Photo by Martin Anderson

Crossroads

The University of Michigan Undergraduate Journal of Anthropology

University of Michigan, Ann Arbor – Department of Anthropology

Fall 2019 Edition

Letter from the Editor

Dear Readers,

On behalf of the Editorial Board, it is my pleasure to share with you this volume of *Crossroads*: The University of Michigan Undergraduate Journal of Anthropology. The articles in this volume represent the outstanding anthropological research and writing that is currently being accomplished at the undergraduate level at the University of Michigan and many other institutions across the country and the world. We are proud that this journal represents the diversity of theoretical and methodological approaches at use in anthropology today.

This volume is comprised of four essays which draw on sociocultural and linguistic anthropology to examine how states and societies interact to influence various aspects of identity, economics, and healthcare. In the first essay, "Discursive Power Dynamics and Identity Construction: Case Studies of Conversations in Beijing Vegetable Markets," author Wenjia Song discusses how discursive identities are constructed in everyday conversations and how degrees of localness have contributed to identity building and the Chinese socio-linguistic environment. Author Shihua Lu then considers the historical and cultural influence of ginseng in her article "The Traveling Root: American Ginseng and its Trade Connection to China" by examining the role of ginseng in trade between America and China. In "Immediate Changes and Cultural Competency: Ways to Reduce Preventable Maternal Deaths in Madagascar," Gloria Fall next examines how maternal deaths can be prevented through education and connections to resources in rural regions. Ending this edition of *Crossroads*, author Liyuan Zhang discusses how the state and society collaborate to improve rural healthcare through free clinics supported by governmental support in "Rethinking Public Sphere in Rural China: Healing through the Free Clinic."

I would like to thank each and every member of the Editorial Board, as well as our authors, for the time and effort they have dedicated to the success of this publication. The process would not have been nearly as rewarding without their thoughtful revisions and brilliant ideas. In addition, this issue would not have been possible without the help of faculty in the Department of Anthropology.

Sincerely,

Madeline Topor, Editor-in-Chief, *Crossroads*

Language, Healthcare, and Economics

Discursive Power Dynamics and Identity Construction: Case Studies of Conversations in Beijing Vegetable Markets

by Wenjia Song

This paper is a revised excerpt from a larger ethnographic project, which contributes to the current academic discussions on social-cultural discursive identity and social space by illustrating and explaining how retailers and customers verbally demonstrate themselves in everyday conversations. The two field work sites are Zhaolanyuan vegetable market and Chongwenmen vegetable market in Beijing, the capital of the People's Republic of China. In this paper, I will examine the power dynamics of aspects that co-construct an individual's discursive identity. Moreover, I will illustrate how the degree of localness delivered and received in conversations has bridged the individual's identity building and the formation of the current socio-linguistic environment in China.

Glossing and Transcription Rules

Simultaneous utterances: [

Overlapping utterances: []

Latching: =

Stretched, prolonged sound : :

Rise in pitch: ↑

Lowering in pitch: ↓

Emphasis: _

Softer utterance: °

Speed up: ><

Slow down: <>

Transcription doubt: {}

Other observations, explanations: ()

Yuan(2): 2 here stands for pitch in Chinese

(T44): refers to conversational turn 44

Introduction

As Emanuel Schegloff points out, "conversational interaction may be thought of as a form of social organization through which the work of most, if not all, the major institutions of societies -- the economy, the polity, the family, the reproduction and socialization, etc. gets done" (Schegloff 1996, 54). The speakers in conversation, on the other hand, are "social actors" performing in these institutions and networks (Duranti 1997, 3). By doing a deep comparative analysis of conversations going on in the vegetable markets in Beijing, I would like to join the current academic discussion of discursive identity building and the relevant social context.

I mainly investigate conversational patterns of female speakers in this research so that gender differences will not influence power dynamics in these case studies. The two dimensions shaping identity I look at are transactional roles and accent as I explore conversations between retailers and customers, Beijing-dialect speakers (BDS) and non-Beijing dialect speakers (non-BDS). Note that "BDS" in this paper specifically refers to a speaker who maintains a consistent Beijing accent in the conversations, which is not necessarily equivalent to a native speaker or a local. Two native-born Beijingnese volunteers have helped me to evaluate the degree of consistency in accent.

The field work site I chose for the two case studies in this excerpt is Zhaolanyuan market at Tsinghua university. There are a few reasons why I look at this vegetable market. In the first

place, a vegetable market is an open space available to everyone regardless of personal background and guarantees a relatively constant social situation as well (Labov 2001, 86). Also, the market is a "vernacular" where "varieties…are the most locally differentiated, and associated with locally based populations" (Eckert et.al 2001, 119). What's more, people tend to produce the most mundane, unself-conscious speeches in transactional conversations to which they are most familiar, where "the verbal creation and enhancement" of values is "on display" (Bauman 1975). In terms of feasibility, a vegetable market makes it easier for the researcher to observe and collect data at any time, as it is a public area completely accessible to everyone and the dialogues are not private. Last but not least, Zhaolanyuan market itself is a representative multi-dialect and multi-language environment as it is mostly frequented by students and faculty of the university. In contrast to the diversity in the customers, the retailers in Zhaolanyuan market are mostly from the same region -- Anqing City, Anhui province.

Here are a few concepts, definitions, and theories at stake. First and foremost, identity as an event-stimulated, malleable process evolving from both self-presentation and social negotiation, in which "discursive work" (in Zimmerman and Wieder's words) is done, rather than a natural given or a monolithic construction. Identity is not a placeholder for a set of fixed traits, but dynamic continuity in which one's self-recognition and self-promotion is received by others (Bamberg et al. 2006:2; Giddens 1991).

According to Bamberg's interpretation of Bakhtin's voicing theory, "reported speech in narrative can be presented on a scale of objectivity" as a speaker is also a narrator who speaks in the voice of some underlying "others" (Bamberg et al. 2006, 12-13). In other words, an individual's voice is to some degree a public voice generated from the society. Yet to make sense of the voicing theory, one should not ignore people's subjectivity or exceedingly emphasize the

shadowing process but ought to simultaneously look at both social factors and individual's instant reaction.

Intersubjectivity and reciprocity are helpful concepts in the analysis of discursive identity. Intersubjectivity refers to a shared knowledge basis underlying interaction, and reciprocity indicates that one's speech action is not only "a response to another's prior action" but is also an expectation of "another's upcoming action" (Bamberg et al. 2006, 106-107). These two concepts play significant roles in making sense of how discursive power dynamics work.

Methodologies

Participant observation and non-participant observation as well as textual analysis of speech build up the main methodological framework of this study. Conversation Analysis (CA) and Critical Discourse Analysis (CDA) are the two main approaches used in analyzing texts.

Charles Goodwin points out that the approach of CA deals with language internally and externally, for the application of CA "permits students…to determine empirically functions of many types of conversational objects" and shapes and renews the context as well (Goodwin 1990, 289). Jan Blommaert has comprehensively assessed pros and cons of both approaches as follows: CDA is pretty sensitive to "hidden power dimensions," surrounding or underlying "institutional environments" while breeding provocative dialogues between language and other "social scientific endeavors" (Blommaert 2005, 33). But this approach against "mundanisation" also arouses linguistic bias directly coming from ignorance of other possible yet unrevealed social contexts, discourses and temporalities (2005, 34-37). That is to say, if context is overemphasized in the process of interpretation, immediacy and interaction in the text itself will probably be ignored.

In this sense, a combined use of both CA and CDA in handling sets of natural language data becomes necessary for ethnographers to decipher people's pattern of speech and interaction that has been constructed by the social reality and at the same time, to denaturalize this well-accepted social reality as well. Though CA and CDA intertwine with each other in some cases, I try to use these two approaches in a relatively more clear-cut way in my research.

Transcription of speech data will follow conventions in conversational analysis. After finishing the transcription process, I will give an exhaustive depiction of the given data by examining conversational features listed in H. Sack's systematic instructional manual (Sacks 1974). Through a close reading of these speech texts, I want to present a text-based explanation of the data that minimizes the effect of presuppositions based on social contexts to offer possible interpretations of linguistic features displayed in these conversations. Analysis of turn-takings in the conversation, especially turn competition between retailer and customer is key to uncovering how the interactional patterns are regulated by and how they in turn regulate different kinds of identities. Sequences of conversations implicates that each "current" conversational action embodies a "here and now" definition of the situation to which subsequent talk will be oriented (Goodwin 1990, 287). In other words, a subsequent sentence is a responsive interpretation of the previous verbal action, and also to some degree predetermines what will possibly be said in the next turn.

These turn takings largely affect how utterance is understood by speakers and oblige them to demonstrate their own identities as well. To be more specific, speakers undergo a process of evaluating their own position (superior or inferior) in the dialogue and adjusting responding strategies according to this evaluation, whereby real-time variations and shifts in power relationship are indicated. I will apply critical discourse analysis (CDA) to discuss construction,

demonstration and recognition of identity, an "individual representation of actual or possible worlds", and the "indexical" social fabric (Duranti 1997, 3; Silverstein 1992, 55).

Case Study One

Field: zhaolanyuan market
R1: retailer
W: Wen, the researcher
In this case the researcher Wen, who speaks pretty good mandarin but not a Beijingnese, talks to a retailer in consecutive weeks.

1 R1: ai, ni yao chi shen me, xiao /mie mie/? Xiang chi shen me? (slow, weak voice)
What would you like to eat, Miss?
2 W: [Huang gua ba.]
Cucumbers.
3 R1: [Huang gua ma?] xiao huang gua…{…} Huang gua hao lv o ni xuan hao le.
Cucumbers? Small cucumbers…Cucumbers look so green (representing freshness). You just pick some.
4 W: =zhe ge (huanggua) duo shao qian yi jin?=
How much do cucumbers cost per half-kilo?
5 R1: =na ge? Na la gei ni wu kuai qian yijin.
Which? These cucumbers cost five yuan per half kilo.
6 W: wu kuai qian [yi jin] shi /va/?.
Five yuan, right?
7 R1: [dui dui] dui dui dui. Huanggua wu kuai qian >ni yao bu guolai wo bu duo gei ni qian<, wo ben lai <mei> liu kuai de…jiu liang ge shi ba?
Yes yes yes yes yes. Cucumbers are five yuan per half kilo. I should have sold cucumbers six yuan per half kilo to you. Two cucumbers right?
8 W: a dui.
Yes.
9 R1: si kuai qian a lao shi (speak slower), si kuai qian a laoshi.
Four yuan, teacher, four yuan, teacher.

(A week later)
10 W: /shang'(c)i/ zai nimen zhe'er maile <huanggua> hai tinghao de. =
The cucumbers I bought here last time were pretty good.
11 R1: =zhege huanggua dou(2) mai di(de) hao.
These cucumbers sell good.
12 W: hmm…
Hmm…
13 R1: {…unclear utterance, but the retailer is asking how many cucumbers the customer would like to have}
14 W: e…wo shao'ei(shaowei) lai lianggen. =
I will just take one or two.

15 R1: =san si gen shi…qi'ua(qita) buyao leshima?
Three or four…Don't you get something else?
16 W: wo tiao yixia (laugh). =
Let me pick out some (cucumbers).
17 R1: =meishi, ni tiao ni de. Dou'ri°(doushi) xin shang de.. Liangge ma?
Sure, you may pick as you wish. All of them or newly displayed. You want two?
18 W: enen[en].
Yes.
19 R1: [goubugou?]
Enough?
20 W: goule goule. Meishi'er [wo jiu…]
Enough, enough. Well I just…
21 R1: [{…}]
22 W: o , dao, na zai jia yigen'er ba. =
Oh, then I will take another.
23 R1:= zai lai yi ge ba zhe huanggua haochi.=
Take another one. These cucumbers are delicious.
24 W:=en, shengde daoshihou zai [guolai le].
Yeah, so it's unnecessary (for me to come here to buy cucumbers) again.
25 R1: [duiya, dui,] neng fang…bie di hai yao ma?
Yes! Yeah. Cucumbers don't go bad very quickly. Don't you get something else?
26 W: e buyongle.
Uhhh, no thanks.

These two conversations are less influenced by difference in accent but more by the role each speaker plays as a retailer or a customer. The core interests that the retailer and the customer pursue respectively are crystal clear to both from the beginning, as the former aims to sell as much as possible and the latter wants to buy groceries of the highest quality at the lowest price. This was defined in Clark and Pinch's research on conversations happening in market scenarios as "interactional achievement" (Wooffitt 2005, 187). Therefore, a successful customer-retailer relationship will essentially turn out as a compromise achieved in the balance between these two key interests. The customer and the retailer are using different kinds of conversational strategies to achieve their goals. Although it is the customer who actively dominates the transaction (the customer has more options to fulfill her goal than the retailer does, as the retailer tries to

convince every potential customer to purchase so as to prevent vegetables from going bad), she is also the passive one who relies on the retailer to give her truthful information about the condition of the vegetables.

Meanwhile, an experienced retailer who is local to the market scenario (familiar with the space) will try to figure out what the customer is willing to buy and then make recommendations correspondingly. In the first conversation in this case study, the overlap of "cucumbers" (T2-3) directly shows the expertise of the retailer, for she successfully conjectures the customer's demand. The retailer then emphasizes freshness of cucumbers and claims that she would like to offer a lower price than usual for the customer (T7), which just satisfies what the customer has anticipated. Note that at the end of their conversation, the retailer also changes her way of addressing the customer from an intimate "Miss (little sister)" to "teacher" (T9), which is more respectful and flattering in acclaiming the customer's wise choice.

The second conversation between Wen and the retailer flows more smoothly, as latching and overlapping appear almost at every turn-construction unit, all of which are initiated by the retailer. Previous satisfactory experience avails the customer to actively ask for specific groceries (cucumbers) out of her independent judgment. In terms of the retailer, it's unnecessary for her to cautiously think about how to offer suggestions in a least annoyable way because the transaction is already approved by the customer; all she needs to do is to settle the order and to follow up with more promotions if possible (T25).

At the center of this customer-retailer relationship lies an active-passive model in identity construction and change: information asymmetry makes the customer passive and unfamiliar, as she needs the information provided by the retailer, although she should have been the active one who independently decides whether she will continue the consumption process or not. On the

contrary, the retailer should take the initiative to deliver as much favorable information as possible at her conversational turn in order to influence the customer's decision-making. By doing this the retailer has reversed her previous passivity as an eager salesperson.

This case study illustrates how identity is established, recognized and transformed in a default transactional setting. Even though the roles that the two speakers play (as retailer or customer) remain consistent, their identities presented in the transaction change from time to time based on their speculation of the other's immediate need and thoughts reflected in speech. Besides, to achieve an optimal win-win outcome, it's necessary for the customer to perceive the retailer's identity as a trustworthy and catering (giving discounts and flattering) salesperson because this "other" image in turn strengthens the identity of a wise buyer. This is how reciprocity participates in identity construction and enhancement.

In the next case study, I will show how competition for a higher degree of localness complicates this active-passive model of reciprocity in constructing discursive identity.

Case Study Two

Field: zhaolanyuan market
C1: A customer involved in transaction, a Beijing-dialect-speaker who is not a native Beijingnese
R2: A retailer, a non-Beijing-dialect-speaker
W: Wen, the researcher

27 C1: >ze'me Beijing zhei cai <u>zhe</u> me gui le jin nian?<
Why are vegetables in Beijing so expensive this year?
28 R2: (silence for 2 seconds) Dei:::° = (speaking to G2) =Chi shen me cai *ya?* ↑
Yeah… (speaking to G2) What vegetables would you like to eat?
29 W: wo kan yi xia.
Let me have a look.
30 C1: <u>Tai</u>↑<u>gui</u> la (3-second stop) ni° xiang zai women Shijiazhuang cai <<u>san: kuai: wu</u> yi: jin: ya:>, zhe xi hong shi'er.=
They are too expensive! As you can see, in my (hometown) Shijiazhuang, tomatoes are only 3.5 yuan per half kilo.

31 R2: =Mei ze me huo (hao)…=

Tomatoes there are not as good…

32 W: =[zhe *duo* shao qian yi jin a?] (I pointed at the tomatoes, expecting that the retailer would tell me the price the price.)

How much (are these tomatoes per half kilo)?

33 C1: =[zen me hui, zhe yi yang de,] zhe <qi kuai> ya:::, zhe, zhe shi, zhe tai rang ren sheng qi zhe shi tang zen:::me zuo zen me zuo cheng zhei:::ge yang zi le ne::? (2-second stop) wo >bu ri< ruo guai↑ ni (dui), zheng ge'er bu rang yi Beijing ren zai Beijing sheng huo la, yi ban'er↑ de qian dou chi la.

How come? Tomatoes are the same. These tomatoes cost seven yuan! It's so annoying! How can the canteen do such things like this? I didn't mean to blame you for this. Beijing people are unable to live in Beijing, as half of the money goes to food.

This is a conversation between a non-native Beijingnese retailer and a non-native Beijingnese customer who regards herself as a Beijingnese. An on-looking potential customer also participates in this dialogue. The customer (C1) is complaining about the high price of vegetables sold in Zhaolanyuan market. In the first place she uses "vegetables in Beijing" (T27) instead of a more reasonable reference to "vegetables at your booth" or "vegetables in this market" in her complaints. Obviously C1 cannot not have visited every tomato-selling booth in all vegetable markets in Beijing, so she must have made this argument out of her recent observations or limited consumption experiences somewhere else. But by mentioning "vegetables in Beijing," C1 implicates that it is her knowledge of the city that enables her to assume the general trend of the vegetable price, which establishes in her a high level of authority of her local identity in the conversation.

In addition, as she starts her question (T27) with "zenme" ("how" or "why"), she is either complaining or asking for some explanations for such a high price. The retailer, on the other hand, takes "zenme" as a complaint and accordingly gives a reluctant approval. This retailer's response is illegitimate because she fails to offer a reasonable explanation to justify her pricing, which largely decreases the power she holds in the transaction. There are two possible ways to

explain the retailer's ambiguous approval: it can be a retailer's ingratiation to a potential customer by recognizing the customer's localness and authority as a Beijingnese, while it may also be a helpless confirmation of the rising price. Concluding from the retailer's lowered pitch and wavering response, both explanations make sense in this case. In other words, the retailer avoids potential tensions with the customer by identifying with the customer (though unwillingly) on her local identity and her opinion on price because at this moment the retailer still hopes that they will manage to complete this deal.

Very quickly the retailer turns to the other passing-by customer Wen (T28), not only trying to ease embarrassment in the current bilateral conversation but also to look for new customer in case C1 withdraws from the transaction. While the retailer initiates a new conversational turn with Wen, not assigning any turn-constructional question for C1 to answer, C1 rises her pitch when repeating that the vegetables are too expensive, as if competing for the retailer's attention (T30). C1 then claims that she comes from Shijiazhuang and compares vegetable prices in the two cities to strengthen her previous complaint on pricing (T30). Despite the fact that C1's argument is justified by her exclusive knowledge about both Shijiazhuang and Beijing, she loses her degree of localness accepted by the retailer at the beginning of this dialogue, when she openly admits she is not a local in Beijing. The retailer cleverly discovers this loophole and impatiently latches onto C1's turn by firmly arguing for the difference that lies in the quality of tomatoes in the two places (T31). Then C1 forcefully rebuts that tomatoes are no different from each other (T32), and as soon as Wen takes up her turn to ask for the price of tomatoes, it is C1, not the retailer who eventually tells Wen the price. Note that although Wen does not explicitly select the next speaker to follow (which means both the retailer and C1 can take the next turn), no latching or overlapping occurs. Why doesn't the retailer take up her turn to answer at this

moment? Possibly she sees this new conversation an interaction between the two customers, into which she, as a retailer, ought not to intrude. The retailer's withdrawing from the conversation implies her recognition of a distinctive customer's aligning identity with which she cannot share.

With her customer's activeness and authority being strengthened, C1 returns to the previous conversation with the retailer. She makes her complaints about the "university cafeteria" (the university cafeteria is upstairs and residents usually use the word "cafeteria" to refer to the market downstairs). Although she later adds that she is not blaming the retailer for the high price, she has already anticipated that the retailer may feel scolded. In this sense, she does imply the difference, if not opposition between retailer's transactional identity and the customer's transactional identity. Later C1 offers a very straightforward and powerful comment: "Beijing people are unable to live in Beijing, as half of the income goes to food purchase" (T33). Hereby C1 has identified herself as a Beijingnese and comments on a Beijingnese's life in light of her own experience which, along with her previous reference to her hometown as Shijiazhuang, creates in herself a double identity affiliated to two cities.

The conversation in this case study is comparatively more intricate than ones discussed in the previous case study. There are more apparent tensions, potential conflicts as well as more information related to non-transactional dimension of identity. They expand the existing interactional social space by introducing the spectrum of localness into it. In this conversation, C1 and R2 are not only trying to protect their own transactional interests but are also competing for their familiarity with the local condition. Though different, both are local in some way. The retailer establishes her identity as a local by situating herself in the market scenario. Her claim that "cucumbers in Shijiazhuang are not as good as those in Beijing" reflects her ascending localness. Her exclusive knowledge of Zhaolanyuan market as well as the general vegetable

market in Beijing makes her an authority in communicating with the customer over vegetable-related topics. Note that at this moment, an individual's multiple identities start to interact with each other, changing the power dynamics in the environment. The retailer's transactional identity makes her knowledgeable in buy and sell, which further consolidates her localness in her connection to the vegetable market speech community despite the fact that she is not at all local in a linguistic community (her accent is not assimilated to Beijing dialect, even though she has stayed here for over a decade). The retailer's subtle level of localness in her identity has thus contributed to her shifts in reacting to the customer.

The customer, on the other hand, constructs her localness by relating herself to culture-based or geography-based linguistic community such as cities (differences in dialects used in Beijing and Shijiazhuang are not apparent to non-native speakers). Her accent, dialect and way of speaking sound so local that the retailer does not question the customer's knowledge of vegetable pricing in Beijing. But when the customer mentions the vegetable price in her hometown Shijiazhuang, implicating that she is not completely local, the retailer directly rebuts the customer's judgment. In the end, the customer's complaint on behalf of vegetable buyers in Beijing -- and her "not-blaming" -- suggest that she notices her somewhat irrational comparison between vegetable pricing of the two cities and seeks to retrieve localness in her identity.

Therefore, the customer and the retailer develop a mutual interplay between various dimensions of identity. While the retailer strengthens her identity as a trustworthy salesperson by emphasizing on her localness, the customer groups herself as Beijingnese through invoking her transactional role as a vegetable buyer who knows about the local market. This gives a concrete example of the flexible but systematic identity formation process. Speakers are assuming, analyzing and reacting to each other based on a shared requirement of agency, as they want to

present an image (a wise customer, a Beijing local, a reasonable and trustworthy retailer) to others. In this process, they actively adjust their talking strategies according to evaluation of their own positions in current power dynamics. These adjustments to this image output a complex identity incorporating multiple elements, and such elements interact with each other, which in turn affect how the conversation goes on.

Discussion

In light of these two case studies, I want to reiterate how identity is constructed and recognized in the bargaining process and how competition of "localness" complicates the dynamics. In the first case study, the most apparent identities demonstrated in the conversation are transactional: the retailer who has been passive in a buy-and-sell relationship should take the initiative to convince the active customer to purchase the groceries, while the customer should make her independent judgment based on the information offered by the retailer. They compete for bargaining power to maximize the interest they desire and their identities are largely defined by the kind of interest they pursue.

The default dynamic balance breaks down when a new dimension of discursive identity -- localness -- emerges, which is exactly what retailer 2 and customer 1 compete for in the second case study. This aspect of localness is very important in bargaining because it directly reflects one's familiarity with the local environment and knowledge of nearby issues. If a retailer appears more local, it will be easier for her to gain trust; if a customer appears more local, it is less likely that she will be cheated in the bargain. The customer sounds local as she speaks a consistent and fluent Beijing dialect, but by mentioning her hometown she loses her prestige of localness at once. Meanwhile, the retailer immediately rises to an advantageous position as a knowledgeable

local for she is definitely more familiar to the market in Beijing than the customer from Shijiazhuang, which largely adds to her bargaining power.

I would like to reexamine the customer's "mistake" that finally overturns the bargaining power dynamics with Bourdieu's argument. Bourdieu argues that "locals are able to produce, continuously and apparently without effort, the most correct language, not only as regards syntax but also pronunciation and diction, which provide the surest indices for social placing" (Bourdieu 1977, 659). "Correct" here does not mean absence of mistakes; transgression of the norm by a native speaker is permitted and will not affect the speaker's identity as a local. The dialect speaker's localness will not be undermined except when she herself overtly claims that she is not a local.

To move a step further, the customer's mis-identification of herself as a local in Beijing and the retailer's preliminary misconception with the following passive reaction are both attributed to the hegemonic position of Beijing dialect in the local environment. It is overwhelmingly dominating because it is not only the de facto language but also the criterion of the official language (putonghua). In 1932, the National Language Unification Commission implemented standardization of Chinese language settled on Northern dialect. This standard was maintained after the People's Republic of China was founded. But from my observations, interviews and analysis, putonghua bears more subtle social connotations in Beijing than in other cities in China. Putonghua is phonologically based on a Beijing dialect and that explains why the latter has become a concrete standard to evaluate how well non-locals speak putonghua.

Conclusion

Each of two case studies has its respective focus by design: The first case study exemplifies the way in which people construct and recognize identities in everyday conversations. The

second example reveals how distinctive dimensions of identity interact with each other and how such interaction implicates the broader context of the local society.

This study addresses and enhances previous research in three ways. Firstly, linguistic analysis and anthropological approaches are applied to produce a less unbiased and comprehensive understanding of identity and its context. Secondly, it reexamines the concept of "local/localness" not limited to geographical boundaries, but also involving languages, norms and knowledge acquisition. Meanwhile, it actively affects power dynamics in interaction. Last but not least, this study offers a more concrete discussion of the linguistic environment of putonghua use.

The limitations in the study are as follows: As an ethnographer who participated in or observed the conversation, my presence may have unintentionally yielded bias. Even though I asked locals to help me with the transcription process, I may have not noticed some features at the scene due to my less sensitive non-local identity. Methodologically speaking, as I was not able to stay in the field for a longer period of time, these randomly selected cases may not represent the general picture of conversations going on in the local environment. Furthermore, the influence of other features, such as gender, are not discussed in this work.

Thus, for future research on identity and language, I would like to initiate a long-term ethnographic project to understand how people think about how they speak in a particular way. This will certainly complement the existing research focusing more on observation and naturally produced datasets.

Wenjia Song *is a recent graduate of Tsinghua University, where she studies comparative literature and linguistics. She is curious about how language shapes and is shaped by the various aspects of people's identity, which she believes are critical issues in the field of linguistic anthropology. Wenjia is currently an MA student in International and Regional Studies at the University of Michigan, Ann Arbor.* *She would like to express her gratitude towards Dr. Jie Dong as well as other faculties at the Institute for World Literatures and Cultures for their suggestion and support.*

References

Bamberg, Fina, & Schiffrin. 2006. *Discourse and identity*. Cambridge: Cambridge University Press.

Bauman, R. 1975. *Verbal Art as Performance1*. American Anthropologist, 77: 290-311. doi: 10.1525/aa.1975.77.2.02a00030

Blommaert, J. 2005. *Discourse: A Critical Introduction (Key topics in sociolinguistics)*. Cambridge University Press.

Bourdieu, Pierre. 1977. "The Economics of Linguistic Exchanges." *Information (International Social Science Council)* 16, no. 6: 645–68. doi:10.1177/053901847701600601.

Duranti, Alessandro. 1997. *Linguistic Anthropology*. Cambridge Textbooks in Linguistics. New York: Cambridge University Press.

Eckert, P. E., & Rickford, J. R. 2001. *Style and Sociolinguistic Variation*. Cambridge: Cambridge University Press.

Giddens, A. 1991. *Modernity and self-identity: Self and society in the late modern age*. Stanford: Stanford University Press.

Goodwin, C. 1990. "Conversation Analysis." *Annual Review of Anthropology,19*(1), 283-307. doi:10.1146/annurev.anthro.19.1.283

Labov, William. 2002. "The Anatomy of Style-Shifting." Chapter. In *Style and Sociolinguistic Variation*, edited by Penelope Eckert and John R. Rickford, 85–108. Cambridge: Cambridge University Press. doi:10.1017/CBO9780511613258.006.

Sacks, Schegloff & Jefferson. 1974. "A simplest systematics for the organization of turn-taking for conversation." *Language,50*(4), 696-735. doi:10.1353/lan.1974.0010

Schegloff, Emanuel A. 1996. "Turn Organization: One Intersection of Grammar and Interaction." In *Interaction and Grammar*, edited by Elinor Ochs, Emanuel A. Schegloff, and Sandra A. Thompson, 52–133. Studies in Interactional Sociolinguistics. Cambridge: Cambridge University Press. doi:10.1017/CBO9780511620874.002.

Silverstein, Michael. 1992. "The Indeterminacy of 'Contextualization': When Is Enough Enough?" In *The Contextualization of Language*, ed. P. Auer and A. DiLuzio, 55–75. Amsterdam: Benjamins.

Wooffitt, R. 2005. *Conversation Analysis and Discourse Analysis: A Comparative and Critical Introduction.* London: Sage Publications.

Language, Healthcare, and Economics

The Traveling Root: American Ginseng and its Trade Connection to China

By Shihua Lu

This paper focuses on the trade of ginseng, mainly American ginseng, to China. American ginseng (Panax quinquefolius, Panacis quinquefolis) is a type of herb which is native to North America but widely used in Traditional Chinese Medicine (TCM). From frequent trades to ginseng-lovers, this mythical plant successfully brings the two continents together. Trade, nowadays, is known as an action involving the transfer of goods or services from one person or group to another. However, when one goes back in time, trade is not simply an economic activity; it also shows what is underneath: the culture, history and even philosophy. Thanks to trade activities, different cultures and ideas can travel as far as men can go, and therefore influence the other side of the world. Likewise, the thriving and active ginseng market contains complex ancient Chinese history and culture. I will discuss this topic in historical, cultural and economics context. This paper will be divided into three parts: I. The introduction of ginseng trade history II. Ginseng trade and its cultural influences III. The unstable yet strong ginseng market.

This paper focuses on the trade of ginseng, mainly American ginseng, to China. American ginseng (Panax quinquefolius, Panacis quinquefolis) is a type of herb which is native to North America but widely used in Traditional Chinese Medicine (TCM). From frequent trades to ginseng-lovers, this mythical plant successfully brings the two continents together. Trade, nowadays, is known as an action involving the transfer of goods or services from one person or group to another. However, when one goes back in time, trade is not simply an economic activity; it also shows what is underneath: the culture, history and even philosophy. Thanks to trade activities, different cultures and ideas can travel as far as men can go, and therefore influence the other side of the world. Likewise, the thriving and active ginseng market contains complex ancient Chinese history and culture. I will discuss this topic in historical, cultural and economics context. This paper will be divided into three parts: I. The introduction of ginseng trade history II. Ginseng trade and its cultural influences III. The unstable yet strong ginseng market.

Part I: The Introduction Of Ginseng Trade History

China has a long history of importing ginseng from the United States. This importation dates back to the 1700s—before the United States was even founded. At that time, American ginseng had to travel across the oceans, from North America to Europe before traveling from Europe to Asia. After the founding of the United States, the U.S. started to export goods to the rest of the world directly as an independent nation. The first direct trade between the U.S. and China was also of American ginseng: On the day of President George Washington's birthday, February 22nd, 1784, the first American merchant vessel, *Empress of China*, left New York harbor and headed to China. It was filled with more than 40 tons of American ginseng to China and returned to New York with tons of Chinese tea on May 11, 1785 (Smith 1984, 3). This trade undoubtedly opened a new era and it is the beginning of the so-called Old Trade (A Guide to the United States' History n.d).

The high demand for American Ginseng in China shows not only its uniqueness, but also its great market value. Ginseng is a crucial plant in the history of Traditional Chinese Medicine (TMC). It is known as the king of all herbs and has many benefits to the human body. The genus name of Ginseng, Panax, comes from the Greek word "Πανάκεια (Panakeia)." Panakeia is the goddess of universal remedy and her name means "all healing." The Greek origin of this name emphasizes the medicinal virtues of this plant.

Also, the English name, "ginseng," which comes from Hokkien Chinese, means "human's roots." This is because it was thought by the ancient Chinese to resemble the shape of human beings. Besides the abundant benefits of ginseng, as the ancient Chinese medicine believes the idea of "shape compensation," the shape of ginseng tells that it could be beneficial to human

bodies as a whole. The idea of "shape compensation" is a crucial part in the history of Traditional Chinese Medicine because it means that eating something which looks like a specific part of the human body will help the recovery and improvement of that part. For instance, given that walnuts look like human brains, Chinese parents tend to force their children to eat walnuts so that they can be smarter.

Although ginseng is highly praised by the Chinese, the appreciation is not enough to keep American Ginseng trade as successful as it could be. There are two main elements that can determine a market: supply and demand. While it was necessary for the ginseng demand to increase in Qing, suppliers in the U.S. should also realize its value as an export and were able to provide a large quantity of American ginseng. However, at that time, the U.S. was still a newly founded country and had not developed any popular traditions of using ginseng. In addition, Given the lack of modern technology, there were not many connections between the two continents. It is therefore natural to wonder how these prerequisites were satisfied and this trade could begin.

This trade began with the help of a French missionary P. Jartoux. While he was in China, he was hugely influenced by the ginseng mania and started to be interested in exploring it. Later, Jartoux was commissioned by Emperor Kangxi to draw the map of China. While he was finishing the map, he had a chance to travel around China and was able to take a closer look at the habituations of ginseng in the village located on the border between China and Korea. He predicted that this plant may live in 39° ~ 47° N, 10° ~ 20° E. There were high mountains located in this region and ginseng usually grew on the mountains, between the rivers, under the trees or within the weeds. Followed this prediction, Jartoux made a suggestion that Canada had to be the other country growing ginseng. Jartoux not only appreciated the value of ginseng

himself but also taught other missionaries how to eat and use ginseng. This was the first time that this ancient plant ginseng started to be recognized and valued by the western world. (Fang 2003)

At this time, another French missionary, Joseph- Francois Lafitau, came to the stage. While he was living in Quebec, Canada, he read Jartoux's report about ginseng and quickly realized that Quebec could be the part of Canada indicated in his discovery. He then showed Jartoux' ginseng drawing to some indigenous people, and they soon found out that this plant was what they called "*garantoquen*." Many indigenous people used it as a type of medicine but in different ways not only among themselves but also than the Chinese (Fang 2003).

French merchants (who were in New France) realized how many benefits that ginseng may bring them; therefore, in 1718, they attempted to export ginseng to China and this beginning of the business was of great success (Fang 2003). Therefore, at the same time, other people living in North America started to realize how many profits that ginseng could possibly bring and how much it was loved by people lived in the other half of the earth. They started to find ginseng everywhere and this suddenly became popular in North America. But what happened to China at that time? And what made them need to import ginseng from other countries?

The Jurchen, who traditionally inhabited the region of Manchuria, controlled the ginseng exploitation during the late Ming. Trade was the main income resource for the Jurchen. In the late 16th century, ginseng was the most popularly traded product. In order to protect their rights to harvest ginseng, Jurchen people killed the invaders who came to their land to exploit ginseng. Those invaders escaped to Joseon (a kingdom on the Korean peninsula), which also triggered conflicts between Jurchen and Joseon (Jiang 2015, 57-58).

Conflicts also happened between the Jurchen and the Ming. It showed that ginseng trade became the main income resources for the Jurchen during the Ming dynasty. However, in 1609, because of the financial crisis, Xiong Tingbi, the censor of the Ming Dynasty, closed the Jurchen border trade market and did not allow any ginseng to be imported from Jurchen people. This action led to the overproduction and 50 tons of ginseng being wasted (Jiang 2015, 53-56).

Why does China need to trade with the Jurchen to get more ginseng? During Ming dynasty, the main production place of ginseng had been exhausted due to the massive demands; therefore, the border trade had become the main source of ginseng. Until the late Ming dynasty, the ginseng trade market became the target of the Jurchen tribal leaders and other Chinese merchants. The Jurchen people also won a significant position in that area due to the possession of the ginseng land.

The great market value not only brought financial benefits to the Jurchen and but also lead to the overexploitation of ginseng. During the Qing Dynasty, people were still fond of exploiting ginseng, which led ginseng to extinction. Therefore, later in 1699, the government started to issue a limited amount of "ginseng tickets" in order to control the excessive exploitation; people cannot exploit ginseng privately unless they had the "ginseng ticket." However, this policy did not prevent the extinction of ginseng. Even though in 1852, more restrictions had been put on the ginseng exploitation and the amount of the issued tickets was reduced from 10000 to 753, it was still hard and almost impossible to find wild ginseng (Fang 2003).

While people were finding substitutes for ginseng, American ginseng was imported, and the story goes back to the beginning. Under the help of the missionaries, the ginseng trade appeared on the scene.

Part II: Ginseng Trade and its Cultural Influence

Ginseng is not a common plant to find in natural space, especially today. Nowadays, as wild ginseng is on the edge of extinction, it is nearly impossible to spot in any random area. It is also not possible for untrained people to easily find it, as ginseng diggers are trained to go up to the mountains to find the "golden root." It usually takes them a few weeks or even months to find a ginseng. In the U.S., ginseng is not widely used. However, though ginseng is not a widely known plant, it is closely connected to many people's lives today and is deemed responsible for the closer connection between China and America.

Since the times that The *Empress of China*, the first American merchant vessel, took American ginseng to China, it soon opened the new market. Many Americans started to dig and plant ginseng to make a living. Until now, according to Paul C. Hsu, the founder of Hsu Ginseng Enterprises, Inc. and Hsu Ginseng Farms, though the number has decreased dramatically, there are still over one hundred families connected to the ginseng industry in Wisconsin (Informal Conversation July 17, 2019). Ginseng can also be found in many commercial places in the U.S., usually in Asian grocery stores and drug stores. There are many ginseng related products can be found on the popular web-store Amazon such as ginseng tea bags, ginseng powder, and ginseng capsules. This mysterious plant is now involved in people's daily life and its culture has traveled across the ocean and influenced other places.

All of the activities discussed above are parts of the ginseng trade. The strong connection between ginseng and eastern Asian markets makes the ginseng trade not only a type of economic activity, but also type of culture influence. Trade spreads ideas and culture because it involves human movements. Though trade is more about economics today, it was different centuries ago. Large numbers of people traveled along with the goods and stopped by the city when the goods arrived. Therefore, they could have a chance to interact with local people and exchange their ideas. People would see things like how other cultures cooked, what clothes they wore, and what religious ideas they believed in. In those times, as they traveled, they exposed the people they met to their own culture.

Likewise, Asian immigrants have brought ginseng to the western world along with their histories and traditions and those immigrants have developed a domestic demand for ginseng. To seize the opportunity, many ginseng businesses started to open to meet the domestic needs.

Given that the U.S has been exporting American ginseng for hundreds of years, it is hard to tell how the two cultures work with each other from the beginning. Australia, therefore, becomes a better model to explain this topic. There are only a few places in the world naturally growing ginseng, and mainly in Eastern Asia and North America. Australia is not part of them. It does not naturally grow ginseng, and it does not have a long tradition of using ginseng in daily life. However, Australia has recognized the opportunity to become a supplier of ginseng. The growth in ginseng trading has led to the establishment of an Australian industry based on the growth of American ginseng. Tasmania 41 South, one of the ginseng companies in Australia, spent over 14 years discovering how to grow American ginseng, and successfully brought Australian-grown ginseng to the Australian market (3 unconventional crops you'll find growing here in Australia 2017).

It is not natural to consider that Australia grows ginseng. However, the clear fact is there must be domestic demands for ginseng which encourage the ginseng business to open. Ginseng industry began to burgeon, and it cannot be separated from the help of Asian Immigrants. When the number of Asian immigrants increased, there was an influx of their traditions and unique lifestyle. When coming to Australia, Korean immigrants brought Korean traditional medicine - which is called *hanbang* with them (Han 2001,146). They soon developed their community and kept living their lifestyle. Some of them use ginseng very often in their daily life. For example, Korean families use ginseng in their soups and take ginseng tea for their health.

Tradition is a strong part of people's lives. It contributes a sense of comfort and belonging. It brings families together and enables people to reconnect with friends. For people who are away from home, tradition is the solution of their homesickness, and in this case, ginseng is the taste of home and sweet memories. Therefore, the strong need for ginseng and also some other necessities soon encourage the new business to start. As the saying goes, "where there is demand, there is supply." Asian culture melted into the ginseng industry and spread to some further places.

Compared to the situation in America where most of the ginseng companies were initiated by Asians, Australian companies are owned by people of different races and cultural backgrounds—a refreshing discovery in the ginseng industry. Most of the ginseng companies in America are founded by Asians as they have a long history of using ginseng and have closer connections to it. Though it is hard to tell what the discovery can tell and show, it is still significant that the ginseng culture is spreading to more places and accepted by more people.

It is also interesting to mention the subtle differences between the ginseng companies owned by people with different backgrounds: Asian owned companies usually sell raw or dry

ginseng root; while non-Asians companies tend to produce and sell ginseng candy, spices, and tea bags. There are a few reasons for these differences in product.

Because of different lifestyles and conventions, companies held by people from different backgrounds tend to sell different products. Most of the Chinese are more used to buy the complete ginseng root since they care more about the shapes and the completeness of the ginseng root, but this idea of "shape compensation" is not part of the Western culture. For the Chinese customers, the value of the whole ginseng root itself somehow exceeds that of the ginsenosides, which are the major constituents of ginseng and have been proved to be helpful for health. Ginseng is not only a healthy supplement, but also a social plant, which shows superiority and wealth.This social importance of ginseng also helps create great value for this plant and is an important element to consider when discussing the ginseng culture.

In addition to cultural influences, the location of ginseng shops more or less prevents ginseng from involving Western society. "Though many ginseng companies are held by Australian locals, most of the ginseng and ginseng products are still only sold in Chinatown and Chinese drugstores like Tong-ren Tang (message to the author, July 13, 2019)," said Ruo He, a Chinese student at Australian National University. This is also the condition in the U.S. It is rare to find ginseng or ginseng related products in a normal grocery store and in most of the cases, it can only be found in Asian grocery stores. However, according to the sellers in Chinatown, there are also many American customers coming to the Chinese grocery store and buying ginseng for health. Therefore, lacking demand may not be the reason to prevent ginseng products from launching into the American market.

On the one hand, ginseng, a great example of TCM herbs, successfully linked the two continents together and helped Asian immigrants to keep their traditions alive. On the other hand,

most of the traditional herbs are not fully involved in American society and accepted by the majority.

Part III: The Unstable Yet Strong Ginseng Market

Ginseng is an expensive herb. In China, ginseng is regarded as a precious gift for family members and friends. American ginseng, which is one of the unique plants originated from America, is highly appreciated by Chinese visitors. The high price of ginseng shows people's prestigious social identity and good fortune, and this is part of the reason why ginseng is highly appraised and pursued by people. However, like other industries, the ginseng industry also has its dark side. Indulged in the high benefits, many merchants started to play some tricks to fool their buyers to gain more profits and these actions largely affected the integrity of this whole market.

For instance, many customers reported that the ginseng sold at the Heilongjiang (a province in northeast China) Festival was very easy to break into pieces. According to some further investigation, because many customers believed that the idea that longer the ginseng root, the more valuable the ginseng is, the sellers stick the ginseng root with glue and made the ginseng look "very old (Ginseng in mainland China 2015)." "There are many fake ginsengs sold in Chinatown (Informal Conversation June 10, 2019)," said the seller from De Zhi Co. in Chinatown, Washington D.C. Additionally, Paul C. Hsu also shared his experience and said that many American ginsengs now sold in the U.S. are not from Wisconsin. Instead, they are from China and can be sold with cheaper price for lower quality (Informal Conversation July 17,2019). Deceived by the price, many Chinese pay an expensive price buying the American ginseng which could come from China. This situation also makes customers doubt the authenticity of the ginseng market, which is a serious problem today. Many Chinese customers are careful where they buy ginseng because of the uneven quality levels.

The quality of ginseng is not easy for the average customers to identify. Many buyers are only influenced by the good reputation of ginseng, but do not have much knowledge of it. Some sellers mainly aim at Chinese visitors who do not have the opportunity to complain once they leave the United States. Many Chinese people have experience of buying poor quality herbs like ginseng or Cordyceps Sinensis, and many of them do not buy herbs anymore because of the experiences.

The high profits of ginseng are what contribute to the complicated market. Ginseng is sold at a very high price for several reasons. First, ginseng was highly praised and recommended by emperors during the Ming and Qing dynasties. Especially during the Qing Dynasty, since the Manchus had the habit of using ginseng, the Qing emperors are extremely fond of it (Fang 2003). This is also one of the reasons that ginseng shows good fortune. Therefore, the noble liked to pay an expensive price to buy ginseng so that they could imagine living the emperor's life. Secondly, as ginseng quickly went extinct after the Ming Dynasty, ginseng became more rare to find in nature. The decrease in the supply of ginseng pushed the price of it to go higher and higher and it did not go down until recently. Ginseng itself is also hard to grow. According to Paul Hsu (Informal Conversation July 17, 2019), he faced many problems when he tried to grow ginseng. First, the life cycle of ginseng is long. Ginseng can take from five to ten years to reach a size when the prized root can be harvested. Also, while ginseng is growing, it absorbs most of the nutrition from the soil. The land that holds the ginseng cannot be its home for the next five to ten years. Ginseng companies have to continue buying new land and selling the old land. Ginseng easily dies if it is not taken care of correctly and carefully. This ginseng planting business, therefore, needs wisdom and efforts in order to make the business successful.

It seems reasonable that ginseng could be sold at a very high price. Ginseng somehow is not only a type of herb or food—it's like jade, gold, or wine and can be used for collection. Many people enjoy hunting and collecting wild ginseng just like collecting jewelry. It can be found online that wild American ginseng root can be sold up to 5,000 dollars for each root on Etsy. Because of the quality differences, the price range of ginseng is large: ginseng is sold for only 30 dollars per pound in some normal Asian Grocery Stores. On the other hand, buyers are also willing to buy 500 – 600 dollars per pound for a "real" ginseng root. Ginseng is no longer a plant; it carries the burden of social activities and economic games.

The ginseng market generally is small in area but large in populations. Most of the customers are from Eastern Asia, especially China. In April 2018, China assigned a 15 percent tariff to ginseng imports in response to tariffs on U.S. imports like steel and aluminum that U.S. President Donald Trump signed off on in early March (Haase 2018). The ginseng market was affected by the conflicts between the United States and China and the ginseng industry was affected in the tariff wars. According to Paul Hsu, his business has been hugely damaged by the trade war. Because of the high tariffs, Hsu had to increase the price of his American ginseng and the higher price may prevent many Chinese customers from buying his ginseng products.

Wisconsin American ginseng is proven to be the most valuable American ginseng in the world. It is also considered the premium quality ginseng and sold at a higher price. American ginseng can be grown in many other places: Canada, Hong Kong, and mainland China. The ginseng grown in Wisconsin has the best flavor of root and quality. However, the more expensive Wisconsin American ginseng encourage the customers to buy Canadian ginseng. "Chinese distributors have warned that they may shift their purchasing to Canadian ginseng," said Jackie Fett, executive director of the Ginseng Board of Wisconsin (Yap 2018). The ginseng market

hugely relies on the Chinese market. Because of the appreciation of Chinese customers, ginseng, a picky plant, can now be the mainstay of many Wisconsin farmers and become well-known around the world.

However, because the choices of the target markets are limited, the industry is easily affected by political conflicts. Finding new markets is important for the ginseng industry but difficult to do. This was also a question raised at the Sixth North American Ginseng Conference, 1984. "To keep expanding the markets for American ginseng, as well as to be prepared for the changes in Hong Kong, we would advise the American ginseng industry to develop new markets, if possible, in western countries. The office of Monopoly of the Republic of Korea, a government unit, organized serious efforts in expanding and developing new markets for their ginseng. Their efforts have made South Korean ginseng one of the best-selling ginsengs worldwide. Additionally, it may be advisable to consider new formulations for American ginseng (Paul P.H. et al 1984)." Though the ginseng companies and traders have realized the importance of finding new markets, it turns out to be hard to achieve. However, it is still a problem needs to be solved to make the market more stable and also a crucial step for better culture influences discussed in section two.

American ginseng, a mythical plant, travels across the oceans and spreads widely in the world. The ginseng history is undoubtedly a crucial period in the history of international trade, and it is precisely because of the special history, ginseng is highly favored by people today. Also, the ginseng market is of great complexity and this complexity is a unique representation of this profound history and the benefits that history could bring. No matter what dark sides this market could have, they are the signs of human activities and how this interesting plant could have such

extraordinary power to play with human beings and therefore it can survive in history.

Shihua Lu *is a junior at the University of Michigan double-majoring in Anthropology and Philosophy. She is interested in human rights movement, the discussions of philosophy and anything related to Cuba. She hopes to pursue a PhD in Sociocultural Anthropology.* *This paper was inspired and written during the internship at the Smithsonian Center for Folklife and Cultural Heritage. She would like to express her deepest gratitude to everyone who has contributed to this paper.*

References

Australian Farmers. 2017. "3 Unconventional Crops You'll Find Growing Here in Australia." Australian Farmers. Accessed July 25, 2019 at https://farmers.org.au/blog/3-unconventional-crops-youll-find-growing-here-in-australia/

Fang Zhouzi. 2003. "Renshen yu Xiyangshen: lishi yu xianshi, Shenhua yu shishi (Ginseng and American Ginseng: History and Reality, Mysteries and Truths)." Accessed July 10, 2019 at http://www.xys.org/xys/netters/Fang-Zhouzi/science/ginseng2.txt

Haase, Nicole. 2018. "Tariffs, China and American Ginseng: A Case Study in Wisconsin." Modern Farmer. Oct 23, 2018. Accessed July 12,2019 at https://modernfarmer.com/2018/10/tariffs-china-and-american-ginseng-a-case-study-in-wisconsin/

Han, Gil-Soo. 2001. "The provision of hanbang herbal medicine in the Korean community in Australia: entrepreneurial or caring for fellow Koreans?" Australian Health Review 24(4) 146 – 155.

Jiang Zhushan. 2015. *Renshen diguo, Qingdai Renshen de Shengchan, Xiaofei yu Yiliao (the Ginseng Empire, the Consumption and Medical Treatment of Ginseng in the Qing Dynasty)*. Zhejiang: Zhejiang Daxue Chubanshe (Zhejiang University Press)

Office of the Historian. N.D. "A Guide to the United States' History of Recognition, Diplomatic, and Consular Relations, by Country, since 1776: China." Accessed Novernber.23, 2019 at https://history.state.gov/countries/china

Paul P.H. and Tammy P.C. 1984. "Hong Kong - The buyers of American Ginseng". 6th North Am. Ginseng Conference. Univ. of Guelph. Ontario. Canada.

Rothman, Lauren. 2015. "China Is Paying Top Dollar for American Ginseng That Might Be Chinese." Vice. March 2, 2015. Accessed July 23,2019 at https://www.vice.com/en_us/article/9ag7dy/china-is-paying-top-dollar-for-american-ginseng-that-might-be-chinese

Smith, Philip Chadwick Foster. 1984. "Western Eyes Turn Eastward." In *The Empress of China.* Philadelphia: Philadelphia Maritime Museum.

Vision Times. 2015. "Dalu Renshen Zaojia Luanxiang Jiaoshui Nianjie Moubaoli (Low Quality Ginseng is Glued for Profits in China Mainland)." May 4th, 2015. Accessed Nov 21, 2019 at https://www.secretchina.com/news/b5/2015/05/04/575131.html

Yap, Chuin-Wei.2018. "Chinese Tariffs Take Root in American Ginseng." WSJ. April 25, 2018. Accessed July 18,2019 at https://www.wsj.com/articles/chinese-tariffs-perfect-target-american-ginseng-1524678849

Language, Healthcare, and Economics

Immediate Changes and Cultural Competency: Ways to Reduce Preventable Maternal Death in Madagascar

by Gloria Fall

Maternal mortality is a significant problem in the developing world, specifically Sub-Saharan Africa. The majority of these deaths are preventable, and therefore it is a problem that needs to be addressed immediately and effectively. Within Madagascar, maternal deaths generally occur because of a lack of access to and affordability of healthcare services. The majority of the population lives in rural regions, where healthcare facilities are typically far away, and *reninjaza,* Malagasy traditional birth attendants (TBAs), are usually the main birth attendant. Interviews were conducted with *reninjaza* who live and work in the rural region of Andasibe, Madagascar. The *reninjaza* were asked about their experiences with pregnancy and delivery complications they faced, as well as their experience with maternal death. The interview method included question and answer sessions, with one translator. By educating both women and TBAs about pregnancy risks and ways to address them with the resources available within the community, maternal mortality can be reduced within Madagascar.
Keywords: maternal mortality, traditional birth attendants, reninjaza, Madagascar, affordability, accessibility, childbirth, pregnancy

Introduction

Women's access to reproductive health is a global issue, and maternal mortality is one of the largest challenges that women face. Maternal mortality can be due to direct or indirect issues, however, almost 75% of maternal deaths are caused by severe bleeding, infections, hypertension disorders during pregnancy, delivery complications, and unsafe abortion ("Maternal Mortality" 2018). According to the World Health Organization (WHO), around 830 women die every day from preventable complications in pregnancy and childbirth ("Maternal Mortality" 2018).

Additionally, developing nations account for 99% of maternal deaths, and over half of these occur in Sub-Saharan Africa ("Maternal Mortality" 2018). In Sub-Saharan Africa, the average maternal mortality ratio, which is counted as maternal deaths per 100,000 live births, is 546, yet Madagascar averages at 353 (Salem et al. 2018). Part of this difference in numbers can be attributed to the fact that Madagascar typically has better public health than the other Sub-Saharan nations, and also has higher rates of contraceptive use and prenatal care, which are directly linked to maternal health (Hernandez and Moser 2013, 119). However, the majority of these maternal deaths are still preventable; therefore, action must be taken in order for Madagascar to continue to lower their maternal mortality ratio.

Madagascar has had commitments to bettering maternal health and decreasing maternal mortality in the health sector of the government since the early 2000s (Ramihantaniarivo 2019), but the health system of the nation continues to have difficulties with finding sufficient financing (Honda et al. 2011, 11). Additionally, the majority of people in Madagascar live in poverty, and with a low budget from the government for healthcare, many services require out-of-pocket payments, which creates the issue of affordability and accessibility within the healthcare system (Honda et al. 2011, 11). Even though the government has a commitment to bettering healthcare, the process is not moving fast enough to save lives immediately.

New strategies must be put into place in order to more effectively and more immediately reduce the number of maternal deaths occurring in Madagascar. More specifically, there needs to be infrastructure to reduce the main complications that exist in pregnancy in childbirth. Since poverty is so prevalent in Madagascar, the strategies must be affordable for the whole population. Furthermore, accessibility in terms of physical distance is crucial as well. 63% of the Malagasy population lives in rural areas, where roads can be difficult to travel and transportation is

extremely limited ("Rural Population (% of population)" 2018). This creates another barrier to sufficient care during pregnancy and childbirth that the majority of the population faces. Therefore, it is necessary to consider the different factors that influence maternal death rates in order to effectively reduce rates throughout the entire country.

To immediately begin reducing the number of maternal deaths each year in Madagascar, it is important to approach the problem from multiple angles while focusing on addressing the leading causes of maternal mortality. One strategy is the implementation of educational and awareness programs in communities, but specifically rural communities. Pregnant women should be able to identify atypical pregnancy symptoms in themselves in order to get care in a timely matter. Also, traditional birth attendants, who are responsible for delivering the majority of babies in rural communities, should be trained to understand and identify complications that require attention. Additionally, it is important to implement safer abortion strategies. While abortion is illegal in Madagascar, there are still methods of practicing safer abortion in order to reduce maternal mortality. Healthcare providers in both allopathic and traditional roles must be informed on proper dosage for the use of misoprostol, one of the most commonly used abortion medications, in order to make sure that women do not face complications after administering the drug (Pourette et al. 2018). Misoprostol can be used for medical conditions that are unrelated to abortion, such as gastric ulcers, making it accessible even in countries with restrictive abortion laws, such as Madagascar (Sneeringer et al. 2012). Furthermore, allopathic healthcare providers who work in rural areas must be educated on what is culturally appropriate in order to best serve their community. These changes can be realized through collaborative work between allopathic and traditional healthcare providers across the nation, which will help to ensure that maternal health care is both accessible and affordable for all women. While certain risks of maternal

mortality cannot be addressed without better access to medical facilities, by educating both women and healthcare providers on avoidable complications, there will be an immediate reduction in maternal deaths.

Literature Review

The literature surrounding maternal mortality solely in Madagascar is limited, as it is frequently grouped in with all of Sub-Saharan Africa. However, there is still literature pertaining to Madagascar specifically, and it addresses various topics such as pre-eclampsia, unsafe abortion, accessibility to sufficient care in rural regions, and women's perceptions and understandings of safe pregnancy and childbirth (Collins et al. 2016). Some of the research focuses specifically on cultural and traditional beliefs surrounding childbirth (Morris et al. 2014), and the majority of the literature mentions poverty and the extreme impacts it has on maternal mortality (Honda et al. 2011). There is some variation in the literature due to the fact that studies were conducted in different years and regions of Madagascar. However, this variation is not significant enough to cause an inconclusive review.

In Madagascar, only 35% of women give birth in health facilities, and even less than that deliver in health facilities in rural communities (Collins et al. 2016). This has implications for complications which occur during labor and delivery, and also from unsafe abortion practices. One of the biggest concerns with delivering outside of health facilities is the limited access to effective uterotonics. Uterotonics, such as misoprostol, can be used to prevent maternal deaths from unsafe abortion and post-partum hemorrhage (Collins et al. 2016). In rural areas, where the majority of women are delivering with traditional birth attendants (TBAs), pharmaceutical uterotonics are not used, but many TBAs use tambavys, or medicinal teas, as uterotonics (Collins et al. 2016). There are a variety of plants that are used at different times of year as uterotonics,

but there is little research surrounding the effectiveness of these traditional medicines. However, there is some research that shows certain plants used by TBAs in birth contain cyclotides, which helps cause uterine contractions (Collins et al. 2016). Therefore, even when women have no access to pharmaceutical uterotonics for delivery complications, there are options that can be safer than others. The study conducted by Collins et al. (2016) supports the argument for educational and awareness programs in rural communities. If TBAs are informed on which medicinal plants to use that will be less likely to cause severe complications, delivery practices will be safer, and the number of maternal deaths will be reduced.

With regard to misoprostol use for safer abortion practices in Madagascar, education of all healthcare providers is greatly needed throughout the nation. Women in urban areas, like the capital, are more likely to seek out an abortion (Pourette et al. 2018a). According to a study done by Pourette et al. (2018a), women seek advice from friends, TBAs, doctors, midwives, and nurses. In theory, asking someone with experience of abortion is a safer way to induce abortion, but according to Pourette et al. (2018a), the majority of the women taking misoprostol to induce abortion are taking incorrect dosages that are potentially dangerous, even with guidance from healthcare professionals. However, it is possible to train healthcare professionals on appropriate dosages. A study done by Diop et al. (2009) showed that misoprostol in low doses can be used to treat incomplete abortion with up to 99% effectiveness. Part of the research involved training nurses to effectively identify and treat incomplete abortion, which proved to be successful and typically did not require intervention from a physician (Diop et al. 2009). This study shows that training for healthcare professionals, regardless of degree, can create an immediate change in care. While the study was conducted about incomplete abortion, it still can be used to show the benefits of educational programs and trainings in terms of any misoprostol use.

Pre-eclampsia, a hypertension disorder that occurs during pregnancy, is one of the leading causes of maternal deaths in Madagascar (Romuald et al. 2019). One of the biggest contributors to this is the fact that patients with pre-eclampsia are not seeking medical care until the extreme stages of the illness, where risk of complication, and potential fatality, is highest (Romauld et al 2019). Romauld et al. (2019) conducted a study at University Hospital Center of Obstetric Gynecology of Befelatanana Antananarivo to assess the knowledge of pre-eclampsia and symptoms in pregnant women. The study showed that the majority of women did not learn of pre-eclampsia until they entered the hospital for labor or complications, and the information that was provided was limited (Romauld et al. 2019). One third of the women who participated in the study did not even know the condition was fatal, and the majority of women believed that reducing salt intake would eliminate concerns of pre-eclampsia (Romauld et al. 2019). Since many women are not aware of the risks or major symptoms of pre-eclampsia, lack of knowledge can lead to delayed care, which increases the risk of maternal death (Romauld et al. 2019). This shows an increased need for education relating to maternal death risks. Additionally, women are supposed to learn about the risks and symptoms of pre-eclampsia in prenatal care visits (Romauld et al. 2019). Therefore, there must also be increased training for healthcare providers in order for pregnant women to get proper knowledge pertaining to pre-eclampsia and other hypertension disorders. While this research was only conducted in one hospital in Madagascar, the data can be used to support the need for better education for both allopathic and traditional healthcare providers throughout the entire country.

Location and accessibility to healthcare facilities is a huge factor in maternal death risk. Women in rural communities have little access to hospitals, so many of them do not make the journey during labor and delivery (Hernandez and Moser 2013). Clearly, this can prevent women

from getting the care they need in case of emergencies. Hernandez and Moser (2013), argue that the Malagasy government must improve transportation systems and hospital accessibility in order to reduce maternal deaths from delivery complications. While transportation is an issue that should be addressed in order to ensure adequate care, this is a change that could take a considerable amount of time and will not necessarily be affordable to the majority of the population. Simultaneously though, this research shows the need for better training and education of healthcare providers in rural communities. If TBAs and other community members involved in pregnancy and childbirth know how to identify complications in delivery and are also informed on how to address them with the resources they have, there could be a reduction in maternal deaths.

In addition to educating healthcare providers in any health sector on danger signs during pregnancy and childbirth, it is also essential that women who are pregnant or planning on becoming pregnant learn warning signs as well. If women are aware of the health problems that can come up during pregnancy and childbirth, they will be better equipped to ask for medical help if necessary (Salem et al. 2018). There has currently been no program developed that makes a significant impact on increasing awareness surrounding pregnancy complications, however, it is possible that one could be developed by working with communities and TBAs in rural areas, as well as with urban communities and healthcare providers as well (Salem et al. 2018).

Another considerable problem that pregnant women face in Madagascar is cost of care. Emergency medical care in hospitals can be expensive, and require high out-of-pocket payments, which creates a financial burden for the mother and her family (Honda et al. 2011). One of the only ways to address this financial inaccessibility is to create a reformed healthcare system with better funding and less out-of-pocket costs, and to make it easier for all women, regardless of

location, to have access to healthcare facilities (Honda et al. 2011). This is another change that requires government funding and a considerable amount of time, therefore healthcare reform is not an immediate or effective solution. Yet again, this shows a need for better training and education of both women and healthcare providers in rural areas, because immediate changes to access are not realistic.

In terms of cultural impact on maternal mortality, it is clear that cultural beliefs, which change depending on the region of Madagascar, can greatly influence the type of care that women receive. In Fort Dauphin, an urban region in Southeast Madagascar, cultural beliefs and traditions about pregnancy, childbirth, and postpartum care contribute to the rates of maternal mortality (Morris et al. 2014). For example, women avoid certain foods and have cultural ideas surrounding what is proper nutrition during pregnancy, yet these rules do not necessarily align with proper prenatal care and nutrition (Morris et al. 2014). Furthermore, risky birth and postpartum practices which are culturally important can create complications for both the mother and child. According to Morris et al. (2014) women are confined after delivering, and typically are exposed to overheating and lack of bathing during this time period, which increases risk of infection. Also, other practices such as pushing on the abdomen during labor to speed the process, which is another traditional practice in the region, are harmful to the mother and child (Morris et al. 2014). These socio-cultural practices can in fact increase the risk of maternal mortality in regions, which shows a need for education on ways to maintain important cultural practices while also creating safer pregnancy and delivery practices.

In another region of Madagascar, Menabe, there are cultural fears over having a “big” baby, and there are many social expectations of pregnant women (Pourette et al. 2018b). Pourette et al. (2018b) argue that social expectations of mothers that are derived from cultural traditions

have a negative impact on maternal health. However, according to Pourette et al., even with access to biomedicine in the Menabe region, many pregnant women will not rely on this care (2018b). Women in Menabe are often distrustful of biomedical personnel and rely heavily on traditional birth attendants like *reninjaza* for care, which can lead to lack of emergency care when necessary (Pourette et al. 2018b). The reason behind this disconnect between pregnant women and biomedical professionals is linked to a lack of cultural understanding and acceptance from healthcare providers. Often times, the healthcare providers in Menabe, and the rest of the nation, do not come from the region and do not understand socio-cultural expectations of the communities they work in, which means that their care is not always appropriate (Pourette et al. 2018b). This shows a need for culturally relevant and appropriate care in all regions of Madagascar, in both allopathic and traditional medicine, in order to help reduce the number of maternal deaths that occur in the country.

Methodology

The majority of data collection for this research was through literature review, and lectures through the University of Ankatso. These lectures provided general information about Madagascar and its history, which helped frame traditional medicine in terms of the current medical system. The literature review provided context for maternal mortality rates within Madagascar, and also provided information on multiple regions of the country, which allows for a better understanding of maternal deaths that occur in Madagascar. This information was helpful in defending the need for education and training. Additionally, interviews were conducted with *reninjaza*, one type of traditional birth attendant present on Madagascar, and healers who live and work in Andasibe, a rural region of Madagascar. These interviews provided a framework for methods of training and education that are both relevant and socio-culturally respectful and

appropriate. While in Andasibe, an interview was also conducted with the head physician at the CSBII about birthing practices and complications that arise. This interview provided context for how communities rely on different healthcare services for needs during pregnancy and childbirth. Furthermore, the combination of interviews provided evidence on the effectiveness of allopathic and traditional healthcare providers working together to ensure the safest conditions for both the mother and the child. It should be noted that the conversations with the *reninjaza* and the physician at CSBII were translated from Malagasy to English by Dr. Nat Quansah.

Results

Four *reninjaza* were interviewed in Andasibe about their experiences delivering babies and providing care to pregnant women. The first woman interviewed, Rasoarimanga, reported that since she began practicing in 1972, she has not had any cases of maternal death (personal communication July 9, 2019). She works with the local hospital and CSBII to ensure that her clients have the best care possible (Rasoarimanga, personal communication, July 9, 2019). Rasoarimanga stated that if she encounters a problem in a patient that she cannot treat within three days to a week, she will refer them to the hospital, as she has learned when complications are beyond her skills (personal communication July 9, 2019). Rasoarimanga said that she learned when complications require allopathic care by working and collaborating with the local clinic, which shows the reliance on integrated healthcare, where doctors and traditional healers work together, in the Andasibe region (personal communication July 9, 2019). When taking patients to the local clinics, she will go with them to explain the problems that are occurring with the pregnancy; she reported that this is rarely necessary with her clients as she is typically able to address any complications that might arise during pregnancy (Rasoarimanga, personal communication, July 9, 2019). Additionally, Rasoarimanga is a registered member of the

National Traditional Healers Association, which means that she works with the local allopathic care providers and can be called to the hospital if they want to utilize her skills in a difficult labor (personal communication July 9, 2019). Rasoarimanga also reported that some of clients see her and the local clinic for services, which is another example of integrated care in the region (personal communication July 9, 2019).

The next two *reninjaza* were interviewed together as mother and daughter, Helene and Denisse. Helene is a retired *reninjaza* who passed the gift to her daughter, Denisse. When asked about maternal deaths, Helene did not answer but Denisse reported that she had not lost a mother or child since she began working in 1988 (personal communication July 9, 2019). Both women were registered with the National Traditional Healers Association and reported that they worked with the local clinic and hospital (Helene and Denisse, personal communication July 9, 2019). Denisse stated that she will only work with clients if they trust her and exclusively use her services (personal communication July 9, 2019). However, both Denisse and Helene said that they would refer clients to allopathic care providers if there were complications that they could not address by themselves (personal communication July 9, 2019). They also said that they would help women in more rural areas reach the clinic or hospital if they required more specialized care during pregnancy, labor, or delivery (Helen and Denisse, personal communication July 9, 2019). Both women reported using herbal remedies to address problems like hemorrhage and high blood pressure in patients but were also willing to take women to the hospital if these remedies did not address the problem (Helene and Denisse, personal communication July 9, 2019).

The final *reninjaza* interviewed, Telovavy, is both a traditional birth attendant and a traditional healer. She had similar reports to the other three *reninjaza*, although she also stated

that she typically does more traditional healing than pregnancy and delivery work (Telovavy, personal communication July 10, 2019). Telovavy worked with local doctors and midwives at the clinic and is also a member of the National Traditional Healers Association (personal communication July 10, 2019). She was the only *reninjaza* to report the loss of a child, which was due to a stillbirth (Telovavy, personal communication July 10, 2019). Like the other women interviewed, Telovavy said that she would take clients to the hospital if there are complications with pregnancy or delivery that she did not have the skills to address herself (personal communication July 10, 2019).

Of the four *reninjaza* interviewed, all reported that they would not help women who were seeking abortions (personal communication July 2019). However, Telovavy said that she would help women who had experienced incomplete miscarriage, which can be the result of a failed abortion attempt (personal communication, July 10, 2019). In regard to family planning, Telovavy and Rasoarimanga stated that both would provide family planning services, but Helene and Denisse would not (personal communication July 2019). All of the women also reported that they considered collaborations with the local clinic and allopathic providers as beneficial for their patients and them, and they all were appreciative of the benefits from the National Traditional Healers Association as well (personal communication July 2019).

Dr. H. Randriarilala, the current head physician at the CSBII in Andasibe, was interviewed about his experiences with pregnancy and childbirth at the clinic, as well as his work with local traditional birth attendants. Dr. Randriarilala has been at the CSBII for eight months and in that time has only experienced one stillbirth and no maternal deaths, but he was not sure on the number of maternal deaths that occurred before he arrived (personal communication July 10, 2019). At the CSBII, they do prenatal and post-natal care, along with health education and

family planning (H. Randriarilala, personal communication July 10, 2019). However, Dr. Radriarilala stated that while they try to make sure the cost of care is low with free prenatal consultations, any sort of medication required must be paid for (personal communication, July 10, 2019). He explained that if there are complications during delivery or a cesarean section is required, women must be transferred to the hospital in Moramanga, which is thirty minutes away (H. Randriarilala, personal communication July 10, 2019). Dr. Randriarilala also discussed his relationship with the National Traditional Healers Association. He said that he finds the association to be beneficial, as it provides effective care to those who lack access to allopathic care; the only issue that he has with traditional healers and birth attendants is when they refuse to work with allopathic providers (H. Randriarilala, personal communication July 10, 2019).

Discussion

Recent literature on maternal mortality in Madagascar suggests that there are a multitude of reasons why maternal deaths occur, many of which can only be addressed through infrastructure changes, transportation reforms, healthcare reforms, and other processes that require a considerable amount of time and money. However, changes must be implemented in an immediate way in order to reduce the number of unnecessary maternal deaths that occur in this country. Therefore, there is clearly a need for alternative methods of reducing maternal deaths. The literature also shows a gap in the research, as the focus has been in specific regions, while some areas are left out. There is also a lack of complete data pertaining to maternal deaths in Madagascar, due to the fact that there are many maternal deaths that go unreported or are not counted because of where they occur in the country. The literature does not focus on one method of reducing maternal deaths, but instead highlights a variety of ways to decrease maternal

mortality in both immediate and long-term ways, like education and governmental reforms and funding.

The interviews conducted for this research provided an in-depth look into maternal health in Andasibe, Madagascar. These interviews show evidence of a successful collaboration between allopathic and traditional care providers. The *reninjaza* in Andasibe were able to learn about complications that require biomedical care, while the physician in the CSBII was able to learn how *reninjaza* provide effective and affordable care to many members of the community (personal communications July 2019). All of the healthcare providers interviewed reported no maternal mortalities, which shows that this collaboration can be greatly beneficial to women in rural communities specifically. However, there are weaknesses in this research as well. Only four *reninjaza* and one general physician were interviewed for this research, which means that the data is not entirely conclusive for Andasibe, let alone the entire country. Nonetheless, it is clear that there needs to be educational and awareness efforts about different topics relating to maternal mortality, alongside collaborative care initiatives, in order to begin reducing deaths.

Education about maternal death risks must be improved for all healthcare providers, both allopathic and traditional. Healthcare providers in all settings need to understand certain risks that contribute to a high number of maternal deaths in Madagascar, such as pre-eclampsia, so that they can inform pregnant women of symptoms to look out for (Romuald et al. 2019). Additionally, *reninjaza* and other TBAs can benefit from learning about pregnancy risks as well. *Reninjaza* can learn to recognize pregnancy complications that are out of their reach, and therefore be able to refer women to allopathic providers before there is an emergency (Rasoarimanga, personal communication July 9, 2019). Additionally, if *reninjaza* are informed on the most effective and safe herbal remedies to use during labor and delivery, women will be

less likely to suffer complications when relying solely on traditional medicine for labor and delivery (Collins et al. 2016). There is limited research surrounding exactly what herbal remedies are safe to use during pregnancy and childbirth, however, there has been research on specific uterotonics that are used by TBAs and are effective for causing uterine contractions (Collins et al. 2016). While not all of the plants used by TBAs have been studied, and further research would require a considerable amount of funding, there is at least a base source for successful uterotonics that can be used in traditional care settings. This is information that could be distributed on a national level to all *reninjaza* and TBAs that are registered through the National Traditional Healers Association, which could create an immediate reduction in maternal deaths. Clearly, educating healthcare providers can help ensure that women address potential risks in a timely fashion, and can also help providers use effective treatment methods, which will help to immediately decrease maternal mortality.

Awareness and education about pregnancy complications must also be spread directly to pregnant women and in all regions of Madagascar, especially rural areas. Women living in rural communities typically do not have easy access to hospitals or clinics, and therefore are less likely to make the journey to reach an allopathic care center during labor and delivery (Hernandez & Moser 2013). The long travel times also make prenatal care inaccessible, which means that many women are relying on TBAs and their own knowledge of pregnancy to ensure that there are no complications (Hernandez & Moser 2013). If women are educated on the symptoms of different risk factors that can occur during pregnancy, it can help them seek out necessary care before it is too late. This also shows a need for educating TBAs on health complications that require allopathic care, which would benefit women in rural communities who have concerns about their pregnancies and are unable to access hospital care. This collaborative care has proven effective

in Andasibe, seeing as all of the *reninjaza* stated that they recognized the signs of complications that required allopathic care, and also reported no maternal deaths (personal communication July 2019). If TBAs were able to help educate women on the issues that pregnant women might face, educational efforts could reach the majority of communities in Madagascar. Women also must be able to access this information without the help of a care provider in order to ensure they seek out care if necessary.

Cultural awareness and sensitivity must be taught to healthcare providers, specifically in the biomedical paradigm. Cultural traditions and practices can be harmful to both mothers and babies, which increases the risk of maternal death (Morris et al. 2014). However, it is important that allopathic care providers respect cultural practices in order to gain the trust of women who might be needing medical care (Pourette et al. 2018b). If allopathic care providers learn to respect the socio-cultural expectations of the regions in which they work, it eliminates a barrier that might cause women to avoid necessary care, especially in cases of emergencies. Part of this cultural sensitivity includes respecting the work of *reninjaza* and other traditional birth attendants. When allopathic care providers respect and value the work of their traditional counterparts, they are inherently respecting the community that they work in. This can be realized through encouraging *reninjaza* and other TBAs to register with the National Traditional Healers Association, which makes collaboration between allopathic and traditional providers easier.

Healthcare providers must be educated on safe abortion practices as another reduction strategy regarding maternal mortality. One of the easiest ways to provide safer abortions to women is through correct misoprostol use, which is available in Madagascar (Pourette et al. 2018a). However, most women who are using misoprostol in Madagascar are using incorrect,

and potentially unsafe, dosages of misoprostol even when they receive guidance from healthcare professionals (Pourette et al. 2018a). All healthcare professionals, including TBAs, must be educated on the proper dosages of misoprostol for abortion practices in order to reduce the number of abortion-related complications that occur in the country. While the *reninjaza* interviewed in Andasibe stated that they did not help women with abortions (personal communications July 2019), there are studies that state that women seek advice on misoprostol dosage from TBAs (Pourette et al. 2018a). In rural communities in particular, women might only have access to TBAs for guidance on abortion. While it is not respectful to expect *reninjaza* to provide comprehensive abortion services, it is not unrealistic to provide the correct knowledge on misoprostol use to both *reninjaza* and allopathic care providers, so that if women need guidance someone in their community might have the proper information. Education initiatives for Malagasy nurses that teach them to treat incomplete abortion without physician intervention have proved to be greatly effective (Diop et al. 2009). This supports the argument that education on safer abortion practices, and ways to treat complications, can make a difference in the number of maternal deaths that occur in Madagascar due to unsafe abortion.

Cost of care and accessibility are huge factors in the maternal mortality rate in Madagascar (Honda et al. 2011). While it is important to address these issues through budgeting changes within the government and the creation of effective road and travel infrastructure, these changes cannot be completed in an immediate way. This is more support for collaborative care between allopathic and traditional medicine providers. When women do not have access to hospitals or clinics, it is typically due to inability to reach the destination or inability to afford the care they need (Honda et al. 2011). This leads to a heavy reliance on *reninjaza* and other TBAs. If allopathic care providers worked alongside *reninjaza* and TBAs to help ensure the best care at

an affordable price for any and all women, there would be lower rates of maternal mortality. This collaboration must include educational and awareness efforts for *reninjaza* and TBAs working in different communities in order to provide correct information on complications that could arise to pregnant women who never seek allopathic care. This has proven to be an effective method of handling pregnancies and deliveries in Andasibe. Dr. Randriarilala openly acknowledged that care from the CSBII is not always accessible to women, which is why he appreciates the work of traditional healers like *reninjaza* and TBAs (personal communication July 10, 2019). This provides further evidence that collaborative methods of pregnancy care can help create accessible ways for women to avoid complications, and therefore, unnecessary maternal deaths.

Ultimately, it is clear that preventable maternal deaths cannot be completely eliminated from Madagascar without significant governmental and infrastructural changes, as noted by the literature. However, it is important to focus on the ways in which educational efforts have made an impact on the quality of care that women receive in regard to pregnancy-related health complications (Diop et al. 2009). While no educational and awareness initiatives about maternal mortality for both women and care providers have been implemented in this research, the literature and interviews with *reninjaza* and a physician support the need for such a program.

Conclusion

Like the majority of countries of the world, Madagascar faces high rates of preventable maternal deaths. There are many changes that must be implemented in order to completely eliminate unnecessary maternal mortalities, but most of these changes require a considerable amount of time and money, along with significant infrastructure changes within the government. This research has been conducted in order to find immediate solutions to help reduce the maternal mortality for Madagascar. It is clear that much of the problem relates to access and

affordability, specifically in rural communities where the majority of the population of Madagascar resides.

While the government continues to try and address maternal health as a public health issue, they face challenges such as insufficient funding and poor infrastructure. In order to immediately begin helping women, awareness and educational methods about the leading causes of maternal deaths need to be brought directly to communities all over Madagascar, specifically those in rural areas. Women must be able to identify symptoms that could require care that might be far away from them. Simultaneously, healthcare providers from both the biomedical and traditional paradigms must begin to work together in all settings to ensure affordability and accessibility to all women. By working together, TBAs and doctors can also learn from each other, which will continue the spread of knowledge through the country. Cultural sensitivity and awareness must be brought into the allopathic healthcare setting as well, so that women feel comfortable seeking care from all of the providers that they can access.

By educating healthcare providers and women, women will be able to have better care, and therefore safer pregnancies and safer abortions. This is a process that can happen without drastic legislative change, which means that it can be implemented quickly to reduce unnecessary maternal deaths that occur in Madagascar. These educational and awareness initiatives can be achieved and have more immediate results than waiting for a redistribution of government funds and better access to healthcare facilities; it can also be done in a way that is relevant to each community. By addressing maternal mortality in a way that is both culturally sensitive and affordable to anyone, women in Madagascar will be safer in pregnancy, childbirth, and postpartum care.

***Gloria Fall** is a senior at the University of Michigan majoring in Gender and Health with minors in English and medical anthropology. She is interested in maternal and child health on a national and global scale, and hopes to pursue a career in public health*

References

Collins, Lillian, Mmari, Kristin, Mullany, Luke C., Gruber, Christian W., and Rachel Favero. 2016. "An exploration of village-level uterotonic practices in Fenerive-Est, Madagascar." *BMC Pregnancy and Childbirth,* 16 (69). doi: 10.1186/s12884-016-0858-3.

Diop, Ayisha, Raghavan, Sheila, Rakotovao, Jean-Pierre, Comendant, Rodica, Blumenthal, Paul D., and Beverly Winikoff. 2009."Two routes of administration for misoprostol in the treatment of incomplete abortion: a randomized clinical trial." *Contraception,* 79 (6): 456-462. doi:10.1016/j.contraception.2008.11.016.

Hernandez, Julio C. and Moser, Christine M. 2013. "Community Level Risk Factors for Maternal Mortality in Madagascar." *African Journal of Reproductive Health/La Revue Africaine de la Reproductive,* 17 (4): 118-129. Retrieved from https://www.jstor.org/stable/24362418.

Honda, Aayako, Randaoharison, Pierana Gabriel, and Mitsuaki Matsui. 2011. "Affordability of emergency obstetrics and neonatal care at public hospitals in Madagascar." *Reproductive Health Matters,* 19 (37)10 10-20. Retrieved from https://www.jstor.org/stable/41409146

"Maternal Mortality." 2018. Accessed July 4, 2019 https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality.

Morris, Jessica L., Short, Samm, Robson, Laura, and Mamy Soafaly Andriatsihosena. 2014. "Maternal Health Practices, Beliefs and Traditions in Southeast Madagascar." *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive,* 18 (3): 101-117. Retrieved from https://www.j *stor.org/stable/24362069*.

Pourette, Delorès, Mattern, Chiarella, Ratovoson, Rila, and Patricia Raharimalala. 2018a. "Complication with use of misoprostol for abortion in Madagascar: between ease of access and lack of information." *Contraception,* 97: 116-121. doi: 10.1016/j.contraception.2017.12.005.

Pourette, Delorès, Pierlovisi, Carole, Randriantsara, Ranjatiana, Rakotomanana, Elliot, and Chiarella Mattern. 2018b. "Avoiding a "big" baby: Local perceptions and social responses toward birth-related complications in Menabe, Madagascar." *Social Science & Medicine,* 218: 52-61. doi: https://doi.org/10.1016/j/socscimed.2018.10.002.

Ramihantaniarivo, H. 2019. *The Political, Socioeconomic, and Health Sector in Madagascar* [PowerPoint Presentation].

Romuald, Randriamahavonjy, Ratsiatosika, Tanjona A., Martial, Rakotonirina A., Lantonirina, Rainibarijaona A., Ando-Miora, Rakotonirina, and Andrianampanalinarivo H. Rakotovao. 2019. "The women knowledge, attitude, and perceptions of pre-eclampsia and eclampsia in Madagascar." *International Journal of Reproduction, Contraception, Obstetrics and Gynecology,* 8 (4): 1233-1239. doi: http://dx.doi.org/10.182o3/2320-

1770.ijrcog20191177.

"Rural population (% of total population)." 2018. Accessed July 4, 2019 https://data.world bank.org/indicator/SP.RUR.TOTL.ZS?locations=MG.

Salem, Ania, Lacour, Oriane, Scaringella, Stefano, Herinianasolo, Josea, Benski, Anne Caroline, Stancanelli, Giovanna, Vassilakos, Pierre, Petignat, Patrick, and Nicole Christine Schmidt. 2018. "Cross-sectional survey of knowledge of obstetric danger signs among women in rural Madagascar." *BMC Pregnancy and Childbirth,* 18 (46). doi: 10.1186/s12 884-018-1664-x.

Sneeringer, Robyn K., Billings, Deborah L., Ganatra, Bela, and Traci L. Baird 2012. "Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: A review of the literature." *Journal of Public Health Policy,* 33 (2): 218-229. doi: 10.1057/jphp.2012.11.

Language, Healthcare, and Economics

Rethinking Public Sphere in Rural China: Healing Through the Free Clinic

by Liyuan Zhang

Drawing upon scholars' debate over the public sphere in China, this paper explores how the collaboration between the state and society creates the free clinic as a public sphere of healing in Heijing, Yunnan Province to tackle the lack of quality rural health services. In Heijing, many local patients meet barriers when the village doctors fail to diagnose and treat their illnesses. Patients either continue living with the illness or travel a long distance to urban hospitals with better health services. To improve local healthcare, a senior traditional Chinese medicine (TCM) doctor decides to run the free clinic with the help of the township health center. By examining the process of the free clinic's establishment, the paper argues that the participation of local medical elites can reinforce the quality of rural health services when the state faces troubles meeting society's demands. However, the free clinic cannot be implemented without governmental support and state governance. The paper also argues that the image of a good doctor in rural China is constructed through state legitimization, moral qualification, and social networks. The increasing number of patients in the free clinic is attributed not only to the shortage of quality health services but also to the trust between doctors and patients.

Introduction

There had never been such a crowd at Heijing Health Center in Yunnan Province before Dr. He's arrival. During Dr. He's "free clinic" every weekend, the dark hallway of Zhong Yi clinic (中彝医馆) on the first floor of Heijing Health Center is always filled with patients. Zhong Yi clinic was specially established to provide traditional Chinese medicine (TCM) and Yi medicine (彝药, Yi people's medicine) at every township health center by the government in Chuxiong City, including Heijing Health Center. Most of the patients come down from the villages in the surrounding mountainous areas. Their ages range from 50 to 80 years old. On weekdays, patients seldom need to wait in the hallway. A row of chairs outside the clinic seems

to be used for display instead of being used by patients. The clinic comes alive only when Dr. He arrives.

The free clinic in Heijing is either a government's pilot project or an individual's act of kindness. To understand how this special form of healing is created, we need to first introduce Heijing's context. Heijing is a small town located in the northwest of Lufeng County in Yunnan Province. A mere 100 kilometers away from Yunnan's booming capital Kunming, Heijing nevertheless belongs to another time and place. Every day here are only two slow trains traveling from Kunming to Heijing. Inside the town, the streets are narrow and paved with red flagstones; most houses are kept in the old style with two floors normally. Heijing used to be famous for its salt production as the salt capital of China: you can trace its glorious history from the Ming Dynasty to the middle of the 20th century. During the Qing Dynasty, Heijing's taxation for salt accounted for 64 percent of all in the Yunnan Province. However, salt production has declined since the establishment of the People's Republic of China (PRC). When the salt factory was shut down years ago, Heijing became an unpopular tourist site with unheeded history and cruel reality. Slogans about health and education can easily be found in this town, especially around the Heijing Health Center. For villagers, Heijing Health Center is the biggest public healthcare institution in this town. Without enough support for transportation and the healthcare system, villagers face limitations in finding better healthcare resources when the local clinics or health centers fail to diagnose or heal their illnesses. For local people, dealing with diseases becomes a choice either to travel to urban hospitals or to live with the illness.

Facing this kind of situation, Dr. He, who grew up in Heijing and left for Kunming at sixteen, decided to make up for the shortage of good doctors. When Dr. He ultimately got Heijing Health Center's support and the approval of Lufeng County's health bureau, the "free clinic" obtained its official identity and became legitimized in April 2019. Dr. He travels from

Kunming to Heijing every week to run the free clinic with the other two TCM doctors from Heijing Health Center, Dr. Feng and Dr. Yang. The free clinic only opens during weekends in Zhong Yi Clinic at Heijing Health Center, and does not charge any registration fees from patients; patients only need to pay for medicine which their medical insurance does not cover. Dr. He does not earn any financial payback from anyone or any institution; the free clinic gives patients an opportunity to treat diseases at a relatively short distance, low cost, and with a doctor who they trust.

Just as local patients in Heijing learn of Dr. He through word of mouth, I got to know Dr. He and the free clinic from villagers. Local people repeatedly mentioned Dr. He's free clinic and showed their appreciation and respect for him. Intrigued by this unique event, I soon visited Zhong Yi Clinic at Heijing Health Center and met Dr. Feng, who later nicely introduced me to Director of Heijing Health Center and Dr. He. Even though I am not trained as a doctor, I do have a background in public health, and they gave me permission to observe the whole free clinic and provided me with a great deal of information. In the free clinic, I was not only an observer. Sometimes when doctors got too busy, I would assist them in collecting patients' basic information, including name, age, and address. I did not only conduct my research during the time I stayed in the free clinic. Lots of data I collected came from my informal and semi-structured interviews with people in the market, on the streets, or even at their homes. Both doctors and local patients contributed to my research and helped me understand the free clinic in Heijing.

Nevertheless, more questions needed to be raised. Why did Dr. He want to open the "free clinic" in this small town? How did the government agree to let Dr. He open the free clinic inside a township health center? What does the upsurge of patients in the free clinic mean? To answer these questions, I divide my paper into four sections. The first section is a short literature review

to set up the context of a Chinese variety of public spheres between the state and society. In the second section, I trace the process of establishing the free clinic -- both the government and individual play essential roles in its opening. Then, I depict a normal morning in the free clinic. Finally, I show what a good doctor is in in the minds of people living in Heijing. This paper examines how the free clinic is created as a public sphere in healing by both the state and society in rural China. To clarify, I distinguish the realm of the political— "the state"—from the realm of the social— "society" (Brook 1997, 32). When the state faces troubles providing quality health services, the participation of individuals can reinforce the quality of local medical services. Local patients' passion for the free clinic is not only the result of the shortage of good health services but also the recognition of Dr. He as a good doctor. In the free clinic, a new kind of patient-physician relationship has emerged. Patients' trust toward the free clinic is not based on the state's legitimization but on the public acknowledgment of Dr. He's reputation.

The Public Sphere in China

To understand this philanthropic act of healing in relation to the state and society, I introduce the Chinese variety of the public sphere in this section. When scholars apply the concept of public sphere in a Chinese context, they break free of the conceptual constraints and establish a theoretical autonomy for the Chinese public sphere. When Jürgen Habermas (1989) talks about the public sphere, he uses this term as a shorthand reference for the bourgeois public sphere under the context of capitalist society. He identifies the public sphere as the phenomenon of private people coming together as a public against the authorities, particularly in England and Continental Europe in the eighteenth century. Habermas particularly emphasizes on the emergence of the rational public debate. However, the bourgeois public sphere is only one variety of the public sphere, which is set up in particular historical circumstances. Even though the concept of public sphere originated in the West, more scholars associate this concept with

China. In a more general sense, the public sphere can refer to "an expanding public realm of life in modern society, which can take on different forms and involve different power relationships between state and society" (Huang 1993, 217). It may be derived from the formal state apparatus, civic associations and activities outside the state, or the existence or pursuit of some general good (Rowe 1984; Rankin 1993). Philip C. C. Huang (1993) argues that the binary opposition between state and society is unsuitable for analyzing China (221). He purposes the term "the third realm" or "the third sphere" instead of "public sphere" to emphasize the equivalent positions of state and society in a third space where they can both participate in (Huang 1993; Huang 2019). It refers to an intermediate space between state and society which is either just societal organization or just state agency.

The discussion of public spheres in China can be traced back to the early Ming Dynasty. It is common in Chinese history that local elites initiated and fostered the public sphere. In Timothy Brook's (1994) study of monastic patronage in the late Ming Dynasty, he illustrates the new elite class of gentry actively used philanthropy to promote the worship of a deity and encourage religious devotion. Local elites also formed "benevolent societies" (*tongshan hui, tongshan tang*) to carry out charitable work (Liang 2001). In 1870, the Infant Protection Bureau of Shanghai funded by local gentry replaced the role of local officials to reduce the infant mortality rate (Fuma 1995). On lots of occasions, the state's role in the public sphere can largely affect the rise of private philanthropic activities. Angela K. C. Leung (1987) concludes "The decline of the state's role and the rise of organized private initiative in public health was important in China more for social than for health reasons. It marked an avenue for local elites to assert their leadership and influence in an area where the state had left a vacuum" (156). The ineffective central government's role in social problems ceded the space for local elites to provide individual acts of aid.

So, how can we understand the free clinic in Heijing using the concept of public sphere? Despite the privatization after the economic reforms, the vast majority of patients in China received medical services delivered by the government (Eggleston et al. 2008, 149). In the meantime, rural areas faced health care challenges both in terms of quality and accessibility. Despite the nation-dominated health care setting in China, the large potential for improvement in rural healthcare gives opportunities for individuals and the private sector to intervene. Undoubtedly, the opening of a free clinic within a township health center becomes an exemplar and exception.

The Road to Free Clinic

> *"Traditional Chinese medicine (TCM) was well-known in Heijing in the past. I listened to the feedback and opinions from the villagers, they said that they were unable to receive good treatment here. The patients would go outside to find a doctor. I felt a little uncomfortable about the situation. In the past, doctors at Heijing were very famous for treating illnesses based on TCM. Now, TCM doctors cannot treat them well. I asked a few people how many patients they had on Sundays. There were only two or three patients, which is not normal, so I have an idea. I am going to treat patients here."*
>
> --Dr. He

This was the first time that Dr. He had the idea to open the free clinic; however, it was not an easy road that led to what the free clinic was now. As we all know, Dr. He took on the role of opening the free clinic and making contributions to his hometown. However, it was not entirely achieved by himself. The invention of the free clinic in Heijing needs collaboration from the government and individuals. This section traces the process of how the free clinic opened in Heijing, a small town in Yunnan Province.

In 2009, a unique chance brought Dr. He back to Heijing, where he had lived until he was sixteen. At that time, Dr. He no longer worked in Beijing and had returned to Kunming. On a special occasion, he came back to Heijing to attend the funeral of his relative's 99-year-old mother. This funeral also gathered lots of his old friends and classmates. Due to the decline of Heijing, they started to talk about what they could do to contribute to their hometown. Dr. He suggested it was necessary to organize Heijing's historical documents into books. With support from the previous mayor of the town, they started to publish books about Heijing's history. To write books, Dr. He started to visit his hometown constantly and remade his connections to local people. Having a background in traditional Chinese medicine, Dr. He was also disappointed after he got to know that villagers could not access better medical services. He told me, "Heijing has more than seven hundred years of history in traditional Chinese medicine. When I grew up in Heijing, there were seven or eight TCM doctors. Now, there are only two at Heijing Health Center. I cannot let TCM in Heijing continue going downhill."

At the end of 2016, Zhong Yi Clinic at Heijing Health Center finally opened. As a part of the government's scheme, its establishment is aimed at providing TCM treatments at every township health center in Chuxiong City. TCM doctors provide services such as acupuncture, moxibustion, massage, scraping, cupping, and other related traditional medical skills. As soon as I stepped into Heijing Health Center's front gate, I saw propaganda posters about TCM and Yi medicine decorating the walls all the way to Zhong Yi Clinic's consulting room. It is easy to immerse yourself in the culture of traditional medicine that the government tries to create, which also creates an illusion opposed to Zhong Yi Clinic's reality.

The establishment of Zhong Yi Clinic only attracted a limited number of patients coming to visit. And the overall situation at Heijing Health Center was not optimistic. When Dr. He discovered the condition in Zhong Yi Clinic, he dedicated himself to helping train two young

TCM doctors and treat more patients. In 2016, Dr. He told to the previous director of Heijing Health Center that he was willing to treat patients here. Director Lu told me that her predecessor mentioned Dr. He to her before she took the job. However, Dr. He's good intention never put into practice until the free clinic eventually opened after more than two years. The delay of Dr. He's personal wish can be attributed to lots of factors, most of them on the governmental side.

Even though Director Lu was not opposed to Dr. He's proposal, she needed to get permission from Lufeng county. The township health center was governed by the county government. There are three tiers of network in China's rural health care system. From small to large scale, it consists of village clinics, township health centers, and county hospitals. The township health center is in the middle of the three-tier network. Therefore, Heijing Health Center is supervised by the health bureau of Lufeng county. As Eggleston et al. (2008) claim, "government-owned public service units that have little control over the selection, hiring, firing, and compensation of staff" (160). Most new pharmacists, doctors, and nurses are recruited through public recruitment, interview, and general testing. The question Heijing Health Center faced is how to place a 79-year-old TCM doctor in this situation. The uniqueness of Dr. He's proposal offered them no precedent for reference. When the Heijing Health Center first appealed to the health bureau of Lufeng county about Dr. He's idea, they denied it. The health bureau of Lufeng county was worried about Dr. He's health and safety. It would be troublesome for an old doctor to travel between Heijing and Kunming every week, while neither of his wife nor children are in Heijing. More importantly, it would be difficult to handle any potential medical disputes caused by a doctor outside of Heijing Health Center. The health bureau was not unreasonable. Who should be responsible if Dr. He had any accidents during travel or caused any unexpected medical disputes? After the health bureau's refusal, Director Lu told me, "I didn't think too much. Since my leaders disagree, we just don't use Dr. He." When Dr. He recalled the health

bureau's response, he used "it is better to save trouble whenever possible" to describe their nonfeasance.

Dr. He's idea of the free clinic was dismissed and hardly brought up again. In 2018, Director Lu suddenly got a phone call from the office of the health bureau and Dr. He's free clinic was permitted. Why did the health bureau of Lufeng county suddenly approve Dr. He to practice medicine at Heijing Health Center? How did the turnaround happen? It turned out that Dr. He wrote a letter to the health bureau of Lufeng County after the Chinese New Year in 2018. He decided to skip the health center and contact the health bureau directly. In this letter he again explained his medical experience and proposed the idea of free clinic to the health bureau. In the meantime, the health bureau went through a few personnel changes. The new director was satisfied with Dr. He's idea, and instead of putting this matter aside, he directly gave permission and asked Heijing Health Center to assist Dr. He in opening the free clinic.

I asked Director Lu why the health bureau changed its mind. She answered with two points. First, the medical documents qualify Dr. He's identity as a medical professional, which allows him to practice TCM at Heijing Health Center. Second, the change of leadership in the health bureau contributed a lot to making the free clinic happen. Director Lu and Dr. He both did not talk much about what was going on in the health bureau of Lufeng county. Nevertheless, with permission from above, Dr. He could eventually prepare his free clinic in Heijing. From January to April, Heijing Health Center helped Dr. He make his transition from Kunming to Heijing. It took them three months to finish all the paperwork, online registration, and so on. Heijing Health Center signed a two-year contract to employ him as an external TCM doctor in Zhong Yi Clinic, which required him to take one or two days in Heijing to run the free clinic. After all the preparation was done to legitimize the identity of Dr. He and the free clinic, on April 10th it finally opened.

The road to the free clinic is a long-term negotiation and interaction between the state and society. The invention of the free clinic could not be independent of the state's support. Without permission from the health bureau of Lufeng County, the free clinic cannot operate. At the same time, local patients are able to use the new rural cooperative medical insurance to pay for their medicine. To local patients, it is a win-win situation of low cost and high quality in medical services. On the other side, the whole idea of free clinic relies on the society. Dr. He's role is too crucial to be ignored. Dr. He takes responsibility as a local elite and provides better health service to the villagers. The free clinic can be considered to be the public sphere as an intermediate space between the state and society. I suggest there are three main characteristics that make the free clinic in Heijing noteworthy. First, it is a variety of local and rural public spheres. When the state-dominated rural health care system is unable to meet the demand of the public, the private sector and individual force an attempt to intervene. Moreover, the free clinic in Heijing can hardly be found in another town in rural China. The health bureau hesitated to approve it at first because they had never encountered this before. The second characteristic is its purpose for societal development without opposition to the state. Broadening Habermas's concept of public sphere, the free clinic never challenged the government's authority. Third, the free clinic cannot operate without the state's supervision and governance. Dr. He's free clinic becomes an extension of the medical services provided by Heijing Health Center. It is necessary to emphasize that two TCM doctors from Heijing Health Center also assist the entire free clinic. Patients are able to use their medical insurance to get medicine from the health center. The free clinic's unique characteristics also manifest in Philip C. C. Huang (1993)'s argument toward the public sphere in China. Huang questions the binary juxtapositions of state and society, in fact, he proposes that the state and society interact with each other and mutually shape one another. The high degree of centralized power also confronts the private voluntary act. The invention of the

free clinic in Heijing is the result of the state and society's interaction. Without the mutual contribution, the free clinic could not have opened.

The Uncontrollable Free Clinic

The consulting room of Zhong Yi Clinic on the first floor is well-designed with wooden furniture and floors. Outside the room, posters with traditional Chinese medicine knowledge are hung along the hallway; however, the lights on the hallway never turn on, which makes it a little shabby. Compared with other facilities at Heijing Health Center, Zhong Yi Clinic does look fancier with support from the government as I mentioned in the above section.

The free clinic goes on like a symphony with sections, which takes time to reach the climax. A symphony is divided into different movements by composers intentionally; however, the flow of the free clinic is clearly out of doctors' control. Based on the numbering system, each patient must register and collect a small piece of paper with a number on it the day before the free clinic. The simple number holds multiple meanings to the doctors and patients. For doctors, the number becomes a guideline for them to put which patient at first to treat. There will be 50 slots available for the free clinic in one day. Patients sometimes need to fight to get registered within the first 50 patients, and they can also know a suitable time to come based on the number they collect. "15" means the fifteenth patient who will be treated in the free clinic on that day. And it would be better for this patient to come to the free clinic in the morning since doctors normally can treat more than half of the patients in the morning. Nevertheless, not everyone follows the rules of the numbering system.

The free clinic usually starts at 8 o'clock in the morning. The temperature was cold on the early Sunday morning in Yunnan Province, and the hallway outside the consulting room was empty and silent, as the patients were still on their way to Heijing Health Center. Dr. He, the other two doctors, and I were waiting in the room for patients to come, some of them come from

the town nearby, some of them take cars to transport from the mountains to the town. However, this moment of quietness was soon swept away by the arrival of patients. At 9 o'clock, doctors became busy treating patients. Dr. He was in charge of the treatment, including taking the patient's pulse, looking at their tongue, and asking some necessary questions. These are the basic steps for TCM doctors to diagnose patients' illnesses. Sometimes he would also ask the other doctors to participate in the diagnosis to discuss together or to teach them. Dr. Feng and Dr. Yang were dealing with all the medical records of the patient. I was surprised that they had so many documents to handle. There is no computer on the desk, all the documents and records need to be handwritten. Sometimes they could not finish them in time, so they would have to finish filling in the documents after the free clinic closed. I had already got my head spinning around by the situation in the consulting room, meanwhile, I started to hear the noises from the hallway. After an hour, patients began to lose their patience and the consulting room was filled with patients. The climax of the free clinic arrived. The numbering system could not keep functioning, and patients stopped following the order by number. They stood closely around the doctors, it seemed that whoever stood closest to the doctors was the one who got the next opportunity to be treated. Doctors and even I were besieged by layers of patients inside the small consulting room. It became extremely hard for us to attempt to go outside the consulting room to find the next patient in order. I have only experienced the role as a patient before the free clinic; however, now I sat with doctors. Even though I only helped them fill out patient's basic information into the forms, I felt overwhelmed by the atmosphere and hoped the morning session could soon be over. "11 o'clock", one voice prompt came from someone's smartphone in the consulting room, Dr. He noticed the time and said, "I have used my brain too much, I forget some medicines when it's 11 o'clock." Dr. He was too busy to treat patients and he seldom noticed the time flow by. The long duration and highly intensive process of treating one patient after another also made him tired.

This was not the only time Dr. He mentioned this intensity of his work: the free clinic usually lasts until 12 o'clock, then after lunch and a short break, doctors work from 2 to 5 o'clock in the afternoon. Dr. He always tends to see more patients in the morning session to make more space available for the afternoon in case of the new patients who are not in the numbering system. Heijing Health Center only registers 50 patients for the free clinic per day. However, unexpected patients always show up in the middle or at the end of every day in the free clinic. On Sunday, the day I observed in the free clinic, there must have been around 60 patients in the end who were treated by Dr. He and the other two doctors.

This is only a fragment of one typical free clinic day I observed in August; however, it can hardly represent the overall situation of the free clinic in Heijing. When the free clinic started this April, Dr. He only stayed in Heijing one day a week. In the first week of the free clinic, Dr. He told me there were only a dozen patients. In the second week, the number of patients grew to around forty, the growth continued every week, then gradually the situation in the free clinic got uncontrollable. In May and June, the average number of patients reached 70-80 per day, sometimes it could be a hundred. Dr. He's free clinic no longer lasted for only Sunday, he started to stay the whole weekend in Heijing. If he did not have things to deal with in Kunming, he would stay for an extra day for the patients who did not get the chance to be treated this week.

Furthermore, Dr. He's free clinic became more standardized under the pressure of the growing number of patients. The numbering system is established only for Dr. He's free clinic. At Heijing Health Center, one seeing a doctor does not need to go through the complicated procedures in the urban hospital. Patients seldom need to wait outside the consulting room to see a doctor except for the free clinic. Patients never need to register or pick a number, health service at Heijing Health Center is accessible in terms of the availability of doctors and nurses. The director of Heijing Health Center even described Heijing Health Center as a health center

without patients during 2013-2017. In Heijing, the quality of healthcare is rather low. The new rural cooperative medical insurance system only covers a part of their medical expenses at township health centers. In county hospitals, the insurance only covers their expenses when they are hospitalized. It would be extremely inconvenient and costly for a patient to travel from Heijing to Lufeng County to access better treatment. Nevertheless, the state creates the medical insurance for its own reasons. The design of the medical service system aims to achieve a hierarchical diagnosis. In rural China, patients are advised to visit village clinics and township health centers first. They will be advised to seek better treatment in the county or city's hospital only if it is necessary. On one hand, it definitely reduces the burden for larger hospitals. On the other hand, villagers are also limited to poor health care services by the design of medical insurance system. The state focuses on the supply side of medical services, not the demand side. One of Dr. He's patients told me that she paid the new rural cooperative medical insurance for ten years but never used it at the health center until Dr. He's free clinic. I was shocked by her behavior. However, she considered this reasonable in her own circumstances. This patient spends most of her life in Heijing, but she begun to work in Kunming in recent years, and she only comes back when she has free time. When I asked her why she bought the insurance but never used it before, she simply attributed to the low quality of overall medical resources at Heijing Health Center. She ignored the potential benefits from the new rural cooperative medical insurance and managed to access better medical treatment in a bigger city that she relied on. Nevertheless, she still buys the health insurance for the last ten years just in case of emergencies. For the rest of villagers in Heijing who do not have other alternatives, they choose to bear the illness and put off their treatment process. Since most of Dr. He's patients live in the surrounding mountains, they told me they probably would not see a doctor due to the inconvenience of

transportation and the high cost of medical services. Once the free clinic opened, these patients began to take their illness seriously and seek treatment.

A Good Doctor

Dr. He's good deed to open the free clinic earned the villagers' admiration and respect in Heijing. Except for some young generations who may not be familiar with him, most of the villagers have at least heard of his name and perceived him as a good doctor. However, how is Dr. He's identity as a good doctor constructed? What are the standards to be a good doctor in Heijing? Why can Dr. He fit into the category of a good doctor? To some extent, Dr. He's experiences and practices as a doctor are beyond people's imaginations. This section examines how villagers in Heijing perceive a good doctor and why Dr. He is qualified by the villagers to be a good doctor. It demonstrates that the image of a good doctor is constructed both by the state and society.

The dramatic increase in the number of patients within four months was due to word of mouth, which also illustrates a hidden social network behind this phenomenon. Patients get to know Dr. He through relatives and friends who went to the free clinic before or work at the Heijing Health Center. To villagers, nothing is more convincing than what their relatives and friends have said. They knew who visited the free clinic before and who was cured by Dr. He before they came by themselves. There is also a famous case spreading out among villagers: an old man could barely hear anything before visiting the free clinic. After taking Dr. He's medicine, he now can hear sounds. Another interesting case I encountered during the free clinic is a patient with *fanguan mai* (反关脉), which suggests that his pulse is located at the opposite side of normal people. It is very rare to meet a patient like him. This patient told us that he used to see a TCM doctor who could not find his pulse and predicted he would die soon. However, Dr. He found his pulse and he told me that he only encountered three cases like this so far in his life.

Dr. He's capability to tackle difficult cases earns local people's trust, which further establishes himself as a good doctor.

Moreover, villagers also care about a doctor's moral standards. A patient once compared Dr. He with another TCM doctor living in the mountainous areas of Heijing. She described the second doctor as the worst doctor she ever met in her life. This doctor would take advantage of female patients by checking their bodies to touch their breasts. In order to win their trust, he does not charge fees to patients he considers beautiful. Even though I cannot confirm whether this anomaly is true, this comparison between a good doctor and a bad doctor illustrates that the local people think highly of medical ethics. As a doctor, Dr. He never crossed the line, which earned him credibility from the point view of local people. In addition to that, Dr. He is able to communicate in the local dialect, opens the free clinic voluntarily, carefully chooses the medicine to be as cheap as possible, and has sometimes even comforted patients by quoting Heijing's folktales. Villagers have regarded Dr. He as a "Heijingnese" (黑井人, who comes from Heijing) who returns and contributes to his hometown. Those small factors add up to the reason why Dr. He is a good doctor in the local people's minds.

Despite the fact that he had already been commonly admired as a good doctor, Dr. He constantly brought up his past cases to demonstrate his medical skills to me. On several occasions during our conversations and meetings, Dr. He proudly told me a few interesting examples of how he felt other patients' pulses before. He told me that he also treated a Hawaiian patient before. Through his pulse, Dr. He predicted that he and his father both have high blood pressure. Obviously, this foreigner was shocked at Dr. He's ability and traditional Chinese medicine since Dr. He was completely right. Next, Dr. He once predicted that one of his patients would marry again, for the third time. Surprisingly, it turned out that this man had a girlfriend soon afterward. I wondered how he managed to achieve that. He explained that his pulse told

him his kidney was very strong. In traditional Chinese medicine, the kidney represents sexual desire. Dr. He's prediction fits into what happens in the future. To me, it is like Chinese fortune telling but still has its own logic and reasons. Furthermore, Dr. He once went to Heijing's local famous temple called Zhutian Temple to diagnose Buddhist nuns there. He visited Zhutian Temple very early in the morning so that he did not interrupt the nuns' daily schedule. After feeling every nun's pulse, he told me only one nun's pulse indicated good health. This nun is also the one with the best reputation among them and other nuns respect her since she despises money and power. Among the three cases, the last one is the most interesting. Not only does it show Dr. He's strong medical skills, but also his attitude towards life. During our conversation, he quotes the traditional Chinese idiom "human beings will die for riches, just as birds will for food." It means that a man will do anything in his means to become rich. Nevertheless, Dr. He uses this idiom to demonstrate that he has no intention of great fortune. He believes that his good health strongly ties to his lack of concern about fortune. Additionally, it is the reason why he can travel frequently between Heijing and Kunming to maintain the free clinic at the age of 79.

Nevertheless, Dr. He is not a typical doctor that people imagine who practices medicine for his entire life. At first, I was shocked to learn that Dr. He spent most of his life in another profession. Before retirement, Dr. He was a senior engineer at the National Forestry and Grassland Administration and once taught classes as a lecturer at Beijing Forestry University. The three examples I gave above might give the readers a clue. Dr. He treated a Hawaiian, a man with a third marriage, and Buddhist nuns in the past. These are not general cases that a typical doctor would face in daily life. According to Dr. He, practicing medicine is his interest. During the Cultural Revolution, he told me everyone was busy engaging in the revolution but he was not. So he decided instead to learn traditional Chinese medicine. Since lots of his work had to be conducted in the Yunnan Province's rural areas, he got the chance to follow the barefoot doctors

and became one of them. Barefoot doctors usually referred to a group of farmers, folk healers, and rural healthcare providers who only received basic medical training and worked in rural China during the Cultural Revolution. At that time, he recalled it was not hard to become a barefoot doctor since the rural areas were in need of medical practitioners. In 1984, he graduated from Yunnan Traditional Chinese Medicine College, with an associate's degree in TCM and Western medicine. He also spent spare time at Yunnan First People's Hospital to learn from old doctors. He told me, "If these doctors were alive today, they would all be more than 100 years old." Dr. He followed his teachers treating patients and making ward rounds. Most of his experience was obtained and accumulated at that time.

Dr. He's role in the hospital also pushed me to think further about the definition of medical professionals. Dr. He spent most of his career on the development of forestry, learning TCM and practicing physician were his personal interests. Who should be qualified as a medical professional? Is a medical professional equal to a good doctor? Or is a good doctor a medical professional? As Dr. He said, his cousin is also good at acupuncture but he is not allowed to practice it since he does not have any certificates to prove it. The criteria to be a medical professional today are much stricter than they were in the barefoot doctor era. The training requirements for medical practice licenses and for some professional categories are articulated in *Law on Physicians* published in 1999. Moreover, in 2005 the *Village Doctor Practice Regulation* required village doctors to be certified physicians or assistant physicians before being entitled to a license (Eggleston et al. 2008, 160). Dr. He reiterated that he had all the required documents to practice medicine. In addition, he graduated from Yunnan Traditional Chinese Medicine College with an associate's degree in TCM and Western medicine. This instance addresses the conflict between medical skills and legitimization from the state. When we talk about medical professionals, they generally refer to doctors and physicians with documents to practice in the

hospital. The premise of the free clinic's opening is also Dr. He's legitimized status as a doctor. When I asked Director Lu why the health bureau eventually agreed with Dr. He's idea, Director Lu reemphasized that Dr. He's professional identity qualified him to do so. Without certain documents, practicing medicine is illegal. Nevertheless, a professional medical license did not always exist in Chinese history. The emerging professionalization is strongly related to the growth of a modern state apparatus. The existence of a profession symbolizes the "civilization and progress" of a state (Burnham 1996, 2). The state establishes its legal system to empower and govern medical professionals. Medical professionals' legitimacy is proved by higher education, or more specifically in China, medical license. Before the state was able to legitimize medical professionals, who were the medical professionals in ancient China? What qualified a medical professional in the past?

In late imperial China, there were two groups of physicians apart from the traditional folk healers. Both of them established their professional identity through cultural and social means, rather than institutional or legal means (Chao 2000, 69). Hereditary physicians set up their own legitimacy through their long tradition of practicing medicine in their families. It is believed that a hereditary physician had generations of experience and a certain specialty. Apart from hereditary physicians, elite participation in medicine also fostered another group of physicians: Confucian physicians. They emphasized "an ethical model, intellectual intelligence shaped by training in the classics, and membership based upon specialized knowledge that came from the classical tradition" (Chao 2000, 68). Studying Confucian traditions and classics had a large impact on medical practices in ancient China. It not only emphasized the efficiency of the medicine but also the virtues of an ideal Confucian. Transforming Confucian classics into the practice of medicine let Confucian physicians serve the authorities (Cheng 2014, 40). Moreover, more moral standards for practicing medicine can be easily found in Sun Ssu-miao (2015)'s book

The Thousand Golden Remedies. The practice of medicine should commonly be recognized as a philanthropic undertaking or a benevolent act (Lee 1943).

Even though Dr. He's identity as a medical professional is legitimized by his license, his good reputation as a doctor is established through other factors. Generations of family members practice medicine is not uncommon in China. Dr. He's family members were also involved with medicine. In the book *Heijing Guzhen Shiyi*, Dr. He's uncle was the director of Yanxing Hospital in Heijing from 1954 to 1964 (Liu et al. 2015, 142). Like his father, his cousin also practices medicine. Even though Dr. He's father was a salt merchant, he was also a philanthropist who distributed medicines to poor people. Learning from the past, Dr. He's voluntary act to open the free clinic is also embedded in the long tradition of family history.

A good doctor means a skilled and moral doctor. To answer the questions I raised before, a good doctor must be a medical professional; a medical professional is not necessarily a good doctor. To be a good doctor needs both state's legitimization and society's recognition of skills and morals. Dr. He's philanthropic act to his hometown and his good medical skills all contribute to his image of a good doctor. As we previously discussed, the public sphere can be created through the participation of the state and society. Similarly, a good doctor is also constructed both by the state and society. However, the villagers seldom care or doubt whether Dr. He is a legitimized doctor or not. The villagers hardly know the complex story behind free clinic's invention. What they value is the doctor's reputation in terms of skills and morals. Dr. He is held in high esteem by the villagers. Someone might still question Dr. He's medical skills since it is not his main profession. However, faced with the huge inequalities between urban and rural health care, Dr. He's capability certainly fulfills villagers' expectations to access good medical services.

Conclusion

This paper traces the process of the free clinic's establishment and the reasons behind its popularity. I argue that the free clinic as a public sphere in healing is created with participation both from the state and society. The upsurge of the patients is the result of a new type of patient-doctor relationship between Dr. He and local patients, which is embedded in rural Chinese culture and tradition. However, his good doctor's identity first needs to obtain the state's legitimization as a medical professional, as the free clinic cannot run without the health bureau's permission. The villagers' trust is the core of maintaining the free clinic and the reputation of Dr. He.

As the free clinic has only run for four months, it is hard for me to judge whether it is a successful example of rural health service delivery, but I believe it is on a good track. Many patients told me their diseases were cured by Dr. He. Nevertheless, lots of chronic diseases villagers have can hardly be resolved in such a short period. A shortage of hands is the major issue that the free clinic faces, so Heijing Health Center had to make adjustments in order to serve patients better. Sometimes they had to find a pharmacist to assist the work. It also has other limitations, such as short consultation hours, a large number of patients, and difficulty in getting patients registered in the free clinic. Due to the popularity of the free clinic, many patients do not have the chance to be one of the 50 patients in the free clinic per day. Villagers also told me they heard the complaints by the staff at the health center that their work has gotten much busier than that it used to be.

In the end, what can we learn from the free clinic in Heijing? Dr. He signed a two-year contract with Heijing Health Center, which means that the free clinic only has a two-year duration. Due to the uniqueness of the free clinic, I doubt that it can be duplicated in other places. But it does not mean Dr. He's contribution is only temporary--he analyzed the common

diseases in Heijing and compiled these prescriptions to Dr. Feng and Dr. Yang. He told me that he intends to publish a book about TCM's history and past famous doctors in Heijing. He has already gathered some information on this subject. I cannot imagine how the free clinic would turn out if Dr. He was replaced by an experienced doctor who is not familiar with Heijing and could not speak the local dialect.

Liyuan Zhang *is a third-year undergraduate student at New York University Shanghai studying Social Science (Anthropology Track), with a minor in History. Liyuan's academic interests include medical anthropology, science and technology studies, and gender studies. She hopes to explore more in the intersection between medicine and social science and utilize her knowledge to integrate patient voices into healthcare practices.*

References

Burnham, John C. 1996. How the Concept of Profession Evolved in the Work of Historians of Medicine. *Bulletin of the History of Medicine* 70(1): 1-24.

Brook, Timothy. 1994. *Praying for Power: Buddhism and the Formation of Gentry Society in Late-Ming China*. Harvard University Asia Center, Harvard University.

Brook, Timothy. 1997. "Auto-Organization in Chinese Society." In *Civil Society in China*. edited by Timothy Brook and B. Michael Frolic, 32-58, New York: M E Sharpe.

Chao, Yüan-ling. 2000. "The Ideal Physician in Late Imperial China: The Question of Sanshi." *East Asian Science, Technology, and Medicine* 17(1): 66-93.

Cheng, Guobin. 2014. "'Ruyi' gainian de wenhua yu zhenzhi yiyun." [Cultural and Political Meanings behind The Concept of Confusion Doctor.] *International Journal of Chinese & Comparative Philosophy of Medicine* 12(1): 39-54.

Eggleston, Karen, Ling Li, Qingyue Meng, Magnus Lindelow, and Adam Wagstaff. (2008). "Health service delivery in China: A literature review." *Health Economics* 17(1): 149–65.

Fuma, Susumu. (1995). "Infant Protection Societies in the Late Qing." Translated by Peter Perdue. *Sino-Japanese Studies* 7(1): 42–64.

Habermas, Jürgen. 1989. *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society*. Cambridge, Mass.: MIT Press.

Huang, Philip C. C. 1993. "Public sphere "/"Civil Society" in China? The Third Realm between State and Society. *Modern China* 19(2): 216-240.

Huang, Philip C. C. 2019. "Rethinking 'the Third Sphere': The Dualistic Unity of State and Society in China, Past and Present." *Modern China* 45(4): 355-391.

Lee, Tao. 1943. "Medical Ethics in Ancient China." *Bulletin of the History of Medicine* 13(3): 268-277.

Leung, Angela Ki Che. 1987. "Organized medicine in Ming-Qing China: state and private medical institutions in the lower Yangzi region." *Late Imperial China* 8(1): 134-166.

Liang, Qizi. 2001. *Shishan yu jiaohua: mingqing de cishan zuzhi*. [To do good: The organization of charity during the Ming and Qing Dynasties]. Taibei: Lianjing chubanshe.

Liu, Jianrong, Xingguo Peng, Pikun He, Yuhua Li, Jiahui Ding, and Yue Liu. 2015. *Heijing guzhen shiyi*. [The Past Stories in Heijing Old Town]. Yunnan: Yunnan mingzu chubanshe.

Rankin, Mary B. 1993. "Some Observations on a Chinese Public Sphere." *Modern China* 19(2): 158-182.

Rowe, William T. 1984. *Hankow: Commerce and Society in a Chinese City, 1796-1889*. Stanford, CA: Stanford University Press.

Sun, Ssu-miao. 2015. *Thousand Golden Prescriptions in Modern Chinese*. Heilongjiang: Heilongjiang Science and Technology Press.