own experience. Then they act as multipliers for same language speaking families in a series of home and school visits. The families consider the highest increase in learning on the topic of healthy nutrition.

The personal interviews revealed women considering themselves as responsible for the well-being of the family and hence influential regarding food habits. Nonetheless they have to negotiate with or inspire their relatives. Peer pressure regarding the consumption of refined sugary products among children was a topic of concern. Overweight was linked to cultural representation but sometimes depression and immobility as well. Trustful, formal or informal circuits of congruent information were always necessary for validation/invalidation of practices and tastes.

Ways of supporting their use of kitchen remedies as self-help strategy were subsequently proposed. The research was followed up with the project named mamacura. Workshops and some medically proved and partly socioculturally contextualized written and filmed products were developed. The book named Hausmittel aus aller Welt (En: “kitchen remedies from all over the world”) came out of this collaboration. I also explore the differentiation in the individual construction of taste through the citizen science project Schmeck! (En: Taste!).

The purpose of the presentation is to discuss the possibilities and limits of the use of ethnographical/ethnological methods like participant observation, notes and interviews in the workshops for supporting the circulation of information. Respectively it aims at finding new possibilities for linking a directly useful practice with relevant research.

Dickel, Philipp & Fiedler, Jonas & Schuster, Angela; Gesundheitskollektiv Berlin/Poliklinik Veddel, Hamburg; **„Roundtable: Community Health Care Interventions as Real Utopias to Transform Society”**

The Berlin Health Collective and the Poliklinik Veddel are establishing Community Health Care Centres in deprived urban neighbourhoods in Berlin and Hamburg. We are part of a movement of health activists and professionals that aims to transform health care services towards integrated, community based, participatory and truly interdisciplinary care to serve the needs of structurally disadvantaged communities. These initiatives are thereby reacting to the fact that health is socially and ecologically shaped and unequally distributed across society following the “social arrangements of power, property, and the production and reproduction of both social and biological life” (Krieger 2011, p 215). We regard health care services as a possibility to connect people and organise communities to gain power over their lives and health. This process of experiencing individual and collective efficacy are at the same time seen as prerequisites for social and political participation and hence the possibility to live a healthy life and transform society. In this workshop we would like to present and discuss the work of our initiatives in Hamburg and Berlin, give an overview of the theoretical and epidemiological background and the experiences we made during the first years of our struggle for a radical change in primary health care. Furthermore, we would like to discuss the promises and limitations of collectively organised and community-based health care as a *Real Utopia.* What are the fissures these utopias could widen to simultaneously transform health care and society? Or what might be the limitations and potential drawbacks of such an approach?

Dlamini-Simelane, Thandeka; University of Amsterdam; **“One model of caregiving but different costs”**

Due to shrinking resources, community-based solutions are increasingly preferred because they are cost-effective, more efficacious and sustainable. A volunteerism framework by design means flexible engagement, partial work and one’s volition being a main characteristic. However, varying forms of volunteerism are manifested in poor resourced countries where HIV is the greatest burden, which are deviating from the norm. Increasingly, people within communities are engaged in health programs as ‘volunteers’ yet under unscrupulous conditions and circumstances. In Swaziland PLHIV providing care within clinic settings (known as expert clients-EC) were initially engaged as volunteers to support the HIV response with conditions as; work thrice per week for half a day focusing squarely on providing counseling services to newly diagnose PLHIV. However, at the time of the study when HIV treatment was expanded radically, the roles of ECs had doubled if not tripled in scope; from mere counsellors to operating medical equipment-testing people for HIV, disclosing test results, enrolling patient to HIV care, scheduling appointments and follow up, tracking patients, managing of side effects, dispensing and packaging drugs and being reports officers. Also, during the tenure of the study, to become a volunteer one had to fulfil an educational requirement and possess a high school certificate whilst at outset of the HIV response adherent behavior and looking healthy coupled with a good word from the community and conversational English would suffice to become an EC. Furthermore, ECs worked same hours as federal nurses; 5 days a week, from 8 am till 4pm.

This is all atypical of volunteerism framework and it falls outside the periphery of what volunteerism is known to be. There is need for anthropologists to take lead in the discourse to define and clarify what the scenario alluded above is. Whether it is ethical to continue using this framework and if not offer insights on terminology that can be used to describe the set of unique learnings from HIV treatment expansion. Social science has an important role to ensure that science and technology are socially robust and that in the process of health interventions implementation, ethical processes and practises arenot disconnected from local and global politics that may advance neoliberal tendencies under the guise of public good.

Dowrick, Anna; Queen Mary University of London; **“Workarounds and kludges – what ‘good’ can healthcare professionals do about domestic violence and abuse?”**

Deaths due to domestic homicide reached a five-year high in 2019 in the UK. This has galvanised public debate as to how to address the pernicious issue of domestic violence and abuse (DVA). Within these debates, there is increasing emphasis on healthcare professionals to identify abuse and direct patients towards supports services.

The Identification and Referral to Improve Safety (IRIS) programme (Feder et al., 2011) is being delivered in the UK to improve the care provided by general practitioners to patients who have experienced domestic abuse. This programme aims to shift professional practice, but in doing so radically restructures the interactions between healthcare services and specialist community services, and between the local government bodies which finance and evaluate healthcare activities. This work is challenging, for healthcare professionals feeling the weight of a straining healthcare system, for the providers of community services who are fighting to retain funding, and for commissioners who are having their budgets slashed.

We examined the challenges of implementing change in provision of ‘good’ healthcare in the context of DVA in an ethnographic study of this programme in two urban areas of the UK. We explored how actors sustain work in spite of obstacles and challenges under conditions of increasing austerity and withdrawal of public services.

We brought to light the important role of workarounds – informal and often undocumented practices which keep activities on track - in processes of programme implementation. This approach focuses attention on the agency of actors to innovate when faced with perceived barriers, and how negotiate these solutions in relation to what is ‘good’ about the work. Reflecting this back to professionals in workshops has shown the value of the theoretical notion of ‘workarounds’ for demonstrating the creativity and flexibility of practitioners in spite of challenges, as well as enabling discussion and reinterpretation of the obstacles they felt unable to overcome.

Falge, Christiane; Hochschule für Gesundheit Bochum & **Strauss, Annika**; IFAK e. V. Bochum **& Betscher, Silke**; University of Bremen; **„Radical research. Attempting a collaborative approach to address structural discrimination and access health promoting resources in a multidiverse quarter”**

The paper presents the collaborative health project ‘QUERgesund’ and introduces the different agents that interact and collaboratively create knowledge in and about a particular multi-diverse quarter in the Ruhr.

The inner Hustadt in Bochum was conceptualized as part of the ‘Universitätsrahmenstadt’ in the 1960s. It accommodates 1100 flats in four to fourteen level high-rise buildings. Around 3000 people from over 40 nations and with different socio-cultural backgrounds live here, constituting a heterogeneous neighborhood. On the one hand many of the inhabitants face discrimination concerning education, health and employment, on the other hand ethnic and social communities constitute an important health promoting resource. ‘QUERgesund’ is a culturally sensitive and collaborative health project, which aims at developing health promoting and demand-oriented facilities together with residents.

Besides the implementation of concrete measures the project team focuses on probing and developing collaborative methods. QUERgesund is coordinated by a local association of multicultural child, youth and migration welfare service. QUERgesund cooperates with ‘HULAbor’ (City Lab) that is affiliated with the university of health, located at the central of the quarter and used as an experimental space for events and encounters. A committee of health experts navigates QUERgesund and residents, social workers and scientists research, reflect and work together to initiate changes in the Hustadt. As a first step scientists from university together with inhabitants and students conducted a needs and status analysis about health perception and promotion in the quarter. Interview guidelines were collaboratively conceptualized and negotiated by health experts, ethnographers, students and residents.

The paper discusses the innovative approach of the project and reflects the advantages and pitfalls of collaborative research. In particular we want to shed light on the emerging power hierarchies between the different agents and how these transformed or reversed in the context of transcultural, -institutional and -millieu encounters.

Garabedian, Benjamin; Berlin; **“Undoing the physician-nurse binary: Healthcare workers in an emerging non-state medical system in the Kurdish regions of Iraq and Syria”**

This research examines how the Kurdish Liberation Movement (KLM), a non-state transnational network in the Kurdish regions of Mesopotamia, is currently unraveling the traditional physician-nurse hierarchy by training its own medical workers independently of the state licensing system. Through participant observation as a physician trained in Germany, I draw on my own experience working side by side with healthcare workers in clinics established by the KLM in Northern Syria (Rojava) and in Shingal, Iraq. I will describe how the movement, driven by both necessity and ideology, is decentralizing medical training and establishing a unique pedagogical system.

In this system trainees assume ever more responsibility in accordance with their individual development. Thus, there is no clear distinction between roles traditionally assumed by a higher-income ‘academic’ doctor and a lower-ranking 'caring' nurse. Rupturing the physician-nurse binary lowers barriers to medical training, increases access, allows trainees to develop according to passion and ability, and ultimately, benefits patients.

This experimental model developed not only through an ideological critique of capitalist modernity and patriarchy but also out of bitter necessity: the overwhelming majority of physicians in Northern Syria have fled since the start of the revolution, as the war brought direct military attacks upon medical staff and facilities. Moreover, the Syrian state located its medical colleges outside of Kurdish areas and denied many Kurds the right to study. These conditions made it imperative for the fledgling democratic confederation to overcome the hostile state-system’s monopoly on healthcare, opening the way for a new model of medical care that may offer an effective path to medical self-sufficiency for these communities. The model of medical education that is developing here through trial and error may offer important lessons for other liberation movements around the world.

Kingsley, Rachel; Tampa, University of South Florida; **“DACAmented uncertainty: Emotional and mental wellbeing in changing political climates”**

Changes in United States federal immigration policies of the 1980s and 1990s have produced a large settled undocumented population in the US. As a result of increased undocumented family settlements, an unprecedented number of children grow up without legal residency status in the US. Policy makers have been reluctant to respond to undocumented youths’ long-term presence.

In 2012 President Obama enacted the Deferred Action for Childhood Arrivals (DACA) program by executive order, which allows temporary deportation relief for young undocumented adults for two years, temporary Social Security numbers, and

renewable work permits. Although eligibility requirements for the program are extensive, DACA has provided nearly 800,000 individuals with work authorization and protection from deportation over the past five years.
Although DACA does not offer a pathway to citizenship, it has the potential to improve the incorporation and mobility trajectories of eligible youth. In September of 2017, the newly elected President Trump announced the termination of the DACA program, questioning the constitutionality of the executive order that was issued by President Obama. Although various US federal courts have blocked President Trump from ending the program, it is likely the fight for the program will be heard in the Supreme Court. This qualitative study explores the impact of changing "legality" on mental and emotional wellbeing for DACA recipients in the mist of an uncertain future. Specifically, this study examines how changing political climates impact the severity and prevalence of mental health disorders for DACA recipients and the ways in which DACAmented individuals are coping with their uncertainty and their changing mental and emotional wellbeing. This study helps advance understanding of the impacts that DACA and similar programs have had on their recipients' mental and emotional wellbeing and offers suggestions for community members, institutions, and mental health providers in the face of changing societal and political climates.

Krüger, Daniela; HU Berlin**; "Care beyond the protocol: When medical practice meets social marginality"**

In this presentation, address the relation between urban institutions and social marginality. I use the example of frontline workers in the ambulance service and hospitals' emergency departments to analyze care practices by nurses, doctors and paramedics in relation to institutionalized care. I show that ambulances and emergency departments can have a crucial role for people at the social margins and their needs. These needs, however, produce ambivalence and a paradoxical situation at the ground-level of medical care: while focusing on urgent medical conditions and "bare life", the frontline workers are confronted with the chronicity of social needs of the everyday. What happens if the needs do not fit a given category or logic of medical practice? How do frontline workers navigate, especially in a resource-scarce and highly formalized working environment?
Social science literature tends to criticize medical practice for turning a blind eye towards the social condition of their patients. But can frontline workers actually manoeuvre to do good beyond the protocol? And how could this look like? In this presentation, I engage with these questions by firstly, introducing the concept of the social safety net. I will show that frontline workers in emergency wards and the ambulance services can produce these social safety nets by going beyond the standard protocol. Secondly, I will discuss the methodological challenges of analyzing these care practices. To this end, I present empirical data from interviews and observational participation in the ambulance service and three different emergency departments in a German metropolitan city.

Kutalek, Ruth; Jeleff, Maren; University of Vienna; **„Vulnerable patients and vulnerable practitioners: How the pandemic radically changed our understandings of good care"**

In this current crisis, health care workers are the personalized „good" – they were applauded by the public and the media, depicted as heroes, almost "marvelized". After all, they helped us fight this pandemic, they cared for our loved ones and were ready to work under incredible difficult conditions, physically and mentally: sweating under layers of personal protective equipment, unable to take a break, drink, eat or visit the restroom, experiencing extremely demanding situations with severely sick or dying patients, ill-prepared and overwhelmed working in the midst of a crisis.
In this paper we will deep-dive into the lived realities of health care workers in Vienna, Austria, caring for patients suffering from Covid-19. We would like to understand how the new protective technologies, the stressful physical working conditions, the demands applying new SOPs and IPC guidelines, the mental burden of working with severely sick patients, and the expectations and fears of relatives and loved ones impacted the care of patients. More specifically, we want to explore how the new technologies interfered with communication. In what ways were communicative challenges in the triad patient-relative-health care worker dealt with? And finally, how were vulnerable patients protected and in what ways did that interfere with concepts of good care and principles of medical ethics?
(This study was supported by the Vienna Science and Technology Fund (WWTF) COVID-19 Rapid Response Funding 2020.)

Lang, Claudia; University of Leipzig & **Gaudillière, Jean-Paul**; Paris; „Radical primary health care in Kerala, South India”

Health has been one of the central features of the ‘Kerala model of development’ right from the time when this term has been coined in the 1970s. De-centralized primary health centres and their cadres of community health workers are the backbone of Kerala’s public health system and the reason for the state’s high health indexes. Dating back to a public health system set up by the pre-colonial princely state of Travancore, primary health care evolved over the decades after Independence with shifting involvement of international organizations such as UNICEF and WHO. After a period of crisis in the 1980s, decentralization of governance and planning in 1996 was implemented as an alternative to the rise of private medical care. It further aimed at granting local bodies financial and decision making power in areas such as health and education in order to radically improve the infrastructure and services of primary health care in the communities. Very recently, Kerala’s Aardram mission since 2016 further envisions “radical changes in healthcare” in improving primary health services, tailoring them to changed needs such as non-communicable diseases and mental health and bringing patients back from the private to the public sector. By exploring the contemporary practice and the history of primary health care in Kerala, this paper addresses the radicality of primary health care in Kerala in three ways: (1) As right to health understood as universal access to health services and alternative to marked-based approaches; (2) as including not only biomedicine but also Ayurveda and homeopathy; and (3) as democratic in that local communities decide on and triage their own needs and services.

Laurens, Vivian; University of Connecticut ; “Building health and peace from below: Buen Vivir and the transitional justice process in Colombia”

The 2016 peace accord between the Colombian government and FARC-EP outlines a provision to develop a national plan for rural health in close collaboration with local communities. Importantly, the accord states that the implementation of the rural health provision is indispensable to building long lasting peace in Colombia. It also stipulates that the development of the national plan for rural health should be guided by the principles of Buen Vivir (BV), an indigenous epistemology of the Andean region that prioritizes harmonious relationships among humans and between humans and the rest of the natural world. The idea of using health as a tool to build peace has been part of the strategies of global humanitarian groups in the last three decades. However, this linkage between health and peace has never been included in formalized peace building structures such as transitional justice. The Colombian accord is unique in its inclusion of health care as tool to build peace in the transitional justice plan. It is also unique in the inclusion of BV, which has become a powerful tool deployed by indigenous groups throughout Latin America to advocate for equal political representation, gender equality, recognition of cultural plurality and the protection of the environment. This paper explores how Buen Vivir and transitional justice coalesce to: 1) support the design and implementation of a rural health care system that is truly developed by local communities and that can resist the current inclination of the government to expand the existing urban neoliberal health care system to rural Colombia. And 2) potentially support peace-building efforts through the construction of a rural health care system from below.

Lee, Sangyoub; FU Berlin & **Park, Young Su**; University College London; “A new health platform that cafes can build. Clinic Cafes in South Korea”

Can cafés become a new health care unit? Do we need more hospitals to build a better health care environment? If the primary goal of future medicine shifts its fundamental focus to development of human capabilities, rather than treatment and management of diseases, will hospitals serve a central role in health care environment? Can health care infrastructure—which more people can ‘share health’ by using urban surplus infrastructure such as shared cars, offices and houses—be made? There are so many cafés in South Korea. Café is a shared office for freelancers, a shared house where people can stay pleasantly at the price of a cup of coffee to avoid crazy housing costs and a virtual currency market in that it is service space of many users paying with mileage or coupon of mobile apps, beyond a place to drink coffee. We started ‘clinic in café’ project with the hypothesis that the café is in its early stage of playing a role like spatial version of PC. Just like PC, that was considered as expensive calculator, evolved into the current smartphone, we thought whether we can insert “medical time” in a very common and trivial dessert time.

We made café menu like medical examination chart by using diagnosis system of Korean medicine. Customers choose desserts talking about their health problems and share their information while enjoying this process as a serious but playful game. They enjoy teas, alcohols, chocolates and ice creams prescribed only with medicinal food according to the chart, and if they want more details with continuous treatment, they add a menu for consultation with doctors. Doctors prescribe periodic trekking or hiking programs medically designed for patients or cooking, writing and language lessons. Doctors recommend music concert, museum tour and food festivals held throughout local cafés.

Lees, Shelley; London School of Hygiene and Tropical Medicine & **Enria, Luisa**; University of Bath;
“Comparative ethnographies of medical research: Materialities, hope and citizenship in Sierra Leone und Tanzania”

In this paper we bring together ethnographic research carried out during microbicide against HIV trials in Tanzania and the Ebola vaccine trials in Sierra Leone to explore the identities, relations and political imaginations that were brought to life by these different technologies. We highlight the ways in which critical anthropological engagement in clinical trials, by unearthing global and local power dynamics as well as giving space to the voices and imaginaries of trial participants and their communities, can help us radically reconsider the parameters and standards of medical research. In the paper we firstly take a historical approach to medical research in East and West Africa, paying attention to the ways in which it has been implicated first in colonial relations and later in the functionings of global capitalism. Analysing the very different circumstances that made these two trials possible, we highlight the different temporalities and politics of HIV and Ebola as epidemics in the global imagination. In the second part of the paper we find four of common themes across the two trial sites revealed by ethnographic research with participants and their communities, but mediated by the specific socio-political contexts in which the trials were taking place. In both countries we found *materiality and notions of exchange* to be important to participants’ understanding of the value of medical research and their role within it. Attached to these material exchanges were also expressions of ‘*therapeutic hope’* steeped in locally distinctive notions of destiny and expectations of the future. These dynamics were governed through *social relations and moral economies* that also underpinned challenges to Western notions of research ethics. Finally, clinical trials offered a language to express both disaffection and disillusionment with the political status quo (e.g. through rumours and anxieties) whilst at the same time setting the foundations for emancipatory visions of global and local citizenship.

Nippoldt, Lauren; University of California, San Diego; **„Meeting at the margins: Transforming healthcare through informal faith-based mobile clinics”**

Seva, a practice of voluntary social work among members of the Sikh faith, often takes the form of informal, free mobile clinics in contemporary, urban India. In this paper, based on 16-months of ethnographic research in Delhi, India, I argue that informal seva groups provide a radical healthcare alternative to government clinics, hospitals, and formalized non-governmental organization medical services that bypasses the "red-tape" of formalized healthcare. Individuals in India who are marginalized due to caste, religion, class, and migration status have even more difficulty navigating these formalized systems, and thus, many patients in need turn to these mobile clinics for "good" care.

Mobile seva clinics better serve patients in a number of alternative ways. First, due to the informality of such groups, the goal to serve and care for others is not impeded by organizational politics, funding concerns, and bureaucratic recordkeeping. Second, while the care is somewhat limited in scope, it provides a necessary triage for both acute and chronic, non-life threatening wound care and common viral or bacterial infections. Furthermore, and arguably most important, the underlying religious ideology that guides and informs practitioners in caring for patients is a radically different orientation to patients. This ideology treats all patients, regardless of caste, gender, ethnicity, and creed, as equals or even as God. Thus, patients are seen as deserving of care and given greater dignity than typical for marginalized patients at other hospitals or formal clinics in Delhi, India. This type of care offers a practical and good alternative to mainstream outlets for medical care in multicultural, urban India and perhaps other developing countries.

Nolas, Sevasti-Melissa; University of London; **"Creating an agenda for collective action in women's gynaecological health: The case of fibroids"**

Fibroids are an under-researched gynaecological condition. Described as 'benign' tumours (i.e. non cancerous) in the medical literature, fibroids are found inside and/or outside the womb. Estimates of prevalence vary considerably. Estimates of UK and US women place prevalence between 70% of white and 80% of black women by age 50 (NICE, 2018). There is scant biomedical research on fibroids compared to other conditions. An early systematic review conducted in 2006 described fibroids as 'enigmatic' (Payson, Leppert and Segars, 2006), while more recent reviews (Stewart et al, 2017) confirm that the strongest risk factor in the development of uterine fibroids is race: black women are more at risk. There is virtually no anthropological or sociological research on the experiences and circumstances of women who live with fibroids. To date, two small qualitative studies have looked at women's experiences (Ghant et al, 2015; Nicholls, Glover and Pistrang, 2004). Framed within normative biomedical discourses and assumptions, these studies assess the psychological burden of the disease and women's 'coping' strategies but do not challenge received wisdom about fibroids ('benign') or structural issues that lead to such wisdom (e.g. race, limited research funding). From a lived experience perspective this means that there are very few cultural resources – information pages, support groups, public discussions- for women to make sense of their situation and to take medically, psychologically, and socially informed decisions about their condition and to connect with others with similar experiences. The proposed paper will be a first social science foray into the topic from a life writing perspective. Life writing is a well-establish feminist practice which recognizes the personal as being political. It is also a practice which resonates with classic sociology (e.g. C Wright Mills) that understands private troubles as public issues. Life writing has been used to bring to light personal/private troubles in a number of other women's health experiences (childbirth, menopause, and, most recently, endometriosis) and in so doing has contributed to the invention of publics for issues that previously had none. In this genre the paper, an essay, will provide a (limited) memoir account of living with fibroids and encounters with the medical profession in the UK, problematizing the orienting medical metaphors for fibroids as 'benign' at the same time as theorising life writing as a form of political intervention necessary for collective action. The paper will draw on the author's lived experience, diary, and memories of living with fibroids, as well as a reading of her medical record documenting her pregnancy and fibroid treatment. The paper will consider the possibilities and limitations of life writing for mobilizing collective action in a historical moment of changing feminisms (e.g. #metoo movement). Written from a position of whiteness and privilege, the paper engages with the racialised aspects of having fibroids throughout.

Pollmann, Tyyne Claudia; UDK Berlin; **"Made in academia"**

My contribution commences with unfolding the human mind as embodied and embedded. From here, I will substantiate and critically unfold the approaches and methods developed and probed during the artistic research project visions4people, realized from 2016-2018 as a cooperation between the Clinic for Psychiatry and Psychotherapy Charite Berlin Mitte and Weissensee Kunsthochschule berlin. The questioning of our own roles in the structure of psychiatry resulted in omitting conventional design methods and led to behavioral changes among all participating agents. The investigation of the investigation and its investigators became essential. The sub-terrain moved to the foreground, eliciting theoretical, societal and political matters and ramifications.

https://www.jovis.de/de/buecher/details/product/visions-4-people.html
https://www.kh-berlin.de/projekt-detail/Project/detail/visions4people-2241.html

Pratt-Boyden, Keira; University of Kent; **"Economies of care and spaces of autonomy among mental health service "evaders" and "survivors" in London"**

The UK's welfare system is in crisis and people are made fragile by the retrenchment of services, austerity measures, enigmatic beauacratic systems and punitive welfare systems. In this context, individuals experiencing mental distress in London aim to collectivise and 'speak out' about iatrogenic harm resulting from mental health treatments, services and professionals. Mental health service 'evaders' and 'survivors' argue that services do not respond adequately to the complexity and variety of human distress and cannot offer the reciprocal, continual relationships that they seek for their health. In a context where social relationships have often been exhausted, or trust has broken down, activists aim to incorporate care into their every-day lives. Rejecting (dyadic) therapeutic relationships as unequal and individualising, many advocate collective, non-clinical methods and mutual support such as 'being alongside' each other in a crisis. This paper thus examines processes of relatedness and economies of care using Strathern's notion of 'recombinant kin' to demonstrate how relationships among activists are made, broken, remade and reconfigured. In doing so, this paper problematises existing dichotomies in the care literature which reflect the notion that being a care provider is socially powerful and reflects personal capability, whereas receiving care entails vulnerability, need and deservingness (Glenn 2010).

This paper is also concerned with how activists imagine and live out alternative realities by generating spaces of autonomy where multiple ontologies are negotiated, listened to and accepted.

This research highlights the value service evaders and survivors place on relational and affective aspects of care and their capacity to sustain relationships in times of personal, social and economic crisis. In doing so, it reveals mental 'illness' and vulnerability as potential conditions for social disruption but also importantly for personal transformation and social re-generation.

Pushkar, Piyush; University of Manchester; **"Accountabilities in the NHS: Coercion, finance, responsibility and democracy"**

This ethnographic study of accountabilities moves beyond the established literature on "audit cultures". Where previous scholars documented the eclipsing of other forms of accountability by the calculative rationalities of accounting, I argue that in my field, multiple forms of accountability interweaved and overlapped, often contradicting one another. In this mish-mash of accountabilities, the duty to "balance the books" was a key driver, but one that relied on other forms of coercion in order to be enforced.

My paper is based on ethnographic fieldwork in the UK public healthcare system, which is undergoing wide-reaching transformations and fiscal austerity. I undertook participant-observation with political activists who objected to these transformations, as well as interviewing the managers and politicians who were administering the reforms.

Campaigners sought to mobilise the concept of political accountability against cuts and privatisation, arguing that managers and politicians were not being honest about the potential consequences. While managers and politicians were often sympathetic to activists' point of view, they felt constrained by "the reality" of limited funds. However, managers felt unable to speak honestly in public either regarding the financial rationale for reforms, or the possibility of negative consequences, because they feared losing their jobs. Thus accountability to one's employer became a means of enforcing reforms that were necessary to balance the books according to budgets set by central government.

Activists recognised the primary responsibility of central government, but had no means of engaging with Westminster politicians. Thus they "held accountable" the local managers and politicians with whom they had a relationship. This recognition of accountability as a relational technology sheds light on the workings of the contemporary state. The various meanings of accountability end up working in favour of increasing power centralisation, as the people *responsible* for making decisions driving iniquitous healthcare reforms remain insulated from political accountability.

Reichert, Anne-Sophie; Chicago; **Vorwerk, Esther; “What is Feminist Intersectional Community Care? A Creative Lab”**

Conventional Western health care lacks a crucial component: it does not educate female identifying persons, or, anybody, for that matter, sufficiently about the structures and practices, the history and the ontology of female embodiment. This is a result of medicine’s mutual development with patriarchal culture. But what exactly are obstacles for women when they try to understand and heal their bodyminds? How are they treated in a world where the standard measure for organizing and regulating people’s lives has been the male bodymind?

Hearing from friends and colleagues, it appears that people don’t know enough about the female bodymind and that the information they are desiring is not accessible. Thus, ALASKA will realize a utopian spa clinic and information center for the female bodymind. This clinic will not be a real clinic but an artistic environment that offers playful, performative and educational events and services. At the same time, the clinic is envisioned as a space for citizen science and community gathering around the topic of female and feminist embodiment, open for all genders. The clinic will primarily cater to women and female identifying people yet is ambitious to be inclusive beyond these identifiers.

ALASKA is currently conducting research to assess how women feel cared for with regards to their health and which resources they are lacking. On the basis of questionnaires and through conversations with female health experts, doctors and (citizen) scientists, ALASKA is developing the first iteration of the feminist spa clinic.

For the Radical Health Conference, we propose a pop-up of the clinic that is on site for the full duration of the conference. Conference participants can fill out the questionnaire, engage with each other, explore our library of alternative health legacies (e.g. Legacies of midwifery and bio-hacking) and participate in workshops and talks on feminist and female care health and embodiment.

ALASKA - Studio for Feelings investigates emotions as bodily, sensuous phenomena. We understand humans as participant in their experiential evolutions and the development of what they can feel. Feelings are trained, habituated, and valorized, incorporated into our bodies and thus enacting the normative regimes of our societies. Therefore we ask: How and to what end are we moved and touched? Our work takes the shape of environments, workshops, performances and interactive installations.

Reinsch, Stefan; University of Lübeck; **“Exhaustion of hoping: Production and self-management of emotions in patients and caregivers while waiting for an organ transplant”**

Rather than merely following Robbins’ (2013) and Ortners’ (2016) call to turn our attention from suffering and the harsh socio-material conditions towards alternative imaginaries of hope and a good life, I propose to look at the situated practices of producing hoping and suffering while people attempt to deal in “good” ways with the challenge of biomedicine’s growing possibilities of prolonging life. It does so by investigating the counter effects of the practices of maintaining emotions of hope while waiting for an organ transplant. My analysis draws on long-term ethnographic fieldwork with a community organized around a fatal chronic condition. Since 2007, I followed and partook, as both anthropologist and physician, a group of people with cystic fibrosis (CF), and those caring for them, in their pursuit of a good life. CF is a rare, genetic, multi-organ disease. CF manifests itself mainly through frequent pulmonary infection that lead to scarring of the airways. The condition is ultimately fatal through suffocation. An unpredictable course, anxiety of actual suffocation, as well as doubts and frustration of waiting for years for a life-saving transplant are some of the hallmarks of living with a severe form of CF. However, with tremendous investments in therapy, disease progression can be slowed. In the first part of the paper, I show how, through repetitively being reminded of this, patients with CF are told that disease progression is no longer founded on the fate of inheriting a faulty gene. Their ‘fate’ is increasingly the fruit of their own responsibility and initiative. This produces two emotions, hope and exhaustion, where exhaustion is the counterpart of the energy that everyone has to mobilize to realize the best possible future – which, in the words of one physician, is “a life as good a possible, as long as possible”. The second part of the paper focusses on the self-management of emotion in the setting of transplantation evaluations. In order to be a “good candidate for transplantation”, patients are required to convincingly show to be adherent to therapy, and hopeful of success. Here, the expression of hope produces a counter effect of ‘exhaustion of hoping’. I will illustrate this with two contrasting cases: In one, a patient that is hopeful and fighting draws the care team into a spiral of physical and emotional exhaustion. In the other, a patient who is exhausted of hoping, that is, not showing and properly experiencing the “good emotions” incites hope in the care team that the patient might make more efforts.

Here, hoping acts as a measure of patients’ and care givers’ demand to control socially undesired emotions of despair and stipulates the individual’s proper experience of “good feelings”, like confidence. The analysis hereby also aims at a destabilization of the dichotomies between sufferers and carers.

Rutishauser, Melina; University of Basel; **“Participating in social health protection to live ‘good’ with Diabetes and Hypertension – The example of the Kilombero Valley in Tanzania”**

The aspirations of the Tanzanian government to transform Tanzania into a middle-income country are linked with new forms of welfare and social protection. One of these visible initiatives is targeting the health insurance landscape, which is at the core of the national strategy to reach Universal Health Coverage (UHC). On the other hand, the prevalence of NCD’s (Non-Communicable Diseases) such as Diabetes and Hypertension is growing in Tanzania, and both diseases are affected by sociomaterial infrastructures. This contribution will therefore elucidate socio-material infrastructures that actors with diabetes and/or hypertension in the Kilombero Valley in Tanzania build on to counter structural impediments to their health. Furthermore, we consider who can build on which specific socio-material infrastructures. Depending on the social position, there are different ways how actors build on socio- material infrastructures to counter healthcare impediments. Our research indicates that patients actively participate in building their own social health protection – and therefore also influence social structures. The activities and structures are hence always in the making, they are changeable and adaptable and thus open for possible forms of ‘doing’ and imagining a ‘healthy future’, for example when insurances are used not only as a form of cost alleviation in case of a patient’s sickness, but also to influence the treatment or to experience a feeling of being modern. To understand these – sometimes even contradictory forms – this contribution takes an approach that is inspired by critical medical anthropology. Such a body of critical (anthropological) thoughts allows us to take a reflexive outside perspective to understand changes as well as persistency. This enables us to grasp resisting dynamics - sometimes even forms of undermining dominant social structures and forces - to strive for ‘good’ health.

Schlesinger, William; Los Angeles, CA, U.S.; **„Radical negativity? Risk, subjectivity, and 'good' sexual health in the time of PrEP”**

When the antiretroviral medication Truvada was approved for use as pre-exposure prophylaxis (PrEP) to HIV by the US Food and Drug Administration in 2012, “the long history of medicalizing homosexuality … embarked upon a significant new phase” (Dean 2015, 228). Since the early 1980s, the inception of the period now reflected on as the AIDS crisis moment, gay male sexual subjectivity has been powerfully shaped by the clarion call for condom use. Even considered to be “the singular … marker of moral sexual citizenship,” the condom became an iconic symbol of, if not synonymous with, safe(r) sex (Koester et al. 2017, 1310). With the advent of PrEP—a biopharmaceutical, chemoprophylactic technology that reduces the risk of HIV transmission to the point of functional elimination with a once-daily pill—condomless anal sex absent the fear of potential seroconversion is now possible. Widespread use of PrEP portends a seismic shift in the HIV prevention landscape and a productive refashioning of the meanings linking HIV, safety, and risk—that is, for those able to access it.

Drawing on ethnographic fieldwork conducted in Los Angeles, California with queer health advocates, PrEP-prescribing clinicians, and PrEP patients past, present, and prospective, this paper queries if and how PrEP augurs a radical refashioning of sexual subjectivity and for whom. As an MD/PhD candidate training as a physician and medical anthropologist, and a PrEP patient since 2015, I position myself to critically engage with PrEP on mutually informative discursive and material levels. I argue that while the implementation of PrEP has motivated evolution towards an updated understanding of “good” sexual health, inequitable patterns of access constrain the potential of this putatively revolutionary advance, threatening to reinscribe the pathologization and marginalization of gay men, especially the most vulnerable who bear the highest burden of risk.

Selim, Nasima; FU Berlin; **“Why Public Anthropology matters in Planetary Health? Playing the fields of radical inquiry and pedagogic engagement in a (post/) pandemic, more-than-human world”**

“The overriding purpose of anthropology is not ethnographic but educational” (Ingold 2018, 14). This paper takes inspiration from the controversies triggered by Ingold’s approach to anthropology, extends them to address the divisive politics around the ontology of our discipline, with a focus on global health. The internal debate whether anthropology is theoretical or applied, ethnographic or educational, done elsewhere or at home, needs to be reconciled in meeting the challenges of planetary health. *Public anthropology in planetary health* proposes to do this by reconceptualizing the conventional notions of the field and fieldwork. Instead of limiting ourselves only to the *ethnographic* field(s) of researching medicine, health, and healing, anthropologists must conceptualize what they do in the field (s) of education, both inside and outside of the classroom, as work in the *field of engagement* (Selim et al. 2018): To learn and teach how to represent complex insights with jargon-free articulations in writing, speaking, and multi-modal expressions (Stoller 2018). Playing the field of radical inquiries and the field of pedagogic engagements need not be played against each other but embraced in solidarity with the actors whose lives are fraught with vulnerabilities in the rapidly changing precarious world. These fields involve and affect not only humans and bodily practices (e.g., breathing) but also trees, animals, inanimate matters such as air, and the climates of our planetary condition in a neo-liberalized, (post-) pandemic world(Lewis 2020, Wolf 2015). As anthropologists, we can radicalize our practice as “scholar-activists” (Nichter 2006) and more fundamentally as learners and educators of radical epistemologies, vocabularies, conceptualizations, and diversified modes of articulations and actions in both the field of inquiry and the field of engagement. Public anthropology in planetary health, therefore, is not *only* about writing and representing medicine, health, and healing that concern more-than-human lives, but about joining with the humans and non-humans in our radical efforts to live well.

Stodulka, Thomas; FU Berlin; **“Why I believe teaching diversified ethnographic methods is key to avoid fieldwork blues and emotional turmoil”**

This talk explores the possibility of engaging in non-disruptive methods when researching with vulnerable persons and communities. Building on the methodology of affective scholarship that acknowledges the epistemic potential of researchers’ affects and emotions, this talk reflects on the ethical, social, and political potential of methodological horizons that combine the ‘flow’ of arts-based methods with the (positively) disruptive qualities of social science methods.

Vinente dos Santos, Fabiane; Manaus, Amazonas; **„The health care of Venezuelan refugees and the challenges for a ‘real utopia’ of the Brazilian health system: ‘recognize’ to ‘take care’”**

In the last four years a substantial part of Venezuela's population has left their country, fleeing the serious crisis caused by the economic blockade inflicted by the United States on the Venezuelan economy. It is estimated that over 10% of the Venezuelan population has already migrated in what is the largest internal migratory wave in the history of the continent. While “internalization” actions (the removal of immigrants from border areas) are carried out with the support of national governments, the situation of immigrants is a challenge for health systems and for their managers and caregivers, that are facing an unexpected contingent of people growing exponentially month by month. In Brazil, the entry of Venezuelans has been through the northern border, precisely where the single health system is less structured and faces greater challenges due to endemic diseases whose spread is facilitated by the Amazonian environment, such as malaria, dengue, and zika. Without forgetting the most intense aspects of this humanitarian crisis, in this communication, taking advantage of the “real utopias” motto that guides the event, I would like to reflect on the possibilities of building solidarity networks and inclusion actions of these subjects, both institutionalized as well as informal, involving various stakeholders in the health care of immigrants. I base my reflections on an initial work of ethnographic research with managers, health care givers, and members of civil society who have been working to welcome Venezuelans in Brazil, in the border states of Amazonas and Roraima. The research problematizes the constant tension between a health system guided by the principles of universality, integrality, and equity and the daily practices of those who deal with the health care of a population of fragile legal status and stay in a precarious recognition by public policies.

Weingartner, Katharina; „The Fever“ (Austria/Germany/Switzerland)

https://www.thefevermovie.com/#about

Wuttke, Nora; University of London; “Notes from the field. What can ethnography of a Myanmar hospital campus bring to the table for future healthcare infrastructure developments?”

Through the lens of the infrastructure, private and public spaces and the architecture of Myanmar's biggest and most prestigious hospital, Yangon General Hospital (YGH), the ethnography maps daily life on campus. Through this ethnographic approach the research investigates what a good hospital is and can be in today’s world; a world in ruins which is struggling to formulate political and social structures amidst deteriorating cities and destroyed nature.

This paper will specifically engage with a question the researcher keeps facing: What can be learn from studying the daily life of a hospital in Myanmar; a country experiencing a rapidly transitioning economy alongside struggles for nation building and peace formation. The ethnographic research turns its lens on the daily life of the 2000-bedded hospital campus as a radical healthcare space, reading the campus within the paradigms of a post-exotic framework. Here YGH is not understood as a “peripheral” institution in a “developing country” but as tertiary healthcare facility in a capital city. The paper builds on the researcher’s background as the project architect for the development of the campus’ masterplan between 2015 and 2017 as well as her current research for which she returned to the same hospital in 2019/2020 for a year of fieldwork.

What can be learn from the hospital’s overlapping, colliding and complementing rhythms beyond the Myanmar context? The paper will engage with the hospital campus as a workplace, healing space, training ground and marketplace, reading its many reiterations and the synergies between people, places and services.

The paper aims to open a discussion about what an ethnography of the daily life of a hospital in a country such as Myanmar can bring to the table when academics’, planners’ and policy makers’ plan welfare infrastructure developments today (and tomorrow).