PEOPLE AND THE STATE
DIVERGENT MEDICAL DISCOURSES
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Introduction

I should start by telling how we reached to this collective volume of articles. The story isn’t quite short. Three years ago I and a small team of junior researchers assembled around one idea – the medicalization in the rural area in Romania. Two of the researchers, the senior ones – I and Constantin Bărbulescu – have had two fields of expertize: ethnology and history, the juniors were all four with historical background. The idea came from Constantin Bărbulescu who had been working on a similar topic for the 19th century, and the rest of the team had worked on different subjects related to medicalization and medical anthropology or history: birth, abortion, alcoholism, hygiene etc. Putting the pieces together we realized that the process of medicalization started one hundred and fifty years ago was almost unsuccessful and so came the question, ‘why?’ and so this question generated the hypothesis for the beginning of a research. In order to get some pertinent answers we started a grant research that led us to a three years hard work. The results are convincing, pertinent though not exhaustive.
We focused our research on two main levels – one was regarding the official medical system and the other was regarding the rural area. The time period chosen for the research was the communist period, from 1948 to 1989.

For the first level of research we started to gather all the official documents we could find in edited form, mainly, regarding the medical system for the period mentioned. This great amount of work was concretized in the publishing of two volumes, *Documents Regarding the Sanitary Policy in Romania (1948–1964)* and *Documents Regarding the Sanitary Policy in Romania (1965–1989)*\(^1\) that consist of edited documents issued by the central communist bodies for the sanitary system. The two volumes correspond to the two main stages of the communist regime in Romania: the Gheorghe Gheorghiu-Dej and Ceaușescu periods.

We could notice by quick reviewing the information held in these two volumes that in the first period the main goal was nationalizing everything that belonged to the sanitary system and closed most private pharmacies and whatever was related to the medical system under the careful supervision of the Party. The whole sanitary system was reorganized, new hospitals, maternities were built. Then followed a period of quietness until the 1970s when new normative acts are issued. Interesting is that 1976 is the year when Great Britain is organizing its medical system under NHS. Should it be a connection with it? Hard to say, but a future research from a comparative perspective to show if and to what extent an influence from the capitalist regimes could be taken into consideration remains to be done.

We may also see how the whole sanitary system is reorganized, new premises built and very important new courses to form nurses and physicians from the rural areas for the rural areas, the basic idea being to prepare people from rural areas in medical specialities and then sent back in their villages to practice. It was truly a general ebullience that touched and changed completely the sanitary system.

But having all these official records is not the whole story. We needed to know for real which was the rate of success and which was the feedback for such a deployment of forces.

And here the ethnological methodology was used. We proceeded to more than three months of intense interviewing sessions. Whom did we interview? The peasants. We started with the oldest, and so we had persons born in 1913 and ended with the youngest, people born in 1975. It was a qualitative research. They all told us about their own experiences with the medical system of the communist regime. We were particularly interested in recording their own experiences in the first place and then their general opinion upon the sanitary system of that period in the second place. Thus, we gathered an impressive material that gives voice to their life histories in relation to their illnesses, families, communities and the medical system. Consequently, we published also two volumes of narratives, *Peasants, Illnesses and Healers during the Communist Period. Oral Testimonies. Vol. I and II* focused mainly on how they ‘lived’ their illnesses during those times, but also how they felt about the medical institutions and their representatives. One important outcome was that they didn’t like them at all and

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they would try everything before resorting to the modern medical system, for various reasons. Some of the narratives are telling it bluntly, others are suggesting it but all of them create diffusely the negation of a modern sanitary system. This system was never welcomed in the countryside.

Consequently, this volume is only partly a closure. A closure of one research which in fact it is a beginning for others. It shows that one stage ended just to open another. The present volume was thought as a collection of studies regarding the relation between the sanitary system and its beneficiaries. It was mainly thought to cover Romania as a geographic area and the communist regime as a historical perspective.

In the end, it became a little more than that, as we discovered that our research interest is unique. It is true that the main idea of the grant\(^3\) was to deliver the results of a pioneering research but we did not fully realized until the end that we were indeed pioneers in this field in Romania. Since we know that despite the advantages of monologues, the dialogues are better we thought to enlarge the topic of the volume both geographically – by including articles referring to other geographic areas: Russia, Hungary and historically by referring to other regimes, basically communist as well. At the same time we also extended the time reference to the entire 20th century. The result will show its benefits by reading these articles. It is still a modest outcome as most of the researchers invited initially declined by various reasons and so the largest circle – a comparative perspective through articles referring to both capitalist and communist blocks during the second half of the 20th century on the topic of the medicalization of society was not fulfilled. But this was a secondary aim of our research, and proved to be too ambitious for the amount of time that we objectively had

\(^{3}\) Grant CNCSIS type ID 1647.
for the research. It will be pursued in a future research, respectively in a future volume.

We still managed to give a round shape to a smaller circle – a comparative perspective inside the communist block through the articles referring to Russia, Hungary, and China. It is nevertheless an important perspective as the Eastern Block was always seen and treated separately. I think that these three other countries taken into consideration even through their geopolitical position are bringing a contextualization of the matter of medicalization inside the communist epoch. We may have this way a comparative perspective on how successful or not the medicalization was from one case to another.

Still, the weigh is held in the volume by the articles that refer to Romania, and the communist period, in relation with implementation of a certain sanitary system. Few of the articles are bringing a feedback to what the communist officials tried to impose, others are presenting exactly what and how the regime tried to impose on the people.

The volume begins with the article on Russia, dealing with the problem of infant care in the villages in the 1920s. Its place is well determined also by the fact that it precedes in a historical manner what will happen in Romania few decades after. The period of study brings similarities with the research of our grant for the fact that both deal with what has happened in a country after the instauration of communism. The article begins by presenting how the Commissariat of Health was founded and other organizational forms that were covering the medical system. It continues by presenting the struggle and the whole efforts to bring modern medicine in infant care in the cities and rural areas in Leningrad province but with little or no success. Due to budgetary constraints the Bolshevik propaganda made use mostly of published material: posters, health manuals, etc., but concentrated
on the dichotomic idea of ‘harmful inherited practices and enlightened scientific knowledge’⁴.

One channel in enlightening the peasants was the introduction of ‘mobile dispensaries’ that even if rejected or mistrusted at first by the old generation they eventually gained acceptance from the younger generations. A second channel was the summer nurseries as a means of influencing the peasantry and the author points out that it became ‘the preferred site of educational work with peasant women’⁵. The author continues by presenting three types of stories related to the situation in the countryside: the personal stories, the reportage, and the up-to-date medical advice ones. The author is concluding that the fight against infant mortality was a secondary aim, and the whole work of increasing facilities and the medical personnel in the first 1920s turned to a down slope in the late 1920s.

The second article, written by Alexandru Onojescu begins by framing the movement of emancipation of Hungarian women into the general Soviet pattern imposed to the socialist countries belonging to the Eastern Block. The first matter approached is that of the laws issued in the first years of the communist regime regarding mainly the equality in rights for men and women. Then he continues by discussing the three possible reasons for the social-economic emancipation of Hungarian women: the need to copy the Soviet model imposed through Soviet experts implementing socialism in satellite countries, the need for labor force in the attempt of building the new society, and the need of the communist regime to insinuate inside the family. This was visible in the way the state maneuvered the reproductive role of women that became equally important with the productive one. After the events in 1956 the new leader Janos

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⁴ See David Ransel, Soviet Efforts to Transform Infant Care in the Villages: Leningrad Province in the 1920s, infra.
⁵ Ibidem.
Kádár brought a certain flexibility inside the totalitarian regime by relaxing the investment in industry and bringing two measures with direct impact on women: raising wages and liberalization of abortion. The Kádár regime would build a new image of women by stressing their maternal role. The argument is continued by bringing lots of details about how the Hungarian regime tackled the issue of abortion and by highlighting the role of GYES in bringing an innovation in the field of pro-natalist policies. Further on the presentation discusses the problem of discrimination of Hungarian women, especially at occupying certain public positions. The author concludes by making few statements regarding the women's emancipation policy that despite its shortcomings it was still perceived by women as successful.

Florin Soare deals with the problem of pro-natalism in an article that makes a in-depth review of the demographic policies of Ceauşescu’s regime. It starts the analysis from the Decree banning abortion in 1966 which was so to speak mild regarding the matter compared to what followed, and takes us to the last decade of the communist regime, the 1980s. This is the period when the Party changes its view regarding the demographic issue by implementing a Stalinist model that culminated in the modifications done in 1985 to the Decree mentioned above. The 1980s were the most draconic years generally and in the demographic policies especially as it proved a total indifference from the Party, Nicolae Ceauşescu, and other leaders to the needs of population by reinforcing severe legislation measures in a truly dogmatic vision. The conclusion is bitter as the effects of such policies had only negative results: death of women, raised infant mortality, new-borns with disabilities.

The article written by Mihai Croitor is closing the articles on the issue of pro-natalist policies, as it is trying to make a comparison

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between three communist countries: Romania, the Soviet Republic and China. The article presents the Russian situation that despite the fact that it was previous to the Romanian and showed the negative results of such a policy by the time it was to be implemented in Romania still the authorities at Bucharest neglected it. In doing so the policies of Romanian government became the harshest in all the Eastern Block. At a different pole, China restricted abortion as well but its problem was not to increase the birth rate but on the contrary. In such a situation the main discussion there was around the family planning.

The next article brings into our attention the situation of an ethnic group from the South-East of Romania – the Macedo-Romanians. In the beginning we are introduced to the ‘two dominant social mechanisms’ that are the basis of their construction of identity: practice of endogamy and exchange networks. Further on the author argues on the basic conditions that regulate endogamy, an important one being the physical and mental health of the bride and the groom, and the strategies of the two groups to avoid exposure of some possible illnesses. Then we are introduced into a different type of marriage strategy – related to medical profession as young girls especially, chose to obtain a medical degree to increase the marriage chances. The author concludes by telling us how the standards imposed on the individual in order to conclude a marriage have changed.

The article of Constantin Bărbulescu makes a thorough analysis of the narratives of the peasants regarding their childhood and youth years by contrasting two aspects: illness and death. The exposé starts by presenting the possible causes of illness as they come up from the interviews. Regarding death, beside its causes we are also presented the situation of mortality and birth for the

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age cohort interviewed and then compared to the official records edited by historians, having as reference point the concept of demographic transition. The author concludes that both official statistics and peasants’ interviews concur to the same end: their lives are better today then they were in their childhood or youth years.

The article regarding homebirthing is bringing forward a delicate matter, seen by contrast. Following the fieldresearches done along a large amount of time, the author, Elena Bărbulescu brings forward the testimonies of a generation of women that have birthed at home, and they were content with their choice. The article goes on by presenting that the place of birth is part of the process itself, and is practically related to much more than the physical act. It is mainly a manifest of the way of life, the way the women lived in those days and what birth and a child meant to them and the communities they belonged. The conclusion is that even if the modern medicine has gained the battle and women are birthing in hospitals, something has been lost, like the idea of having a choice, or that we have a drastic interruption in the transmission of knowledge, or that we could have a gender issue, as most gynecologists are men.

The next paper introduces us into the problematic of the body as a primary (re) source for cultural understanding. Then we are taken across centuries in an exposé that present the passage from the body-subject to the body-object where the bio-medical vision prevails. The analysis continues by presenting few cases where the idea is to link the body with its political/social environment. Storytelling becomes a means to rebuild life experiences where suffering/sufferance has a key role. The body is analyzed as a discursive universe. In the second part the author is more practical and presents an anthropological research done in Romania on the topic of reproductive and contraceptive practices. The subjects were people with poor standard of living and the Roma. We find out so that the experience of illness is determined by the socio-economic
status. Most of the women interviewed complain about their lives which caused them to be ill in the first place while there are cases where problems of health prevent them to work and so inflicted poverty on the family. In the end we have a narrative body built up by the individual in specific circumstances.

Ciprian Moldovan ends up the series of articles published in this volume. The main idea of his work is bringing in a dichotomy created by the two images of the modern doctor: the good doctor and the bad doctor. The starting point for this idea must be found in the two volumes of interviews\textsuperscript{8} where the people talk about their life experiences in relation to illness and talk about the physicians who helped them and cured them, and about physicians who were rude, refused to cure or made the wrong choices in curing them or other members of their families. On the other hand the author is bringing in a parallel of the same story by quoting from the written press articles regarding to the manner medicine was practiced by its modern representatives.

In conclusion this volume is a miscellanea showing how many facets we can deal with if we start from one single point of reference: the medicalization of society and its beneficiaries. It is to be noted though that most of historians and other researchers were interested especially in topics referring to women and their ‘basic’ activity: natality, as if the 20th century is marked by these two issues: women and natality. And indeed so probably a history of the past century would bring women’ history and that of natality and child care as key subjects of scientific debate.

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Fields of interest: history of mentalities, Școala Ardeleană, history of Transylvania in the modern epoch, Revolution from 1848, the Habsburg regime in Transylvania.
Soviet Efforts to Transform Infant Care in the Villages: Leningrad Province in the 1920s

David L. Ransel

The nearly three years of civil war that followed the revolution of October 1917 in Russia disrupted or destroyed what few child welfare institutions had been functioning under the tsarist and Provisional Government regimes. Remaining activity consisted of local ad hoc efforts to assist birthing mothers, refugees, and abandoned children. Although an office of Maternal and Infant Care (Okhrana materinstva i mladenchestva, or OMM) was organized early in 1918 under the People’s Commissariat of Social Welfare, this supposedly national office had difficulty mounting anything more than local relief efforts in and around the large cities. During the course of 1918, the OMM absorbed what was left of the pre-October Trusteeship for Maternal and Child Welfare and began to revive it and other urban child birth and child care facilities left over from the old regime.

The director of the OMM, Vera Pavlovna Lebedeva, and her co-workers were eager to
David L. Ransel

consolidate their institutional base and to attack the problem of infant and maternal mortality by transforming the medical and child birth culture of the country. Progress was hampered, however, by the OMM’s lack of resources and a stable institutional foundation within the new governing order. Its responsibilities were at first divided between the Commissariats of Social Welfare and of Education, then shifted to two others, the Commissariats of Labor and Health. The leaders of the OMM fought against this parceling up of its work and in May 1920 finally won approval to concentrate all its operations under the Commissariat of Health. Having achieved a more solid administrative position, the OMM was able to begin building institutional networks. In December 1920, it convened the first All-Russian Conference of Maternal and Infant Care. The meeting took place in conjunction with the Congress of Working Women, as the two organizations shared many concerns.

Officers of the Women’s Section (Zhenotdel) of the Party were important collaborators with the OMM, especially in supporting outreach to factories and in publicizing decrees issued by the government and Party that encouraged efforts on behalf of mothers and children. But the reality of the OMM, as of other welfare operations, was decline from the prerevolutionary period. Even in Petrograd, the most developed locale where before the Revolution nearly 90 percent of births took place in maternity wards, the rate fell in two years to about 70 percent. The reason was the lack of transport and especially the lack of heat in maternity facilities. If conditions were poor in the large urban centers, a look a few miles outside of Petrograd revealed the near total collapse of maternal and child welfare services. Dr. Marshak from Detskoe Selo district southeast of Petrograd reported having just a handful of maternity beds, one maternity shelter and two pediatricians to serve the densely populated district. A doctor from the
city of Luga farther south lamented that his far-flung district was served by two obstetricians and one pediatrician, doctors who did not even live in the district but rode in from Petrograd. He added that not a single OMM institution was operating and that welfare activity, such as it was, consisted of the distribution of milk. When questioned about this specific activity, the doctor further admitted that milk distribution had been available only in the summer and that the milk was spoiled and came not from public but from private sources. In short, nothing was functioning. Even where welfare facilities were operating conditions were far from rosy, as may be judged by complaints about the most elite of them, the former imperial foundling home in Moscow, that told of neglect by the medical staff and of mice and worms being found in the cereal fed to children and midwives.

A common practice of Soviet leaders during their first years of rule was to seek popular approval by advertising programs and issuing decrees to implement them, even when they knew that most of the decrees were unenforceable. The OMM was no different. Officials and delegates at the first conference of the OMM in December 1920, for example, proposed expansive plans for developing a modern welfare program. This was a key item in a Soviet modernization that included scientific authority, industrialization, and a fully developed bureaucratic welfare state. OMM officials looked to a new day when all women would have access to modern gynecological and obstetrical care and when house work and child rearing responsibilities would be communally supported and conducted by professionals.

They understood, of course, that the great majority of women in the Soviet Union still resided in the countryside and were subject to patriarchal power and an agrarian cultural system that had to be transformed before the modernization of motherhood could be realized. The OMM officers and medical staff were
in agreement that the object had to be not merely changing a few practices but a systematic assault on village culture. They would have to eradicate or transform virtually every aspect of traditional birthing and care, starting with what they considered the most obviously harmful practices and their associated “superstitions.” Their catalog of “barbarous” practices echoed those that had been condemned by Russian physicians since the eighteenth century and combated by zemstvo doctors in the next era. Peasant women gave birth alone, hidden in some out of the way spot, or they were delivered by untrained granny midwives who had no conception of hygiene or what to do in difficult births. Birthing mothers were walked to exhaustion or in prolonged labors suspended from a ceiling beam, babies were swaddled tightly, breastfed on demand rather than on a doctor-approved schedule, or otherwise nourished with a rag pacifier (soska), “chaws” (chewed bread), or cow-horn cow-teat bottle (all of which were ripe with pathogens), and finally rocked continually in their hanging cribs (a box filled with straw or rags and suspended from a ceiling beam). This was the “dark” world of the peasant baba, one of two prominent images of women in Soviet discourse.

Because the means the OMM had to conduct this transformation were limited, it had to count on mobilizing support among the citizenry, engaging the help in particular of the “conscious” activist woman, the other prominent image of womanhood in Bolshevik rhetoric. One of the first such efforts was a “Week of the Child” running from September 26 to October 3, 1920. To judge from reports in Petrograd province, the home of the OMM Institute, the results were not impressive. The official in charge of Luga district wrote that requests for food aid during the week had yielded a mere one pound of groats. At Detskoe Selo, the week featured inspections of child welfare institutions, lectures on illnesses and on maternal and child care, plus an excursion
for women to Petrograd to look at nurseries, prenatal dispensaries and the OMM museum on Vasilevskii Island. One wonders what the forty-two women who took part in the excursion (workers at children’s homes, nurseries and a hospital, and housewives) thought of the facilities in the city, many of which were in desperate condition. The Vasilevskii Island maternity home, for example, was nearly out of wood to heat the facility and in danger of closing its doors.

The Petrograd district, the rural area immediately adjacent to the city and containing 80,000 inhabitants, was served in 1921 by 25 doctors of every kind (some of whom were in private practice) and only one trained OMM nurse. Maternity beds were in better supply, about 50 being scattered through the district in public and private facilities. Summer nurseries did not yet exist and were apparently not in great demand because of the non-agrarian character of much of the area. Few trained hygiene teachers were available, and many of the women who worked in child care facilities were illiterate. According to Dr. Brazhenikova, head of the OMM office for the district, disease was rampant among children in institutional care, and the health of children generally was poor. During the “Week of the Child,” she reported, they examined all the children in institutions and all the children of some villages and found that a majority suffered from anemia, swollen glands, and bad teeth.

After the Civil War, matters improved in the largest cities, where the OMM was able to concentrate on putting prerevolutionary facilities back into operation. It was hoped that after reestablishing services in the major centers, the agency would have the resources to expand gradually into the countryside where the greatest number of women still resided. But, contrary to expectations, activists soon had to adjust to a new and much narrower field of activity. The advent of the New Economic Policy dramatically
limited what the OMM could hope to accomplish. Budgetary con-
straints not only put a stop to plans for institution building. It put
the program into reverse. In 1922, the OMM was forced to curtail
much of its activity, close one-third of its facilities, and accept the
fiction that many of its responsibilities were being transferred to
local authorities. It was, however, obvious to everyone that local
bodies were even less capable than the central government of pro-
viding the services needed by mothers and children.

In adjusting to the New Economic Policy, OMM lead-
ers found that one of their biggest challenges was the imbalance
between live-in (zakrytye) institutions such as children’s homes or
shelters for homeless mothers and children and the service (otkry-
tye) facilities such as prenatal dispensaries, milk kitchens, nurseries
and kindergartens that were essential to deliver on the promises
of the revolution to provide benefits to women and families gen-
erally and not just relief operations for the most needy. Another
crucial function of the service facilities was to provide sites at
which women and girls would be educated in hygiene and mod-
er methods of child birth, child care and upbringing; this type
of education was thought to be the most effective means of bring-
ing down the shocking rates of infant mortality. The NEP frus-
trated this mission in two ways. First, it caused radical cutbacks
in government funding for health services and likewise annulled
a number of benefits specifically aimed at pregnant women and
new mothers, including a so-called dowry for newborns (a packet
of clothing and baby care items), supplementary food for preg-
nant women and for children up to age three, and free milk alloca-
tions. Second, the market mechanisms of NEP, the return of men
from the Civil War, and discrimination against women in hiring
threw large numbers of women out of work. The combination of
decreased benefits and decreased employment pushed more and
more women and children into shelters for the homeless, and these
costly live-in institutions soaked up an ever larger percentage of the declining health and welfare budget. The OMM leaders understood that the live-in facilities, while of some help in combating infant mortality, were narrowly-based, expensive relief operations that would never be able to exert the kind of broad impact that service and educational outreach facilities would have in advancing the cause. They needed therefore to seek out means to turn around this downward spiral.

Lacking financial resources for fixed educational outreach and maternity services to women in the provinces, the OMM had to resort to the devices that figured prominently in other Bolshevik propaganda campaigns: posters, exhibits, magic lantern projections, health manuals and other publications, and more “week of the child” drives. Print media were the most prominent means used and, although the agency began with puny print runs of its posters and magazines, by the end of 1920s it was publishing in numbers sufficient to make contact with a substantial section of the provincial town, if not the far larger rural, female population. The main periodical publications used by the OMM to reach activists in the countryside were *Krest’ianka* (Peasant Woman) and *Krest’ianskaia gazeta* (Peasant Newspaper), and the stories they featured were based on reports from correspondents who wrote about conditions in the rural areas, reports that were framed either by the correspondents or editors in the accepted contrast between harmful inherited practices and enlightened scientific knowledge. By the mid 1920s the OMM was able to go beyond publications alone and to mount efforts to reach small towns and villages directly with education and temporary services, above all medical check-ups and summer nurseries.
First Try: Mobile Dispensaries

Reports from the countryside had made clear that it would take more than agitation to gain the attention of rural women. Tangible assistance programs were needed. Once OMM leaders began to recover from the ruinous budgetary cutbacks of the first NEP years, they planned outreach to the villages in the form first developed by charitable institutions in tsarist times: nurseries during the summer work season and mobile medical teams to give check-ups to mothers and children. Here, they believed, were services of immediate benefit to village mothers and their children and of importance in meeting the two main challenges of OMM work. First, the provision of day care, proper food and clean surroundings for children in the summer months would reduce substantially the high infant and childhood mortality that occurred in that season due to poor feeding, accidents and neglect. Second, the mobile dispensaries and summer nurseries could serve as sites for educating mothers in proper care of themselves and their children. The expectation was that once the mothers came to understand the benefits of these facilities, they would be eager to cooperate with other efforts at improvement and to learn about and exercise the political and social rights that the revolution had won for them.

A push for action of this kind began in 1924, spurred by the call at the 12th Party Congress at the end of 1923 for “all-round assistance by the city to the countryside” and a renewed “common effort with the peasantry” (smychka s krest’ianstvom). The message was reinforced at the next year’s congress, which demanded “every possible cooperation with the peasant masses.” The OMM mustered what resources it could from its own budget and at the same time signaled activists in the countryside to request assistance from local bodies in conformity with Party directives about assistance to the villages.
Although the campaign began in 1924, difficulties in organizing and finding resources delayed most action until the following year. Even then, efforts remained sporadic. In the relatively well-staffed Leningrad region, the best the OMM could do in 1925 was to send out small teams of traveling medics who stayed a week or two in a particular township and then moved on. Dr. L. O. Sverdlova took such a team to the northeast part of Leningrad province beginning in the spring of 1925 and offered some sobering observations. Only about half of the pregnant women they examined were healthy. The children were even worse. In one township, the team looked at 90 children age 0–3 and found only 12 in good health. Of the 25 children age 3–13, three were healthy. The rates of infant mortality were appalling. In one locale, of 19 children recently born, only 3 survived, and all three were ill. In several other villages visited by Sverdlova, she found similar losses. In one, of 45 recent births, 35 of the babies had died in the first months of life. “In another, during the two weeks prior to our visit 20 women had given birth, and now only a few of the babies remain alive; but, in compensation,” she remarked dryly, “the village’s cemetery was adorned with fresh little graves.” These results, she wrote, “can only be attributed to the darkness and ignorance of our women.” Wherever she went, Sverdlova tried to leave behind OMM cells composed of any literate women she could find. They were given literature and urged to gather the village women together at least twice a month and somehow “wake them from their heavy slumber.”

Later in the summer, Sverdlova visited a township about 30 kilometers from her medical station in the district capital and there ran across a situation common enough in many parts of Russia and distressing to this medical missionary: the women either did not speak Russian at all or spoke it so poorly that communication was difficult. She had evidently entered a Finnish or Karelian-speaking
region. “This township is a primitive outback where the women are very dark and ignorant,” Sverdlova remarked, using her two favorite words for characterizing peasant women. Then in describing the conditions she found so discouraging, she repeated almost word for word what ethnographers and rural doctors had been writing about village Russia for the past 100 years.

A mother is forced to leave home for work early in the morning and returns late at night, leaving her baby in the care of a child 8 or 9 years old or with an utterly blind old man. It is very difficult to describe the miserable conditions in which the infant exists, lying all day long in a stuffy or even smoke-filled house in a hanging crib next to the oven, a chaw in its mouth so that he does not cry.

Here, she emphasized, is where the OMM needs to help out by establishing summer nurseries at which “these boorish women” could receive instruction in child care and which would also serve as centers of enlightenment.

Sverdlova wrote of the sorry lot of a pregnant woman. “She has to work up the very last minute before labor, and because of her darkness and ignorance that are deeply rooted in prejudices about the evil eye causing harm to a birth mother and her baby, peasant women do not ask for help but give birth alone in a barn or go off to the other side of a lake or deep into the forest.” She noted that a trained midwife had tried to start a practice in the township but could not attract enough business to make a living because of this peasant attitude toward birthing. As for the children in the township, like elsewhere, a substantial majority suffered from rickets and other diseases. On the positive side, Sverdlova could report a good turnout for their talks and dramatizations done with exhibitions and slides. But she worried about
follow-up in an area with almost no literate women and almost no schools so that the younger generation was growing up as illiterate as their elders.

Another team led by Dr. D. Kuritsina was active in June 1925 near the district center of Lodeinoe Pole. The villagers in this area had more experience with medical practitioners, even if they still believed in witches and spells, Kuritsina remarked. The women gladly brought their children for check-ups and even wanted to leave them at the medical station while they went to work. It was clear that a summer nursery would have been welcomed here, but the medical team did not have resources to do it properly. The examinations of the children also revealed the need for regular professional care and observation, since the children were in no better shape here than elsewhere. Only 10 percent of the 220 examined proved to be “relatively healthy.”

Kuritsina made an important observation about where the OMM needed to target its efforts. “I think it is necessary to work with the young girls,” she wrote, “because they do a lot of the child care. A baby is with them more than with its mother.” She went on to tell about how she made a rag doll and used it to show the girls the proper way to handle and care for infants, and she believed that she had some success, as a visiting nurse who followed up three weeks later found that these young nannies retained some notion of what Kuritsina had taught them. The greatest challenge for the medical workers was the grandmothers and other older care givers. The medical staff found that they sometimes had to threaten police action to get the old women to stop feeding the babies chaws and other harmful foods. When it came to the hanging crib, however, everyone opposed the medical workers, young girls and grandmothers alike. Doctors had long considered this device dangerous and debilitating. Babies could occasionally fall out of this high crib and be crippled or die, and doctors for some reason decried even
more what they regarded as the stupefying effect on the child of being continually rocked in the crib. Peasant women, for their part, thought it cruel to deprive a baby of this comforting motion and wondered why the doctors wanted them to torment their babies. In any event, Kuritsina had identified the three-generational pattern of the Russian child care culture. Child care was usually taught to young girls by their grandmothers, skipping a generation and consequently building in a strong conservative bias that kept alive and powerfully reinforced the beliefs and practices of the past.

A team working in the opposite end of Leningrad province, the southwestern district of Gdov, found the situation no better. Dr. L. L. Burshtein, the team leader, reported there, too, the early introduction of solid food, endless crib rocking, heavy swaddling, covering the crib with dark cloth, and fear of exposing infants to the outdoors or to fresh air indoors even on warm sunny days (villagers thought it caused colds), in short, all the practices the doctors considered baneful. Even the smell of peasant homes offended this urbanite. “In the homes it is stifling,” Burshtein wrote, “and each has its own characteristic smell. When you approach the crib, you are assaulted by the stench of urine and baby excrement.”

The practices of the peasants constituted a true culture of child care, for, as Burshtein discovered, they were common to all the villagers and not just a particular stratum of them.

[Even in prosperous homes where the rooms are clean and bright, snow-white curtains grace the windows, you still find the baby lying in filth, stinking of urine and kept under three layers of crib curtains, tightly swaddled and with the ever-present rag pacifier in its mouth.

As for giving birth, most women in this community delivered their babies kneeling on a dirt floor on dirty hay, according to Burshtein, and without any assistance but that of a granny midwife. In this
Soviet Efforts to Transform Infant Care in the Villages

community not far from major urban centers, there was not a single medical midwife available even though approximately 800 children were born each year.

The best Burshtein could report was that the team seemed to be making some progress on the issue of cleanliness. They noticed that after lectures, people tried to find a clean shirt for their children and improved their use of the crib.

More lasting success was reported by a team that had the opportunity to work closely with peasants in a single locale for a long period of time. This team was able to set up a pediatric dispensary in the village of Potanino northeast of Novaia Ladoga in early spring and continue working uninterruptedly for nine months, the object being to examine all the children in the surrounding area. According to the account of its leader, Dr. Nikolaeva, the peasants initially greeted the team with mistrust and made clear that they did not welcome the service or even understand the point of bringing healthy children in to be examined by a doctor. Again, the strongest challenge came from the old women of the village, who were often heard to say things like: “We gave birth and brought up our children just fine without you.” They had to be reminded, Nikolaeva remarked, that although they had given birth to many children, they brought up fewer than half of them.

By June, the report declared, the team was enjoying greater trust and seeing an increasing number of office visits, including requests of treatment for adults as well children. The team also opened a nursery for 20 children and was able to keep them healthy, which stimulated interest in a nursery by the people of a neighboring village. Although at the time of Nikolaeva’s report the majority of children still suffered from skin diseases and other ills and were inadequately nourished, she thought that the dispensary had become accepted by the peasants and she wrote that, indeed, they “are now afraid that we might decide to close it.”
This first effort in 1925 was an opportunity for the OMM physicians and activists to acquire some experience of conditions in rural areas, to assess the scope of the need, and to make plans for future work. The stories they told contained many of the same elements that appeared in letters and stories from activists in the countryside archived or printed in Krest’ianka magazine. Wherever efforts were undertaken to bring medical assistance and especially nurseries to the villages, women were said to be suspicious at first and local male supervisors unhelpful, yet in time trust developed and by the end of the stay, mothers were clamoring for continued services and even offering to contribute to them personally. So, this way of describing the interaction between peasant mothers and activists was a well established narrative form shared by village correspondents and medical workers alike.

Push for Nurseries

The Third All-Union OMM Congress met in Moscow in December 1925 and assessed the results of the current year’s work. Much attention was devoted to the countryside. Although OMM director, Vera Lebedeva, believed that her agency’s primary objective should be to establish medical facilities wherever possible, the experience of 1925 convinced many OMM workers that summer nurseries were their best means of reaching peasant women. Dr. N. F. Shtiftar spoke for these people in her speech at the congress. She pointed out that the idea of preventive care was altogether new for the peasants and very difficult to get across by treatment and lectures alone. The reports she received about educational efforts in the villages uniformly noted that the peasant audiences listened politely to presentations, “but left the meetings convinced that none of what was said was much use to them; they
could not imagine applying such advice in conditions of village life, amid grinding poverty and backbreaking labor.” In contrast, Shtiftar continued, the village nurseries taught by example and in a familiar setting. “Even in a facility set up in village conditions and outfitted primitively, a mother could learn many things that she could do for her child, things that she was not doing now out of ignorance.”

This message was echoed by Commissar of Health Nikolai Semashko in his circular of February 1926 to provincial and regional health administrators about the campaign of that year. He noted that the OMM Congress found summer nurseries to be one of the most important means of influencing the peasantry and urged that activists begin well ahead of the summer field work season to prepare and encourage an expansion of nurseries. Semashko added that local organizers should heed the resolutions of the congress and focus on keeping the nurseries open for a minimum of three months, increasing the percentage of infants and children up to age 4 in the nurseries (older children had been a large component, whereas infant and early childhood mortality was the government’s chief concern), ensure that poor and middle peasants be served unless they were loafers who did not engage in field work. Vera Lebedeva also joined the chorus with a circular that urged women activists to mobilize all possible resources in the fight. We need to see “pressure from the female peasant masses on the township and regional committees,” she wrote, “so that they will allocate the means essential for the establishment of maternal and child welfare facilities such as more maternity beds in hospitals, an increased number of traveling medical midwives, village nurseries, and dispensaries.” Though still foregrounding the medical facilities, Lebedeva stressed the value of nurseries for engaging and organizing local women activists (delegatki). They could be trained to assist their fellow village women who were having
babies. By helping these women with chores, the activists would build solidarity and could use the practice of mutual aid and the promise of summer nurseries as a year-round theme for organization. “The nursery campaign is senseless,” she argued, “without wide participation of delegatki. The nurseries are an important part of the new village, and township organizers should develop work in and around them for involving delegatki. Work should start on the nurseries long before they are to open. They should be made into cells of collective life.” She also urged that the material base of village operations should be strengthened by attracting help from other groups active locally such as child assistance commissions, the Red Cross, “Friends of Children” cells, committees of mutual aid and the like.

There could be no doubt that the leadership’s purpose with the OMM facilities in the villages, especially the nurseries, was not simply to improve child survival and maternal health but also to use them as vehicles for changing the whole peasant way of thinking and acting in the world. “Educational-sanitation” work was to be one of the essential elements of nurseries, as a directive from this time indicates.

Since dispensaries in the villages are few, this educational work should be concentrated in the nurseries. If a nursery is not doing this, it is not fully meeting its obligations. It would be good if a special room could be attached to the nursery for a library or exhibit for this work, to hold conversations with mothers....Taking into consideration that questions of a sanitary-educational character are closely tied to the conditions of everyday life, that is to societal issues and likewise political questions, it is essential to address and illuminate these matters during conversations with the women.
In short, summer nurseries in the villages had become the preferred site of educational work with peasant women in regard not only to health issues but also to larger social and political consciousness raising. *Krest’ianka* and other publications aimed at activists interested in the countryside cranked up the volume of stories and letters on summer nurseries and similar facilities such as supervised playgrounds for children past infancy. Three genres were prominent in carrying the message. One featured personal stories of tragedy and success. The main character in the stories of tragedy was the village babka, a term that referred variously to women who served as granny midwives, abortionists, and healers of women and young children. The babka was blamed for inflicting pain and death on women and children. In her role as midwife, she was accused of continuing all the useless and harmful practices of the past such as isolating the mother, placing her in filthy conditions, reaching into her with dirty hands, the results of which were allegedly 40–50 thousand deaths by childbed fevers each year. Abortions by babki crippled large numbers of women, and writers often followed criticisms of abortion by a call for more emphasis on contraception and production of contraceptive devices, a controversial stance even in the 1920s and one that later was condemned. A few items were also included about women who had seen the light and transcended the past. These stories contained the key elements of the model didactic tale of female consciousness raising. For example, there was Aunt Marfa, a much beloved granny midwife (*povitukha*) who realized that she did not have the training she needed to help her patients. She decided that she had to go to a two-month medical training course in the city. But when she turned to the patriarchal village head for financial assistance, he responded with derision. Undeterred, Aunt Marfa gathered the women of the village and convinced them to act as a pressure group to get the needed support,
and she ended up with the wherewithal to attend the special midwife course. The same cast of characters appeared in many tales: the patriarchal village power structure that impeded enlightened change was confronted and overcome by women using organization and self-help to make needed reforms. A second type of article included straightforward reportage on the growth in the number of summer nurseries, dispensaries, and playgrounds. Related to these items was a series of articles starting in April and continuing into the height of the field work season that told about preparing for the opening of summer care facilities and offered step-by-step advice on how women could cooperate to organize such facilities in their own locales with a minimum of help from official agencies. Finally, another series offered up-to-date medical advice. This series began with a tough attack on babki and then proceeded to lessons on how to nurse infants, when to begin solid food, how to properly care for infants, the importance of sunlight and fresh air, how to avoid malaria and rickets. Each lesson was accompanied by pictures, often the traditional Russian lubok-type print, that contrasted proper care and the harmful practices associated with the babka. The publishing house likewise continued its behind-the-scenes work of forwarding complaints to local governing bodies and requesting responses to problems pointed out by correspondents.

Whatever the hopes of OMM leaders, the guidelines for use of the nurseries ran into difficulty when the workers tried to apply them in the countryside. A close look again at activities in Leningrad province demonstrates the point. A detailed report on Kingisepp district southwest of Leningrad noted that the idea was first to seek financial backing from the provincial health ministry and then to agitate for contributions from mothers in the villages targeted for action. Activists were able to get help from the ministry and also succeeded in drafting child care workers from among students at a technicum for training physician’s assistants.
and midwives. But when it came to the women in the locales being served, financial aid and work support was less forthcoming. Local women expressed some interest in having child care but did not offer to contribute more than a few rubles. Where nurseries were active, the work with the children reportedly went well. The children were said to have gained weight and played all day outside in a yard and sand pile in good weather. Nurses examined the children, gave small pox vaccinations, and taught basic hygiene such as washing hands before eating, using the chamber pot, cutting hair, trimming nails. But, again, the mothers, who were the primary educational target, had neither the time nor evidently the interest to be indoctrinated with new ways of doing things. “The period in which nurseries function,” the district health officer wrote, “corresponds to the time of agricultural labor, when mothers are not always available even on Sundays. Moreover, we have not yet outlived the torpor of village life...in which women demonstrate little initiative in their own behalf.”

The same kind of situation confronted Dr. Brianskaia, who took a medical team to the village, or perhaps better, small town of Voznesen'e, on the south end of Lake Onega, a transfer point for the Onega Canal. Brianskaia was working for the Red Cross in cooperation with the OMM. Her team arrived on July 19, 1926 and stayed until mid October. Despite resistance from the township supervisors, who refused to provide housing, the team was able to set up in a school while local Zhenotdel organizers spread the word of their arrival and encouraged women to come for check-ups. This opportunity for one-on-one visits with some of the mothers was considered a success, except that each visit proved to be very time-consuming. “You have to talk to every mother about things that in the city were known long ago even by women of very little education,” Brianskaia wrote. “Here you have to speak of the harm of the hanging crib and swaddling, about chaws and cow teat
nipples, and show that they should not give an infant the breast on demand 15 or so times a day and the like.” The team could even report some success in seeing a large number of babies for check-ups. In the three-month period of work, the team saw 360 children, many of them more than once. But they could not stick to their program of doing strictly well-baby care and education, as planned, since families called them for home visits to sick children. The team realized that their authority would quickly evaporate if they failed to respond to such requests. “The healthy ones they say they’ll look at, but as soon as one gets sick, they leave it without help,” would be the reaction, Brianskaia feared. Here, as elsewhere in Russia and in poverty-stricken regions throughout the world, every effort at public health based in education and preventive care was in danger of being swamped by the need for ordinary outpatient treatment for the sick.

Brianskaia’s team was continually frustrated in its central purpose of making regular, instructional contact with the pregnant women and mothers of the community. Prenatal work with pregnant women proved to be especially hard. Brianskaia reported that “our work in Voznesen’e came at the height of the field work season when it was very hard for a peasant woman to go to the doctor unless she was too sick even to stand up.” As for meetings after work hours, these too were nearly impossible to organize because the women were just too exhausted after a day of field work or barge hauling.

Another service provided by the team that could not operate as proposed was a milk kitchen. Guidelines told the team that they were supposed to furnish milk to families based on a rough means test that permitted assistance only to day laborers or large families earning very low wages. But Brianskaia soon learned what Dr. Burshtein and other medical workers going to Russian villages for the first time had discovered. The care of children had very little to do with the wealth of their households. It was a pervasive cultural
pattern controlled by the rhythms of female work and long-held ideas about infant needs.

[O]ften we had to think not so much about the material position of the parents, since in the best case the mother, when she goes to work, leaves her child in the care of some old woman or an 8 year old nanny, and from as early as two weeks of age they begin feeding the infant on semolina kasha or biscuits. Biscuits and the cow teat are the true bane of babies in Voznesen’e. I have a number of infants who nearly every Monday show up with diarrhea and vomiting. You start in talking with the mother about how important it is to keep her child at least a little while on a proper dietary regimen until he is completely well, but at the same time you know perfectly well that as soon as the child arrives home it will again get fed in the best case biscuits, or even bread and potatoes; so, these children had to be fed from the milk kitchen until they got well, plus a visiting nurse had to go to their homes and convince the 8 year old nanny not to feed the child anything extraneous.

It was clear that the approach had to be general if the goal was to change beliefs and practices and not simply deliver a few services on a temporary basis.

This was the situation in a large community located along an important transportation route. The real countryside beyond was scarcely touched. Brianskaia’s instructions also called for outreach to the surrounding villages. But this work was stymied from the start for lack of assistance from local people. “If by chance I got out to one of [the other villages], I could see maybe 20 persons, talk with the mothers, but that was the limit of my contact. I was not able to return a second time to any village, or to warn people when I might be coming. So the work had an entirely haphazard character.” She actually was able to visit only three villages in the entire period of her stay, not counting a few trips to nurseries in Oshta, which like Voznesen’e was another large community on the Onega Canal.
In Gdov district results were mixed. At the beginning of the year, the OMM instructor in Gdov, V. Khramchenko, found that township organizers assigned to work among women had gotten the message about nurseries, and she was able to obtain help from township executive committees in finding space to house children. Eventually, sixteen nurseries were operating in the district in the summer of 1926, and information had also arrived about seven more begun on private initiative, although the OMM did not know much about them. The main problems for virtually all the nurseries were, again: inadequate financial support from official bodies, an inability or unwillingness on the part of peasant families themselves to pay for the programs, and linked to this lack of financing, difficulty in recruiting trained personnel to staff facilities. The problem of personnel was not only affecting the summer nurseries but had even caused a termination of well-baby and maternal care at a long-established year-round dispensary.

The OMM ran into one further difficulty in Gdov, namely, outright hostility and direct opposition among the peasants of one township to the nursery program and the political education associated with it. Not surprisingly, officials attributed such resistance to “terrible backwardness” (strashnaia kosnost’) of the populace in that area. But in more sober moments, they acknowledged that difficulties sometimes stemmed from their own rules, such as the preference in admissions to the nurseries for poor and middle peasants. Some townships admitted only the children of poor peasants, and this policy, in the bureaucratese of the officials, “evoked a negative attitude on the part of the population and somewhat impeded the collection of voluntary contributions.” Indeed, other reports suggest that the bias in favor of poor peasants may have stigmatized the nursery operations and undermined support for them in some locales.

Still, the concluding report on work in the summer of 1926 was upbeat. In this second year of an all-out effort for summer
nurseries in the villages, the Leningrad OMM could announce a total of 102 programs serving over 2,000 children. The year before they had fielded less than half this number: 43 nurseries serving 1,005 children. Officials also claimed to be able to take heart at the large number of villages in the program that passed resolutions about their desire for nurseries again next summer, two townships even offering to use their own means and personal efforts to help out.

This jump in the number of nurseries in Leningrad province was similar to that for the Russian federation as a whole. Starting with only 125 summer nurseries in 1922 and rising slowly to no more than 524 in 1924, the first big campaign of 1924–25 more than tripled the number in Russia to 1,853 in 1925, and the second campaign raised the total substantially again to 2,924 for the summer of 1926. But the advent of the industrialization drive in the last years of the 1920s meant less attention to the countryside, at least in the short run. Nurseries continued to be of importance, but the focus shifted to supplying industrial sites and the slogan became “the more factory smoke stacks we have, the more nurseries we need.” In the countryside, emphasis moved to creating nurseries on the small number of state and collective farms, again using slogans that emphasized productivity more than the fight against infant mortality, for example, “summer nurseries help to raise crop yields.” In any case, the lack of resources and personnel caused a decrease during the late 1920s in the earlier rapid growth of village summer nurseries.
Images for possible use with the essay:

Poster published by the Office of Maternal and Infant Care, 1925. Translation: “Rag pacifiers and chaws kill more peasant children than bullets do soldiers.” Note the cow-horn bottle with a difficult to clean cow-teat nipple on the table.
Poster published by the Office of Maternal and Infant Care, early 1920s. The children are demanding medically trained instead of granny midwives, breast feeding, and cleanliness.
One of the main innovations of the communist regimes installed after 1945 in Eastern Europe was the social emancipation of women and their massive integration within the socialist workforce. At a close look on the entire social range from within the Communist Block, we observe the care these régimes displayed in their policies towards these objectives, marking a remarkable difference as compared to all capitalist systems. On this background, Barbara Wolfe Jancar raises two fundamental questions, which, if looked at from a different perspective (declaratively), became constants of this societal phenomenon: First, despite the development of their economic status, why didn’t women managed to break men’s monopoly on power? After all, the failure of this declared policy meant the failure of the communist policies for

women’s emancipation. Second, how is it that despite the numerous economic, cultural and social differences, women reached about the same status level in all communist countries? This second question leads to the conclusion that there existed a pre-established pattern featuring certain ideological coordinates borrowed and implemented from the outside and above, rather than the existence of any internal motivations, intrinsic to the societies in question.

Regarding this latter aspect, it is informative to look at the findings of Lena Dominelli, who, in one paper on social policies affecting women from various systems and political régimes throughout the world and focusing on the cases of the Soviet Union and the People’s Republic of China, highlights a series of coordinates which prove largely common also to the other countries of the socialist camp. These policies includes endorsing various social divisions—including age, race, gender, sexual orientation—and through these, oppressive social relations; subordinating family policy to economic exigencies; the political subordination of women’s interests to those of men, children and the economy; reinforcing gender based inequality in both social and domestic production; changing women’s behaviour rather than men’s; limiting state resources assigned to improving women’s position; formulating policies for women without extensively involving women; reinforcing the primacy of the heterosexual nuclear family; benignly neglecting the existence of family poverty; strengthening the impact of all social policy to family policy; and aggregating the incomes of family members for official statistical purposes. Even without an explicit description of all these characteristics, Hungary’s example is primarily developed from this Soviet-principle model.

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The primary goal of this essay is to highlight the characteristics of the condition of women in Hungary during the entire communist period. What were the motivations of the Hungarian communist regime and how it managed to build and manage feminine gender roles? We will take into account a number of factors such as the general political-ideological and economical context of communist Hungary; the context of social policies and how they change during the specified period; the demographic policy context; and the elucidation of the role that the mother and the child played in a communist society.

The beginning of a revolutionary feminist policy originated from the ideology of the Soviet Union, a fact which was to be proudly highlighted by Lenin: “Not a single state... has done even half of what the Soviet Government did for women in the very first months.” The Family Code of 1918, as the basis of this policy, together with other laws, favourably regulated all the social, economic, political and biologic aspects related to this gender category: residential, property and inheritance laws gave women equal rights in land, households, and communes; civil marriage and divorce on demand was introduced; illegitimacy was abolished; and abortion was legalized. The intentions of the Soviet leaders contrasted with “The Theses of the Communist Women’s Movement,” presented in 1920 and ratified in 1921 in the 3rd Communist International Congress. If the first paragraph of the statement intended to ensure the full commitment of the International in the fight for women’s political equality and the warranty of their social right, the second paragraph identified the two coordinates which constituted the basis of this emancipation: the collectivization of the private property (socialization of household work) and women’s integration

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in the Socialist production. Thus, the Theses sacredly followed Engel’s ideas from “The Origin of the Family, Private Property and the State,” a book which ever since 1884 had promoted the same two elements as the basis of women’s emancipation from under men’s economic suppression⁶.

Hungary, as well as the other satellite states of the Soviet Union, could not deviate from this model, the basis for which a similar legislation was introduced in the country immediately after the rise of the Communists as rulers. After 1945, all women were granted the right to vote, and in 1949 Hungary’s Constitution stated and guaranteed the equality of women and men’s rights without any kind of discrimination, equal labour conditions for the two genders and a formal commitment to protect the marriage and family. The Criminal Code followed in 1950, amended in 1961, which re-assured women of a series of fundamental rights. But the most interesting piece of legislation was the Family Code from 1952⁷, which regulated all the aspects concerning couple relationships. The new law stipulated the common property right of men and women on the properties acquired during marriage. Women were granted the right to file for divorce, and in the favourable cases they benefited from great advantages in their relationship with the former partners: they had the right of residence in the family’s apartment if she received the children’s custody. Even when the apartment had been acquired by the husband before marriage, the woman benefited from the right of residence until the state solved the domicile issue. In consequence, the marriage turned into a much more equal institution, which also resulted from the


necessity that children had two official tutors. With small amendments, these fundamental laws remained effective until the end of the communist period, completed by others regarding especially a series of social policies, implemented as needed by the urgent matters of the régime.

And still, how did this social-economic emancipation phenomenon of the Socialist woman arise? The question is open and many specialists tried to answer it. Some consider that there existed an intrinsic interest of Communists for the "feminine liberation," a fact revealed by the writings of founders Marx and Engels. Some on the other hand consider that the mouth-filling theses, the governmental decrees and the various pro-women legislations hid much more pragmatic objectives such as economic, demographic and patriarchal ones. In Hungary’s case, considering the rural-patriarchal tradition and the lack of a feminist tradition, we can advance at least three motivations, some subtle, some bolder, but all strongly interconnected. The first is an ideological one and is probably the easiest to notice. As in the majority of satellite countries, the bases of the Stalinist régime in Hungary were grounded with the help of Soviet experts and according to the ideological perceptive they assessed. The future Hungarian society was to follow the Soviet model, and if the latter included the political, social and economical emancipation of women, all Hungary had to do was to submit to this ideological direction.

A second pragmatic reason for which the new regime carried a deliberate policy of "emancipation" for women was the need for a broadly based labour force, necessary for the Socialist economic project on a disastrous post-war background for Hungary. In 1947 Mátyás Rákosi announced the start of a three-year plan which mapped out impressive investments in heavy industry.

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and construction, typical for the Soviet five-year plans\(^9\). In parallel there developed a strong nationalization process, which was to end in 1948 with the state owning 90% of the country’s economic capacity. In 1950, according to the five-year plan elaborated by the Hungarians, industrial investment rose 51.3%, with 92% of the total invested in heavy industry\(^{10}\). According to such ambitious plans, the necessity to integrate new social categories within the Socialist production was obvious and labor was one way for women to emancipate in the program. It was a sufficient reason for which both by legislation and propaganda, the new régime in Budapest followed a voluntary policy of women’s integration in the labour force. In this integrationist sense, the Family Code was sufficiently explicit: “Women’s equality within the marriage is therefore primarily ensured by the wife also being a working man, participating in the productive labour, economically independent of her husband”\(^{11}\). In order to ensure the success of such an emancipation project, Communists lowered wages so strongly that there hardly existed families which could resist on a single salary\(^{12}\). Moreover, the party constituted quotas to integrate women in the labour force and for their professional training: the first five-year plan asserted a 38% representation of the female workforce from

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the total active workforce\textsuperscript{13} (a limit which obviously could not be reached at the time). The consequence was the strong insertion of women in all the branches of Socialist economy, including the raw fields such as heavy industry and vehicle construction. The phenomenon was constant along the entire communist period (see Table 1), resulting in 1988 in a 46% feminine representation within the country’s active workforce. Some women may have felt this as a fundamental change, as their integration into the workforce contrasted greatly with their status before the war: for the first time they were independent from an economic point of view and lived with a feeling of achievement by equally contributing to the family’s income. However, beside the emancipating characteristic, it must be mentioned that in the Socialist economy, work was a right and an obligation for women and men at the same time, the status of citizen being intrinsically tied to this concept. Moreover, all the social benefits granted by the states to individuals depended on the status of worker, and on the various semantic meanings the régime assigned to the concept.

Table 1: Percentage of employees in Hungary, women and men, from the total percent of population\textsuperscript{14}

<table>
<thead>
<tr>
<th>Year</th>
<th>Total active population, women and men</th>
<th>Women (aged 15–54)</th>
<th>Men (aged 15–54)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949</td>
<td>62,6</td>
<td>34,6</td>
<td>91</td>
</tr>
<tr>
<td>1960</td>
<td>71,3</td>
<td>49,9</td>
<td>92,1</td>
</tr>
<tr>
<td>1970</td>
<td>76</td>
<td>63,7</td>
<td>87,4</td>
</tr>
<tr>
<td>1980</td>
<td>79,5</td>
<td>70,8</td>
<td>87,4</td>
</tr>
<tr>
<td>1990</td>
<td>75,2</td>
<td>69,6</td>
<td>80,4</td>
</tr>
</tbody>
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\textsuperscript{13} Idem, Inventing the needy..., p. 32.
The third motivation for which Communists wanted women’s emancipation was the need to encourage the régime’s insinuation into each fundamental institution in Hungarian society, including family. This motivation is best described by Joanna Goven: “By going out to work... by receiving legal protection and material benefits from the state, women participated in the shifting of family authority from the father to the state.”15 Women’s emancipation modified the traditional character of the nuclear family, by shifting from the one-wage-earner family to the two-wage-earner one. The woman was practically becoming a state’s agent in the family, thus limiting her husband’s authority. This shift lead to a change of the traditional patriarchate to a statal one by encroaching on the husband’s status as pater familias. A new authoritative relationship was being shaped this way between the régime (Party and State) and the family, the members of the latter transforming into subjects of the former and developing their existence under the impression that nothing depended on them16. The result was the creation of a manoeuvre space generous to the régime, in order to allow it to intrude in the family’s private life.

The intervention in the family’s intimate affairs was carried out by promoting and sustaining the reproductive role of women, considered equally important to the productive one. The reproductive role included all the aspects related to giving birth and raising children, but also to organizing the home. Once exiting the plant or institution where she worked full time, the woman took

on her second role, the “second-shift” as housewife and mother. Thus, the paradox of women’s emancipation within all communist régimes, not only in the case of Hungary, consists in the fact that this process did not mean the transformation of the gender roles, but only adding on some more. As such, up to 1965, the regime has failed in what should be, according to Marxist-Leninist ideology, the socialization of domestic work and child care. In other words, the system lacked a coherent social policy, due to both ideological and economic obstacles. Communist elites shared the belief that the socialist economic system was so good that it didn’t need a distinct social policy, autonomous from the economic one. In their opinion, poverty could not exist within the Socialist system, so they vehemently denied it. This was the reason why the Ministry of Welfare was dissolved in 1952. Even more, as long as the entire social security system was subject to an economic vision, it was only natural to be under-financed, being by no means a priority. Until Kádár’s reforms in the 60s, the major investments in each five-year plan were done in those economic segments considered productive, and less in the unproductive ones such as healthcare, education, services, social security or construction of accommodations.

However, the existence of such a vision did not imply the disappearance of social security policies, but only their blanket-ing-their integration within other policies-especially within the economic ones or those concerning education and family. In her study Lynne Haney demonstrated the validity and functionality of local institutions called Gyámhatóság. Their employees, mostly women, were assigned a wide range of tasks that affected all that

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we today call social security\textsuperscript{19}. Likewise, the state was also involved in building nurseries and kindergartens, but limited their development with the available budget and resources. Between 1951 and 1965, the number of nurseries increased by 372\%, while the number of accepted children increased by 562\% (see Table 2), which in fact meant that these facilities were becoming more and more crowded. The increase rate of kindergartens was much lower: in the same period the number of facilities increased by 156\%, while the number of accepted children increased by only 146\% (see Table 3), a fact owed to the existence of an inherited infrastructure. In both cases the available places were more than insufficient: in 1965, 8,1\%, respectively 47,1\% from the total number of eligible children could be accommodated in nurseries or kindergartens. Besides being insufficient, most of these facilities were crowded, highly degraded and offered scarce and untrained personnel\textsuperscript{20}.

This policy would fundamentally change once with the beginning of the 7th decade, following certain social and political convulsions which shook the Hungarian Stalinist régime to the root. The irrationally-planned Stalinist economic policies lead to exhausting material, human and social resources, a fact revealed by the active participation of worker committees during the revolution as part of the strongest centres of resistance. Following the events of 1955–56, the political and economic establishment was radically transformed, leading to amendments in the elaboration and implementation of social policies. The new régime established by Moscow and governed by Janos Kádár would prove much more economically pragmatic and more ideologically flexible. The relation of authority between the régime and population changed, reaching a political compromise which had been called

\textsuperscript{19} Haney, Lynne A. \textit{Inventing the needy…}, various pages.

by specialists in various ways: “goulash communism,” “refrigerator communism,” and so on. In exchange for an improved standard of living – which meant higher income and access to commercial goods – the population would close its eyes to certain political aspects characteristic of a totalitarian régime. The first changes were felt in the planned economy, where the second three-year plan (1958–60) and especially the second five-year plan (1961–65) marked a light decrease in heavy industry and a reorientation towards agriculture or production of commercial goods. Between 1961–65, only 44.3% of the national income was invested in industry, 18.6% in agriculture, 13.8% in transport and communications and 21.3% in unproductive fields. The annual rate of economic growth also decreased to 5–6%. The changes resulted in an increase of the family’s real income by 12% in the first stage and by 9% during the second; Kádár increased salaries by 11% in 1956 and 18% in 1957.

A change of the approach was needed by the regime to contain social unrest. But at the same time, a certain ideologist appearance needed to be maintained, a reason for which even the project of economic reformation to be implemented bore a Leninist name. There existed a certain semblance, at least on a linguistic level, between the New Economic Mechanism and the New Economic Policy established by Lenin to the Soviet Union in 1921. Terms such as “reform” or “market socialism” were considered too strong. Designed in 1965 and implemented after 1968, NEM was the most complex and important reform program of a Socialist economy from the entire Eastern Block, outclassed only

21 Swain, Nigel. *op. cit.*, p. 95.
23 Haney, Lynne A. *Inventing the needy..., p. 39.*
by Gorbachev’s Perestroika during the final years of USSR\(^{25}\). Heavy industry remained a priority, but the regime invested in other various branches such as electric energy production and the chemical industry. A great part of industry was reoriented to producing commercial goods, aiming to lift the proletarians’ living standards.

The flexibility of production by orienting it toward the consumer market as well as maintaining investments in new technologies led to a renewed focus on the agricultural and industrial sectors, which potentially faced increasing demand. Recognizing this potential crisis, the regime eliminated many elements of centralized planning in agriculture and industry and plant managers were given larger freedom to exert their influence\(^{26}\). Ultimately, the largest achievement of NEM was the creation of what was called a “secondary economy” by authorizing the foundation of agricultural associations, the development of local family businesses and even their association with foreign firms. Of course this implied the existence of a private initiative, of personal freedom and taking on entrepreneurial risks, innovative concepts for any of the time’s Communist countries. The magnitude this form of economy had required its authentication in 1979 by Kádár’s régime. It was a brave measure of the leader in Budapest, which in a way helped the population to survive during the economic crisis from the 80s, but which long-term had a corrosive effect on the Communist political system\(^{27}\).

Closely related to the régime’s economic policy was also the condition of women. Employed women represented an important force during the social movements from 1956; some of the

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\(^{27}\) Falk, Barbara. *op. cit.*, p. 117.
first working councils created were organized in predominantly feminine industrial fields, such as textiles or footwear\(^{28}\). Their requests had by no means a feminist character, but a deep social-economic one, with some nationalist hues: national independence and national control of economy, lowering the retirement age for women and men to the same extent, as well as raising the wages of workers with low income, who were mainly women. Beside the abolishment of the tax for those who had no children, women did not raise claims regarding the rigidity of the Rákó régime, for example\(^ {29}\). The new communist leadership would take into consideration all these requests, making the implemented social policy revolve especially around the woman’s social condition. The first two measures with direct impact were raising wages and liberalizing abortions in 1956. Others would also follow.

In fact, the entire conception on the woman’s role in the Hungarian communist society would change radically. The Kádár régime would build a new image of women, highlighting her maternal role. If by now the Stalinism of the ’50s focused on the idea of the working woman who must catch up to men, after 1960 the accent is placed on the differences between genders and on their complementary aspects. The party’s documents describe women as a well-defined and relatively homogeneous social group whose members had abilities, problems, opportunities and a different mission from men\(^ {30}\). As such, the woman did not need to follow the man in the mine, to drive the tractor or to work in the steel works. In a relatively short time women would be excluded from a series of economic sectors, considered predominantly

\(^{28}\) Goven, Joanna. *op. cit.*, p. 117.

\(^{29}\) The characteristics of this reproductive régime will be approached in the below.

masculine. The new gender-segregationist trends were enacted by orders of the Ministry of Labour. A first order from 1962 established that women could not be hired in fields involving sustained physical labour, vibrations or hazard of irradiation. In 1966 this order was amended to more explicit provisions; it listed hundreds of jobs for which women were considered incompatible. Moreover in 1965, the same governmental organism demarcated certain fields of work, especially from the category of services, as being exclusively feminine and opened men’s access to occupy them. All these culminated with the introduction of the legislation regarding the maternity leave (GYES – gyermekgondozási segély) in 1967, and with modifying the Constitution from 1972, which approved by fundamental enactment the new vision of the régime upon women: the expression “equal labour conditions” was to be replaced with “acceptable labour conditions,” thus marking the difference between genders.

In Éva Fodor’s opinion, the vision shift was caused by three important factors: the modification of the régime’s economic priorities; the state’s incapacity to build childcare and education facilities; and the drop of the fertility rate due to the liberalization of abortions. It is not by chance that the new maternity leave was introduced one year before the implementation of NEM in 1968. In the opinion of the party’s economic strategists, the newly coming reforms would decrease the need for labour force. Concomitantly, the work field would welcome the cohorts of young people born during the Ratkó régime, who had just reached adulthood. The coincidence of these two phenomena became quite problematic,

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31 Goven, Joanna. op. cit., p. 177; Haney, Lynne A. Inventing the needy..., p. 104.
32 Fodor, Éva. op. cit., p. 125; Haney, Lynne A. Inventing the needy..., p. 104.
33 Fodor, Éva. op. cit., p. 122.
because the following years were suspected to bring a surplus of working women on the labour market, surplus which needed to be assimilated by the latter. But the government wanted to seed in the same women the inclination for giving birth and raising children. The GYES would thus become an intelligent symbiosis between economic and pro-natalist policies having multiple functions. First, it ensured the maintenance of women within the work field: for three years women would figure as employed, and after ending the leave they could at any moment return to the job they previously held. Second, it attenuated the effect of the demographic mini-boom from the Ratkó years; third, it substituted the deficient policy in the field of building childcare facilities, especially nurseries; finally – at least theoretically – it was associated with other positive financial-economic stimuli in an effort to redress the continuously decreasing fertility rate in Hungary.

The downfall of fertility represented a demographic problem not only for Hungary, but for the entire Eastern Block. Living for a long time under the impression that the demographic winter is a phenomenon typical only for the capitalist world, Communist leaders preferred to ignore this issue at first and focused on the political efforts towards addressing economic discrepancies and “modernizing” the countries of the Block. Two studies of Jerzy Berent from 1970 revealed that it was specifically the industrialization and massive urbanization of population, the increase of the education level, and the woman’s social emancipation that lead to the decrease of the fertility rate and the total fertility rate. The

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34 Goven, Joanna. *op. cit.*, p. 179.
phenomenon was similar in Western Europe, but the rapidity with which it developed in Eastern Europe was a stark difference. In Hungary the fertility rate, with few exceptions, decreased from 12.9 in 1962, reaching the lowest level in Europe\textsuperscript{36}, and the TFR decreased from 2.6 in 1950 to 1.82 in 1965\textsuperscript{37}. If this trend could not be reversed, the effective Hungarian population would diminish. In parallel with the dropdown of the fertility rate, Hungary was also marked by what Libor Stloukal called “the culture of abortion”\textsuperscript{38}: making use of the voluntary interruption of the pregnancy as the first family planning method, a constant of the demographic régimes from the Eastern Block up until the collapse of Communism, being motivated by ideological and politic factors as permanently compared to the Soviet Union. The association of the decreasing fertility rate with the constant increase of the number of abortions (legal or illegal) led to a psychological block within the leaders of all the communist régimes in Eastern Europe, who concentrated their policies around the issue of abortion.

It is also Hungary’s case that in 1953, by a law elaborated by the Minister of Health of the time, Anna Ratkó, abortion was outlawed in Hungary, even for medical reasons. The law was ostensibly designed to end the alarming number of illegal abortions that


ended in numerous complications. The draconian law was framed within the general coercive character of Hungarian Stalinism and manifested through provisioning hard corrections such as imprisonment and the introduction of medical commissions who were to choose the necessity of abortions in serious social and medical cases. The law was clearly pro-natalist, because it also introduced a series of other similar stipulations: improvement of the medical services for pregnant women, social compensations for families with children and multiplying the number of institutions destined to receiving and caring for children, but especially introducing a tax for those who had no children. The immediate effect was dual: the fertility rate increased in 1953 (21.6) and 1954 (23) as compared to 1952 (19.6); in 1955, fertility would decrease again. The year 1954 represented the peak of the increase in the gross fertility rate from the whole communist period. Despite the severity of its establishment, at least in the first two years, the abortion rate did not decrease; this was because the foundation of medical commissions resulted in an explosion of legal abortions. Consequently, the total rate of abortions exceeded the rate of fertility in 1957.

The new liberal legislation elaborated under the influence of the Soviet model would formalize this trend. The only stipulations maintained from the “Ratkó age” were the maintenance of medical commissions with a rather formal role and the prerequisite that the abortion procedure was only carried out by specialized medical personnel. For almost 20 years, the pro-natalist policies

40 Fodor, Éva. op. cit., p. 170.
43 David, Henry P. op. cit., p. 152.
of the communist régime in Hungary did not voluntarily concentrate efforts towards decreasing the abortion rate. It was only in 1973 that harsher legislation was introduced, but this practice was already diminishing following the large-scale introduction of various modern contraceptive methods. Instead of choosing a coercive solution, the leaders in Budapest opted for a less draconian solution: limiting the number of abortions by preventing the pregnancy. It is one of the reasons why medical commissions were dissolved in 1988. The degrading procedural model and the impression of a court that treated defendants as if they were murders or social deviants could represent another reason for which they dissolved these commissions\textsuperscript{44}. However, despite the legality of abortions, most people of the medical corpus had serious reserves concerning this procedure, a reason for which patients who went to the hospital were not treated as special cases: wards were crowded, the medical staffs was scarce, and treatments and medication were often inadequate. Even if from a legislative viewpoint abortion was not condemned, medical institutions--probably under the silent agreement of the authorities--symbolically criminalized this practice.

As a result, the pro-natalist policy of the Communist régime in Hungary did not concentrate on the legislative enactment of access to abortion. Adopting a more elaborated and complex vision, Hungarian leaders chose to social-economically stimulate the maternal instinct by two basic measures: the state allowance for children and the maternity leave (the GYES). The only variables in granting these social benefits were the 1-year of seniority in the work field and the number of children in the family. Actually, the family model promoted by the Hungarian leaders was the average one with two, and a maximum of three children, a concept closely related to the population’s major opinion: following certain polls

carried out in 1958 and 1972, results showed that the number of families who wanted 2 children increased from 49% to 71%.\textsuperscript{45} Beside the number of children, the emphasis of the whole system of social-economic stimuli was placed on giving birth, caring and raising children (Haney 2002, 93). This targeted a quantitative growth, but even better, a qualitative one. The utmost argument in this sense is the very existence of the GYES, which represented the true innovation of the Hungarian régime in the field of pro-natalist policies.\textsuperscript{46}

Initially, this maternity leave provisioned a period of 6 months after bearing the child, during which the mother received her full salary, and in the next 24 months a fixed amount per month, which varied from the city to the countryside. Starting from 1969, the maternity leave gained another 6 months, so that mothers could stay home with their babies for 3 years in total—that is, until the age they could go to kindergartens. Between 1967 and 1972, the level of the indemnification varied between 40 and 60% from the average national salary of women, and since 1973 the indemnification was differentiated according to the number of children: 800 HUF for the first child, 900 HUF for the second and 1000 HUF for the third child or more.\textsuperscript{47} The measure was welcomed by mothers, who fully benefited from this maternity leave (see Tables 4 and 5). Until 1973, over 80% of the eligible mothers chose this form of raising children, totally confirming the régime’s expectations. After 1978, the weak correlation of the indemnification with the rate of inflation diminished mothers’ interest, the reason for which in 1985 the GYES was significantly transformed: following the 6 fully-paid months, mothers could stay home until the

\textsuperscript{45} Klinger, András. “Fertility and Family Planning in Hungary” Studies in Family Planning 8, nr. 7 (July 1977), p. 172.

\textsuperscript{46} Haney, Lynne A. “From Proud Worker...”, p. 120.

\textsuperscript{47} Idem, Inventing the needy..., p. 105.
children were 2 years old, receiving an indemnification of 75% of the income. If they wanted an additional year, they received that fixed indemnification which had been indexed with the rate of inflation. The name of the leave was also changed from GYES to GYED (=gyermekgondozási díj, child care fee). The new type of leave would repair a series of social discrepancies accrued over time by correlating itself to the income gained previously. Women with poor professional education fully benefited from GYES, as it was more financially convenient to stay home and raise their children. Moreover, they could benefit from more leaves, one after another. In exchange, women with better or superior professional training benefited to a smaller extent of the 3 years in full, considering they were losing more financially speaking, as well as professionally.

The government did not need to insist anymore on building nurseries and continuously focused on increasing the absorption capacity of kindergartens. In 1985 Hungary could ensure places for 87.2% of the total number of eligible children (see Table 3), a better percentage than reported around the Eastern Block. In her work, Julia Szalai showed a compromise in this policy between the régime and mothers and their need to work and the state’s demographic requirements: from among children between 1–3 years of age, only 25% were raised in nurseries, with the remaining 75% being raised by mothers, through the GYES. In the second lifecycle (3–6 years), the percentages were somewhat in reverse: 78% of the children were in kindergartens or pre-school institutions, with the remaining being kept home. In the third lifecycle (7–10 years), 66% of the children were institutionalized in day care centers belonging to schools. In these cases, the role of grandparents seems to be the biggest: 7% of them were cared after by grandparents, which shows that the role of the extended family had not been

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extinguished, despite the transformation of the family towards a nuclear type\textsuperscript{49}.

Despite the existence of a coherent pro-natalist policy which, as seen above, comprised the GYES, family allowances, birth gratuities or protective labour legislation, Hungary continued to be confronted with a low fertility rate. The Budapest régime only succeeded two times to establish a consistent increase of fertility and only for a limited period of time. The first time was after the Ratkó law; the second time followed the combined measures from 1974 to restrict abortions and to foster social-economic stimuli, when the fertility and TFRs grew from 15, respectively to 1.95 in 1973, to 17.8, respectively 2.3 in 1974 and 18.4, respectively 2.38. Beside these two peaks, Hungary confronted total fertility rates under the replacement index of 2.1, which resulted from 1981 in a downfall of the general population, a phenomenon that continues also today. As a result, if by definition a pro-natalist policy means the active interest and effort of a government to impose a growth of the population by stimulating the fertility rate\textsuperscript{50}, then it can be asserted that the Hungarian communist régime failed in such initiatives, and one of the possible explanations is the continuous political, social-educational and economic discrimination of women.

We have seen above how the Communist régime issued an entire legislative body meant to ensure women’s emancipation by proclaiming the equality of genders. The measures were revolutionary and allowed for most of the Communist countries to gain positive points in their competition with capitalist ones. However, the liberalization of women was rather on paper than real, and we can best observe this discrepancy in the way how women were

\textsuperscript{49} Ibidem, p. 168.

co-opted in the decisional political process of the régime. Szonja Szelényi, cited by Éva Fodor, had calculated in 1998 that on average women represented 13% from the total Hungarian elites\(^5^1\). In all the 40 years of Communism there was never more than at most one representative of the gender in the Political Bureau or in the government, the main executive decisional institutions. At the Central Committee, a document issued by this entity in 1968 showed that in 1959 – 7 women had been chosen as members, in 1962 – 8, in 1965 – 5\(^5^2\), and in 1974 – 9 members. Never did their number exceed 10% from the total members of the respective political entity. Representativeness was larger within the legislative frame, an organism with no real power of decision in the system; the weight of feminine representatives was sensitively equal to the number of women in the party. At local level, the situation was similar. In 1974, at the level of local and county popular councils the percentage of women deputies was 25.1%, and respectively 30%\(^5^3\). If we refer to leadership positions, only 6.6% of the popular councils were led by women and none of the county councils were similarly represented. These percentages greatly resembled what was happening in two sister-countries, Romania and Poland, where Daniel Nelson cited a range between 23 and 35% of feminine representation in all the local leadership entities\(^5^4\). Regarding public management, a similar trend can be noticed. For instance, even if women formed the majority of teachers in the education system, at the level of school managers they were very poorly represented.

\(^{51}\) Fodor, Éva. *op. cit.*, p. 67.

\(^{52}\) Goven, Joanna. *op. cit.*, p. 190.


At the level of secondary manager, the proportion was similar to representation at the level of professorial board\textsuperscript{55}. Even where they did not constitute an absolute majority, women were led by men\textsuperscript{56}. Thus, it can be noticed that despite the continuous insurances about the equality between genders, the social pyramid was much more difficult to climb for women than for men. The chances of a woman to reach the second place in the hierarchy were quite significant, but it always proved impossible for her to hold the first place\textsuperscript{57}. In what regards the political representation, Nelson and Fischer’s conclusions for Romania and Poland can be extended to Hungary: there was a decrease of the number of feminine representatives from the base upwards (from local to central level), and a larger presence of women in legislative bodies rather than in the executive ones or in the organisms directly concerned with feminine preoccupations\textsuperscript{58}. In other words, the lower the authority of institutions, the larger the chances they are better populated by women. Fodor calls this type of politics as limited inclusion; the necessity to justify the régime resulted in the sufficient representation of women at the average and inferior levels\textsuperscript{59}.

The scarce social promotion of the woman in the public space is owed to a series of circumstances. In the first place, the woman’s household and reproductive attributions represented a real “handicap.” Giving birth, raising and caring for children were incompatible with developing a political/public activity, more so as the majority of meetings and political-civic actions took place

\begin{itemize}
\item \textsuperscript{55} Fodor, Éva. \textit{op. cit.}, p. 67.
\item \textsuperscript{56} Einhorn, Barbara. “Where Have All…”, p. 21.
\item \textsuperscript{57} Fodor, Éva. \textit{op. cit.}, p. 67.
\item \textsuperscript{59} Fodor, Éva. \textit{op. cit.}, p. 63.
\end{itemize}
in afternoons or weekends, periods dedicated to the preoccupations specific to the feminine gender. Already burdened with two duties, it was hard to believe that the majority of women wanted a third one. A second aspect, at least equally important, is the mentality of party leaders who considered that women were unreliable politically speaking, and therefore, so much easier to manipulate. In their opinion, a massive participation of women in the party’s activities would have resulted in its destabilization by weakening its authority.

Surprisingly, women also supported this masculine perspective: politics and implicitly the public space was not a scene for women. The traditional patriarchal vision that asserted the protective and leading role of men in comparison to women also applied to the political/public space and was embraced by both genders. Historically, the woman’s secondary role and status in society placed obstacles in the development of feminism from becoming a self-supporting ideology. Put simply, women never had the necessary power to support their own interests, so that feminism was integrated either into nationalism or into socialism. In turn, Communism assimilated a feminist vision, manifested through its emancipating project; but once this ended, it excluded the possibility that a feminist problematic could exist. In order to ensure this ideological coherence, the Communist Hungarian

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60 Ibidem, p. 83.
61 Ibidem, p. 95.
Women in Communist Hungary, 1947–1989

Party (Magyar Kommunista Párt) united all women’s organizations in 1948 (under the patronage of Magyar Nők Demokratikus Szövetsége [Democratic Alliance of Hungarian Women], founded in 1945) and outlawed all others that were not affiliated to the party. Further, MNDSz was an extremely efficient instrument in the campaign of the régime for integrating women in the work field or in making them aware of their motherly roles. After the 1956 revolution, with the rebranding of the Hungarian Workers Party (Magyar Dolgozól Pártja) – which transformed into the Magyar Szocialista Munkáspárt (Hungarian Socialist Workers Party) – the women’s organization also underwent considerable changes: MNDSz became MNOT (= National Council of Hungarian Women, Magyar Nők Országos Tanácsa), which, as its predecessor, functioned only within the limits set by the state-party. This time, the voice of women’s organization was quieter, its activity focusing more in the cultural area, rather than in the politic or family one.

I chose to begin with women’s discrimination in occupying certain public positions, because this stands as the most obvious aspect of the regime. It is practically the ultimate form of discrimination and probably the most important, because it prevents women not necessarily from making decisions for themselves, but at least from participating to the decisional process that involved them so directly, at least equally as it involves men. We should not forget that there is a demographic balance between women and men within the entire population that is not reflected in the

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political representation structure. The only field where this balance was reached was work: in 1988, 46% of the total active workforce of the country was represented by women. Despite these, there also existed differences in the Socialist work field. First, there was the weak level of women’s qualifications: most of them occupied positions which required an unskilled or semi-skilled level, while men held the highest qualification positions, especially at a technical level. Second, in the realm of career development and through the education system—but also by the force of the general opinion—women were pushed towards certain economic sectors considered of less importance, profitability or consumers of budget resources. Thus, social services (nurseries, kindergartens, homes and asylums), commerce, education, and medical and sanitary systems, light industry (food, textiles) were market sectors for the feminine workforce and became largely feminine themselves, especially after passing the legislation of the ’60s, which forbid women to occupy jobs which could bring on risks for their physical integrity. The prestige associated to these jobs was not very high in comparison to those occupied by men. Even within the predominantly feminine fields, the more prestigious branches or top-management positions were held by men. Examples in this sense could be certain medical fields or higher education, where women represented only 30% from the total university professors.65

The education system plays a determinant role in shaping the direction of a career. Iván Völgyes proved that the existence of stereotypes and the selections made by teachers to push girls towards certain careers66. We must mention from the beginning that the education of most Hungarian young people, male or

65 Haney, Lynne A. “From Proud Worker...”, p. 119.
female, ends at an 8th grade level: in 1980 the percentage was about 70%, but fell towards 1990 to 63%\(^{67}\). At this stage the percentage of girls’ withdrawal from school was permanently larger than boys'. From the total of the remaining, most boys chose vocational schools, while girls chose other forms of education. From these choices, the gendered nature of education took place, because vocational schools ensured specialization and professionalization, and therefore a higher salary and increased promotional chances to economic management positions. In the communist period, high school and faculty diploma weighed about the same in social promotion\(^ {68}\). Moreover, the régime considered the acquired abilities more important than theoretical knowledge. But the gendered selection did not end there: an overwhelming majority of girls who do chose vocational schools preferred the fields described above as being predominantly feminine\(^ {69}\).

Concerning higher education, boys’ proportion in further education was larger than that of girls’, with a trend of continuous growth and of reducing the gap: 0.9% (1960) \(\rightarrow\) 6.9 (1990) for girls and 3.2% (1960) \(\rightarrow\) 8.4 (1990). It is interesting that in 1990, from among the higher-educated employees 12.7% were women, as compared to 11.9% men\(^ {70}\).

The numbers above show that there was a constant growth of the educational level of the youth during the Communist years, especially in what concerns women’s education, but the system pushed them on purpose towards earning less than men. And this took place despite the legislation that stipulated the equal remuneration of women and men. The labour market needed a qualified workforce and rewarded it as such; therefore women


\(^{68}\) Fodor, Éva. op. cit., p. 78.


never earned more than men even when occupying the same positions. In the '60s women earned around 65% from men’s income, in 1972, this grew to 69%, so that in 1977 it stabilized to 72% until in 1989. In 1976, qualified women received 71% of the salary of their male colleagues, semi-qualified women received 73%, and the unqualified ones 76%. The situation was slightly better in management fields, where women could earn up to a maximum of 82% from what men earned. Overall, women’s salaries were lower than men’s (see Table 6), with the best paid feminine sector being services toward the end of the regime. A disturbing difference presented by Julia Szalai shows that better-educated white-collar women tend to have relatively lower incomes than blue-collar men. The very low quantum of women’s salary was disturbing, and served as the background of the crisis that occurred in Hungary as what the author called “the feminization of poverty”. For instance, during 1979–81, between 78–91% of women earned a salary under 4000 HUF, while men’s percentage was anchored between 41 and 58%. In the ’80s, the minimum threshold of poverty was lifted to 2600 HUF monthly income, as compared to the 1600 from the end of the ’70s; 28% of the population earned below this threshold (see Table 7). Poverty, although it didn’t exist ideologically or on paper, was step by step filling the Hungarian communist society, and the most affected by this trend were women.

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72 Haney, Lynne A. “From Proud Worker...”, p. 119.
74 Ibidem, p. 155.
The economic crisis that worsened after 1977, the increased social inequalities – as a result of Kadar’s reforms – and the growth of the second economy had significant effects on the condition of women in the last decade of communist Hungary. Women’s income, both obtained from work and those derived from social policy, increasingly diminished, mainly due to galloping inflation. As a result, they began to get more and more involved in the second economy, especially women who had the necessary expertise. Most of the others preferred to stay home to raise their children and help their husband, who now also had two jobs: one at the state and the other in the private sector, which rounded the family revenue. We can see an opposite trend than the one in the first period of the communist regime: the withdrawal of women in the household, as a housewife or as a family business manager. This trend was encouraged by the post-communist transition of the 90s when women thickened the unemployment rates and their proportion of involvement in the public sphere reached historical minimums since 1945.

In conclusion, women’s emancipation policy evaluation is a process with many facets. We cannot deny the regime’s success in terms of political and economical integration, as well as educational attainment. Likewise, coupled with a demographic policy, the emancipation process led to the development and implementation of a quite coherent social policy, whose failure is due to economic or social contexts. The two coordinates of this policy, labour and childbirth, were reflected best in a survey conducted by authorities in 1989. According to it, 70% of women surveyed believed they should work and 77% desired to have a family and children. This survey, as far as the data are real and can be credible, shows that at least in the perception of the female population, the emancipation

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policies of the Communists were successful. However, this “lib-
eration” process was marked by a series of ideological and mental
obtuseness that perpetuated a patriarchal tradition and prevented
a better distribution of gender roles between male and female. The
consequence was the insufficient real freedom of women in public
life, and their continuous negative discrimination in the field of
work, their remuneration, and even household duties. Also, it must
be said that empowerment of women in the communist period was
not due to a purely feminist vision, but rather was the result of
certain requirements, especially political and economic. This is the
reason why the whole emancipation process occurred from the top
down and not as it was normal, from the bottom up.

Table 2: Trends in the Delivery of Childcare: Nurseries, 1951–1989 (acc. to
Szalai, 1991, 164)

<table>
<thead>
<tr>
<th>Year</th>
<th>Nurseries</th>
<th>Places in nurseries</th>
<th>Children in nurseries</th>
<th>Ratio of crowdedness (ratio of children per 100 places)</th>
<th>Number of children attending nurseries as percentage of population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of units</td>
<td>Rate of Growth</td>
<td>Number of units</td>
<td>Rate of Growth</td>
<td>Number of units</td>
</tr>
<tr>
<td>1951</td>
<td>256</td>
<td>100</td>
<td>8 433</td>
<td>100</td>
<td>7 268</td>
</tr>
<tr>
<td>1955</td>
<td>683</td>
<td>267</td>
<td>25 243</td>
<td>299</td>
<td>23 466</td>
</tr>
<tr>
<td>1960</td>
<td>816</td>
<td>319</td>
<td>29 436</td>
<td>349</td>
<td>31 970</td>
</tr>
<tr>
<td>1965</td>
<td>952</td>
<td>372</td>
<td>35 184</td>
<td>417</td>
<td>40 864</td>
</tr>
<tr>
<td>1970</td>
<td>1044</td>
<td>408</td>
<td>40 010</td>
<td>474</td>
<td>41 771</td>
</tr>
<tr>
<td>1975</td>
<td>1132</td>
<td>442</td>
<td>49 986</td>
<td>593</td>
<td>55 371</td>
</tr>
<tr>
<td>1980</td>
<td>1305</td>
<td>510</td>
<td>64 502</td>
<td>765</td>
<td>69 768</td>
</tr>
<tr>
<td>1985</td>
<td>1293</td>
<td>505</td>
<td>68 274</td>
<td>810</td>
<td>53 970</td>
</tr>
<tr>
<td>1988</td>
<td>1146</td>
<td>448</td>
<td>60 312</td>
<td>715</td>
<td>44 362</td>
</tr>
<tr>
<td>1989</td>
<td>1096</td>
<td>428</td>
<td>56 460</td>
<td>670</td>
<td>42 870</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Kindergartens/Preeschools</th>
<th>Places in Kindergartens/Preeschools</th>
<th>Children in Kindergartens/Preeschools</th>
<th>Ratio of crowdedness (Ratio of Children per 100 places)</th>
<th>Number of children attending Kindergartens/Preeschools as a percentage of population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of units</td>
<td>Rate of Growth</td>
<td>Number of units</td>
<td>Rate of Growth</td>
<td>Number of units</td>
</tr>
<tr>
<td>1952</td>
<td>2072</td>
<td>100</td>
<td>99 398</td>
<td>100</td>
<td>130 056</td>
</tr>
<tr>
<td>1955</td>
<td>2503</td>
<td>121</td>
<td>129 344</td>
<td>130</td>
<td>145 948</td>
</tr>
<tr>
<td>1960</td>
<td>2865</td>
<td>138</td>
<td>162 282</td>
<td>163</td>
<td>183 766</td>
</tr>
<tr>
<td>1965</td>
<td>3227</td>
<td>156</td>
<td>185 768</td>
<td>187</td>
<td>189 372</td>
</tr>
<tr>
<td>1970</td>
<td>3457</td>
<td>167</td>
<td>208 647</td>
<td>210</td>
<td>227 279</td>
</tr>
<tr>
<td>1975</td>
<td>4077</td>
<td>197</td>
<td>295 722</td>
<td>298</td>
<td>329 408</td>
</tr>
<tr>
<td>1980</td>
<td>4690</td>
<td>226</td>
<td>385 533</td>
<td>388</td>
<td>478 100</td>
</tr>
<tr>
<td>1985</td>
<td>4823</td>
<td>233</td>
<td>413 803</td>
<td>416</td>
<td>424 678</td>
</tr>
<tr>
<td>1988</td>
<td>4772</td>
<td>230</td>
<td>402 424</td>
<td>405</td>
<td>393 735</td>
</tr>
<tr>
<td>1989</td>
<td>4748</td>
<td>229</td>
<td>390 871</td>
<td>393</td>
<td>392 273</td>
</tr>
</tbody>
</table>

Table 4: Use of the GYES as a percentage of those eligible (acc. to Szalai, 1991, p. 167)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>75.6</td>
<td>76.6</td>
<td>81.8</td>
<td>83.1</td>
<td>88.9</td>
</tr>
</tbody>
</table>

Table 5: Use of the Gyes by level of schooling (percentage of those eligible) (acc. to Szalai, 1991, p. 167)

<table>
<thead>
<tr>
<th>Primary school</th>
<th>Vocational Training</th>
<th>Secondary School</th>
<th>Higher Education</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>84.3</td>
<td>88.5</td>
<td>83</td>
<td>68.7</td>
</tr>
<tr>
<td>1986</td>
<td>88.6</td>
<td>89.2</td>
<td>88.8</td>
<td>81.8</td>
</tr>
</tbody>
</table>

Table 6: Women’s average monthly wages in the nonprivate spheres of the economy as percentages of those of men in 1989

<table>
<thead>
<tr>
<th></th>
<th>Blue-collar women</th>
<th>White-collar women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industry</td>
<td>64.5</td>
<td>52.1</td>
</tr>
<tr>
<td>Construction</td>
<td>65.2</td>
<td>55.6</td>
</tr>
<tr>
<td>Agriculture</td>
<td>67.7</td>
<td>54.8</td>
</tr>
<tr>
<td>Transportation</td>
<td>69.5</td>
<td>56.7</td>
</tr>
<tr>
<td>Trading</td>
<td>76.2</td>
<td>66.8</td>
</tr>
<tr>
<td>Services</td>
<td>75.8</td>
<td>64.2</td>
</tr>
</tbody>
</table>
CONTROLLING AND CONSTRAINING. THE PROHIBITION OF ABORTION IN 1980’S ROMANIA

FLORIN S. SOARE

No initiative (whether critical idea or a cry for help) may be proposed by an engineer, an economist, agricultural engineer: there is no point, it is a waste of time; one might as well put nails in one’s head. All changes comes from above, under the form of orders, decrees, laws; power orders, not even the displeased groans of the ministers reaching its ears¹.

(Ion D. Sirbu)

The subject of birth policy in the contemporary states is a controversial and at the same time, well-covered topic by the western historiography. Complex interpretations were proposed in order to analyze the phenomena, which go beyond the religious and institutional spheres, toward a structural analysis of the political-ideological, economic and social motivations of the modern state.

¹ Ion D. Sirbu, Jurnalul unui jurnalist fără jurnal [The Diary/Journal of a Journalist without a Journal], vol. 1, Craiova, Scrisul românesc, 1991, p. 239.
intervention of the state, motivated by the interests stated above, manifests itself in the intention of transforming the ethnic and demographic structures and those of individual and collective control. Whether we speak of totalitarian or democratic regimes, the demographic policies of the 20th century manifest themselves through the creation by the state of certain mechanisms and institutions which aim to positively or negatively influence the natural movement of the population. Although extremely controversial, the extreme measure of banning abortion, as an attempt to raise the level of fertility represented the key measure of the pro-birthrate policies of the past century.

The demographic legislation of Romania must not be understood as a typical component of communist ideology. The type of legislation initiated in Romania after 1966 does not resemble any other state’s in Eastern Europe. The uniqueness of the Romanian case comes from the coercive character of the measures adopted by the political leadership of the country, centered on the idea of raising birthrates by any means, without taking into consideration the opinions of specialists of the field, potential side effects, the lack of promotion, and even the prohibition of modern contraception and sexual education in order to prevent abortion and without a minimal infrastructure which would have sustained such an attempt.

Although the inauguration of the demographic policy was done via the adoption of a restrictive measure, the first period between 1966 and 1973 is characterized by a prevalence of initiatives to stimulate population growth (children’s grants, birth prizes, maternity leaves, various benefits for large families), coercive measures serving more as a warning example. In 1972, as a consequence of the numerous reports coming from medical personnel, but also as an attempt at synchronization to international demographic conventions, the 53rd Decree was adopted, which set the minimal age for legal abortion at 40 years.
After a spectacular evolution in the first year (27.4‰ in 1967 in comparison with only 14.3‰ in 1966), birthrates decreased once again, determining the authorities to harden the measures, by the revision of the application instruction to the 770th Decree of 17th of January 1974. These modifications addressed the heightened involvement in the monitoring and control of medical cadres, the militia and the prosecutors in the process.

The 1980’s in Romania may be seen as the high age of restrictive measures in demography, concreted through the modification of legislation, but also through a toughening of societal control, the growth of the attributions of repressive institutions, the transformation of certain institutions of the state in surveillance and control instruments, all this on the backdrop of the worsening economic problems of Romania, and the drop in living standards. The last decade of the communist regime in Romania is one characterized by the megalomaniacal tendencies of Ceaușescu’s regime, and the omnipresence of the cult of personality, visible also at the level of the demographic policies. The simplistic view on the problem of birthrate, the dogmatism and lack of forward thinking grew to paroxysm. If until the 1980’s the initiative and actions which favored the growth of childbirth were melded with stimulatory measures, in the 1980’s and mostly in the second half of the decade, the entire attention of the political sector was directed toward the question of abortions, pro-birth policy becoming synonymous with the limitation of them. The Superior Sanitary Council was transformed, and was assigned in 1983 to take the role as the primary instrument responsible for the implementation of the party’s vision on issues of demography.

The 1984–1989 period may be seen as the most restrictive stage of the pro-birth policy in Romania, through the toughening of the anti-abortion legislation, the strengthening of the surveillance and control mechanism of the population and the most
dramatically, through the direct and indirect victims of these policies; the deaths of mothers and children, the growth of the number of unwanted children, abandoned in orphanages, born with malformations, hereditary diseases, the spread of AIDS among institutionalized children, the physical and emotional traumas of women. The end of the communist regimes revealed all these problems, which shocked the western world.


If behind the decision from 1966 of banning abortions was a necessity of stopping the downward turn of population growth, the action being legitimized and sustained by propaganda means as a form of protecting the women’s health, after 1973–74 the ideological factor appeared to have gained more ground, on the backdrop of so-called “national Stalinism”. The portraying of woman as mother, wife, and worker was ideologically inspired by the model applied by Stalin since 1936, used and exploited by the Romanian propaganda through the intense promotion of Elena Ceaușescu’s role model.

The 80’s bring to the fore the concerns of the political leadership towards the decrease of birthrate, fact which was

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jeopardizing the very development of the socialist construction. The Social-Economic development plan of the country was approximating a population growth of 25 million for the year of 1990 and 30 million by the year 2000\(^4\). Moreover, at the 13\(^{th}\) Congress of the RCP, the communist leader estimated at 23.4–23.7 million scale of population by the end of the 5 year-plan from 1980–1985\(^5\). The numbers were however far from reality. According to a secret report of the Central Statistical Directorate, in March 1983, Romania had a birthrate of 15.8‰, compared to 17.3‰ of the previous year and a negative growth rate of 5–6%\(^6\). In July the 1st of 1985 the population of Romania reached the number of 22,724,836 inhabitants, with almost a million less than estimated. The demographic predictions were also worrisome: the decrease of child birth rates was estimated to grow as a consequence of reaching the maximum fertility rate of women born in the interval 1957–1966\(^7\).

The Session of the Political-Executive Committee of the C.C. of the R.C.P. from 26 April 1983\(^8\) represented an important moment which we may consider the debut of the process of strengthening of anti-abortion legislation, which culminated with the modification

\(^4\) Programul Partidului Comunist Român de făurire a societăţii socialiste multilateral dezvoltate şi înaintare a României spre comunism [Programme of the Romanian Communist Party for the building of the multilaterally developed socialist society and Romania’s advance toward communism], Bucureşti, Politică, 1975, p. 92.

\(^5\) Nicolae Ceauşescu, Raport la cel de-al XII-lea Congres al Partidului Comunist Român [Report on the XII Congress of the Romanian Communist Party], Bucureşti, Politică, 1979, p. 46–47.

\(^6\) Arhiva Ministerului Sănătăţii (AMS) [Ministry of Health Archive], Fund Cabinet 1, File 4/1982, unnumbered.

\(^7\) Period with a sharp decrease in the number of births.

\(^8\) The Session of the Political-Executive Committee of the Central Committee of the Romanian Communist Party, Scânteia, year LII, nr. 12651, Wednesday 27 April 1983.
of Decree 770 of 1985. Beginning with this period, we may speak of a pro-birth policy which was mostly coercive, and meant to supplant the stimulatory measures, due to the worsened economic situation. According to the schematic vision of Nicolae Ceaușescu on the demographic issue, a growth of the number of births could have been obtained only by constraining the population. Abortions were once again responsible for the decline in population numbers, the causes being rather ignored, while the measures adopted were mainly concentrating on handling the effects. The Ministry of Health followed the orders given by the political leadership and organized a number of measures in the April-August period meant to combat abortions and harden restrictions:

1. the revision of the composition of all commissions which oversaw abortions and supplant them with specialists who have proven through their activity their professional credentials, correctness and principled behavior;
2. the permanent control over the manner in which the legislation toward abortion is adhered to in medical units, with special attention given to the circuit of distribution of abortion kits, in order to prevent abusive use of therapeutic abortion;
3. limiting the medical criteria which authorized abortion
4. the reduction of the number of medications which could have been prescribed to pregnant women;
5. controls of the militia and prosecutor to track down abortion hubs;
6. the reduction, in each county, of maternities in which legal abortions could be carried out;
7. gynecological examinations on all women who are admitted to hospitals, in order to discover gynecological afflictions and pregnancy;
8. gynecological examinations, within the periodic medical control of women in the production sector, especially of the 20 to 30 age group.

Convinced by the lack of efficiency of the Ministry of Health in solving the problem of birthrate, the communist leader decided to revitalize and actively involve the Higher Sanitary Council in demographic policy. Between 1983 and 1989 the Council became the main element of the demographic policy, an instrument of coercion and control in the hands of the party, which exercised full control over matters of health and demographic policy, beginning with the ministry, to the sanitary directions and ending with sanitary units, even in the small villages, objectives stated by Ceaușescu in the inaugural session of 1975.

Alexandrina Găinușe, vice-prime minister of the government was named as the head of the Council. This was the moment

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9 Measures taken by the Ministry of Health to increase the birth rate and reduce the number of abortions after The Session of the Political-Executive Committee of the Central Committee of the Romanian Communist Party 26 April 1983, AMS, Fund Cabinet 1, File 7/1983, unnumbered.

10 Cuvântarea tovarășului Nicolae Ceaușescu la încheierea lucrărilor de constituire a Consiliului Sanitar Superior [Nicolae Ceaușescu’s speech at the conclusion of the Superior Health Council constitution, Scânteia, no. 10323, October 26, 1975.

11 Of profession worker, graduate of the History Faculty and Superior School of the Party “Ștefan Gheorghiu”, has a fulminate ascension within the party with the help of Elena Ceausescu, firstly occupying the office of prime-secretary of the District County Committee – Bacau, vice-president of the Counsel of State and vice prim- minister of the government (21 of May 1982 – 7 of May 1986); see Central Historical National Archives, Fond Comitetul Central al Partidului Comunist Român (ANIC, CC al PCR), Secția Cadre, [Central Historical National Archives, Bucharest, Fond Central Comate of the Romanian Communist Party], File G/990, ff. 127–128; şi Dobre Florica, op. cit., p. 282.
in which the National Demographic Commission\textsuperscript{12} was relegated into a secondary position; research in this field was deemed useless, due to the proposed strategies which proved to be ineffective.

The total involvement in demographic issue of the Council came after the emission of the presidential decree 210/1983\textsuperscript{13} and a long plenary session of the party, with the participation of Nicolae Ceaușescu\textsuperscript{14}. The first document produced in collaboration with the Ministry of Health was a \textit{Plan of measures meant to promote the growth of birthrate and to secure the steady growth of population}; the plan was drawn up by the General Assembly of Romanian Trade Unions, The National Council of Women, The Communist Youth, the National Council of the Red Cross, the Education and Teaching Ministry, the Ministry of Agriculture and Food Industry, the Ministry of Chemical Industry, the Ministry of Internal Commerce and the National Commission of Demography\textsuperscript{15}.

The document is a heterogeneous amalgam of restrictive measures, concentrated upon effects and not causes, with the central element of combating abortions. Changes may be observed even in the style of the official documents, “the stimulation of births” as replaced with “growth of births”. The document of September 24th 1983 molds itself to the order of the communist leader who asked

\begin{footnotesize}
\begin{enumerate}
\item Until 1983 the role of control instrument, coordination and legitimating the demographical plans of Ceaușescu’s regime was assured by CND, an extreme politicized institution, but which found resources for attenuating the effects of the legislation initiated in 1966. Once the pro birth rates started to decrease at the beginning of the 80s, the result was put also on the shoulders of CND’s inefficiency, the instution being rather marginalized, its role being given to CSS.
\item The Presidential Decree no. 210 /1983 for approval of the Superior Sanitary Counsel’s composition, in ‘Official Bulletin”, no. 61 from 10 of August 1983.
\item Extended Plenary of the Superior Sanitary Counsel organized in 18 of August. AMS, fond Cabinet 1, File 22/1982, unnumbered.
\item AMS, fond Cabinet 1, File 7/1983, unnumbered.
\end{enumerate}
\end{footnotesize}
for the development of a program of measures for the growth of births, which should be well thought-out, with bold objectives\textsuperscript{16}.

Structured in 5 main points, it proposed, in the ad-hoc style of the 5 year-plan, the reduction by 30\% of the number of abortions, the betterment of medical assistance given to pregnant women and the supervision of the evolution of pregnancy, assuring the health of the women, the reduction by 8\textendash{}10\% of the rate of child mortality and the education of the population toward the growth of births\textsuperscript{17}.

The excess of zeal of the authorities was proven by the complex actions which comprised gynecological examinations, for 50\% of the working women, in the first three months of 1983. The rest of the women should have been examined by the first trimester of 1984.

Although it was meant to be a complex assembly of measures meant to boost child births, none of the 40 points referred to the stimulation of families through social measures.

The introduction into manufacture of juices and fruit and vegetable products destined for pregnant women and children; the diversification of the Gospodina line of products, and the organization of more distributions centers for them, in the idea of making the work of women easier, and freeing up some of their time, that they should devote to the rearing and education of children; the production of clothes and shoes for children, light, comfortable and hygienic\textsuperscript{18}.

Voted on by the enlarged plenary session of the RCP, the program of measures constituted just one of the pillars of the pro-birth

\textsuperscript{16} AMS, fond DCCPI, File 24/1981, unnumbered.
\textsuperscript{17} AMS, fond Cabinet 1, File 2/1983, unnumbered.
\textsuperscript{18} AMS, fond Cabinet 1, File 2/1983, unnumbered.
policy of the 1980’s, which was followed up by three subsequent essential documents, the 489/1983 Instructions and the CPEx. Decision of March 3, 1984 and the 411/1985 Decree.

The Instructions 489/1983 concerning the applications of the Decree 770/1966

The Ministry of Health conformed itself with the Decision taken by CPEx. from 26th of April 1983, at the same time with the emission of the new Instructions concerning the application of the Decree 770/1966. These included the removal of the representative of the prosecutor’s office from the competence of the medical commissions which decided legal abortions and substituted him with a representative of the Ministry of the Interior, who received a fundamental role in demographic policy.

Perhaps the most controversial modifications made were that of limiting medical circumstances for abortions to a number of ailments and diseases based on “strictly scientific” criteria, for diseases with hereditary transmission, the diagnostic being given by university centers with genetic laboratories.

The Instructions were completed by the Order no. 473/1983, which brought new criteria (more restrictive) of “solving incomplete abortions”, of “diagnosing and reporting

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19 AMS, fond Cabinet 1, File 22/1982, unnumbered.
20 According to no 1446/C/1298/1983 Prosecutor’s Office of RSR was stating the fact that “the representative of the prosecutor’s office, given his profession cannot be member of a medical commission”. See AMS, fond Cabinet 1, File 22/1982, unnumbered.
21 Order no. 473 from 9 of December 1983 concerning the approval of certain technical norms for improving the medical assistance of the pregnant women, AMS, Fond Ordine M.S., File 5/1983, f. 128.
the state of gestations” and “technical norms of solving caesarian sections”22.

**The Decision of the Political Executive Committee of the C.C. of the RCP of 3rd of March 1984**23

The CPEX. session from February 24th 1984, and its final product, the Decision, are important as evidence of the rudimentary understanding of the population of the final 5 year plan, which heralded the failure of the entire communist demographic program, with consequences reaching into the present.

The meeting brought forward a change of view about the responsibilities for the situation of pro-birthrate, “the doctor” being considered by the authorities as the main culprit for the low number of births, a true “saboteur” and an internal enemy for nation’s future. Among the guests was Eugen Proca24—the minister of Health, Olimpia Solomonescu25, the president of the National

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22 The Caesarian interventions were made only in strict circumstances, this justification of this measure going in the same direction with the limitation of abortions. According with the norms, only after 3 operations of caesarian, the woman had the right to have an abortion.


Demographic Commission and Ilie Şalapa— the director of the Central Statistical Direction.

The new type of servility that characterized the members of the CPEX in this period is to be noted, Alexandrina Găinușe, the vice-prime minister of the government being a typical example of the type of party staff whose interventions in the sessions served no other role but that of whole-heartedly supporting the statements of the leader: “responsibility must be great, and the activity of the physicians must be appreciated according the number of births, according to the way in which they contribute to the growth of births.”

Ceaușescu supported, without practical evidence, the reversal of the relationship between abortions and pro-birth, placing the whole responsibility upon the activity of the medical personnel:

„the activity of the physician must be appreciated according to how many births he has, not after how may abortions, the more he has of these, the more his activity must be deemed unsatisfactory (…) The main cause is that doctors have made abortions a source of income on the back of the population and the country and doctors such as these must be sanctioned, and their rights to practice lifted. We must put an end to these irresponsible people who should not practice medicine.”

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26 Ilie Şalapa – President of the Commission for Industrial and Economic-financial activities; General director of the Central Direction of Statistics; general director of the Central Institute for Economic Researches; from January 1975 fulfilled the function of editor of the al weekly Economic Magazine. (see The Council of Ministers, State Council, and National Assembly after The Elections HU-OSA, Rumanian Unit, RAD Background Report/62, Box 52, File3, p. 80).

27 ANIC, Fond C.C. al P.C.R., Sectia Cancelarie, File No. 12/1984, p. 29. 28 Ibid.
He is supported in his claims by Elena Ceaușescu: “there are only a few counties in which births have declined drastically. Why? This means that abortions are practiced more in big cities, where there are more doctors and they perform them.”

The objective outlined was a clear one: “we had a 220,000 natural growth in 1975 and arrived at 87,000 (...) we must come back to the growth of 1975, of over 200 thousand yearly.” His strong position was to be reflected in a document which highlighted the conceptions which were at the basis of the demographic program, of the last and most harsh period of the Ceaușescu project:

“...due to the abortions the number of births is small. We must look in the right direction for the reasons. (...) I ask that the Higher Sanitary Council may be called together, so that I may have a talk with them, and the heads of the Ministry and make order and in each county we should discuss the way in which we can put an end to this state of affairs, because these 420,000 abortions are inconceivable, when in 1975 we had 350,000.”

The Decision of the CPEX. of the C.C. of the RCP, put together on the indication of the general secretary, was published officially in March 3rd, 1984. According to this document, the institutions

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29 Ibid., p. 31.
30 Ibid., p. 32.
31 Ibid., fila 29.
32 Decision of the Political Executive Committee of PCR regarding the growing responsibilities of the organs and organizations of the party and the medical-sanitary of the cadres for accomplishing the demographic policy and assuring a suitable coefficient of the population, 3 of March 1984. In ‘Official Bulletin of RSR’, part 1, year XX, no. 18, 3 of March 1984; see also ANIC, Fond C.C. al P.C.R., Secția Cancelarie, file Nr. 12/1984, pp. 69–72.
considered to be responsible for the failure to carry out the objectives of “strengthening of family and the growth of pro-birth” were: the popular councils, the Ministry of Health, the county sanitary directions and the sanitary direction of the municipality of Bucharest, but also the county committees of the party and other organs of the party, mass and cultural organizations, which did not exercise a strong and permanent control on the activities of the sanitary organs (...) to combat and hold the abusive and unjustified practices concerning abortions. Illegal abortions were catalogued as antinational and antisocial actions, which stunted the normal development of our people.

The document outlines in 11 main points the most important tasks given to the party organs and organizations and to the medical staff. At the end of the Decision, according to the usual lofty language of the party, an appeal is given to the population, who must:

“Understand that the insurance of the normal demographic rise of the population represents a highest honor and patriotic duty to each family and for the entire people, which has always prided itself with long-lasting families, with many children, which they raised with love, thereby ensuring the vitality, youth and vigor of the entire nation. Even more so, today, we have the high duty to provide the country with newer and newer generations who shall contribute to the flowering of our socialist nation, to the triumph of socialism and communism in Romania.”

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34 Ibid.
35 Ibid.
Table no. 1. Plan of measures established through the Decision of the Political Executive Committee of the CC of RCP for the growth of the responsibility of party organs and organizations, state organs and medical-sanitary cadres to realize the demographic policy and ensuring a suitable development of the population, of December 1984.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. County Committees</td>
<td>– Debates on the evolution of demographic phenomena and establishment of measures and responsibilities for each county</td>
</tr>
</tbody>
</table>
| B. Party organs and organizations | – the application of laws and regulations concerning abortions;  
– the strengthening of control over the manner in which medical units ensure the healthy stays of the woman, the supervision of the pregnant woman, medical assistance in the delivery, the normal development of the infant and the child |
| C. The Ministry of Health and the county and Bucharest sanitary directions | – a special organ of the state, which bear the entire responsibility for the application and observance of the laws concerning the normal and suitable growth of the population.  
– controls for the location and analysis of the causes determining the decline in childbirths.  
– measures for the limitation of abortions  
– sanctions for all cadres responsible for abortions  
– the perfecting of the activity in the maternal-infant sector |
| D. Party, mass and cultural organs and organizations, County, Municipal, City and Communal Committees | – Attributes in matters of patriotic, moral and citizenship and sanitary education  
– organizes debates on matters of stimulation of marriages, strengthening family. |
<table>
<thead>
<tr>
<th>Institution</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. The Union of Communist Youth, The National Council of Women, The General Assembly of Trade Unions, The Red Cross Society</td>
<td>– organization, at county, municipal, city and village level, of actions for the recognition and publication of the measures taken by the socialist state for the protection of mother and infant, the strengthening of the role of the family, the formation among youth and workers of a healthy opinion of marriage, family and society.</td>
</tr>
<tr>
<td>F. Central and local press, radio and television</td>
<td>– the organization of programs and special bulletins, of large debates on the problems and the measures which are imposed for the growth of births, development of family, the nurturing and education of children</td>
</tr>
<tr>
<td>G. The National Demographic Commission</td>
<td>– responsible for the observance of the measures established by the party and state leadership for the phenomena involving the population – periodically analyze the demographic indicators – proposes measures for the betterment of them</td>
</tr>
<tr>
<td>H. The Superior Sanitary Council</td>
<td>– periodically analyzes the evolution of demographic phenomena – establishes measures and concrete tasks for the betterment of activity in the medical-sanitary field (the guarantee of the healthy status of the population and the growth of births)</td>
</tr>
</tbody>
</table>


The results of the new rules were to be analyzed after a year at the Session of the Political Executive Committee of the CC of the RCP on the 15th of February 1985\textsuperscript{36}. The Report concerning

the evolution of the population and the principal demographic phenomena of 1984 was presented by Alexandrina Găinușe, in her quality of the president of the Superior Sanitary Council. What evidently displeased the party leadership was the still high numbers of requested abortions (approx. 300,000), Romania being placed number one in Europe. Compared to 1984, their number decreased by 118,263, but it was still insufficient to give a birth rate of 18–20%, as outlined by the CPEx session of February 1984.

The numbers concerning maternal and infant mortality rates were ignored. The only person who raised the problem of mortality at childbirth was the son of the General Secretary, Nicu Ceaușescu, but his questioning of the problem remained unanswered. Nicolae Ceaușescu admitted the situation of infantile mortality, but for the communist leader the abortions primed: “Surely, the number of the deceased children under a year is high, but the real problems remain the abortions.”

The entire demographic policy undertaken in the 1966–1989 period, but mostly in the 80’s represents the clearest manifestation of the “policy of numbers”, the sole and most important aspect being the report of positive numbers to the leadership. The manner in which the problem was approached, the type of discourse underlines this fact. Alexandrina Găinușe communicated to Nicolae Ceaușescu, during a session of the CPEx that: “we are speaking with comrade Pacoste, and he reports that he is missing only 72 children to reach the positive report in 1985.”

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37 Ibid, f. 12.
This situation was prevalent not only in this field, but in all sectors of planned activity. The reporting of positive indicators of nativity became synonymous with holding onto the appointment to office.

The perseverance with which those who were politically responsible brought fore the problem of “the education of the population in order to obtain a growth in births” represented, at the same time, the division between the great mass of citizens and the privileged category of the nomenclature. There existed a political leadership incapable of understanding the fact that limiting the number of births within one family is not the consequence of a certain type of mentality, which could be influenced by education and propaganda, but generated by the insufficient primary resources of the individual: food, shelter, security and so forth. The lack of results of the “educational” activity of the masses was undoubtedly evident and could have easily been anticipated. We may then see the demographic propaganda from the perspective of an attempt at legitimation of the restrictive measures which were imposed.

The type of planned economy, which had a 5 year model of demographic plan, impeded the development of a coherent long-term strategy. In this situation the communist authorities activated “the backup plan”, which had given positive results in 1966 and 1974 (albeit on a short term basis, but enough to meet the quota set up by the leadership): the heightening of the restrictions provided in the legislation.

For the first time after 1972, the problem of a new modification of the 770/1966 Decree was circulated; it meant a reversion to the minimum age of 45, which a woman had to have in order to request a legal abortion. The measures proposed by Nicolae Ceaușescu were more restrictive, when compared to those of 1966; he requested, within the same CPEx. session of February 24th, the modification of the part of the law which permitted women to
have an abortion, if she had given birth or already had 4 children in her care:

„The number of over 300,000 abortions is high, only 29,000 are medical, women over 40 23 thousand, 125,000 cases of women having over 4 children and another 125,000 by other reasons is without any justification, even when the women have over 4 children. There is a law for these situations but we must modify it (…) modify the current regulated and instead of 4 children, abortion to be made legal for women with 5 children.40”

The same issue is brought up in the CPEx. session of August 3rd of 1985, when the Secretary General stated strongly: “women with 4 children can have the fifth.41” The problem was posited even more strongly on the backdrop of the rising number of abortions, and birth rates having a positive rate of only 1.3%, compared by the minimum projected rate of 5%. Nicolae Ceaușescu showed himself as being extremely displeased with the situation: “I see, comrades, that the number of abortions in June has already increased by 4000, when compared to the same period of last year, which means that scrutiny has decreased, there is anarchy yet again.42”

In the established pattern of the modification of legislation and political moves, the Minister of Health was changed. Eugenia Proca was substituted for Victor Ciobanu (29th of March 1985-22 December 1989), who was put in charge of fixing the situation: “I assure you that we will take all measures and I pledge that I will

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42 Ibid., p. 44.
bring you better results.” Following the line set by the Secretary General, he reaffirmed the necessity of harsher application of the anti-abortion legislation through the stronger implication of the control and surveillance institutions: “we shall appeal to the organs of the Ministry of the Interior to trace the hives still in existence, the criminal elements”\textsuperscript{43}.

The balance sheet of 1985 was analyzed in the CPEx. session of December 16th, during which propositions for the “perfecting” of anti-abortion legislation were advanced and adopted\textsuperscript{44}.

Aware of the impossibility of halting the phenomena of clandestine abortions, Alexandrina Găinușe proposed (supported by Ceaușescu) that women brought in bad condition to the hospitals “pay a tax, because large sums of money are spent by the state to save them.”\textsuperscript{45}

Birth rates reach 15.3% in 1985, which represented a growth of only 0.3%. Without understanding the fact that drop in birth rates is a general European phenomenon, present in all western or eastern states, the communist leader proved to be again extremely critical, venting his anger primarily against doctors: “those who continue to approve abortions (…) must be replaced and fired.”\textsuperscript{46}

It is clear that the percentages of child births and natural growth of population put forward by him, 20–22%, and 9–10%, respectively, were though to realize, especially in the conditions that all European states (with the exception of Albania) were far from these figures. Only the USSR approached a birth rate of 19.8%. The rest of states had an average birth rate of 12–13\%\textsuperscript{47}.

\textsuperscript{43} Ibid.
\textsuperscript{44} ANIC, Fond C.C. al P.C.R., Secția Cancelarie, File No. 82/1985, p. 4.
\textsuperscript{45} Ibid., p 45.
\textsuperscript{46} According with the minute of the meeting of CPEx from 14\textsuperscript{th} of December 1985.
\textsuperscript{47} AMS, fond Cabinet 1, File 39/1988, unnumbered.
If in the case of deliberate and medically motivated abortions, prevention could not bring significant results; there was sufficient room for maneuvering in the area of social motivations, of women over 40 and those with 4 children. They represented more than half of all abortions.

The transcript of the session of the CC of the RCP of December 1985 is relevant from the point of view of the type of reasoning used by the political leadership in approaching a problem which generated the next year a historic high of maternal deaths due to abortion-related and obstetrical complications. A few remarks, on the subject of the number of children to be barred by one woman from the discussions of the trio of Alexandrina Găinușe, Nicolae and Elena Ceaușescu, show their primitive thought processes but also the passivity of the other participants toward this sensitive topic:

**Tov. Nicolae Ceaușescu:**
Let’s increase the number of children to 5, that is, abortion should be permitted only over 5 children – not 4, as it is now. So we should introduce a number of 5 children.

**Tov. Elena Ceaușescu:**
But if we establish the age limit at 45, women can have 6 to 7 children by this age.

**Nicolae Ceaușescu:**
We have women with even 10 children, but from 5 children up we can approve abortions, so that the 6th child can come on approval.

**Elena Ceaușescu:**
They can have 5 children earlier, not necessarily by the age of 45.
Alexandrina Găinușe:
Most women that have 4 children are between 30 and 40. So they are at an age where they can have a fifth child.

Nicolae Ceaușescu:
They have time to have the 5th and the 6th child. There are many women who have had 10 children. I was also in a family with 10 children.

Elena Ceaușescu:
Women who have 4 children by the time they are 30, had a child every year?

Nicolae Ceaușescu:
Not one after the other. They had them from 18 to the age of 30–34 years. This is what comrade Găinușe meant, not that they had 4 children in 4 years. That is all concerning the problems of legislation.”48.

This is the manner in which the modification of legislation concerning abortions through the 411/198549 Decree was settled, partly returning to the initial provision of the 1966 Decree, highly criticized by the medical staff. The main addition to the 770/1966 Decree was the raising of the number of children from 4 to 5 for a legal approval of abortion.

After over 13 years from the last modification of the decree (due to the numerous recommendations coming from doctors)

49 Decree of the State Counsel regarding the modification of the article 2 of the Decree no. 770/1966 for regulating the abortion, no. 411 from 26 of December 1985, in ‘Official Bulletin of RSR’, part 1, Year XXI, no 76 from 26 of December 1985.
the leadership of the state continued the trend of easy solutions, allocating minimal resources and expecting immediate effects, disregarding the medium and long-term consequences. The measure seems even more difficult to understand, when confronted with the numerous statistics proving the percentage of pregnant women between the ages of 40 and 45 as being relatively low and not being able to affect overall birth rates. Moreover, the negative consequences of the modification of the legislation started to show in the period immediately following its application. Infant mortality rates grew from 22 to 30%, with similar numbers of dystrophic children and those with birth defects.\footnote{ANIC, Fond C.C. al P.C.R., Secția Cancelarie, File No. 40/1987, p. 72.}

As the legislation grew more restrictive, the number of illegal abortions was continually growing. The shock of reverting to the 770th Decree’s provision was not as large as in 1966.

In attempting to maintain a control over one’s own family and person, during the almost 23 years of severe restriction of abortions, the population managed to develop means of defense against this measure, with which to “circumvent” the legislation. Statistics show that there was no direct proportional relationship between restrictive measures on abortions and the carrying out of them. The problems came from the fact that women, who for various reasons decided not to carry to term, could not appeal to specialized clinical help, developed alternative means of abortion. The direct results were high numbers of maternal deaths and physical and emotional traumas in women.

**Instead of conclusions**

During the 80’s, as the legislation was more and more restrictive, the number of illegal abortions grew proportionally. The shock
of returning to the initial provisions of the 770th Decree could not be as high as in 1966. The population was already prepared and had developed own means of defense. The statistical analysis of the phenomenon underlines the fact that there was no direct proportional relationship between the restrictive measures concerning abortions and the making of abortions themselves. As shown by experience, the direct effect of the measure of banning free abortion does not directly lead to the growth of birth rates, but to the growth of the number of illegal abortions, with all of the negative consequences derived from them. The problems appear due to the fact that women, who for various reasons do not wish to carry to term, in the circumstances of not being able to go to specialized clinics, reorient themselves to alternative means of abortion. The direct effect were the thousands of deaths of mothers but also physical and emotional scarring of women.

In the period of 1980–1989, 2,883,471 abortions were recorded in Romania, out of which 1,536,783 were recorded as incomplete abortions. The true face of the Ceaușescu demographic project is exposed by the numbers. In this period, out of a total of 5,589 maternal deaths, 4,816 were a result of a voluntary abortion and 773 were the result of obstetrical complications\(^5\)

At the level of 1965, the year preceding the start of the demographic policy, there were only 47 deaths for a number of 1,112,704 abortions. In comparison, in 1989, for a number seven times smaller of abortions (160,277), we may count a number over 12 times as high of maternal deaths (545).

Economic measures proved also to be ineffective. The raise in children’s allowances was insignificant, and other measures, like family allowances, prenatal allowances, allowances for single parents, various aids for housing, heating, lighting, tax cuts, placing

the children in kindergartens did not cause, as the regime wished, a continuous numeric rise in population.

Due to the severe limiting of the access to modern means of contraception, de facto (through the lack of these means on the Romanian market) but also de jure, through the banning of surgical sterilization and the use of diaphragm (the Order of the Ministry of Health of 300/18 August 1986\(^{52}\)), of the prescriptions of birth control (the Circular no. VI.C1. – 3496 of 4 September 1986\(^{53}\)), and the halt of research activity in the area of birth control or the limiting of births through Caesarian sections (Order 473/ 9 December 1983\(^{54}\)), the results of the anti-abortion legislation of Romania were severe.

The measure of the severe limitation of abortion did not stimulate birth rates, but represented a true mechanism of constraint and control exercised by the communist state, through a repressive legislative framework and institutions transformed into instruments of the demographic experiment raised to the level of state policy.

Vlad Georgescu grasps the essence of the Ceaușescu demographic project:

"...The image of a party leadership appeared before my eyes, of a ruling class insensitive to the suffering and needs of an entire people, indifferent toward its future, cynical, which juggled with the destinies of men as one juggles inanimate objects, incapable of understanding that the fate of a people cannot be made right by repressive decrees and measures, and incapable of comprehending that more is required to get out of a lull then putting on airs of genius and of great leadership.\(^{55}\)"

\(^{52}\) AMS, fond Ordine MS, File 3/1986 (unnumbered).
\(^{53}\) AMS, fond DAM-OMCT, File 15/1984 (unnumbered).
\(^{54}\) AMS, fond Ordine MS, File 5/1983, f. 128.
\(^{55}\) Vlad Georgescu, România anilor ’80 (Romania during the 80s), Jon Dumitru Verlag, München, 1994, p. 71.
The “Revolutionary Liberation” proclaimed by the Bolsheviks during the October Revolution and the civil war that followed it included women’s empowerment, a goal pursued by the Russian intelligentsia as early as the second half of the 19th century. A small percentage of the Bolsheviks even campaigned to destroy the concept of “family,” but the greater part of Russian Communists felt that women and children were potential victims of oppression within the family, and, as such, were labeled as an exploited group.¹ According to Marxist philosophy, all inequalities based on gender or ethnicity had to disappear once the “proletariat” controlled the “means of production.” After the October Revolution, there were a few prominent women among the Bolsheviks, such as Alexandra Kollontai (empowerment activist and founder of

the women worker’s organizations) and Nadezhda Krupskaya (who was actively involved in the development of the new Soviet educational system and the creation of establishments for orphans). In 1919, as a result of their work, the Zhenotdel (Women’s Section of the Central Committee of the Communist Party of the Soviet Union – CPSU) was established, with Inessa Armand appointed as the first director of this department.² In 1930, however, the Zhenotdel was abolished, and the communist regime from Soviet Union proclaimed the equality between men and women as a fully accomplished fact.³

Shortly after the revolution of 1917, an extensive legislation in favor of women which provided more rights than in the Tsarist period: simplification of divorce, the right to paid maternity leave, children’s food programs and, since 1920, the right to carry out abortions upon request, was promulgated.⁴ As a result of low living standards, the number of abortions increased considerably in the 1930s, surpassing in urban areas – to the consternation of Soviet leaders – the number of births.⁵

Furthermore, the cost of performing abortions was a moderate one, being, according to figures advanced by Sarah Davies, around the amount of 28–32 rubles. According to the British author, the statistics of abortions, performed in Leningrad between 1930–1934, provides the following data:

The number of abortions performed in Leningrad (per thousand inhabitants)

<table>
<thead>
<tr>
<th>Year</th>
<th>Births</th>
<th>Legal abortions</th>
<th>Illegal abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930</td>
<td>21.2</td>
<td>33.7</td>
<td>–</td>
</tr>
<tr>
<td>1931</td>
<td>20.7</td>
<td>36.3</td>
<td>–</td>
</tr>
<tr>
<td>1932</td>
<td>19.9</td>
<td>32.0</td>
<td>–</td>
</tr>
<tr>
<td>1933</td>
<td>17.2</td>
<td>39.4</td>
<td>4.0</td>
</tr>
<tr>
<td>1934</td>
<td>15.9</td>
<td>43.2</td>
<td>5.0</td>
</tr>
</tbody>
</table>


At the beginning of 1936, the Soviet policy makers launched an extensive media campaign that called for the banning of abortion. According to the message of this campaign, the permissive attitude of the authorities towards this problem was due to the low living standards that characterized the 1920s. But the 1930s, according to the official version propagated by Kremlin, brought higher living standards and a consistent improvement of social services. As a consequence, on June 27, 1936, the decree banning the abortions was promulgated, stating that they could be performed only in serious medical cases. According to Frank Lorimer, medical reasons that justify a legal abortion, were as follows:

1. Serious chronic diseases of the heart and blood vessels (…)
2. Chronic inflammatory and sclerotic processes of the kidneys
3. Nephrolithiasis on both sides (…)
4. Pulmonary tuberculosis (…)
5. Tuberculosis of the urinary tract (…)
6. Chronic diseases of the liver with manifest functional disturbances

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7. Serious diseases, with certain complicating symptoms
8. Pernicious anemia
9. Leukemias
10. Malignant tumors
11. Epilepsy, diagnosed in a medical institution
12. Retinitis or neuritis of the optic nerve caused by pregnancy or by disease of the peripheral vascular system
13. Serious diseases of the cornea as a result of physical exhaustion (…)
14. Pelvic conditions making natural birth impossible
15. Presence in the prospective mother, father or one of their children of one of the following hereditary diseases: haemophilia, (…) genuine epilepsy, severe schizophrenia, maniac-depressive psychosis (with hospital history), hereditary eye disease causing blindness, hereditary deaf-mute, hereditary progressive diseases of the nervous system.”

At the same time, according to this Decree, the doctors involved in performing illegal abortions risked imprisonment from 1 to 2 years. As a measure to prevent the dissolution of families, divorce law was hardened and the presence of both parties during the divorce proceedings become compulsory. Divorce fees were also increased consistently: 50 rubles for the first divorce, 150 rubles for the second and 300 rubles for the third. Paraphrasing Elena Shulman, the regime developed the concept of the New Soviet Women, other than that imagined by Alexandra Kollontai, with a focus on strengthening the family and

The implementation of the provisions of the Decree of June 27, 1936 sparked numerous protests among women, and the number of illegal abortions rose sharply in urban areas, especially in Moscow and Leningrad. Faced with this situation, the Soviet authorities responded with a media campaign that emphasized the negative effects of abortion on health; the medical complications included barrenness and premature ageing. 

Clearly, the campaign in question failed to produce the desired effect. According to a Soviet gynecologist, 70% of available beds in the hospital in which he operated were occupied by women suffering from medical complications resulting from illegal abortions. Furthermore, after 1938, the birth-rate began to decline, and in 1940 it reached the level of 1935. In the early 1950s it became clear that the decree of June 27, 1936, should be repealed, but such an approach was impossible, given the fact that no one dared to suggest such a solution to Stalin.

Stalin’s death on March 5, 1953, and the establishment of collective leadership in the USSR (under Khrushchev and Malenkov) would lead to a change in the Soviet view on the issue of illegal abortion. Thus, in 1955, the decree of June 27, 1936 was repealed, emphasizing the medical complications that the performance of

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13 Sarah Davies, op. cit., p. 106.

abortions--outside specialized medical units--had on women’s health. Therefore, the old Leninist vision, implemented in 1920, was restored. At the same time, delegates attending the 20th Congress of the CPSU emphasized the need to increase the number of days allocated to maternity leave. On April 1, 1956, according to a directive of the Supreme Soviet, the number of days allocated to maternity leave, was increased from 77 days to 112.\textsuperscript{15} The Soviet example of the legalization of abortions was followed by the Communist States of Central and Eastern Europe: Bulgaria, Poland and Hungary (1956), Romania (1957), Czechoslovakia (1958) and Yugoslavia (1961).\textsuperscript{16}

The communist regime in Romania, once institutionalized, incorporated the Stalinist views on abortion. Thus, during 1948, Article 482 of the Penal Code was revised, and the interruption of a normal pregnancy became a criminal act.\textsuperscript{17} As previously stated, the new vision promoted by Kremlin after 1955 would also be implemented in Romania starting with 1957. Thus, according to Decree 463, published in the Official Monitor:

\begin{quote}
Art. 1 – Interruption of the normal course of pregnancy can be made at the request of the pregnant woman.

Art. 2 – Interventions for the interruption of the normal course of pregnancy is performed in state medical institutions, according to the instructions of the Ministry of Health and Social Provision.”\textsuperscript{18}
\end{quote}

\begin{footnotes}
\item[16] Jerome S. Legge, \textit{op. cit.}, p. 59.
\end{footnotes}
During 1966, due to the increased number of abortions, Romanian authorities took the initiative to create a commission whose purpose was to draw up a report on the birth-rate in Romania. The report in question stated that after 1960, the birth-rate in Romania was sharply reduced; among the factors that contributed to such a situation were the urbanization process; the absence of acceptable financial incentives; the increasing number of divorces; and the legalization of abortion by decree 463/1957.19 The Executive Committee meeting of the Romanian Communist Party of August 2, 1966, discussed the report in question, and Nicolae Ceausescu and Alexandru Draghici acted on the perceived need to ban abortions, except for some “special cases.”20 Thus, on October 1, 1966, the decree 770/1966 was published, and abortions were prohibited. The interruption of pregnancy was permitted in six separate cases:

1. pregnancy endangers the woman’s life
2. one of the parents suffer from a serious illness, which is hereditary, or causes serious congenital malformation
3. the pregnant woman has severe disabilities, physical, mental or sensorial
4. the woman has over 45 years
5. the woman gave birth to four children
6. the pregnancy is a result of a rape or incest.21

The approval of an abortion was to be given by a “medical committee” created for this purpose.22 According to article 6 of the

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21 BO, No. 60, October 1, 1966, p. 2.
22 Ibidem.
decree in question, in cases of a medical emergency that required an abortion, the doctor had “an obligation that before the intervention, or when it is not possible, within 24 hours after this, to notify in writing the prosecutor” who would determine, based on medical advice, if the intervention for an abortion was necessary. Decree 770/1966 entered into force 30 days after publication, with the instructions for its implementation being drawn up by the Ministry of Health and Social Provisions. Decree 776/1966 (also published on October 1, 1966) stipulated the amendment of articles 482 and 483 of the Penal Code, and emphasized the penal consequences that the performance of an illegal abortion involved. In full accordance with the ideological “commandments” of the moment, divorce proceedings were consistently hampered, being characterized by repeated delays, in order to reconcile the parties involved.

During its implementation, the pro-natalist policy pursued by the Ceausescu regime underwent constant reformulations. Thus, in February 1972, Article 2, paragraph d of the Decree 770/1966 was amended, and the interruption of the normal course of pregnancy was permitted to women “aged over 40 years.” In an effort to strengthen the state control of the application of pro-natalist policy, two years later, the Decree 770/1966 was again modified. Thus, the medical commissions (appointed in each county by the local authorities – that were to authorize a legal abortion – were

23 Ibidem.


25 BO, No. 60, October 1, 1966, pp. 2–3.

26 BO, No. 64, October 8, 1966, pp. 2–4.

27 BO, No. 21, February 17, 1972, p. 2.
comprised of three doctors and a secretary. During the meetings of the Commission in question, the presence of a representative of the Prosecutor’s Office, and a delegate of the Ministry of the Interior was compulsory. Finally, in December 1985, Article 2, paragraphs d and e of the Decree 770/1966, was again amended, and the interruption of the normal course of pregnancy was permitted to women “aged over 45 years,” or to those who have five children in their care.

It should be noted that Soviet authorities openly expressed their disapproval to the pro-natalist policies pursued by policy makers in Bucharest; the main argument invoked was the unfortunate experience of the USSR during the period 1936–1955. The Soviets warned the Romanian Communist leaders of the fact that such a vision would not result in an increase of the birth-rate, but on the contrary, would determine an exponential growth of illegal abortions. Such a statement was correct given that, according to Jerome S. Legge, between 1969–1972 in Romania, 1.307 maternal deaths from abortion were recorded. Of these only 11 deaths were the result of legal abortions.

Although Czechoslovakia (1962) Bulgaria (1967) and Hungary (1974) also introduced a legislation restricting abortion, the Romanian communist view was the most severe. The pro-natalist policy, so assiduously promoted by the communist regime from Romania, would not end with the expected result. Thus to the surprise of Romanian policymakers, in 1983 the birth-rate and the total fertility rate were similar to those of 1966. In this

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29 BO, No. 76, December 26, 1985, p. 7.
30 Gail Kligman, op. cit., pp. 53–54.
31 Jerome S. Legge, op. cit., p. 62.
33 Gail Kligman, op. cit., p. 67; See also: Anuarul statistic al României, 1990, pp. 74–77
context, it should be noted that the second decree issued by the Romanian government, after the fall of communism in Romania, focused on the legalization of abortion.\textsuperscript{34}

A special situation in the communist bloc is represented by the demographic dynamics of China. With the proclamation of the People’s Republic of China (PRC), Mao Zedong shared his conviction that huge demographic potential of the Chinese state could compensate for the lack of modern technology.\textsuperscript{35} In the context of the \textit{Great Leap Forward}, the Chinese leader emphasized the relevance of Chinese demographic advantage:

Apart from their other characteristics, the outstanding thing about China’s 600 million people is that they are «poor and blank». This may seem a bad thing, but in reality it is a good thing. Poverty gives rise to the desire for change, the desire for action and the desire for revolution. On a blank sheet of paper free from any mark, the freshest and most beautiful characters can be written, the freshest and most beautiful pictures can be painted.\textsuperscript{36}


\textsuperscript{35} On March 31, 1956 during his meeting with the Soviet Ambassador in China (Paul Yudin), Mao Zedong pointed out that with the accession of China to the socialist camp, the communist camp population increased to 900 million people. See: Mihai Croitor, Sanda Borşa, \textit{Unitate şi conflict în lagărul comunist: dialectica rupturii sovieto-chineze}, Editura Mega, Cluj-Napoca, 2007, pp. 126–127.

According to the Chinese authorities, the dynamics of life expectancy in the Twentieth and Twenty-first Centuries witnessed important mutations: from 35 years in the first half of the twentieth century, life expectancy rose to 56 years in China in 1957, 64 in the early 70’s, 68 years in 1981 and 70 years at the beginning of Twenty-first Century.\(^{37}\) The census organized by authorities in 1953 surprised Chinese demographers, who expected China’s population to be about 450 million. Instead, the final result of the census revealed that the actual number was 582 million (587 million according to other sources).\(^{38}\) A year later, in December 1954, Liu Shaoqi, during a meeting with Chinese communist leaders, raised for the first time the need for family planning policies in China. On this occasion, the future Chinese president underlined that the Chinese Communist Party (CCP) approved contraception. In January 1955, the Ministry of Health prepared a report on the usefulness of the family planning policy, underlining that the access to contraception should be unrestricted. However, access to abortion was strictly restricted, due to the medical consequences it would have on women’s health. Two months later the CCP Central Committee endorsed the report in question.\(^{39}\) With the proclamation of the People’s Republic of China, abortions were prohibited, with the exception to the rule being a situation in which the pregnancy endangered the mother’s health; in these cases, abortion was allowed. 1957 witnessed the legalization of abortion, allowed under


the condition that it was performed within the first ten weeks of pregnancy. Poor medical conditions and medical staff reluctance to perform such interventions did not cause a major increase in the number of abortions.\textsuperscript{40}

In the first half of the ‘50s, among the Chinese intellectuals, a real debate started on the principles of family planning policy and the relationship to Chinese realities. Such was the case of the then-President of Beijing University – Ma Yinchu. In his book, entitled \textit{The New Population Theory}, Ma Yinchu challenged the Marxist view according to which a socialist state could not encounter difficulties in relation to number of population. According to the Chinese intellectual, in a state with a planned economy, the demographic potential should, also, be subject to such planning. But the CCP’s hard core labeled him as a follower of Malthusianism, and in the context of launching the \textit{Great Leap Forward}, this label led to the most serious consequences for the author. Therefore, Ma Yinchu was listed as “political rightist” and in 1960 was forced to resign as president of the University of Beijing.\textsuperscript{41}

Misguided economic policies promoted by Mao Zedong, in conjunction with a series of natural disasters, confirmed the failure of the \textit{Great Leap Forward}, which claimed over 30 million victims.\textsuperscript{42} But, starting with 1962, a consistent increase of the birth-rate can be identified:


\textsuperscript{41} Qiusheng Liang, Che-Fu Lee, “Fertility and population policy. An overview”, in Dudley L. Poston, Jr, Che-Fu Lee, Chiung-Fang Chang, Sherry L. McKibben, Carol S.Walther (ed.), \textit{op. cit.}, p. 9.

Year | Population (in millions) | Total fertility rate
---|-------------------------|-------------------
1958 | 659.94                  | 6.679 5.775 5.253
1959 | 672.02                  | 4.303 4.323 4.172
1960 | 662.07                  | 4.015 3.996 4.057
1961 | 658.59                  | 3.287 3.349 2.982
1962 | 672.95                  | 6.023 6.303 4.789
1963 | 691.72                  | 7.502 7.784 6.207
1965 | 725.3                   | 6.076 6.597 3.749

Source: Qiusheng Liang, Che-Fu Lee, *op. cit.*, p. 11.

During the ‘60s and early ‘70s a few timid attempts were initiated by the Chinese Central Government towards the implementation of a family planning policy. However, these measures did not end with the expected results. Along with the “reformism era” launched by Deng Xiaoping after 1978, the Chinese view on family planning policy radically changed. Thus, during 1979, the so-called “one child policy” was adopted, according to which families from urban areas were entitled to have only one child (otherwise being subject to fines). Families in rural areas, according to the same policy, were entitled to have two children. But this “one child policy” had a consequence that the decision makers from Beijing did not anticipate. Due to the Confucian beliefs of rural residents, Chinese authorities observed a preference for sons and not daughters. As a consequence, there was an increase in the abortions of female fetuses and, tragically, even female infanticide.  

According to data provided by the State Family Planning Commission, in 1981 nearly 6 million children were born into families that already had at least one child. Of these, 1.7 million children were born into families that already had five or more

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children. In such circumstances, starting with 1982, the Chinese government has opted for a firmer family planning policy: “intrauterine device insertion after the first birth and sterilization after the second birth” in the rural areas. Between September 1981 and December 1982, 16.4 million women were sterilized, and 4 million men had vasectomies. Following the application “one child policy,” the number of abortions increased dramatically. Statistics on the number of abortions performed in China provides the following data: 1979 – 7.8 million; 1982 – 12 million; 1983 – 14.4 million; 1984 – 9 million; 1986 – 12 million. It is estimated that between the ’70s and ’80s in China were performed over 200 million abortions. The Chinese view, adopted after 1979, reduced the fertility rate from more than 6 children per woman in the early ’50s to 1.6 in 2005.

In conclusion, we can say that pro-natalist policy pursued by policy makers in Bucharest was a profoundly radical one, bordering the proportions of a national trauma. In contrast, the Chinese communist regime, which initially considered its demographic potential as an asset of China, gradually became aware of the need to implement a family planning policy. The results of the new vision, promoted by Beijing, became visible only with the accession to power of Deng Xiaoping.

45 Apud Can Liu, Chiung-Fang Chang, “Patterns of sterilization”, in Dudley L. Poston, Jr, Che-Fu Lee, Chiung-Fang Chang, Sherry L. McKibben, Carol S. Walther (ed.), op. cit., p. 35.
46 Jonathan D. Spence, op. cit., p. 686.
47 Juan Wu, Carol S.Walther, op. cit., p. 22.
First of all I shall say that the facts I intend to discuss here are part of a larger topic which is the building of community, as well as of that of ethnic borders. I have been interested in these issues for more than 15 years, during the work for my PhD thesis and even beyond. The community on which this research took place is the larger Aromanian one, a community formed of groups originating in the Balkans who emigrated to Romania around 1928. These groups, settled in the Dobrogea region of south-east of Romania, had developed a very strong community system, before, during and after the communist regime.

The emigrated Aromanians had defined their group identity in connection to – and under the influence of – the Romanian state. Beginning with the last decades of the Nineteenth Century, the newly formed Romanian state began to send teachers and priests to the Aromanian communities in the
Balkans. Thus, the ethnic self-identification of the Aromanians with the Romanians from the Carpathian area was encouraged\(^1\). This policy of the Romanian state was one of the main reasons for a part of Aromanian population to leave their original territories after the Balkan wars in order to establish themselves in Romania as colonists. At the time of the emigration the Aromanians came from strong lineage systems. The organizational logic of these tribes (centered on the identity of the group of brothers) constituted the model of community construction after the emigration.

My research topic has been focused on this construction of the Aromanians’ collective or common identity, more specifically on an ethnic identity as shown in social practice\(^2\).

There were two dominant social mechanisms that are the basis of this identity construction. The first one is the practice of endogamy; the second is that of the exchange networks that build a community system whose logic is originated in the kinship system\(^3\). If endogamy ensures the goods’ (money and objects) orientation inward to the community, the exchange institutions cover and regulate their redistribution inside the social system. The two main institutions that provide the redistribution are the “marriage-alliance” (the goods and money exchanges that take place on this occasion) and the institution of gift\(^4\).

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Of these two social mechanisms, the first one, namely the practice of endogamy, focuses on one of its primary components: the health of the individual as an essential condition for the conclusion of a marriage. In my previous researches I had little explored the aspects concerning the health of the individual in relation with the building of the community system. It is only recently that I started to be interested in this topic, first of all due to the social changes characterizing – especially during the last decade – this extremely dynamic social system. Thus, if the “field” is rather familiar to me, the facts (the empirical evidence) that I’m about to present here are part of a research that is only beginning. They provide the general framework for building the object of the research.

There are a few basic conditions that regulate the practice of endogamy. I will present them briefly and I will focus on the aspects important to this paper. The first one prescribes that the families that are about to conclude a marriage-alliance have to know each other as well as possible. The second one is that of the wealth, which has to be proved by signs recognized by the whole community. In the past, when the Aromanians were especially shepherds and tradesmen, the wealth was proven especially by the number of sheep, goats and horses one group owned, and by the importance of gifts that it made. The wealth was especially proven by the number of golden necklaces that a girl wore when getting married (objects that are part of the bride’s wealth) or more generally by the quantity of gold that a young man’s family could offer to the bride (as part of the same institution of the bride wealth). After the emigration, the dynamics of these signs and tokens made their social value shift; gradually, after the nationalization of the land at

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the beginning of the communist regime, the house and the money offered as gifts at weddings began to express the wealth; after the fall of the communism the tokens of the importance of wealth became the size of the private villa, the number of cars owned and the monetary gifts that were offered by the group in the moment of a wedding. I give all these details to show the importance of the exchanges which took place between two groups of allies when a marriage was concluded and also to show their economic implications. These consequences are strong justifications of the social regulations that the marriage supposes.

The third condition was, and still is, that of the physical and mental health of the potential bride and/or bridegroom. This is the aspect which interests me the most for this presentation. Until the emigration of a part of Aromanians from the Balkan region to Romania, the custom of hiding any disease a young person could suffer at the age of marriage was accompanied by related practices that made the illness hard to detect by the potentially allied group. The norm strictly forbade the acquaintance of the young people before the marriage was settled, and the bride-to-be was carefully hidden from all those in the potentially allied group (group means here a lineage system). As an example, in the 1950s, in the villages colonized by the Aromanians, the official marriage was often concluded in the absence of the bride, to which the custom was forbidding to come in the groom’s group before the wedding. (We will not discuss here the symbolic dimension of this practice.) One of the women I had interviewed told me that when she was a young girl she used to sign on behalf of the bride – who, as a common rule, was absent on this occasion – at the city hall marriage of her cousins. And this didn’t happen only once. The village mayor, a Romanian, preferred not to interfere with the community.

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institutions and accepted the situation. More than that, he taught the girl to change her handwriting when signing, according to the name of the one she was signing for. And if we are to believe those interviewed, for the medical investigations (both clinic and blood tests) necessary for the marriage, in order to hide any possible diseases, other known healthy members of the family took, and still take today, the medical tests instead of the future groom or bride. In cases in which some signs of any disease are perceptible, the disease is still firmly denied, and the weakness of the individual is justified either through tiredness or a bad mood.

This taboo marking the disease (and its exhibition) which became obvious in the eve of the marriage is explained by the Aromanians through the absolute requirement to conclude the marriage once the young people attain the right age. (We must say that the concealment of a disease is a much more extended practice, than what comes to light in the period preceding the marriage.) The significance of this necessity resides both in the social constrains of concluding the alliance for the groups and in the symbolic dimension of the social requirement of getting married. Those alliances are marked by the value of the “given word” (corresponding to the Albanian institution of bessa, an institution also present in the Aromanian culture⁷), a word defined by notions as “promise,” “honor,” “faith,” “trust,” “loyalty”⁸. The social bond – in fact, the community ties – are reproduced and reinforced with each generation through the marriage alliances which integrate the individuals in a moral system that assures individual security and builds one of the most important dimensions of the community

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system. (In fact, until almost 40 years ago, there was a rule prescribing that in case a young man or woman died before the marriage his/her family must provide another person from the group, “not to break the alliance”). Following the same logic, the symbolic dimension of concluding the marriage-alliance becomes obvious in the kinship language in the manner the discourse on the kinship is built. Thus, the symbolic construction of the marriage alliance can be read for instance in the way the “love” for the in-laws is stated, and in prescriptions that articulate the “ideology” of the indissoluble character of the alliance between the groups thus connected.

The norm related to the necessity of marriage often makes the groups to settle for the marriage of an ill member at any cost (“at least to be married, how to lose his/her turn?”) even if the person dies right after that. Each time, in this case, the justification of the death is the same: “the marriage didn’t suit him/her”.

For the past 20 years or more, these aspects pertaining to the logic of the ancient Aromanian tribal system are facing the challenges of a social change that is pushing the individuals to integrate in the global society whose dynamics is exterior to the logic of the community system. I will shortly describe the history of this change to ease the understanding of the phenomenon.

In the Romanian society before 1989, medicine was a top-rank profession in the social prestige hierarchy, both as professional and financial excellence. The admission exam to the Faculty of Medicine was considered to be one of the toughest. It was often repeated by people in order to gain access to the faculty, while the number of students was limited. Thus, after graduation, the doctors were perceived as persons at the top of the social hierarchy. This status won not only by the validation of individual qualities, but also by overcoming the difficulties of the study, was furthermore

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consolidated by incomes that this job supposed, especially through the practice of the “gift,” “bribe,” or “tip” (ciubuc) in money or foods. Thus, in the ancient regime, doctors not only had the reputation of wealthy people, but also that of a specific type of intellectual: to give only one example, they had the possibility to travel and to gain access to a certain type of education that many people did not have.

After the fall of communism, the position of the doctor in the social symbolic hierarchy had become more accessible to the population due to the increased number of places available in medical schools and especially due to the emergence of private universities. For the latter, the admission was no longer based only on an exam. Furthermore, to attract even more students, some faculties lowered to a minimum the intellectual level of professional learning; in some cases, the final diploma was obtained by the student with a very low attendance of the courses and seminars.

In the desire to achieve this privileged rank of the symbolic hierarchy of the Romanian society, the young Aromanians (especially girls) have oriented towards the medical profession. Through an increasingly mimetic behavior inside the community, regardless of the individuals training and their intellectual capacity, the families have elaborated the matrimonial strategies accordingly: this profession has become one of the important symbolic criterion in choosing the partner. “Buying” doctor diplomas apparently became a wide-range used practice. (Buying diplomas means here also the diplomas obtained from private faculties, where the attendance to courses is minimum.) This situation, however, doesn’t exclude the cases of a real professional training in renowned medical schools. Simultaneously, the general economic level of Aromanian families has been increasing. Their incomes result from commercial activities, the hotel industry and especially the food industry, mostly that coming from sheep breeding, the traditional occupation of the Aromanians.
Thus, the last 10 years have brought a situation in which, at least in the framework of the Aromanians community dynamics, a de facto dissociation has been made between the formal achievement of a doctor diploma and the real practice of this profession. While the achievement of the formal recognition of the doctor profession is beginning to reconfigure the model of excellence in choosing the partner, its practice steps out from the group strategies. Here are 2 examples:

1. Q: And now, if the girls are more and more rich, do they still want a physician’s diploma?
A: Of course! If they have money, this is it! She attends one faculty year and she gets engaged because she’s a “Doctor”. In Bucharest the situation is different, but here… After she takes her diploma, why should she practice? She has a nice villa, a car, money, a servant… She stays at home taking care of the children. Why should she need to work? And in Tulcea is even worse.

2. I had a neighbor where I lived; their daughter-in-law when she married was in the third year in medical school. Then she had two children and her husband with his parents opened a cheese shop at the ground floor of the house. She became a nurse for all the neighbors from the street. The son of my neighbors was a cheese maker and they bragged that they took a doctor. She has a villa, two children, she’s carefully dressed, rides her car… why should she practice medicine?

In cases where the real medical expertise is necessary, it is done following the professional performance criteria, regardless of ethnic origin: best doctors will be chosen from the local hospitals or, better, from Bucharest, where the access to medical care is less exposed to the attention of the community.
It is true that during the communist regime, there were a few Aromanian doctors very well trained in the region who were intensely frequented by the members of the community. One of them, a gynecologist, in a time where abortion was prohibited, made this service to young unmarried women. As an interviewed person tells, “the mother came with the girl to the doctor, the girl remained silent and the mother talked in her name. The doctor made the abortion, and the girl didn’t make a sound. Then he sew her to be as good as new again [i.e. virgin] for the wedding night.” But, in this case, the interpretation which can be done of this situation does not rely on the professional quality of the doctor as the first criterion of choice. The important thing when addressing a doctor inside the community for this type of problem seems to be the fact that the community constraints obliged the Aromanian doctor to surpass the legal prohibition of abortion. The risk of facing the community penalties seems to be much more important than that of facing legal consequences for this practice.

To summarize and synthesize the above discussion we may say that there are two phenomena whose social dynamics intersect in the presented topic. On the one hand, the illness as taboo is reproduced according to the norms of traditional culture, and on the other hand, we can see the reconfiguration of the standards imposed to the individual in order to conclude a marriage. This process takes place through the appropriation (the symbolic usurpation) of a privileged position, a privilege active only inside the community. But this time, the model of the social hierarchy that the privilege reproduces is originated outside the community and characterizes the whole Romanian society. The change is brought into discourse by the members of the community as emancipation. In exchange, its meaning, as its mimetic character as well, diverts the direction of the emancipation and strengthens the community system in its pre-existing logic. In these systemic circumstances, the
professional qualification as a doctor and the practice of this profession are dissociated and the formal appropriation of the privileged symbolic position is recognized and functions only inside the community. In relation with the endogamic marriage this practice is built as an ethnic boundary.
Narratives Upon Life, Illness and Death

Constantin Bărbulescu

This paper has its origin in a field research done during the summer of 2009 in one of the mountain townships of Cluj County. I gathered then numberless narratives upon the experience of illness and healing as also upon the general manner in which the informants integrate these events in the personal biography. The most part of informants are born in the fourth, fifth and sixth decades of the past century, generations from the decade preceding the World War Two and from the one that followed it. We were interested in the narratives, as I mentioned above, upon illness and healing, but also upon illness and death from the childhood of our informants.

In other words, we try to catch in the present paper the way in which our informants perceive the

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1 Researches were financed through Grant CNCSIS type Ideas, code 1647, competition 2008, with the title: “Reception of Modernization of Sanitary System in Communist Romania by the Rural World (1948–1989).
illness, death, and the life once, at the beginning of their lives, of course by relating it to the contemporary situation. Then and Now could not be understood but together and consequently in contrast. Obviously, their projections and judgements are subjective, and we deal with the world of the past seven decades seen through their eyes and subjectivity.

**The once hard life**

Talking about illness and death means implicitly to talk about their causes. And in the field death and illness are always associated the general life conditions in a relation of reversed proportionality: the better the general life conditions, the more reduced the incidence of illness and death are.

But the general image coming up invariably from the narratives of our informants is an extremely negative one: then the life was hard, even the basic food needs were difficult to fulfill:

You could not find that, because there was no sugar, there wasn’t (...) and we went and bought two hundred grams, two hundred and fifty grams of sugar. One quarter. And about two hundred and fifty grams of il. Who could afford to go like today, to buy lots like now and they still say they are bad! They are not bad! They have never been better ever since the God made this world! We saw meat rolled cabbage with rice only at Christmas. Only millet (*pasat*). From corn we made. It was a mill. But there was only one on this hill. And had a stone above and a stone underneath. And it was a stick. Above there was a beam. And that beam had a hole. And in that hole they put a stick and the stone had also a hole. And you kept throwing a handful of
corn. It was a small hole there and you kept on circling... but you did that only for holidays, and if you did not prepare in advance you queue until you were sick. Who had... Mind your own business! The small children with sweets and... You think they put minced meat in the meat rolled cabbage!? You know what we put? A slice... a slice of lard. Lard. Like this, in each meat rolled cabbage, you put a small piece of lard and good luck. And they made roasted flour like for a soup².

A world of food poverty, of self rationalizations, in contrast to the beginnings of the consumer society nowadays. The positive perception of the contemporary situation by these people comes from the constant relation between Then and Now: only those who lived Then can understand the privileged situation of Now. The younger generations, deprived by the hardships of the informants' childhood and teen will never understand anything of their privileged situation. A simple temporal gap of few decades changes the whole perspective.

But the hard old times are not reduced only to food deprivation but also to the general conditions of work that were extremely hard. An informant born in 1936 re-calls sadly and painfully his and his older brother' childhood spent with the animals as shepherds:

His hand hurt here, he could not raise it like this. But he lived until seventy-two, he could not lift it (...) I will tell you why, because we were so poor, in the summer

we went with my brother… we went first time we were little, we went with the cattle, with the milking cattle. After we grew up a little we went to sheep, there were three flocks here, in autumn when we gave the sheep we went to goats, there were one hundred and seventy goats here and the people gave them away every day because they did not have hays like now, they brought up cattle (…) each day we went with the goats (…) in spring when the sheep had to go out in the flock, we put the goats with the sheep, and we were both again with the sheep (…) we lived like this, and clothes, to have sheets: it was tol (a sheet made of hemp) and a brother in law, married to my sister kept saying <<make bunda (sheeskin coat) on you>>. He said to us because he had. <<With bunda, you put in the snow and sleep>> He said. We were so wet from the rain, there was no nylon in those times, there was no rain coat, no rubber boots, just opinci (skin shoes) with strings, and they tore up, turned on your feet! And then with sheep, in spring, they do not stay for milking, they run, other is too young, first time having a cub. And my brother swore them, he was four years older… and it rained slowly: <<You shut up, don’t say like this, don’t swear!>> I said. He said <<What?>> And he looked up: <<God, strike me here!>>

Breeding animals, especially shepherding appears as a disagreeable job, especially under the circumstances described by the

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quote above. Dry clothes and a sleep in a warm place become ideals rarely touchable. The childhood transforms into a tough period that ends for our informant in a well aimed marriage that will assure a superior social status. Another risk factor was the cold and not the cold outside but the one inside the inhabited space:

„I was [sick] when I was on the sixth grade. I went because it was a boarding school there in the valley in the centre (...) and they made us a boarding school, and they gave us food and dormitories so as to group us not to... one from one hill, other from another hill. You missed the school. And there we kids, went on skiing and it was cold and I got sick. It was not warm there, because the water in the bucket would froze during the night, and with that thin blanket on you... and I was, it attacked my lungs then, you know, I caught a cold. Ever since I was not sick.4

And to go back to food, during the childhood of our informants do not appear only the matters of the general food poverty but also of the quality of the consumed products, that could generate illness to the digestive apparatus.

I was sick of hepatitis, in 1950, when I was eleven (...) I was taking care of the cattle, here to a man, and he gave me in my bag, lard, and the lard was bad, too old, and it was on the edge, and I got sick, I can’t eat lard even now, even if fifty years have passed. (...) There were little worms on the lard (...) And I had to eat, they put it in

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my bag and all day long during summer with the cattle there... I was, I was a servant till 18, when I got married. My parents died, I mean my mother died when I was 15 and my father was paralyzed, you can imagine, I had to take care of my father.

In fact, of all the illnesses of digestive system, hepatitis is most often invoked, most of times contacted, as in the quote above following the consumption of food on the edge. The description above is significant through the general circumstances that cause the illness, that is, the social status of the child. The illness is not coming from the family, but when he was servant to a man, that almost always is translated through deficient nourishment, and precarious bodily and clothes hygiene: in conclusion, an inferior social condition. Unfortunately, the work of the children outside their own household or of the relatives, as “servants” that seemed to be quite spread in the childhood of our informants, that is at least until the 1960s, did not make the object of research inside the social sciences in Romania.

But if our informants can identify in most cases the cause of their illness, sometimes the illness comes from nowhere, with unidentifiable symptoms and surprising evolutions that confused the local system of beliefs and representations of the sickness. It is the case of one of our best informants, who recalls through intermediaries a health problem of her childhood:

“My mother just told me and my sister, how I was, I don’t know how old I was, because I was little, about

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two years? Like this... I went to sleep in the evening and I didn’t have anything, and in the morning she said, that my eyes were stuck I could not open, they heated water and they put that warm water to open them. And then my head ached, and then my ears, you know something flew from my ears. And they said that they carried me because I could no walk, and they said they carried me like on a bench. And they said they cried because they thought I would remain like that with a headache, and who knows?6

Eventually, we deal with happy ending story: slowly, the illness disappeared as it appeared. This is the kind of illnesses the informants usually ascribe to a magical action.

But the most spread cause of the once health problems at least the most visible in the discourse of our interviewees is accidents. The daily life, subjected the individual, child or adult to constant risks of accidents. A mobility problem of an arm, obvious when face to face is explained by an informant now very old:

At my hand, when I was very little, there were no beds like now, there were beds (…) tall, like this (…) and mother went to some neighbors (…) to boil hemp, to work there (…) I, as a child, my father was fond of me, like the children are to their parents (…) my father slept in bed, it was winter and I said to let me on the margin, and he did. I don’t know how I slept, I turned and fell down. And father took me and put me back in

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bed but he said I kept groaning. And mother came and he said «Look the child fell of the bed and he keeps groaning…»> Mother came and took me in her arms to see what was going on, and then I screamed, my hand hurt. She undressed me, and the arm was already swollen. It was a man here, he knew how to fix the arm, nobody went to a doctor. I don’t know how he did it. Nobody went to doctor in those times. (...) and then after a while I healed and so did the arm.\(^7\)

In childhood too goes back the story of the accident of another informant, accident that marked his destiny – he would never get married because of his locomotor deficiency following a work accident:

I (...) had troubles with my knees, I went to M. with some wood, with oxen, some business, and I climbed in the wagon, and then there were no, we were poor, to bring some wheat, to cut a wagon of wood. I was with my father, we had some (...) young oxen, they were not used to like the older ones, and after we sold the wood, while getting out of the yard, they hit with the shaft in the back. The old man was furious and pulled back, and so it caught my knees. In one-two years some liquid came up and my knees were moving like this (...) and I stayed like that for years, we saw some doctors, some bathes (...) but if they took me then, at once after the accident to get an operation, maybe it

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would have been different, I was young, I was thirteen, maybe…

Late regrets, expressed in old age, in front of a stranger trying to make him understand the starting point of the tragedy of his destiny.

Death

Sometimes, the illness proves to be the smallest evil. Compared to it, death is ubiquitous and strikes mostly the infants. In old times, in not far away past since it is rememorized as personal experience, children simply died in the general indifference of the adults:

My mother in law (…) had sixteen [children]. But I don’t recall how many lived. The rest died. And nobody took them anywhere because there was no place to go. You didn’t have. But nobody cared. That now he is sick and take him… (…) He was sick, he died and he was buried.

Life and death were going together, mingling in harmony weaving a demographic regime of old type. The next testimony seems to sketch an identical situation – in the first four years of life only approximately half of the siblings survived:

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Seven, but we were more, I don’t know all, some of them died, we were ten, twelve [brothers], like that. But I do not recall anyone because they did not live longer than three-four months, only a girl lived four years and at four she died. If they were sick, they didn’t have where to go to a doctor, where to go? Take her to Cluj? 

I will not extend the quotes that prove the frailty of the children in their first years of life after birth, the demographers had done it long before us and better. The testimonies we gathered for the middle of the 20-th century seem to situate us more likely in a demographic regime of an old type rather than in the famous demographic transition. Transition of mortality had not been taken place yet.

According to another informant, a third of siblings are decimated in the first years by childhood diseases, where measles was the fiercest. Six weeks, six months and six years are the ages for death:

We were six at our parents. Nine my mother gave birth. And three died: one was six years, one was six months, and a little girl of six weeks. In those times it was sickness like this, measles, we called it zapor. And we didn’t have where, nobody knew about a doctor. I was and a brother but it came out on our skin. The skin was vivid

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11 For defining the concept of demographic transition see Traian Rotaru, ”A doua tranziție demografică” – o analiză critică a conceptului, în Traian Rotaru, Sorina Paula Bolovan, Ioan Bolovan (coord...), , Presa Universitară Clujeană, Cluj-Napoca, 2006, pp. 455–468.
red. And we get away but the one six years old, died. This was our world.\(^\text{12}\)

The adults either, those people who succeeded the performance of surviving to their many brothers and sisters, do not escape dangers. The hard work and lack of prevision proved fatal sometimes:

> My grandfather died at thirty eight (…) he was with oxen to carry wood and one ox was not good, was weaker, and could not carry the wagon. He hit the ox and tore three ribs, and he put himself in the place of the ox and got out the wagon, but he no longer was right. After three or four months he died.\(^\text{13}\)

Do we have here the mythization of a character maybe exceptional? Such characters that raise with their bare arms logs to change a wheel or who like our hero are stronger than an ox, populate the collective memory of our villages. They are exemplary through their physical force out of common, but also through their sacrifice.

The activity of the peasant is most of the times in open field and the summer storms can be a real danger for the peasant caught in the field:

> Our father was thunderstruck. It was summer time and went to cattle, and they were many and one with


the sheep, and they stayed under a birch tree. And they only saw that the thunder struck hard once, that everybody got frightened, one even fell down. But it touched him on one side. The shirt was all burnt.\footnote{Woman, born in 1929. See Elena Bărbulescu (coord.), Constantin Bărbulescu, Mihai Croitor, Ciprian Pavel Moldovan, Alexandru Onojescu, Alina Ioana Suta, \textit{Ţărani, boli şi vindecători in perioada comunistă. Mărturii orale}, [Peasants, Illnesses and Healers during Communist Period] vol. I, Editura Mega, Cluj-Napoca, 2010, p. 196.}

As I was expected, the mortality of young and adults was not caused only by accidents, different diseases brought an important contribution. Tuberculosis was one of them:

We were none. One died, two died... one died at four. I asked my parents but she was ill, I don't know... but the other one, I know. When she was seventeen, one sister, from lungs, from what they called dry illness. She caught a cold at her lungs and, well she died of lungs (…). She caught a cold and did not cure. Because they didn't go to doctors then. At seventeen. Seven of us lived\footnote{Man, born in 1950. See Elena Bărbulescu (coord.), Constantin Birbulescu, Mihai Croitor, Ciprian Pavel Moldovan, Alexandru Onojescu, Alina Ioana Suta, \textit{Ţărani, boli şi vindecători in perioada comunistă. Mărturii orale}, [Peasants, Illnesses and Healers during Communist Period] vol. I, Editura Mega, Cluj-Napoca, 2010, p. 124.}.

The oral testimonies gathered in summer 2009 and used in this paper are sending us back in the decades from the middle of the past century in the childhood and youth of our informants. In order to understand this narratives but also to verify them in a way we will try a demographic excursion into those decades; we will try to count the live and the dead, the healthy and the sick and we will see if the informants subjectivity played
tricks, as a recent research done in the same project of research is demonstrating\textsuperscript{16}.

The first problem we try to clear up is if at the middle of the past century Romania was in the so-called demographic transition. Recent demographic researches done by the school of historical demography in Cluj tend to accept as starting date for demographic transition in Transylvania the years 1875–1880. Indeed the gross ratio of mortality, that is number of dead for one thousand inhabitants decrease from 40.9, the average for 1871–1875 to 25.8 for 1911–1914. A considerable decrease that should be identified with the transition of mortality is the first element that manifests inside the demographic transition. But if we come back in time, we notice that before 1871 for the interval 1851–1855 the gross ratio of mortality is 29.3 and the following temporal interval (1856–1859) it decreases to 24.9 even smaller than between 1911–1914! Regarding natality, the number of births for one thousand inhabitants between 1856 and 1914 in Transylvania doesn’t seem to decrease: the demographic transition did not start yet\textsuperscript{17}. And all the data above represent a total at the level of the entire province, without a split on areas rural or urban.

We left Transylvania with a gross ratio of mortality of 25.8 before the First World War. After the war, Romania presents the same ratio sensitively increased to 29.1 for decreasing gradually along the interwar period: 1925 – 23.3; 1930 – 19.8 and at last 1939 – 18.5\textsuperscript{18}.


\textsuperscript{17} All data from the pragraph are taken from Ioan Bolovan, \textit{Transilvania între Revoluția de la 1848 și Unirea din 1918. Contribuții demografice}, Fundația Culturală Română, Cluj-Napoca, 2000, p. 158.

\textsuperscript{18} \textit{Anuarul statistic al României. 1939 și 1940}, Institutul Central de Statistică, București, 1940, pp. 142–143.
Interwar statistical data allow us to go further down, at the level of the province and even at the level of the county and, important, allow us an analysis on areas: rural or urban. Thus, in the same year 1939, the gross ratio of mortality for rural population is 16.9 and for Cluj County is 17.2\(^\text{19}\). Thus with great approximation taken as mark years 1871–1875, after six decades the number of deaths to one thousand inhabitants is halved.

As we have seen in the pages above, the informants confessed a raised infantile mortality. Let us see what was the situation in the field during the same period they also talk about. Firstly let us try to establish the ratio of the dead children under four from the total number of the dead. At the level of the entire country, but only for the rural area, in the interval 1931–1938 of the total of 2,254,816 dead, 773,502 are children under one year, that is 34.3\% and 419,618 are children with ages between one and four, that is 18.6\%\(^\text{20}\). On the whole – 52.9\%. In other words, in the fourth decade of the past century over half of the total deaths is represented by children under four years! And again making an average for 1931–1936 on the rural area but for the entire country, from the total of births alive of 3,220,188\(^\text{21}\), till one year die 566,335 representing 18.2\%. In other words, during the period mentioned almost one from five peasant children die in their first year of life. If we continue analyses on the same time interval under the same conditions we notice that for 586,355 dead children correspond 327,350 dead children with ages between one and four. In other words between 1931 and 1936 dead children between one to

\(^{19}\) Anuarul statistic al României. 1939 şi 1940, Institutul Central de Statistică, Bucureşti, 1940, p. 152.

\(^{20}\) Anuarul statistic al României. 1939 şi 1940, Institutul Central de Statistică, Bucureşti, 1940, p. 163.

\(^{21}\) Anuarul statistic al României. 1939 şi 1940, Institutul Central de Statistică, Bucureşti, 1940, p. 156.
four years represent 55.82% of the children dead before one year. This means *grosso-modo* that until four years survive only 71.65% of the peasant children; that is almost two of three. In a family of six children, two would not reach four, and to a bigger one – of nine children – three would die before four. Generally this is the situation presented by our informants.

In conclusion, our informants keep in their memories the time of their childhood and youth situated somewhere in the middle of the past century so different of the childhood and youth of their grandchildren: a tough world where the child ever since his first step has a well defined role in the domestic economy, a world where disease and death strike often the kin: a grandfather, a parent, but especially a younger brother or sister. If we think better, the same life cycle: birth, illness and death, just that illness and death interfered more often in those times than today. Today it is much better than in those days, and they know why.
We look back with pride and also fearful feelings, we look forward insecurely but also hopefully. We are always in-between, and we always try to change, try to do things better... But is this 'better' on the bright side? In other words, will a change that we make remain or will be always on the positive side? The topic I chose for this article is no longer an issue. It would be appropriate for a historian to study it as it is not occurring in the new villages and towns of my country. The debates on the topic are quite feeble from time to time on some TV channels but they have a star effect. The option of having a baby in your own home is no longer an option, here. It could be probably in the future as the idea is trying to come up shyly for now as I have mentioned above. Who would have known that some decades ago women were giving birth at home in Romania and they enjoyed it. They have good memories about it if there is someone willing to listen to. They did it their
way and they are still living and in good health. Interesting is that such an idea with such powerful effects did not have any continuity in our culture. The new trend of homebirthing when it will get more supporters will have as origin the fact that is also done in the western, civilized countries and not because it was something common for our grandmothers. Our dear grandmothers could not pass this knowledge to us. The communist regime cut the ropes. But it is knowledge indeed, and it will take a long circling trip through western culture until it reaches us again.

Women have always given birth to babies in their homes, for most regions of the planet, for most of the times during the past two milleniums. What has changed? I should say nothing, still, everything changed. My intention is not to discuss the matter of homebirthing globally but to refer strictly to the changes that occurred during the communist regime in Romania. Women were let to give birth at home at different times in different regional spaces all over the world, and this was the case for Romania before the foundation of the communist regime.

The communist regime inflicted some major series of changes inside social, political, economic life of Romania and there is quite a rich literature upon the topic in the books of Gail Kligman, Katherine Verdery, Maria Bucur¹, and I will not insist on the matter here.

What is important is that the state was everywhere, it immersed everywhere by creating a new collective life, and a new man/woman – the multilateral developed one as the official discourses were endlessly repeating at all Congresses².


² See for this syntagm the published brochures on National Congresses of the Romanian Communist Party.
Consequently we had a deep intrusion of the omnipotent state into the private lives and the intimate life. Upon these situation of the policy of reproduction there are some works quite well documented of Gail Kligman, Adriana Baban, Elena Bărbulescu. Kligman is talking a great deal about the politics of duplicity as if making of it a characteristic of Romanian communist regime. Unfortunately duplicity is not a communist outcome, it can be found at different levels in the capitalist regimes as well, but it is a good exercise of presenting the shortcomings of an authoritative regime.

The subject that attracted the most part of researchers regarding the reproduction and the communist regime was that referring to abortion. Since the ban of abortion, the results were disastrous both at physical level – a great number of dead women (few thousands) in an attempt of getting an illegal abortion, and at psychological level – the manner of recalling their intimate life of that period. Little was written about the infliction upon intimate life, the sexual life, and the impact it had upon the normal pregnancies.

During all this time when all the attention was drawn mostly towards abortion and its disastrous effects, something was also happening related to the birth itself: it was simply moved from home to hospital for a great part of women in Romania (an exact, even approximately number is hard to give as no researcher cared to study the topic at the time, and there are no official records of this type of event). Why is that? Basically, because birthing at home was considered obsolete and a definite sign of backwardness compared to the new modern idea of birthing in a hospital.

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is important here and needs to be fully stressed is that we are talking here about an alteration of the power structure: the feminine body was no longer controlled only regarding the abortion but also regarding birth, as this was taken from the woman and given to the state through the staff and medical institutions newly founded in Romania... The woman was taken off not only the power to decide whether or not to have a baby, or how many babies should she have, but also how she would have them. The state was the “entity” that knew better for her and especially for the baby. We may notice how the stress moved drastically on child – as a finite product, that was what ultimately counted. What the mother felt or desired was not taken into account, moreover, she was told and made to feel like an ignorant, that whatever knowledge she had, was no longer corresponding to the “new age”...

At the time (sometime during the 1950s, 1960s, 1970s) there was still a large number of population living in rural area. Furthermore the infrastructure was highly underdeveloped. Thus, in such circumstances getting to a hospital was quite a difficult task and consequently what seemed natural for a modern eye, was strenuous for the rurals. I found about homebirthing as a general practice when as ethnologist I started to study a rural community for my Ph.D dissertation. The topic was approaching the study of how gender is constructed inside a community. Consequently, I reached the idea that if I wanted to study the construction of gender I should go to the point zero that in my mind was the birth. At that point I came to know that most women in the village (almost all, with few exceptions for the age cohort born before the 1950s) gave birth to their children at home. I was astonished. When years back, during communist regime as well, one of my neighbors in town gave birth to her fifth child at home – as a voluntary choice –, everybody around saw her as a freak of nature. It is true, the hospital was at ten minutes walk distance...
It was one of those times in my career when again, the subject was coming full speed towards me. I was having a topic for study without looking for it, without asking preliminary questions, without formulating preliminary hypotheses. The topic was overwhelming me with a lot of information that needed a researcher. Accordingly, together with the gender construction I started to gather interviews from women who have experienced birth at home and thus assembling a ‘small’ collection of narratives focused on birth. The second chance to gather information on this topic was two years ago when I started some systematic field researches financed through a CNCSIS grant regarding the manner in which the rural population in Cluj country perceived the sanitary system – physicians, nurses, hospitals – during the communist regime. The main method used in my research is the interview, plus a great deal of informal talks. Being such a delicate subject, the interviews themselves were more like discussions and story telling than as actual interviews. It is true though that I have guided these interviews so as to be as much detailed as possible. My interest was to have a full description of every detail the woman could remember also regarding the day before birth and the days after it: what exactly did she do, where she was, who she was with, who came, and how, when, where she gave birth. I needed this as my goal was to re-create the context of birthing, as much as it was possible from these recollections. It proved to be a very good idea as it opened the way into a different, yet feminine world.

Thus, when reading the interviews, what is striking is that the major change is not in the place only – house or hospital but it is one at a symbolical level – the whole birth has changed; changing this defining event changed also their world as I will present

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4 CNCSIS grant ID 1647, *The Perception of the Modernization of the Sanitary System by the Rural World During the Communist Period (1948–1989).*
and argument further on. I could notice by reading the interviews that changing the place of birth provoked a series of changes at a social level regarding the manner of perceiving the birth inside the community. But these interviews have their limits as well. Paradoxically what misses from these interviews is, in a way, the birth itself as a climax, because the accounts are focused on the context, that is they present by describing it what birth meant to them, the naturalness of the birth, how normal it was for a woman to give birth at her home, in her natural environment. In fact this was exactly the aspect that stressed the importance: a natural event taking place in a natural rightful space for it. Still, besides the short interventions through which the birth was presented as a painful and unknown event, we can’t realize that it is all about a climax, or about a point where the feminine body is placed at a highest level of risk. Anything could happened then. Brigitte Jordan in her study upon the birth in Yucatan, stresses the fact that for the women there, expulsion of the placenta was more important than that of the child, and that the women there are not avoiding the subject of death, on the contrary, they confront it through a series of stories centered on it but wherefrom the main character comes out victorious. In the cases related to me, the role of the people present at birth is exactly the one of detouring the subject of death from the mind of the parturient, just at the moment of birth when the pains and all the situation seem to reach the highest limit. The parturient is calmed down and encouraged all the time:

*And I kept saying “Oh, God, help me!”, “Oh, God, help me!”, “Oh, God, help me!” and after some time the pains became unbearable and I said: ”Oh, God, let me die!”,*

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'cause I no longer knew what to do and my sister [who midwived the baby] kept saying: ”My, dear, my dear, don’t be afraid [you won’t die]”. (woman, born in 1941)

When talking about the event, the women are presenting more the context of the birth and less the birth itself. Generally they have the tendency to avoid it, maybe because it was a shocking event and they do not want to revive it. If it was for them the story of a birth would take five minutes. It was my insistences with very detailed questions that triggered the stories. Few arguments are possible here for this idea: one would be traumatization – as it was an event felt much too acute physiologically, and so they try to expedite it as reviving it would be unpleasant; another argument would be that it is a common experience for women and they supposed every woman has had it – me being a woman, I should know about it...; they started talking easier after I told them that I do not have children, and I didn’t give birth to any, but then I lost the women with difficult births as they didn’t want to give details for fear they might frighten me... A different argument would be that it happened long time ago for many of them and the memory play tricks. This is a sustainable argument to some point, but falls down when I get quite accurate descriptions from the past... and we all know that memory is not a static but a dynamic function. Still I tend to believe that they do remember some reliable things that caught their eyes and mind at that time. On the other hand, one very important argument is that for their generation and maybe even nowadays, birth is something you don’t generally talk about. It belongs to the feminine secrets. It is something that is done, that is different for each woman, and it is something that is learned diffusely or indirectly. The women who gave birth in hospitals do not talk at all about their births, and my guess is that they do it because they felt more traumatized than the ones that gave birth at home.
They even told me they didn’t want anymore children, implying that the event was so unpleasant that they do not want to repeat it again.

In the studied community until the 1960s, even 1970s, the most common birth was at home. The village under study is situated in a mountain area with dispersed houses, this making the travel from one house to the other quite long. Some houses are in the valleys of the small water courses in the area, others are at the top of the hills. Some of them are gathered together in small groups – as an expression mainly of some family groups: brothers and sisters live as neighbors with each other or with their parents.

During the communist regime the situation of the road, connecting the village to the nearest town was deplorable. To this added up also the fact that the transportation means were scarce. All this situation: no road, no transportation means could lead to an isolation of the community to the exterior world. Such circumstances would make it understandable why women would give birth at home. But from ethnological/anthropological point of view, this argument is not the only one standing and not even the most important as we sure know that women have always given birth in their homes for most part of history, and we also know that nowadays women from the same village are doing it at hospitals. Birthing in a maternity is a new, modern idea and it is linked to the general trend of modernizing the Romanian society as a whole but also with a crescendo medicalization of the same society as main processes characterizing the 20th century⁶. No matter how isolated, the village of this presentation did not escape the trend, even though that trend reached it pretty late, in the last quarter of the 20th century. As we will see, all this process did go neither smooth, nor quickly.

When asking women in the village about how did women gave birth in those times, they all recollect one story, assumed also by most of the men as well. This story is very important for this study as it is a prototype-story – it is used by all informants, female or male as a representative story for their community in considering this particular event – the birthing.

They say it was a woman here in our village, here, and her husband was mowing in the field. And he was thinking <<Why isn't this woman bringing lunch, already?!>> She 'made' the baby, she wrapped it, she washed it, she made a layer of noodles, and this is not a lie! She cooked milk with noodles and went to her husband in the field. And there were other men helping with her husband. <<But, what the devil took you so long to bring the lunch?>> <<Well, until I made[meaning giving birth], until I delivered...>> And then the man looked at her and saw she no longer had the big belly.
Yes. Yes. So were women then. (woman, born in 1941)

We may see that this story is a factor of identification as it is also bringing a contribution at building their identity: who they are in relation to where they are... This story brings more than that, by letting us know how the work relations were, the gender issues – the man in the field, the woman at home, and the importance of birthing itself: I came late with the lunch as I have had a baby meanwhile... It is very important as we have here the very local definition of the birth, this influencing the manner in which both the competences and the expectations are formed.7

Consequently, we may deduce that birthing wasn't such a ‘big deal,’ there were more important things to do for a woman such as feeding the mowers. I have numerous interviews where the birthing

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7 B. Jordan, op. cit., p. 60.
occurred when fetching water, cooking or working in the fields, as also plenty of the interviews relating how the woman was all alone during birthing. All these imply that birthing is contextualized, it means that birthing is something usual that has just happened, it belonged to the natural and ordinary set of peasant situations… The stories do not tell us anything that would make it extra-ordinary. On the contrary, these stories build up birth as an ordinary event, something that happens while other things happen, too. It is an action with a pre-established importance in the peasant life, and it belongs to the feminine set of tasks in the household. One point that this story wants to stress is the fact that the woman was alone, and this is something that refers to actual living conditions of the villagers – the houses are far enough one from another to make the presence of a midwife being too late compared to the speed of birth itself, and the second major point is that women were giving birth very quickly, much quickly than today, as a consequence of the way they lived. All of these points are making reference to the naturalness of the process of birth and also to the exclusive contribution of the mother to the process. The woman is ‘making’ the baby as shown by the term they used locally for giving birth. Moreover the local term for laboring is ‘works’ strongly making reference to the working effort of the woman when birthing. Birth is one of the other tasks of the woman inside her household. She is actively doing it. It is a different responsibilization of birth compared to Holland or Sweden. They dealt with wanted pregnancies in the absence of any interdictions regarding abortion. The women in this Romanian village are responsible for a child that comes from God. Their idea is that a child comes from God, through God’s will. The child did not appear as a voluntary choice but as a result of divine will putting the woman in the position of a receptacle. This situation of receiver,

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doubled by scarce contraception knowledge, brought less responsibility from the part of woman, as this divine “gift” was unstoppable. It resulted a normal reaction generated by a normal thing. Thus the women did not decide to have children but they simple did not have the knowledge to stop babies from coming. Consequently, they thought that they did through birth what they were meant to do. They considered that this was written for them. Hence, the almost excessive care, towards the symbolical level. They had to be careful in not upsetting the supernatural, the major responsible for the apparition of these children, according to rural mentality.

Consequently, this whole ordinary situation is doubled by a very powerful symbolical one. Even if the action itself – delivery – is a profane one, the mother and child are immediately introduced into a symbolical dimension when they become impure and need to be purified to enter the village community, as the villagers don’t know where the baby is coming from (Irina Nicolau)\(^9\) and what perils might occur while the mother as the means of delivering the baby has contact with the impure and thus with a potential danger.

Consequently, there are few rites performed in order to re-establish the positive order of things inside the community: the baby is shown/dedicated to the icons, is given a name, and the mother is not allowed to go out the household for six weeks and then only after she had fetched a *molitva* (offering) to the church as a sign of the fact that the period of purification is over. There are also restrictions regarding who is allowed to see the baby, how and where to wash and dry his/her clothes, how to sleep etc. All these rites are necessary so as the passage from the ‘white world’ (Irina Nicolau)\(^10\) to the world of the village community be done in the natural, normal way, by observing the social symbolical rules.

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\(^10\) *Ibidem*. 
We see here that the birth though a private mater in a physiological, profane sense is in fact a collective matter at a symbolical level.

The new born belongs to the family, to kinship, and to village community. The whole community participate in one way or another to it. There are few people allowed to participate literally in the event – the mother, the mother in law, a sister, the husband, but when this is not possible due to an emergency situation the people present could be a neighbor or the neighbor’s husband.

Considering the process of delivering the baby itself there were no restrictions for women as regards the position at birth so all of them gave birth on their knees, down on the floor near a bed or a chair used as support for their hands. They put a cloth on the floor so as not to harm the baby’s head. There were basically three reasons for it: firstly, because it was easier this way, as the woman was helped during labor by the gravitational force, plus the position allowed her to have a better use of her abdominal muscles¹¹, secondly because most of them were home alone for most part of their deliveries and this position allowed them to deal better with the handling of the new born and cutting the navel, and thirdly because it was also a way of concealing her genitals from the other women if present at birth. Then they waited for the ‘place’ (placenta) to come. If it came well it was ok, as otherwise there was no qualified people around to check and see if everything was all right, and they would go to a doctor only if there was an extremely serious situation: a constant and powerful bleeding, for example. It comes out from the interviews that the improvised midwives present, were not actually qualified to check the integrity of the ‘place’, and so if abundant bleeding occurred or other signs of weakness were displayed within few days, there was a need for a doctor.

¹¹ Brigitte Jordan, op. cit., p. 84–85.
Again the interviews showed that even in these extreme cases, women seldom appealed to a physician’s expertise.

All women said that they worked right before their delivery and started to work within two days from delivery. To this situation a multiple set of factors contributed: the relations between the woman and her mother in law, her relation with her husband, the period of the year when the birth occurred. It is also worth restating that at birth the woman could have been alone but also she could have been surrounded by relatives or neighbors and the husband’s presence was not excluded. There was still a preference for the women inside the kinship to be present at birth.

There are today multiple web sites that contain information about home birthing as an alternative to birthing in hospital. I do not know to what extent a woman in Romania would resort to it. At least until now, for the young generation I did not hear about this being used as an option. The only situations I have heard of were those when the child was born on the way to hospital so not as a voluntary choice outside the hospital. Women today prefer the hospital and do not think that there are other alternatives. This also comes from the fact that other options are not presented. From this point of view the medical education prevailed, as birthing is no longer a family event, or a community event, but it has become an exterior phenomenon that needs to be introduced to the community. The birth at home was considered an inside event as the villagers consider their lives inside a community while the hospital represents an outside place as it is exterior, no matter its location (in the village or the nearest town) but in a cultural sense. The older women are quite upset and reproaching at the way things are:

‘Now you don’t know, you just see they go to the hospital and pop up with a baby at home!’ (woman, born in 1944)
Regarding the birth in a hospital, the main idea coming out of the interviews is that it provoked an enormous stress, and consequently generated a reaction of rejection from the village woman. Moving the birth from home to a delivery room and bed meant a symbolic move – the passage from the woman’s birth to a hospitalized birth. Most of women, refused to deliver in bed and created strategies to avoid birthing in bed while being in the hospital by telling that they needed to walk or go to the toilet etc., then they would go on the hallway, leaned on their knees and deliver the baby to the distress of the medical staff… Those women sensed that they were losing something precious and tried to hold on to it as much as they could. They said that ‘it is to woman to give birth’ just as the way they say that the woman is to cook, clean, wash...or other feminine tasks. Thus the location of birth is part of birth itself.

The midwife said to me: “Sit, Ms. Victoria.” I said: ”I go in the room, in the delivery room to undress”. I just undressed and...[gave birth] She said after she came, because she heard it form outside, she said: ”You gave birth to a girl, because I know them from the shouts” “You gave birth to a girl”. And I said: ”I don’t know ‘cause I didn’t look.” She said: “You are not allowed down [on the floor]”. And I said: “This is how I am used to. I gave birth only this way.” I could not give birth unless I kneeled. So it was. It is how you learn...  

One other important aspect was that in hospital the baby was taken away from the mother, and she didn’t know anything from it for days or even weeks if there were some problems. At home a woman learns how to check the physical integrity of her baby, at hospital nobody tells anything and you have to wait a response

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12 Brigitte Jordan, op. cit., p. 68.
13 For deontological reasons the name of informant was changed.
from the medical staff. It is again a crush of two worlds... A woman goes to the hospital with a certain background concerning birth but enters a different background regarding the same subject and so she finds herself outside both of them, displaced and helpless. Even though in the village background there was no explicit birth education of a girl, there was something that we may call a diffuse education as the members of the family were not and could not be absolutely excluded from an event like birth, and so the girls had had direct or indirect contact with a birth.

There must be some ladies [midwives] who know how to take you, to show you, it was necessary especially for young mothers, didn’t they? Didn’t they see that I was also a child? They had to come and say: “Look, woman, you girl, you hold it like this.” I didn’t now how to hold a baby in my arms. If I didn’t have any younger brothers, I didn’t know. “Look you hold it like this to suckle, you put your nipple in his mouth like this, he has to suckle like this, this is how you should feel.” I didn’t know. How could I know it? Well I learned afterwards. I knew it well. (...) In the first stage I didn’t know[if the baby was alive or not] I didn’t know to ask where was the baby? And after two or three days they told me the baby was in the incubator. [This happened] because they didn’t show it to me. Four days they didn’t show it to me. And they said to milk myself and they took the milk to him. (...) And I was thinking why [they didn’t show it to me]. They had such an attitude that you didn’t dare to ask questions. You asked once, they answered, that was all. They did not explain, they did not prepare a girl to... I don’t know. (woman, born in 1962)

When talking about hospital birthing we should notice that to the profane action of delivery is given symbolical, sacral valences, now
after the initial symbolistics has been lost, exemplified through the fact that those practices at home birthing considered as usual and normal, insignificant, become now important in the process: how many days before to go to hospital, what clothes to take, what color should they be etc. At the same time, what was sacral and ritually important at home birthing becomes irrelevant if it occurs at all: showing the baby to the icons after birth, for example. It is like the hospital birthing is reversing the home birthing: what was ritualized before is de-ritualized and at the same time we have a process of ritualizing the new habits.

When giving birth in a hospital we have a passage from a collective to a private sphere. More explicitly, the collective, public space is changed as it is highly populated with strangers and devices. The birth takes place in an impersonal, public, collective place, surrounded by medical staff. Then the baby and mother go to their private family, in their community space. Except from baptism, there are no other rites performing. At home birthing, the process was occurring in the intimate space and then through specific rites delivered to the larger community. Besides, the women and child were visited by the other women in the community, who were also bringing gifts. This ritual visit was transforming this act into a feminine action, as the birth was a major action belonging primarily to the feminine circle. Baptism, a ritual performed also nowadays, despite the fact that it is a woman who becomes the godmother and the role of the godfather is minor, is more like a mixed activity: both women and men participate. Thus we may also add the idea that the process of birth suffers a transmutation from the feminine circle to the masculine circle or a mixed circle in the best case. To this adds also the fact that in hospitals there is a great number of male physicians (gynecologists) while midwives are females.

There were in the past, one or more midwives in the village. The midwife was selected firstly by using the criterion of similarity. She had to be old and have had births of her own. Sometimes, in urgent cases, and if she lived too far, they called a neighbor or a relative but who, as *sine qua non condition* had at least one birth of her own... Looking at things from this perspective it is easy to understand why those women were so reticent, or even refused the help of the midwives hired at the village maternity or dispensary. They simply had two major disadvantages: they were too young and hadn’t had experienced births of their own. We may bring here a parallel with another system of similarities: the shamans became healers because they had been seriously ill and prevailed the disease\(^\text{15}\), the same logic is put to action with the birth – some women have the right to midwife and assist at birth because they gave birth and prevailed it, they survived after giving birth...

In conclusion, home birthing has become a historical subject. It was a natural event for the past, it belonged to the daily culture of our grandmothers or in some cases of our mothers. The communist regime for the case of Romania, – the capitalist regimes for other countries – has changed the event and transformed it into something else. Accordingly, we grew up not knowing of this practice and when knowing it rejecting it as obsolete because this is the way we were taught. But we didn’t have the whole picture of it. Somehow the knowledge stopped at some point between mother and daughter. It was no longer transmitted. The mothers could not/ were no longer allowed to teach their daughters how to give birth. In fact no one did teach them, *the state wanted to and did the deliveries for them*... This makes me wonder how birth will look like in the future as it

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is emerging a new medical conscience and awareness regarding one’s own body and whatever relates to it. Birth is an important bodily experience. Will the women still prefer the medicalized birth when they know there is another safe option?
They give you pills, if you have money, you take them, if not, you die…

Body, gender and illness narratives in poor communities

Petruța Teampau

The body is a natural symbol for understanding social and political institutions, but also the material basis for all our social relations, the symbolic and sensorial interface of our connection to the world. An extremely generous literature has been investigating, among others, the role of the body as a surface of inscription for the social and cultural norms and values, the body as object of social and political control, as source of cultural discourses and narratives actively implied in (re)producing meanings and norms, and, last but not least, the body as epitome of a(ny) culture.

Ever since Mary Douglas has pioneered the field of body studies several decades ago with her famous analogy between the physical and the social body, viewing the former as “a microcosm of society”, the metaphor of the body as cultural text has gained momentum in (Western) social sciences. Mary Douglas has shown that the body is not only the
material and symbolic basis of any social and political assembly, but also the most ancient and pervasive natural symbol for understanding society, culture and any kind of social group. Starting from the premise that “the way in which the physical body is perceived and represented in a culture will reflect the preoccupations of that culture”\(^1\), Susan Benson considers the body “a cultural text, giving material expression to the cultural values, the preoccupations and anxieties of a culture”\(^2\). In fact, the metaphor of “reading” the body as a narrative of cultural values and obsessions will become quite fashionable in social sciences.

Susan Bordo, viewing the body as a powerful symbolic medium, a surface on which all major rules and forms are being inscribed\(^3\), used this perspective to expose the inner contradictions of consumer society, arguing that eating disorders in consumer society are clearly a symptom and constituent part of its functioning. In the last decades, social constructionist ideas have almost become conventional knowledge in most socio-cultural disciplines. According to these, bodies are produced by the prevalent discourse(s) and as such they are created, inscribed and managed according to the norms of this/these discourse(s). Moving beyond a static vision on the body, as plain text to be deciphered or imprinted upon, Chris Shilling projects it as a multidimensional medium for constituting the society: a source, a locus and a way of positioning individuals inside the society. In fact, the body as symbol, the body as text, the absent body, the gendered body, the body as interaction,


\(^2\) \textit{Ibidem}, p. 128.

the body as discourse are all dimensions of the same Body, cut across by different ontological and epistemological concerns.

In late modernity, the body is spoken of as more and more a phenomenon expressing the personal identity of the individual; one might argue that the body has become the hero of post-modernity; in the age of loose, flexible, fluid relations and identities, the body nourishes an illusion of stability, through anchoring the self in the concreteness of its fleshiness. The individual is no longer a body, but the owner of one. There is still an illusion, though. The body itself has become fluid, fragmented, unstable, ever since it has been stamped as “perfectible”. The post modern obsession with the body, or rather with some features of it – those features encoding the “signs” of beauty, youth, attractiveness – serves but to hide, or even to postpone, the one most certain reality of our bodies: death. In passing from an instrumental, functional vision over the body in traditional cultures/communities, the body has become not an instrument, but an end in itself, an object of salvation. Acquiring moral dimensions, where the correct management of our corporality speaks about our inner morality, the body is itself a producer of signs and meanings.

However, the body is never effortlessly defined, since it is at once biology and culture, sign and significance, material and discourse. Moreover, “body” already implies a reification. We speak of the concept and its reality at the same time. Also, we speak of the body as if it were stable, objective and unchanging historically, immune to cultural influence.

In the scientific model that has dominated medical thinking from Antiquity into the Middle Ages, the body has always been perceived in a system of correspondence with the world, “resonating” with it⁴. Elements of the body were seen as strictly linked to

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⁴ Roy Porter, Georges Vigarello, “Corpuł, sănătatea și bolile”, in Alain Corbin, Jean-Jacques Courtine, Georges Vigarello (coord), op. cit., p. 423.
elements of environment, and the bodily organs acquired features of the physical environment: wet, warm, cold, dry\textsuperscript{5}.

However, the emergence of the modern body, somewhere in the middle of the seventeenth century, according to cultural historians, has dislocated the body from the center of this complex system of correspondences; from now on, the body is detached from the individual, from the others and from the universe\textsuperscript{6}. From now on, the body is analyzed, dissected, and treated as any other object of study; its anatomy has lost all mystery. Gradually, “medicine has occupied the social space freed by the erosion of religion”, with “a transfer of moral regulation from church to the clinic”\textsuperscript{7}. The logic of the body’s functionality has become strictly mechanical, and not spiritual, emotional or metaphysical, and its workings are always transparent to the trained specialist: the doctor\textsuperscript{8}. As Lock and Fraquhar have underlined, “the common assumptions that states of health and illness are confined to individual bodies, that illness and disease are best managed by medical specialists, that an absence of measurable disease in effect signifies that nothing is amiss, and that the preservation of health is primarily the responsibility of individuals are products of the bio-medically inflected times in which we live. These ideas have political ramifications, but they could not have taken root without a tacit agreement about the existence of a universal material body whose condition is determined by nature alone”\textsuperscript{9}. In the bio-medical model of the body, “diseases are entities

\textsuperscript{5} Roy Porter, Georges Vigarello, \textit{op. cit.}, p. 408.
\textsuperscript{7} Bryan S. Turner, \textit{op. cit.}, 1992, p. 22.
\textsuperscript{8} Susan Bordo, \textit{op. cit.}, 1993, p. 66.
in themselves, affecting all bodies similarly, knowable in isolation, and in theory without moral, social, or political significance”\(^{10}\); also, in this model, “the body is a relatively stable entity, predictable and objective”, “a complex bio-chemical machinery that can be fixed by medical intervention”\(^{11}\). The doctor can “read” the body according to precise symptoms, and the presence of these symptoms is the ultimate proof of illness.

However, the recent effervescent debates about body in social theory have had a major impact on other fields of inquiry, and medicine has been no exception. Starting from the premise that the body is a metaphor of society, diseases are seen as individual disturbances that correspond to macro-social disturbances in the social body. Purity, polluting phenomena, symbolic practices related to these, all have to do with the purity and equilibrium of the social system, not only that of the body\(^ {12}\).

Originally a positivist discipline, and extremely vain, conventional medicine was forced to look into questions for which there was no “scientific” answer, and found itself destabilized by the vision according to which “diseases have a history of their own, they are culturally shaped by prevalent discourses and owe their existence to relations of power”\(^ {13}\). Moreover, there is no neutral body anymore, one that would exist “outside of any process of producing meaning”, and “would await passively the objective reading of trained specialists”\(^ {14}\). As a consequence, pain, illness experience, body narratives have all become legitimate topics of social inquiry.

\(^{10}\) Judith Farquhar, Margaret Lock, *op. cit.*, p. 436.


In recuperating the vision of the body as social and political metaphor, these new analyses started to look at the lived dimension of disease, including terminal ones, and at the way they influence the individual’s life and her relations with others and with the world. If in a day-to-day life the body is mostly “absent” (Leder), Simon Williams shows how experiencing a chronic illness, for instance, can force the individual to undergo a translation from “an “initial” state of embodiment to dis-embodiment and re-embodiment”; and this process requires a considerable “biographical work” or what Williams calls “narrative of reconstruction”\(^\text{15}\). The illness experience can be powerful enough to alter the relation between the body and the self, in which the suffering body requires urgently some form of a medical and symbolic management\(^\text{16}\). As Waskul and van der Riet have shown, in the case of terminal illnesses, “the ‘natural’ relationships among the self, body, and society have ceased. Instead, the inherent trust in the fidelity of their bodies – those previous ‘natural’ relationships – have forever been undermined”\(^\text{17}\).

Almost always a corollary of illness, pain is understood by Bryan S. Turner as “an emotion in a social context”\(^\text{18}\): the sick person is looking desperately for “a medical diagnostic, a spiritual interpretation, a cultural guiding, a psychological explanation, anything that would make the experience of pain meaningful, predictable, ordered and understandable”\(^\text{19}\). Pain should not be anymore,


\(^{17}\) Dennis D. Waskul, Pamela van der Riet, *op. cit.*, p. 510.


\(^{19}\) Dennis D. Waskul, Pamela van der Riet, *op. cit.*, p. 503.
as in the bio-medical model, a mere “elaborated system of monitoring symptoms”\textsuperscript{20}, but “a quotidien experience, one embedded in the lived structures of corporality”\textsuperscript{21}. Gender differences also prove relevant; according to a study of Gillian A. Bendelow and Simon J. Williams, women are considered, by both sexes, as more endowed to face pain. The possible explanations combine arguments relating to sex and gender: women are closer to their own bodies (due to the “universal” experience of menstruation and pregnancy), women “belong” to the domestic sphere, where corporal realities might be “naturally” experienced and women are more involved into the emotional, affective and bodily interwoven threads of what we call family. Moreover, according to gender ideology, men should restrain themselves from public displays of suffering, including crying, while women can freely give in to their emotions: “the ontological security and the identity of women are less undermined by the recognition of suffering as in the case of men, where the psychological structure of masculinity tends to inhibit the recognition of vulnerability”\textsuperscript{22}.

Recent inquiries about body, illness and identity have visibly shifted their focus to narrativity, subjectivity, the discursive dimension of disease and of its effects, working to expose “the relationship among discourses (subjective, popular, and professional) embodiment, and lived experience. Through this approach the embodied individual is reinserted into social and political contexts, the contribution of which to the physical reality of disease and distress then becomes evident”\textsuperscript{23}.


\textsuperscript{21} \textit{Ibidem}, p. 199.

\textsuperscript{22} \textit{Ibidem}, p. 215.

\textsuperscript{23} Judith Farquhar, Margaret Lock, \textit{op. cit.}, p. 437.
In a very sensitive and profound analysis of a disease that seems to affect the poor communities in South America, nervous, Nancy Scheper-Hughes sees in it “a complex, somatic, and political idiom”, irreducible to “an insipid discourse on patient somatization”24. Scheper-Hughes argues that “from the phenomenological perspective, all the mundane activities of working, eating, grooming, resting and sleeping, having sex, and getting sick and getting well are forms of body praxis and expressive of dynamic social, cultural and political relations” and she further suggests that “the structure of individual and collective sentiments down to the feel of one’s body is a function of one’s position and role in the technical and productive order”25.

According to the author, “nervous has generally been understood as a flexible folk idiom of distress having its probable origins in Greek humor pathology. Often nervous is described as the somatization of emotional stress originating in domestic or work relations. Gender conflicts, status deprivation, marital tensions and suppressed rage have been suspected in the etymology of nervous”26. More than anything, this affliction seems to be a social and political one, especially if we look more closely at the symptoms and attempt to “read” them beyond the bio-medical framework: “a person who ‘suffers from nerves’ is understood to be both sick and weak, lacking in strength, stamina and resistance. And weakness has physical, social and moral dimensions. Tired, overworked, and chronically malnourished squatters see themselves and their children as innately sick and weak, constitutionally nervous, and in need of medications and doctoring”27.


27 Ibidem, p. 460.
Nancy Scheper-Hughes pertinently shows how the conversion of hunger into nervous “insures that systematic problems of poverty and political-economic oppression become cases of individual sickness for which no social blame can be allotted. The bodies of men and women so afflicted can be understood, […] as both metaphors and metonyms for the sociopolitical system at large and as the media through which their weakness, literal and structural, is simultaneously expressed”\(^2\). She explains very clearly how the transition from a “popular discourse on hunger to one on sickness is subtle but essential in the perception of the body and its needs. A hungry body needs food. A sick and ‘nervous’ body needs medication. A hungry body exists as a potent critique of the society in which it exists. A sick body implicates no one. Such is the special privilege of sickness as a neutral social role, its exemptible status. In sickness there is (ideally) no blame, no guilt, no responsibility. Sickness falls into the moral category of bad things that ‘just happen’ to people. Not only the sick person but society and its ‘sickening’ social relations are gotten off the hook”.\(^2\)

Thus, nervous becomes, in Scheper-Hughes’ analysis, a “somewhat inchoate, oblique, but nonetheless critical reflection by the poor on their bodies and on the work that has sapped their force and their vitality, leaving them dizzy, unbalanced and, as it were, without a ‘leg to stand on’. […] But nervous is also the “double”, the second and “social” illness that has gathered around the primary experience of chronic hunger, a hunger that has made them irritable, depressed, angry, and tired and has paralyzed them so that they sense their legs giving way beneath the weight of their affliction”\(^3\).

A similar analysis, in terms of linking the body with its political/social environment, has performed Mariella Pandolfi, in

\(^2\) Judith Farquhar, Margaret Lock, \textit{op. cit.}, p. 439.

\(^2\) Nancy Scheper-Hughes, \textit{op. cit.}, p. 461.

\(^3\) \textit{Ibidem}, p. 467.
a study of the feminine universe in an Italian village, where women
tend to somatize the events of their families and community,
inscribing these events not only in their own subjective suffering,
but at the same time on the collective memory. Pandolfi shows how
“village women, located at the margins of their society, create an
identity of belonging through storytelling. Moreover, when narrat-
ing the ‘troubles’ of their bodies, women insert the emotional events
of their lives into both national history and village history. In so
doing they describe a metaphorical body that transcends material
boundaries and the usual parameter of feeling well or ill. [...] nar-
reration is about a form of shared suffering experienced exclusively
by village women through the generations, and its telling brings
about renewal and affirmations of identity”31.

In Pandolfi’s analyses, storytelling appears to be vital for
these women’ identity, sense of belonging and place in the com-
unity; it is about stability, meaningfulness, participation and, last
but not least, “being”. As the author puts it, “women rebuild life
experience through narrative, through the discourse and the mem-
ory of suffering interwoven with the past and the present. But if
they want to talk about the village, or about family events, past and
present, they begin by narrating the troubles in their own bodies.
They describe a constellation of symptoms using terms borrowed
from the interpenetration of official and traditional medicine, and
delineate a new narrative grammar that transposes the historical
extraordinary event into the body’s extraordinary event”32.

It seems that this “feminine” language of narrating illness
speaks also of a particular anchoring in time as part of a specific

32 Mariella Pandolfi, “Memory within the body: women’s narrative and
identity in a Southern Italian village”, in Margaret Lock, Judith Farquhar
(eds.), *Beyond the Body Proper. Reading the Anthropology of Material Life*,
way of being a woman in that community; it is always about waiting for something better to happen, as a compensation for the unrest and unhappiness of a present in which women cannot really find a safe place: “The central point is that the dimension in which the women project themselves is that of expectation or realization of the event, real or metaphoric, past or present. Excluded from the central masculine world of ‘doing’ and ‘making’, and excluded from the sense of this doing and making, women wait and often reconstruct their ‘own’ stories or histories”. One of Pandolfi’s respondents puts it very painfully: ‘what I would like is another time, another history, another body. Instead, a woman is a gypsy for life. That is her fate. First she is a stranger in her husband’s house”.

Pandolfi finds that this idiom of narration is utterly different, although it describes symptoms that might be confused for a real pathology. In fact, for the women in her study, “being well or ill is not something that depends on physical health, having a good doctor, or taking the right medicine. Feeling well or not depends on whether life spares us or bows us, and you are bowed and brought lower not so much by misfortune or death, which are considered almost natural aspects, as by events that alter and disrupt social relations (emigration in the past, rigid relations between the families of husband and wife, gossip, family quarrels etc.)”. After all, the body narrated by these women is a “sore body that hurts and expresses the discomfort of living”.

All of these analyses open up a new space for analyzing the body as a discursive universe, where narration reconstruct identities and social relations, while cementing the existing ones, and

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34 Ibidem, p. 456.
36 Ibidem, p. 455.
help the individuals cope with the uncertainties and vagaries of day-to-day life.

**Body narratives and issues:** *If you’re sick, you go to the city, at ER and get hospitalized; they give you pills, if you have money, you take them, if not, you die.*

This analysis is based on anthropological research conducted in 2004 in the county of Hunedoara. The main focus of the research was reproductive and contraceptive practices, on the background of specific gender ideologies and relations. However, the body and its afflictions were always present in all the discussions.

The area of research included both urban places (Orăștie, Geoagiu), as well as rural (the villages of Pricaz, Orăști-oara de Jos, Sibișel, Romos, Căstău, Gelmar). With very few exceptions, the population was composed of couples with medium or low education, a poor standard of living and, in the case of the marginal neighborhoods of Orăștie, Geoagiu and some of the rural communities, of Roma background.

We have conducted narrative interviews, using at first pre-designed questions, but later on, some of the “interviews” turned out to be naturally occurring “woman-to-woman” discussions about women’ issues, illnesses and problems. In the case of older women, sometimes the interview became a life story, while in most Roma communities the interviews were very close to a form of ad-hoc focus groups. However, this methodological flexibility allowed for the collection of a rich and fascinating material that included

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37 The research was a team effort, coordinated by professor Vincze Enikő. The team was composed also of Zsuzsa Plainer, Iulia Hossu, Viorela Ducu, Diana Damean, Gelu Teampău and Marcel Mateş.
more topics than we originally intended. One of the possible readings of this material looks at the way the body and its afflictions are perceived, met and narrated in these poor communities.

The quotation in the subtitle above is a very plastic expression of how the experience of illness is always intertwined and determined by socio-economic status. We had plenty of narratives in the interviews, most of them unsolicited, and almost all of them brought the “money” topic into discussion.

After I gave births, I started having problems. I had horrible pain in my belly, for three months they did not tell me what it was. They said: maybe it is a disturbance from delivery. After about two years, I was sicker and sicker, I had a hemorrhage, and I went to the hospital. The doctor told me I was pregnant and that she would put me up for abortion if I wanted, since I already had four children and my husband was ill. There is no way I could have been pregnant, I thought, I am aware when I’m pregnant and when I’m not. And I had an ecography and the doctor saw that I was having a cyst on my uterus, I was hospitalized for two weeks. They said I should go to Cluj to have an operation. Go without money? I said I couldn’t, just give me some treatment. They said there isn’t any treatment, except the scalpel. Since then, I was hospitalized again, I went there in a desperate state again. I should go again, I felt sick lately, but I kept postponing. I should rather save these money for food and bread for my children (woman, 37 years old).

Unfortunately, health care is regarded as a luxury; women, mostly, prefer to postpone or avoid the medical consult:

You know, I told you I had problems with my heart, but at the same time I discovered a small uterine cyst,
that was the size of a cherry. The way I am, I just let it there... to grow... I had a lot on my mind... that's the way I am, I take care of my health by myself. I do not go to the doctor. Believe me, I never had such kind of problems, I went to a gynecologist twenty years ago, but now, this autumn I had to go. Because of my age, I found out there are some phenomena. But it wasn't my age. It started to grow... then I got scared. I asked a friend, a neighbor of mine, I didn't tell anyone else, and she took me to the doctor. She said: you have to go to the hospital! I said: no way, I won't, I don't like hospitals. I went, however, the place was ok, but I did not stay there. They gave me a bottle, and, as crazy as I am, I said: what is it? No way! I won't take it! I felt ok, I was using my legs, but every time I stood up, it felt like I was floating. I came home, and after a week it stroke me again and my son took me to the hospital. The cyst had grown again. “You have to go to surgery!”.

My son took me to Deva, for investigations, and then I didn't go to surgery after all. My boy went to take the results, and since we didn't really have money, and the holidays were coming, I said: if you have to pay anything, just let it be, fuck it, I'll survive, as I did until now. [...] after that, I got even sicker, I felt all the power was leaving me day by day. But in my soul, I was thinking: no problem, it’ll pass, we go to church... but still, I thought: I got so weak... what if I die? That's how I felt. And I said: if I die, what will happen to my child? And I prayed and cried all night long, there had to be a way! The doctor gave me a treatment, but I didn't have money to take it, just a few pieces at a time, but I felt worse and worse. Once, my boy bought a whole box
and it had a recipe also, and I read it and I was shocked: I wasn’t supposed to take that stuff, it was not good for me! And I stopped taking the drugs. I was weaker and weaker, but I was praying and God is almighty. I found this newspaper, Formula AS, and there was a recipe for a tea, and I sent my son to a lady, I cannot say who, to bring me that tea. And I drank it, and in a week I was better, I washed the carpets for the holidays, I made some cookies. Now I feel like I’m twenty again. I don’t know for how long, I never went back to the doctor (woman, 40 years old).

Women would rather avoid the medical encounter for themselves (most of the times for reasons related to money), but are always worried for their children:

I’m not used to going to the doctor, except when I feel it’s really critical. If it’s just a cold or something, I take some medicine, I always keep such stuff in my house. If there is a pain that just won’t go away, than I go to the doctor. But mostly I go for my kids (woman, 29 years old).

In many cases, the medical encounter itself is unpleasant, to say the least; especially in the case of childbirth, the relations with the doctors and nurses is perceived as tensional.

Well, my pregnancy was very difficult, and I got stuck with these pains in my back, I had a cesarean and they gave me a shot in my spine and they didn’t do it right, they had to stick the needle twice. And three days after, when I was able to get out of bed and I saw my baby, I thought I would paralyze. My back, my head, my hands were numb and I fell down. The baby was blue
and small and I thought he was going to die and got so scared that it got me sick! And I got stuck with this back pain. It’s a good thing I can work, though, and I work. I never had any problems, to be ill or something… (woman, 35 years old).

Perhaps also due to the topic of our investigation, many illness narratives had to do with diseases of the reproductive apparatus, or unattended complications after childbirth:

After my fourth child I had my cervix cauterized, I had a wound, I do not know why, maybe doctors’ negligence, but after two years they had to cauterize my cervix, and, well, I also have problems with my belly, the gland, a lot of problems, well… when you have one problem with your body, then everything tumble down (woman, 30 years old).

Regarding the experience of childbirth, many women shared the belief that women are supposed to suffer, or at least that they could endure it more easily than men. Many women regarded caesarean as “unnatural” and as an unwanted complication:

With my first boy, I had a twelve hours travalium. But, again, it depends on your personality. I have encouraged myself thinking that so many women have been through that, how come I wouldn’t be able? And now, with my second child, I was so stressed, thinking how it would be, that I told my husband I wanted a caesarean. He said he wouldn’t let me! I just wanted to avoid the pain! Thank God I didn’t, in the end. I had a very easy travalium, from 9 to 1.30, started at 9 with a light pain, that anyone could stand, well, anyone! Any woman! Then the intense pain came, but only for half an hour,
but I say it was worth it. If you can bear it, it’s worth it. Afterwards, there’s a period of about a week after birth which is more difficult, cause that’s the way it is. If there’s a natural, normal birth, it’s easier (woman, 29 years old).

As mentioned, a caesarean is something that most women think it is “against the natural way”. One woman was already in the hospital for delivery, but she couldn’t go into labor, and in the end, after hours of pain, she agreed to being cut herself instead of undergoing the operation:

They gathered around eleven doctors and wanted to operate on me. There were some complications with the baby but they wouldn’t tell me. And I said, no way, after all this suffering you’re not cutting me open. And in the end I gave birth naturally, and I had 18 stitches, as the girl was quite big. I always thought that a woman is destined to give birth, so I see no point for a caesarean. Otherwise, how can you call yourself a mother? You have to go through these pains. In the end, you have nice memories of it. If you’re supposed to give birth, why not? Otherwise, they put you to sleep and you just wake up with a baby in your arms! Can you still say you gave birth? Men have to go to army, women have to give birth, this is our fate. And plus, after a caesarean, you cannot do physical work, you’re alone in the house and you cannot lift anything, you’re powerless… (woman, 34 years old).

In some cases, the pregnancy narrative is told very clearly in the idiom of nervous.

I always felt very nervous, everything was aching, all my bones, I couldn’t sleep while I was pregnant. I had
to move in a different bed. It’s not that I was too big, but I felt big and heavy... I wouldn’t take any medicine, I didn’t care if I could lose the baby. If only I knew he was a boy! I didn’t wanna go to the hospital. I had pains all over my body, twinges, my hands, my legs, I couldn’t find my place, I was restless... I had a terrible twinge in my back, I used to sit by the stove, than sit on my belly in bed, when my partner came in the room I pretended to laugh. I was really sick, but I couldn’t show it in front of him, so ... I went to the hospital and in half an hour I gave birth. There were these pains! Terrible pains, but no tear on my face. I cannot cry, to make a fool of myself! I scream, whatever, but no cry. And if I cried, what? The pain would be the same and it’s still me to bear it! And I was so curious to see what it is, a boy or a girl. And when I found out it’s a boy, I was so extremely happy, that I didn’t feel anything anymore, just wanted to see him. I couldn’t sleep for two days in a row for happiness, then I started to worry. At first, I wanted to lose this baby, and I got scared that God would take him away. That’s why I didn’t baptize him, just took him to a baptist gathering and they prayed for him. And they blessed him, and he’s here with me now (woman, 25 years old).

Sometimes, illnesses change the life of the individual in dramatic ways. One woman explained that she could not work and she lived in poor conditions with her daughter because of her diseases.

I cannot go to work, cause I’m sick with my head and with my belly. I gave birth with a caesarean, I was too old, the doctors told me, I was 28 already, and nobody took care of me, I wasn’t working... I had complications
afterwards. I should go again to surgery, but I don’t have the money. I also have a neurotic syndrome, I forget everything, and I suffer with my nerves. And the sleep disease: I cannot sleep. And when I cannot sleep, I have terrible headaches. And they are horrible, my headaches… (woman, 31 years old).

Generally, the aim of these “body narratives” is to find a meaning, an explanation, mostly retrospective, for diseases and accidents that affect one’s life. It is especially women who tend to look for meaning in the relations they have with (significant) others and to contextualize whatever is happening to them:

After my second pregnancy, when I was seven months pregnant, my grandmother died, and she has been like a mother to me, and I was so upset and so sad, and maybe that is why my hypophysis went wrong… after I gave birth, my hands were always swollen, at night my hands would paralyze and would still be like that in the morning, and I wasn’t feeling good at all. My legs were swollen and my shoes didn’t fit me anymore. And I got scared and went to a doctor. I was all swollen in my body, and my bones were growing. I knew it because I had to take off my wedding ring, for the flesh was already growing over it and I had to take it off while I still could. In 2000 I was sick again, when my father-in-law died, I almost fell down, I stayed at home for five days without being able to turn in bed… I didn’t go to the hospital hoping that it would go away, and then I went and they hospitalized me. I was having an urinary infection, and then they checked my head and knew what I was having, they saw that the bone in my hypophysis is bigger than it normally should be.
They sent me to endocrinology, I stayed in Deva for two weeks, they didn’t do anything to me except for some treatment that I couldn’t afford, it cost me about 60 million lei back then, and the doctor wanted to put me to rays and I wouldn’t… They operated on me in Timisoara, because that’s where I wanted, because in Bucharest they would say it to your face how much you have to pay, otherwise they wouldn’t operate on you. I also had diabetes, the doctors were wondering how I didn’t get into a coma. And they kept asking me about my children, how much they weighted at birth, because they say that mothers who deliver heavy babies, over four kilos, are predisposed to diabetes after a certain age, but mine were not so heavy. If I didn’t have the babies, I wouldn’t have had them ever, for the doctors would have forbidden me (woman, 34 years old).

Women also tend to somatize the problems they have in the family and with their partner and to make symbolic connections between these and the body problems they might be having:

I couldn’t breastfeed my baby since he was four months old, for I lost my milk. I’m too skinny and I’m nervous all the time. I’m nervous because nobody helps me, my husband spends his time playing on the PC, if I ask him to stay with the baby so I can wash and cook, he doesn’t really want to. I leave him with the baby, and the baby cries and he’s playing games. It’s so sad to be all alone… and yesterday I called my mother in Spain and I cried, I wanted to go there. I always cry for her, she’s the only one I can talk to (woman, 19 years old).
Many illnesses are determined by the poor living conditions. One woman who had a cyst was told by doctors that it was because of the cold:

I stayed too long with my hands in cold water... illness not taken care off; cause if they gave me a receipt, I didn’t have money to buy the medication, so I didn’t take it. I took instead some aspirin and cheap medication and it was fine... my husband also had some problems, he had blood in his urine, and he drank some plant infusions and he’s ok (woman, 31 years old).

For most of these people, daily life is lived very arbitrarily, a syndrome that affects all dimensions of their life: the couple, the home, the job, the affective and sexual life. It is what Vincze calls “the culture of living in the present”, where living in the present could be “a way of avoiding dependency, of feeling free, but also a form of resistance”, and, at the same time, “an active and not passive response to marginalization and social exclusion”38. Most narratives end up in a defeatist tone, expressing deeply-felt regrets, mostly about marital life:

Oh God, if I were 16 again and knew what times would follow... (woman, 37 years old).

All of the women we have talked to were complaining of chronic fatigue or were overworked and overcome by the permanent demands of their gender role: cooking, taking care of children (and sometimes extended family), washing etc. and all of them saw marriage as rather a partnership based on common interests than a relationship based on love or enjoyment. Children were absolute

priorities for all of them, including the cases in which their own health was at stake. Overall, it seems that women (and sometimes men also) tend to regard health care as a luxury, and not a necessity and tend to accept illness or bodily discomforts as part of the hardships of daily life. All narratives about health and illness were in fact participating in a larger discourse about socio-economic difficulties and about gender roles.

My field research presents practices and discourses pertaining to the body, in particular contexts, but allowing for a larger picture; it is about investigating how the body is “constructed” not only discursively (at the crossroads of different ideologies and macro-discourses), but also narratively, by the individual, in specific circumstances that allow for a withdrawal of the body from daily anonymity (illness, pregnancy and birth). In viewing the body as the locus of a symbolic and material negotiation of diverse norms and values, in a period of intense social, political and cultural change, this research operates an introspection into the cultural imaginary and bodily practices and narratives of transition. However, this research can only elucidate a small piece of this intricate discourse that describes the relation between body and illness, a relation further complicated by other all-encompassing discourses such as gender ideology or socio-economic status.
The Good Doctor
and the Bad Doctor.
The Story of a Contrast

Ciprian Moldovan

Many times, thinking about the last century’s 50s, we think of forced collectivization, processes and conviction of “class enemies” or Communist Party, the Danube – Black Sea Channel, “the class struggle of workers and of the exploited peasants“. Most often we have an overview of what happened in Romania in those years, without trying to stop to look at the details, the names, the stories. We are often interested in the general phenomena, not in the lives of those who give rise to these phenomena, forgetting that history is composed of these small universes. In the following pages we will stop precisely on such a micro universe. We will take a look at the period mentioned, but only to dwell on issues related to the daily life of some people in some villages in the County of Cluj.

Our study is intended as a comparison between two types of discourse, and why not, between two ways of viewing the world and relate to it. The first speech is the speech of the peasant who grew up
with a certain conception of life, whose existence was held being led by some very clear rules drawn (relationships within the family, food, daily existence). The second discourse is the official discourse promoted by the communist authorities, which comes into contact – and sometimes even conflict – with the peasant speech. But we will not make an analogy between the two types of discourse, respectively between the two worldviews, in all their aspects, but we will limit the search to one aspect, namely that of the doctor seen through the eyes of the peasant of Cluj county and through the eyes of the central authorities. In other words, we will try to decipher how the doctor was seen during the communist period by the peasants and then we will compare this image with the image of the doctor that communist officials wanted to create.

One of the things that beautify our world is otherness, there are people who dress, work, live and even think differently from us, people who lead their life according to principles and values different from ours and, moreover, seem to lead a happy life. And this otherness can be found very close to us. This is the very thing that our study proves: that the world is divided in Ourselves and Others, and Others are much closer to us than we think.¹

For a citizen of the twenty-first century, used from his childhood to health checks, with drugs, with vaccines, with the very presence of the doctor, in other words, leading a medicalized existence, meeting with people who do not share these beliefs in the medical field could give birth to a great surprise.² And this happens

¹ The first part of our theme, the image of the doctor in the mentality of the peasant was approached by Mrs. Elena Bărbulescu in the study: At the Edge of Modernity: Physicians, Priests and Healers (1940–1990), published in “Philobiblon”, vol. XVI, 2011, no. 2, pp. 549–561, article which is also the basis of this work.

because, although Others are very close, we find it hard to see them and we consider that all those around us have the same vision upon the world and upon life, when in fact they perceive it in a different way, they see life with different eyes.

Only by acknowledging the existence of the Other, can we know and grasp an understanding of the world. This is the subject of our study, the Other’s perception of life. The Other for our study is represented by the peasants of five villages situated in the County of Cluj, respectively the older people of this villages, who, at the time when the communism was established, were around the age of 20 years, but not only them.

The mentality of the Romanian peasant from the area of Cluj is a topic too broad and too deep and has evolved over time, to be treated in a few pages, we will therefore confine ourselves to take a glance at a small aspect of the collective mental, namely we will see how the doctor was regarded by the villagers around Cluj during the communist period. We do not claim that we will fully outline the image of the doctor, or that this picture is characteristic of all the inhabitants of this area. We believe nonetheless that the interviews that were taken helped us to get an idea of the existing dominant image among peasants about the person of the physician, and the images that we present in the following lines are a starting point towards a more detailed study.\(^3\)

Why choose the doctor? Together with the midwife and nurse, the doctor is the main representative of the modern medical system, a centralized system imposed by the communist

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\(^3\) Interviews were conducted by Constantin and Elena Bărbulescu in several villages in the county of Cluj, the research being financed through a grant CNCSIS, type Ideas, Code 1647, entitled: “Receptarea modernizării sistemului sanitar în România comunistă de către lumea rurală (1948–1989)”. 
authorities, sometimes by force. The doctor is a figure that stands out when talking about illness, treatment, cure or, sometimes, death. Given the fact that farmers are often hostile towards the health system, the doctor is the one who can dismantle this hostility or can strengthen it. He is the one who convinces the patient who does not trust the system that what is about to happen is to his benefit and may save his life. Often the doctor is the very image of the system, peasants judging all the medical structure via a single man whom they come into contact with. This is why we chose to study the image that the doctor created.

The first thing we need to emphasize is that the doctor, midwife and nurse together with representatives of the official modern health system, are not the only ones who operate in this domain. Modern health system coexists together with a group of rural healers (midwife, priest, witch doctor, and sorceress). The system’s representatives do not have the health monopoly, but must share it with the latter. Medicine man, priest, sorceress etc. are remnants of a pre-modern sanitation, the disease was often the result of divine punishment, charms or negative actions of other villagers, and healing came the same way, through spells and incantations. These characters are endowed with supernatural powers that can heal or destroy.

A special case is the priest who can lift up curses but can also damn/throw curse that have adverse consequences for those over which were thrown. Unlike doctors whose job can be learned by anyone the sorcerers keep their secrets for themselves:

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So there were from the old times, there were some spells, some stuff like that … but they didn’t share them with anyone … Maybe they did tell their relatives, but no one does that sort of things anymore.\(^6\)

One of the concerns of the communist regime was to destroy this health system (we might say archaic) and to replace it with a modern one, but the communist efforts weren’t crowned entirely successful, the two types of healers coexisting during the period that we have in discussion.\(^7\)

The history of the interaction between the doctor and the village is relatively short. Only in the second half of the nineteenth century can we talk about a stable, lasting contact between doctor and peasants. Then, another aspect to take in consideration is that, until the late nineteenth century medicine didn’t have the spectacular healing abilities which it has at this moment. The progress medicine has made starting with the twentieth century, particularly in bacteriology, advances that have led to the disappearance of major epidemics in the rural areas, have increased the prestige of the doctor inside the rural society. At the same time, society itself has gone through a process of modernization, which also led to an increase of the prestige of the doctor. And a third factor in this direction is the monopoly that the state health system gives to the doctor about everything concerning curative activities.\(^8\)

Despite this increase in prestige, the doctor didn’t stand, as I said above, as the only healer. Testimonies of those interviewed

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\(^6\) Because of ethical reasons personal names that appear in quotations taken from interviews have been modified, and the name of the localities referred to in quotes or interviews where they were collected have been circumvented.


\(^8\) *Ibidem* p. 551.
reveal some tension between the representatives of the old and the new system, the old and the new healer. In the rural communities where the interviews took place we could notice the existence of uncertainty in the doctor’s healing abilities among the population:

And then maybe they did not know very well, to go to the doctor to treat themselves. What do I know? Maybe … And then, there were other … they didn’t go, but still they were wailing about it.

Thus, the positive image of the doctor is not spread everywhere, as we could expect.

We can say that the image of the doctor is a dual image: there are both positive and negative aspects, respectively there are both bad doctors and good doctors. But many times, the two are closely related to each other. The image of the good doctor is created in contrast with the image of the bad doctor.

The good doctor meets several features that make him stand out, by which he earns the respect and even the affection of his patients. First of all it’s his professionalism. ⁹ The good doctor is distinguished by his ability to cure patients. All the interviewees show a deep respect for the doctors who healed them, recognizing their quality of healers as a speaker confesses:

We can go to Cluj also, but we have the doctor from here, we are fine with the doctor, we always gave as much as was suitable, and he was a good man.

Many times, an unfortunate happening, a death or an accident does not change people’s opinions about the doctor. Patients are aware that during anybody’s life and work activity accidents may occur and therefore the doctor is judged by his entire activity. A

⁹ Ibidem, p. 552.
speaker who believes that he barely escaped death due to medical intervention confesses:

And I went and there was a very good doctor but he was older and ... (...) what should I have done? But he tried his best, I am sorry to say something bad, because he was very nice otherwise. (...) He got scared himself. He got scared the poor. I am telling you he was very nice and I don't know what came into him when he wanted to...

The healer skills once proven, the doctor enjoys almost absolute confidence of the peasants he comes into contact with. His advice is better and more closely followed than any advice of any other physicians that they meet.

The good/bad nature is not only determined by his ability to cure patients but also by his human qualities. A good doctor is one who, beyond his skills in medicine, puts soul in healing patients. He treats patients with compassion, giving proof of sympathy, devotion, affection. The good doctor not only treats illness but relieves suffering. In a word, he gives evidence of “humanity”, a thing which modern health system misses, but is particularly important in the rural society. “There was a lack in medicine and when ... Dr. Popescu put a great heart for every child.”

The good doctor succeeds, through his ability to heal both body and soul, to gain the appreciation of the inhabitants of villages and communes studied. We must not forget that the doctor is a stranger, not local, and this is a disadvantage for him. It is true that the ideal image of the rural doctor is a doctor born and raised in that village and after school returning to practice in his native village, but the picture it remains only to state the ideal. Then, the rural doctor is part of the “gentlemen” category together with the priest and the teacher. The school that he followed places him in
a different social class and thus makes him an outsider. The good doctor is the one who manages to overcome these barriers through its professionalism and dedication. 10

Another characteristic of the good doctor is the way he relates to the money and presents that peasants bring him. The image of the doctor is inversely proportional to the interest he shows to the “attentions” that patients bring. It is true that this practice is accepted by both sides, becoming even a custom, but the key is how the doctor agrees, if he proves common sense, if he does not require himself these favors, or if he doesn’t leave broke the poor who come to be treated by him.

And he says: I gave five hundred, yet he didn’t seem to want to take it. He didn’t really want, because he says I Did … this is my job, and me … I’m paid by the state, and I don’t want to …. But he said that only forced he had accepted.

The supreme act is to treat the poor and refused to take money from them. 11

Nonetheless, we must keep in mind that the rural society is mainly a Christian one, where people are still judged by religious affiliation. And the doctor doesn’t make an exception from this rule. To be a good doctor you must firstly be a good Christian. The other image of the doctor who appears in rural communities is the negative one, the image of the bad doctor. And, surprisingly or not, the image of the bad doctor appears more often than the one of the good doctor.

Before taking a look at the characteristics of the bad doctor, it would be interesting to cast a look at how this image was born and which were the causes of its apparition. First, we must keep in

10 Ibidem.
11 Ibidem.
mind that the doctor is, in a sense, the symbol of a state of crisis. Nobody goes to the doctor when he is healthy and happy, but only when he has a medical illness so the presence of the doctor in a person’s life is a proof of illness, discomfort, of crisis. Automatically, almost unconsciously, the word “doctor” is associated with the idea of disease and the fear of doctor is implicitly the fear of disease, as an informer testifies:

Me, I didn’t go to the doctor for any cause (...) All my life I wasn’t keen on going to the doctor just for anything because I say:” Then he tells me something and I become worried, and then all I think is directed that way, but still to go and tell him that my back hurts or that I have a twinge or such…», I went on.

Then in the mentality of the peasant still survive beliefs about some diseases that haven’t got natural causes, and to whom modern medicine is ineffective. The doctor is ineffective in facing these problems, so it is useless to turn to him. One such problem appears at the contact of a woman at her period and an infant up to six weeks. This approach leads to the appearance on the skin of the infant of baby’s skin “bumps” all over the body, which are considered to be impossible to cure by the doctor. The remedy is to wash the infant with water in which menstrual blood from the person who “defiled” the child was mixed. Another example is that of a speaker who manages to cure “sties” and “warts” only after a magical intervention:

But instead, when I was a small child I used to have sties on my eyes. What can I tell you? One appeared up here and right when I thought it healed and disappeared, another one appeared on the down side. When this one healed, another one appeared down on the other side … Continuously everywhere … And here
in the village there was an old lady. They said: “Go to Marusca”, that’s how they called her, “to get it reap” “Ok, let’s go then.” Well I don’t know what she was muttering there, it could not be understood … And she was doing something with the … Do you know what a sickle is? Used for cutting … Since then I don’t have any … They didn’t appear anymore.” Following that, in the same period of my childhood, I had warts/mijei on my hands. Many … Warts so to speak … Previously, on the country side they used to call them mijei … So, then, they grew up big, this big … And they cracked … And now again another old lady says: Let me do it for you, I will disentangle them” When they used to do the tissue in the loom at the end it remained something … This is called urioci, it’s a sort of home thread, which is woven, you know? And this could not be used anymore because it couldn’t reach the spar anymore, that on which … And then people used to cut it and use it for sewing: bags, a button, I don’t know what … It was a white thread. That is not white-white, but … And with one of those treads she made crosses in the same way on these warts and she buried them at the eaves of the house. You know, where the water falls after … from the top of the house. “When this thread rots your warts disappear” And all the warts disappeared. It worked … But I cannot understand … I don’t know, I don’t know what to say … I cannot understand how they went away …

But beyond these reasons belonging to the mental, unconscious level, the image of the doctor was born out of everyday situations, out of the interaction of the peasants with the doctors, both with
those in the communities they belonged to, and with hospital doctors. From the account of these concrete experiences we can distinguish features forming the portrait of the bad doctor.

Firstly it’s about incompetence, both in establishing the diagnosis and in taking measures to cure the patient. Some of the doctors make a mistakes right from the first moment, making the wrong diagnosis, which can conduct to severe situations, some patients reaching the brink of death.\(^\text{12}\)

In addition to mistaking the diagnosis, doctors are also guilty of giving wrong cures, they are guilty of incompetence in the treatment of the diseases, even when these diseases are known:

My mother had a ... I don’t know how to tell you. This is what the doctors said, cause I went down to H. on foot, at her hospital when I was twelve years, scarlet fever. And she had a surgery. They said she had some stomach tumour. She had a boil on the head, a swelling, but not too big, that boil was not so big. And they cut her at H. I will never forget, I was just twelve years old, it was doctor B. And he put her, so he went on vacation, doctor B., and she was operated by another, one so called I., and he put her back the guts and stomach upside-down. Pay attention! And a week she lived with the stomach this way and when B. came back from his holiday, mother was weak, weak and she didn’t recognize anyone, cause I went to her in the morning and the doctor took me on the side that my father should come because she is so skinny and when my father went she had died. They made her a cut this big, to put her stomach back to its place and she died because of that. Yes and the four of us children

\(^{12}\) \textit{Ibidem}, p. 553.
were left behind. Because of his lack of attention. Do you know what that one said to my father? “Sue them, cause they shouldn’t have started, cause I was on vacation, he shouldn’t have started if he thought he didn’t know how.

One of the problems that sometimes occur in the doctor-patient relationship, one that leaves a bitter taste for the latter, is the lack of communication between them. Patients are very disturbed by the fact that doctors don’t communicate, they don’t say what the problems they are facing are, or how serious they are. A female interlocutor told us:

I kept on taking her to the doctor here. He never once said, go further. Once she was hospitalized, 2 times in the same summer. With the same urinary infection, with streptococcus. Not with infection, but with streptococcus. Well, we kept on giving her the streptococcal treaty but … I think they gave her too many antibiotics so that her kidneys went dry. Here, doctors are also very much to blame, cause they don’t tell the parents. They don’t communicate with the person.

The problem is much deeper than it may look at a first glance. Patients feel how the relationship between them and the doctor dehumanizes; they become only objects that need to be fixed. It’s actually one of the complaints that peasants bring to all modern medicine, loss of the relational dimension of the healing process. The doctor does not treat the patient, he doesn’t cure him, but he fixes him. His actions are not full of affection, but for him it is just a job like any other, which he performs without investing feelings in it. ¹³

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¹³ Bărbulescu Elena (coord. ...), Constantin Bărbulescu, Mihai Croitor, Ciprian Pavel Moldovan, Alexandru Onojescu, Alina Ioana Șuta,
Doctors are sometimes accused of those that have been interviewed about the death of their relatives, either by their inefficiency, or by ill-will (rarely, it is true). An informer believes that her husband was killed by the doctors who refused a 90 days’ hospitalization, which impeded his illness based retirement to be given to him and forced him to return to the site, which caused him a heart attack.

One thing to remember is that in the case of many interlocutors both the positive and the negative image of the physician appears, varying according to the experiences they had with the representatives of the medical system. This leads us to the idea that in creating an image of the doctor, personal experience is essential and generalizing is impossible.

In addition to this dual image the good doctor – the bad doctor, we can identify some characteristics of the way peasants relate to person and to the work, of the doctor, thus contributing to shaping his portrait.

Thus, some respondents confessed a fear of doctor, and of medicine, without being able to give reasons for their fear:

No, he didn’t go. Just to have baths, several times he went to have the treatment, the baths I mean, but to the doctor he doesn’t go, he fears. He’s old, but he does not drink any tablet. Me I am drinking tablets even now for my blood pressure but he doesn’t drink anything.

Sometimes the death of some sick people is seen as a repercussion of this attitude of refusal towards drugs and medical advice:

No, he doesn’t want any. I used to tell him: “Hey you, have you taken your peels?” “Let me willingly!” Oh,

well then, I let him his way, see? If he had taken them he wouldn’t have ended ... 

In these cases doctors are not the ones to blame because of the patient’s death, but the patient himself is guilty, a fact recognized by his relatives. Doctor’s efforts are recognized, but they are ineffective due to the attitude of the patient.

Doctor’s advice is still considered important: You have to take what the doctor says, even if you don’t take everything, ‘cause he gives you plenty” but not necessarily followed strictly:

He gave me something, “Omeran“. I took it two weeks. A year ago, now he gave it to me again. In fact, in the winter, he gave it to me again, but I have not taken it. If it doesn’t hurt me, why should I load myself with drugs?“.

We see that treatment is associated thus, with physical discomfort: when the latter disappears, the treatment is no longer considered indispensable anymore. There can also occur situations where the inability to perform daily activities in the household “shortens” treatment. Recommended rest after surgery or after fractures of the limbs is often not obeyed:

Now, he moves it back to its place, cause he told me he moved it well, and he tied me in plaster, six weeks I should not work. Only four I held and with the trimming sheep shears I cut my plaster, and I took my plaster out. I had to milk two cows; I had to cook for the girls I had to work, at the country side you have to work.

This is the doctor for some of the farmers in the county of Cluj. He is the ambassador of the System, a system that strikes the principles of the peasants, in their way of life and their way of relating to one
another, who comes with a new perspective on life, different from theirs. Having such a view on things, we can better understand the image that is created. But in the same time we can appreciate those doctors who have managed to win the respect of patients belonging to the rural areas by their professionalism, but especially by the respect shown to them, by the “humanity” they have proven.

As I said in the above lines, there is a hidden beauty in otherness, therefore we will avoid generalizations. We will not affirm that all inhabitants of the villages in this county think likewise. Not even the fact that all the inhabitants of the villages in which the interview was performed think likewise. We do not claim it and it was not our intention to claim it. We only wanted to present a small part of this fascinating universe called peasant collective mind.

Along with this picture there is the official image of the physician, the one built by the communist officials. Sources used to find this images were various articles about the health system in the newspaper Faclia (initially Lupta Ardealului and then Faclia Ardealului, before becoming Faclia). The newspaper in question represented throughout the communist period the media instrument of the Region of Cluj of the Romanian Communist Party, his articles representing all in all the communist ideology. For this reason we chose these articles as sources for our research, being the perfect illustrations of the official conception of the role of doctor in the new society desired by the communists.

The literacy of the rural population, the introduction of a modern healthcare system, coordinated and controlled by the communist authorities represented a central objective of the officials, as part of the building process of the new society desired by the communists. Communist newspapers always greeted the construction of new schools and new clinics, clinics or home births, especially in rural areas.
The central figure of the system is this time as well, the doctor, he is not alone but he is working with nurses, cleaners, colleagues. He has superiors to whom he must give an account and who can excoriate him (both on medical and political line).

One thing that constantly appears in articles about medical issues is the care that the regime has for the people of the country. Health of “the working people” represented, according to official statements, a chief concern of the Communist Party. Doctors working in communist hospitals are professionals, who work by modern methods, both of prevention and treatment – of course that modern methods are of Soviet origin! The construction of dispensaries, home births or hospitals are examples of the care that the Communist Party has for farmers, they represent the achievements of the communist regime under intense campaigns, conducted by the official health services. Health care towards the residents of the communist villages is put in contrast with the misery in which they were held under the previous regime, both by neglect and by malevolence:

Long and hard have the locals of the mountains suffered under the bourgeois-landowners’ regime […] Never, coopers in Arieşeni, Garda and Scărişoara will not forget the kulak Paşca Joseph, a former forest brigadier, which devastated endlessly the forests and got enriched on their unpaid work.

Thanks to the efforts of communists the health situation in Romania has improved visibly compared to the period before the establishment of the communism. The great number of dispensaries and

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14 *Grija faţă de sănătatea oamenilor muncii*, in “Fâclia”, 12 dec. 1952, no. 1922, p. 3.
hospitals established both in cities and villages or within factories represent an undeniable proof of the constant care shown by the Communist Party towards the health of the working class. It also greatly increases the number of mothers who choose to give birth in birth homes within the rural areas.16

Another difference to the period previous to the establishment of communism in Romania is given by the fact that in the previous regime the gates of the faculty of medicine were open only to children coming from rich families, while now, children of workers and peasants have access to this college as well. Moreover, poor students are not left to chance by the University of Medicine’s leadership, but they are supported in all possible ways, as they are expected to finish college and contribute to the building of communism. Then, the material of the faculty has extremely increased after the establishment of the communist regime, a fact which allows a better preparation of the students.17

Special care towards the public health comes from the concept expressed by the party leadership, according to which man is the most valuable capital of the state that is why all measures are taken in his favor. Doctors, nurses, all health workers must turn all efforts for the good of the workers, and this thing takes place in the communist hospitals and dispensaries.18

For this reason, all employees in the communist health system prove great love and special care for patients, and this speeds up their recovery. Nurses who put personal issues above patient care (and such cases exist, rare, it is true) “do not understand the

16 G. Szekely, Pentru sănătatea poporului muncitor, in “Fâclia”, 23 aprilie 1953, no. 2024, p. 3.
17 Alexandru Marinescu, Institutul Medico-Farmaceutic din Cluj în slujba sănătății poporului, in “Fâclia”, 20 mai 1954, no. 2366, p. 3.
18 Ioan Vlad, Înărijirea sănătății oamenilor muncii o preocupare de câpetime a regimului nostru de democrație populară, in “Fâclia”, 4 dec. 1952, no. 1916, p. 3.
great importance of their profession.” A negative example is a nurse, who “on duty on a Sunday afternoon, left the inpatient without announcing anyone, leaving to solve certain personal problems, forgetting that she should take care of the patients.” The motto of doctors and nurses must be Pavlov’s statement: “Whatever I do, I am constantly aware that above all I am serving my country to the best of my ability.”

A constant concern of the physician must be constantly raising their political-ideological level, but also their professional level. Also primary care physicians are responsible for the progress of medical officers (beginners or residents) with a duty to ensure the growth of their preparation. Even if this does not happen always, it is required. Doctors should not forget that they are both communists and members of a union. As such they must fulfill their obligations to participate in union meetings organized within the hospital. Also, as communists, just like the other employees, doctors also take their commitments to improve the activity and efficiency (filling of papers, improving of the diagnosis, reducing of the infant mortality, etc.).

The training of the doctors is proven superior by the impressive results obtained while still in faculty. Because they are part of a communist society, characterized, among others, by a “multilateral” development of the individual, students must demonstrate a very good training in all subjects, not just in those in which they want to follow a specialization.

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20 Ibidem.
21 Ibidem.
After the inauguration of the popular democracy regime, in all areas of activity it could be seen an improvement in results. The improvement of the doctors’ activity is mainly due to the use of scientific methods of Soviet origin. 24

Besides the role they occupy in assuring the working people’s health, doctors and nurses have an extremely important role, especially those working in rural areas. They must lead a steadfast struggle against superstition and empirical remedies, which are seen as a major obstacle to the progress and the achievement of the new society. 25 (1778, June 18, 1952)

As in the case of peasant speech, we can not only discuss about a positive image here, there are also negative elements of this image, there are also individuals who “defile” the name of doctor. Even among doctors of the new system there are doctors who give evidence of outrageous attitudes. Their main fault: they put their personal interests above the collective interest – in the number of May 20, 1952 we are told about a doctor who refuses to consult a patient because he finished his work program:

At the gynecological clinic, in addition to doctors whose names are spoken with great esteem and love by the sick, as the communist PBN, S.Ș, etc. there are also doctors who keep towards the working people who come for treatment an attitude of forbidden contempt, doctors who put personal interest above the interest of the community. Thus, Dr. C. refused to consult a sick woman who came in serious condition from Petrosani because of iteration, on the grounds that he was not on duty.” 26

25 Mai multă grijă organizării asistenței sanitare la arii, in “Fâclia”, 28 iunie 1952, no. 1778, p. 3.
Of course, these doctors are not communists!

A special category of doctors is represented by the old doctors, friends of the kulaks, who choose to help them in violating of the law, in exchange for “benefits” (one pound of wheat, a pound of flour, a car of wood). They are portrayed as enemies of the workers, whom they extort, asking enormous prices for both advice and treatments. Their main concern is enrichment, purpose for which they are ready to sell even drugs meant for the children:

Many things are out of their place at the dispensary of the village S. The work is left to the official health nurse and the doctor goes only where he sees he can get something. He gets, he doesn’t get, but the dispensary drugs, especially penicillin allocated for infant is used for pigs or for other people who pay him well. 27

We can say that the two speeches have certain common points, certain areas, in other words, where they meet and where farmers have the same views with communist officials, but as a whole, we can say that the doctor in the mind of peasants is very different from the doctor desired by the authorities.

In conclusion the two speeches – the official one and the peasant one – built in dual mode the image of the doctor, there are good doctors and bad doctors both for the interviewed peasants and for the communist authorities of the ‘50s, but the way these characters are portrayed in the two discourses differs widely. For the farmer, a good doctor is the one proving empathy and “humanity” for the patient, while a good doctor from the perspective of communist officials is primarily a good communist.

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