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Reproduction on the Margins: The Moral Economies of Romani Fertility

Disertační práce

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Summary

Situated at the intersections of reproduction, population politics, health care services, and marginality in Central Europe, this dissertation explores the diverse ways Romani women living in precarious circumstances demonstrate reproductive agency. In particular, it examines the ways their agency critically engages with the discourse of responsibilization (Rose 1996, 2007) on the affective and social levels in a context ruled by a moral regime that calls for reproductive governance (Morgan & Roberts, 2012, 2019). Discussion and analysis are based on long-term participant observation in a segregated Romani settlement in Slovakia, as well as a short-term observation of staff and patients at a maternity ward in the Czech Republic. The ethnographic methodology and analysis are inspired by critical medical anthropology and the anthropology of reproduction. Building on this mixed-method approach, the analysis focuses on the individual, communal, and societal aspects of reproductive decision-making. It discloses the significant material and moral constraints surrounding women's reproductive decisions and it shows that marginalized Roma women both revere and refuse the discourses of self-governance, responsibility, and accountability in their reproductive practices. The text tackles the economics of childbearing in a resource-scare environment and it analyzes Romani women's birth narratives to show where personal autonomy is exercised before, during, and after labor. Agency does not necessarily mean resistance, and it does not automatically lead to increased inclusion and involvement in an institutionalized setting. An additional angle is provided through the perspectives of birth workers, and the dissertation accounts for ways they renegotiate and rationalize potentially conflicting situations with Romani women in a maternity care setting. Romani ethnicity is recognized at maternity wards, and it can have consequences with regard to care at the level of institutional approaches and practices.

Key words: ethnography, anthropology, reproduction, Roma, women, responzibilization, reproductive governance, maternity care, fertility choices

Abstrakt

Předložená disertační práce se pohybuje na průsečíku témat reprodukce, populační politiky, zdravotnictví a marginality ve Střední Evropě a sleduje způsoby, jak romské ženy žijící v prekérních podmínkách projevují svoji reprodukční *agency*. Práce se soustředí na způsoby, jak tyto ženy afektivně a sociálně vyjednávají diskurz „responsibilizace“ (Rose 1996, 2007) v kontextu převládajících reprodukčních režimů vládnutí (Morgan & Roberts, 2012, 2019). Poznatky a závěry práce jsou založené na dlouhodobém zúčastněném pozorováním v segregované romské osadě na Slovensku a sérii krátkodobých pozorování nemocničního personálu a rodiček na porodním oddělení jedné nemocnice v Česku. Etnografická metodologie a analýza je inspirovaná kritickou medicínskou antropologií a antropologií reprodukce. S využitím smíšených metod se předkládaná analýza soustředí na individuální, komunální a společenské aspekty reprodukčního rozhodování. Odkrývá významná materiální a morální omezení implikovaná v reprodukčních rozhodnutích žen, přičemž poukazuje na to, jak romské ženy své reprodukční praxe na jednu stranu na diskurzech sebekontorly, responzibilizace a zodpovědnosti zakládají, a zároveň tyto diskurzy v jistých ohledech odmítají. Dizertace řeší i ekonomické aspekty plodnosti v prostředí velmi omezených zdrojů a analyzuje porodní narativy romských žen z hlediska uplatňování jejich osobní *agency* před, v průběhu a po porodu. Projevování *agency* není nutně provázané s rezistencí a v rámci institucionálního prostředí nevede automaticky ke zvýšení inkluze a zapojení. Dalším významným prvkem analýzy jsou perspektivy porodního personálu. Text se zabývá způsoby jejich vyjednávání a racionalizace potenciálně konfliktních situací s romskými ženami v kontextu porodní péče. Romská etnicita je v kontextu porodního oddělení rozpoznávána, což může mít na úrovni institucionálních přístupů a praktik důsledky pro kvalitu poskytované péči.

Klíčová slova: etnografie, antropologie, reprodukce, Romové, ženy, responsibilizace, reprodukční vládnutí, porodní péče, rozhodování na poli plodnosti

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1. Introduction

Twenty-three-year-old Alexandra Kiňová, who was already a mother to a five-year old boy, was probably the most famous Czech woman to give birth in 2013 – because she delivered quintuplets. The chance of naturally conceiving quintuplets, according to the head doctor at the prestigious maternity ward at Podolí hospital in Prague, where the babies were born, is one in 48 million. This means that, statistically, a quintuplet pregnancy should occur once every 480 years in the Czech Republic (Válková, 2013). Ms. Kiňová's pregnancy and birth were lavished with a corresponding measure of public attention: media outlets around the world reported on her successful delivery of healthy quintuplets via Caesarean section (BBC, 2013), and the newborns were visited by the Czech Minister of Labor and Social Affairs. A thirteen-episode reality show about the first year of the children's lives was aired on national television.[1]

Public curiosity abouts the quintuplets' family was enormous, and much of this attention was altruistic: newspaper headlines boasted that the country was overwhelmed by a wave of solidarity (Extra.cz, 2013) and that the family received an outpouring of donations of baby accessories (Válková, 2013). Cash donations were sent to a transparent bank account set up for the family by the Club of Twins and Higher Multiples [Klub dvojčat a vícerčat]. This club is chaired by Klára Vítková Rulíková, who was also an employee at the Ministry of Labor and Social Affairs at that time and was specially appointed by her employer to support the quintuplet family. The quintuplets' mother was dubbed a ”supermom” [*supermáma*] in the Czech media and Ms. Rulíková was called the quintuplets' patroness [*patronka*]. As she was intensely involved in the quintuplet family's life, she also became the godmother of one of the baby boys.

The babies were not yet toddlers before Ms. Rulíková started distancing herself from the family and publicly castigating their lifestyle choices. In a January 2015 interview (Matějů, 2015) she expressed her disbelief that a family with so many mouths to feed was disposing of stale food. She frowned upon Ms. Kiňová for taking the advice of her own mother (instead of that of her family's ”patroness”), and she took it upon herself to reform (or in her own word “rectify”) the mother so that the family would be deserving of the state support it received. She criticized Ms. Kiňová for complaining too much about exhaustion and noted that “our rules do not apply to them, they follow a different life rhythm.” In the same interview she also opined

[1] The reality show Quintuplets [*Paterčata*] is available online at: https://www.ceskatelevize.cz/porady/10655291123-patercata/dily/

that had it not been for her helpfulness, the quintuplets would already have been forcibly taken away from the parents by social services and placed in state institutional care.

Ms. Kiňová described herself in an interview as half-Czech and half-Roma, and her husband as Roma (Wilková, 2013), and Ms. Rulíková's judgmental statements echoed deep rooted, taken-for-granted bias against Roma people in the Czech Republic. According to an interview with the mother, Ms. Rulíková was not the first official to have implied to the parents that the babies may be taken away from them. Not only did Ms. Kiňová receive unsolicited offers for paid adoption from strangers who claimed they could raise her children under better material circumstances than she ever could, but prior to the delivery she was informed by child protection authorities that if she wanted to take her babies home from the hospital the family's living conditions would have to improve. After the birth, the family was given a municipal apartment, for which they were liable to pay rent. The following excerpt from an interview (Wilková, 2013) three months after the quintuplets' birth best describes Ms. Kiňová's fears:

> Ms. Kiňová: I didn't see the apartment initially, so I didn't know where we were going after the birth, so I kept saying to myself: just don't let the social worker take [the babies] away from us.
>
> Interviewer: Did you really think she would?
>
> Ms. Kiňová: I feared it. The social services said that the babies must have everything they need. And I didn't have everything for them. Everything was acquired in a rush. To this day I have a strange feeling. Caregivers who help me with the babies notify the social services what happens in my home, how things look. I'm careful about what I say, what I do, I try to keep everything tidy. A baby spits up some milk and I immediately change the clothes. I'm quite unnerved by all this, I feel like I'm under constant supervision.

Ms. Kiňová's fears were not unfounded: according to the European Roma Rights Centre, Romani children are disproportionally overrepresented in state care in the Czech Republic, Slovakia, Hungary, Serbia, and Albania (ERRC, 2017). Research conducted in 2011 revealed that in the Czech Republic, Romani children account for between 30-60% of all children in state care facilities (ERRC 2011, p. 26), which is entirely disproportionate to the number of Roma living in the country. For many, the ”supermom” failed the test of deservingness long before it was arbitrarily imposed on her by a ministerial employee who had inappropriately uncovered intimate details about a family she was supposed to support in a professional capacity, or by the child protection authorities, who intimidated her into fearing that her babies may be taken away from her instead of taking active steps to prevent it. Ms. Kiňová gave birth on June 2nd 2013 and left the maternity ward with her breastfed newborns at

the beginning of August, but unlike her delivery, the discharge date was not publicized by the hospital owing to fears about the family's security.

The Bratislava-born performance artist Tamara Moyzes, who is based in Prague and describes herself as representing an intersection of various minorities, including Roma, dedicated an installation at the Strasbourg European Roma art exhibition in 2014 (Moyzes, 2014) to the extra baggage Ms. Kiňová carried home from the maternity ward. In an allusion to commercial gifts that mothers of newborn babies often receive upon hospital discharge, the six-minute television show parody features a woman presenter advertising the "Prenatal Luxury Box" to new mothers. The items in the box are introduced by the mock-mother of the first quintuplet family, and they constitute the following: police escort home from the maternity ward, feces sent as a gift, safety window film to protect the family from Molotov cocktails, a fire extinguisher, police patrol for three months for the family's protection, and threat letters.

The contents of the box, the artist emphasizes, is based on the quintuplet family's real-life experiences of the conditions that awaited them upon the babies' and their mother's discharge from the maternity ward. In the reality show produced about the quintuplet family's first year, the parents talked at length about the abundance of hate speech and death threats they received from people who opined that far too many Roma babies are being born and much too much state money is spent supporting them. Once the reality show ended in 2014, Ms. Kiňová strictly limited the family's media presence, and since then the quintuplets and their parents have only made a handful of media appearances. The wave of threats that Alexandra Kiňová, the Czech-Romani mother of quintuplets, faced upon the birth of her children, took place in a highly charged social context.

It would be apt to share a personal anecdote now, lest I stigmatize the fear of more Roma babies being born as something only found among others – presumably less cultured people – in the Central European context. I was a freshman studying for a liberal arts degree at a university in Hungary when, during a visit to my hometown Komárno-Komárom in southern Slovakia, I heard rumors circulating in town that, according to a medical professional working at the municipal maternity ward, seven out of ten babies born there were of Romani origin. The news unsettled me; I was unequipped with the critical conceptual tools with which to dissect a reproductive moral panic of this type. This episode took place around the year 2000, and in the two decades which preceded it I had been socialized into a cultural landscape which diligently rationalized widely held sentiments that Romani people as too many and too much. That landscape, as this dissertation attests, has not shifted significantly since then.

In my estimation, around the turn of the millennium my hometown may have had several hundred Romani residents,[2] many of whom talked and dressed so differently from the ethnic-majority Slovaks and Hungarians that they were easy to identify. Growing up in this town of 35,000 inhabitants, I thought I didn't know any Romani people personally – yet I actually did. When I was a child, there was an elderly umbrella repairman who would regularly knock on the door of our seventh-floor apartment in the prefab tower block. At a time when faulty umbrellas were not automatically discarded to be replaced by new ones, but were instead mended, he scared me, because I knew to keep my distance from a "Gypsy". There were also the street vendors, Vlach Romani women roaming the city center, selling cosmetics and underwear to passersby, or offering to read palms in exchange for money. Imitating their accent in Hungarian is still a common joke in my family. And there were the children in the beautiful, formerly bourgeois houses located in the city center.[3] Many of these children had extremely curved legs due to a genetic disorder and walked with difficulty. They were dressed in rags, had messy hair, and were often seen picking through the trash. When I was a child I felt little connection to (or empathy for) them.

In the second half of the eighties, I was attending a large municipal primary school for Hungarian speakers. A small house containing merely one classroom stood out both in its size and style on the school compound. While the main buildings were made of prefabricated concrete wall panels, the favored construction material of the time, the small structure was made of brick and had a tiled roof. As a child I had imagined the building was intended for mentally challenged children (whose integration into mainstream education was inconceivable both to the educational system and my childhood self), but I later learned the separate school within the school was reserved for Romani children. By the time I was enrolled in grade school at the age of six, the structure was empty and Romani children were more or less diverted out of non-Roma sight. They were sent into "special" schools that were officially for mentally disadvantaged children, but were unofficially known to be reserved for Roma. I recall being mystified by the fact that we had a few children who passed as "orderly Gypsies" [*rendes cigányok*] in our class. Our class teacher explicitly forbade us, the children from the Hungarian

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[2] Population censuses are not a reliable source of ethnic statistics, as they are notorious for not giving an accurate count of the number of Roma living in Central European countries. After the Velvet Revolution in Slovakia the government's first comprehensive attempt to estimate the number of Roma living in the country and their approximate living conditions was in 2004 when the first Atlas of Romani Communities was published. The project was funded by the World Bank and the Canadian International Development Agency. This publication does not list my hometown Komárno-Komárom (Government of Slovakia, 2004).

[3] Socialist housing policy in Czechoslovakia prescribed moving Roma to municipally-managed buildings in historical town centers. These were usually in dilapidated condition and often even lacked bathrooms. From the 1990s onward, the buildings started to be reclaimed by municipal authorities and a gentrification process took place (see Szilvasi, 2016).

majority, to make references to the ethnic background of these classmates.[4] Only much later did I realize that this kind of whitewashing produces invisibility. Before the mid-2000s, when they were evicted and offered new "social housing" built with EU funding at a segregated location at its outskirts, the town also had its own Romani ghetto located in a secluded part of the 19th century fortress system built around it. . I grew up knowing that the ghetto and the people living in it were taboo for us.

The Village, the Settlement, and its Occupants

In 2005, one year after Slovakia joined the European Union, I visited a village in the east of the country which contained a segregated Romani settlement where people spoke Romani as their first language. It was my first exposure to an *osada*.[5] Segregated settlements were and still are rare, though certainly not non-existent, in the south of the country where I grew up. But in the east — where my field was located — they seemed to be adjacent to almost every Slovak-majority village. By then, I had taken many courses in anthropology, cultural theory, and gender studies, and as someone who was planning to start her doctoral studies in anthropology I felt equipped to have an analytical grasp on this "exotic culture" in my own country. I accompanied my then-boyfriend to Veľká Dedinka,[6] a Romani settlement in the eastern part of Slovakia where he (also an anthropologist in training) had already established contacts. My first memory of the summer day when I initially went to Veľká Dedinka is of walking down the valley to where the Romani settlement was and feeling a sense of dismay about the number of children out on the streets. The demographic makeup was startling in view of the Slovak-majority village that surrounded the settlement. In the Slovak part I spotted

[4] On school segregation for Roma in Slovakia, including the town of Komárno, see the following civil society research reports: Friedman, Ebel et al., 2009. School as Ghetto: Systemic Overrepresentation of Roma in Special Education in Slovakia. Budapest: Roma Education Fund; Amnesty International. 2007. Still Separate, Still Unequal: Violations of the Right to Education of Romani Children in Slovakia. London: Amnesty International; Amnesty International. 2008. A Tale of Two Schools: Segregating Roma into Special Education in Slovakia. London: Amnesty International.

[5] The term *osada* (literally "settlement" in Slovak) in the Slovak context is associated with a settlement possessing insufficient infrastructure, illegally occupied land, and unauthorized dwelling structures, but which is nevertheless used by my informants to refer to their village. In this dissertation I adopted it as an emic term, but I interchange it with the word village (my informants referred to it both as *osada* and *gav*, which stands for village in Romani). The dissertation uses the Romani verb *gadžo* (and its appropriate inflections) to refer to non-Roma people. It is a non-judgmental term used by Roma to differentiate their own ethnic belonging from that of local Slovaks, Czechs, etc.

[6] As an indication of the tensions because of the size of the Romani population in what is otherwise a small Slovak village I use the oxymoronic pseudonym Veľká Dedinka (which literally translates as Big Little Village). To protect my informants, unless indicated otherwise, I am using pseudonyms for all persons as well. As is conventional in the settlement, the pseudonyms used are often nicknames. The nicknames used in this text are either ones I heard in the settlement or I invented them to indicate something about a person's disposition or characteristics. Some of them can be translated to Romani (such as Tiny, *cikno*, which means "small"), while others are objects that have some meaning, such as Trabant.

mostly older people, but the streets were largely empty and many of the houses were uninhabited; however, in what was effectively a Roma ghetto located in a valley in the middle of the village, both the houses and the streets were bursting with people.

This dissertation began as a quest to understand the ways extreme marginality situated in a relatively peripheral but comparatively affluent setting coincides with social aspiration for a high number of offspring. It began with an earnest (in retrospect, perhaps somewhat voyeuristic) awe my mid-twenties self experienced as I attempted to make sense of the poverty, frustration, and anger, but also joy, optimism, and sense of normality that I witnessed during my first visit in a segregated Roma village in 2005. With time and training, I learned to reshape my consternation into focused research on the intersections of Romani fertility, reproductive care, and reproductive decision-making, poverty, and population politics. The dissertation I wrote after my 15 years of entanglement with the lives of my Slovak Romani friends is as much about the understanding of these concepts I achieved through ethnographic fieldwork research as it is about my own personal coming-of-age journey as an anthropologist and an adult woman.

In order to find out more about the social spaces Romani fertility carves out in a society which is largely hostile to Roma, in March 2010 I moved to Veľká Dedinka and spent almost a year there conducting long-term ethnographic research.[7] Adhering to the ethnographic tradition of being in the field as a female anthropologist, I reserved most of my time for Romani women (or *Romina* in Romanes, their language). Their lives were brimming with reproductive dilemmas and they seemed eager to share them with me. The lives of these women largely revolved around the mundane logistics of taking care of children, but they were also filled with a lot of entertainment and indulgence in the small joys that food, drink, music, and the company of friends and family offer. During my time in the settlement I pitch-perfected what Stacy Leigh Pigg (2013, p.128) describes as anthropology's method of sitting with different sets of people at various locations, and which she calls "a counter to the neoliberal ethic of speed and efficiency that has become normalized, and moralized". Whether sitting together and chatting, watching television, preparing food, or accompanying friends on shopping tours, I co-created the social world I was researching.

I was not only witness to, but also participated in many discussions about the precarity of people's economic situation, and I heard and recorded stories of abusive relationships and accounts of health problems. I also shared segments of my life story – sometimes as an anthropologist eliciting research participants' opinions, other times as a human being sharing her beliefs and convictions with fellow human beings. Much of my time was spent listening to

[7] My long-term research was generously supported by a Dissertation Fieldwork Grant awarded by the Wenner-Gren Foundation for Anthropological Research.

the narratives my research participants created of the present and co-daydreaming about possible imaginary futures. These were futures in which my informants' children landed good jobs, and had supportive life partners and brick houses instead of the wooden or semi-brick huts their parents raised them in. One of the favored activities of Kira, who was my best friend at the settlement and my patroness, as well as one of my key informants, was to daydream about adding a bathroom to the one-room house where she, her husband, and their six children lived (the remaining three out of their nine offspring were already living with their spouses). Together, we lamented which walls would be opened to add the bathroom door, or we imagined the measurements of the bathtub, and the color of the tiles. While for me these fantasies mostly only added to my frustration about Roma people's unequal access to decent housing, for Kira they served as a way to distance herself from her current living conditions – conditions she was appalled by and constantly complained about. At the same time, these daydreams sometimes also served as occasions where past fertility decisions were bemoaned and reproductive care options questioned. Kira, for instance, would often end these fantasies saying that with so many children in the house the bathroom would soon be spoiled, the faucets would be permanently running, and the toilet would most likely be stuck forever. If she could somehow get a small loan to build the bathroom it would be great, but where would she get the money to pay for running water? If only she had not absconded from the hospital where, after having her first three children, she had signed up for a voluntary surgical sterilization procedure.

After ten months of fieldwork in Veľká Dedinka, where I lodged with an elderly ethnic Slovak couple in the Slovak-majority part of the village while spending my days in the Romani part, my original intention was to conduct at least two more months of fieldwork research in the maternity ward where the women I knew from my long-term field site went to deliver their babies. For various reasons which were both logistical and personal, this plan was not feasible, and in January 2011 I left the field. I returned three weeks later for a short visit, but never went back there again after that. Besides occasional phone calls, I have maintained contact with a number of my closer friends via social media. Facebook has not only helped me to maintain relationships with my informants and kept me up to date on their lives, but it's also extended the fieldwork both in time and space and softened the borders between being inside and outside the field (see Beneito-Montagut, 2011).

In December 2016 I received a research grant from my university which enabled me to spend ten days at the maternity ward of a peripheral Czech town with a large Romani community that I will call Továrnov for the purposes of this dissertation.[8] Once again, my focus

[8] The pseudonym alludes to the fact that the town is largely industrial as the Czech word *továrna* translates to factory in English.

was on marginalized Romani women, but at this field site my interest was extended to the medical professionals who guided the women through their birth experiences. At the ward I conducted interviews and observed the care practices they were involved in providing, but the depth of my immersion was incomparable to the extent to which I was absorbed into and influenced the lives of my friends and informants at Veľká Dedinka. The multiplicity of fieldwork sites is reflected in this dissertation: the dominant field site of the first three chapters is the Slovak town of Veľká Dedinka, and the last two chapters largely focus on the Továrnov maternity ward in the Czech Republic.

Studying Marginality, Finding Agency, and Doing Ethnography Among Poor Roma

In resource-poor environments the concept of marginality is largely defined by two conceptual frameworks: social and spatial marginality (Cullen and Pretes, 2000; von Braun and Gatzweiler, 2014). The anthropologist Anna Tsing (1994) theorized marginality as cultural exclusion. According to Tsing, marginality is characterized by constraints that lead to subordinate social positions. Marginalization, in Tsing's perception, can be an "exclusion from the assumption of being ordinary" (1994, p. 279). Contemporary ethnographers who have engaged with the experience of poverty have focused on the power dynamics that shape social inequality, while also allowing for the poor to have their agency. Most famously, the American anthropologist Philippe Bourgois conducted long-term ethnographic research among New York crack dealers and drug users in a Puerto Rican neighborhood. In his ethnography *In Search of Respect: Selling Crack in El Barrio* (1996), Bourgois depicts the socio-economic factors that channel young people into selling drugs. Lacking other formal employment opportunities and facing racism on an everyday basis, Bourgois describes the drug trade and its participants not as people who perpetuate their own poverty, but as actors who are caught in a web of unequal relations that are symptomatic in marginalized populations. While clearly delineating the structural factors which shape the social conditions that prevent people from social participation, Bourgois also puts an emphasis on the ways individuals seek to articulate their identities and find respect within street culture. In his second-most influential book, *Righteous Dopefiend* (2009), Bourgois takes a similar approach in exploring the San Francisco drug scene and its effects on people who are homeless drug addicts.

A recent interest in Roma, marginality, and poverty by Czech and Slovak ethnographers has led to a series of ethnographically-based analyses that informed my research. Jaroslav Šotola and Mario Rodríguez Polo (2016) explored social mobility in marginalized Romani communities, while Tomáš Kobes (2009) researched the attempts non-governmental organizations made at increasing marginalized Romani social involvement.

Others have explicitly focused on the co-existence of the Romani minority and the Slovak ethnic majority. Jan Ort's (2022) ethnographic work is centered around the local experiences and divisions that shape the hierarchies present in a village in eastern Slovakia (also see Scheffel, 2005). Through questioning what and who is counted as local, Ort explored broader issues of belonging and ethnicity. Tatiana Podolinská and Tomáš Hrustič (2011 and 2014) undertook extensive research on the effects of religion and religious missions in marginalized Slovak Romani settlements and concluded that religious change can, at least in some cases, lead to increased social inclusion. Jan Grill's (2012, 2015, 2018) focus was on the migration trajectories of Slovak Roma who moved to the United Kingdom starting in the early 2000s. It is against this backdrop that my ethnographic research and analysis is situated; however, it also brings in a much-needed gendered perspective that connects it to larger anthropological discourses on governmentality and reproduction.

This dissertation is situated at the intersections of reproduction, population politics, health care services, and marginality in Central Europe. My ethnographic methodology and analysis are inspired by critical medical anthropology and the anthropology of reproduction, and my aspiration is to contribute to the literature on marginalized Romani women by bringing these fields of inquiry to bear on their situation. The dissertation heavily relies on a mixed-method analysis, encompassing interviews with Romani and *gadžo* villagers, social workers, Catholic priests, NGO workers, and local authorities, but also doctors, nurses, midwives, and Romani or *gadži* women who were about to give birth, or just had. By choosing a racially marked perspective, my writing about Romani women's reproduction cannot avoid re-establishing boundaries between Roma and non-Roma people. At the same time, I wish to emphasize that reaffirming such boundaries is not my goal, and Roma and non-Roma identities (whether self- or socially ascribed) are not always distinctly discernable in reality.

Anthropology and Reproduction: A Fertile Field

Until the 1960s, reproduction was cast to the margins of the discipline as a "women's topic," and if any scholarly attention was paid to it all, it came in the form of descriptive cross-cultural explorations about reproduction-related beliefs, norms, and values (Ginsburg and Rapp, 1991, p. 311). Reproductive practices were investigated as explanatory systems behind kinship structures (see Malinowsky, 1932) and ethnographers framed reproductive capacities mainly in the context of intimate bodily processes, such as menstruation, breastfeeding, or birth. These were discussed in relation to symbolic cultural practices rather than as practices and processes shaping and reflective of collective dynamics, which have a propensity to produce new political and economic subjects.

Anthropology's entanglement with reproduction as a political concept emerged in the wake of the second wave of the feminist movement and it evolved as part of a larger feminist agenda for global reproductive health in the 1980s and 1990s. It is also intertwined with the political economy approach that had started to gain influence in anthropology in the 1980s. Of course, the efforts to expand the contents of reproduction from biological procreation toward issues in the socio-political arena were not unique to anthropology – it was a flourishing trend in social sciences in general (Almeling, 2015, p. 425) and feminist anthropologists played a pivotal role in this shift. Some of the most influential texts brought a powerful critique of the increasing medicalization of pregnancy and especially childbirth. In 1978, Brigitte Jordan published her book *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*, in which she held that birth is not only a biomedical event but it is also culturally produced – an unorthodox argument at that time. Emily Martin's *The Woman in the Body* (1992) pushed the boundaries of the field by undergirding reproduction as a field in which wider debates about scientific knowledge and bodily practices are played out. Martin captured women's resistance to the hegemonic biomedical models of reproductive care, linking these to wider debates about production and reproduction.

Faye Ginsburg and Rayna Rapp's 1991 article and the subsequent edited volume *Conceiving the New World Order: The Global Politics of Reproduction* (1995) both reiterated and expanded this conceptual framework. Overriding the paradigm of a natural, private phenomenon largely connected to the female sphere, the authors construed reproduction more broadly as they encompassed research on infertility, abortion, pregnancy loss, genetics, reproductive technologies, and many other related fields. Using a political-economic approach along with a poststructuralist, Foucauldian analytical framework, they enriched the debate on reproduction with more perspectives that took race, sex, and class into account. Theorizing reproduction as shaped by processes which are inherently political and reflective of wider power relations embedded in societal inequalities became the norm; the formerly ethnographically unfathomable field which was largely restricted to women's bodies became "central to social theory" (1995, p.1). The authors in Ginsburg and Rapp's volume underline the stratified nature of reproduction, a term coined by Shellee Colen to express how certain populations' reproduction is prioritized over others by those in power (1995, p. 3). Nearly 30 years after its publication, this volume is still credited as a milestone in the emergence of a feminist anthropological perspective on reproduction (Taussig, 2017, p. 171). It was this book which firmly installed reproduction as not disconnected from, but in fact integral to understanding "the big ideas" in anthropology (Taylor, 2004, p. 143).

The rising popularity of reproduction as a topic for anthropological research has been intertwined with the upsurge of medical, and particularly critical medical anthropology as a

subfield, and in the past three decades a range of vastly different topics and standpoints emerged. Within the discourse on global health, anthropologists who study reproduction focused on maternal and child health and mortality issues as well as women's reproductive health in the global south (Scheper-Hughes, 1992). They also delved into the newly forming debates about assisted reproductive technologies and the ways such innovations prompt new understandings of kinship, personhood, and family (Strathern, 1992; Rapp, 1999) or elicit "political economies of hope" (Rose and Novas, 2005) around the world in connection with involuntary childlessness (Inhorn, 2007). Anthropologists have conceptualized reproductive technologies from an ontological perspective (Thompson, 2005) and questioned the long-standing binary of nature versus culture in reproduction by steering away from a perspective in which ethnographic inquiry is limited only to the social, leaving out the biological (Franklin and Ragoné, 1998). Critiquing medicalization (Lock et al., 1998), which sidelines the socio-political aspect of practices, anthropologists working on reproduction also integrated men into the subdiscipline's purview, reasserting the idea that fertility decisions are not a domain that should be exclusively connected with women (Gutmann, 2007).

The intersection of demography, reproductive decisions, and reproductive health remains a fertile field (Greenhalgh, 2005; Kanaaneh, 2002). It builds heavily on Ginsburg and Rapp's notion of reproduction as stratified by political processes, practices, and ideologies which prioritize the reproduction of certain (socially, culturally, or economically more advantaged) groups over people who are less privileged and thus less desirable as a future population. Issues such as fertility change, which stand at the intersection of a number of disciplines, have been conceptualized in various ways by ethnographers who work at the intersection between medical anthropology, the anthropology of reproduction, and anthropological demography. Their ethnographies show intricate relationships between fertility change, social class, gender, and population politics (Krause and Marchesi, 2007; Greenhalgh, 1995; Douglass, 2005).

Ethnographic accounts of reproduction have intersected with medical anthropology, science and technology studies, demography, women's studies, and disability studies, and – perhaps unsurprisingly – the anthropology of reproduction has become a subfield which is predominantly shaped both in volume and in theoretical weight by female ethnographers. Instead of targeting only post-colonial geopolitical contexts, the anthropology of reproduction has been on the frontline of doing anthropology "at home". This "home," however, was more often than not confined to Anglo-American contexts. Only a handful of authors who bring critical medical anthropology together with the anthropology of reproduction have ethnographically explored the Central European region in the past three decades. Alena Heitlinger's work on population policies and women's reproductive care and rights in socialist countries (1987) laid

the foundation for anthropological research on reproduction in this geopolitical region, but this line of scholarship has gained more momentum in historical sociology (Hašková and Dudová, 2020; Dudová, 2012), especially when it takes a broader scope and includes discussions of family support programs and women's relationship to the welfare state (Fodor et al., 2002). The most notable contribution to our understanding of the socialist heritage in population politics and abortion policies was written by Gail Kligman (1998), who pioneered ethnographic research on illegal abortion practices in socialist Romania (also see Kligman and Gal, 2000).

More contemporary ethnographic accounts of reproductive rights and wrongs (Hartman, 1995) are scarce. Notable exceptions involve Michele Rivkin-Fish's work on Russia, which addresses the class and gender inequities omitted by other scholars studying reproductive issues in post-socialist contexts (2003) as well as the political dimensions of pregnancy termination, surrogate motherhood, and family support from the perspective of women's autonomy (2013). Joanna Mishtal's ethnography of Polish gender politics as influenced by the reproductive rights movement, religion, and state in the context of EU governance (2015) is another important contribution in this field. Other themes that anthropologists have engaged with include the formation of maternal subjectivities in post-socialist and neoliberal regimes, such as in connection with pregnancy loss in Romania (Van der Sijpt, 2018) and women's birthing experiences and choices in the Czech Republic (Hrešanová, 2014). Amy Speier delineates the ways fertility tourism plays out for American couples in the Czech Republic (2016).

Governing Reproduction

Much of the contemporary understanding of the relationship between the state, demography, and individual reproductive outcomes is based on Foucauldian biopolitics discourse, which still provides the most coherent and convincing framework for understanding the state's vested interests in supporting the reproduction of certain segments of the population while discouraging it for others (1978, 1980). Foucault dated the scientific study of populations back to 18th century Western Europe, where modern forms of governance analyzed not only the quantity, but also the quality of the population, imposing a perspective which allowed for targeted, "normalizing interventions" (Gal and Kligman, 2000, p. 19). Foucault elegantly theorized the state's power over life, the central interest of which is to optimize the population. The population, according to Foucault, became a bio/political power to be regulated and disciplined through various scientifically framed technologies. The biopolitical perspective has, at least since the beginning of the 1990s, been the most influential line of thought guiding feminist anthropologists in theorizing reproduction.

Two major interlinked concepts frame this dissertation, both built on Foucauldian ideas about the governmentality of subjects: responsibilization and reproductive governance. Morgan and Roberts coined the term reproductive governance (2012, 2019) to scrutinize the systematic processes through which not only the state and religious authorities, but also non-governmental organizations, international financial institutions, and social movements make use of legislative and economic means, motivations, or forces to oversee and influence the populations' reproductive conduct. In reference to public policies regulating reproduction in Latin America, Morgan and Roberts emphasize that contemporary understandings of fertility are embedded both in moral assumptions and a rights-based discourse. Since the 1990s, international donors to non-governmental organizations have introduced strongly gendered frameworks, in the context in which women's rights and sexual rights have gained unprecedented attention – as well as provoking some backlash. This increased focus on gender has inevitably translated to significant policy changes.

Morgan and Roberts suggest that the meaning behind the concept of "population" has undergone a shift, as life itself and reproduction are increasingly understood to belong to the domain of individual rights (2012, p. 250). Since at least the 1990s, reproduction has been discussed within a rights-based framework, and there has been a palpable shift toward judicialization, resulting in a strong push for battles over reproductive rights to take place in courts – for instance, in courts that decide in favor of, or against abortion. In response to the tendency for growing judicialization, Morgan notes that anthropologists have had to shift their attention toward sexual and reproductive rights "lawfare" (Gloppen, 2014, quoted in Morgan 2019, p. 114), which carries the increasing necessity for the social scientists who work in this field to qualify themselves by obtaining expert legal knowledge. Discursively, the rights-based framework has been utilized in divergent, often contradictory ways. It has been employed both to advance women's rights, and, for instance, also to propose the idea that "unborn babies" have a right to life (Morgan and Roberts, 2012, p. 243). Morgan and Roberts point out that competing notions of morality and worthiness of rights have dominated these discussions in Latin America and beyond, and that these discussions translate into laws that contribute to the regulation, prosecution, and monitoring of reproductive events (2012, p. 251).

Importantly, the concept of reproductive governance goes beyond the nation state. It foregrounds international actors and their policies in shaping national reproductive outcomes, while at the same time drawing attention to national legal instruments that govern reproduction. It allows for a link between individual bodies and global moralities and economies of fertility, as it is viewed within a neoliberal setting which emphasizes individual consumer rights and freedom of choice (2012, p. 244). Reproductive governance now transcends the perspective that the state's aim is to control the individual fertility outcomes only of its citizens, because it

also attends to cross-border movement and the reproductive behaviors of migrants (2012, p. 245).

Closely intertwined with reproductive governance, at least for those like me who position themselves within the women's rights framework, is the promotion of reproductive justice. The term was originally coined in the 1990s by organizations founded by American women of color. This was a time when several other significant feminist events dedicated to reproduction, such as the International Conference on Population and Development in Cairo, took place and brought the feminist agenda into much more prominence. In dialogue with the development of the pro-choice versus pro-life movement in the US, Ross et al. explain that the term was coined in reaction to the ways liberalism hijacked the concept of individual rights and misused it as a vehicle for the idea that institutional barriers can be transcended through responsible individual choices (2017, p. 16). Reproductive justice, on the contrary, moved away from an emphasis on individual rights and responsibilities toward the importance of making structural improvements in reproductive circumstances, especially with respect to affordable and accessible reproductive healthcare (Ross et al., 2017, p. 17). Although the term itself was coined by African American women, it found its way into the mainstream discourse. Ross et al. remind us that the endorsement of the reproductive justice framework by the larger feminist movement should not preclude the experiences of vulnerable populations living in institutionalized systems of inequality (2017, p. 17).

The idea of "responsible" reproduction connects with the reproductive governance discourse in multiple ways. The sociologist Nicholas Rose sparked an interest in responsibilization as an analytical concept based on his work on Foucauldian biopolitics and technologies of the self (Rose 1996, 2007; Rose and Lentzos, 2017). Rose suggested that in the neoliberal world order, responsibility, autonomy, and personal choice have become integral parts of understanding one's "investment" in oneself, in a context where each person's life is turned into a "project" that they should aim to optimize (Rose, 2007, p. 125). Responsibilization typically entails an emphatic insistence that individual people should apply more self-governance to their behavior instead of relying on existing, state-supported structures and services. Responsibility is re-positioned here from feeling a sense of accountability for one's own life to a pressure that links individuals to specific consumption patterns, or choices that emphasize the individual level of experience and outcomes over the social. Responsibility should be exercised toward oneself in miniscule everyday techniques that work together to produce individuals who subscribe to market-centered values.

Rose as well as other anthropologists have pointed out that by positioning individuals at center stage, this discourse precludes one's obligation to participate in matters that are not market-driven, but that emphasize social justice and care for others (Rose, 1996 and 2007;

Trnka and Trundle, 2014 and 2017). A discourse in which decisions concerning one's health or well-being are considered to be mainly in the individual's hands implicitly depoliticizes these matters and reasserts the status quo by implying that poor people's poor health is a result of their lack of prudence and inability to make responsible lifestyle choices. Exercising responsibility with respect to one's health thus becomes a moral obligation. Accountability lies not with the state, but with individuals, who, according to this logic, have unlimited power to exercise prudence over their lives through self-help techniques. By emphasizing individual choice, the responsibilization discourse largely disregards the social and economic limits that shape people's ability to make decisions that are "health-conscious".

Anthropologists Susanna Trnka and Catherine Trundle note that in a discursive sense on a global scale there is an "increasing pervasiveness of responsibility" (2017, p. 1) to the extent that such concepts have become "morally untouchable" (2017, p. 2). This dissertation heeds their call to provide more social reflection on the omnipresence of responsibility as an ideal. Like practices in other spheres of life, reproductive practices are also shaped by the rights and obligations that define morally acceptable individual choices. Rationality and responsibility with respect to reproductive practices are virtues that poor people are assumed to be lacking (De Zoro, 2012).

Based on data acquired through ethnographic fieldwork, this dissertation captures specific local moral worlds in which reproductive trajectories are formulated. The chapters that follow examine the everyday life events and practices in which responsibilization as a discourse is mobilized with respect to the fertility of disadvantaged Roma people. My interest is in the extent to which Romani women and the maternity care professionals who work with them embrace the responsibilization narrative, and in what ways they disrupt or resist it. The text analyzes the divergent mundane narratives and practices that are employed around Romani women as reproductive subjects and highlights the moments when responsibilization becomes mobilized and activated by Romani women, health professionals, or other actors. At the same time, it explores the autonomous choices that Romani women make in their reproductive trajectories – choices that may or may not emphasize or enact the neoliberal ideal of self-responsibility.

Summary of Chapters

Chapter One focuses on reproductive subjectivity and reproductive decisions as they appeared in my main fieldwork site in the Slovak village of Veľká Dedinka. The chapter addresses the relationality of reproduction as articulated by my research participants. Reproductive decisions are not made in a vacuum, and in this chapter I examine how fertility ambitions and events coincided throughout the almost whole year I spent directly and locally

involved in my informants' lives. The chapter unpacks the ways gendered relations, ideas about ideal family size, reproductive knowledge, education, contraception use, and chance and (mis)fortune are inextricably intertwined, and it discusses how they result in a high birth rate in a setting marked by extreme discrimination and poverty. The Roma in my research both revere and refuse the discourses of self-governance, responsibility, and accountability with regard to reproduction. The chapter shows that in spite of the high fertility rate in the settlement there is a social aspiration among Romani women to represent themselves as modern, autonomous reproductive agents and responsible family planners. Women pragmatically adjust to the life circumstances in which they find themselves, and their reproductive trajectories are often not in conformity with the rationality approach to reproduction.

Chapter Two is centered around the fact that Roma have a different fertility pattern than *gadže*, and they bear remarkably more children than any other ethnic group in the larger region of Central Europe. The high number of children born is of concern not only to their parents, who are striving to make a living amidst unemployment and systematic discrimination in virtually all areas of life, but also to state authorities and the larger society. It shows how economic arguments were and continue to be employed to defend various attempts to curb Romani reproduction, on the basis of an underlying assumption that Romani births are of negative value. It reflects on the earlier sterilization campaign as an attempt to avert a negative demographic development for the future population. Birth-related violence against women is certainly not limited to Roma in the Czechoslovak context, as sterilization and other abuse continue to be used as a tool to govern women's bodies worldwide. Yet, as Chapter Two of this dissertation shows, sexual sterilization can not only preclude, but also reaffirm Romani's women reproductive autonomy; however, in a resource-scare setting where access to both means and knowledge of contraception is lacking, it must be viewed as a complicated contraceptive choice. The chapter also reflects on the economics of childbearing from the perspective of Romani women.

The **third chapter** focuses on birth care in a Slovak hospital, as the quintessential point of intersection of Romani women with the state is the maternity ward. The chapter analyzes Romani women's birth narratives to examine personal autonomy in the birthing process. Feminist accounts of women's encounters in the delivery setting often focus on the assertion of agency in opposition to or in reaction to the rigid power structures women find themselves facing in health care facilities. The chapter contends that Romani women do not participate in the rearticulation of a neoliberal self during birth, and they do not have a preoccupation with (self) control, decision-making, and resistance during the delivery process. The accent on choice during the birthing process, so common in the social science literature about birth, may in fact preclude the experiences of marginalized women who frame their birth encounters in

different terms. Birth-related choice and decision-making appear to be important for my research participants, but only in relation to their social selves outside of the maternity ward. Romani women internalize the medical gaze while they are giving birth, but actively seek to escape from it and find support in their communities as soon as possible afterward.

The **fourth chapter** brings a shift both in perspective, time and geographic terms. It takes the reader to my second field site in the Czech town of Továrnov. The medical professionals at the local maternity ward, from whose perspective the chapter was written, find Romani women to be difficult patients in many ways; yet they also see them as “ideal” patients because they don’t put up resistance during the delivery process. They appreciate Romani women for not making nuanced maternity care and birth choices, but they also criticize them for it. However, when Romani women exhibit resistance, medical staff do not see it as demonstrations of agency, but rather as cultural particularities. In the view of medical staff, Romani women have tendencies to escape the domain of rationality and responsibility, but, as this chapter asserts, they can still be considered good patients. In cases where friction arises between Romani women and medical professionals at the ward, staff renegotiate and rationalize potentially conflicting situations. I understand these actions as attempts to reinstate good care when it has been disrupted. The delivery of good care is the essence of the professional identity of nurses, and in the hospital good care is imagined by medical professionals as a top-down effort. By constructing positive stereotypes of Romani patients, midwives and nurses not only facilitate the care process, but they also dismantle stereotypes of themselves as racially biased, prejudiced medical professionals.

The **fifth and final chapter** examines the practice of room segregation at the maternity ward in Továrnov. While medical professionals, at least in their interviews with me, did not exhibit bias against Roma, Romani ethnicity was recognized and had very real consequences with regard to care, because on the level of institutional practices certain rooms were pre-selected for Romani women in the ward. I found that in the understanding of medical professionals the culture and/or nature of Roma (as perceived by medical professionals) serves as an explanatory model that enables the cultivation of this informal and possibly illegal practice. While staff maintain the necessity of room segregation mainly for logistical reasons, I reveal that the reasons behind the existence of segregated rooms are more complex, including the fact that *gadži* birthing women’s preferences are recognized and prioritized, and that Romani patients’ preferences are more often assumed than solicited. The practice of room segregation thus builds on, and exacerbates, reproductive governance.

2. Living Reproductive Subjectivity

Based on ethnographic materials gathered from March 2010 to January 2011 in the village of Veľká Dedinka located in eastern Slovakia, the first chapter of this dissertation explores the local moral worlds embedded in fertility choices and the ways individual women relate to the courses of action available to them. My interest lies where Romani women's reproductive agencies intertwine with a socio-economically disadvantaged environment. Reproductive outcomes are messy entanglements constituted by culturally informed expectations, wishes or choices, community moral regimes, economic impetuses, serendipity, religious frameworks, public health capacities, and, ultimately, corporeal practices that enable or disable conception to take place and a pregnancy to be carried to term. Here, I will disentangle the politics of fertility behavior by foregrounding disadvantaged Romani women's subjectivity, intent, decision-making and responsibility with respect to their fertility.

The chapter is a socially grounded account that explores the everyday lives of Romani women through interactive practice, embodied knowledge, and shared social existence; it focuses on the nuance involved in ethnographic perceptions of planning, intention, control, agency, and action with respect to reproduction. I frame the heterogenous discourses and contradictory attitudes in my interlocutors' narratives in larger social relationships and interactions, and emphasize that there is always a complex web of causes and effects at play in reproductive outcomes. At the same time, my goal is to dismantle the idea that poor Romani women who have many children are victims of circumstances or are bound by cultural ideals or kinship relations that exercise decisive power over their fertility outcomes.

The first part of this chapter will focus on anthropological framings of fertility choice, fertility intent, and reproductive decision-making. It deconstructs the idea that these concepts are self-evident, clear-cut, or even easily applicable across cultural settings. The second part of the chapter analyzes fertility situations: The ways Romani women make both active and empowered reproductive decisions, as well as choices that are non-choices. I will not address clinical pathways of fertility, the effects of "new" reproductive technologies, or infertility, adoption, and other ways of obtaining children than through biological conception because these topics were not significantly represented among my interlocutors.

Me na Kamav Buter Čhave! [I Don't Want More Children!]

State actors and ethnic majority populations across Central and Eastern Europe are in agreement that Romani women give birth to far more children than they should (see Chapter 2). Similarly, within the community of Veľká Dedinka where I conducted long-term ethnographic

fieldwork, there was a consensus that the ideal number of children women should bear is lower than the actual reproductive outcome for women in the osada. In conversations with both teenage girls and their mothers, who were often my age, I heard that it's best [*najfeder*] to have between three to six children and that the most appropriate age to enter a monogamous marriage or lifelong cohabiting relationship is between 18 and 20 years. However, these standards existed mainly in conversations; in their lived realities, my interlocutors inhabited a wide diversity of family arrangements. Teenage pregnancies were frequent, as were families with eight to ten biological children. Women who were beyond their fertile years and had three children or fewer were an exception. Most of my interlocutors were critical of the fertility trajectories they had taken, and making moral assumptions about other people's reproductive choices was a frequent and favored subject of talk in the community. Analyzing the lived trajectories from an ethnographic point of view alongside the social norms that shape them is central to understanding the text below.

In the initial phase of my fieldwork at Veľká Dedinka I deliberately refrained from asking women targeted questions about their reproductive trajectories, but soon I learned that what I had assumed were candid questions were not considered too intimate even within the frames of an introductory interaction. I learned from my own example: virtually every new acquaintance quizzed me about how many children I was a mother to. Once I admitted to not having any, this was followed by the question of whether I had a partner. Subsequently, the conversation would turn toward how many children I or my partner wanted to have (to verify whether we shared the same family goals), and how old I was (to check these goals against my biological clock).[9] With increasing time in the settlement I learned to give more definite answers to these questions, especially after I noticed that my informants were concerned about my apparent lack of interest in my own reproductive future. Based on the depth of my relationship with my interlocutor, the fluctuating levels of satisfaction I was experiencing in my long-distance relationship, and the level of my anxiety about my uncertain prospects once my fieldwork grant ran out, I replied that in the future I'd want between one to three children. To me, this answer seemed neither far from the truth, nor close enough to a lie; it was neither a plan nor a total impossibility. And to my interlocutors it confirmed that I shared their pronatalist values and it increased my relatability as a normative, heterosexual woman.[10] It showed that although I did not meet their socio-cultural expectations commensurate with my age ("You should have had

[9] Perhaps it was my inner PhD Yoda (Mewburn, 2011) conspiring with the universe, or some "Gypsy witch" engaging in fertility issues (Čvorović, 2013) who had been keeping track of my dissertation writing process, but as I was working on this section a brief message popped up on my social media message box. It was written in broken Slovak by a Roma man whose ex-wife I had been close to in the settlement: "Hello, how are you? How many children do you have?" This had been his first attempt to contact me after many years of not engaging in a mutual conversation.

[10] On non-heteronormative identities among Roma people see the recently published book *Queer Roma* by Lucie Fremlová (2022).

at least one little boy by now," Kira, my closest friend and patron would often say), my ultimate social goal was motherhood, in conformity with their expectations.

To some extent, this mirrored my publicly-stated relationship with God. When questioned about whether I believed in God, with increasing time spent in the settlement I learned to affirm that I did. But, truth be told, I expressed my belief in the deity's existence there in a manner that showed much more confidence than I truly felt in my Christian cultural belonging and convictions. When I said I believed in God, what I meant to express was that I subscribed to the ethics of behavior that Christianity inspired in the settlement. To my interlocutors, this signified that I was a person with morals, even though I still failed to make the sign of the cross at culturally appropriate moments, such as when passing by a church or a graveyard. Being in the position of a trusted moral person was of key significance in a setting where rumors of marital jealousy or cursing by the evil eye [*jakhendar*] circulated widely (also see Hajská, 2003; Mann, 2004; Lacková, 1997).

Once I learned that fertility talk was an integral and legitimate conversation topic, even among new acquaintances who barely knew each other's names, I started to inquire about people's current reproductive profiles with much more confidence. Virtually all the women above 20 years of age with whom I conversed were already mothers. I only met one woman in the settlement who was beyond reproductive age and did not have children – Eva claimed to have never married because she never found the right man. Even the same-sex female couples I knew raised children born out of former heterosexual unions. The Romani proverb which says that if there are no children, there is no happiness [*nane čhave, nane bacht*], certainly seemed to be a widely accepted norm, and after a certain age, an expectation. On my birthday, my closest friends wished me happiness, health, and many children, and some teenagers joked that I should not stop until I have one hundred.

After hearing how many children my interlocutors currently had, I asked how many more they wanted to bear. If they were capable of childbearing,[11] some of my informants would say they wanted one or two more babies, and a few, usually young mothers, told me they wished for three or four more children. But the majority of my interlocutors would vehemently deny wanting any future children. *Me na kamav buter čhave*! [I don't want more children!] they would exclaim. This wish could not have been less consistent with our mutual corporealities, as from a demographic point of view children dominated the settlement and outnumbered the adult population by several times.[12] Children surrounded women constantly; I cannot recall an interaction between my interlocutors and me that did not take place in the presence of several small children, unless we intentionally physically separated ourselves from them.

[11] Several women I knew were sterilized, see Chapter 2.
[12] On the demographic profile of the village see Chapter 2.

Conversations about reproduction sometimes led to situations where the needs of existing children were pushed to the background. For example, my fieldnotes contain a scene where my pregnant friend Alica chased her crying 6-year-old son out of their one-room house into the cold winter afternoon so that the two of us could discuss the process of making children.

The relationship between stated fertility intentions and concomitant reproductive outcomes was entangled. Some of the women who stated that they didn't wish to have any more babies ended up getting pregnant by the time I left the field. A few of them even gave birth to a baby and were pregnant again as we were saying our final goodbyes. When I considered how resolutely they denied wanting another baby, it inspired me to think about intentionality and relationality in reproduction. Reproductive decisions are not made in a vacuum, and my goal became to unpack the ways in which fertility ambitions and events coincided throughout the year we spent together in my informants' lives.

Rationality, Choice, and Intent in Reproduction

To understand what processes result in the number of children women bear (besides their bodies' reproductive capacities), anthropologists have sought to untangle the meanings of autonomy, agency, and subjectivity within the reproductive context. Central to this discussion are the notions of decision-making and choice. While decision-making is utilized in this dissertation as a concept primarily in connection to fertility and reproduction, Jan Patrick Heiss notes that anthropologically informed perspectives on decision-making concern a variety of research areas such as the anthropologies of social change, economy, and religion (2018, p. 236). He identifies two main approaches to understanding human decisions: the rationality approach and the ethnographic approach.[13] Heiss explains that within the rationality approach human decision-making is "a form of mediation between the actors' preferences and situational circumstances by rational calculation of means and ends" (2018, p. 237). Quoting Becker (1976), he asserts that the actor's preferences, desires, or wishes are evaluated against his or her situation. The actor's aim is always to maximize his or her benefit in a given situation, and thus when making a decision the actor weighs up all possible alternatives and chooses the alternative which brings about the highest benefit. This is deemed to be a rational model in which a lack of available information can result in wrong decisions or inept actions. Heiss turns to Boholm, Henning, and Krzyworzeka (2013) for help in identifying the second approach to understanding decision-making processes. Terming it the ethnographic approach, these

[13] He also proposes his own, third approach called the "maturing decision". His case study of Hanusa men "highlight[s] two aspects of decision-making which have not been highlighted in previous studies: the role of emotions in providing direction for decision-making processes and the role of emic understandings of decision-making processes" (Heiss, 2018, p. 237).

authors describe it as using ethnographic nuance to understand human decisions. According to Heiss (2018, p. 240), the proponents of the ethnographic approach opine that the goal of decision-making is often not to engage in an action in itself, but "to determine a course of action when the actor does not immediately know what to do".

Another important school of thought to consider here is the theory of demographic transition. Demographic transition denotes a process whereby many societies have, since the mid-18th century, undergone a significant demographic decline: lower fertility rates have been accompanied by lower mortality rates. In her critical review on the theories of demographic transition and modernity Johnson-Hanks (2008) explains that rational choice theories presumed that the shift from high to low fertility and mortality takes place in clearly definable ways. They also portrayed this shift as an inexorable, one-time event. The period preceding the transition is characterized by high fertility and high mortality rates; in a context where life expectancy is low, it "makes sense" for people to have many children, but ultimately populations neither significantly increase nor decrease. As socio-economic conditions change and life expectancy increases, a transition period begins, which is characterized by a sharp increase in population. This is then followed yet again by a balanced phase, where the fertility rate drops and population growth becomes minimal. Originating in the American post second-world war climate of strong belief in unilinear progress, these hypotheses were proposed by experts in engineering and agricultural science (2008, pp. 302–303). In societies where the demographic transition already took place fertility decline is strongly linked to fertility control, and couples' intentions for family planning are based in rational deliberations over their ideal family size (2008, p. 307). Within this calculated logic, fertility outcomes are carefully designed plans put into precisely executed actions. However, Johnson-Hanks' conclusion (2005, 2008), based on her own ethnographic research and on the review of corresponding sociological and demographic literature, will come as no fundamental revelation to anthropologists: the lived realities of reproductive conduct bear little resemblance to the tailored thinking described by theorists of rational choice.

Translated into the study of demographic behaviors, rational choice theories applied to reproduction also focus on the calculation of means and ends, and it was within this scholarly context that the notion of individual reproductive choice took center stage. Yet anthropologists have documented that reproductive intentions are subject to change over time, malleable in the face of life events, or simply non-existent. Terms such as a "planned pregnancy" and the notions of what qualifies a pregnancy as such may vary significantly across social class and socio-economic status (Moos et al., 1997). Greil and McQuillan state that it is not possible to divide women into those who intend to get pregnant and those who do not, and that intentions are surrounded by ambiguities and definitional uncertainties (2010, p. 151). Quoting Holland

et al. (1998), they emphasize that instead of trying to capture fertility intentions that are simply “out there,” a more constructive approach is to focus on the interpersonal, material, and socio-cultural foundations that frame pregnancy intentions (Greil and McQuillan, 2010, p. 140). The experience of having more children than one originally intended is not restricted to high fertility contexts. Elizabeth L. Krause’s (2012) research is centered on Italy, where the fertility rate is one of the lowest in Europe, and even in this context at least one in four babies is unplanned.

The limitations posed by human biology and technology further complicate matters. In her research with Irish couples who face infertility issues, Allison (2010) emphasizes that societal discussions of reproductive choice primarily center around a binary type of thinking, in which individuals or couples either choose not to conceive or actively choose to conceive by ceasing to use contraception. Invoking ideas of rationality, autonomy, and agency, this perspective depicts fertility as controllable and portrays reproduction as something that can be mastered. However, according to Allison, reproductive choice becomes discursively meaningless for those who chose to have children but fail to conceive them (2010, p. 7). Reproductive technologies can change the field in which choices are made; specifically, she describes how fetal ultrasounds that indicate abnormal fetal development can lead to reproductive decisions that are by nature more specific, though no less intricate. Tine Gammeltoft’s (2007, 2014) ethnographic research on couples who receive such diagnoses upon an ultrasonographic examination in Hanoi, Vietnam, implies that making reproductive decisions that involve life and death is not an individual matter, but ultimately a communal enterprise. Her research reshapes anthropological understandings of choice by emphasizing that in difficult reproductive dilemmas choices are not acts of individual freedom which mold social reality according to one’s will, but acts of belonging where the individual is ”responding to and seizing others” (Gammeltoft, 2014, p. 9).

Johnson-Hanks (2005) claims that the unpredictability and inconsistency of existential conditions in Cameroon prevent young women from making concrete reproductive plans. The educated Cameroonian women she interviewed would not answer her questions about the number of children they wished to have, and instead, they told her when they intended to have their first child. Timing their first birth did not function, according to Johnson-Hanks (2005, p. 376), as a way to predict their own future reproductive outcomes, but as a signpost: Cameroonian women thought differently about the link between intention, action, and the object of their intentionality. In a context where people routinely experience crisis and uncertainty is constant, people developed a habitus (Bourdieu, 1990) which “predisposes the actor to discount choice and refrain from committing himself to specific imagined futures” (2005, p. 367). Johnson-Hanks’s results are in contrast with the Weberian logic that action is the fulfillment of prior intention, yet she still asserts that strategizing, planning and acting

effectively is possible in the context of reproduction. Actors do not so much plan as use "judicious opportunism": they seize promising chances when they occur (2005, p. 370), and they live in a permanent state of openness in which they maintain many options.[14] Acting here involves not contriving and executing a plan but finding an effective way of responding to unexpected opportunities. It is through such effective responses that formerly ambiguous wishes and desires will solidify (2005, p. 376).

The anthropologist Rhoda Ann Kanaaneh explores the positions that people take toward the state's population politics. Kanaaneh, who grew up in Galilee as the daughter of a Palestinian father and Chinese-Hawaiian-American mother, provides an account of the intersection between the Israeli state's pro-Jewish demographic policies and the strategic reproductive choices that Palestinian women make. Her ethnography *Birthing the Nation* is an analysis of reproductive agency among Palestinians, and she explores the ways fertility outcomes meet new and old local conceptualizations of tradition, the narrative of modernization, consumerism and the gendered body in a disadvantaged minority group. Kanaaneh's book emphasizes the incongruities between people's stated reproductive preferences and their real-life actions with respect to childbearing. Instead of outlining a discrete Palestinian identity based on the differentiation of ethnic belongings, Kanaaneh advances that Israeli norms increasingly intermingle with "authentic," static understandings of Palestinian traditional values and lifestyles. State population policies, economic development, biomedicalization, and local dynamics form a nexus in which reproductive outcomes are nested (2002, p. 165). Palestinians do not have a uniform response to this general trend and demonstrate reproductive agencies in divergent ways. Certain segments of the Palestinian population deliberately have large families in an effort to counter the Israeli state's pressure on Palestinian families. Others demonstrate their reproductive agency by deliberately having small families, and believe that investing in a small number of children who can compete with the Israelis will strengthen the Palestinian cause.

Reasoning that a sense of "creative adaptation" is needed when one lives in a state of constant uncertainty, Cornwall (2007, p. 230) draws on De Certeau (1984) to distinguish between strategies and tactics. According to De Certeau, the term strategy implies that the actor undertakes a calculated process while always keeping an eye on the end goals of the action. As opposed to strategies, which cast the actor in the position of power, tactics are

[14] Johnson-Hanks compares this to the multitude of personal and professional possibilities and the lack of certainty about their outcomes which conventionally arise when someone is close to finishing their dissertation: "Will I find a job? Where will I be living? Will my relationship survive the move? Should I do a post-doc? The end of the dissertation process is a moment when potential futures are maximally open and the actor's potential to act intentionally to bring about some specific desired future is particularly limited" (2005, p. 370).

coping techniques, which are improvised in reaction to the contingencies of everyday life. Based on her ethnographic research among Nigerian women, Cornwall suggests that talking about reproductive strategies might be misleading, and that it is important not to only analyze whether fertility outcomes are the results of choice, but also to consider the other choices and agents that are involved in these outcomes (2007, p. 234). In fact, Cornwall asserts that certain reproductive outcomes have nothing to do with fertility choices as such (p. 235), and that greater emphasis should be placed on the social processes which mediate reproduction. Her ethnographic material showcases that for young Yoruba women pregnancy is often not the result of a conscious choice, but an outcome which women must cope with in creative ways.

Still, the notion that intentional reasoning and planning processes mold reproductive outcomes is not to be disparaged, even though ethnographic literature is increasingly steering away from compartmentalizing pregnancies into categories such as un/planned, un/wanted or un/intended (Seeman et al., 2016; Bledsoe, 2002; Cornwall, 2007). Abstract ethical principles and fertility-related individual wishes and ambitions exist across societies, regardless of the society's fertility rate. However, such values have never not existed. The conviction that their emergence is tied to modernity is based on outdated theories of rational action that lack empirical substantiation. The perception that modernity caused rationality to take over the place of values is also based on error. Rationality "matters only as a culturally meaningful portrayal of reproductive action, and not as an empirical description of it" (Johnson-Hanks, 2008, pp. 307–308).

Contingent Intentions: Reproductive Agency in Kelly's Family

The question of who bears the responsibility for individual reproductive outcomes was central to discussions surrounding childbearing in Veľká Dedinka. Teenage pregnancies were a frequent occurrence, even though they went against societal expectations. Kelly was related to Kira, my best friend and patron in the settlement. I had occasionally met Kelly during my short-term visits in the summers preceding my long-term fieldwork, but it was only when I moved in to Veľká Dedinka that I got to know her family better. Kelly was in her early thirties when we became friends – so we were close in age. At that time her oldest son, Benny, who was 19 years old, had been living with his new wife for a few months. Because the couple had not amassed the finances to build a house yet, they sometimes lived with his parents, and at other times with the his wife's family. Benny, and a couple who were friends with him and his wife were chatting when I dropped in for a visit one afternoon. By then I knew that quizzing people about fertility-related issues was not a methodological faux pas, so I asked Benny if his wife was pregnant yet. He told me she was not. He said that they were only getting to know

each other [*sprindžaras pes*], and that he did not yet wish to have a baby.[15] The conversation that followed was reconstructed in my fieldnotes from my memory:

> Edit: Don't you want children?
>
> Benny: I want children! But not just yet. We don't even have a place to live now.
>
> Benny's friend: You've got that right [*lačhes phenes*].
>
> Benny's friend's wife: Yes! Look how he's contemplating [*rozmyšlinel peske*]. Where would he go with his wife and kids?
>
> Edit: Well…
>
> Benny: I don't care that [my wife] already wants [children]…
>
> Edit: She wants children more than you do?
>
> Benny: I don't care if she does, but I don't! I am the man, I will do it in such a way so we don't have any [*me kerava avkes, kaj te na ela amen*].

Benny was gauging the possibilities of what having a child with his wife would mean in their current situation. He had a clear vision of the material circumstances that ought to precede childbearing, and he assessed what a future child would mean for their present life together. He aligned his reproductive actions with this vision. Taking on the role of the responsible family man and planner (also see Gutman, 2006), the one who ponders the couple's reproductive options against their socio-economic reality, Benny said he made up his mind to use condoms until the couple's housing situation improved. As having a child would irreversibly bind his family together with his wife's and define them as a couple (Kovai, 2010), delaying childbearing also gave Benny and his wife time to verify the durability of their match. The participants continued discussing the discomfort that using condoms involved – the men were blaming women for not wanting to use them, while Benny's friend's wife retorted that it was men who were unwilling to make use of this form of contraceptive.

Kelly's oldest daughter did not have such a clear sense of intentionality about family planning, social mobility, and partnership strategies. At 16, Vanilla was a mother of two children; the younger one was born when she was only 13. In the case of teenage pregnancies, especially when they happen at such an early age, the girl's mother tends to take care of the baby, bringing it up as her own child. But since she still had several young children of her own, Kelly refused to care for her young daughter's children and constantly chastised her for getting pregnant too early. Although they had a rocky relationship filled with loud public quarrels on

[15] When I talked with men, especially younger men, they frequently boasted about the number of children they were planning to father. Older men would find pride in explaining to me that they had many children, and it was rare to encounter a man who said he had too many children.

the street, which bystanders, including myself, would eagerly gather to witness, Kelly loved her daughter and wished her grandchildren well.

Kelly emphasized that it was her daughter's decision [(*joj pes avkes rozhodnindža*] to get married and have children so early in life, and therefore it was she who should bear the consequences (see Chalmiers, 2020). In Kelly's understanding, by making these decisions, Vanilla went against the values her mother imparted, and already during her first sexual encounter she must have known the potential ramifications of her actions. In Kelly's view, when she opted to have sex Vanilla chose to stop being a child and she renounced the protection and support that she would otherwise be automatically entitled to from her family. Choosing to have sex with a boy meant that her daughter chose the near-certainty of a pregnancy and a new family arrangement. The action of having had intercourse was inextricable from the potential (and indeed almost certain) outcomes of that action. And, at least in conversations with me, Kelly never pondered the possibility that her daughter was simply exploring her sexual curiosity.[16]

Kelly seemed not to take into account that Vanilla was only 13, and she may have been unaware of how babies were made and how to prevent making them during intimate moments with her boyfriend. Within the community, girls who got pregnant too young were the objects of moral disdain. But discussions with 20–30-year-olds who had children when they were 15 or younger showed that reliable information on consensual sex, contraceptive options, and access to pregnancy prevention methods was scarce. With the advancement of the internet and smart phones, teenagers and even young children in Veľká Dedinka sourced most of their information about sexual matters from pornographic content, which was widely available, and mostly showed unprotected intercourse. Children enjoyed little protection from exposure to online porn, and in my observation, parents had limited means for preventing them from seeing it.[17] Although there is no consistent evidence to support the thesis that use of pornography promotes lenient attitudes towards sex (Raine et al., 2020), some primary school teachers and social workers I interviewed drew a strong link between what they considered a higher parental tolerance toward sexually explicit content and children's risky sexual behavior. I witnessed many instances of children's exposure to pornographic visual content and online sexting with strangers.

When hearing Vanilla's version of how her family life evolved, I found it difficult to understand when and where she had made what Kelly framed as a clearly defined decision.

[16]A contextual detail worth considering is that Vanilla's husband was prosecuted for having sex with a girl below the legal age for consent and he was given a conditional prison sentence. He was 16 when they had their first baby.
[17] For the detrimental effects of pornography on children's development in other socio-cultural contexts see Flood, 2009; Mitchell et al., 2012; Zillmann, 2000.

Vanilla was not eager to share many details, but she told me that she got pregnant during her first sexual encounter, and she moved in with her boyfriend's family because her mother threw her out of the house when it transpired that she was expecting a baby. Vanilla's early pregnancy shed a negative light on the entire family, but especially on Kelly, who was thought to have failed as a mother for not raising a girl who chose to remain a virgin [*pativali*] until she reached a socially more acceptable age for sex – an abstract ideal that many girls did not adhere to in practice. In our many conversations about her daughter's situation not once did Kelly contemplate her own culpability in her daughter's reproductive outcome; at least to me she never expressed the idea that educating her daughter about sexuality, consent, or contraceptive options would have been part of responsible parenting. She and her husband had their own unconventional reproductive history to use as a reference point: Kelly was only 14 when she gave birth to their first baby. After the experience with Vanilla, Kelly and her husband may have become more vocal about their expectations for their remaining children at home. Kelly's youngest daughter, the couple's ninth child, once explained to me that she would not marry early [*na džal sig romeske*] like her older sister, and that her father's wish was for her to live with him until she reaches the age of majority [*ačhol paš leste dži avel plnoletno*].

Just like many other women I spoke to, Kelly said she had not wanted so many children. In the case of her youngest daughter (the one who vowed to stay with her parents until she becomes an adult) this was not only retrospective thinking. Kelly recounted the story of how she almost had an abortion to me two times, each time shifting her own agency in the process.[18] Here are the two versions I was able to write down in detail once I got to my field journal, shortly after our conversations. I jotted down the first conversation from my memory the following way:

> Kelly: After [I gave birth to] the [previous baby], I did not get my period [*na chudľom te džanel*]. I went to my gynecologist, and he didn't tell me that I was pregnant. [The pregnancy] had not yet been a month. He is stupid [*dilino*]. He gave me some kind of injection [*kajsi inekcia*], to bring on my period.
>
> Edit (confused): Wait, but for what reason … ?
>
> Kelly (firmly): So. He gave me the injection, I came home, and I felt very unwell. Oh dear [*jaj mamo*] … But [the fetus] did not go away [*na odgejľa*]. God did not want it to.

[18] Or was this "Gypsy speech"? Cecília Kovai termed this the situational dependency of "Gypsy speech": people's opinions seem to fluctuate and there's a lack of consistency. For instance a mother exclaiming that she "wouldn't want her daughter running around with half her pussy showing so that everyone" in the settlement "would be talkin' about who fucked her," and then shortly afterwards stating that she "let the young ones dress as they please" (Kovai, 2010, p. 108).

It is unclear what Kelly meant by getting an injection so her period would return – to my knowledge there is no abortion injection in Slovakia, and only abortion pills are available. It is also highly unlikely that a gynecologist would administer an abortion injection without her knowledge, although Romani women had been subject to illegal or forced sterilization by medical professionals for decades (see Chapter 2). In any case, my point here is not to determine the truth content of her story, but to dissect the ways she framed her agency in her reproductive outcome. In this narrative, Kelly was on the receiving end of events – in her account she went for the check-up not to find out if she was pregnant because she did not get her period. She said that her doctor was not competent enough to determine the pregnancy, yet for reasons that Kelly did not question in her narrative the doctor decided to administer an injection that would make her get her period. Kelly did not suggest a malicious intent from the doctor's side, and the injection was simply supposed to restore her normal reproductive functioning. It is only at this point in the conversation, by not questioning the doctor's actions, that Kelly admitted to being aware of a causal relationship between getting one's period and aborting a potential pregnancy. God figured in this story as a force that overwrote the doctor's (and perhaps Kelly's) plan: God clearly knew about the pregnancy and actively intervened to save it. Unlike Kelly, God seemed to have a clear plan.

When she told me about this pregnancy the next time, she framed it the following way: "I wanted to have an abortion performed [*kamavas peske potrat te del*], I had me an injection [*diňom peske injekcia*], but it didn't work". Unlike before, in this account Kelly was a resolute agent in ending a pregnancy she clearly did not wish to carry to term; she made an active effort to steer the direction of the events. She made up her mind to have an abortion, and she found the method and the financial means to have one. The doctor who performed the abortion was wholly absent from this narrative, as was God's intervention. It was the erratic workings of biomedical substances on her body that decided that in spite of Kelly's actions, the pregnancy did not terminate.

In the narratives Kelly shared with me she employed *retrofitting agency*, a concept that Charis Thompson (2005) used in her influential book *Making Parents: The Ontological Choreography of Reproductive Technologies.* The term serves as a framework to understand how women reformulate their agencies based on the differential outcomes of fertility treatments they are undergoing, and it discusses their retrospective evaluations of reproductive healthcare. While Thompson's informants underwent fertility treatment because they very much wanted children, I use it the concept of retrofitting agency here to parse Kelly's interpretation of what happened when she didn't want a child. In this narrative, she deployed various interpretations of reproductive intent that she, her doctor, her body, or God wanted. The narrative re-negotiation of reproductive outcomes, and the diverse ways of rearticulating

reproductive agency took place in many other discussions I had with friends in the settlement. This fact initially posed a methodological conundrum for me: did my informants feel pressured to deny their childbearing intentions to me, just like I felt I must express my willingness to have children in words that were more explicit than my actual momentary fertility ambitions? As the weeks spent in the field became months, I was increasingly persuaded that this is not a case of informants lying (see Long et al., 2009).

Managing Fertility

My informants could envision a trajectory of not having more children, but they could not know (as, according to their logic, only God knew) whether that trajectory would turn out to be achievable for them. Reproduction was neither fully in the hands of individual women, nor fully in human hands. In fact, another frequent answer to my question of how many children individual women still wanted was that they will have as many as God shall give them [*keci o Del dela*]. Religious and spiritual beliefs on reproductive trajectories have been researched by anthropologists across various cultural settings (Bledsoe, 2002). Seeman et al. (2016) conducted ethnographic research with homeless African American mothers who claimed that their pregnancies were unintentional and, in some cases, directly resulted in them becoming homeless. Nevertheless, in connection with the religiously inflected moral worlds the women inhabited, they framed their unintended pregnancies as a “blessing” in their lives. Rather than deciding for a pregnancy, the women Seeman et al interviewed “resist having to decide” about them (2016, p. 31). Human agency in influencing one’s reproduction is limited and must make way for the plans and purposes of God’s intentions (2016, p. 35). Religion and spirituality appear not as institutionalized, doctrinal subjects, but as vernacular ethos, whose agency in shaping women’s reproductive paths can and should not be precluded (2016, p. 38).

Roma fertility was not something that could be fully planned or fully controlled, but *gadžo* fertility was framed as a result of rational decision-making aligned with calculated actions. The perception that the Roma were irrational or even erratic in their reproductive decision-making echoed *gadžo* notions around Romani fertility. The difference between the low *gadžo* fertility rate and the high number of children Roma had was brought up in many conversations, in which Romani fertility was described by my informants as less rational (yet, paradoxically, it was also thought to be more economically calculated).[19] Kira’s older brother Trabant had three sons, the second of which married 18-year-old Whitie [*Parni*] during my time spent in the field. Whitie later introduced me to her own family and I spent a good deal of time with two of her seven siblings. Whitie’s sister Ornella and her husband were in their early

[19] On the economic aspects of childbearing, see Chapter 2.

twenties. They had three children under 4 years of age; the youngest baby was only a few months old when I got to know them. The family lived in a wooden hut which consisted of a small kitchen and a slightly larger bedroom. It was located close to the bank of the creek and was constantly threatened by erosion. A conversation between Whitie's sister Ornella, her husband, and me centered around, once again, the reasons why I did not have children (recorded in my fieldwork journal based on a recollection):

> Ornella's husband: Well, what do I know… The *gadže* don't make children hastily [*na keren kavkes o čhaven, že raz-dva*], like the Roma do. They make them slowly but surely [*polikes a istotne*].
>
> Edit: What do you mean "slowly and surely"?
>
> Ornella's husband: That they have time for children, no? [*Hin len časos pro čhave, na?*]

Ornella and Whitie had very low opinions of *gadžo* parenting techniques. While I often thought to myself that their two older children looked very neglected and one may have had an undiagnosed mental condition, they disparaged the ways *gadže* supposedly ignored their babies' needs. One day I was playing [*bavinel*] with Ornella's baby daughter, calling her little pussy [*pička*] and similar nicknames, much to the satisfaction of my host, who concluded that I know how to handle children. A conversation, perhaps indirectly addressed to me, ensued between Whitie and Ornella (my recollection):

> Whitie: But the *gadže* do not play with their children like this, no?
>
> Ornella: Of course not [*ta kaj*]! They just throw them in the crib and that's it [*Jon ča thoven len are haďocis, a imar*]. They don't like playing with them!

I spent New Year's Eve at Manka's place – she was a friend of Ornella's sister, who became one of my main informants in the field. She and her husband had a two-bedroom apartment in the block of houses [*bytovka*] built with European Union sponsorship – on the outskirts of the segregated settlement. Manka was 30 years old and had three children; her first one was born when she was only 15 years old. After her third surgical delivery she was pressured into getting a sexual sterilization (tubal ligation) at the maternity ward. Manka invited around fifteen adults over to celebrate New Year's Eve together, and many of them brought their children along. Elenka, Manka's sister-in-law [*šogorkyňa*], Puma, Manka's best friend, Manka and I took a break from dancing and went to check on the children in the secluded bedroom. Once again, my friends were discussing the differences between their and my reproductive trajectories. I tried hard to remember the conversation that ensued and recorded it in my journal as soon as possible:

> Elenka (to me): Just look. How old are you?

Manka: One year less than I am.

Elenka (to Manka): Just look at us. You have three children, because they sterilized you [*zaphandle tut*].

Manka: I got me a sterilization [*diňom man te zaphandel*].

Elenka: I'm 25 and I already have four children. And that one (pointing to Puma) … 21 years and she's expecting the third one. Three Caesarean sections, you know what [hardship] that is [*džanes s'oda*]?

Manka: Sure, you bet [*no a sar*].

Elenka (to me): And you are 29 and you don't even have a single child. How is that possible? Your husband doesn't want to have his own children [*na kamel te dikhel peskere čhave*]?

Edit: I guess he wants to, but …

Manka (interrupting): But how smart [*godžaver*] the *gadže* are, no? What do we have children for [*pre soste amenge čhave*]?

Elenka: It's the men … they want them … [the *gadžo*] men are different [*inakšo*].

One needed a supportive partner, a different disposition, and to be smart in order to avoid having many children. The fact that curbing their fertility was an ambition that was difficult for disadvantaged Romani women to fulfill did not mean that women did not actively engage in various contraceptive techniques. Contraception was, especially in financial terms, difficult to access. Therefore, their use was often inconsistent, and religious reasons or pressure from the partner or the extended family to have more children also contributed to Romani women having more children than they declared they wanted to have. Yet once they had at least three to four children (or whatever the desired number of children was) many women used intrauterine devices (IUDs). These were by some thought to cause women's hair to fall out and potentially even cancer (*džungali*), and some users complained about the device's price or the physical inconvenience it caused them. Another method used was deliberate pregnancy loss. Medical abortions were not infrequent, but they were expensive, religiously unacceptable, and morally disapproved of, so other, more subtle, and less effective methods were sometimes resorted to. If they did not use medical methods of contraception, women terminated their pregnancies by non-medical, self-induced abortions to space children apart. These attempts were often framed as a wish to regain one's period, rather than as an explicit intent to terminate a pregnancy. The actions taken could range from drinking large amounts of liquor, carrying heavy things, having children jump on mothers' bellies, or taking a bath in a substance which

was believed to induce an abortion. The intentionality in these actions was gingerly negotiated and not explicitly formulated.

All three of Ornella's children were born by Caesarean section, and Ornella declared that having another surgical birth only a few months after the last baby would put her life in danger. Therefore, she was very worried about getting pregnant too soon. She was afraid of using an IUD due to its alleged effect of causing hair loss or the assumed threat of causing cancer, but other forms of contraception such as pills or condoms were inconvenient for her and her husband, and also very expensive. Ornella said that the only reliable way to avoid a pregnancy was to refuse to have sex with her husband, but she found this hard to implement in practice. The next best option was to use the withdrawal method. This put her on constant edge, and she often worried about not getting her next period. During one of our chats when her sister-in-law was also present, she told me that she had missed her last two periods, and that her husband failed to pull out twice in the in the previous weeks – not too many times, but enough to put her in risk of a pregnancy. The conversation was written down in my fieldwork journal based on my recollection:

Ornella: Well, what shall I do now … [*No ta so kerava ...*]

Edit: Wait, but do you think [you might be pregnant] … ?

Ornella (interrupting): Yesterday I threw salt in the [bathing] water [in the wash basin], and I went in the water. I sat in the hot water. And nothing!

Edit (not understanding clearly): Wait, but what was supposed to …

Ornella: I threw salt [in the water]! (pause)

Edit: So, salt is being used … [to induce an abortion]

Ornella: Nothing [happened]! Those are just beliefs! [My husband] even argued with me. [But] it is early [to have another child]!

Edit: Well, that is true, girl …

Ornella's sister-in-law: Well, what shall she do now [*Ta so kerela akana*], is she to kill the child?! (…) When [the pregnancy] is more months, it's like you murder [the child].

Edit: And like this, at the beginning [of the pregnancy] … it's not murder?

Ornella: It's like you commit a sin [*keres hriechos pre tute*]. You kind of murder [*Murdares avkes sar te bi*].

Edit: Even like this [at the beginning of the pregnancy]?

Ornella: Of course. (Pause) [My husband] would kill me if he found out that I would go to the doctor [to have an abortion]. He just heard that I threw salt in the water … and he wanted to kill me right away.

Ornella explained that she prepared the bath at night, when her husband could not see her, but her own sister gave her secret away to the husband. Not only did she try the hot bath with salt, but she also tried denying the fetus good food. Pregnancy is seen as a time of heightened risk and vulnerability among Roma, and in this state of elevated vulnerability the pregnant woman (as well as her social collective) must actively work towards pleasing the fetus and nurturing it inside the womb. It is believed that women must eat everything they like when they are pregnant, and when the fetus does not get whatever it desires (whatever it sees through the mother's eyes), it may go away. Women may not plan on getting pregnant or want another child, but they are still morally obliged to shape their everyday behavior in a manner that sustains the pregnancy. Reproductive intentionality here is not a singular, discrete event, but a sustained, systematic set of decisions. It consists of actions and behaviors which the pregnant woman as well as the entire community needs to invest in and bear responsibility for in order for the pregnancy to result in a healthy child.

Ornella told me that her husband was observing her, and that he knew she was deliberately not eating the food she liked. If Ornella had wanted to end her supposed pregnancy in a resolute way, she could have tried to borrow money from family and friends to go for a medical abortion. But abortion was expensive, and she was reluctant to carry the emotional and spiritual burden that would have resulted from it. An overnight stay at the hospital would have been hard to conceal from the community. She therefore set in motion an open-ended flow of events – actions which could potentially have different outcomes. Instead of making one specific resolute decision (getting a medical abortion), she activated the potential for the pregnancy to terminate. During all of this, the pregnancy was never confirmed in the first place, and it remained only a possibility against which Ornella's actions took place.

For whatever reason, in the end Ornella got her period, but she said she would still like to have one or two children in a few years' time. Those women who already reached their desired number of children talked about a certain sense of canniness around learning to shape the number of children they had. Kira explained to me that she "*chudľa godži*" [got smart] only after eight children; this comprised both getting to know her own reproductive dispositions (whether she had the propensity to get pregnancy early after childbirth or not) and using various methods of contraception.

Modernity, Mobility, and Responsibilization

Kira's younger brother Tiny [*Cikno*] had seven children when we first met, and the family's economic situation (and hence social standing) improved considerably between 2005 and 2011. The family renovated their house, set up a bathroom with a flushing toilet, purchased a car, and even started taking package holidays abroad. They were unable to take all the children to the seaside hotel destinations in Asia and Africa they visited, so they only took two or three of them – the ones they considered to have the greatest prospect of a future good marriage or a prestigious job. They were only in their early thirties when I first got to know them, yet they only had one more child in this period. Tiny's wife Diana was very open about the fact that this pregnancy was not planned. She talked in length about how children bound her to the house, and how having to take care of them had prevented her from engaging in the consumer activities she enjoyed – activities that now she could finally afford to participate in. She requested that her ob-gyn surgically sterilize her after she gave birth. The family was very religious and regularly went to church and had the priest visiting their house. (However, at the same time, Diana also frequented the local gambling bar and played the slot machine). Diana knew that her Catholic faith and the sterilization were difficult to reconcile, but she took full charge of her reproductive trajectory and proclaimed that this was a matter between her and God. The opportunities that a new type of consumerism opened up to her made her "get smart" and even take on the spiritual burden of carrying a sin. In her case, there was no disjunction between discourse and actions – she did not distance herself from fecundity only in a narrative sense, but she took resolute actions that would prevent another pregnancy. Her reasoning was reminiscent of Hirsch's (2008) concept of grassroots theology. Hirsch defined this as a process of reinterpreting Catholic ideologies in locally embedded contexts to find a justification for certain sexual and contraceptive practices.

Discourses of modernity and the possibilities that are open for young girls in current times also featured in the arguments of women about childbearing. Kira would often educate her teenage daughters, two of whom were pursuing vocational studies and had higher social aspirations than marrying after the end of primary school: they intended to keep studying and delay motherhood. I was not a good example as I had been delaying motherhood for too long, but she would sometimes refer to other *gadži* women, such as a hairdresser in town who was 21 and had yet to give birth to her first child, as examples to follow. Fearing that Apricot *(Marhuľka)*, the younger of the two girls, would end up having a boyfriend and become pregnant before she finished school she told her (as I recalled from my memory):

> “What do you want! I was 17 when I married, but you, just go and study, today is a different era [*akana imar inakšia doba*]. Not like us before, when you had children and that was it [*že ca čhave hin tut a imar*]! Go and study so you can get a good job!”[20]

Kanaaheh (2002, p. 165) notes that the putative one-to-one correlation between the number of children a woman has and how modern she is thought to be does not stand up to scrutiny. There are many emotional and psychological dynamics involved in reproductive decision-making; as Kanaaneh’s 8-year-old informant told her: “My mother had me because she wanted to love me” (2002, p. 166). This resonates with the Romani proverb mentioned at the beginning of this chapter – if there are no children, there is no happiness [*nane čhave, nane bacht*]. Yet having too many children did not always result in an increased sense of satisfaction, and it was sometimes equated with being backward or primitive (*zadubimen*). Leading a good life meant rejecting biological determinism, and it implied refusing to constantly suffer from the burden of childcare. Suffering [*trápenie*] was compensated in a variety of ways: some women went for shopping trips or family visits to get out of the house and away from the children, others took sedative pills or anti-anxiety medication because, they said, “children make me nervous” [*chudav nervy le čhavendar*]. Modernity, in the sense of higher degrees of consumerism and social mobility, is framed here as the opposite of *zadubimen* [backwardness]. My research participants both revered and refused the discourses of self-governance, responsibility, and accountability – the three traits closely associated with neoliberalism – with regard to reproduction (Rose, 1999, p.142). Such understandings of decision-making on healthcare issues (and beyond) are characteristic of Western liberal democracies, where, as Nicholas Rose and others point out, making choices and enacting these is not merely an option, but a moral obligation (1999, p. 87).

I woke up shortly after sunrise on a summer day to meet up with Whitie at their yard and accompany her to the *žensko*, the male gynecologist whose office was at the polyclinic in the nearby town. Whitie, who was then 18 years old, was Trabant’s daughter, the newest *bori* (daughter-in-law) in Kira’s extended family, and she had been living with her husband for about four months at this point. She had already been actively worrying about her reproductive capacities and was hoping that the doctor would confirm her yearned-for pregnancy. Her husband was Kira’s older brother’s son; she lived in the same yard as Kira in the back of a shabby one-and-half-room house with her husband, his two brothers (one of whom already had a wife and child), and the husband’s parents. Whitie was fascinated by my frequent visits and my involvement in her new family’s life, but in the first few months of our acquaintance she was very timid. It took months to gain her trust to the extent that she engaged in a genuine

[20] For a comprehensive analysis on the effects of education on Romani women’s fertility, see Adamecz-Völgyi and Scharle, 2020.

conversation with me. After some months passed, she introduced me to two of her sisters (Ornella was one of them) and their group of friends (Manka, Puma, Elenka, and others), with whom I became close. However, on the morning when the events described below took place, my relationship with Whitie was still fragile: the rest of the extended family had known me for years and treated me as a family friend and confidante to varying degrees, yet after months of meeting on a daily basis Whitie would still sometimes ask me if I was a journalist. Each time, I hoped that I had sufficiently explained the reasons behind my presence in the settlement and in their yard – until she asked me again. Still, on one summer day we chatted about her plans to visit the gynecologist into whose catchment area she fell, and she agreed that I could accompany her.

Against my best – but apparently awkward – efforts I must have failed to convince Whitie that I did not plan to be present during her pelvic exam, and that my aim was merely to have a separate talk with the doctor about his views on the reproductive health issues concerning Roma. On the way to their yard, I unexpectedly encountered Marika, Whitie's mother-in-law (Trabant's wife). She told me Whitie canceled her plans to visit the *žensko* that day. Perhaps sensing my disappointment that the trip did not work out for me (although later that day I found out that it actually had for Whitie), Marika proposed that I follow her and her younger son who was about 15–16 years old to the pediatrician. I am failing as an ethnographer, my informants do not trust me (Hamal, 2020) – I ruminated all the way to the pediatrician's office, until I experienced the most illuminating public conversation.

As we reached the office before 7 a.m., we joined a group of seven to eight Romani mothers who were waiting outside the gate with their children. Marika, her son, and I found ourselves in the middle of an animated discussion. The women present were discussing an extremely slender Romani woman who must have been in her late thirties and who brought her newborn baby, tightly swaddled in a warm blanket, for the first post-natal pediatric checkup. The other women were stupefied when she admitted that this baby was her twelfth child. Already the twelfth? That's too many! The mother of twelve was visibly embarrassed and buried her face in the swaddled baby as the group of women discussed her reproductive path. The group's verdict was unequivocal: twelve children are too many. Marika commented that the mother was visibly lean [*šuki*], suggesting her health was frail and her body was worn out from successive pregnancies and deliveries. Another woman remarked that even the woman's older children thought their mother had too many children, and that they were ashamed of her. Allegedly, they had been heard saying in public that they did not wish to have more siblings – or at least this was an assertion which no one contested. Yet another discussant volunteered her opinion: with so many children in the house you don't even see how the maternity benefit disappears, as the money is barely enough to cover the baby's most basic needs such as

formula, clothes, and diapers. Marika confronted the mother of twelve, saying that she should have had an IUD inserted to prevent further pregnancies if she already had so many children. The mother gave a meek, phlegmatic response, indicating she did not wish to divulge the details of her contraceptive habits, or to be the target of the group's flagrant disdain for failing to prevent another pregnancy. Someone stepped forward to say that the mother of twelve may not have had the financial means to cover the costs of the IUD, but others quickly brushed this argument off. A woman commented that it is financially much more advantageous to pay for the IUD than to have another child. What is she going to do with all those children anyway? Marika opined that having so many children translated to much suffering for the mother, but another woman retorted: God gave the pregnancy to her! So what if he gave it, said Marika, when he also gave the IUD for women to use. Too much suffering for the mother is what all those children were! Once we were allowed into the pediatric waiting room, Marika whispered in my ear, in a condescending tone, that I should glance to the side: over there the mother of twelve was sitting with her daughter-in-law [*bori*], whose child was older than the mother-in-law's youngest baby. Overhearing Marika's words, a Romani woman I did not know turned to me and said: So what if the *bori* has an older child!? According to Marika, well, that's *bari ladž* [great shame]. The woman claimed it was not *ladž.* What shall she mother of twelve do now that she has already given birth to the baby [*akana imar so kerela*]? The baby will grow up without her even noticing [*vybarola lake sar nič*].

According to the women involved in the conversation above, the reproductive choices the mother who had brough her twelfth child to the pediatrician's first check-up made may have been ambiguous, perhaps against her best interest, or even unsound. Yet her critics were willing to take into account a variety of zigzagging processes and factors. The fact that she had her twelfth child was not so much interpreted as a result of an intentional choice, but rather as an outcome of the mother not having made other choices. The discussion was heavily moralized, but it was also framed by the mother's current reality in which the baby was constructed not as a burden, but as instrument with an inborn capacity to self-cultivate. The comment "What shall she do now?" [*akana imar so kerela*] was not so much a fatalistic statement about a present that cannot be changed, but the acknowledgement that the future is unknown and thus, perhaps, could turn out to be good.

Conclusion

Anthropologists who research reproduction especially in underprivileged, poor socio-economic settings have shown that reproductive decisions are not clear-cut categories (Greil and McQuillan, 2010). They are not made by individuals, but are nested in social relations (Gammeltoft, 2014), and they are not so much the fulfillment of an articulated intention as a

response to a current life situation (Johnson-Hanks, 2005). Women employ strategies and make plans about their fertility, but at the same time they also actively respond to any changes in their plans (Cornwall, 2007). Classifying pregnancies into planned, wanted, or intended (or their opposites) does not accurately reflect the complexity of social realities (Seeman et al., 2016; Bledsoe, 2002).

Family formation can be the result of many divergent strategies and my Romani informants had a tendency to value larger families over smaller ones; yet, ultimately, reproductive (like any other) agencies are always intermingled and power complicated. My aim here was to disclose the messiness of these entanglements. The high fertility rate of disadvantaged Romani women is juxtaposed in this chapter with their everyday sense of precariousness and a life marked by discrimination and poverty. Poor Romani women's statistically high fertility outcomes are compounded by a multiplicity of converging, often conflicting circumstances and individual subjectivities co-produce reproductive outcomes along with a variety of other forces. This chapter unpacked both the narrative that presumes that women are fully autonomous agents of their reproductive destinies and the one that presents them as victims of their fertile capacities. Reproductive agency is embedded in relations of power, gender, kinship, economic uncertainty, as well as bodily caprices, contraceptive issues, and religion. Zigzag processes, characterized by disparities, rather than unidirectional ones, are at work. Often, it is not that women's intention to curb the number of their children is lacking, but that other factors come in the fore which co-opt the desire to have fewer children. In spite of (or perhaps due to) the high fertility rate in the settlement, there is a social aspiration among Romani women to represent themselves as modern, autonomous reproductive agents who can take advantage of family planning techniques. And although it is still culturally mandatory for women to have multiple children, they also experience similarly strong pressures to exert agency over their reproductive capacities and actively control their fertility.

For some of the women who declared their disinclination to bear more children, it seemed more important to state this intention than to reach the stated outcome. Within this logic, intent does not always have to be followed by consistent action – one can declare not to want more children and at the same time be sexually active and use limited contraception, or perhaps none at all. Stating the intention of not wanting more children asserted control over one's life in the face of an unpredictable socio-economic reality and convoluted family relations. The publicly stated reproductive intent served as a reference point not about the woman's actual future reproductive outcome, but about her present disposition as a governed self. As in all social realities, there is much room for inconsistency.

In connection with reproductive outcomes, the societal discourse in the settlement evolved around the agency and responsibility of Romani women. Prestige and aspiration are attached to *gadže* norms and lifestyles with respect to reproductive matters. Romani women are also seen to be capable and empowered enough to make their own fertility decisions, but individual and structural issues, such as financial constraints or individual distaste for available contraceptive options are acknowledged. The community did not fully adopt a neoliberal responsibilization narrative, but modernity and consumerist choices were prominent values that influenced reproductive decision-making. Responsibilization is present as a framework that emphasizes the importance of avoiding or decreasing suffering in life, an after a certain number of children there is a moral obligation for self-care.

The following chapter will foreground the fact that different rationalities and notions of responsible reproduction circulate both within the settlement and on the level of the state. It is not only many disadvantaged Roma who wish for there to be fewer Romani babies, but also the *gadžo* majority. Roma living in segregated settlements may be overlooked as political citizens, but in a context where the reproductive rate of poor Roma is several times above that of the majority population they cannot be ignored as reproductive citizens.

3. Valuing Romani Children

The first chapter of this dissertation outlined the heterogenous discourses and contradictory attitudes held by Roma in a segregated settlement in eastern Slovakia regarding fertility decisions. On the basis of evidence compiled during my long-term fieldwork I show that reproductive decision-making among Romani women is entangled in a complex web of relations. While poverty, marginality, and economic considerations powerfully influence the choices women make, the values underlying the fertility-related discourses are at the same time culturally specific and individually contingent. Disadvantaged Romani women (and men) actively engage in dialogue with *gadžo* values and lifestyles, to the extent that reproducing some segments of these lifestyles in the area of fertility choices carries a certain prestige in the settlement. Many of my Romani interlocutors have to some extent appropriated the responsibilization narrative with respect to reproductive choices.

The second chapter nests individual reproductive decision-making in the larger framework of the social and economic value that Romani children carry. This chapter has two major aims. First, it examines what responsible reproduction denotes for the white majority and the state when evaluating Romani and non-Romani women. It engages with the concept of reproductive governance (Morgan and Roberts, 2012), which draws on the fact that state actors and other social stakeholders use legislative and financial incentives, or even coercion, to shape the fertility of certain populations. It understands the former sterilization campaign as an attempt to avert negative demographic (and thus economic) development for future populations. The chapter explores the assumptions inherent in the concept of ”population” and reflects how it is entwined in the “histories of colonialism, governmentality, and capitalism” (Murphy 2017, p. 135), and it shows how these shape population (and Roma fecundity in particular) as a “problem”.

The second aim of the chapter is to provide an ethnographic reflection on the same issues. The discourse around Romani women’s sterilizations has mostly focused on the illegality and illegitimacy of the practice, and when analysis has incorporated women’s positions, it mostly relied on data collected through qualitative interviews rather than field research. Within these framings, Romani women have mostly appeared as ”victims” or ”survivors,” but not as agents who operate within challenging socio-economic constraints. My aim is to complement the existing human rights discourse with an ethnographic perspective, and to prioritize women’s personal autonomy and lived experiences. The fieldwork data in the chapter focus on the ways sterilizations can either erase or strengthen Romani women’s reproductive agency, depending on the circumstances.

The fieldwork data also explores the contentious relationship between economic strategizing and the impact of childbearing at the family level. I acknowledge that writing about poor Roma, family economics, social benefits (a term I use here in the generic sense to include parental allowance), and fertility is a delicate, perhaps even risky scholarly endeavor. It is an even more taxing venture for an ethnographer who proudly embraces anthropology's leftist legacy in studying populations whose subaltern position is a result of long-term social, historical, and economic disenfranchisement (see Farmer, 2004; Ong, 1987; Scheper-Hughes, 1992). Anthropologists have long made an effort to address the nexus of poverty and exclusion in multidimensional ways. Instead of pointing to single individual causes, ethnographers have sought to provide comprehensive understandings of the factors underlying poverty, and the structural forces that shape social and spatial marginalization (Bourgois, 1996 and 2009).

Romani Children Meriting Attention

The ideas that children are central to a society's engagements with possible futures and that they are objects of people's hopes is neither new nor specifically tied to Romani cultures. Yet childhood as a category has always been historically contingent and defined by certain social processes. Based on her long-term ethnographic research with young mothers in Cameroon, Jennifer Johnson-Hanks (2002) even argues against the need to define what, exactly, constitutes childhood. Johnson-Hanks opines that the analytical focus should not be on defining life stages, but instead, on understanding "vital conjunctures," which bring to light the ways individual aspirations intersect with societal institutions in loosely-bound, fluid ways. In her edited volume *The Routledge History of Childhood in the Western World*, Paula S. Fass and her contributing authors (2012) give a detailed account of the shifts that occurred in the Western World's perceptions of what constitutes childhood in divergent historical eras. Childhood as we know it today was largely formed by the socio-economic changes that took place in Western societies in the late 19th and 20th centuries, and it is closely intertwined with changes in economic production processes. In her influential book *Pricing the Priceless Child* (1985), sociologist Viviana Zelizer pointed out that this shift in perception was accompanied by a distinctly class-bound understanding of the value of children: the idea that children were "sacred" initially resonated with the middle class. Children were viewed by the lower classes as agents of production, whose contribution to the economy of the household was vital before these social classes gradually embraced children's non-economic value. At the same time, children started to be understood in social welfare terms, as vulnerable beings who require adults to protect them, and whose lives are to be constrained and regulated by age-appropriate measures. Compulsory schooling emerged as a key child protection measure (also see Lassonde, 2012).

International discussions on Romani children have been strongly influenced by the idea that the state must exercise certain constraints over their appropriate development, especially in the past two decades. Even though since at least the Enlightenment much of the attention paid to Romani children has been paternalistic if not downright oppressive (Kubanik, 2017), today transnational organizations exert an increasing pressure on national governments to recognize the key importance of Romani children's education, and the ethnic group's increased involvement in society (Council of Europe, 2021). Influencing reproductive outcomes plays a significant role in this effort. Romani teenage pregnancies have generated some scholarly attention, especially in connection with their inability to finish compulsory schooling. Political analysts in Hungary emphasize that raising the compulsory school leaving age decreases the incidence of Romani teenage pregnancies (Adamecz-Völgyi & Scharle, 2020). Social health researchers in Slovakia point out the lack of access to contraceptives and insufficient sex education, as well as a "different lifestyle and cultural traditions" (Ludvigh Cintulová & Radková, 2018, p. 108), as causes that factor into Roma girls' active sex life before they reach 15 years of age (the legal minimum for consent) and their early pregnancies. Within the field of Romani studies, scholarly attention in connection with children also largely centers on schooling and socialization (Tauber, 2004), or children as the foundation for new kinship arrangements. Based on her ethnographic research among Hungarian Gypsies, Kovai (2010) proposes that the common child is the center of gendered relations, as it is through having a child that a man becomes a husband and a woman becomes a wife (p. 120). The child is not primarily regarded as a personality, but as a figure through whom kinship relations are delineated and solidified. In connection with children, transnational non-governmental organizations such as the ERRC (European Roma Rights Center) mostly engage in research, advocacy, and litigation efforts in the areas of school segregation, police brutality against children, inequalities in healthcare (ERRC and Center for Civil and Human Rights, 2016; ERRC, 2017) and Romani children's over-representation is state care institutions (ERRC, 2011). For the governments of Eastern and Central Europe, Romani children have historically constituted a predicament because Romani births are viewed as negative in their value (Murphy, 2017, p. 42).

Competing Demographics

In spite of some regional differences, Europe has undergone an overall fertility decline in the past few decades, and the former Malthusian concerns about the population bomb (Hartman, 1995) were replaced by anxieties over a population "implosion" (Douglass, 2005). Central and Eastern Europe are no exceptions to this trend, and since the end of the communist period, Czech and Slovak policymakers have expressed concern about the birth rate (Nash, 2005; Hašková & Dudová, 2020). The idea of the demographic "crisis" continued

to the 2000s both in the Czech Republic and in Slovakia, and according to World Bank data, the fertility rates in 2020 stood at 1.7 children and 1.6 children per woman respectively. As elsewhere in the Central European region (see Mishtal, 2012), birth rates below the replacement level have been associated with shifting gender relations, changes in the labor market, and difficulties in adjusting work-life balance under neoliberal capitalism (Dudová et al., 2020; Klímová Chaloupková & Hašková, 2020; Potančoková et al., 2008).

In this context, much popular and policy attention – but little empirical research – is concerned with the reproductive rate of Roma, whose birth rate in Slovakia is several times higher than that of ethnic-majority Slovak women (Potačoková et al., 2008, p. 991). According to the most recent statistical survey from the Bratislava-based Demographic Research Centre (Vaňo & Mészáros, 2004), the overall fertility rate of Roma in Slovakia was 2.5 times higher than the majority population's, and Roma living in segregated settlements had a fertility rate 4.5 times higher than non-Roma. The researchers account for the differences in total fertility rate using traditionalist and culturalist arguments (2004, p. 10), which anthropologists of demography have identified as problematic (Greenhalgh, 1995). Ethnographic research does confirm that segregation and high fertility are interconnected, but instead of inculpating culture and tradition it suggests that factors such as socio-economic marginalization might be at play. The Hungarian sociologist Judit Durst conducted long-term ethnographic research in two Hungarian Roma-majority settlements (2006). Data collected at her main field site, a strongly segregated Romani settlement, indicated that the fertility rate of Roma women was 3.5 times higher there than the fertility rate of the total population. A different picture emerged at her second field site: at the neighboring settlement where local Roma enjoyed higher rates of social involvement and mobility, the fertility rate was considerably lower than the fertility rate of the Roma living in the segregated settlement.

It is important to recall that not only Roma reproductive choices are framed by states in moral terms, and the idea that there is a competition between ethnic fertility rates is neither new nor limited to the Central and Eastern European geopolitical context. For example, Marchesi (2012) examines the Italian state's disparate expectations toward the reproductive capacities of its ethnically diverse populations, and the competing notions of rationality and responsibility which are evoked within the moral discourses surrounding human reproduction in Italy. She quotes the legal scholar Patrick Hanafin, whose work examined the state's policies and politics toward women who are thought to be making morally wrong reproductive choices. In a twist on the Foucauldian understandings of biopolitics, Hanafin coined the term *vitapolitics* to characterize the state's and the Vatican's effort to reinstate the imagined natural reproductive order (Marchesi 2012, p. 172). Vitapolitics implies a strong pro-life (anti-abortion) perspective fused with traditionalist views on the nuclear family and culturally essentialist,

Christian constructions of European and Italian identity. Marchesi points out two paradoxes present in the Italian state's policies based in vitapolitics. First, religiously informed concerns over the protection of the embryo lead to a situation in which in a country with extremely low fertility rates heavily restricted access to assisted reproductive technologies in the 2000s. In 2004, Italy passed one of the continent's most restrictive laws with respect to assisted reproductive technologies; however, the law was gradually dismantled over the following ten years (Riezzo et al., 2016). Secondly, while the state views ethnic Italians' low fertility rate as a serious demographic concern requiring overt pro-natalist interventions, immigrant women's high fertility is regarded with disapproval. Marchesi characterizes the state's demographic concern over the high Italian abortion rate coupled with a low birth rate as "replacement anxiety," implying that the Italian nation is being replaced by immigrant populations. As their reproductive behavior stands in opposition to the state's expectations, both ethnic Italian and immigrant women are discursively framed as irresponsible, immoral, and irrational – the former for having too few children, the latter for giving birth to too many children (Marchesi, 2012, p. 173). It is a framing that both ethnic Italian and migrant women actively contest and resist (2012, p. 182).

Israel and its demographic policies provide another example of the state's demographic anxiety, leading to state-led efforts to "counterbalance" the high fertility rates of Arabs with intensive efforts to increase the Jewish birth rate (Steinfeld, 2015; Weiss, 2002). Precarious socio-economic futures and increasing inequalities are intertwined with and galvanized by demographic anxieties, which constitute an instrumental part of reproductive governance (De Zordo et al., 2022).

Although in Slovakia ethnically segregated data are still unavailable or unreliable, many municipalities keep informal statistics on the number of Romani children born, and the anthropologist David Scheffel argues that some do so with governmental support (2005, p. 26). Almost every entry of the village chronicle[21] of Veľká Dedinka, which was started in the 1950s, contained accounts of the local population's ethnic profile, and the number of Roma were clearly denoted. Ethnically segregated data was even available on library visitors, and there are records indicating the number of books that Slovak majority versus Romani readers borrowed. Wherever a discussion of the annual birth rate appeared, it was accompanied by a comment on the number of Romani children born. From the 1960s on, the chronicler indicated a higher fertility rate for Roma than for *ostatní* or *bielí* ("other" or "white" people), and starting in the 1970s the chronicler expressed that more consistent efforts were needed to bring down the Romani fertility rate. The percentage of Romani inhabitants, who became the ethnic

[21] Due to ethical concerns, I am unable to provide extensive direct quotations and precise citations from the village chronicle – this would render my main field site recognizable.

majority in the early 1970s, was calculated, and according to the chronicler the increase in the Romani population in the 1980s contributed to ethnic Slovaks moving away from the village to more urbanized settings. The late 1980s witnessed the development of open inter-ethnic tension, and there was even village talk of “getting rid of” and “liquidating” the Romani population. The chronicler reminded the reader that such talk was unworthy of Christians and that *prevýchova* (a term denoting undoing parental upbringing and substituting it with different value systems) was needed. The 1990s brought a clear Romani majority, with Roma children representing two-thirds of those born there, and after the mid-2000s only a few babies with Slovak ethnicity were still being born in the village. The issue of Romani “overpopulation” was constantly raised in my conversations with village people, authorities, and social workers.

Sterilizations With or Without Consent: Romani Women are not Cucumbers[22]

During the era of state socialism Eastern and Central European countries adopted differential positions toward reproductive choice and contraception (Gal and Kligman 2000, Heitlinger 1987), and while countries such as Romania fully outlawed abortion (Kligman 1998), it was legal in the former Czechoslovakia from 1957 onward. The Czech sociologist Radka Dudová (2012) reminds that this did not happen so much in response to the women’s rights movement, but because medical experts argued that the high number of illegally performed abortions had grave consequences for women’s health (p. 132). From the state’s perspective, women needed safe abortions not in order to protect their reproductive capability, but because the society needed them as healthy mothers for their healthy future children (Dudová, 2012, p. 136). Dudová notes that the state’s pronatalist policies were strongly intertwined with a governmentalist approach, and medical experts required women-as-future-mothers to both succumb to state intervention and use technologies of the self to manage their fertility. Managing Roma women’s reproductive outcomes was central to the state’s governmentalizing efforts (p.139). The fact that these efforts were framed by medical professionals and thus based on scientifically established parameters was supposed to guarantee that the state could not be accused of being racist or discriminatory.

In the past few decades in the Czech Republic, Slovakia, and beyond, reproductive healthcare institutions became the prime sites of injustice for disadvantaged Romani women, and the fight for reproductive justice is an ongoing, active struggle. The earlier Czechoslovak government’s pronatalist population policies had not been applied universally to all demographic segments, but this in itself was not a unique or surprising phenomenon. As

[22] The slogan “Sterilize cucumbers, not women” (Sterilizujte okurky, ne ženy) appeared on a banner that a handful of Romani demonstrators held up at a Roma women’s protest in the Czech Republic. See Rorke and Szilvasi, 2017. “Sterilization,” in the case of cucumbers, refers to making pickles.

Ginsburg and Rapp emphasize in their groundbreaking 1995 edited volume *Conceiving the New World Order: The Global Politics of Reproduction*, reproduction is always a stratified phenomenon, and those in power prioritize the reproduction of certain populations over others (1995, p. 3). The Czechoslovak population discourse was more explicit, however, in stating a hierarchical order of ethnicities, and Roma occupied the lowest rung in the social ladder (Sokolová, 2005). Disadvantaged Romani women were not only discouraged from having more children by providing them with financial incentives for getting surgically sterilized, but some Romani women were even coerced into consenting to sterilization, and others were sterilized after they gave birth without their knowledge or consent.

The first thorough investigations into the illegal and/or coercive sexual sterilization of Romani women began after 2003, when the Slovak NGO Centre for Civil and Human Rights [Poradňa pre občianske a ľudské práva] and the US-based NGO Center for Reproductive Rights released their report *Body and Soul: Forced Sterilisation and Other Assaults on Roma Reproductive Freedom on Slovakia*. This report was preceded by several other (much less known) publications that pointed toward highly problematic practices by Czechoslovak medical professionals. The most prominent of these was released by the dissident group Charter 77. They were the first to point out, in Document No. 23, that Romani women were sterilized by Czechoslovak doctors with the explicit aim of eliminating the Roma population and “solving” the “Gypsy problem”. The authors of the document demanded that official charges be brought against certain authorities who participated in promoting this practice, and accused the state of engaging in an intentional genocide against the Romani population.[23]

In 1989 Ruben Pellar and Zbyněk Andrš organized the first field research to determine the extent to which Romani women underwent sterilization in the 1967–1989 period, and they concluded that financial and material incentives given to Romani women who opted for sterilization greatly increased women’s participation in the program.[24] The practice was further documented by Helsinki Watch (Tritt, 1992), the predecessor of the NGO Human Rights Watch, which launched an investigation into the issue based on their observation that an unprecedentedly high number of Romani women who arrived as asylum seekers in Finland were reproductively sterilized. The 2003 publication of the *Body and Soul* NGO report prompted Czechoslovak state authorities to truly explore the history and presence of the sterilization practice and to respond to accusations of genocidal intent for the first time. Based

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[23] For a detailed description of the document’s content see the former Czech Public Defender of Rights’ official position paper (Motejl, 2005). Cahn’s 2015 book, written from the perspective of a human rights lawyer, gives a minutely detailed account of the history of all research efforts, and subsequent policy implications and judicial proceeding both in Slovakia and the Czech Republic.

[24] The report is unpublished, but it contents are discussed in detail in both in Motejl 2005 and Cahn 2015.

on interviews with both Romani women from disadvantaged backgrounds and Slovak ob-gyn practitioners and hospital staff, the report alleged that the practice of coercive sterilizations did not die with state socialism, but was actively practiced in certain maternity departments of hospitals where a large number of Romani women went to give birth (also see Sokolová, 2005).

The report received unprecedented international attention and it was impossible for authorities not to respond. Slovak authorities threatened the authors of the report as well as some research participants who were sterilization victims with criminal prosecution (Cahn, 2015, p. 61). Although an investigation was launched, it contained serious procedural flaws (p. 63). In the Czech Republic, the Budapest-based European Roma Rights Center (ERRC) conducted field research and arrived at the conclusion that potentially until as late as the early 2000s a handful of Czech maternity wards still participated in maintaining the practice of coercive sterilization of Romani women. While the Slovak Public Defender of Rights largely remained silent on the issue, Otakar Motejl, the Czech Ombudsperson, launched a research effort that culminated in the publication of a 2005 report and position paper. This established that the consent some Romani women provided to surgical sterilization was neither free nor informed, and in some cases it took place under considerable external pressure (for details see Cahn 2015, pp. 84–91). Criminal proceedings were pursued at Slovak and Czech courts, and later the European Court of Human Rights, and the Council of Europe and the UN Committee on the Elimination of Discrimination against Women also got involved. However, it was not until 2021 when a collective compensation method was launched which was available for all victims of coerced sterilizations in the Czech Republic. In Slovakia, to date, financial compensations have only been awarded in individually litigated cases.

The shifting rationalities prompted by rights-based actors prompted the formation of a new moral landscape around Romani women's reproductive rights. Cahn points out that the utilization of international law, and advocacy efforts by supra- and international organizations, were instrumental in creating a momentum and making sure that the issue of coercive sterilization were afforded sufficient attention in the countries where they had been performed (2015, pp. 104–105). This international involvement seems to have been of key importance, as for mainstream, non-Roma NGOs the issue was overly racially charged, and for Roma NGOs it was much too narrowly focused on women's rights. With exceptions, the most prominent Czech and Slovak NGOs largely ignored the topic, including NGOs which focus on women's rights. Cahn criticizes the Romani elite for creating a climate in which the sterilization and the subsequent effort to gain compensation was obstructed and utilized by Romani political actors for pursuing their own political agendas (2015, p. 222). In the Czech Republic it was left to a handful of activists to purse the issue of coerced sterilizations and the subsequent campaign for financial compensation for survivors (see Albert, 2019).

In both in the Slovak and Czech contexts, deliberations on informed and free consent to medical procedures before, during, and after birth are burning human rights issues that exceed racial (or gendered) boundaries. With respect to coerced sterilizations, the extent to which the practice was limited only to Romani women remains still unclear. Little doubt remains about the fact that the sterilization campaigns of the 1970s and 80s were ethnically marked and primarily targeted poor Romani women, but as the Czech Ombudsperson's 2005 report documented. 1,989 financial incentives were paid to 803 women to undergo voluntary sterilizations, and only somewhat more than half of these were Roma (2005, p. 30). At present, there are no indications that other than Romani women were subject to coerced sterilizations since the 1990s, but to my knowledge no stakeholders are involved in the further exploration of this issue.

Forced or coerced sterilizations are a global phenomenon that concern poor, racially marked, or disadvantaged men and women in various geopolitical settings. Led by eugenic ideas in the first half of the 20th century, American policymakers and medical professionals actively endorsed the reproductive sterilization of poor, and often predominantly Black, men and women (Kluchin, 2009). In Puerto Rico, an American colonial legacy of control over women's bodies resulted in the highest sterilization rate anywhere in the world: between 1930 and 1970 about one-third of women of childbearing age underwent the operation, many of them against their will (Lopez, 1997). Internal armed conflict in the last two decades of the 20th century resulted in the forced sterilization of many indigenous Peruvian women (Carranza Ko, 2019), and poor women were also the targets of systematic family planning efforts in Haiti (Maternowska, 2006).

Children, Household Economics, and the Potentialities of a Good Life in Kira's Family

Ten days were left before the next monthly benefit check, which represented a combination of social benefits, child allowance, and activation work allowance,[25] was scheduled to arrive to the post office to be collected by the beneficiaries, and Kira's family – the people I was closest to in my main field site of Veľká Dedinka – was out of cash. Like most families in the settlement, Kira was burdened with a combination of personal debts owed to loan sharks, to extended family, and to her cell phone service operator, and she had been buying food in the local grocery shop *pro pačaben* [on credit] for a while now, much to the annoyance of her husband Markus. From time to time Markus worked under the table on

[25] For a critical assessment of the activation work scheme targeted at the long-term unemployed (many of whom were Roma), see an evaluation of the European Social Fund Programmes for the period 2007–2013 (Škobla et al., 2016).

seasonal jobs arranged by local Romani men with connections in the construction industry. On the days when he came home from work, Markus, who otherwise talked almost only when he was drunk, gave a profuse account of his workday, to the extent that he became a target for the family's jokes about his self-professed Stakhanovite performances. On most other days – when there was no work – Markus drank and loitered around the house complaining that there was nothing to do [*nane so te kerel*]. The last two weeks before the main monthly income arrived, the tension in the family was palpable. Kira and I went to the post office two days before the due date for the money to check whether it didn't happen to come early, but there was no flexibility in the date. When her eldest son came home Kira asked if he had bet on sports [*diňa stavka*], hoping for some cash inflow. The family's social networks were exhausted, and I had already borrowed all the cash I could spare for that month to help my other close informants. It was wintertime and there was no more firewood in the house, and it made no sense to collect wood illegally from the nearby forests because it had been raining for the past few days and the wood was wet. So Kira pulled out the drawers to select out clothes her family members could spare; then, in lieu of wood, she stuffed the clothing into the stove. She got into an argument with Apricot, who was unwilling to let go of a pair of pants, although Kira claimed her 16-year-old daughter almost never wore them. The secondhand clothes one of Kira's brothers had recently acquired from a Red Cross distribution were also burned as heating material, and the room gradually warmed up. But, because many of these items of clothing were made from synthetic fabrics, they left a heavy chemical smell in the room that irritated our throats.

After ten days, the money arrived and we went to the nearby town for a shopping spree. Kira, Apricot, two of Kira's smaller sons and I took the bus along with many other Roma from the settlement who were also doing their big monthly shopping trip. All of their staple foods were bought at the big discount supermarket, and afterwards we treated ourselves to a hamburger at a standing buffet next to the station (on other occasions, we went for something to eat at a Chinese restaurant). Apricot was cross with Kira for how much she had spent: she turned to me and said, in reference to her mother, "Jesus, whenever she has money she wastes all of it" [*sar la hin love sa rozkerel*]. My friends expressed that there were *pherdo Roma* (too many Roma people) at the bus stop, so we moved away a little to the side. Kira explained that she was disgusted of the odor in the bus when it is overloaded with Roma – those from other settlements can be very dirty, she said. We got home and invited one of Kira's married daughters over to show off the products we had bought and to chat about discounts. Sandwiches were prepared with various sophisticated spreads, and extended family members were invited over to have a bite.

I found it difficult to understand and even much more complicated to verify what sources made up Kira's monthly family budget. She told me that in a normal month the family of seven lived on 400– 500 euros, but this amount kept changing, depending on whether Markus had any short-term jobs as well as on who else was living with the family that month. At one point, the possibility of Kira getting a cleaning job at the local school emerged and she got very excited by this prospect. It would have provided her with the opportunity to leave the house and be involved with the world outside of the settlement – employment contracts carried high prestige. This was Kira's dream job: the work was easy, the hours were short, and allegedly one spent much of the time just drinking coffee with coworkers, including *gadže* coworkers, in the school basement. Kira had put a great deal of effort into mobilizing her connections in order to get the offer. But when it finally materialized, Markus made a quick calculation and came to the conclusion that it was not worth it for Kira to take up the position. A regular salary on minimum wage would mean that the family would officially no longer qualify for material need [*hmotná núdza* in Slovak] and the children's school stipends would be cancelled. Overall, Markus calculated that their monthly budget would decrease. From a financial perspective, it would only have made sense for Kira to start wage employment if her husband also had a legal job earning at least the minimum wage. I tried to argue that Kira could perhaps still take up the job because the years spent in paid employment would allow her to qualify for a pension when the time came. But my reference to an imagined future financial security in old age was unimpressive compared to the prospect of an insecure present in which the authorities could "*začharen amenge o love*" – stop paying the family's benefits. Economic scarcity and the lack of employment and social involvement opportunities meant that Kira decided against taking up the position.

The occasional jobs Markus picked up provided no stability and his wages were often spent to cover what Kira owed to various people (there were usually high interest rates involved). Money was particularly tight when the oldest daughter temporarily separated from her husband and moved back to her parents' house with her newborn and toddler. There was also no space in the one-room house, so not only did two people share single beds, but several mattresses were laid down on the floor for the night. Kira complained – as did many other informants of mine who were mothers – that children were very expensive. Babies were thought to be particularly costly, as they needed pricey, specialized products like formula and diapers that could not be substituted with anything else. In a marginalized environment economic scarcity and labor market exclusion lead to a situation where family benefits were the only reliable source of income. Child allowance, and in particular parental benefits (a sum disbursed over 2–4 years after the birth of the baby to one of the parents regardless of employment status) constituted a stable income. It was clear that child allowances made up a

considerable part of the family budget, and that in her family, as in many other families in the settlement, they were considered to be the main, or at least the most reliable source of income.

The link between a potentially better quality of life and the number of children a couple had was being discussed by Kira and her husband one afternoon when Kira was particularly exhausted from caring for her eight children – five of whom still lived with the couple in their one-room hut. The house was filled with needy children, and at one point in the afternoon Kira exploded, exclaiming: "We should have had just had three children!" in front of the whole family. Her husband brought up the story of how, motivated by a financial incentive, Kira signed up for voluntary sterilization at the end of the 1980s but ended up absconding from the hospital out of fear of the surgery. At that time, the couple were in their early twenties and only had their first three children. Upon hearing her parents' discussion, Apricot, their fifth child by order of birth, burst out shouting that, indeed, her parents should not have had this many children if they could not properly provide for them. She held it against her parents that she had to attend the local vocational school where only Roma children went instead of the one in the nearby town. Attending the town's school had more appeal to Apricot because it would have allowed her to commute out of the village on a daily basis, and also because most of her classmates would have been *gadže*. For her, getting an education in the town's school would have been a lifestyle upgrade – she would have had more exposure to the world outside of Veľká Dedinka and more adventure. Upon hearing her daughter's rant, Kira's husband Markus broke down in tears. He said that he was thankful that Kira had absconded from the sterilization surgery, as he would have missed out on the five children who were born afterward. He cried, expressing how much he loved his children, how beautiful and smart his daughters were, and how their toddler brought so much joy into their lives. Apricot kept making sarcastic comments about how love is not enough for one to live a good life [*lačhes dživel peske*].

Reproductive Agency in Relation to Sterilizations in Veľká Dedinka

I am unable to provide a nuanced account of the ways the state-led sterilization effort manifested in Veľká Dedinka without referencing the written records. However, doing so would render my field site identifiable. I will therefore focus here on my fieldwork data from the settlement. A number of women in Veľká Dedinka had experience with the sterilization campaign launched in the 1980s. The extent to which this effort may have been a response to an existing demand for fertility reduction is unclear, but it is possible that some demand had been present. My closest friend Kira, whose story I told at the beginning of this chapter, opted for sterilization after having given birth to three children. She was very clear about the fact that both the sterilization incentive and the prospect of not having to worry about future pregnancies appealed to her and her husband. Kira took full responsibility for her decision to opt for the

surgery, as well as her decision to abscond from the hospital before the surgery would have taken place. She sometimes later complained that she wished she had gone through with the procedure because she ended up being a mother to eight children. She told me of a woman who allegedly underwent the procedure, received the sterilization incentive, and still ended up having children afterwards. In Kira's words, this woman "won" [*vyhrajindža*].

Similarly to Kira, some of my other informants also explicitly stated that the offer of the financial incentive coincided with their pre-existing wish to curb their fertility, and that they had a full understanding of the implications of the surgery for their future fertility options. In other cases, much more ambivalence was present. When I asked my friends if they could recommend some women who underwent sterilization at the time when doing so entailed material incentives as informants, someone took me to see 40-year-old Marcela. She had two daughters and she signed up for tubal ligation after her second birth at the age of 19. Marcela and I had not met before our recorded interview took place, and she was rather shy about discussing her sterilization experience. She recounted that she had heard about the possibility of surgical sterilization from other women who told her that she would receive money if she consented to the procedure. Initially, she mentioned several factors that contributed to her decision. She had had two difficult births and she was afraid of the prospect of another delivery. She received a lot of encouragement from her family, including her husband. The money was also a significant incentive: she received 25,000 Czechoslovak crowns, mostly in vouchers, which allowed her to furnish her little one-bedroom house. This was in 1990, and for this amount she was able to buy "everything that was needed" [*sa so kampol*].

Later on in the interview it emerged that she had been apprehensive about the sterilization surgery and that she absconded from the hospital the first time. The second time, she underwent it and shortly afterward she received the remuneration. Initially, Marcela appeared as a conscious agent in the most important reproductive decision of her life, but later in the interview this picture became more nuanced when I asked what her mother's opinion had been. It emerged that her mother was terminally ill at that time, and she still had eight children at home, for whom Marcela was responsible for taking care of. "She encouraged me [*kerlas man*] to go!" Marcela said, reasoning that Marcela had enough children of her own already. "So I had the surgery done [*me man diňom te operinel*]," Marcela said. After her mother died at the age of 42, Marcela became the primary caregiver for her eight siblings. I asked if IUDs were available to her as an option, but she answered that she was too young at that time to know about contraception.

From a legal point of view, Marcela consented to the sterilization – she was fully aware of its consequences on her future fertility prospects and she was not prevented from absconding from the hospital the first time she signed up for the procedure. But in the light of

her personal circumstances, her decision was intricate and could hardly be characterized as an act of free will. Instead, it was a choice based on a lack of other alternatives. The financial incentive Marcela received after the surgery did not allow her any extravagance: it was just enough for her to furnish her house. Marcela chose financial security in a situation of precarity, and she consented to raising her siblings when the other option would have been to place them in a state care facility. Facing an uncertain future, lacking a benevolent social and child protection support system, and without adequate access to other contraceptive options, she underwent a tubal ligation. Ultimately, Marcela regretted the surgery. She said she and her husband were too young at the time, and she implied that the decision had not been thought through with sufficient care. Clearly her mother's impending death was a significant factor, as was economic strategizing at a time when Marcela was left with eight of her siblings to raise along with her own two small daughters. She was regretful that she and her husband never had a son, and 7 years after the surgery she requested that the tubal ligation be reversed. She said that she "had [her ovaries] opened" [*me mange diňom pale te phundravel*]. She paid for the reverse surgery, but it was not successful and she never had any more biological children.

My informants were very aware of the sterilization scandal that took place in the mid-2000s, and some followed the issue of financial compensation for forced sterilizations. Several women who had problems conceiving another child considered the possibility that they had been sterilized without their knowledge. In at least one case this presumption was not corroborated by the local gynecologist, but my informant said the doctor was *vibito* (shrewd, a liar). Conflicting narratives surrounded the issue of access to sterilizations after the change in legislation. The legislation on the conditions for reproductive sterilization changed significantly in 2004, and the new legislation established a clearer definition of informed consent, including the fact that a written request must be submitted 30 days prior to approval for the procedure. Puma feared that she had been illegally sterilized upon her last delivery, yet she also wished sterilization was more attainable for her. Puma was Manka's friend who had already had two surgical deliveries at the age of 21. Manka and I were once joking that her eldest daughter was already big – she was three – and that it was time for another baby. Puma did not use a contraceptive and she and her husband relied on the withdrawal method, which most women did not consider to be too effective. She jokingly suggested that she was perhaps already pregnant (it later turned out that this was indeed the case). But she also mentioned the possibility that she may have been sterilized at the time of her last birth without her knowledge. At the same time, during a recorded interview she complained that she had requested to be sterilized already during her second delivery at the age of 18, but that she was denied this option, as the doctor told her that she would have needed to submit the consent form prior to giving birth.

Puma was cross that she now had to pay for a procedure that used to be accessible upon immediate request and free of charge. Some Romani women recognized that the legal atmosphere had changed and the doctors were now wary to perform tubal ligation surgeries. My friend Alica claimed that she had asked the doctors to be sterilized during her last birth, but the doctor told her she was too young. Alica said "They don't do it just like that anymore, because [the doctors] were [criminally] charged [*podiňan len*], and they paid a price for it [*poplacindžan pre kada*]." This was technically not true, as no doctor in Slovakia or the Czech Republic has been criminally charged with performing a sexual sterilization surgery without due consent. Tubal ligation as a popular form of contraception has been widely researched by anthropologists especially in Brazil, where women's eagerness to undergo the procedure has been linked to an increased agency to improve their social standing (Dalsgaard, 2004; O'Dougherty, 2008). Edu (2018, p. 558) pointed out that Brazilian women who undergo sterilization receive social recognition as responsible and rational reproductive decision-makers. But along with exerting their reproductive agencies, these women also subject themselves to medical governance and surveillance.

The discussions around sterilization that took place before the beginning of the 2000s raised ambivalences around the issue of free and informed consent. My 30-year-old friend Manka had her third child at the age of 18, and she was sterilized upon her last surgical delivery. I recorded an interview with Manka, Puma, Elenka, and Eva during which we were discussing their deliveries (see Chapter 3). At one point, Manka mentioned that she signed the sterilization consent form during her last delivery. I will include a longer edited excerpt here from the conversation, as it illustrates the conditions under which Manka gave her consent:

> Edit: So wait, this paper you signed – when did you sign it?
>
> Manka: Right there on the bed.
>
> Edit (verifying the exact timing of the consent): But when, exactly? You were [at the ward] for three days, and then the [doctors] told you that you would give birth by C-section. And when did they give you [the form to sign]?
>
> Manka: On the 8th [of the given month]!
>
> Edit: No, I mean … And what did they tell you about what you were signing up for?
>
> Manka: They asked if I wanted to have more children. I told them I did not want more children.
>
> Edit: You said it yourself.
>
> Manka: Yes. They gave me that paper, I signed my name [*podpisindžom man*].
>
> Edit: But how did they ask you? Do you remember how exactly they asked you…?

Manka: [The doctor] said [in Slovak] ”Do you want [more] children? Because it’s been two C-sections already.” (…) So I said ”No.” So they gave me that large form [*kajso baro papiris*], and I signed it. They said ”Sign it!” And I signed it. They stopped my contractions … they said: You are going for a C-section immediately”.

Edit: And who … were you aware of what you had signed?

Manka: That I would not have more children!

Edit: You mean how [would it happen that] you would not have more children?

Manka (laughing about my overly quizzical attitude): That I would not have more!

Edit: But what did you think they would do so that you would not have more children?

Manka: I thought they would close my ovaries [*zaphande mange o vaječníkos*].

Edit: So you basically knew what you were signing up for.

Manka (in an offended manner): Yes! I knew what I had signed … what am I, an idiot [*ta so som, diliňi*]? I know that what they do is they close the ovaries.

At this point Eva, who had never given birth, intervened and suggested that the timing of the signature was inappropriate, as Manka signed the consent form while she was having contractions. Eva argued that because Manka was in pain the health professionals could not have provided her with a proper explanation. Manka refused Eva’s argument and said that she was told what she signed up for, although she admitted that she was not provided with any further information besides the health professionals asking her if she wanted more children in the future. My focus was on understanding whether this was a premediated decision, or a decision made on the spot:

Edit: And you really didn’t want more children? Did you decide right there [when the question was asked] or earlier?

Manka: I decided at home! I was saying at home ”If [the current pregnancy] is a C-section then I will have it done so I will not have more children” [*dav man že te na ela man čhave*]”. Even [her husband] agreed.

Edit: Oh, really?

Manka: And I said “If I give birth nicely [vaginally]” ... but I knew I would maybe have a C-section.

Edit: And he also didn’t want any more children?

Manka: How should I say it … He knows what kind of suffering it is to have children [*s'oda trapenie le čhavenca*]. We suffered enough with our kids and we were still kids, too.

We discussed troubles with children. But Manka then remembered a further detail:

Manka: A female doctor came and she asked: ”Has she signed [the form] already? Because if not, then I'll do [the tubal ligation] on her anyway”. She said that – that they would close my ovaries. She even said ”It's because of [Manka] that we did not manage to go for lunch, and now we have to operate on her”. Now, this is what she said, and I could hear all of what they were saying. And the [other] doctor asked [the female doctor] why she was so irritated [*choľamen*]. (…) [The female doctor] said ”These Gypsies, they give birth so often!” She meant young [girls]. She was pissed! She said that [Roma] women gave birth too much.

Edit: The doctor said this.

Manka: She had blonde hair. I remember it.

Eva interjected again that the health professionals deliberately gave the form to Romani women while the women were having contractions. She felt that it was unfair to exert this type of pressure on women who were in pain, implying that doctors knew very well that women were more likely to agree to the procedure under these particular circumstances. We discussed a case like that – when a woman we all knew was unable to get pregnant after her second child, and only after years of trying did she find out that she had been sterilized during her second delivery. Manka then repeated the whole story again – what the blonde doctor said about performing the surgery on her, even if she had not signed up for the procedure, and that she was cross because she missed out on her lunch. I asked Manka how she felt about the procedure now, and whether she had any regrets. She said:

Sometimes I regret it when … But now I don't regret is anymore because … Only sometimes do I regret it. I would have wanted another daughter. But ... not anymore.

Manka prided herself in the fact that her children, two teenage boys and a girl, had a shared bedroom of their own, and in particular that there was a study desk in the room. She explained that these were conditions she never could have provided if they had had more children. She appreciated the lifestyle choices that became available to her and her husband as a result of not being bound to small children, they way other women of her age were. She had regrets that she did not finish her studies – that she flunked out of school at 15. She explained that she took driving lessons and passed the test not because she really wants to drive a car, but just to prove it to herself that she was not *diliňi* [stupid]. As we were finishing up the tour of her apartment she said to herself: “How many children would I have had by now!

It's good that they sterilized me" [*mištes, že man zaphandle*]. Manka embraced the reproductive outcomes she ended up with, and she found agency and a means of empowerment in her reproductive trajectory. Although from a legal perspective Manka's consent would most likely qualify as coerced, in her narrative she did not take up the position of a victim. During my stay in the village, Manka started raising her relative's mentally disabled toddler and she and her husband gradually acquired full legal guardianship over the child. She was very proud that the judge who dealt with the adoption regarded them as good parents.

Manka's story is only one of the many narratives I heard and recorded about a young woman, who had barely reached legal majority, being offered sterilization by medical professionals as the safest or most rational option – and who was presented with this choice during her birthing process. Other versions included women who were told during the third delivery (and after two surgical deliveries) that a potential fourth pregnancy would risk their lives, and that sterilization was the only safe decision. Threatened with a supposedly unavoidable tragedy, the women "opted" for tubal ligation, but their free consent is debatable. The tubal ligations that were conducted under significant external pressure – whether from the family or medical personnel – raised conflicting feelings in my informants. Women's positions on the topic were rarely fixed, and their interpretations of the consequences of sterilization fluctuated. Women like Manka, who provided consent to sterilization under significant duress in the hospital, had a fluid narrative about her fertility wishes: at times she was grateful for not having more children, other times she talked about another baby girl [*čhajori*]. She was both content with her family arrangement and open to adopting yet another child.

While this chapter largely focuses on individual reproductive agencies and tubal ligation, in my understanding, the issue of coercive or sterilizations or sterilizations without due consent is entangled in a broader debate on violence against women in maternity care settings (Chadwick, 2018; Davis, 2018, 2019; Dixon, 2015). The *gadžo* medical professionals who steered women like Manka into sterilization, who implied that another pregnancy may endanger a woman's life, or who effectively erased reproductive agency by pronouncing that they would tie the fallopian tubes even if the woman did not give her consent had internalized and engaged in obstetric racism. Davis (2018) coined the term "obstetric racism" to denote that obstetric violence may overlap with medical racism to exert reproductive dominance over women of color who are obstetric subjects. Medical personnel's internalized racist assumptions about Roma and their fertility enabled coerced sterilizations to take place well into the beginning of the 2000s. This logic recasts the practice as defensible even in a Catholic country like Slovakia. It is difficult to guess how long the practice would have persisted without the investigation and intervention by human rights NGOs.

Financial Strategizing and the Value of Children

I have pointed out elsewhere (Szénássy, 2010) that in Slovakia, especially in the early 2000s, a great deal of media attention surrounded the issue of Romani reproduction. Much of this attention centered around the allegation that parental allowances and child support benefits encouraged women to bear more children. I realized that writing about the economics of childbearing among poor Roma was particularly sensitive while I was delivering a guest lecture about the fieldwork I had done in the Czech Republic on Romani women and the maternity system. A Czech Romani studies scholar approached me asking – at first circumspectly and then later more explicitly – whether I was willing to address in my dissertation the notion that economic stability provided by maternity benefits contributes to higher Romani fecundity.[26]

My landlords, an elderly Slovak couple who housed me and who had many concerns about the increasing Romani population in Veľká Dedinka, were convinced that this was the case. We were watching the evening news together when a sequence came up about Roma who lived under dismal conditions in a settlement not dissimilar to the one in Veľká Dedinka. Watching the sequence, my landlord said: "There's only one thing that works on the Gypsies. Circus animal training techniques [*drezúra*]!" I normally took it upon myself to politely address what I considered to be my landlord's openly racist statements about Roma, but on this particular evening I was exhausted and undiplomatic. I retorted that he talked about Roma people as if they were animals. He refused my accusation and said that at least the state should stop paying parental benefits to young girls so they would not be encouraged to have children so early. In many ways, the idea that state benefits (whether parental benefits or child allowances) encourage women to bear more children fulfills the most egregious stereotypes that non-Roma can have about Roma in the Central European social context. And to my utter confusion, my Romani informants echoed this perception.

In the second month of my fieldwork, Apricot and I were gossiping about her brother-in-law's wife, who had just recently given birth to her second baby and collected the cash birth grant [*pôrodné*] of approximately 700 euros that the Slovak state provided for each of the first

[26] A similarly candid issue is perhaps violence against children in poor Romani settlements – a wide-spread phenomenon that Radek Banga, a well-known Czech rapper who comes from a disadvantaged Romani background, discussed extensively in his autobiography (Banga, 2021). My fieldnotes contain many entries where I either personally witnessed or was told by parents (usually mothers) about the various ways they beat their children. I also witnessed an astounding amount of verbal abuse leveled against children. Corporal punishment is in fact widely used to "discipline" children in both Slovakia and the Czech Republic across social classes, and the two countries have failed to establish the prohibition of physical and other forms of violence against children within the family setting. For the ways violence against children is related to parental stress caused by poverty, unemployment, and social isolation see United Nations, 2006.

three children a woman gave birth to.[27] Apricot was not on friendly terms with the woman, and alleged that the woman spent all the money playing slot machines the day before we spoke. I asked Apricot if she thought that the woman would wish to have more children in the future. Apricot said, answering in the same way some of my other interviewees would answer such loaded questions of mine: "She will, *te del o Deloro*" [should God provide]. Then she added that her cousin's wife would try to get pregnant again as soon as possible. I expressed my astonishment at Apricot's assumption that someone with a newborn would strive to get pregnant within a short time after her delivery. Why would she want that, I wondered aloud. Apricot turned to me and said, in her characteristically ironic tone: because of the money they get for the babies [*Ta vaš o love so chuden pro čhave*]! I dismissed Apricot's words not only because of her antagonistic attitude towards her cousin's wife, but also because from an economic point of view her argument seemed absurd to me. In the initial part of my long-term fieldwork, I conceptualized reproduction from a rationality perspective, and I reasoned to Apricot that it made no sense for the woman – any woman – to bear a baby and then spend the entire birth grant on a gambling spree. But Apricot was not the only one to give me the stereotypical explanation that Romani women's childbearing was heavily encouraged by the birth grant (applicable for up to three children) or the parental benefit (applicable for all children). In a different discussion about reproductive decisions, Apricot's older, married, but childless sister told me the following, when I expressed my doubts:

> You've never heard it when somebody asks "Are you pregnant?" and the woman would say "Yeah, I'll get that large amount of money" [*chudava kole bare love*]![28]

I often heard conversations in which people accused family members or friends of not taking care of their children, and of having had the children only "for the money" [*vaš o love*]. I heard the statement that women had children *vaš o love* over and over again, from different types of informants, including small children, and in a variety of contexts. Ornella, who had two sons and a newborn baby girl, showed me the new room that her husband added to their house from the birth grant the family received after the third baby was born. The money was just enough to buy the timber and bricks, and with a loan from her family Ornella managed to buy purple paint to paint the new room's walls. Having had a third child, Ornella would not have access to another birth grant – still, she was actively planning a future fourth child. When,

[27] Robert Fico's populist government introduced the cash birth grant in 2008 for the first child, and in 2009 the grant was extended to women who had their second and third child. In 2010, all women who gave birth were given approximately € 150 for every baby that lived longer than 28 days, but an extra € 700 was given only to families who had up to three children. For the fourth child and beyond, there was no extra cash grant. Slovak media (Sélešová, 2008) speculated that the introduction of the cash birth benefit led to a significant increase in childbearing in marginalized Romani communities, but this was difficult to prove as no official ethnically segregated statistics existed.

[28] The recollection is based on my field notes.

during my visit, her friend who had also recently had a baby came over, she remarked that unlike Ornella, she would not have had a baby just for the money, implying that this had been Ornella's scheme. The woman absconded from the maternity ward, and therefore she was not eligible for the birth grant after her second baby was born. She went back to take care of her first child at home, leaving her baby at the maternity ward for a few days.[29] She was aware that doing so would result in the grant being cancelled, but she told me she did not, after all, have the baby for the money.

Disability pensions could not compensate for the disparity involved, but they were sufficient to provide a long-term stable income that doesn't end once the child turns 3 or 4 years old. We were watching the last episode of the Latin American soap opera Wild Angel with my friend Elenka, who had four children. Elenka was letting out loud shrieks of joy as the main female protagonist was approaching the altar in her wedding gown, and Elenka's eldest daughter was sitting very close to the television set. Upon my questioning, Elenka told me that she suspected that her daughter had a hearing disability, as she did not seem to communicate well when she would not clearly see her interlocutor's mouth. We pondered the possibilities of her daughter receiving financial assistance with her disability. Elenka told me she that she kept delaying a visit to the pediatrician, as she does not want to face this further obstacle in her life. She then contemplated the possibility that her daughter might become eligible for a disability pension, which seemed to be consoling thought.

I want to make it clear that in the context of long-term poverty, systemic discrimination, and lack of social mobility the state financial support provided to poor Roma parents serves as a source of security and predictability. But financial support to any parent or future parent can play an important part in reproductive decisions. Linking fertility outcomes to financial strategizing is usually only stigmatized, however, in socio-economically disadvantaged communities. A double standard is used for Roma, who are racially marked in Central Europe, compared to majority populations, whose middle-class members are financially incentivized by the state to bear more children. Over the past few years in Hungary and Poland, right-wing governments have not only implemented campaigns to raise the middle classes' enthusiasm for childbearing, but they have also offered significant tax reductions, loans, and premiums for couples who had or were willing to commit to having more children (Walker, 2020). In Hungary, the financial incentives are not provided across all social strata, but are designed to be used by the middleclass, and they are not intended to cause any shame or stigma for those who

[29] It is unclear why she was not granted the money – my theory is that the maternity department personnel of the hospital where the woman left back her child for a few days before collecting it (see Chapter 4) connived with the child protection authorities to deny the grant to women who abscond and leave their babies behind in the hospital, perhaps in the hope of preventing them from doing it.

take advantage of them. The amount given for the parental allowance, which is provided to all families regardless of employment status, was not significantly raised.

My informants from the *gadžo* part of Veľká Dedinka made frequent critical, borderline racist comments asserting that Roma women opt for a high number of children only to receive parental allowances. Yet some of them didn't seem to have reservations about capitalizing on Romani poverty. A local businessman set up slot machines in the village, knowing that the high number of Roma inhabitants provided a ripe market for gambling. The ethnic Slovak inhabitants constituted a considerably older and smaller demographic segment and the slot machines were frequented mostly by Roma, including teenagers. Kira and others told me that one could pay the local pediatrician a few euros, and in return the doctor would provide an absent-note for the school even if the child was not ill. My landlords would request me to ask around in the settlement whether any "good Roma family" would be interested in buying old furniture – old furniture that their relatives had collected in the city the day before for free, and my landlords priced it at 35 euros. Barbells' husband bought himself a driving license, yet I knew for certain that he was illiterate, as I was the one who read out his medical diagnoses reports for him and his wife. An ethnic Slovak informant told me they always get their Christmas tree from the nearby forest, and the sweet corn they ate from the collective farm's nearby field. Why would he pay if he could get them for free, like the Roma do? he reasoned. I could go on adding further and further items to this list, but the nature of the pattern should already be clear.

Conclusion

While Chapter One centered on the views of my informants from the segregated settlement, Chapter Two contextualized the value Romani parents and the larger society perceive in Romani children from marginalized backgrounds. The chapter contextualized Romani fecundity as part of a moral and demographic crisis. It discusses the demographic anxieties that majority populations have about ethnically marked, more fecund minorities in various countries around the world (Marchesi, 2012; de Zordo et al., 2022), and it recounts the history and the aftermath of sterilization campaigns in the former Czechoslovakia.

The ethnographic data in this chapter captured the disruptions, conflicts, and ambivalences in the lives of my informants with respect to the financial support provided by the state for parents. But household economics plays a significant role in reproductive decisions for all social classes, and population policies invoke moral regimes that aim to affect the individual populations' reproductive conduct. Economic strategizing with respect to fertility choices is not limited to Roma, but it is common among all social actors. Children are a subject of financial deliberations, including deliberations about social benefits and policies, across all

social strata, which is acknowledged by state actors that seek to boost fertility rates in favored populations. It is in this context that Roma families' economic strategizing with respects to fertility is attended to and analyzed in this chapter. Instead of leaving it unarticulated or unaddressed, the chapter undertakes the fact that economic strategizing plays into reproductive decisions.

It is in this heavily marked backdrop that voluntary sterilizations for a financial incentive must be seen as performance of reproductive agency in a field where there are powerful financial parameters. Through ethnographic data, I illustrate that the reproductive decisions of women who consented to tubal ligation are negotiated in multiple, often contradictory discourses, and ambivalences are present also in the case of women who were sterilized under pressure from health professionals without having given appropriately informed consent. Marginalized Romani women might be caught within a web of unequal constraints and incitements, but within their everyday lives they do not come out a passive victims or heroic survivors. By showing some of the potential challenges that Romani women face in the maternity care system, the chapter lays out the ground for the topic of the upcoming chapter, which focuses on women's agency during birth giving in a Slovak hospital.

4. Obstetric Encounters

In the weeks leading up to the completion of my fieldwork in the settlement, I conducted recorded interviews focused on the birth experiences of the women I had become best acquainted with in the course of the previous eleven months (and, in some cases, several years before). Involving birth in the larger field of reproductive decision-making was a logical extension of my research topic, and my original plan had included a brief stint of field research in the maternity ward where the women from the settlement went to give birth. For reasons of both personal and logistical natures, this option was out of reach, and thus I could only ask women to recount their births to me instead of observing what took place when they were in labor.[30]

Chapter Three is based on birth accounts from the settlement and it moves the reader from the *osada* to the maternity ward of a larger city in eastern Slovakia where all of my interlocutors who are quoted here gave birth between 1985 to 2010. It is a transition from examining reproduction in everyday life to analyzing reproductive agencies as they appears in medical settings. As in the previous two chapters, this chapter is largely written from the perspective of marginalized Roma, especially women, and it describes the encounters of poor Romani women who give birth with the assistance of non-Roma healthcare professionals. I use narrative discourse analysis to examine personal autonomy, control, and choice in the birthing process experienced by Romani women from a segregated community. Positioning my interlocutors' narratives against the way the anthropological literature frames agency and decision-making in the obstetric context, I will examine the ways divergent responsibilities coincide and coexist in the face of personal choice and acquiescence to medical expertise.
Here, at the beginning of this chapter, I would like to acknowledge that I neither participated in nor observed these birth experiences directly. I never set foot in the ward my interlocutors describe here, and I did not interview any of the medical professionals they make references to. The perspectives of medical professionals will be addressed in Chapter Four. The chapter is entirely based on recorded interviews with my informants from Veľká Dedinka, most of whom were my close friends, or whom with whom I had developed a confidential relationship with. The chapter starts with a critical assessment of the natural birth narrative, and a reflection on the extent to which it resonates with women from disadvantaged backgrounds.

[30] With the help of a grant from my university (GAUK No.1110116) I managed to conduct two weeks of fieldwork research in a Czech maternity ward popular with Romani women in December 2016. The final two chapters of the dissertation are based on observations made at that research site.

Natural Birth as a Social Responsibility

The issues of control and autonomy, or dominance and resistance, have been at the center of anthropological inquires into birthing for several decades. The idea that women can manage their birth experiences and should strive to give birth without the hegemonic biomedical, increasingly technicized birth model overly intervening in such a life-changing, personal event as childbirth is firmly intertwined with the natural birth movement. One of the leading ideas of natural birth is reclaiming authoritative knowledge (David-Floyd & Sargent, 1997)[i] from obstetricians and reinstating the birthing female body as the expert in birth giving. Natural birth advocates emphasize that low (or no)-intervention, midwife-led births allow women to retain a sense of self (MacDonald, 2006, p. 236). Predictably, social scientists question the idea that any birth can be considered fully natural, and both the meaning of the term and the labor experiences bundled under it have shifted over time (MacDonald, 2011 and 2006; Mansfield, 2007).

The past decades have witnessed growing criticism of the romance of nature as the driving force behind birthing and the implicit moral imperatives suggesting that natural births are the most suitable or desired birthing options for all women (Malacrida & Boulton, 2014). Natural birth is an ideal that not many women can or may want to achieve. Anthropologists researching childbirth have pointed out the peremptory belief that no or low-intervention births are universally empowering and that a women can also gain a sense of control from birth experiences where technological interventions abound (Davis-Floyd, 1994; Akrich & Pasveer, 2004; Carter, 2010; Davis-Floyd, 1994, 2003; Martin, 1992).

Implicit in the discourse on natural birth is the idea of control – the retention of control by the birthing woman and the reclaiming of authority over delivery-related decisions from birth professionals, especially doctors. Layne (2003, p. 188) described this emphasis on autonomy as the ethics of individual control, which is ingrained in a culture of meritocracy. The number and nature of medical interventions are seen as an indicator that assesses women's ability to control the birthing process and a barometer for the amount of reproductive autonomy women have during delivery. McCable (2016, p. 183) describes the concept of mothercraft as "the shaping of maternal identities to reflect neoliberal ideals of self-sufficiency and individual responsibility" as widely appropriated not only by some women, but also by medical professionals, especially midwives, in contemporary birth culture. Childbirth is portrayed in the logic of mothercraft "as an individualistic journey during which one conquers their fears and emerges transformed" (2016, p. 181) and birth pain, especially if it is unalleviated, serves as a harbinger of the "reward of producing a healthy child" (Carson et al., 2017, p. 822).

In contemporary biomedical contexts, a low-intervention birth is something women must actively work for by making responsible choices before, during, and after birth. These choices include writing up birth plans in which women detail their wishes or preferences during delivery, and equipping themselves with biomedical knowledge. Not "achieving" a no or low-intervention delivery can be seen both by birthing women and their social worlds as a personal failure (Clift-Matthews, 2010), attributable to insufficient cultural capital (in the form of knowledge of health), determination, or willingness to resist medical interventions, and ineptitude in taking full ownership of the birth experience. Engraved in the significance attributed to responding to the range of birthing choices available in contemporary birthing culture and making informed, responsible decisions are neoliberal ideals of choice by subjects who act autonomously and rationally (Lupton & Schmied, 2013, p. 828). The expansion of choices amplifies women's responsibility for their birth outcomes (McCabe, 2016, p. 178), and, in a healthcare setting, discourses on empowerment and choice not only obscure the needs of poorer people, but also disadvantage them (Anderson, p. 1996). The feminist critique of birthing choices complicates the idea that women should strive for full control of their birth experience (or that such a thing is even possible), yet it also acknowledges that birthing women should have more autonomy in an increasingly technicized biomedical birth model than what they currently exercise (Malacrida & Boulton, 2014, p. 45).

According to Liamputtong (2005, p. 247), women's self-perception of "risk" influences their willingness to accept or reject medical interventions during childbirth. Similarly to all fields of healthcare, social class membership matters significantly in the individual experience of birth (Williams, 1995, p. 597 cited in Liamputtong 2005, p. 246), even if birth is experienced similarly by women across class and race. There are several understandings of what forces shape the amount of agency that women can and want to have in the birthing process. Miller and Shriver (2012) utilize Pierre Bourdieu's concept of habitus to gain a clearer perception of women's birth preferences, but note that the lived experience of birth is molded at a structural level by economic constraints and the availability of birthing options. They assert that women's childbirth preferences and concurrent decisions depend on which of the three types of habitus – the scientific-medical framework, a lifestyle centered on religion, or the natural family perspective – they subscribe to. Habitus is decisive in women's understanding of risk, but regardless of the type of habitus, women make childbirth choices which they believe will have the best outcomes both for themselves and their babies.

Birth and pregnancy-related expectations and wishes are the central topic of Emily Martin's influential book *The Woman in the Body* (1992). Martin asserts that the need to perform self-control was much stronger among middle class women than among those who are working-class, who were more preoccupied with the lived reality of childbirth, focusing on

the pain and the length of the labor process. Middle class women, however, both in their practices and their communication during childbirth actively sought to resist technological interventions and minimalize medical control. Another influential anthropologist of birth, Ellen Lazarus, came to a similar conclusion when she wrote that middle class women leaned toward sets of choices which enabled them to exert more control over how they give birth, whereas working-class women did not desire or assume to have control and their emphasis was on the continuity of care (1994, p. 25). Researching the birth preferences of Australian middle- and working-class women, Zadoroznyj (1999) also argues that the issue of choice and control was increasingly important for middle class women, and that working class women tended to be more “fatalistic” in the birth process. Working on Lebanese women’s birth choices, Kabakian-Khasholian et al. (2000) found that socio-economic status negatively influences women’s ability to assert their agencies during childbirth. There seems to be a general consensus among feminist social scientists who research birth that poorer women’s lack of ability to meaningfully take responsibility for their deliveries can be attributed to a somewhat non-specific intersection of economic problems and social inequalities.

Building on the body of scholarship above, in this chapter I have three main objectives. First, I will examine Romani women’s attitudes to childbirth interventions. My data suggests that childbirth is not understood by Romani women in terms of moral regimes, and their focus is on the outcome of the delivery, rather than its performative or transformative potential. My second point is that for the women I conducted research with, autonomy and control are important values in connection with birthing, but in practice they are difficult to attain within the hospital setting. This is not only because Roma actively feel a sense of not-belonging in the maternity ward, but, importantly, because birthing is an arena reserved for *gadžo* medical expertise in which Roma do not feel empowered to interfere. However, Romani women actively strive for agency imminently before or after birth by delaying hospitalization or leaving the maternity before official discharge. They do not (cannot) envisage a hospital where their bodies would belong to them, and going to the maternity ward late or absconding early are mechanisms for reappropriating control. The last point I want to make in this chapter is that disadvantaged Romani women seek to achieve a feeling of control over the fear of birth, and over the quality of their hospital stay. Since they do not actively compete with or question medical decisions and they do not feel they belong in the *gadžo* hospital environment, what Romani women are concerned with is being recognized as being equal to non-Roma patients by *gadžo* staff. Equality for my informants translates to fair access to the material goods and services non-Roma women take for granted.

Tell Me Your Story

I will start the ethnographic part of this chapter by making a number of methodological observations. I scheduled my recorded interviews for the last two weeks of my eleven-month fieldwork period, since the more strongly I bonded with my research participants, the more clearly I understood their potential discomfort with recorded semi-formal interview situations. Having a recording device with me, however small, and thus formalizing my position as the inquirer was a different setup from our usual interactions. The women (and sometimes men) I talked with kept making references to the presence of my recording device in the room, but they did not behave like disciplined interview subjects. Although my digital recorder equipped me with a sense of mystique, we still interacted jovially. Because I'd already established deep personal connections and a history of friendship with some of my interlocutors which reached back several years, I by no means appear as a disembodied being in my interviews, and I teased, gave unsolicited advice, or argued with my interlocutors just as often as they did with me. Some women took the interviews as an opportunity to share their experience with me as seniors in the field of birthing, since at that time I had no personal experience with it. With some people, I only asked about the birth experience (starting from the contractions, asking "*varker mange sar has sar gejľal te lochol*" – tell me how it was when you went to give birth), while with others it was an opportunity to put the missing pieces together about their reproductive trajectories or family histories. Some interlocutors intuitively started their narrative with a reference to cohabitation or dating. Other interviews turned into de facto life story interviews.

Overall, I recorded thirteen interviews which dealt with childbirth to some extent. Although only four out of these are group interviews, all the others were recorded with the participation of many more people than the interviewee, as family members or unannounced friends and acquaintances dropped into the usually one-room houses where we talked. Most of them contributed to the interview with frequent jokes, giggles, and comments. Children were always present, unless their mothers felt that she shouldn't hear about certain subjects. Initially I felt frustrated that much – if not most – of what was discussed during the interviews was off-topic. All sorts of subjects emerged spontaneously and were debated without delay, and thus my transcripts of what "should have been" birth narratives instead are often about couples or girlfriends discussing their sexual lives, complaining about good-for-nothing husbands, or sharing dinner receipts.

Initially, I made attempts to strongly guide the discussions and remind my interlocutors about the topic of labor and delivery when their interest dwindled or alternated with other matters that they felt warranted discussion. After a while, I accepted that my interviews would be nothing like those in the methods section of a how-to-do-ethnography textbook. Our group

conversations often dissolved into simultaneous chatter between individuals, and I frequently asked myself what other anthropologists would do in a situation like this. I measured myself against the ideal ethnographer, as did John Law (1994, p. 43) when he researched a laboratory setting, thinking that others would make better choices of words, lead the conversation more solemnly, or stick to a more firmly set list of questions. Abandoning this ideal was – still is – a process, but the fact that I had to go with the flow was a decision made as much by my interlocutors as by myself. Perhaps this is also a form of collaborative ethnography (Lassiter, 2005), or maybe it was just a lesson on my own preconceptions of control while I was researching the issue of control. In any case, in one group interview the topic of childbirth came up only one and a half hours after I pushed the recording button: we discussed fussy children, made phone calls, welcomed guests, and debated the daily news and *osada* gossip first. Crying children, background noise from the perpetually running TV or other devices, and frequent disruptions due to my interlocutors' constant availability to fulfill the needs and obligations of their kin in the home environment meant that few of the topics we explored were pursued in as much detail as I would have wished to. Occasionally, the recordings were hard to decipher and I often experienced "researcher's guilt" (Mamali, 2019). Sometimes, I pressed for interviews even in moments where my interlocutors were obviously busy doing household chores or taking care of their children, knowing that a more relaxed moment or opportunity to have a recorded discussion may not come at all.

It didn't help my feelings of methodological failure that after obtaining their verbal consent for recording and explaining that the interviews will be used for my dissertation (which I phrased as the book I was writing for my school so that I can finish my studies), an alarming number of my interlocutors, including those who had become my close friends, expressed genuine surprise and uneasiness about the fact that I would write about their lives.[31] In moments like this, sometimes other interlocutors would come to my rescue, explaining to the person who shared their concern that my writing will be anonymous and that their identity will not be traceable. Permission to record was never denied and at times my interlocutors came up with a solution themselves: Daisy [*Sedmikráska*], for example, was not concerned about the recording itself, but about the fact that I planned to store (at least for a while) the file in my laptop, which I sometimes carried in the field to show the photos I had taken. Daisy worried that people [*o Roma*] would get ahold of my laptop and listen to her narrative account. In the end, she winked at me and said on the record that she was telling me the story of another

[31] I will assert here again, as I did in the previous chapters, that I do not think that most of my informants fully understood how my long-term presence in the settlement amounted to empirical research. This was similar, however, to the attitudes my family or some friends had, who also expressed skepticism both about the ethnographic method and my field site choice (see Chapter 1).

woman with whom she had shared a room at the maternity ward. Framing her story as another woman's story made her feel less vulnerable.

Narratives of Childbirth: Wrangling the Genre

In narratives of childbirth, but by extension in any narrative analysis, one concern is the lapse of time between the recounted event taking place and when the event is told, and another issue is that narrative accounts of lived events are situated narrative perspectives. My analysis in this chapter is based on maternal memory narratives and I made no attempts to fact-check the stories which were presented to me. Already during the interviews, it was apparent that the stories women presented about individual birth experiences were frequently contradictory. I usually made attempts to clear up inconsistencies during our interaction, but this was not always possible, nor always welcome. But should narratives express actual lived experience, or interpretations of experiences (Carter, 2010, p. 998)? Having had up to eight births, many women may simply did not have had vivid memories of each labor experience. In other cases, an interlocutor recounted the same birth story to me several times during the interview, each time rewriting the scene with her words in a way that positioned her as a more authoritative agent in her interaction with medical professionals. Instead of putting the truth content of such narratives into question, I found such reframing analytically valuable. Maternal memory is compelling in that can grant women the opportunity to retrospectively reassert their agencies in past events marked by loss of autonomy, thus effectively repositioning their involvement in these events as active social selves (Oakley, 2016, p. 533).

Within the genre of childbirth narratives, first-hand, retrospective accounts of labor are often used to gain insights about women's bodies as politicized subject in an increasingly medicalized birth culture. But much of the literature I rely on in this chapter includes interview quotations which are elaborate and highly reflective of birthing women's intentions, wishes and expectations. This was not characteristic for the type of language I encountered among the women of Veľká Dedinka. Most of the narratives I collected there were far from embellished accounts and I struggled to epistemologically make sense of them. This was especially true for uncomplicated deliveries when the birth story was recounted in two to three simple sentences. Petra's narrative is a typical example:

> Edit: Tell me about your birth experience.
>
> Petra: It was good. It was nothing! I had good births. [*Lačhes! Ta nič! Lačhe porody man has.*]

She then proceeded to talk about another topic. Petra, a 46-year-old mother of five, was one of my first interviewees and since her last delivery had taken place 22 years prior to the interview, I had originally attributed her lack of detail to the loss of vivid memories. But others, like 26-year-old Daisy, a mother of four who gave birth for the first time at the age of 21, recounted her experience similarly strikingly briefly. When describing one of her uncomplicated deliveries, she told me her contractions started, after which she quickly washed up, then a family member called the ambulance that took her to the maternity ward.

> Daisy: They put me in the birthing delivery room, I delivered and that was it [*thode man pre sala, odlochiľom, a imar*]. What else do you want to hear?
>
> Edit: Whatever you want to tell me ...
>
> Daisy: Well, I'll tell you, childbirth is ... some deliveries are easy, some are difficult. It's like this: when the baby weights more, the birth is easier. When the baby weighs little, the delivery is really difficult.

Other variations included the time when contractions started, the time when the ambulance came and the exact time when the baby was born. Twenty-six-year-old Elenka, a mother of four, described one of her easy births the following way:

> So I went, (...) the doctor was taking care of me ... It's better when the doctor does because the nurses [midwives] – what do they know? He put his hand inside me [to check for cervical dilation], he saw it and said "she is going to deliver". I just push, girl, I push twice and I deliver. I just pushed twice and I'm already delivering the baby.

When it came to uncomplicated vaginal deliveries, especially when there were no significant medical interventions, there was a narrative, but no elaborate story to tell. This was striking, as the births described to me qualified as natural births, but the language in which they were presented resembled nothing like the emancipating language used in the natural birth movement. There was no talk of elation, bonding, no appreciation of freedom from interventions, no assertions of the ability to retain the integrity of body and mind.

Attitudes and Interventions

In the women's health movement, birth stories have traditionally been used to advocate for natural birthing options (Halfon, 2010, p. 73), and women who not subscribe to the ideas of natural birthing do not recount their births as a transformative, life changing experiences (Fitzpatrick, 2019). My friends in the settlement had very limited exposure to the natural birth discourse and in no discussions about birth in Slovakia or the Czech Republic have I ever heard any poor Romani woman, be they from urban ghettos or rural segregated settlements,

endorse the idea of home birth. Pre-meditated home birth came up in our informal conversations as a practice strongly associated with the *gadžo* world; women who underwent homebirth were labeled by my informants as *diliňi* [crazy, stupid)] and the process itself was referred to as *džungalo* [disgusting]. Always framed as unpredictable and full of risk, childbirth in a hospital setting was the only acceptable option in my recorded interviews as well. Vaginal birth was always valued over Caesarean section, and these were described as disabling physical movement, causing protracted pain, and increasing the risk of future labor complications. Yet none of my interlocutors expressed that no or low-intervention birth was a more empowering experience than technologized birth.

My friend, 30 year-old Manka, a biological mother of three children, whose consent to surgical sterilization is debatable (see Chapter 2) and who had recently adopted a relative's two year-old at the time we conducted the interview, described all her births as *phare* [difficult]. Manka experienced childbirth at the age of 16 for the first time, and in her narrative she appears as a compliant suffering patient in a birthing process which turned out to be rife with medical interventions. Compared with my other interlocutors, her account was atypical, in that she described what took place after settling in the ward in much detail.

Here, as elsewhere in this chapter, I use ample direct quotations from interviews both in an effort to let my interlocutors speak for themselves and also to allow space for their shifting voices to unfold – the voices in which they position themselves when they were in dialogue with medical caregivers, and the voices in which they recall caregivers talking among each other about the women.

> The nurse came, she told me to undress and put on the hospital gown. I undressed and put on the gown. Then the doctor came and he put me on the obstetric delivery table, you now? He put his hand inside me, examined me, and said that I'm open three fingers; he said I was going to give birth tomorrow. "Tomorrow she's going to give birth". But I was in great pain. They shaved me so that the baby's head can be seen better as it comes out, so that he doesn't suffocate. ... There was a *rakľi* [white girl] with me in the delivery room. They checked [with the tocodynamometer machine] to see what contractions I have. I was just a girl; I was so afraid of what they will do to me. I got up, they told me to go and sleep because I would deliver tomorrow. I said I can't take it, I can't lie down, I was in such pain. I just kept looking [out the window] at the clouds until the morning came, I just kept going to the bathroom. And I looked at the clouds, saw how the sun rises, stuff like that. I waited for the nurses, it was already so late, 8 a.m. ... There still wasn't anyone else just me and the *rakľi*. The *rakľi* was sleeping, she had the IV on. It was about 8:30 when the nurse came. She asked the *rakľi* whether I had

> slept and she said that I hadn't, that I had only been watching the clouds all night. The nurse said that I would get a ... how should I say it ... that my blood would be weak because I kept looking at the clouds and going to the bathroom all night. She gave me an injection and the enema. .... She told me to wash up, I washed up in the bathroom there. ... She told me to walk in the hallway, to do a lot of walking! I walked, it hurt a lot, I couldn't stand the pain. They gave me this type of injection which made me feel lots of pain, lots of pain! ... I felt as if ... I don't even know how to explain it to you... as if I had been opening up ... I can't explain. It was an unpleasant feeling. Then they said "go now". They put me on the obstetric delivery table. [The doctor] put his entire hand in me. His whole hand! He said "I can see it already" – he said he saw the baby's head. They gave me an IV ... I was shouting, I couldn't move ... They said I had to withstand the pain, that's what they said. They were nice. The two staff were doing their thing. And then [the doctor] says to me that I should push, right? A nurse came, she pushed my belly with her body and said "push". ... "Put your hands on your heart" she told me, and she tied up my legs so that they couldn't move ... they have to do this! They tie up your legs. I pushed, there was no progress, I pushed again and they said "push again". No progress. ... And then the baby came out, I wasn't hurting anymore ... girl, you have no idea! ... They left me there. They stitched me up because I tore a lot. They anesthetized it. As [the midwife] was stitching ... I feel the injection and I cried out. And she says "don't worry, it's just anesthesia." They anesthetized and I didn't feel anything, I slept because I hadn't slept all night. I was worn out. [The nurse] brought the baby in cart and said "Jesus, so large!" because the baby was large. And then they took the baby and stitched me up ... I don't know, I don't remember what they did to me. And then they left me, it was over, and they gave me food.

In her narrative, Manka was never offered an array of birthing options to choose from, but neither did she express an interest in having any. In line with how Lazarus (1994) described working class women's preferences, Manka's birthing wishes were tied to controlling labor pain and reducing the length of suffering she had to go through. She interpreted medical professionals' decision to allow a whole night for her cervix to dilate as being left alone with her suffering, unable to sleep and having only the clouds and the rising sun as her support on this painful journey to becoming a mother. There are no traces for self-blame or questioning in either Manka's or any of the other woman's narratives that I elicited. Even medical interventions such as injections or fundal pressure to expedite the baby's arrival are framed as a method to alleviate unnecessarily protracted suffering. They are uninterrogated and seen as contributing to the larger goal of delivering a healthy baby. Even if it unfolds naturally, childbirth is to be managed by medical professionals and not the mothers. Childbirth is unpredictable and the

best outcome can be reached by following doctors' orders and praying to God. Easy births [*loke porody*], like tough births (*phare porody*), are a fact of life and do not carry connotations of deservingness.

Manka's third birth at the age of 17 was via emergency abdominal surgery. Even though she had given birth once already and was familiar with the maternity environment and the processes that awaited her in the hospital, she was unaware of most medical terminology, and when a doctor informed her about the necessity of a surgical delivery, acquaintances from Veľká Dedinka had to explain to her the implications:

> Manka: Little Banana [a friend from the settlement] cried for me. I tell her "listen [the doctor] told me ... I don't understand [what], he told me 'you are going for a section'". I didn't know what a section was! Because I delivered well [*lačhes ločhiľom* – delivered vaginally] with [my firstborn] Esmeralda. [The doctor] says "you are going for a section," he says "go and bring toilet paper, bring a towel, and come shower downstairs and then you go". I didn't understand what that meant. Kittycat asked me "where are you going?" "I'm going …" I say 'the doctor told me to bring a towel and toilet paper and that I should go down to Floor X," I say. She says "it's a C-section then!" I was shocked when I heard it. I started to cry.
>
> Edit: Why?
>
> Manka: I was afraid!
>
> Edit: Why?
>
> Manka: Because I didn't know it was a C-section! I started to cry, I said ... [Kittycat] was about to go home that day and I told her "send Mom!" I say "send Dad!" I was afraid, you know? Just imagine ... [the doctors] said "you are going to deliver". They didn't say it was going to be a C-section, they said I would deliver [vaginally]. At [the floor where the operation took place], the medical staff locked the door so that I wouldn't run away. Because I wanted to go to Mom, you get me. But they didn't let me.

The prospect of a C-section alarmed Manka, but in her narrative she never interrogated the medical exigency of the operation. I asked Manka to describe to me what took place as the medical staff began the preparations for the surgery. Her best friend, 21-year old Puma, was present during this group conversation. She had already gone through two C-sections and because she was pregnant as we were talking she was mentally preparing for her third abdominal delivery. They took me through the process:

Manka: First they do this. They give you an enema, you have to shower. They also undress you, they put you on the [operating] table ... a flat table. They tie your legs. They tie your [incomprehensible]. They put the IV on ...

Edit: It's not good when they make a C-section?

Puma: No!

Manka: And the *gadže* even want a C-section! Like one would say "why didn't you do a C-section on 6 June 2006?" The *rakľia* [white girls] want things like this! They don't want to give birth the normal way!

Manka reasserted that interventions are not objects of scrutiny if suggested by a health professional, but what she found incomprehensible was that a layperson would seriously consider opting for a surgical delivery.[32] Only a *gadži* could come up with such blatant nonsense! Elenka, a 26-year-old mother of four small children, found the fact that one would opt for a surgical delivery also nonsensical and even fraudulent. When I asked her whether she had ever had a C-section, the following conversation ensued:

Elenka: No! You have a C-section when the baby is the wrong way, like when the cord is entangled around it or when you have a narrow pelvis. Such things. But ...

Edit: And you're saying that you wouldn't want a C-section.

Elenka: When I was having a difficult delivery with the baby girl I wanted them to make me a C-section.

Edit: You wanted it?

Elenka: I wanted it. I wasn't able to push.

Edit: And you told [the doctors]?

Elenka: No ... I would never make up something like that ... They know how you are supposed to deliver – they will not take you for a C-section [in vain].

Edit: But someone told me that some *gadže* opt for it.

Elenka: The *gadže* do! You see, one *gadži* said this ... one *rakľi*, a young one ... "I can't bear it any longer, I'm in such pain!" she says. She had been there for two weeks! ... And she says "I want you to make me a C–section". "If you want a C-section," says the doctor "you'll have to pay me 170 euros" he says. I heard these words with my own

[32] On the idea that some women are "too posh to push", that is, they do not want to give birth vaginally and they opt for surgical deliveries without medical indication see Tully & Ball, 2013.

ears. “If you have 170 [euros] I'll make a C-section for you today”. Of course! And she gave it! 170! ... The *gadže* don't want to give birth [vaginally], they want a C-section!

Edit: Why is that?

Elenka: The C-section is better for them! They are even older and they get a C-section!

Elenka wanted badly for her protracted delivery to end, and if a surgical birth was the price for that, she was prepared to pay it. But she perceived optional C-sections as a layperson‘s excess which should not be prioritized over professional, biomedically-based expertise.[33]

Belongings and Strategies

Romani women's presence in the ward is noted to the extent that it is marked both by caregivers and other non-Roma women (see Chapter 5 on the practice of ethnic room segregation at maternity wards). My Roma informants expressed much concern, and even a sense of angst, when the eventuality of hospitalization was raised, and the medical caregivers who treated them may have had similar feelings about their Romani patients (Belák, 2013). Two parallel dynamics provide a framework to further analyze why Romani women do not actively express their wishes and preferences during birth. First, the hospital is a predominantly *gadžo* environment dominated by pain, insecurity, and lack of clarity, and even humiliation. Pain, shame, and fear are prominent topics in most interviews about complicated births, and so are narratives of medical professionals' unsympathetic attitudes. Michala was 30 years old and had three children; she was surgically sterilized after her third birth. Her first delivery (at 19 years of age) was vaginal, but the next one was via C-section situation, which Michala had neither anticipated, nor fully comprehended:

I was crying, I didn't understand what [a C-section] meant. Right? ... A lot of doctors take care of you when they take the baby from the belly. And they said among themselves that I have a narrow chamber, that I have a narrow pelvis. And I didn't understand what that meant, because you don't know anything when it's your first childbirth. And in the morning, [the doctor] says “we are going to do it, prepare yourself, we are doing a section”. And they start pulling off my clothes. ... It's good that you're not awake [during the surgery]. How much I cried! I saw how they measured my belly to see how much they should cut! Do you know how much I cried? I was completely

[33] On the fact that biomedically unwarranted C-sections can often take place for reasons of hospital profit see Hoxha & Syrogiannouli & Braha et al., 2017.

finished! (*Imar pal mande has.*) I say to myself: how many doctors see me [naked], I say, what are they doing to me? I cried so much!

With her naked body fully exposed, possibly for the first time in her life, Michala was obviously seriously distressed in the situation she described above. Notably, there were no traces of a caregiver's verbal reassurance or support in her narrative.

The Romani women I knew well enough to call my friends, and whose daily physical mobility trajectories I had mapped out, mostly stayed at home or in the settlement. Whenever they left the settlement, they would always go in the company of other Roma. Men were more mobile than women, but even they rarely drove a car alone. In light of this, the amount of mental pressure hospitalization put on women should not be underestimated. Still, staying at the maternity ward could be a time when women met other Romani women, formed new friendships, and had fun together. It could potentially be a relaxing time spent away from home, and there was the opportunity to access some much needed self-care. Kira, for instance, explained to me that it after her deliveries she always had her hair done at the hair salon located in the hospital complex. But the occasional sense of community Romani women experienced at the ward was prompted by a feeling of alienation in an institution dominated by *gadže*. When I asked Ornella how she had felt after she was transported to the ward to deliver, she said that she was afraid because she was alone in the room. In the course of conversation it gradually became clear that she had in fact had a *gadži* roommate – her solitariness was framed in ethnic terms. When talking about another birth, she described the dynamics between women of different ethnic background:

Ornella: It was like... there was one half-Roma with us ... Her mother was a *gadži*. And her husband visited her. She was [initially] put in a room with *gadže*, but she came to us anyway. The *gadže* weren't friends with her. She said it was better for her with us ... Because with us it's so much fun ... we walked together everywhere …

Edit: The women were nice [in the ward]?

Ornella: Yes, they were funny … She ... even cried after me when I went home. She cried! We didn't even sleep at night. We just went to bed at 2-3 a.m., sometimes we were up until the morning came. We chatted ...

Some of my informants preferred to be placed in rooms with other Roma, and when this was not arranged, or when the other Roma were discharged earlier, they often felt deserted and afraid. In order to feel more at ease after their deliveries, both Puma and Manka requested to be placed with Romani women when they had been initially roomed with *gadže*. When I asked them to explain, they reasoned the following way:

Manka: I don’t know, I felt like ...

Puma (interrupting): Will you feel the same way among *gadže* as you will feel among Roma?

Manka: Yes. It’s kind of sad [*oda smutnes*]. Yes! And then they put me with the Roma ...

Puma: Me too, when I was alone in the room, well, how should I explain? ... I told [the nurses] I don’t want to be alone in the room! And then they put me in the room with many [Romani] women.

Manka: See, it’s better when there are many women, because you chat, they crack jokes ...

Puma (interjecting): Sure they do!

Manka: ... for instance you go and you have some kind of a girlfriend there; it doesn’t matter that you just met, because you will become friends and the two of you take a walk [on the floors above and below] and the day goes by like nothing [*raz dva tuke odžal o džives*]! When you’re alone there ... the *gadže* ... you think they will talk to you?

Besides estrangement with regard to people, processes, and even the cuisine in the maternity ward, which according to my interlocutors ethnically-based camaraderie can alleviate, there is yet another dynamic at play. The women framed their hospital stay as an array of biomedical events in which they were neither qualified, nor interested in making significant decisions. The fact that Roma women accede to the delivery process being governed by medical professionals is a result of the perception that childbirth is not a natural process guided by the female body, but an unpredictable and always potentially dangerous set of circumstances over which only those who are in possession of expert knowledge can gain mastery. Based on his long-term fieldwork research in a segregated Central-Slovakian Romani community anthropologist Andrej Belák (2017, p. 10) claims that among marginalized Roma biomedical expertise is strongly associated with the *gadžo* world – it is a type of knowledge that Roma claim not to possess, but it is something they revere. I agree that Romani women submitted to biomedical expert governance, but I also found that this deference is overruled when it clashed with other, more vital belongings. While Romani women from marginalized communities might be obedient during labor, they exert considerable autonomy in the times immediately preceding and following it – that is, when what they understand to be birth in biomedical terms has not yet began or has already ended.

Elenka and I discussed the extent to which she interacted with other *gadži* women who also delivered or were waiting to deliver at the ward. She assured me their interaction was

minimal and that, for instance, the dining room was ethnically divided. This is what she recounted:

> I stayed there alone, girl, with the baby. "It's good that you're not leaving" [a white girl] told me. They talked to me like this ... But when I'm alone I'm scared, girl! Alone! At least if there had been someone [Romani] to sit [and chat] with me! Veronika (a woman from the settlement) came, she just delivered, she was barely brought to the room and girl, she ran home! I told her not to go, but she's like she has to go because of the [other] children [she has at home]. I tell her "you're still bleeding, aren't you afraid of getting out of bed? You're bleeding!" They had just brought her the food to the room and she ran home!

I asked Elenka whether she would ever consider "running away".

> Elenka: I wouldn't run away like that, but ... the thing is ... if somebody stays there I would stay, but if there's no one ... I'm scared to be alone [*me man darav korkori*]!
>
> Edit: So you ran away too [*he tu denašľal*]?
>
> Elenka: I did, later. I came home. Because [staying] alone ... no way!

During labor, the mother's allegiance is chiefly to her new baby, but shortly after the delivery she regains her decision-making power and is again participating in different ecologies of belonging which shape her potential decision to abscond. While many Romani women remain at the ward for the customary two to four days after birth and are generally cooperative and even easy patients, some decide to depart before their official discharge, normally leaving their newborns behind and collecting the baby at a later date (see Chapter 4). Veronika was already a mother of multiple children, and after delivering her new baby she opted to go to the place where she was most needed: at home. In spite of Romani families being large and living in close proximity to each other, I was often told that when the mother leaves for the hospital, no family member volunteers to make sure the children are kept clean and well-fed. For Elenka, taking care of her older children was never an issue – she had a supportive mother-in-law who would always assist with family chores when she went to the maternity ward. Elenka "ran away" because she felt deserted at the ward and needed to be at home so she could feel at ease and reinstate her identity as a useful member of her community.

As the hospital is not a place where Romani women feel secure and autonomous, when the birth process began, all my interlocutors chose to remain in their home environments for as long as they felt it was safe for the baby and themselves to do so. During my long-term research, I registered a small number of cases of women being driven to the maternity ward for delivery by their husbands or other family members, but this exclusively applied to Romani

women from socially upwardly mobile families. Except for the local elite, the routine scenario for being transported to the hospital, which was at a distance of approximately 25 km, was to call the ambulance. Delaying calling the ambulance, and thus postponing the moment when women enter the foreign environment of the maternity ward and succumb to the medical gaze was another highly autonomous decision that strongly transpired from our interviews.

When I asked my friend Barbells [*Činky*] to describe where she was when the contractions started during her first birth (at the age of 15), which was out of the five deliveries she had already experienced by the time I interviewed her, she said she waited for a day after the contractions started and only called the ambulance when the delivery was imminent. Her next birth took place in the ambulance, on the way to the maternity ward. Ornella also explained that it was better to wait in familiar home surroundings as long as possible once the contractions started. "Why would I go [to the hospital] so early? They will just let you suffer," she said.

Many women talked about first washing up before calling the ambulance and even finishing the cooking or cleaning or other activities they were engaged in. The breaking of the water was normally the right time for an ambulance to be called, but in case of medical emergencies, such as bleeding, the ambulance was summoned without delay. Its arrival was a socially sanctioned moment of the beginning of birth when people came out of their houses and publicly debated the situation of the laboring woman in question. Women perceived this as the moment when birth as a biomedical process truly began and from that moment on the responsibility for its progress and outcome was to be borne by obstetric professionals. Once the (exclusively *gadžo*) medical professionals arrived, Romani women ceased striving to actively shape their deliveries.

What Marginalized Romani Women Want

When medical anthropologist Elen Lazarus published her article titled "What Do Women Want?" addressing the issues of choice, control, and social class with respect to birthing and pregnancy, she found that poor women experience limits in their choices and control over their birth. Lazarus attributed these to a sense of being "overwhelmed" with socio-economic constraints: certain inhibiting conditions, according to Lazarus, preclude "their ability to acquire knowledge about birth and their ability to act on such knowledge" (1994, p. 26). The lack of this knowledge impedes their ability to "manipulate the system," and as a consequence they are unable to significantly impact their own childbirth (1994, p. 39). Almost all the characteristics Lazarus uses to describe these women fit the description of my interlocutors quite well – they, too, have lower educational levels coupled with unemployment, and early

and unplanned childbearing.[34] But while Lazarus's interviewees expressed a strong interest in being cared for by medical personnel with whom they had a history of interaction (which the authors describes as the "continuity of care"), I found that the women I interviewed did not express much interest in building a relationship with their doctors or nurses.[35] Instead, what they wanted was to be seen and recognized as patients with equal rights to those who had a Slovak ethnic background. Their definition of equity was mainly tied to two aspects of care in particular: they demanded non-judgmental communication by caregivers and to be given a fair share of material benefits.

Romani women gave very vivid accounts of their verbal communication experiences at the maternity ward. When describing their deliveries, what women in almost all interviews recounted were direct quotations of medical professionals chatting amongst themselves either about private matters or matters relevant to their work environment. In these accounts, the position of the women who recounted these interactions was that of silent listeners. Sometimes, my interlocutors claimed, caregivers talked about them as if they had not been present at all. Other times, women reported being involved in the conversation in an ambiguous way. To get a clearer understanding of how Elenka evaluated the quality of support provided by her caregivers, I asked her what the nurses were doing while she was in the final stage of labor. She recounted the following conversation:

> Elenka: They stand, look how it's going ... for instance, so that when it goes badly. They don't care that you are in great pain, that you're crying, freaking out ... they are unconcerned. They start taking care of you when they see that the baby's head is emerging. Otherwise not.
>
> Edit: And they didn't talk to you at all?
>
> Elenka: They did! This is what they said. [One nurse] says "you see," she says – and I say "[lady] doctor ... " "I'm not a doctor!" she says. "I'm a ... [incomprehensible], we are all nurses". I say "yeah?" She says "we have to work now," she says, "we work now and the doctor," she says "he is there, he's lying down," she says, "he knows well," she says "how to put money in his pocket and we work instead of him". She told me just like that, girl! They talked to me, I can't say that they didn't.

[34] Lazarus also mentions that her interviewees often do not have adequate health insurance, but because there is a universal health insurance plan in Slovakia this is rarely a cause for concern there. Unlike the women Lazarus talked with, my interlocutors also were not single, although many described their marriage or cohabitation as volatile.

[35] This was however also never a realistic option, as women attended most of their prenatal care (if any) at the office of their gynecologist, who was located at their catchment area, but in a different city.

I never learned what Elenka had wanted to say to the nurses or midwives (whom she had mistaken for doctors) when she initiated the conversation. The medical staff, interrupting her too early, may not have found out either. The nurses conversed with Elenka, but in her narrative they did not address her needs, but instead spoke about their own; the interaction with Elenka was an opportunity for the nurses/midwives to vent their feelings of unfairness about a hegemonically structured workplace.

Roma are acutely aware of the majority population's concern about a rising Romani birth rate, and I was often told that doctors and nurses at the maternity ward are frequently vocal in their denunciations of the higher than average Romani fertility. We were in the middle of a recorded group interview when Puma suddenly remembered that she needed to book an ultrasound appointment at the maternity ward. I did not turn off my recorder, and all of us listened in nervous silence as she was making a phone call in Slovak – a feat she performed with much trepidation. The nurse on the other side of the line made it clear from the beginning of the telephone call that she was aware of Puma's ethnic identity. Puma spoke relatively fluent Slovak, but her distinctly Romani accent and syntax must have served as instant signifiers. The nurse made several sarcastic comments about Puma's pregnancy, conveying the message that Romani women were perpetually pregnant but always unknowledgeable about where or how to seek prenatal care. After she hung up, everyone at the table relaxed and patted Puma's back. We chatted about how the call went, but no one broached the subject of the nurse's acerbic remarks with me – not because they went unnoticed, but because overt racism in communication with *gadže* obstetric professionals was so commonplace that it was unremarkable.

Considering the recent scandals over poorly-informed consent obtained for Romani women's sterilizations, which allegedly also took place at this specific maternity ward, medical advice on the advantages of contraception must have been just as sensitive and racially charged for medical professionals as it was for my interlocutors. Yet, if it had been voiced in a friendly manner, my interlocutors were only rarely critical of this kind of advice. After a recent difficult birth, Elenka said a nurse told her:

> You shouldn't one [nurse] says "have that many children, because" she says "you have difficult births," she says. I say "I don't want [any more children/births], I'm going to get an IUD!" I say. "Well, you should," she says "because you know how tough your deliveries are." "Indeed" I say, "yeah". I had a difficult one with this baby. It's good you don't die during a delivery! [*Oda lačhes kaj na meres paš o porodos.*]

Elenka did not end up getting an IUD during my time in the field, but she described herself, as did many other women, as being worn out by children.[36] But when I asked her – or any other woman who had given birth at the ward – whether she actually received detailed, personalized contraceptive guidance upon her discharge other than a general encouragement to take more personal responsibility for her reproductive trajectory, the answer was negative. Some caregivers went further than providing well-meaning fertility advice. Michala recounted that she once got into an uncomfortable argument with an ambulance driver who drove her to the maternity ward. As Michala was experiencing contractions, the driver allegedly told her off.

> They told me "girl, you wanted to have children when you are still yourself a child?" Every doctor will tell you this. If you go to give birth at the age of 13 or 14 ... each and every doctor will tell you this. "You wanted to have children when you are still a child!" So I say: "So what now, when it's on the way?" And he says "indeed".

Whenever my interlocutors felt that medical professionals were not communicating a clinical message but were bringing their personal opinions that expressed racist beliefs into the encounter, it left the women feeling mortified. Again, a few women recounted that this happened most often when the mother was an underaged Romani girl. A teenage mother whom I did not know very well made the following conclusions:

> You couldn't tell that I was 16. They thought that I'm 18 or 19. They even told me that "you don't look like you're so young." There was another [Romani girl giving birth] with me, Ivanka, and she was 19 and she looked like she was 15-16. And as [the medical staff] see that [the girl] looks older than her real age, they just speak normally to her. [Incomprehensible]. They shout, saying "such young girl and you'll already be having a child". They scream at her. If it's [a girl who looks more mature than her real age] they talk normally to her.

Manka explained to me that even if Roma girls have children at an early age and even if Roma have a higher number of deliveries, caregivers should talk to them in a decent manner [*majinen slušnes te vakerel*]. She reasoned that Romani women take the position of patients in the medical encounter, and just as any other patients, they deserve to be treated equitably. When she told me the story below she was much more emotional than when she described her deliveries:

> Manka: You know, when you get the [maternity] presents, [the nurses] take out the things ...
>
> Edit: What presents?

[36] On contraceptive use see Chapter 1.

Puma: The ones you get in the box! Check out what they did to me ...

Manka [interrupting]: ... they took out the things! And the *gadže*'s [box] was unopened!

Puma: Check out what happened to me. I knew they were taking some stuff out of my [package], because I saw that the box was open. They took out the feeding bottle and there was just a lot of paper inside.

Eva: They didn't give her the kind of package she deserved! They take out stuff!

Manka: I threw away the box! All the Roma had theirs open!

Manka, Puma, and Eva (who interjected a comment even though she had never given birth) perceived the tampering with their package as both insulting their patient rights ("They didn't give her the kind of package she deserved!") and as an evidence of a practice implying ethnic discrimination at the ward ("All the Roma had theirs open!"). They were far less infuriated by any other aspect of maternity care. The packages became an ultimate litmus test of the staff's equal approach to patients of different ethnic background and social standing: when no other but material circumstances are at play, why don't they treat Romani women the same as the others?

Conclusion

This chapter analyzed women's birth narratives from Veľká Dedinka and examined the issue of personal autonomy in the context of childbirth at a maternity ward, which is one of the most fraught locations of intersection between Roma women and the state. Cultural narratives shape the way women think about the decisions that surround childbirth. Social scientists researching women's birth-related decisions have contended that a preoccupation with (self-) control, decision-making and resistance are characteristics that describe middle class women. Similarly to Liamputtong who conducted research among poor Thai rural women (2005) I found that most disadvantaged Romani women did not discuss their deliveries at length, and my research corroborates the also conclusions of other anthropologists whose focus is birth narratives of women of lower class status (Martin, 1992; Lazarus, 1994; Zadoroznyj, 1999; Kabakian-Khasholian et al., 2000). These women tend to focus on the pain, the process of birth, and the personal care they receive instead of emphasizing their own choices.

The Romani women who participated in my fieldwork were likewise focused on their delivery results and not the transformative process of birthing. They did not appropriate the narrative of mothercraft (McCabe, 2016); instead, they talked about the practicalities and logistics of birthing, the associated pain, and the communication of and with medical professionals. Even in the case of deliveries which qualify as non or low-intervention "natural

births," childbirth was not framed in an emancipatory language. Women who delivered easily did not give accounts of elation, empowerment, or self-fulfillment, and their narratives did not reveal any appreciation of freedom from interventions. Most women who shared their birth narratives had limited interest in and knowledge of ways to actively shape their birth experience. They frequently reported being told to do certain actions (e.g., "push," "undress," "go to the operating theatre"), and it seems that medical professionals rarely solicited women's opinions on what their bodily selves were about to experience. When pondering complicated, painful deliveries, the emerging birth narratives created a sense that women experienced their births as careful observers, rather than participants with specific wishes and preferences regarding how the birth should proceed. Poor Romani women internalize the medical gaze, interfere little in the birthing process, and largely accept biomedical hegemony. Yet discourses of victimization do not emanate from their narratives and they are not obedient reproductive subjects throughout the maternity care process.

Marginalized Romani women defer to the biomedical care model. They consider childbirth to be a messy, incalculable event, for which the female body requires external expert management and such medical savviness is associated with *gadžo* caregivers. Women were often unclear about the medical procedures that were involved in their hospital births, and their knowledge was limited especially in the case of young and inexperienced first-time mothers. In addition, Romani women coming from marginalized backgrounds perceived their own situation as vulnerable in a foreign, institutionalized environment where most birthing mothers are *gadži* women who seem to have different needs and preferences even with respect to giving birth. They were well aware of their ethnically-marked position at the maternity ward and many women found that the health professionals' behavior was prejudiced or openly racist.

My interlocutors' hospital stay was often marked by feelings of loneliness, fear, or a sense of being unequal to the women from the majority Slovak community. At the same time, Romani women employed strategies which reasserted their agency before and after giving birth. Autonomy and agency *are* things that Romani women seek during a certain phase of childbirth – by delaying their entry into or hastily exiting from the maternity care system. But when they employ uncooperative strategies such as absconding, these are interpreted by medical professionals as women's lack of ability to take full responsibility for their own bodies and that of their newborn babies. Romani women may not participate in the rearticulation of a neoliberal self during birth, but they emphasized the need to be given the same discursive as well as material treatment offered to majority Slovak women. According to my interviews and observations, what they want is not an increased array of choices during birth, but caregivers who give them equitable treatment and whom they can trust to lead a low-pain delivery process. As Rose (2001) reminds us and Trnka (2014, p. 139) underlines, autonomy and

choice are sometimes unattainable, and they are not necessarily something individuals desire. The accent on choice, so common in the social science literature about birth, may in fact preclude the experiences of marginalized women who frame their birth encounters in the terms of reproductive justice.

The following two chapters steer away from the focus on Romani women's individual reproductive choices, as they examine agency and racially marked patienthood at a Czech maternity ward.

5. Rationalization, Stereotyping, and Good Patienthood at the Maternity Ward

In the previous chapters, I situated Romani fertility at the community level through an analysis of individual trajectories, and by reflecting on the intersections between reproductive decisions and broader population politics as they materialized in my informants' lives. I examined reproductive actions and desires that may or may not result in pregnancies or their termination, and I reflected on the space that existing children carve out in the lives of my informants. In the chapter before this one I analyzed birth narratives told from the point of view of women from Veľká Dedinka. In this chapter, I leave my long-term fieldwork site and shift in time, space, and perspective to pursue the question of Roma fertility as seen by healthcare professionals in an institutional setting. I will linger here for this and the next chapter, taking stock of situations connected with Romani presence at the place where Roma children are born.

Conducting fieldwork in a hospital was part of my initial research plans back in 2010 when I began my ethnographic investigations at what was my main field – the segregated village of Veľká Dedinka in eastern Slovakia. Initially, my hope was to follow reproductive decisions to the very place where the abstract choices and vague possibilities about having children (or not) turn into corporeal, ontological realities both for the parents of these children and the larger society: the maternity ward. Due to a constellation of personal mishaps and institutional inflexibilities, after eleven months of fieldwork in the settlement I abandoned this plan in January 2011, and my life took a course that had diverted me away from academia and ethnographic research for a number of years. Once I returned to working on my dissertation, I strongly felt that it was important to take reproduction as an analytical category physically out of the boundaries of the segregated settlement and observe it in a context where it is confronted with the norms and expectations of the medical system. This became possible in December 2016 thanks to a grant from my university,[37] which enabled me to spend ten days observing and discussing the processes of pre- and postnatal care at a maternity ward of a large industrial Czech town which I call *Továrnov* in this dissertation. Due to a large Romani population in the catchment area many Romani women give birth at the maternity wards where the research was conducted.

This chapter focuses on the ways medical professionals strive to provide good care to reproductive others in spite of holding stereotypical opinions of them, but I will begin with a short detour. Although my main fieldwork site is located in eastern Slovakia, the maternity ward

[37] I was the beneficiary of GAUK Grant No. 1110116.

I chose for my second field site is in the Czech Republic. My decision to opt for this specific Czech hospital was based in a number of factors. First, to my knowledge, there are almost no qualitative studies (academic or other) examining the interactions of Romani women and medical professionals at Czech maternity wards, whereas in Slovakia there are at least two publications by the non-governmental organization *Poradna pre občianská práva* (2003, 2017) exploring this topic. These studies, sadly, uncover significant human rights-related abuses and possible mistreatment of Romani women in the reproductive health system. I take the issues they raise very seriously, but I also felt that these publications and their aftermath rendered ethnographic research focusing on Roma at maternity ward settings a potentially contentious issue in the country, if not entirely impossible, at least at the present time. I was not interested in working in a high-conflict situation and I wanted to conduct my research at a hospital which is known for its good treatment of Romani patients. I was interested in enquiring into what happens to Romani fertility in a medical setting where inter-ethnic animosity does not surface explicitly and where motherhood functions as a master status (Hughes, 1963) that, at least potentially, overrides ethnic belonging. I knew of only one such ward, and it was located in the Czech Republic. Its geographical proximity to my home in Prague posed an additional advantage.

In this chapter, I will describe two situations in which friction tends to occur between Romani patients and non-Roma medical professionals. I will show that medical professionals re-negotiate these situations in ways that enable them to think positively of their Romani patients, even in spite of potential conflicts of interest between staff and patient. Showing an empathic attitude towards Romani patients' particular behaviors serves as a standard that in turn influences the care process: it helps staff to maintain their professional identity as good caregivers. Good caregivers were defined by staff as professionals who are perceptive of patients' particular needs. At the same time, good caregivers also invisibly shape the care process in the normative directions prescribed by contemporary Czech maternity care, which is driven by consumerism and the commercialization of birth care (as described by Hrešanová and Hasmanová Marhánková, 2008).

Doing Ethnography at a Maternity Ward Setting

In December 2016 I spent ten days observing a Czech maternity ward with a relatively high number of Romani women-patients, the overwhelming majority of whom come from socially excluded localities.[38] Compared to my previous long-term fieldwork experience where

[38] For reasons of anonymity, no clues are provided in this paper about the size, location, or patient culture of the hospital. While no details are given about the estimated number of Romani women who

I was accustomed to being actively engaged in shaping what took place in my field, my position in the hospital was relatively limited. For researchers who are not medical professionals, there are obvious restrictions to the participatory aspect of doing fieldwork in a hospital setting, and anthropologists conducting hospital ethnography essentially have three possibilities: joining the staff, the visitors, or the patients (van der Geest and Finkler, 2004, p. 1998). I selected the staff and the patients. I alternated between the postnatal ward and the department for high risk pregnancy, spending between three and eight hours observing either one of these during each day of my fieldwork period. Besides taking notes on what was happening around me, I conducted semi-structured interviews with nurses, midwives and patients. My focus was on the hospital staff and the women who gave birth there,[39] but I also conducted a focus group interview on birth and pregnancy experiences with the Romani mothers who were involved with a non-governmental organization in the city.

Altogether, I conducted seven semi-formal interviews with staff, none of whom were Roma. Five interviews were with nurses and midwives, one was with a student-midwife and a final one was with the head doctor of the ward. Two were recorded and transcribed verbatim, and the remaining five took place with me taking immediate notes during our interaction. I had a few attempts to semi-formally interview Romani women who were present at both departments to give birth, but these interviews felt rigid and awkward. Building on my previous experience with interviewing disadvantaged Romani interlocutors in environments that are primarily associated with the *gadžo* world, I did not find this surprising. My informal interactions with Romani patients bore more resemblance to the casual conversations I was used to from my long-term fieldwork in eastern Slovakia. With one Romani woman, who did not describe herself as coming from an impoverished background, I succeeded in creating a rapport which enabled deeper, repeated conversations over a course of five days. I also interviewed two Czech women who came to the ward to give birth. All my interlocutors were requested to sign an informed consent form before or during our conversation. My research proposal was approved by the hospital's ethical board, but, understandably, my presence was, at least in the initial phase, viewed with a reasonable amount of wariness by staff. Since ethnographic research in at a maternity ward setting is very unconventional in the Czech setting (for an

give birth at the hospital, I was meeting with between zero and four Romani patients in the ward on average.

[39] A note on terminology. Within our conversations, midwives and nurses would use the words *pacientka* (female patient) or *maminka* [mommy] to talk about women before or after their births and were in their care. The term *ženy* [women] was also used, though somewhat less frequently, and so was *rodička*, an expression that translates into "woman giving birth". The term *klientka* [female client], advocated within a consumerist approach to birthing in the country (Hrešanová, 2007), was mentioned by one nurse as the phrase that ought to be officially used within the ward, but, as she remarked, "it never quite stuck in the Czech environment". I mostly use the term women here, but occasionally I also refer to patients, because many of the women were hospitalized with birth-related complications and required constant medical attention and intervention.

exception see Hrešanová, 2008), I was sympathetic to the birth workers' misgivings and did not pressure any for interviews in cases where they were obviously uninterested in active participation in my research.

The goal of my fieldwork research was to study the processes of decision-making and care that concern Romani women while in the ward, and my emphasis was on the experiences of medical professionals. My presence in the institution was limited: I was confined to the shared halls, and I only occasionally ventured into patient rooms. I was usually positioned in the open waiting room area at the end of the hallways of both departments, which also served as the space where food was served. While occasionally accompanying nurses for minor procedures (e.g., administering drugs, giving blood tests), this was the place where I spent most of my time, taking notes in a notepad. At both departments, the room where Romani women were normally placed was situated at the back of the hallway[40] and easily accessible from where I sat, which allowed me to easily initiate small talk with these patients. When interacting with patients, I asked them to describe to me what had taken place during their stay from when they were hospitalized. I also asked them to tell me what would make their stay more pleasant and what care processes mattered most to them during their hospitalization. In addition, I inquired about their deliveries or specific treatments they underwent. Most importantly, however, I asked them to describe to me what takes place in situations when they experience good care.

Because I was primarily interested in the opinions of medical professionals, in my interviews with nurses and midwives I first asked them to describe to me what takes place when good care is accomplished. Later on in our conversation, I inquired about what happens when this goal is not achieved. I wanted to know what happens when not-good-enough care takes place, because impediments to good care have arisen. I also asked them to describe which patients were easy and which ones were difficult to care for. The category of Romani women either emerged naturally from our interviews or was prompted by the fact that in my introduction I explained that my interest lies in studying processes of decision-making and care with regard to Roma in the ward. The staff was, from the beginning of our conversation, usually quick to point out the differences between various types of *pacientky* (patients), assigning specific qualities to Romani women. Staff never explicitly talked about good vs. bad patients – these are labels that emerged from my analysis.

[40] The practice of ethnically segregated rooming in the subject of the following chapter.

Maternity Staff Interactions with Romani Women and Other Others

Barriers to Romani women's access to maternity care services have been identified across Europe, and medical professionals' negative typification of Romani women is based on their patients' ethnic and social background (Watson and Dowe, 2017, p. 1). In the Czech setting, the lived experiences and interactions of non-Roma staff and Roma patients are insufficiently explored in the maternity and other wards. In their analysis of consumerism in Czech maternity wards, Hrešanová and Mahranková (2008) mention that women from underprivileged families and ethnically excluded localities (which are both euphemistic expressions for Roma) are categorized by staff as confused patients. The ensuing implications of caring for this group of patients are, however, not depicted in detail. Focusing on the effect of social inequalities among women giving birth at a Czech hospital, Sopuchová and Bužgová (2013) collected midwives' assessments of their own approaches to Romani women. These accounts testify to an alarming extent of unconcealed, self-recognized prejudice, as a number of the midwives confess that they or their colleagues treat their Romani *rodičky* [birthing mothers] both verbally and physically with less respect than they show toward women whom they consider to be of high socio-economic status. For instance, one of their interviewees, a 34-year-old midwife named Simona, says: "One does not have such respect toward [Romani women], I am aware that I probably don't have the same kind of relationship with them as I do with normal, how shall I say, white women. I just kind of don't like them" (Sopuchová and Bužgová, 2013, p. 532, my translation). On the other hand, in the Slovak context Belák has documented that medical staff habitually encounter difficulties when providing service to Romani patients, although his study does not specifically refer to maternity care. In emergency-rescue and clinical practices medical professionals often find that standard clinical procedures are ineffective when applied to segregated Roma, which causes much frustration to the former (Belák, 2013, p. 24). Healthcare workers, especially at pediatric and obstetric wards, routinely face extreme verbal abuse, mocking, and physical attacks by Romani patients and pediatric patients' parents to an extent that is incomparable with the behavior of other ethnic groups or of ethnic Slovak patients (Belák, 2013, p. 24).

The racializing and typification of ethnic minority women by healthcare workers at maternity and obstetric wards and has been recorded by the anthropological, public health and nursing literature worldwide. Based on qualitative interviews with medical staff at a Dublin maternity ward with a high number of mothers with a non-Irish background, Lyons et al. conclude that service providers often used words such as "stress," "worry," and "difficult" to describe caring for ethnic minority mothers (2008, p. 268) and considered these as not conforming to the Irish system of maternity services (2008, p. 270). This is in line with the findings from other studies, which describe such groups of women as being, at least from the

perspective of medical staff, non-compliant (Bowler, 1993; Katbamna, 2000). Women perceived as coming from ethnic minorities are often reported to exhibit behaviors that sharply differ from their non-ethnically-marked fellow patients in the ward. Lyons et al., for example, found that ethnic minority women were described as making significantly more noise while in labor, therefore demanding more attention from midwives at the expense of other patients who tend to be less "dramatic" during labor (2008, p. 267). According to Bowler, visibility (darker skin color) contributes to the negative typification of black and other ethnic minority mothers in the ward (1993, p. 170). Members of racially or socially marked groups often encounter stereotyping by healthcare professionals, and a certain (lower) moral status is often attributed to women belonging to such groups (Bowler, 1993, p. 158).

However, classification does not always exclusively pertain to women coming from different ethnic backgrounds or races (Thompson, 2005), and stereotyping is not always meant in a negative way. Macinty (1978, p. 598) notes that maternity nurses frequently typify birthing women in order to gauge the type of communication that women would prefer. The nurses gathered information about women's husbands' occupations, and based on this information the nurses adjusted their communication with the wives. Schramm and Beaudevin (2019, p. 277) emphasize that classifications are common epistemic practices for health professionals and policymakers, whose work often requires them to create categories related to disease or risk. These are informed by and intertwined with belonging related to race, class or religion. Categorizations are thus not just abstract practices, but have significant, material impacts on the lives of the who are subject to them. Those who form categories rarely address or discuss them, as within their local moral worlds the categories they form are assumed to be true and do not require questioning (Schramm and Beaudevin, 2019, p. 277).

Negative stereotyping in maternity care (or any other medical field) is of concern to social scientists and human rights activists, and the subject must be pursued further in order to achieve reproductive justice for all. Yet, by narrowing their attention to the adverse situations in the reproductive healthcare system and ignoring situations of successful Roma-caregiver cooperation, researchers who focus on the negative implication of categorization processes in healthcare settings unwittingly contribute to the portrayal of Romani women as "difficult patients". My study addresses the fact that the relationship between Romani female patients and medical staff at a maternity ward is not always discordant.

Good Care and Classification: The Issue of Compatibility

Care is at the very core of the nursing profession (Leininger, 1988, p. 154), and Czech nurses are no different in their commitment to this value. Their understanding of themselves as professionals and their judgements of their colleagues' professionalism is contingent on the

type of care they are able to provide to the patients assigned to them (Bludau, 2017, p. 8). According to Roach, caregiving in any medical context is a "moral enterprise" (1984, p. 2), an act that is best described as virtuous (1984, p. 4), involving a sense of "sacredness" (p. 77). Going beyond the caregiving professional and care-receiving patient dichotomy and situating care in the physical reality of its everyday setting, Mol (2008) talks about the "art of care" and dissects the roles various actors in the care process play. Good care here is a collaboration: in Mol's understanding, care is not provided by a single person or a team of professionals, but is done collaboratively by service providers, patients, families and machines. Importantly, patients are "crucial members of the care team" (2008, p. 23).

My position is that good care, which is primarily conceptualized as an individualized approach to patients, and the categorical thinking by staff are not mutually exclusive. In this chapter, my focus is not primarily on how stereotypes are formed, but instead on how they intersect with the category of the "good patient" and what happens when the latter gets disrupted. Contrary to Hrešanová's (2008) approach, the emphasis here is not on the categorization process itself, but on the ways staff strive to maintain or cultivate a positive image of Roma patients. This is in spite of the fact that, based on their behavior, these women could easily be written off as "bad patients" – and yet they are not. I discern points of friction, when staff consciously re-negotiate a relationship that reinstates women who break moral or institutional rules as "good patients". And I agree with Bolwer (1993, p. 167) that it is possible for medical staff to hold stereotypical opinions of a group without being unsympathetic to them. The scope of my research borders on the topic of the nurse-patient relationship at the maternity and related wards, which has so far attracted much less attention from anthropologists than the doctor-patient relationship (Lazarus, 1988; Fainzang, 2015).

In our interviews, the nurses underlined the importance of providing good care to all women in the sensitive postpartum period, and tailoring care processes to perceived individual needs. Needs are diverse, reflecting socially significant differences, and staff claimed it was their job to find a suitable communication channel with all women while also, at the same time, softly guiding them in their transition to motherhood. As one nurse put it:

> Especially when it's their first child, women need a lot of [professional] attention. I mean, it depends where they come from, but … You need to explain everything several times … All of a sudden everything is different [because they have a baby now]; you must be extremely patient with them, explaining everything ... but it depends on the type of woman. You need to find out what she is like.

In order to provide care that meets these standards, the healthcare staff say that their task is to fine-tune their understanding of women's individual needs and guide them toward

normative treatment options. Categorizing[41] is a complex process that involves the physical assessment of newly admitted patients in the ward. Skin color and tone, for, instance, as well as surnames, or linguistic cues serve for the nurses and midwives who talked to me as guides in judging ethnic belonging. Staff can also check medical records, which may reveal a history of depression, or drug or alcohol use, and find clues about the women's social class by checking their records for their self-reported employment status and professions. Within the process of sorting all of these are essential signposts at the beginning of the patient-nurse encounter.

With regard to the way categories are formed in the maternity setting, ethnicity emerges as more significant than social class (also see Bowler, 1993, p. 167). Among the nurses I talked with, there was a firm consensus that Romani women (or Vietnamese women, whom I did not encounter during my fieldwork) are groups that are clearly distinct from one another as well as from ethnic Czech women, and that this translates into disparate attitudes and behaviors. Several themes emerged that, according to staff, are particular to Roma patients. For instance, Romani women were said to be both more natural [*vic přírodní*] and more experienced. Since they give birth more frequently, their deliveries were described as smoother and easier. Their supposedly inherent spontaneity qualifies them as better mothers of newborns. Midwives said that Romani women start breastfeeding easily, nurse upon demand, and instinctively know what to do with their newborns to the extent that "you don't hear their babies cry". While their experience pain more intensively and are likely to "throw a fit" during delivery (meaning that they use obscene language, kick, and cry louder than non-Roma), afterwards they tend to apologize. They are restless, difficult to confine to bed even when medical reasons mandate it. They do not like solitude, frequently visit other Romani women in the ward, and sometimes sleep at night with the lights on. Some of the nurses and midwives I talked to during my fieldwork research also recounted unpleasant interactions with Romani women, including verbal abuse and vulgar language. Some described situations in which their conflict with Romani patients or their families jeopardized staff's physical safety.

Staff maintained that they need to assume different positions and actions towards Romani women compared with when they deal with non-Roma (especially those with a higher level of education). First, when sharing information, nurses say they need to adjust their speech (vocabulary, syntax and tone) when talking with Romani women. This includes avoiding technical terms and, as one nurse put it "you need to talk to them as if you were talking to a

[41] This is my reconstruction of the categorization process, based on my observation and interviews. I stress this to clarify that this is an ethnographic interpretation, based on the staff's replies to my question regarding how they know a patient is Roma or how they find out about a patient's educational or professional background.

child”.[42] Secondly, Romani women “take whatever [medication] you give them” and, unlike more educated women with a socially higher standing, they do not argue about treatment options or interventions during delivery. As one midwife student put it: “if they don’t abscond then it’s really easy to give them good care. You don’t need to discuss everything with them, it’s the best – [you’re in the] position of power”.

Staff found that with Romani women it was easy to deliver good care – at least in the sense that staff defined good care practices. When asked to describe what takes place when good care is delivered, a nurse replied: “You tell her what you are going to do, you answer her questions, and she accepts the care I offer”. One nurse, for example, noted that when a woman consistently refuses a certain treatment option, a doctor is to be called “and the [patients] would then listen to his words.” With Romani women such extra pressure was not needed. In fact, from the perspective of the provision of care, nurses and midwives would in our interviews often characterize Romani women as nothing less but “ideal,” “perfect,” “great,” or “superb” patients.[43] Although the narratives of medical professionals tell of good care being given and received (that is, good care is conceptualized as a top-down approach), the examples below will still show that in practice in some aspects the good care medical professionals in the maternity hospital of Továrnov provide is reminiscent of the collaborative, team-like approach described by Mol (2008, p. 23).

Restoring the “Good” Romani Patient

Patients for whom nurses can provide good care, based on the interviews, are patients who accept the care practices the staff want to give them. When several treatment options are available, in order to provide good care, staff need to anticipate women’s preferences: “Romani patients, you know, they can be so submissive, they take whatever you offer them,[44] so you need to figure out what it is they actually need”. Women who do not feel comfortable and confident in the hospital setting or are “unsatisfied” will not be open to the best possible treatment options medical professionals can provide: “I need her to trust me. If she doesn’t, I can’t do much, she isn’t going to accept my care”. In order to receive good care, women must evince a receptive attitude toward what the staff offer them. But I suggest that this mechanism

[42] This corresponds to the advice given to medical professionals by Šlechtová and Bürgerová (2009, p. 191), who suggest that an increased sense of empathy is indispensable in order for communication to be effective between ethnic Czech medical staff and their Roma patients. Such empathy includes simplicity of speech and emphasis on positive non-verbal communication.

[43] Parallelly, other discourses were also at play. For instance, Romani women had a habit of not bringing their pregnancy records [*těhotenská knížka*] upon delivery, or not having it sufficiently filled out. This would be a great nuisance to nurses and it hindered their work.

[44] This is meant for standard interventions during the delivery process as well as medicines to alleviate pain in the postpartum period.

needs to work the other way around as well: in order to provide good care, nurses need to feel sympathetic toward the women whose care they are responsible for. This became apparent when I took a closer look at how they dealt with practices and behavior that went against the paradigm of a stereotypical “good patient”. In order to make my point, I will analyze two practices that nurses strongly associated with Romani women and which made them view this group of patients in potentially unfavorable light. In our interviews, both practices were depicted by staff as typical situations of conflict between medical professionals and Romani women who went to give birth to the hospital. In both cases, caregivers negotiated the practices in question in a way that reasserted Romani women as compliant – and thus good – patients.

Smoking was one of these practices. The percent of Romani women who are pregnant or lactate and smoke is significantly higher compared to the majority population (Rambousková et al., 2009) and, according to staff, one of the first things Romani women would normally do after a delivery is go for a smoke. Smoking is – naturally – banned in the ward, so hospitalized women needed to go outside into the designated smoking area located a few meters away from the main entrance to the building. Although a nurse commented that smoking was bad for both babies and mothers, she debated whether weaning patients from this habit was part of the care process. Instead, she recounted the unwritten policy of the ward:

> So we taught them the following. First of all, they need to tell us before they leave the baby in the room and go out. One of them [assuming two Romani women share a room and want to go for a cigarette at the same time] needs to stay with the babies, they can’t just leave them in their beds. But also, they just need to dress up [warmly] when they go out! These women never wear socks, even in this cold!

Although they are well aware of the consequences of smoking on the mother and newborn, staff do not intervene, because what they consider to be one of the most typical Romani characteristics is *neukázněnost* [lack of discipline]. They may not condone it, but they also don’t attempt to prevent Romani patients from smoking. Smoking becomes acceptable as an obviously out-of-place habit in the hospital – under the condition that Romani women are willing to negotiate the terms of their own behavior. By putting on socks and calling to notify the nurses they reconfirm themselves in the eyes of staff as patients who essentially accept the extra, inconvenient, surplus care and protection that the nurses provide for them. Hence, they reinstate themselves as agreeable, compromising patients. The affability of the pleasant nurse-patient relationship is not hampered by the fact that such paternalizing protection is not, in fact, valued by the patients themselves.

I experienced the significance of dressing up warmly myself when I accompanied a Romani woman outside for a smoke and my teeth chattered in the December cold. Beforehand,

my interlocutor not only dutifully informed the nurses as we were about to leave the ward, but she also demonstratively showed off her socks, saying: “Look, I got these on!” at the end of the interaction. I also observed similar scenes (involving socks or other extra clothing such as winter coats) when Romani women went out of the ward to get coffee from a vending machine, which was placed in the immediate vicinity of the department.

Another practice that is heavily ethnically marked is leaving the hospital early, before the mother and baby are officially discharged by the ward’s gynecologist and neonatologist on duty.[45] This normally takes place 3–4 days (at least 72 hours) after vaginal birth and around 5–6 days after delivery by C-section. A significant number of Romani women, staff claimed, leave much earlier than the prescribed time period for release. Those who make this decision are required to sign out, against the hospital’s advice [*podat negativní reverz*], stating that they are aware of the possible health consequences of their decision to shorten their hospital stay. Staff take this with a mix of frustration and awe:

> They go, they really go! They would sign out … they do this. Of course they would take out the surgical drain, right? And the mother goes home with the stitches still in her … How many times this had happened to us already [that a Romani woman] comes to give birth a year after her previous C-section and she would still have last year’s stitches. (…) These girls are impervious!

While an increasing number of non-Roma women also leave the ward earlier than is conventional in the Czech postpartum care in order to spend the first few days in the home environment rather than the hospital (this is termed *ambulantní porod)*, what is characteristic of Romani women is that their babies remain at the ward until they become eligible for dismissal. Babies are normally collected after they have been pronounced healthy and dismissed by medical professionals. To be sure, these are not “unwanted” babies that become eligible for adoption and the parents remain their official legal guardians. Because of abundant experience with this practice characteristic for Romani mothers, nurses would normally not request the intervention of child protection authorities, as the babies are – as a rule – reclaimed by their families within a few days. This practice causes many frustrations for the medical professionals. As one nurse explained:

> Really, it’s the most fundamental conflict between [Romani women] and us [medical staff]. You see so many of them in really bad shape and they still go home … the babies

[45] In the majority of these cases, neither women nor baby have serious health complications and are held in the hospital as part of the Czech obstetric routine. Often, however, Romani women also abscond while still being treated for serious health conditions.

stay in the hospital and [the Romani women] would even say “it’s your [nurses’] responsibility to take care of them”.

Previous attempts at restricting the physical movement of mothers at maternity wards have not proved to successfully prevent them from absconding. A nurse told me about a past practice at a different hospital when the ward doors were locked and mothers could get out only with staff’s assistance. This resulted in situations when Romani mothers eager to leave the ward would jump out of the window, some of them with a fresh C-section scar (the ward was on the ground floor). A midwife commented it as follows: “Basically, they don’t want our care, so we’re just going to provide that care to those who want us to care for them”.

The habit of smoking may bother staff, but it is not a hindrance to the delivery of care. In its gravity, in both legal and practical senses, it is incomparable with situations where a mother leaves her newborn baby in the ward and goes home. Following an uncomplicated vaginal delivery, women would be offered the chance to station their babies at the neonatal room during the first few hours or overnight so they can rest or get an undisturbed night’s sleep. Women who deliver by C-section would normally start taking care of their babies 48 hours post-surgery. Until then, it’s the pediatric nurses’ duty to care for their newborns. In the neonatal room, as many as ten baby boxes are available for use. After the immediate post-partum period, mothers would normally be expected to take care of their babies themselves, which involves tedious work. Among other chores, this includes changing diapers and cleaning the baby (a newborn’s diapers must be changed up to ten times a day, and in accordance with Czech custom, baby buttocks are usually washed each time they are given a clean diaper), dressing (depending on her digestion and the ability of the diaper to contain fluids, a baby’s clothes may need to be changed several times over during the day) and nursing or formula feeding at least eight times a day (one feeding may take up to 15–20 minutes and in the hospital babies are usually weighed on a scale before and after each feeding session). In addition, nurses explained to me that babies need be bathed on a daily basis, including oiling the body and cleaning the navel. In short, newborns are a hassle when their mothers delegate their care to the staff. The postpartum department is organized in a way that expects healthy and able-bodied mothers to function as caregivers, and not only birthers. A nurse said the following:

> It’s like … it’s not that we wouldn’t want to take care of these babies. But it’s like … those children … they in fact just shouldn’t be here [in the observation room], right? Their mothers should be with them, you know? Of course it’s not all … not all of them are like that, there are also Romani women who … but you see, this issue comes up rarely with normal [sic!] mommies.

The chance of a Romani mother leaving the hospital early is quite high[46] and the impacts on staff, especially as far as the pediatric nurses are concerned, are consequential. Many Romani mothers' departures come as a surprise for staff. A midwife said: "At one moment she tells me: 'Nurse, I'm okay, I'm staying'. The next moment the family comes for a visit, maybe informs her that the husband is not managing [to take care of the other children] … and she's like: 'I'm going'." Nevertheless, at least within the interview with me, staff describe their own reactions to such news as overwhelmingly empathic. This level of compassion is almost striking in a cultural setting where newborn babies are expected to be with their mothers almost all the time and mothers routinely spend the first 3 years of their children's lives on maternity leave.

In the case of Romani women, even though their willingness to leave their newborn baby behind would qualify them as irresponsible mothers and "bad patients," the staff are still able to rationalize these women's behavior. When asked about why they think Romani women leave the hospital (and their babies within it), nurses explained that their families (usually because of their older children) need them. Going home before official discharge and without the newborn is constructed by medical professionals as an unfortunate, but logical decision. After all, the medical personnel are aware that the majority of women abscond exactly because they are loving and caring mothers who are trying to balance caring for children who are at home "alone" and a baby who is in the care of trusted professionals. Romani women may be allowed to break written and unwritten rules of proper motherhood, but in order for staff to reinstate them as "good patients," women must conform to certain expectations.

> And so as she goes, we give her the [ward's] telephone number, or we ask her for her cell phone number and call her … when she says she doesn't have one, or has no data, then we just call the number she gives us. I mean, I always tell them: 'If you want the baby, you really must give me a contact number, your boyfriend's or the grandmother's … so that we can let you know. And they do, they really do.

Both the staff as well as Romani women make significant efforts to find compromises. Romani women exhibit their deservingness for good care and their respect toward the medical establishment through performing the role of the good patient(McCreaddie & Wiggins, 2009). Through this behavior, they positively influence the care process.

[46] No statistics are available at the ward, but the practice was reported to take place "regularly". Also, within my field research at a Roma settlement in Slovakia and focus group discussions with Czech Romani women, many would admit to have left their babies behind at the hospital (also see Chapter 3).

Conclusion

According to van der Geest and Finkler, hospital ethnography does not contrast life in the hospital with life outside the institution (the so-called ''real'' world), but instead focuses on how hospital life is shaped by society (2004, p. 1998). As in other walks of life, Romani women often face challenges and encounter discriminatory practices in reproductive healthcare settings (Watson & Dowe, 2017) and it is not my aim here to refute the claim that negative stereotypes of people known or assumed to belong to this ethnic group can translate to discrimination. The fact that Romani women may be classified in positive ways by medical professionals has, however, received little recognition in the anthropological literature so far. Centering on the positions, views, and experiences of medical staff, I found that staff morally re-evaluate Romani patients who intentionally disobey or ignore established hospital procedures. On these occasions, nurses and midwives stress the putative reasons behind such behavior, waving it off as part of the cultural baggage Romani women bring into the hospital. As a nurse reasoned out loud to me: "The Roma are like that … one must accept it and count on [their otherness]".

As general practices, both smoking while hospitalized and leaving the hospital before an official discharge (and thus temporarily leaving one's newborn behind), are viewed very negatively by staff from moral, health, and possibly legal perspectives. Staff strive to understand the complex gender roles and social ties that lead to these practices in order to actively negotiate the situation. Provided that the patients in question comply with staff's minimum requirements, Romani women can be rehabilitated as good patients. This is not to say that staff do not grow frustrated with Roma patients at all. No rationalization process takes place when nurses face verbal or other forms of violence from Roma patients, for example.

Medical professionals' perceptions of patients are based on a moral economy of values, behavioral norms, and ethical assumptions, all of which are decisive for the care patients receive (Higashi et al., 2013, p. 13). Medical professionals commonly resort to social stereotypes pertaining to the characters and abilities of patients (Barr, 2008; Feagin & Bennefield, 2014; Street et al., 2007). The stereotyping and classification of patients is seen, however, as a largely rigid process (Roth, 1972; Hillman, 2014). Although the medical professionals I talked with often framed Roma patients as a distinct category with typical characteristics, they also sought individual approaches to the actual women classed in this group when they arrived seeking obstetric care. Importantly, Romani patients were not characterized in overwhelmingly negative ways. The contrary was true: provided that staff shared an understanding of Romani women's behavior, their response was empathetic and accommodating. This applies even to situations that may pose a greater strain on staff – for instance, if Romani mothers leave their babies behind and go home, the staff has to take care

of the baby, which adds to their workload. It also applies to situations when staff behave in ways that contradict their professional identity ethics as good caregivers. This was illustrated in the chapter by staff's willingness to negotiate Romani women's smoking practices.

In situations of friction within the ward, the renegotiation and rationalization of potentially conflicting situations can be understood as an attempt to reinstate good care when this gets disrupted. The delivery of good care is the essence of the professional identity of nurses, and in the hospital where I carried out my research good care is imagined by medical professionals as a top down effort, provided by staff to patients. Yet as I have shown above, even if good care is imagined vertically, it can still be negotiated otherwise through strong patient agency that refuses submissive reception. By constructing positive stereotypes of Romani patients, midwives and nurses not only facilitate the care process, but they also challenge stereotypes of themselves as of racially biased, prejudiced medical professionals. The nurses and midwives I encountered during my research at this hospital[47] were not ethnicity-blind, and they had a strong proclivity to distinguish Romani patients from others. When probed, they readily reconstructed this ethnically and socially-marked category. At the same time, I found that the opinions of medical staff about their Romani patients is much better characterized by nuance and fluidity than by strict racial prejudice. Non-Roma medical staff form and transmit stereotypical views of Roma women, yet these co-exist parallelly with the moral economies inherent in the category of a "good patient". Birth workers' perceptions of "good" (vs. "bad") patienthood is helpful in grasping such complexities: good patients accept medical interventions more readily and are thought of as medically interesting (Jeffery, 1979; Stimson, 1976; Kelly and May, 1982).[48]

The last chapter of the dissertation will critically examine another common practice in Czech (or Slovak) hospitals where many Romani women give birth: room segregation. It will assert that the tendency of medical staff to room patients according to perceived ethnic belonging is not the result of explicit discriminatory intent, but the outcome of a particular understanding of cultural sensitivity and attunement, which nurses and midwives consider to be the *sine qua non* of good maternity care.

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[47] Within this and the following chapter, for the sake of simplicity, I use the term "nurse" in a wider, inclusive way, mirroring the position of the patients-birthing women, who, similarly to me, were often not aware of the staff's exact qualifications. Nurses and midwives would thus normally be generically denoted as female nurses [*sestry*]. Some of the Romani patients I interacted with would also describe the female orderlies [*sanitářky*]as nurses.

[48] Bad patients do not conform easily to the "sick role" (Dingwall and Murray, 1983, Parsons, 1975).

6. A Room of Their Own: Equivocal Equality at a Czech Maternity Ward

"This place … it's not like Prague. Here, people are simpler, rougher … so I have to be tougher, too. I need to adjust," a midwife explained when she allowed me to briefly accompany her on her evening round of the multi-bed rooms in the postpartum division of the maternity ward, checking on women after delivery. She had previously worked in a hospital in Prague and described both the conduct of medical professionals and patients there as more genteel. "This is a tough place," she emphasized again, by which she meant both the city of Továrnov, located in a peripheral region of the Czech Republic, and, I suspect, also her workplace, where a remarkable number of women – Romani and non-Romani alike – who give birth are drug users, have alcohol use disorder, or have a sexually transmitted disease.

On the first day of my "negotiated interactive observation" (Wind, 2008) in the maternity ward, there were few signs of just how harsh the ward was. Eager for clues indicating that many Romani women delivered in the ward, I noticed two sets of three photographs in glass frames hanging on the walls. Each set had the same compositional structure: one picture of a blonde or brunette white mother with her baby; one of a fair-skinned mother and her infant, both of them with almond-shaped eyes; and one with a brown-skinned mother and her newborn; two sets of visual representations of diversity along with unity in the representation of early motherhood, a well-intended allusion to the ethnic composition of the ward's clientele. According to medical staff, most women who came to give birth in the ward are white ethnic Czechs, and then there are Czech Roma and fewer Vietnamese women. The staff also mentioned Slovak, Ukrainian, and Russian women. With the vast majority of the women who give birth at this hospital belonging to the ethnic-majority Czech population, I read the pictures as a political claim to acknowledge and affirm the presence of ethnic minority women in the ward. Nevertheless, a more apt description of the ward is as an exclusionary space rather than one that celebrates equality in diversity. Shortly after noticing these deliberate (and in the Czech context rather unusual) references to ethnic diversity, which on closer inspection I learned were designed by the Swiss company Medela, which sells breastfeeding accessories, I discovered that both the postpartum and the high-risk division of the maternity ward have designated rooms where birth workers systematically channel Romani women with the explicit intention of keeping Romani women and women from the majority population apart.

The previous chapter introduced the maternity ward in the Czech industrial town of Továrnov, the location which serves as the field site of the current chapter as well. In Chapter Four I analyzed medical professionals' willingness to acknowledge some of the specific needs of Romani women-mother-patients. In an effort to depict situations where inter-ethnic

collaboration rather than animosity comes to the fore in the medical context – a narrative which is often missing from the accounts of Romani women's reproductive care – I described that in order to affirm their own professional identity and provide the best possible care, the nurses and midwives go to great lengths to reinstate non-conforming Romani women as "good patients". Understanding Roma as having a culturally unique habitus helps staff tolerate and eventually embrace Romani women "as they are," without nudging them to reform themselves or correcting them in their ways. Attributes associated with Romani culture facilitate the acceptance of differences and the building of trustful caregiver-patient relationships. Toward the end of the previous chapter I also indicated, however, that the maternity ward is a contested space where existing social inequities play out in ways that are emblematic of the positions of Romani women and their in society. In the present chapter I want to show how "culture" and "natural disposition," as perceived by medical professionals, can work out the wrong way for Roma. Unlike in the previous chapter, the culture and/or nature of Roma serves not as a vindication for patients' non-adherence to hospital rules, but as an explanatory model enabling the cultivation of an informal and possibly illegal practice by staff.

Once again, this chapter mainly dwells on the perspectives medical professionals working at the Czech maternity ward where I conducted my brief fieldwork in December 2016, and I begin it by giving an overview of patients' entanglement with the biomedical establishment. As is borne witness by the sociological and anthropological literature, hospitals, where people's interaction with the biomedical system usually takes place for a prolonged time, are particularly apt for both reaffirming societal inequalities and overturning them. I then narrow my perspective to current trends in Czech maternity care, examining the seemingly paradoxical situation when maternity care is freely and widely accessible to all, yet Romani women remain in the position of the "other," both within hegemonic maternity care settings as well as within attempts to reform normative maternity care. Having thus situated and contextualized my fieldwork, I continue by discussing the presence of ethnic otherness and its contested identification at the ward. Importantly, being identified as Roma by staff is merely part of a larger attunement process which concerns every woman/patient in the ward. My aim here is to provide an ethnographic interpretation which refuses to reproduce the ahistorical reasonings presented by medical professionals, who frame room segregation as an unproblematic practice implemented for the sake of good maternity care for all, while at the same time rejecting the rigid activist portrayal of ethnic room channeling as intentional human-rights abuse. When allowing all the perspectives to emerge, I do not see an easy way out of this conundrum.

Maternity Wards as Capitals of the Mainland

No contemporary social scientist would subscribe to the pre-Foucauldian (1973) argument that hospitals are to be studied by social scientists as little islands that are essentially separated from the rest of mainstream society (Coser, 1962), or as places and spaces where the rules of normality and everyday life are bent (Parsons, 1951). Present-day anthropological analyses do not regard the activities that take place within hospitals as entirely separate from life outside the hospital. On the contrary: hospitals are recognized as institutions that are shaped by everyday society, and, according to van der Geest and Finkler (2004), they are not islands but the very opposite: they are the capitals of the mainland. Rather than being purely functional, sterile social environments, hospitals are places permeated with social hierarchies, inequality, and conflict.

Patients, nurses, doctors, medical institutions, and biomedicine are all recognized as having their own specific culture (Taylor 2003). This culture has the potential to transmit stigma and incorporate and institutionally maintain racial bias (Kleinman & Benson, 2006, p. 1673), which impedes many people’s access to medical care. Medical gatekeepers have a crucial role in influencing socially or economically disadvantaged patients’ hospital stay; in practice, medical gate-keeping can play out not only in ways which keeps vulnerable patients out of, but also safely within the walls of the hospital building. For instance, in Romanian healthcare facilities, patients labelled as social cases can receive special treatment that addresses their social circumstances rather than their physical condition (Wamsiedel, 2016). Although usually perceived by medical practitioners as irksome, patients labelled as social cases may have their hospital stay prolonged in order to avoid or postpone their being forced to live on the street. Physicians resist the option of abandoning the poor in tuberculosis sanatoria, and thereby effectively medicalize social welfare (Stillo, 2015). Physicians morally resist the desertion of the poor (Friedman, 2009). In the United States some health professionals have adopted the concept of “sanctuary hospitals” and “sanctuary doctoring” (Saadi & McKee, 2018). Endorsing the idea that healthcare is a universal human right, regardless of immigration status, medical and public health professionals working in health bodies agencies, including hospitals, seek to reassure unauthorized immigrant patients that their facilities have a “welcoming culture.”

In Czech maternity care settings, to my knowledge, no initiatives have been implemented that would accommodate the needs of disadvantaged women who do not fit in well with the biomedical system. Reforms designed to humanize maternity care have been made, but their effects are most apparent among the more socio-economically advantaged segments of the population. Within the relatively new consumerist paradigm (Shaw and Aldridge, 2003) maternity wards in the Czech Republic had made controversial attempts at accommodating women’s individual preferences and active participation in the pregnancy and

delivery process (Hrešanová & Mahránková, 2008, p. 88). Since at least the mid-2000s, maternity wards have made various efforts to marketize and commercialize healthcare services, and the post-1989 socio-economic transition has led to health professionals, especially midwives, becoming more open to negotiating the experience of giving birth with mothers themselves, reflecting the wider societal struggle for active citizenship (Hrešanová, 2014, p. 973). The relatively subjugated mothers of the socialist era (Heitlinger, 1987) have been replaced by a distinctly identifiable group of mothers-consumers who actively seek to participate in decisions relating to childbirth. But the increased willingness of medical professionals to include mothers in the decision-making process surrounding parturition is distinctly class-bound, and consumerist choice in the delivery room and beyond has had a limited effects for those at the lower end of the class hierarchy.

While a number of individuals and organizations are increasingly advocating for the wide-scale adoption of more woman-centered styles of birthing, Czech maternity care is still structured in ways that consolidate rather than challenge biomedical hegemony (Jordan 1993). Fraught with institutionalized efforts to stifle the voices of those petitioning for a less rigid birthing experience, delivery practices are highly medicalized and delivering in a hospital is considered the height of late modern healthcare (Šmídová et al., 2015, p. 107). Women normally remain in hospital to receive post-natal care for 3–6 days, and those who choose to stay for a shorter period are frowned upon. Since birth is biomedically framed as an event that is accompanied by immense risk and is surrounded by a sense of emergency (Šmídová et al., 2015, p. 108), the natural birth movement struggles for recognition for institutionalizing home birth, for increasing the role of midwives in the delivery process, for diminishing the technologization of hospital births and for introducing birth centers.

Like other social institutions, hospitals are infused with inequality van der Geest & Finkler, 1998), and this is true even in the ostensibly equitable context of the Czech Republic, where almost every (EU) citizen has health insurance and women can deliver their babies for free. I agree that in a woman-centered reproductive system all of these efforts are pressing, legitimate, and inevitable. But I also want to point out that a broader array of alternative birth experiences and the increased willingness of medical professionals to involve mothers in decision-making around delivery has a distinctly class-bound character. In order to cater for a heterogenous patient population, more or less formal policies and practices are implemented in individual wards. Informal practices are fairly common in Central and Eastern European healthcare settings (Rivkin-Fish, 2005; Stan, 2012; Wamsiedel, 2018), and in the Czech Republic one such overt policy is that by paying a fee patients can obtain an "above-standard" [*nadstandard*], effectively first-class private room. Another one is the practice of directing Romani women into ethnically-marked multiple-bed rooms.

"Every Nurse Must be a Psychologist"

The medical professionals I interviewed claimed that their work cannot be reduced to just the provision of biomedical support: navigating care, especially in a postnatal department where uncomplicated vaginal delivery is the norm "is not primarily about biomedical care, it's more about the fact that every nurse must also be a psychologist." Another nurse described what has taken place when she feels she has provided good care as follows:

> Nurse: I can see [the new mother] is not collapsing, she's accepting the situation, she can deal with it. And when she leaves [the hospital] with a smile then I say to myself that we're doing it right [*děláme to dobře*].
>
> Edit: Can you describe what the support you provide looks like?
>
> Nurse: It's about chatting [*je to o povídání*], talking, showing her how to handle the baby, calming her down. [Mothers] get nervous and it's important to show them that they're the bosses in the situation. Also at home – if the mothers can't deal with [the situation] then the whole family is derailed.

When a woman is hospitalized after delivery or when a pregnant patient who needs constant medical supervision arrives in the high-risk pregnancy ward, nurses employ taxonomic thinking (see also Hrešanová, 2008). At the same time, staff is confronted with a relatively diverse population of mothers/patients whose pre- and postpartum needs must be calibrated individually. In an effort to attune themselves to the patient's needs, care providers think beyond pre-established categories while also reaffirming these categories through their actions. This process, occurring after the patient is admitted to the ward, unfolds gradually and one starting point may involve checking the woman's case-history. One nurse said:

> So we take the *maminka* [mommy] [to the postpartum ward] and then we see what needs to be done. She has a million questions, and then I just can't help myself and I have a look at her file. And I see that it says that she's a teacher, so I'm like: mm-hmm.

Socio-economic status strongly determines how women navigate early motherhood, and nurses often contrasted women with higher education with those who are classified as social cases (Wamsiedel, 2016; Stillo, 2015). I was told that women with a degree in a technical field are good at remembering and activating the information they receive after delivery, but they are not skilled at handling their babies: "The mothers that work with numbers are really

good with ... if you need them to register what time they nursed the baby on a time sheet[49] they'll even add whether they nursed from the right or the left boob. It's important for them to be in control." Another nurse maintained that "policewomen are really specific: they'll say 'no' and the discussion is over." Nurses often contrasted women with higher education against women who are socially vulnerable or are ordinary mommies (*normální maminky*): "Mothers with elementary education ... when they see their baby is crying they simply hold it. [Those with a degree in a technical field] will call us on the patient telephone and be like: 'the baby is crying, what should I do?'" Similarly, according to another account, when highly educated women see that their baby has been asleep for two hours straight they get scared: "they would come to the staff saying 'Jesus Christ, what should I do?'" Another nurse said that she prefers women who already have a history of three to four deliveries:

> These women take it as nature set it up [*berou to tak, jak to příroda nastavila*]; they don't make a fuss [*nědelají z toho problém*]. Women with higher education [*vysokoškolačky*] are much worse: they have some kind of an idea/expectation and when it's not fulfilled ... that's a problem. Blue collar workers don't ruminate so much and take it … not so intellectually, which is better. With the simple ones it's important to explain the right way so they'll grasp the message.

Cross-cultural arguments often came up when comparing social classes. The head nurse explained to me that Romani women were more "natural" during both childbirth and the postpartum period; they automatically nurse and cuddle their newborns. This was contrasted with university-educated women [*intelektuálky*] who "have their entire lives planned out for themselves and the baby spoils it for them; it doesn't fit in well with their life." Romani women tend to have more children than non-Romani, and because they have considerable experience with childbirth, one nurse characterized them as "perfect patients" who deal with motherhood easily: "[Romani women] will dump the baby in its crib and be like 'let's go out for a smoke'"."[50]

In these accounts my interest is not primarily in exploring nurses' conceptualizations of the connection between women's education level, mothering skills, and anxieties,[51] nor is it my intention to evaluate the moral politics condensed in them. An in-depth discussion of how the categories used by staff are often incongruous, flexible, and floating, while at the same time firmly based on everyday experience, will also not take my argument in the intended direction.

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[49] A time sheet is given to mothers after delivery on which they are expected to register what time they fed their baby. In many hospitals mothers must also register the weight of the baby before and after feeding/nursing.

[50] Also see Chapter 4.

[51] In fact ,during our interviews I often burst out laughing when hearing staff describe the clumsiness and exaggerated attempts at regaining control which characterizes the behavior of first-time "intellectual" mothers. My personal experience of navigating a woman-centered a hospital birth and early motherhood at a Czech maternity ward could not have been more similar to these accounts.

I simply interpret the epitomization involved in these processes of attunement as a tool that seeks to enable good care practices, following the logic according to which the better nurses and midwives know who their patient is outside the hospital, the better they can guess her needs within the ward. What is more important for me here is that when they were describing non-Roma women, nurses and midwives tended to emphasize the professional or class background of women as key markers leading staff in their attunement process. But in the case of Romani women, staff accentuated a shared sense of cultural belonging and natural disposition as cues helping staff attune to the care processes which Romani women need. This observation is in line with the study of British maternity care practitioners conducted by McFadden et al. (2012). These researchers found a tendency to both overlook diversity within women with a Bangladeshi background and to downplay similarities between individual Bangladeshi women and women from the majority population.

Who is a Roma? A Situated Diagnosis

Anthropologists who work with the methods of science and technology studies increasingly focus on who constitutes the category of Roma, as classified by the government and other subjects of power. In his 2016 book *Those Who Count: Expert Practices of Roma Classification*, anthropologist Mihai Surdu explores Romani groupness from an epistemological perspective and alleges that the category of Roma is more fictional than real in the sense that it is constituted by the concepts, categories, and classifications that those who count Roma have formed (p. 48). He believes that the Roma population is a "negative and oppositional construction made by dominant groups," and that this category has also been absorbed by those who self-identify as Roma (Surdu, 2016, p. 33). Plájás et al. (2019) assert that in bureaucratic practices "the category of 'Roma' as a material semiotic configuration [is] enacted by various 'data' regarding issues such as territorial segregation, phenotypic appearance, smell, and dialect" (p. 589). The category is relational, and when it comes into existence as a racial category it produces both certain visibilities and invisibilities (p. 590).

Who is considered Romani at the maternity ward in Továrnov is based on a situated diagnosis. On my first day of research in the postnatal ward, I introduced myself and briefly explained my research objectives to staff in the nurses station. I explained that my focus was on processes of decision-making and care, especially with regard to Romani women, and then a neonatologist asked me how I planned to identify which of their patients are of Romani origin. It is not illegal to collect ethnically segregated data in the Czech Republic, but it is very rare, as are open references to ethnic belonging in formal settings. The physician asked his question in a joking way, and I replied, also jokingly: "Whoever you consider to be Romani is Romani for me!" This situation was resolved by the head nurse, who stated matter-of-factly: "Well, don't

we just say it out loud among ourselves anyway?" On certain days I would come into the ward and as I greeted the staff I had already met and did my usual round of introductions to the ones I was meeting for the first time, occasionally a nurse would say "We don't have any [Romani women] for you here today!" Other times birth workers would announce that they had a Romani woman in the ward, but that she was "not that kind" [*není až taková*], implying that she had Romani background, but for the caregivers other factors such as social class or education had a whitening effect on her. Besides appearance, other markers of being Romani included having an identifiably Romani surname, or linguistic cues.

During my research I repeatedly observed staff demonstrating the fluidity of ethnic recognition. As I was chatting with a midwife-in-training in the corridor of the department for high risk pregnancy, hoping to cajole her into agreeing to be interviewed, another student midwife, overhearing my research interest, exclaimed:

> Student 1: I've just delivered a Romani woman! [*odrodila jsem romskou paní!*]
>
> Student 2 (hesitantly): It was ... it wasn't a Romani woman ... [presumably having met the woman in question at some point during the delivery process]
>
> Student 1: Oh, well, I thought ...
>
> Student 2: Nooo, I really don't think she was a Roma. She was ... normal white (*normálně bílá*).
>
> Student 2: Well, okay ...

I do not wish to imply here that taking note of women's ethnic backgrounds is a racist act in itself. Yet I heard the phrases "we don't make distinctions" and "everyone is equal here" so often during my interactions with staff that they felt like claims to impersonal, color-blind patient care. Our interviews and my ethnographic observations show quite the opposite: medical professionals in fact do make distinctions and, as my analysis shows, not every patient's needs matter equally. Two distinct dynamics are at place here. On the one hand, medical staff aim to provide uniformly outstanding professional care for all patients, but the real-life implementation of equal treatment is an intricate issue. On another level, staff strive to provide individually calibrated responses, which result in giving preference to the needs of some women over others. This difference can be ethnically marked.

Between Cultural Sensitivity and Human Rights Abuse

While the care practices provided to women may differ and be largely contingent on their social background, the nurses and midwives I talked to tended to highlight one need that almost all women share after giving birth: the need for rest. Romani women, however, seemed

to be exempt from this rule. Nurses and midwives unanimously agreed that Romani women have a stronger need for collectivity and tend to prefer being with other Romani women, which in practice means they frequently visit each other (if they are not placed in the same room). In some cases, Romani women left the light on during the night, making it difficult for roommates not used to this to fall asleep. Most importantly, Romani women normally have many visitors. This is fully acknowledged and respected by members of the medical staff, who believe that Romani women need the support of their large families to endure their stay in a facility that feels far from home. For the staff, large family visits are one of the many cultural specifics that emerges when caring for Romani women.

Non-Romani women are typically visited by close family members, and not their extended families. According to staff, non-Romani women find large family visits and the noise that accompanies them genuinely disturbing. Feeling disturbed and unable to relax can have serious medical consequences for a woman in the very sensitive pre- or postpartum period. Adopting the perspective of a woman whose roommate has many visitors, one nurse said to me: "When a lot of people [visitors] come to your room, you just don't want it. Imagine, the other [non-Romani] mother could have hypertension and has to rest so that her condition doesn't deteriorate." The (negative) consequences of a patient being unable to get sufficient rest because of the noise in multi-bed hospital rooms are supported by empirical research. Noise in multi-bed hospital rooms is recognized as contributing to sleep loss or sleep fragmentation, high blood pressure and increased heart rates, poor recovery rates from heart attacks, and decreased oxygen saturation in infants in neonatal intensive care (Ulrich, 2006). Patients describe feeling a loss of privacy in a multi-bed hospital room, especially because of visits from roommates' relatives (Persson et al., 2015). Since single rooms are only available for an extra fee, one nurse I talked to offered her own solution, which takes into account both Romani women's need for large family visits and non-Romani patients' need for privacy: "I room [Romani women] together [*dám je pospolu*]."

From anecdotal evidence, it seems that the practice of matching patients with presumably similar needs, interests, and backgrounds is fairly common internationally, but in this specific hospital Romani women are systematically channeled into a room designated for Romani (one such room per division in the ward). This is not about grouping roommates with similarities on an ad hoc basis; it is a preventive measure intended to avoid potential conflict between birthing women of different racial backgrounds. And it is a practice that is neither new nor confined to the hospital where I conducted my research. "Gypsy rooms" are fairly common in maternity wards throughout Eastern Europe, and non-governmental organizations have called attention to the existence of this practice in Hungary, Bulgaria, Macedonia, and Romania (Iszak, 2004; Zoon, 2001) as well. More recently, a Slovak non-governmental organization

issued a fact-finding report on room segregation and the organization is currently involved in court proceedings against a Slovak hospital that practices segregation (Center for Reproductive Rights, 2017). In the Czech Republic, as elsewhere, the extent and the history of the practice is vague. Based on the argument that they have incompatible cultures of visiting, Israeli maternity wards also routinely place Jewish and Arab mothers in separate rooms (Hovel & Efrati, 2018).

Enacting Room Allocation

There is a suite at the end of the hall of the high-risk pregnancy division and of the postpartum division, Room No. 5 (a pseudo-number), the room designated for Romani women, and these are the rooms with the largest occupancy in the ward. While the other rooms are somewhat smaller and have two to three beds, both No. 5 rooms have up to five beds and are in effect two spaces. The two rooms in the suites are partitioned by a wall to provide more privacy, which turns them into conjoined two- and three-bed spaces. As far as I could tell, the difference between these rooms and the "normal rooms," as a Romani research participant phrased it, was in the number of beds and in the fact that the "Gypsy room," for some technical reason, did not have a television set – something the Romani women complained about frequently, both to me and to the medical staff.

Whenever possible, non-Romani women were not placed in the Romani room and Romani were not placed in a room other than Room No. 5. Yet, in compliance with hospital rules, ethnic belonging was not the sole nor the most significant factor determining room assignment – patients are roomed first and foremost on the basis of their diagnosis. Every woman who has a Caesarean section spends the first few hours after surgery in a special recovery room, which is the room closest to the nurses' station (mother-infant rooming-in after a Caesarean section is virtually unheard of in Czech maternity wards). In the high-risk pregnancy division, the rooms closest to the nurses' station are for women who have a medical condition that could require swift intervention. If there is no medical reason determining where a woman should be roomed, she will be placed wherever there is space in the ward.

The staff makes no secret of their practice of separating Romani and non-Romani women, but ethnic mixing may occur when the ward is operating at full capacity. An edited excerpt from my fieldnotes reveals what happens in such situations:

> I am sitting at the place I usually occupy during my fieldwork: the common dining area equipped with tables and chairs at the rear of the postpartum division. It turns out to be, luckily for me, the place closest to Room Number 5. I am taking fieldnotes when a midwife pushes a blonde *gadži* woman lying on a rolling bed who just recently had her

baby toward me and stops right in front of the Romani room. As they approach it the midwife closes the door slightly and turns to the woman, lowering her voice:

Midwife: So you're going in this room here with five beds ... (she gives the patient a meaningful look). If something's wrong, if there are any problems, or something doesn't suit you, you tell us and we'll arrange a room for you in the above-standard section.

Woman: Mhmm.

The midwife opens the door and pulls the rolling bed with the new occupant into the room. As I'd been sitting there for a while I happen to know that there are currently two Romani women inside. I feel uncomfortable, partly because I'd overheard an exchange that I was not meant to be included in, but my astonishment is greater: the woman was offered the option of being placed in a single-bed room, presumably free of charge, just because she might not feel comfortable having Romani roommates? (…) After viewing the rooming process, I sit at the table in the hall and as another midwife approaches me I ask her, first vaguely and then explicitly, what is the reason for placing this ethnic Czech woman in the Romani room.

Midwife 2: Because there's no space [in the non-Romani rooms]. We're waiting for some dismissals and then we'll move her.

Edit: And what if ... she's okay [with the Romani room]? I mean ...

Midwife: We'll move her anyway.

According to the interviews with the staff, ethnic Czech women of every social class would, as a rule, complain if they had to be in the same room as Romani women. The women or their family members would ask the staff to move them to a room with no Romani women. In the staff's view, when the ward is full moving patients around is a logistical nightmare and takes precious time away from care work. In order for the ward to run smoothly and effectively, moving patients is either to be avoided or carefully organized beforehand.

My understanding is that the cultivation of room segregation hinges as much on the logistics as on the logic of care. Trying to explain why there is allegedly no way to avoid room segregation, one midwife recalled an ethnic Czech patient of hers who was reluctant to take a shower in the days after giving birth. The midwife was worried her wounds could become infected and wanted to know why the woman was neglecting her personal hygiene. After repeated queries, the midwife learned that the woman was afraid to leave her newborn child alone with her Romani roommate. At this point in the interview I interrupted, exclaiming that I thought this was pure racial prejudice. The midwife replied: "Well yeah, it is, but at that moment you're not going to start explaining that to her. What matters is the caregiving [*jde o péči*]. And

if she doesn't go and shower, that can really worsen the care process." In the logic of the nurse, inequality cannot be blamed on ordinary individuals and it is certainly not the concern of caregivers to fix it.

A Room of their Own: Experiencing Segregation

The medical professionals I interacted with maintained that it was not just that ethnic Czech women are opposed to being roomed with Romani, but that Romani women also prefer to be placed "together."[52] One midwife cited the advantages of having a designated Romani room as follows: "They are together, they know each other, they accompany each other out for a smoke. They take care of each other, they're like a big family." Yet, when I asked about the above-standard single-room, I was told that Romani women also occasionally choose this option. After I also asked about the socio-economic standing of these women, I was told that at least some of them were unemployed, indicating that these Romani women did not belong to the middle class, which would have had a whitening effect on them. Although data from my year-long fieldwork research at a poor, segregated Romani settlement in Slovakia certainly corroborates the claim that some Romani women prefer to be with other Romani, with whom they can socialize more freely than with non-Romani, this was certainly not true of all my informants. My focus group interview with a group of six Romani women who had earlier given birth in the maternity ward where I was doing my research also paints a more complicated picture. While all of them regarded the care they had received as very good (as did all four Romani women with whom I interacted in the hospital), one woman stated that she blatantly refused to be placed in the Romani room. A conversation ensued about the justification for ethnic profiling in rooming practices:[53]

> Woman 1: I was not placed there [in the Romani room]. They put me together with a [non-Roma] lady [in a different room]. And I also wasn't placed there [during the second delivery] either.
>
> Woman 2: I also wasn‘t placed there with the boy. Because they had vacant rooms and I told them I didn't want to [be placed at the Romani room] and so they didn't place me there. They put me in the *normal one* [a room not designated for Roma].
>
> Edit: So you told them you didn't want to go [in the Romani room].

[52] Also see Chapter 3, where some Romani women from my long-term fieldwork site made the same argument as medical professionals in this maternity ward.

[53] This transcription is an excerpt from an interview during a focus group discussion with Romani women who gave birth in the hospital where my research took place. The discussion was recorded as the women were attending the weekly meeting for marginalized Romani mothers organized by an NGO in Továrnov

Woman 2: Yeah well, for what reason should I [be put in the Romani room]?

Woman 1: I will tell you why. Because Gypsies [*cikáni*] have many visitors.

Woman 2 (explaining to the anthropologist): There are many visitors when [Romani women] give birth; the whites don't have it this way [*u bílých to tak není*]. For them it's usually just the husband and the [nuclear] family. And [with the Roma] it's just ...

Woman 3: And [non-Roma] just go in the room, take a look and go out to the hall so they wouldn't disturb the room-mates.

Woman 2: But the Gypsies have it like: here comes a cousin, a friend, all of a sudden there are like thirty people in the room. I mean I can well understand [the ethnic Czechs who are disturbed by the large Romani family visits].

Woman 4 (laughing): Yes, that was exactly my case when I had my daughter D. Absolutely all of them showed up [*to prišli komplet všichni)*]. And I was at [the Romani room]. But not when I had the boy.

Woman 3: Well, I was automatically placed [at the Roma room].

Not every Romani woman ends up in a room designated for Romani women, and if they do, not all of them are offended by it. In the interviews, staff usually referred to the room into which Romani women were usually channeled by its number and not by its ethnic designation. Moreover, somewhat to my surprise, I encountered non-Roma women in the Romani room twice during my ten days of research. While the first non-Romani woman I saw there was homeless, the second ethnic Czech woman was not socially disadvantaged. She was in fact on visibly friendly terms with her roommate Šárka (a pseudonym), a Romani woman in her twenties with whom I managed to conduct repeated interviews and interact informally during my research. At the time of our first encounter, Šárka was in the high-risk pregnancy division waiting to go into labor. When asked to recount what she thought were examples of good care, she said she found staying in the hospital difficult and that she missed her family, but she felt she had been well cared for:

I mean by now I'm used to the [hospital] regime. In the mornings [a nurse] wakes me up and checks my heartbeat and blood pressure. They do what they have to do, right? But the nurse here, she really tries to satisfy my needs and I can just stick out my arm while lying in bed. I don't have to get up, it's very comfortable. (….) Or they bring us lunch in the room, or when lunch is in the dining room the plates are already on the table. I don't even have to go to the trolley to get my plate. And during breakfast they even ask "Coffee or tea?" Or just the fact that the nurses come to the room and tell us the food's ready.

Šárka emphasized that the treatment she had received went beyond immediate care for her bodily needs. The nurses and midwives anticipated her physical comfort, and thereby contributed to her psychological well-being and fulfilled her need to be cared for and to be viewed as an individual. Yet, like all my Romani interviewees, Šárka knew that the maternity ward had special rooms designated for Romani women and that she had been placed in one. Together we considered what the implications of this would be when she was moved to the postnatal division. She said that she did not expect to be put in the Romani room, that the nurses in the division she was in now would inform their colleagues in the postpartum division that she is entitled to be placed in a regular room. She reasoned: "They will get wind of it (*ono se to donese*). They already have data on me, they know what I'm like, so I don't think I'll end up in Room 5. I mean, I hope not at least. I mean… I don't want [the nurses] to badmouth me … They differentiate here: good Gypsy, bad Gypsy." Since staff described Šárka to me as someone who is "not that kind" [*není až taková*], of Romani and her self-narrative was that of an upwardly mobile Romani, I was astounded to meet her in the postpartum division a few days after this interview took place, on her way to the bathroom, coming out of the Romani room. Based on the condition of their teeth, her Romani roommates seemed to be of lower social standing and possibly drug users. We did not talk about her room placement afterwards, but from our previous interaction it was clear that this was not what she had hoped for.

Sharing Social Distance

The nurses and midwives who participated in my research were well aware that a shared ethnic background need not always mean better mutual understanding among the women in the ward. One nurse commented on two Romani women who were placed in Room No. 5: "You can tell when [Romani women] don't get along. They don't talk." Even though staff were sensitive to the atmosphere in individual rooms, in our interviews they never reflected on the possibility that Romani women may find being placed in Room No. 5 degrading or offensive. This was surprising, because from our conversations it was apparent that in all other areas of hospital care the staff went to great lengths to accommodate individual women's needs. This generally applied to Romani women as well, and I was many times reminded by nurses and midwives that Romani women, just like non-Romani women, can be very different and "you can't lump them all together."

The clue to understanding room segregation involves grasping the larger social context in which the practice takes place. The nurses and midwives who participated in my research, all of whom are ethnic Czechs, share an ingrained way of thinking along ethnic lines and are, at the same time, medical professionals who are open and receptive to every woman under their care, regardless of their ethnic belonging. Living in a country where double standards for

Romani are the norm, nurses and midwives are more likely to empathize with non-Romani women who refuse to room with Romani. When discussing how such a refusal exactly happens, a nurse told me: “A white patient or her family member will come and tell me she doesn’t want to be [roomed] with a Romani. I mean, I’m not surprised, I wouldn’t want that either.” What this reasoning lacks is any empathy with Romani women, who may also not wish to room with other Roma. Although staff recognizes the tension between Romani women in Room No. 5, their sympathies inside and – I would argue – outside the hospital lie with ethnic Czechs. The staff views white majority patients in terms of their social class, but Romani patients are first and foremost ethnically marked and are only secondarily seen in terms of class, which may or may not work against them in the staff’s decision whether or not to put them in Room No. 5.

Anti-Romani bias is so common in the Czech Republic that it is considered normal, and as a result it perpetuates social stratification even in the context of free and universal healthcare. Past accounts of the practice of room segregation that were not based on ethnographic fieldwork stressed that the practice is the direct result of medical professionals’ conscious bias against the Romani. My analysis complicates this picture. The medical professionals who participated in my research did not express explicit hostility toward the Roma in the ward, nor did they profile Romani women for reasons of ethnic animosity. Still, on the level of institutional procedures, whenever possible they channel Romani women into a designated room where, whenever possible, ethnic Czech women are not placed. Confluent regimes and logics defined by medical needs, social class, individual needs, and spatiality determine the extent to which this unofficial rooming policy becomes an everyday practice.

Conclusion

Childbearing in the Czech Republic is marked by hegemonic thinking and practices, and it is largely organized around the principle that dictates: “intervene to prevent risk” (Šmídová et al., 2015, p. 108). Conflict or distrust from the patients’ side can get in the way of providing care and is hence best avoided. From the birth workers’ point of view, room segregation is necessary in order to provide good care, which they conceive of as the provision of individually tailored comforting. Following the logic of cultural compatibility, the staff lump Romani women into one group, a socio-racial category that is simultaneously flexible and fixed, to increase their sense of belonging in an otherwise alien and often tense hospital environment. But the notions of “culture” and “natural disposition” that the medical staff perceive to exist are also used by them to justify the practice of segregation. Social scientists have, however, provided evidence that special arrangements backed by cultural rationalizations – as a rule – do not improve clinical services (Kleinman and Benson, 2006).

In this chapter I argued that assigning people to rooms based on their perceived ethnic belonging is not (in this case) the result of an explicit discriminatory intent, but the outcome of medical professionals' particular interpretation of cultural sensitivity and attunement, which the nurses and midwives consider to be the *sine qua non* of good maternity care. In my interviews with staff their discourse revealed stereotypes about birthing women in relation to a variety of areas, including birthing knowledge, responsibilization, and consumer choice (McCabe, 2016). The staff justifies segregation as a necessary part of their effort to make the patients' stay in the maternity ward a time of relaxation rather than potential conflict between Roma and non-Roma women placed in multiple-bed rooms. But avoiding conflict comes at a cost, which is paid by the Romani women. My analysis reveals that their thoughts on room segregation are much more diverse and contentious than they have been portrayed to be in the past (Watson & Dowe, 2017; Center for Reproductive Rights, 2017; Iszak, 2004; Zoon, 2001; Bodrogi, 2016). My interpretation is ethnographically-based and reproduces neither the ahistorical reasonings used by medical professionals to frame room segregation as an unproblematic practice implemented for the sake of good maternity care for all, nor the rigid activist portrayal of ethnic channeling into separate rooms as an intentional human-rights abuse. Instead, my aim was to grasp the everyday processes that sustain maternity segregation, not just in the hospital where I conducted my research, but also at an unknown number of other maternity wards around and outside the Czech Republic.

The historical roots of this informal practice and its geographical prevalence, locally embedded reasoning, and ramifications for Romani women's health raise a range of questions to which this dissertation is unable to do justice. The fact that ethnic rooming accentuates the otherness of Romani women, even if they do not object to it, cannot be understood without taking into account the centuries of persecution and exclusion that East-European Romani have faced (Donert, 2017). For many (though certainly not all) Romani women, segregated rooms are just more of the same: an everyday re-enactment of their second-hand citizenship in both the reproductive and political sense. This can only change in a cultural climate where the hospital is not only a space designated for physical healing, but also a political arena in which birth workers are willing to use their professional authority to contribute to a form of social healing.

7. Conclusion

My friend Elenka's husband told me he was planning to write a book about his experiences growing up and living as a Roma man in Veľká Dedinka. He said that he wanted to describe the distress and suffering he endured throughout his lifetime. During my stay at this long-term field site he came up with the book's title, which he suggested would be *The Life of Roma: Hunger, Poverty and Racism* [Život Romov: Hlad, chudoba, rasizmus]. One time, I remember Elenka explaining to me how hard she found it to accept her everyday social and material reality. She felt that life had more to offer than the mundaneness of household chores, but she was too aware of the constraints surrounding her life:

> I have to be content, because this is how we live, but … I am not content … what have I gained from this life [*so mange kajso životostar*]? You wake up in the morning, you cook, clean … and it's time to go to sleep again.

Elenka's and her husband's narrative accounts of their lives, as well as contemporary anthropological literature on poverty, structural inequalities, and the violence of everyday life (Scheper-Hughes, 1992; De León, 2015; Farmer, 2004; Mendenhall, 2013; Wacquant, 2008), inspired me to think critically about the story I tell in this dissertation. Much of my narrative is set against a background in which collective hardship and suffering play powerful structuring roles; however, as Elenka emphasized, people constantly question the potentialities their social realities offer to them. My ethnographic materials assemble subject positions and practices in a manner that I hope is reflective of the complex weave of the societal fabric in which they intermingle. Instead of merely focusing on structural inequalities, my aim was to depict the ways a complicated reality allows for the constitution of individual agency. Personal autonomy is always construed in relations, and people always act as social persons and individual agents at the same time (Strathern, 1990).

The dissertation began by a focus on the individual aspect of reproductive decision-making. The text unraveled the significant material and moral constraints that shape women's decisions, and that these decisions are also often controversial and contested by both the individual and the community. My findings inhere in the diverse ways Romani women who live under circumstances of precarity demonstrate reproductive agency, and the ways their agency critically engages with the discourse of responsibilization on the affective and social levels. My aim in using a multitude of oral narratives collected from my research collaborators in the field was to illustrate how that agency does not necessarily mean resistance to given hegemonies that others may resist, and it does not automatically lead to increased inclusion and involvement in an institutionalized setting.

With respect to the position of the Czech and Slovak states toward Romani reproduction, much of the contemporary discourse has so far focused on the illegality and illegitimacy of the practice of tubal ligation either as a population policy, or as doctors' own illegal anti-Roma initiative, which aimed at curbing Romani fecundity in various forms from the 1970s until the beginning of the 2000s. My intention was to complement the existing human rights discourse with an ethnographic perspective, and to prioritize women's personal autonomy and lived experiences of sexual sterilization. I want to reassert here that I deeply sympathize with human rights NGOs and individuals fighting for Romani women's reproductive justice, but my aim here was to go beyond discursively framing the women who were sterilized against their will, informed under duress, or not provided sufficient information about the impact of the procedure on their future fertility, as victims or survivors. Discarding this heroic language allowed me to portray them as complex human beings who had manifold, often conflicting ways of processing their sterilization experiences.

My informants appear in this account as people who consider the financial aspect of childbearing both with respect to the sterilization incentive and to other material resources provided by the state to parents. This is another aspect of reproductive decision-making that ethnographers have so far made little effort to describe. Through foregrounding disadvantaged Romani women's subjectivity, I analyzed the ways in which they strategize about their fertility choices, while at the same time acknowledging the limits of human agency in reproductive matters. Exhibiting self-governance is a social expectation and ideal that many women cannot or do not want to adhere to, and while some frame themselves as self-reliant reproductive subjects, others only partially embrace the responsibilization discourse. Especially within the maternity care context the notion of fairness, lack of discrimination, and justice, however, deeply resonated with my informants.

The people whose perspectives I explored here related to the courses of action accessible to them based on the momentarily available options, and some of the decisions they made, whether in the home environment or in the maternity care setting, seem heavily determined by extrinsic factors. Perhaps more so than their middle-class majority counterparts, the disadvantaged Romani women I described here did not have an array of choices available to them, they did not experience full reproductive freedom, and at times they did not see intrinsic value in making choices. When researching marginalized Romani women's encounters with the maternity setting, I found that even birth workers who make special efforts to attune to Romani women and to consider them "ideal" patients can contribute to practices that push Romani women back into the position of an other. Not only health professionals, but also the larger society must perceive themselves as conduits of social change if practices such as room segregation based on ethnic belonging are to be eliminated. I propose that instead of

blaming Roma for their high fertility rate and expecting individuals to exercise control over their fertility-related decisions, the state and social actors should make adequate measures to involve Roma in social, cultural, and material policies. It is my hope that this dissertation will make a positive contribution in this direction.

As much as I aimed at fulfilling the ethnographic expectation of providing a holistic picture of my informants and the realities surrounding them, I was essentially selective about the topics I addressed and the literature I utilized in this text. I did not dwell on the history of Roma in Czechoslovakia or Central Europe, and their struggle for the recognition of human rights (see Donert, 2017; Barany, 2002), nor did I tackle the privatization and the neoliberal transformation as a form of political rationality in the larger region of Eastern and Central Europe (see Burawoy & Verdery, 1999; Collier, 2011; Dunn, 2004). This dissertation was inspired by but does not directly aim to contribute to the literature on Romani culture and religiosity (Fosztó, 2009), economy (Stewart, 1997), or exclusion (Ládanyi & Szelényi, 2006). I also did not directly address the new Romani feminist movement, which has brought female social science researchers of Romani descent to the fore and took up the issue of Romani women's empowerment from within (Kóczé et al. 2018; Brooks, 2012; Oprea, 2012; Gelbart, 2012).

Closing Thoughts on Methodology

Ethnographers are essentially storytellers, but as John Law said: "we do not take [the stories we tell] too seriously, we do not puff them up with hegemonic pretentions" (1994, p. 14). Ethnographic storytelling is, rather, an "exercise in ordering" (Law, 1994, p. 43). The story I tell here is an ordered account of the stories I encountered and co-enacted during my fieldwork. Especially in Veľká Dedinka I adapted to the role of the *rakľi* [white girl] who accompanied inhabitants for their trips to doctors, went shopping and visited family members with them, and was grateful for any type of communal inclusion. I participated in the settlement's life also in a material sense, proving my friendship through giving small loans to friends, and by taking photographs of inhabitants, developing them, and handing them out. Many times it would take hours of listlessly watching South American telenovelas with Romani friends before an incident took place when fertility came to the fore. While at the end of each day spent in the field I recorded various events in my fieldwork journal, I mostly zoomed in on instances where reproductive decisions were weighted and articulated against the contingent prospects and processes of everyday life. In maternity ward of Továrnov I would sit for hours at the hallway, taking notes of the processes around me, until an opportunity arose to witness the process of caregiving, interview a birth worker, or have a discussion with one of the women about her expectations and experiences at the ward.

Contemporary ethnographic research, especially if it is long-term and based on participatory observation, is an immersive journey full of ethical dilemmas for the researcher (Scheper-Hughes 1995). This is perhaps especially true if they are conducting anthropological research "at home" (Peirano, 1998). My friend Manka once told me that she enjoyed chatting with me because "you listen to what I say" [*tu šunes so vakerav*]. While I sometimes might have successfully tuned in, I also consciously looked for opportunities to tune out of my informants' lives and decrease my immersion in their realities. I spent one day a week at the nearby town volunteering for an NGO and I attended a Spanish language course, just to have interactions without any relation to my field site. As my Romani language skills improved and sense of inclusion grew in the settlement, so did my resistance to intervening in situations in which I have retrospectively questioned my responsibility. Perhaps I should have made greater efforts to pressure some friends into adhering to their antibiotics regimen, or I should have talked them more vehemently out of self-medicating with antibiotics for a sore throat. Was it my responsibility to prevent a one-year old from playing with fire, or a knife, or to dress the child up when it was walking outside in the freezing cold when his parents were also present? Should I have alerted child protection services to cases of children who were clearly neglected? Unsure of how to act, I simply walked away when I saw small children watching pornographic media, and treated these episodes as anecdotes that I would enter into my field journal. Should I have explicitly stated at the maternity ward that systematically channeling Romani women into specific rooms fulfils the definition of discrimination? Human life and interactions are more than just data, and cultural relativism is not excusable in the face of harassment or abuse.[54] My current position on when anthropologists should intervene in the field (Redfield, 2013) and how to most effectively engage (Lamphere, 2004; Sanjek, 2004; Johnston, 2010) is much clearer now than what it was during the time I conduced my fieldwork.

Disengagement, at least on an emotional level, is not something ethnographers can or should strive for while conducting long-term participant observation. Ethnographers must rely on their own feelings (Rosaldo, 1984) and intuition to make sense of the social interactions they participate in. But in my experience doing long-term participant observation is a solitary job, even when one is constantly surrounded by people. Amy Pollard's (2009) article, which asserts that doctoral students in particular need more support when they are conducting ethnographic fieldwork deeply resonated with me during my time in Veľká Dedinka. Based on interviews with sixteen British anthropology doctoral students, Pollack found that they experienced the following range of feelings: "alone, ashamed, bereaved, betrayed, depressed,

[54] I would like to reassert here that while the overwhelming majority of Romani parents whose family lives were accessible to me were caring and loving towards their children, in many cases precarity, marginalization, and poverty lead to the regular use of violent parenting techniques that were clearly harmful for children.

desperate, disappointed, disturbed, embarrassed, fearful, frustrated, guilty, harassed, homeless, paranoid, regretful, silenced, stressed, trapped, uncomfortable, unprepared, unsupported, and unwell" (2009, p. 2). Ethnographers eagerly question their position of power within the field, and in an effort to create ethnography that is based on collaboration with informants, they seek to increase the sense of equity between themselves and the people they study, and strive to emphasize that knowledge is co-produced and co-owned. Gay y Blasco and de la Cruz Hernandez (2012) proposed to write biographical ethnography together with their informants. While I did not aspire to co-produce ethnography, I hope to contribute to Romani-*gadže* feminist alliance (Schultz, 2012; Biţu & Vincze, 2012). Hearing the voices of Roma people (Ryder & Cemlyn & Acton, 2014), and critically questioning my own privilege as a *gadži* absolutely was my intention here (Dunajeva, 2018).

8. References Cited

Adamecz-Völgyi, A. & Scharle, Á. (2020). Books or babies? The incapacitation effect of schooling on minority women. *Journal of Population Economy, 33*, 1219–126. https://doi.org/10.1007/s00148-020-00771-9

Akrich, M. & Pasveer, B. (2004). Embodiment and disembodiment in childbirth narratives. *Body and Society*, *10*(2-3), 63–84. https://doi.org/10.1177/1357034X040429

Albert, G. (2019). Nucené sterilizace jako projev anticikanismu: Příklad Československa a České/Slovenské republiky [Forced sterilizations as an expression of anti-Gypsyism: The example of Czechoslovakia, Czechia, and Slovakia]. *Romano Džaniben, 26*(2), 21–41.

Allison, J. (2010) Contested change and choice: Infertility in Ireland. *Journal of the Society for the Anthropology of Europe*, *10*(2), 4–17. https://doi.org/10.1111/j.1556-5823.2010.00014.x

Almeling, R. (2015). Reproduction. *Annual Review of Sociology*, *41*, 423–42. https://doi.org/10.1146/annurev-soc-073014-112258

Amnesty International (2007). *Still separate, still unequal: Violations of the right to education of Romani children in Slovakia*.

Amnesty International (2008). *A tale of two schools: Segregating Roma into special education in Slovakia.*

Anderson, J. M. (1996). Empowering patients: Issues and strategies. *Social Science and Medicine, 43*(5), 697–705.

Banga, R. (2021). *(Ne)pošli to dál* [*Don't send it on*]. Prague: XYZ.

Barany, Z. (2002). *The East European Gypsies: Regime change, marginality and ethnopolitics.* Cambridge University Press.

Barr, D. A. (2008). *Health disparities in the United States: Social class, race, ethnicity, and health.* The Johns Hopkins University Press.

BBC (2013). Czech woman gives birth to country's first quintuplets, 2 June 2013.

Becker, G. (1976). Introduction. In *The Economic Approach to Human Behaviour*, edited by G. Becker, 3–14. University of Chicago Press. Quoted in Heiss. J. P (2018). A Hanusa man makes a decision: A contribution to the anthropological perspective on decision-Making. *Anthropological Forum*, *28*(3), 236–254. https://doi.org/10.1080/00664677.2018.1482737

Belák, A. (2013). *Health-system limitations of Roma health in Slovakia: A qualitative study*. WHO Country Office in Slovakia.

Belák, A. et al. (2017). Health-endangering everyday settings and practices in a rural segregated Roma settlement in Slovakia: A descriptive summary from an exploratory longitudinal case study. *BMC Public Health* 17(128). https://doi.org/10.1186/s12889-017-4029-x

Beneito-Montagut, R. (2011). Ethnography goes online: Towards a user-centered methodology to research interpersonal communication on the internet. *Qualitative Research, 11*(6), 716–735. https://doi.org/10.1177/1468794111413

Biţu, N., & Vincze, E. (2012). Personal encounters and parallel paths toward Romani feminism. *Signs*, *38*(1), 44–46. https://doi.org/10.1086/665955

Bledsoe, C. H. (2002). *Contingent lives: Fertility, time and aging in West Africa*. University of Chicago Press.

Bludau, Heidi. (2017). Hindered care: Institutional obstructions to carework and professionalism in Czech nursing. *Anthropology of Work Review, 38*(1), 8–17. https://doi.org/10.1111/awr.12108

Bodrogi, B. (2016). *Roma nők helyzete és lehetőségei a szülészeti ellátásban* [The Situation and Possibilities of Romani Women in Maternity Care]. Születésház Egyesület.

Boholm, A., & Henning, A. & Krzyworzeka, A. (2013). Anthropology and Decision-making: An Introduction. *Focaal – Journal of Global and Historical Anthropology, 65*, 97–113. Quoted in Heiss. J. P (2018). A Hanusa man makes a decision: A contribution to the anthropological perspective on decision-making. *Anthropological Forum*, *28*(3), 236–254. https://doi.org/10.1080/00664677.2018.1482737

Bourdieu, P. (1990). *The logic of practice*. Stanford University Press.

Bourgois, P. (1996). *In search of respect: Selling crack in el Barrio*. Cambridge University Press.

Bourgois, P. (2009). *Righteous dopefiend.* University of California Press.

Bowler, I. (1993). “They’re not the same as us”: Midwives’ stereotypes of South Asian descent maternity patients, *Sociology of Health and Illness, 15*(2), 157–178.

von Braun, J. & Gatzweiler, F. (eds). (2013). *Marginality —A framework for analyzing causal complexities of poverty*. Springer, Dordrecht.Bridges, J. et al. (2013). Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing, 69*(4), 760–772. https://doi.org/10.1111/jan.12050

Brooks, E. C. (2012). The possibilities of Romani feminism. *Signs*, *38*(1), 1–11. https://doi.org/10.1086/665947

Burawoy, M. & Verdery, K. (eds). (1999). *Uncertain transition: ethnographies of change in the post-socialist world*. Rowman and Littlefield.

Cahn, C. (2015). *Human rights, state sovereignty and medical ethics: Examining struggles around coercive sterilisation of romani women.* Brill.

Carranza Ko, Ñ. (2019). Forcibly sterilized: Peru's Indigenous women and the battle for rights. In: Blouin-Genest, G., Doran, M. C. & Paquerot, S. (eds.) *Human rights as battlefields: Human rights interventions*. Palgrave Macmillan. https://doi.org/10.1007/978-3-319-91770-2_8

Carson, A. et al. (2017) A narrative analysis of the birth stories of early-age mothers. *Sociology of Health & Illness, 39*(6), 816–831. https://doi.org/10.1111/1467-9566.12518

Carter, S. K. (2010). Beyond control: body and self in women's childbearing narratives. *Sociology of Health & Illness, 32*(7), 993–1009. https://doi.org/10.1111/j.1467-9566.2010.01261.x

Center for Reproductive Rights & Poradňa pre občianske a ľudské práva (2003). *Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia.*

Center for Reproductive Rights & Poradňa pre občianske a ľudské práva. (2017). Vakeras zorales – Speaking out: Roma Women's Experiences in Reproductive Health Care in Slovakia.

de Certeau, M. (1984). *The Practice of Everyday Life*. University of California Press. Quoted in Cornwall, A. (2007). Taking chances, making choices: The tactical dimension of "reproductive strategies" in Southwestern Nigeria. *Medical Anthropology,* 26 (3), 229–54. https://doi.org/10.1080/01459740701457058

Chadwick, R. (2018). *Bodies that birth: Vitalizing birth politics.* Routledge.

Chalmiers, M. A. (2020). The moral valence of intentionality and the modern reproductive subject. *Medical Anthropology*, *39*(6), 506–520. https://doi.org/10.1080/01459740.2020.1711755

Chasteen Miller, A. & Shriver, T. E. (2012). Women's childbirth preferences and practices in the United States, *Social Science & Medicine, 75*, 709–716. https://doi.org/10.1016/j.socscimed.2012.03.051

Clift-Matthews V. (2010). Vaginal birth as a rite of passage. *British Journal of Midwifery* 18 (3), 140. https://doi.org/10.12968/bjom.2010.18.3.46913

Collier, S. J. (2011): *Post-Soviet social: Neoliberalism, social modernity, biopolitics*. Princeton University Press.

Cornwall, A. (2007). Taking Chances, Making Choices: the Tactical Dimension of ‘Reproductive Strategies’ in Southwestern Nigeria, *Medical Anthropology, 26*(3), 229–54. https://doi.org/10.1080/01459740701457058

Coser, R. L. (1962). *Life in the ward*. Michigan State University Press.

Council of Europe (2021). Education of Roma Children.

Cullen B. T. & Pretes, M (2000). The meaning of marginality: Interpretations and perceptions in social science. *Social Science Journal*, *37*(2), 215–229.

Čvorović, J. (2013). Serbian Gypsy witch narratives: “Wherever gypsies go, there the witches are, we know!” *Folklore*, *124*(2) 2214–225. https://www.jstor.org/stable/43297690

Dalsgaard, A. L. (2004). *Matters of life and longing: Female sterilisation in Northeast Brazil.* Museum Tusculanum Press.

Davis, D. (2018). Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Medical Anthropology*, *38*, 560–573. https://doi.org/10.1080/01459740.2018.1549389

Davis, D. (2019). *Reproductive injustice: Racism, pregnancy, and premature birth*. New York University Press.

Davis-Floyd, R. & Sargent, C.F. (eds). (1997). *Childbirth and authoritative knowledge*. University of California Press.

Davis-Floyd, R. (1994). The technocratic body: American childbirth as cultural expression. *Social Science and Medicine, 38*(8), 1125–1140.

Davis-Floyd, R. (2003). *Birth as an American rite of passage* (2nd ed.) University of California Press.

Dingwall, R. & Murray, T. (1983). Categorization in accident departments: “good” patients, “bad” patients and “children”. *Sociology of Health and Illness, 5*(2): 127–48.

Dixon, L. Z. (2015). Obstetrics in a time of violence: Mexican midwives critique routine hospital practices. *Medical Anthropology Quarterly*, *29*(4), 437–454. https://anthrosource.onlinelibrary.wiley.com/doi/10.1111/maq.12174

Donert, C. 2017. *The rights of the Roma: The struggle for citizenship in postwar Czechoslovakia*. Cambridge University Press.

Douglass, Carrie B. (ed.) (2005). *Barren states: The population “implosion” in Europe*. Berg.

Dowling, M. (2006). The sociology of intimacy in the nurse-patient relationship. *Nursing Standard, 20* (23), 48–54.

Dudová, R., Hašková, H. & Klímová Chaloupková, J. (2020). Disentangling the link between having one child and partnership trajectories: A mixed-methods life-course research. *Journal of Family Studies*, *28*(4), https://doi.org/10.1080/13229400.2020.1839534

Dudová, R. (2012). Regulation of abortion as state-socialist governmentality: The case of Czechoslovakia. *Politics and Gender, 8*(1), 123–144. doi:10.1017/S1743923X12000098

Dunajeva, J. (2018). Power hierarchies between the researcher and informants: Critical observations during fieldwork in a Roma settlement. *Critical Romani Studies, 1*(2), 124–143. DOI: 10.29098/crs.v1i2.3

Dunn, E. (2004). *Privatizing Poland: Baby food, big business, and the remaking of labor*. Cornell University Press. 0679724699

Durst, J. (2006). *Kirekesztettség és gyermekvállalás* [Social exclusion and reproduction]. Doctoral dissertation, Corvinus University.

Edu, U. F. (2018). When doctors don't tie: Hierarchical medicalization, reproduction, and sterilization in Brazil. *Medical Anthropology Quarterly*, *32*(4), 556–573. https://doi.org/10.1111/maq.12475

European Roma Rights Centre (2011). Life sentence: Romani children in state care in the Czech Republic. http://www.errc.org/reports-and-submissions/life-sentence-romani-children-in-state-care-in-the-czech-republic

European Roma Rights Centre (2017). RISC: Stop discrimination of Roma in state care, press release, 20 November 2017. http://www.errc.org/press-releases/risc-stop-discrimination-of-roma-in-state-care

European Roma Rights Centre and Center for Civil and Human Rights (2016). Written comments by the European Roma Rights Centre and Center for Civil and Human Rights concerning Slovakia for consideration by the Committee on the Rights of the Child at the 72nd Session (17 May 2016 – 03 June 2016). http://www.errc.org/uploads/upload_en/file/slovakia-crc-submission-april-2016.pdf

Extra.cz (2013, May 29), Česko zavalila vlna solidarity. Matka paterčat si zaslouží luxus: Přečtěte si, co všechno pro ni stát a město chystají! [The Czech Republic is overwhelmed by a wave of solidarity: The mother of quintuplets deserves luxury. Read about what the state and the municipality prepared for her!]. https://www.extra.cz/cesko-zavalila-vlna-solidarity-matka-patercat-si-zaslouzi-luxus-prectete-si-co-vsechno-pro-ni-stat-a-mesto-chystaji

Fainzang, S. (2015). *An anthropology of lying: Information in the doctor–patient relationship*. Ashgate.

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, *45*(3) 305–325. https://doi.org/10.1086/382250

Fass, P. S (ed.) (2012). *The Routledge history of childhood in the western world*. Taylor & Francis, Routledge.

Feagin, J. & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science and Medicine, 103*, 7–14. https://doi.org/10.1016/j.socscimed.2013.09.006

Ferkovics, R., Németh, K. & Schafft, K. A. (2017). Romani identity, cultural trauma, second-class citizenship and the contemporary context for ethnic political representation in Hungary. *Croatian Political Science Review*, *54*(1-2), 74–93.

Fitzpatrick, M. (2019). Birth story interviews: On the assumptions hidden in our research methods. *Medicine Anthropology Theory*.

Flood, M. (2009). The harms of pornography exposure among children and young people. *Child Abuse Review, 18*(6), 384–400. https://doi.org/10.1002/car.1092

Fodor, E. et al. (2002). Family policies and gender in Hungary, Poland, and Romania. *Communist and Post-Communist Studies, 35*(4), 475–490.

Fosztó, L.(2009). *Ritual revitalisation after socialism*. LIT-Verlag.

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. Tavistock.

Foucault, M. (1980). Two lectures. In Gordon, C. (ed.), *Power/Knowledge: Selected interviews and other writings 1972–1977, Michel Foucault.* (ed.). Pantheon Books, 78–108.

Foucault, Michel (1990). *The history of sexuality: An introduction, Volume I.* Vintage Books.

Franklin, S. & Ragoné, H (eds). (1997). *Reproducing reproduction: Kinship, power, and technological innovation*. University of Pennsylvania Press.

Fremlova, Lucie. (2022). *Queer Roma*. Routledge.

Friedman, E. et al. (2009). *School as ghetto: Systemic overrepresentation of Roma in special education in Slovakia*. Roma Education Fund.

Friedman, J. R. (2009). The "social case:" Illness, psychiatry, and deinstitutionalization in postsocialist Romania. *Medical Anthropology Quarterly, 23*(4), 375–96. https://doi.org/10.1111/j.1548-1387.2009.01069.x

Gal, S. & Kligman, G. (2000). *The politics of gender after socialism: A comparative historical essay*. Princeton University Press.

Gammeltoft, T. (2007). Sonography and sociality: Obstetrical ultrasound imaging in urban Vietnam. *Medical Anthropology Quarterly*, *21*(2), 133–153. https://www.jstor.org/stable/4499718

Gammeltoft, T. (2014) *Haunting images: A cultural account of selective reproduction in Vietnam*. University of California Press.

Gay y Blasco, P. & Hernandez, L. de la C. (2012). “Friendship, anthropology.” *Anthropology and Humanism, 37*(1), 1–14. https://doi.org/10.1111/j.1548-1409.2012.01104.x

Gelbart, P. (2012). Either sing or go get the beer: Contradictions of (Romani) female power in Central Europe. *Signs*, *38*(1), 22–29. https://doi.org/10.1086/665944

van der Geest, S. & Finkler, K. (2004). Hospital ethnography: Introduction. *Social Science and Medicine*, 59 (10), 1995-2001. https://doi.org/10.1016/j.socscimed.2004.03.004

Ginsburg, F. & Rapp, R. (1991). The politics of reproduction. *Annual Review of Anthropology*, *20*, 311–43.

Ginsburg, F. & Rapp, R. (1995). *Conceiving the new world order: The global politics of reproduction*. University of California Press.

Gloppen, S. (2014). *Sexual and reproductive Rights lawfare: Global battles*. Chr. Michelsen Institute. Quoted in Morgan, M. L. (2019). Reproductive governance, redux. *Medical Anthropology*, *38*(2), 113–117. https://doi.org/10.1080/01459740.2018.1555829

Government of Slovakia (2004). Atlas rómskych komunít 2004 [The Atlas of Roma Communities 2004[. https://www.minv.sk/?atlas_2004

Greenhalgh, S. (1995). Anthropology theorizes reproduction: Integrating practice, political economic, and feminist perspectives. In: Greenhalgh, S. (ed.) *Situating fertility: Anthropology and demographic inquiry*. Cambridge University Press, 3–28.

Greenhalgh, S. (2005). Globalization and population governance in China. In Ong, A. & Collier, S.J. (eds.), *Global assemblages: technology, politics, and ethics as anthropological problems.* Blackwell Publishing, 354–372.

Greil, A. L. & McQuillan, J. (2010) “Trying” times: Medicalization, intent, and ambiguity in the definition of infertility. *Medical Anthropology Quarterly*, *24*(2), 137–156. https://doi.org/10.1111/j.1548-1387.2010.01094.x

Grill, J. (2012). “Going up to England”: Exploring mobilities among Roma from Eastern Slovakia”. *Journal of Ethnic and Migration Studies, 38*(8), 1269–1287. . https://doi.org/10.1080/1369183X.2012.689187

Grill, J. (2015), “Endured labour” and “fixing up” money: The economic strategies of Roma migrants in Slovakia and the UK. In: Brazzabeni, M, Cunha, M. I. & Fotta, M. (eds.), *Gypsy Economy*. Berghahn Books, 88–106.

Grill, J. (2018). “In England, they don't call you black!” Migrating racialisations and the production of Roma difference across Europe, *Journal of Ethnic and Migration Studies*, *44*(7), 113–117. https://doi.org/10.1080/1369183X.2017.1329007

Gutman, M. C. (2006) *The meanings of macho: Being a man in Mexico City*. University of California Press.

Gutmann, M. C. (2007). *Fixing men: Sex, birth Control, and AIDS in Mexico*. University of California Press.

Hajská, M. (2003). *Fenomén “Zoči”* [The “Zoči” phenomenon]. In: Jakoubek, M. & Poduška, O. (eds.) *Romské osady v kulturologické perspektivě* [Romani settlements from the position of cultural theory]. Doplňek.

Halfon, S. (2010). Encountering birth: Negotiating expertise, networks, and my STS self. *Science as Culture*, *19*(1), 61–77. https://doi.org/10.1080/09505430903558062

Hamal, S. (2020). Trust in ethnography: Narrating the difficulties, rewards and dilemmas of entry, engagement and exit (3Es) in the research field. *Dhaulagiri Journal of Sociology and Anthropology*, *14*, 97–105. https://doi.org/10.3126/dsaj.v14i0.28521

Hanafin, P. (2007). Conceiving life: Reproductive politics and the law in contemporary Italy. Burlington, VT: Ashgate. Quoted in Marchesi, M. (2012). Reproducing Italians: Contested biopolitics in the age of “replacement anxiety”. *Anthropology & Medicine, 19*(2), 171–188. https://doi.org/10.1080/13648470.2012.675043

Hartmann, Betsy (1995). *Reproductive rights and wrongs: The global politics of population control*. South End Press.

Hašková, H. & Dudová, R. (2020). Selective pronatalism in childcare and reproductive health policies in Czechoslovakia. *The History of the Family, 25*(4), 627–648. https://doi.org/10.1080/1081602X.2020.1737561

Heitlinger, A. 1987. *Reproduction, medicine and the socialist state*. St. Martin’s Press.

Hillman, A. (2014). “Why must I wait?” The performance of legitimacy in a hospital emergency department. *Sociology of Health and Illness, 36*(4), 485–99. https://doi.org/10.1111/1467-9566.12072

Hirschfeld, L. (1997). The conceptual politics of race: Lessons from our children. *Ethos, 25* (1), 63–92.

Holland, D. C. et al. (1998). *Identity and agency in cultural worlds*. Harvard University Press. Quoted in Greil, A. L. & McQuillan, J. (2010) “Trying” times: Medicalization, intent, and ambiguity in the definition of infertility. *Medical Anthropology Quarterly*, *24*(2), 137–156. https://doi.org/10.1111/j.1548-1387.2010.01094.x

Hovel, R. & Efrati, I. (2018, May 18). Jewish and Arab Segregation Is the Default. *Haaretz*. https://www.haaretz.com/israel-news/2018-05-18/ty-article/in-israeli-maternity-wards-jewish-and-arab-segregation-is-the-default/0000017f-eff8-da6f-a77f-fffe5a450000

Hoxha, I. et al. (2017) Caesarean sections and private insurance: systematic review and meta-analysis. *BMJ Open* 2017(7:e016600). doi: 10.1136/bmjopen-2017-016600

Hrešanová, E. & Marhánková, J. H. (2008). Nové trendy v českém porodnictví a sociální nerovnosti mezi rodičkami [New trends in Czech birth care and social inequities among birthing women]. *Czech Sociological Review*, *44*(1), 87–111. https://www.jstor.org/stable/41132555

Hrešanová, E. (2007). Midwives, women and the professionalization of midwifery: An ethnographic study of two maternity hospitals in the Czech Republic. *Cognition, Brain, Behavior*, *9*(2), 371–396.

Hrešanová, E. (2008). Kultury dvou porodnic: etnografická studie [The Culture of Two Maternity Wards: An ethnographic Study]. Západočeská univerzita v Plzni.

Hrešanová, E. (2014). “Nobody in a maternity hospital really talks to you”: Socialist legacies and consumerism in Czech women's childbirth narratives. *Czech Sociological Review*, *50*(6): 961–986. http://dx.doi.org/10.13060/00380288.2014.50.6.150

Hughes, E. C. (1963). Race relations and the sociological imagination. *American Sociological Review, 28(*6), 879–890.

Inhorn, M. (ed). (2007). *Reproductive disruptions: Gender, technology, and biopolitics in the new millennium*. Berghahn.

Iszak R. (2004). “Gypsy rooms” and other discriminatory treatment against Romani women in Hungarian hospitals. *Roma Rights Quarterly*, *3*(4), 7–11.

Jeffery, R. (1979). Normal rubbish: Deviant patients in casualty departments. *Sociology of Health and Illness, 1*(1), 90–107.

Johnson-Hanks, J. (2002). On the limits of life stages in ethnography: Toward a theory of vital conjunctures. *American Anthropologist, 104*(3), 865–880.

Johnson-Hanks, J. (2005). When the future decides: Uncertainty and intentional action in contemporary Cameroon. *Current Anthropology, 46*(3), 363–385. https://doi.org/10.1086/428799

Johnson-Hanks, J. (2008). Demographic transitions and modernity. *Annual Review of Anthropology*, *37*, 301–15.

Johnston, B. R. (2010). Social responsibility and the anthropological citizen. *Current Anthropology, 51*(suppl. 2), S235–S247.

Jordan, B. (1978). *Birth in four cultures: A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States*. Eden Books.

Kabakian-Khasholian, T. et al. (2000) Women's experiences of maternity care: satisfaction or passivity? *Social Science & Medicine*, *51*, 103–13. https://doi.org/10.1016/S0277-9536(99)00443-8

Kanaaneh, R. A. (2002). *Birthing the nation: Strategies of Palestinian women in Israel*. University of California Press.

Katbamna, S. (2000). *Race and childbirth*. Open University Press.

Kelly, M. P. & May, D. (1982). Good and bad patients: A review of the literature and a theoretical critique. *Journal of Advanced Nursing, 7*(2), 147–56. https://doi.org/10.1111/j.1365-2648.1982.tb00222.x

Kleinman, A. & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and How to Fix It. *PLoS Med, 3* (10), e294. https://doi.org/10.1371/journal.pmed.0030294

Kligman, G. (1998). *The politics of duplicity: Controlling reproduction in Ceauşescu's Romania.* University of California Press.

Kligram, G. & Gal, S. (2000). *The politics of gender after socialism: A comparative-historical essay.* Princeton University Press.

Klímová Chaloupková, J. & Hašková, H. (2020). The diversity of pathways to childlessness in the Czech Republic: The union histories of childless men and women, *Advances in Life Course Research*, *46*, 100363, https://doi.org/10.1016/j.alcr.2020.100363

Kluchin, R. M. (2009). *Fit to Be tied: Sterilization and reproductive rights in America, 1950–1980*. Rutgers University Press.

Kobes, T. (2009). *Nastartovali nás jako motorky: činnost nevládních organizací při řešení romské problematiky na východním Slovensku* [They started us up like motorbikes: The

activities of non-governmental organizations in solving the Romani problematics in Eastern-Slovakia]. Západočeská univerzita v Plzni.

Kóczé, A. et al. (2018). *The Romani women's movement: Struggles and debates in Central and Eastern Europe*. Routledge Taylor & Francis Group.

Kovai, C. (2010). On the borders of gender: Marriage and the role of the "child' amongst Hungarian Gypsies. In: Stewart, M. & Rövid, M. (eds.) *Multi-disciplinary approaches to Romany studies*. Central European University Press, 108–122.

Krause, E. L. & De Zordo, S. (2012). Introduction. Ethnography and biopolitics: Tracing "rationalities" of reproduction across the north–south divide. *Anthropology & Medicine, 19*(2), 137–151. https://doi.org/10.1080/13648470.2012.675050

Krause, E. L. & Marchesi, M. (2007). Fertility politics as "social Viagra": Reproducing boundaries, social cohesion, and modernity in Italy. *American Anthropologist*, *109*(2), 350–362. https://www.jstor.org/stable/4496648

Krause, E. L. (2012) "They just happened": The curious case of the unplanned baby, Italian low fertility, and the "end" of rationality. *Medical Anthropology Quarterly*, *26*(3), 361–382. https://doi.org/10.1111/j.1548-1387.2012.01223.x

Kubaník, P. (2017). Pohledy na výchovu a dětství v romských rodinách. Úvod k tematickému dvojčíslu. *Romano džaniben*, *24*(1), 5–14.

Lacková, E. (1997). *Narodila jsem se pod šťastnou hvězdou* [I was born under a lucky star]. Triáda.

Ládanyi, J. & Szelényi, I. (2006). *Patterns of exclusion: Constructing Gypsy ethnicity and the making of an underclass in transitional societies of Europe.* East European Monographs.

Lamphere, L. (2004). The convergence of applied, practicing and public anthropology in the 21st century. *Human Organization, 63*(4), 431–443.

Lassiter, L. E. (2005). *The Chicago guide to collaborative ethnography*. University of Chicago Press.

Lassonde, S. (2012). Age, schooling, and development. In Fass, P. S (ed.) (2012). *The Routledge history of childhood in the western world*. Taylor & Francis, Routledge, 211–228.

Law, J. (1994). *Organizing modernity*. Backwell.

Layne, L. L. (2003) Unhappy endings: A feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine, 56*(9), 1881–1891. https://doi.org/10.1016/S0277-9536(02)00211-3

Lazarus, E. S. (1988). Theoretical considerations for the study of the doctor-patient relationship: Implications of a perinatal Study. *Medical Anthropology Quarterly, 2*(1), 34–58. https://www.jstor.org/stable/649260

Lazarus, E. S. (1994). What do women want? Issues of choice, control, and class in pregnancy and childbirth. *Medical Anthropology Quarterly*, *8*(1), 25–46. https://www.jstor.org/stable/648990

Leininger, M. M. (1988). Leininger's theory of nursing: Cultural care, Diversity and Universality. *Nursing Science Quarterly*, *1*(4), 152–60.

De León, J. (2015). *The land of open graves: Living and dying on the migrant trail*. University of California Press.

Liamputtong, P. (2005) Birth and social class: Northern Thai women's lived experiences of caesarean and vaginal birth. *Sociology of Health & Illness, 27*(2), 243–270. https://doi.org/10.1111/j.1467-9566.2005.00441.x

Lock, M. & Kaufert, P.A & Harwood, A. (1998). *Pragmatic women and body politics*. Cambridge University Press.

Long, N. & Bruner, E. M. & Mookherjee, N. (2009). Discussion point: When informants lie. *The Cambridge Journal of Anthropology*, *29*(3), 85–94. https://www.jstor.org/stable/23820825

Lopez, I. (1997). Agency and constraint sterilization and reproductive freedom among Puerto Rican women in New York City. In Lamphere, L. & Ragone, H. & Zavella, P. (eds.) *Situated lives: Gender and culture in everydaylLife*. Routledge, 157–171.

Ludvigh Cintulová, L. & Radková, L. (2018). Social aspects of unplanned pregnancies in teenage Roma girls. *Kontakt*, *21*(1), 106–112. DOI: 10.32725/kont.2018.006

Lupton, D. & Schmied, V. (2013). Splitting bodies⁄selves: women's concepts of embodiment at the moment of birth. *Sociology of Health & Illness, 35*(6), 828–841. https://doi.org/10.1111/j.1467-9566.2012.01532.x

Lyons, S. et al. (2008). Cultural diversity in the Dublin maternity services: The experiences of maternity service providers when caring for ethnic minority women. *Ethnicity and Health* 13 (3), 261–276. https://doi.org/10.1080/13557850801903020

MacDonald, M. (2006) Gender expectations: Natural bodies and natural births in the new midwifery in Canada. *Medical Anthropology Quarterly*, *20*(2), 235–256. https://www.jstor.org/stable/3655414

MacDonald, M. E. (2011). The cultural evolution of natural birth. *The Lancet*, *378*(9789), 394–395. https://doi.org/10.1016/S0140-6736(11)61200-2

Macintyre, S. (1978). Some notes on record taking, and making in an antenatal clinic. *Sociological Review, 26*(3), 595–611.

Malacrida, C. & Boulton, T. (2014). The best laid plans? Women's choices, expectations and experiences in childbirth. *Health, 18*(1), 41– 59. https://doi.org/10.1177/1363459313476964

Malinowski, B. (1932). *The sexual life of savages in North-Western Melanesia: An ethnographic account of courtship, marriage, and family life among the natives of the Trobriand Islands*. Routledge & Sons.

Mamali, E. (2019) Researcher's guilt: Confessions from the darker side of ethnographic consumer research. *Consumption Markets & Culture*, *22*(3), 241–255. https://doi.org/10.1080/10253866.2018.1474109

Mann, A. B. (2004). (1994). Obyčaje pri narodzení dieťaťa u Rómov na Slovensku – Tradičná ľudová kultúra a výchova v Európe [Birth habits of the Roma in Slovakia – Traditional Folklore and Upbringing in Europe]. Akademická Nitra.

Mansfield, B. (2008). The social nature of natural childbirth. *Social Science & Medicine, 66*, 1084–1094. https://doi.org/10.1016/j.socscimed.2007.11.025

Marchesi, M. (2012). Reproducing Italians: contested biopolitics in the age of "replacement anxiety". *Anthropology & Medicine, 19*(2), 171–188. https://doi.org/10.1080/13648470.2012.675043

Martin, E. (1992) *The woman in the body: A cultural analysis of reproduction*. Beacon Press.

Matějů, P. (2015, January 5). "Patronka dětí: Rodiče paterčat musí umět šetřit, jinak skončí špatně" [The children's patron: The quintuplets' parents have to be able to save money, otherwise it will end badly], *Idnes*. . https://www.idnes.cz/onadnes/vztahy/patercata-a-klara-vitkova-rulikova.A141229_184916_spolecnost_jup

Maternowska, C. M. (2006). *Reproducing inequities: Poverty and the politics of population in Haiti*. Rutgers University Press.

McCabe, K. (2016) Mothercraft: Birth work and the making of neoliberal mothers. *Social Science & Medicine, 162*, 177–184. https://doi.org/10.1016/j.socscimed.2016.06.021

McCreaddie, M. & Wiggins, S. (2009). Reconciling the good patient persona with problematic and non-problematic humour: A grounded theory. *International Journal Nursing Studies*, *46*(8), 1079–91. https://doi.org/10.1016/j.ijnurstu.2009.01.008

McFadden, A., & Renfrew, M. J. & Atkin, K. (2012). Does cultural context make a difference to women's experiences of maternity care? A qualitative study comparing the perspectives of breast-feeding women of Bangladeshi origin and health practitioners. *Health Expectations*, *16*, 124–135. doi: 10.1111/j.1369-7625.2012.00770.x

Mendenhall, E. (2013). *Syndemic suffering: Social distress, depression, and diabetes among Mexican immigrant women*. Left Coast Press.

Mewburn, I. (13 March 2011). Developing your inner Yoda – er, scholar. The Thesis Whisperer (blog), https://thesiswhisperer.com/2011/03/03/developing-your-inner-yoda-er-scholar/

Miller, A. C. & Shriver, T. E. (2012) Women's childbirth preferences and practices in the United States. *Social Science & Medicine, 75*, 709–716. https://doi.org/10.1016/j.socscimed.2012.03.051

Mishtal, J. (2012). Irrational non-reproduction? The "dying nation" and the postsocialist logics of declining motherhood in Poland. *Anthropology & Medicine*, *19*(2), 153–169, DOI: 10.1080/13648470.2012.675048

Mishtal, J. (2015). *Politics of morality: The Church, the state, and reproductive rights in postsocialist Poland*. Ohio University Press.

Mitchell, K. J. et al. (2012). Prevalence and characteristics of youth sexting: A national study. *Pediatrics*, *129*, 13–20. DOI: 10.1542/peds.2011-1730

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. Routledge.

Morgan, L. M. (2019). Reproductive governance, redux. *Medical Anthropology, 38*(2), 113–117. https://doi.org/10.1080/01459740.2018.1555829

Morgan, M. L. & Roberts, E. (2012). Reproductive governance in Latin America. *Anthropology & Medicine, 19*(2), 241–254. https://doi.org/10.1080/13648470.2012.675046

Murphy, M. (2017). *The economization of life*. Duke University Press.

Nash, R. (2005). The economy of birthrates in the Czech Republic. In Douglass, C. B. (ed.), *Barren States: The Population "Implosion" in Europe*. Berg, 93–113.

Oakley, A. (2016) A small sociology of maternal memory. *The Sociological Review*, *64*, 533–549. https://doi.org/10.1111/1467-954X.12367

O'Dougherty, M. (2008). Lia won't: Agency in the retrospective pregnancy narrative of low-income Brazilian women. *Journal of Latin American and Caribbean Anthropology, 13*, 414–46. https://doi.org/10.1111/j.1935-4940.2008.00044.xOng, A. (1987). *Spirits of resistance and capitalist discipline: Factory women in Malaysia*. SUNY Press.

Oprea, A. (2012). Romani feminism in reactionary times. *Signs*, *38*(1), 11–21. https://doi.org/10.1086/665945

Ort, J. (2022). *Facets of a Harmony: The Roma and their locatedness in Eastern Slovakia.* Karolinum Press.

Parsons, T. (1951). *The social system.* Free Press.

Parsons, T. (1975). The sick role and the role of the physician reconsidered. *Health and Society*, *53*(3), 257–78. https://doi.org/10.2307/3349493

Pease, N.J. & Finlay, I. G. (2002). Do patients and their relatives prefer single cubicles or shared wards? *Journal of Palliative Medicine, 16*(5), 445–6. https://doi.org/10.1191/0269216302pm5

Peirano, M. G. S. (1998). When anthropology is at home: The different contexts of a single discipline. *Annual Reviews of Anthropology, 27*, 105–28.

Persson, E. & Anderberg, P. & Kristensson Ekwall, A. (2015). A room of one‘s own: Being cared for in a hospital with a single-bed room design. *Scandinavian Journal of Caring Sciences*, *29*, 340–346. https://doi.org/10.1111/scs.12168

Pigg, S. L. (2013). On sitting and doing: Ethnography as action in global health. *Social Science & Medicine*, *99*, 127–134. https://doi.org/10.1016/j.socscimed.2013.07.018

Plájás, I. Z. & M'charek, A. & van Baar, H. 2019. Knowing "the Roma": Visual technologies of sorting populations and the policing of mobility in Europe. *EPD: Society and Space*, *37*(4) 589–605. https://doi.org/10.1177/02637758198372

Podolinská, T. & Hrustič, T. (2011). *Religion as a path to Change? The possibilities of social inclusion of the Roma in Slovakia*. Friedrich Ebert Stiftung, Institute of Ethnology SAS.

Podolinská, T. & Hrustič, T. (2014). Religious change and its effects on social change for Roma in Slovakia. *Acta Ethnographica Hungarica, 59*(1), 235–256. https://doi.org/10.1556/AEthn.59.2014.1.12

Potančoková, M. et al. (2008). Slovakia: Fertility between tradition and modernity. *Demographic Research*, *19*(25), 973–1018. DOI: 10.4054/DemRes.2008.19.25

Raine, G. et al. (2020), Pornography use and sexting amongst children and young people: a systematic overview of reviews. *Systematic Reviews*, *9*(1), 283.https://doi.org/10.1186/s13643-020-01541-0

Rambousková, J. et al. (2009). Health behaviors, nutritional status, and anthropometric parameters of Roma and non-Roma mothers and their infants in the Czech Republic. *Journal of Nutrition Education and Behavior, 41*(1), 58–64. https://doi.org/10.1016/j.jneb.2008.04.360

Rapp, R. (1999). *Testing women, testing the fetus: The social impact of amniocentesis in America*. Routledge.

Redfield, P. (2013). Life in crisis: *The ethical journey of Doctors Without Borders*. University of California Press.

Riezzo, I. et al. (2016). Italian law on medically assisted reproduction: do women's autonomy and health matter? *BMC Women's Health*, *16*(44). https://doi.org/10.1186/s12905-016-0324-4

Rinker, C. H. (2015). Creating neoliberal citizens in Morocco: Reproductive health, development policy, and popular Islamic beliefs. *Medical Anthropology*, *34*(3), 226–242. https://doi.org/10.1080/01459740.2014.922082

Rivkin-Fish, M. (2003). Anthropology, demography, and the search for a critical analysis of fertility: Insights from Russia. *American Anthropologist, 105*(2), 289–301. https://www.jstor.org/stable/3567503

Rivkin-Fish, M. (2005). Bribes, gifts, and unofficial payments: Rethinking corruption in post-Soviet Russian healthcare. In: Haller, D. & Shore, C. (eds.) *Corruption: Anthropological perspectives.* Pluto, 47–64.

Rivkin-Fish, M. (2013). Conceptualizing feminist strategies for Russian reproductive politics: Abortion, surrogate motherhood, and family support after socialism. *Signs*, *38*(3), 569–593. https://doi.org/10.1086/668606

Roach, M. S. (1984). *Caring: The human mode of being: Implications for nursing*, Faculty of Nursing, University of Toronto.

Romane Kale Panthera Groupe – Moyzes, T. & Duždová-Horváthová, V. (2014) *SuperMom.* European Roma art exhibition, Strasbourg.

Rorke, B. & Szilvasi, M. (2017). Racism's cruelest cut: coercive sterilisation of Romani women and their fight for justice in the Czech Republic (1966-2016). *Open Democracy*, *24*, January 2017. Racism's cruelest cut: coercive sterilisation of Romani women and their fight for justice in the Czech Republic (1966-2016)

Rosaldo, M. Z. (1984). Toward an anthropology of self and feeling. In: Shweder, R. A. & LeVine R. A. (eds) *Culture theory: essays on mind, self, and emotion*. Cambridge University Press.

Rose, N. & Novas, C. (2005). Biological citizenship. In: Ong, A. & Collier, S.J. (eds.), *Global assemblages: Technology, politics, and ethics as anthropological problems*. Blackwell Publishing, 439–463.

Rose, N. (1996). The death of the social? Re-figuring the territory of government. *Economy and Society*, *25*(3), 327-356. DOI: 10.1080/03085149600000001

Rose, N. (1999). *Powers of freedom: Reframing political thought.* Cambridge University Press.

Rose, N. (2001). The politics of life itself. *Theory, Culture and Society, 18*(6), 1–30. https://doi.org/10.1177/02632760122052020

Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century.* Princeton University Press.

Rose, N. & Lentzos, F. (2017). Making us resilient: Responsible citizens for uncertain times. In: Trnka, S. & Trundle, C. (eds.) *Competing responsibilities: The ethics and politics of contemporary life*. Duke University Press, 27–48.

Ross, L. et al. (2017). *Radical reproductive justice*. Feminist Press.

Roth, J. A. (1972). Some contingencies of the moral evaluation and control of clientele: The case of the hospital emergency service. *American Journal of Sociology, 77*(5), 839–56.

Ryder, A, Cemlyn, S. & Acton, T., eds. (2014). *Hearing the voices of Gypsy, Roma and Traveller communities: Inclusive community development*. Policy Press.

Saadi, A. & McKee, A. (2018). Hospitals as places of sanctuary. *BMJ*, *361* (k2178). https://doi.org/10.1136/bmj.k2178

Sanjek, R. (2004). Going Public: Responsibility and Strategies in the Aftermath of Ethnography. *Human Organization 63*(4), 444–456.

Sargent, C & Gulbas, L. (2011). Situating birth in the anthropology of reproduction. In: Singer, M. & Erickson, P. I. (eds.) *A companion to medical anthropology.* Blackwell Publishing, 289–303.

Scheffel, D. (2005). *Svinia in black and white: Slovak Roma and their neighbours.* Broadview Press.

Scheper-Hughes, N. (1992). *Death without weeping: The Vvolence of everyday life in Brazil*. University of California Press.

Scheper-Hughes, N. (1995). "The primacy of the ethical: Propositions for a militant anthropology." *Current Anthropology, 36*(3), 409–44. https://doi.org/10.1086/204378.

Schramm, K. & Beaudevin, C. (2019). Sorting, typing, classifying: The elephants in our ethnographic room. *Medicine Anthropology Theory, 6*(4), 276–290. https://doi.org/10.17157/mat.6.4.767

Schultz, D. L. (2012). Translating intersectionality theory into practice: A tale of omani-*gadže* feminist alliance. *Signs*, *38*(1), 37–43. https://doi.org/10.1086/665802

Seeman, D. et al. (2016). Blessing unintended pregnancy: Religion and the discourse of women's agency in public health. *Medicine Anthropology Theory, 3*(1), 29–54. https://doi.org/10.17157/mat.3.1.168

Sélešová, S. (2008, December 1). Tisíce 'za dieťa' lákajú najmä Rómov [Thousands "for a child" are especially attractive for the Roma]. *Pravda*.

Shaw, I. & Aldridge, A. (2003). Consumerism, health and social order. *Social Policy and Society*, *2*(1), 35–43. http://dx.doi.org/10.1017/S147474640300109X

Van der Sijpt, E. (2018). "Soothing my child's soul and my own": Dealing with pregnancy loss in post-communist Romania. *Ethos*, 47(2), 387-405. https://doi.org/10.1111/etho.12222

Škobla, D., Grill, J. & Hurrle, J. (2016). *Exploring field social work in Slovakia (evaluation of the programme funded by the European Social Fund in 2007--2013*). IA MPSVR SR.

Šlechtová, D. & Bürgerová, O. (2009). Specifika romského etnika ve vztahu k poskytování zdravotní a ošetřovatelské péče [The specificities of the Romani Ethnic Group in Relation to Providing health and care services]. *Kontakt,* 1, 187-192. DOI: 10.32725/kont.2009.034

Šmídová, I., & Šlesingerová, E. & Slepičková, L. (2015) *Games of life: Czech reproductive biomedicine. Sociological perspectives.* Brno: Masaryk University.

Sointu, E. (2017). "Good" patient/"bad" patient: Clinical learning and the entrenching of inequality. *Sociology of Health and Illness, 39*(1), 63–77. https://doi.org/10.1111/1467-9566.12487

Sokolová, V. (2005) Planned parenthood behind the curtain: Population policy and sterilization of Romani women in communist Czechoslovakia, 1972-1989. *The Anthropology of East Europe Review, 23*(1), 79–98.

Sopuchová, V. & Bužgová, R. (2013). Problematika sociální nerovnosti v porodní asistenci [The issue of social inequalities in birth care]. *Ošetřovatelství a porodní asistence* [Nursing and Birth Care], *4*(1), 528–536.

Šotola, J. & Polo, M. R. (2016). *Etnografie sociální mobility: etnicita, bariéry, dominance* [Ethnography and social mobility: Ethnicity, barriers, dominance]. Palacký University in Olomouc.

Speier, A. (2016). *Fertility holidays: IVF tourism and the reproduction of whiteness*. New York University Press.

Stan, S. (2012). Neither commodities nor gifts: Post-socialist informal exchanges in the Romanian healthcare system. *The Journal of the Royal Anthropological Institute*, *18*(1), 65–82. https://doi.org/10.1111/j.1467-9655.2011.01731.x

Steinfeld, R. (2015). Wars of the wombs: Struggles over abortion policies in Israel. *Israel Studies*, *20*(2), 1–26. https://doi.org/10.2979/israelstudies.20.2.1

Stewart, M. (1997). *The time of the Gypsies*. Westview Press.

Stillo, J. (2015). "We are the losers of socialism!" Tuberculosis, the limits of bio-citizenship and the future of care in Romania. *Anthropological Journal of European Cultures, 24*(1), 132–40. https://doi.org/10.3167/ajec.2015.240110

Stimson, G. V. (1976). General practitioners, "trouble" and types of patients. *Sociological Review Monograph, 22*(1), 43–60.

Strathern, M. (1990). *The gender of the gift: Problems with women and problems with society in Melanesia*. University of California Press.

Strathern, M. (1992). *Reproducing the future: Anthropology, kinship, and the new reproductive technologies*. Routledge.

Street, R. L. & Gordon, H. & Haidet, P. (2007). Physicians' communication and perceptions of patients: is it how they look, how they talk, or is it just the doctor? *Social Science and Medicine, 65*(3), 586–98. https://doi.org/10.1016/j.socscimed.2007.03.036

Surdu M. (2016). *Those Who Count: Expert Practices of Roma Classification*.Central European University Press.

Szénássy, E. (2010). Culturing the Population Bomb: On Slovak Fears of Roma Wombs, *Viennese Ethnomedicine Newsletter*, *13*(1), 9–18.

Szilvasi, M. (2016). *Separate, unequal and hazardous: the essential guide to Roma housing in Slovakia.* European Roma Rights Centre, 19 January 2016.

Tauber, E. (2004). Sinti Estraixaria children at school, or ow to preserve the Sinti way of thinking. *Romani Studies*, *14*(1), 1–23.

Taussig, K-S. (2017). Reconceiving the new world order: Genes, reproduction, and the politics of regenerative medicine. *Medical Anthropology*, *36*(2), 170–178. https://doi.org/10.1080/01459740.2016.1239619

Taylor, J. (2003). Confronting "culture" in medicine's "culture of no culture." *Academic Medicine*, *78*(6), 555–559.

Taylor, J. (2004). Big ideas: Feminist ethnographies of reproduction. *American Ethnologist*, *31*(1), 123 – 130.

Thompson, C. (2005). *Making parents: The ontological choreography of reproductive technologies*. MIT Press.

Trnka, S. & Trundle, C. (2017). Introduction. Competing responsibilities: Reckoning personal responsibility, care for the other, and the social contract in contemporary life. In: Trnka, S. & Trundle, C. (eds.) *Competing responsibilities: The ethics and politics of contemporary life*. Duke University Press, 1–26.

Trnka, S. & Trundle, C. (2014). Competing responsibilities: Moving beyond neoliberal responsibilisation. *Anthropological Forum: A Journal of Social Anthropology and Comparative Sociology*, *24*(2), 136–153. https://doi.org/10.1080/00664677.2013.879051

Tsing, A. L. (1994). From the margins. *Cultural Anthropology*, *9*(3), 279–297.

Tully, K.P. & Ball, H. L. (2013) Misrecognition of need: Women's experiences of and explanations for undergoing cesarean delivery. *Social Science & Medicine*, *85*, 103–11. https://doi.org/10.1016/j.socscimed.2013.02.039

Ulrich, R. S. (2006). Essay: Evidence-based health-care architecture. *Lancet, 368*(S38-S39), 538–539. https://doi.org/10.1016/S0140-6736(06)69921-2

United Nations (2006). *World report on violence against children: The United Nations Secretary-General's Study*. United Nations. https://digitallibrary.un.org/record/587334?ln=en

Válková, H. (2013, August 1). Paterčata propustí v nejbližších dnech, termín odjezdu rodiče tají [The quintuplets will be discharged in the upcoming days, the parents do not reveal the specific date], *Idnes*.. https://www.idnes.cz/zpravy/domaci/patecata-propusti.A130801_103301_domaci_hv

Válková, H. (2010, June 6). Paterčata zůstanou na JIP ještě týden, navštívila je ministryně [The quintuplets will remain at the ICU for another week, the minister paid them a visit], *Idnes*,. https://www.idnes.cz/zpravy/domaci/zdravotni-stav-prvnich-ceskych-patercat.A130606_114540_domaci_hv

Vaňo, B. & Mészáros, J. (2004). The reproductive behavior in municipalities with low living standard. Infostat. http://www.infostat.sk/vdc/pdf/lowstandard.pdf

Wacquant, L. (2008). *Urban outcasts: A comparative sociology of advanced marginality*. Polity Press.

Walker, S. (2020, March 4). “Baby machines”: eastern Europe's answer to depopulation. *The Guardian*. https://www.theguardian.com/world/2020/mar/04/baby-bonuses-fit-the-nationalist-agenda-but-do-they-work

Wamsiedel, M. (2016). Lay values, organizational concerns, and the handling of “social cases” in Romanian emergency departments. *Transylvanian Review, 25* (1), 61–76.

Wamsiedel, M. (2018). Accomplishing public secrecy: Non-monetary informal practices and their concealment at the emergency department. In: Polese, A. et al. (eds.) *Post-socialist informalities: Power, agency and the construction of extra-legalities from Bosnia to China*. Routledge.

Watson, H. L. & Dowe, S. (2017). Discrimination against childbearing Romani women in maternity care in Europe: A mixed-methods systematic review. *Reproductive Health, 14*(1), 1–16. https://doi.org/10.1186/s12978-016-0263-4

Weiss, M. (2002). *The chosen body: The politics of the body in Israeli society*. Stanford University Press.

Wilková, S. (2013, September 2). Alexandra Kiňová: Můj život s paterčaty [Alexandra Kiňová: My life with quintuplets], *Idnes*. https://www.idnes.cz/onadnes/vztahy/alexandra-kinova-patercata.A130828_142356_deti_jup

Williams, S. J. (1995) Theorising class, health and lifestyles: Can Bourdieu help us? *Sociology of Health and Illness*, *17*(5), 577–604.

Wind, G. (2008). Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropology and Medicine, 15*(2), 79–89. https://doi.org/10.1080/13648470802127098

World Bank, Fertility rate, total (births per woman).

Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth. *Sociology of Health and Illness*, *21*(3), 267–89.

Zelizer, V. (1985). *Pricing the priceless child*. Basic Books.

Zillmann, D. (2000). Influence of unrestrained access to erotica on adolescents’ and young adults’ dispositions toward sexuality. *Journal of Adolescent Health*, *27*, 41–44.

Zoon, I. (2001). *On the margins: Roma and public services in Romania, Bulgaria and Macedonia*. Open Society Institute.

De Zordo, S., Marre, D. & Smietana, M. (2022). Demographic anxieties in the age of “fertility decline”. *Medical Anthropology*, *41*(6-7), 591–599. https://doi.org/10.1080/01459740.2022.2099851

De Zoro, S. (2012). Programming the body, planning reproduction, governing life: The “(ir-) rationality” of family planning and the embodiment of social inequalities in Salvador da Bahia (Brazil). *Anthropology & Medicine, 19*, 207–223.
https://doi.org/10.1080/13648470.2012.675049