

# Between Bureaucracy and Community: Thinking With Public Health Collaboration in Serbia and Croatia



Med birokracijo in skupnostjo: razmišljanje s sodelovan-  
jem na področju javnega zdravja v Srbiji in na Hrvaškem

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## ABSTRACT

This article explores how collaboration operates as both a concept and a practice in the post-socialist public health systems of Serbia and Croatia. Drawing on ethnographic research and expert interviews, it identifies diverse, often conflicting forms of collaboration. By tracing continuities and ruptures with Yugoslav social medicine, the article argues for reflexive, power-aware forms of partnership in contemporary health governance.

KEYWORDS: public health, collaboration, social medicine, post-socialist health systems, medical anthropology, epistemic partnership

## IZVLEČEK

Prispevek proučuje, kako sodelovanje hkrati deluje kot koncept in kot praksa v postsocialističnih sistemih javnega zdravstva v Srbiji ter na Hrvaškem. Na podlagi etnografske raziskave ter intervjujev s strokovnjaki in strokovnjakinjami opredeljuje raznolike, pogosto nasprotno si oblike sodelovanja. Z ozirom na kontinuitete in prelome z jugoslovansko socialno medicino članek zagovarja refleksivne ter razmerja moči upoštevajoče oblike partnerstva v sodobnem upravljanju zdravja.

KLJUČNE BESEDE: javno zdravje, sodelovanje, socialna medicina, postsocialistični zdravstveni sistemi, medicinska antropologija, epistemična partnerstva

## INTRODUCTION

This article emerges from our small collaborative ethnographic project.<sup>1</sup> As two medical anthropologists, one based in Croatia and the other in Serbia, we bring to this research not only our disciplinary training and field experience but also the shared frustrations, questions, and aspirations that led us to collaborate in the first place. Our interest in the history, present, and possible futures of public health and social medicine<sup>2</sup> in the former Yugoslavia has grown from a deep engagement with ethnographic fieldwork, teaching, institutional constraints, and conversations with practitioners, who describe their health systems as “ruined”, fractured, or simply exhausted.

Our research investigates collaboration in public health as both an object of inquiry and a methodological practice. Specifically, we examine how the changing institutional, political, and epistemological landscapes in Serbia and Croatia shape possibilities for collaboration among public health experts, and between those experts and anthropologists and various other interested parties and publics. We have used the notion of “epistemic partnership” (Holmes and Marcus, 2008, 2021) as an aspiring concept to explore how collaborative relations are formed, interrupted, and transformed in institutional public health settings, although we cannot claim that this type of relationship has been achieved. However, it is the work of Anna Tsing and her collaborators (2005, 2015, 2017, 2024) that deeply inspires our own thinking and requires to be noted here.

The main goals of our research are threefold. First, we aim to identify the current challenges facing public health systems in Serbia and Croatia from the perspectives of practitioners working within them. Second, we seek to explore what remains – discursively, institutionally, and practically – of the specific iteration of social medicine developed throughout the 20<sup>th</sup> century, which emphasized community participation, equity, and decentralisation. Third, we aim to establish relationships with experts who are open to future collaboration, especially in envisioning new interdisciplinary and transnational frameworks for health and care in post-socialist contexts. This article, however, does not strive to achieve any of these goals as much as it is guided by them in exploring the very concept of collaboration.

### 1

The project, entitled *In the Frictions of Social(ised) Medicine: A Collaborative Ethnography of Public Health Institutions in Croatia and Serbia*, was granted funding for junior post-doctoral scholars as part of the *A small but fertile field: Strengthening Southeast European Studies in Regensburg* initiative. We are deeply grateful for the funding that supported this research; without it, this work would not have been possible. Additionally, this paper was realised with the support of the Ministry of Science, Technological Development and Innovation of the Republic of Serbia, according to the Agreement on the Realisation and Financing of Scientific Research 451-03-136/2025-03/200025.

### 2

The distinction between public health and social medicine has long been a subject of debate. Public health is usually defined as the organised and interdisciplinary community effort to prevent disease, prolong life, and promote health in populations (Axelsson and Axelsson 2006). Social medicine, on the other hand, stems from the idea of medicine as a social science (Virchow, Grotjahn) and focuses on how social, economic, and environmental conditions shape the health of individuals and groups (Roemer 1993). Although different in their historical trajectories and emphases, the two approaches are today inextricably linked: public health cannot function without the insights of social medicine into the social determinants of health, while social medicine finds its practical application precisely through public health systems (see also Vukmanović 1972 on the Yugoslav model of integrated preventive and curative care).

Collaboration in public health is often invoked as an unquestioned good: an imperative for “better policy”, “stronger institutions”, or “efficient delivery”. Yet what exactly constitutes collaboration remains ambiguous, varied, and deeply contextual (Axelsson and Axelsson 2006; Bennett and Gadlin 2012). In our interviews with public health experts from institutions in Belgrade, Novi Sad, Zagreb, and Rijeka, we encountered a range of collaborative modalities, from bureaucratic and “coerced” forms tied to project funding, to charismatic and participatory engagements driven by individual initiative and informal networks. Drawing on these insights, we discuss possible models of collaboration on a spectrum between bureaucratic, rational-scientific, policy-oriented, charismatic, participatory, globalised, coerced, and aspirational.

These models are not mutually exclusive; rather, they coexist and clash in specific institutional settings marked by transitions (political, economical, social, health, technological, etc.), austerity, and the hollowing out of what was once known as social medicine. Echoing anthropological critiques of collaboration as both a discourse and a situated relation (Holmes and Marcus 2021; Tsing 2015), we approach collaboration not as a neutral tool but as a site of friction – contested, uneven, and sometimes deeply ambivalent.

In this paper, we reflect on our efforts to build collaborative relationships with public health professionals in key institutions historically linked to social medicine: the Andrija Štampar School of Public Health, a teaching branch of the School of Medicine, University of Zagreb (Škola narodnog zdravlja “Andrija Štampar”), the Institute for Social Medicine in Belgrade, Faculty of Medicine, University of Belgrade (Institut za socijalnu medicinu), the Institute for Public Health of Serbia “Dr. Milan Jovanović Batut” (Institut za javno zdravlje Srbije “dr. Milan Jovanović Batut”), the Teaching Institute for Public Health Dr. Andrija Štampar, a public health institution that covers the city of Zagreb and a teaching base of the Faculty of Medicine, University of Zagreb (Nastavni zavod za javno zdravstvo dr. Andrija Štampar), the Institute for Public Health of Vojvodina (Institut za javno zdravlje Vojvodine), and the Department of Social Medicine and Epidemiology, Faculty of Medicine, University of Rijeka (Katedra za socijalnu medicinu i epidemiologiju).

Through expert interviews and informal discussions, we trace how professional values, disciplinary boundaries, political entanglements, and institutional hierarchies shape the contours of public health work today. We also share the dilemmas we encountered as ethnographers seeking to engage not only with individuals but also with institutions whose capacity, and sometimes willingness, for collaboration is constrained by political shifts, lack of funding, and what our interlocutors often describe as a loss of autonomy.

Ultimately, this article is both a report on work-in-progress and a methodological meditation on what it means to collaborate ethnographically in the domain of public health in Southeast Europe. We argue that collaboration, if it is to be transformative rather than rhetorical, must be situated, reflexive, and attentive to power. It must recognise not only the possibilities of shared work but also its limits and failures. By thinking with collaboration, its bureaucratic constraints, its charismatic mobilisations, and its everyday frictions, we aim to contribute to broader debates in medical anthropology, social medicine, and public health governance in post-socialist contexts.

LEGACIES AND RUPTURES: SITUATING PUBLIC HEALTH  
AND SOCIAL MEDICINE  
IN YUGOSLAVIA, CROATIA, AND SERBIA

Our decision to explore collaboration in public health in Croatia and Serbia cannot be separated from the shared historical infrastructure of “public care”<sup>3</sup> in socialist Yugoslavia. This history not only shaped the organisation of care, but also influenced how collaboration itself was understood, as a collective, interdisciplinary, and often intersectoral mode of working oriented toward population health and social equity. It is precisely this legacy that our research seeks to revisit, not nostalgically, but critically, asking what remains of social(ised)<sup>4</sup> medicine today and how it continues to live, fracture, or be repurposed within current public health institutions.

During our early conversations, still on informal Zoom calls in the midst of the pandemic, we often returned to the figures of Andrija Štampar and Milan Jovanović Batut and the lore<sup>5</sup> that surrounds them. For both of us, Štampar and Batut had been names occasionally mentioned in textbooks or at conferences, but rarely engaged with in depth. Yet, in the post-Covid-19 public discourse, their legacy seemed to resurface in Croatia (Štampar) and Serbia (Batut), often framed as a reminder of what public health once stood for: community outreach, prevention, and cross-sectoral collaboration. We began wondering if this was just symbolic revivalism or if there existed a deeper unease about what had been lost.

Yugoslav social medicine, especially in its Croatian and Serbian institutional forms,<sup>6</sup> was more than an ideological project. It was a set of interlinked infrastructures that connected medical faculties, public health institutes, social work, education, and hygiene campaigns. It emphasized decentralisation, interprofessional collaboration, and the alignment of healthcare with broader social goals like housing, employment, and literacy (Dugac 2018, 2019; Parmelee 1992; Porter 2006; Silverstein 2021; Vukmanović 1972).

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Without going into deep theoretical and practical discussions on these notions, how they intersect and are defined in different contexts, we use the term “public care” to cover public health, health care, welfare, education, and other public systems of care to acknowledge the often wider and more connected assemblages of social/public/state care that has historically been demarcated somewhat differently than in some more familiar state examples.

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Like with public care, there is a need to acknowledge that there is a difference between social medicine as a field of medical science and socialised medicine as a system of universally organised and offered medicine, what can at times also be called a national healthcare system, universal health care, publicly funded healthcare, etc. Again, these terms do not sufficiently cover the practical meanings in which we use them to keep in mind that Yugoslavia had a functioning self-managing socialism for a few decades that to various degrees extended to public care systems. While this is not the focus of our article, we plan to address it in future publications, but it is of use to keep this “public care pluralism” in mind.

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We use the term “lore” to emphasize that we are referring to collective knowledge and traditions within connected communities, knowledge that straddles the line between history and myth. When we invoke myth, we draw on its anthropological meaning: not as fiction but as a foundational narrative that explains the origins of social institutions. In this case, the “medical system” is understood as both grounded in historical fact and pliable to contemporary national uses.

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There have always been significant differences between the Yugoslav republics, and it would be very hard for us to make claims beyond the two countries where we live and have done our research, but the assemblages of republics can't be ignored, nor be thought of as entities in the strict national countries sense they exist in today.

We are not historians, and understand that there is always a difference between how something was imagined and how something was brought to life, but we take this basis as a form of thinking with. The Institutes for Public Health in Zagreb and Belgrade, Štampar and Batut, were at the heart of these efforts. As state-building institutions, in the interwar period, they produced data, trained professionals, and coordinated mass campaigns in ways that made public health both technical and deeply political. The efforts of these institutions and the people who inhabited them have continued on these paths in various ways in the second half of the 20<sup>th</sup> century.

The 1990s marked a sharp rupture. With the collapse of Yugoslavia, wars across the territories and the rise of nationalist projects, the systems of care became caught in the cross-currents of war, austerity, and neoliberal restructuring. Concepts central to social medicine, like “participation”, “equity”, or “solidarity”, were either discarded or hollowed out, repackaged into project logics and measurable indicators dictated by international donors or simply the political whims of the time. In Croatia, the specialisation in social medicine was absorbed into public health in the early 2000s; in Serbia, it continued but became increasingly marginalised within the institutional hierarchy. In both cases, we heard from our interlocutors/collaborators that “social medicine no longer exists”, or more precisely, that it exists only as a memory, as something one might be “nostalgic for” but no longer operationalise. One of our interlocutors, a doctor attached to several public health and medical institutions in Croatia, noted that they might not have an accurate picture of the socialist/communist past, but that compared to today, what used to be the hallmarks of socialised medicine are lacking in the contemporary health care systems of both countries.

Healthcare under communism was more flexible, quicker to adapt, and more responsive to people’s needs. I realise this might sound like a cliché, especially since I can’t prove it as easily as I can demonstrate the current lack of prevention and evidence-based action in Croatian public health.

Still, that erasure is uneven and incomplete. As a professor of social medicine at the Medical Faculty at the University of Belgrade told us, “Even if social medicine is no longer a specialisation people want, the problems it addressed haven’t gone away. If anything, they’ve become more urgent.” What struck us in our interviews was how often people would pivot from describing bureaucratic inertia and burnout to invoking collaborative ideals rooted in older models: the need for intersectoral work, for deeper community engagement, and for autonomy in designing context-sensitive interventions.

In these moments, it became clear that the legacy of social medicine lives on, not only in archives or in professional genealogies but also in frustrations, memories, and unfulfilled desires for a more humane (public) health(care) system. What changed, however, was the ability to enact those visions. As a specialist of social medicine from the Institute of Public Health of Vojvodina put it, “Everything now is a project. When the project ends, everything ends. There is no continuity.” The move from embedded institutional planning to externally driven projectisation has created new hierarchies and dependencies, undermining the very idea of long-term, context-attuned public health work.

As we have noted above, we are not historians; however, for us, coming from medical anthropology, a field that itself grapples with tensions, this history raises both ethical and methodological questions. How do we account for our own positionalities when many of the people we talk to see themselves as surviving systems that no longer function as they should? And how do we even gauge what the content of this “was” and “should” is?

We do not seek to romanticise the Yugoslav model, which had its own exclusions, limitations, and blind spots. Nor do we presume that the concept of social medicine can simply be revived in its former form. But we are interested in the frictions produced by its partial erasure, in how its institutional ghosts continue to animate present-day struggles around collaboration, responsibility, and care. Understanding these frictions is essential to grasping the stakes of public health work today and to imagining what kinds of collaboration might still be possible, even in the ruins of transition.

### FORMS AND FRICTIONS OF COLLABORATION

If collaboration in public health was once envisioned in Yugoslavia as a horizontal, interprofessional, and context-sensitive practice (even if it was never fully successful in that achievement), especially within the framework of social medicine (Roemer, 1993), what kinds of collaboration exist today? And just as importantly, how do the people working in public health systems experience, negotiate, or resist them?

Through our interviews and field visits, we encountered a wide range of collaborative formations, not only between institutions or sectors but also between individuals, disciplines, and professional cultures. As we tried to make sense of these variations, several recurring modes began to emerge. These are not rigid categories, nor are they mutually exclusive; they often overlap, blur, or transform over time. But they offer a heuristic for thinking about the landscape of collaboration in Croatia and Serbia today: bureaucratic, rational-scientific, charismatic, participatory, globalised, coerced, and aspirational. Each of these forms comes with its own promises, limits, and frictions.

(1) *Bureaucratic collaboration* would represent a sort of duty without dialogue. This is perhaps the most pervasive and simultaneously the most hollowed-out form of collaboration. Bureaucratic collaboration is mandated through formal hierarchies: institutes collaborate because they are told to, because a ministry orders it, or because an official memo requires a report.

Our interlocutors spoke of being summoned into task forces, advisory groups, or project boards without clarifications about goals or roles, or real decision-making power. For some, like our interlocutors from the Department of Social Medicine and Health Statistics with Informatics at the Institute for Public Health of Vojvodina, who met us as a group, this meant travelling to Belgrade for tedious meetings with no particular point:

We were regularly called into expert bodies, working groups, committees, advisory boards, whether at the city level or within the Ministry of Health. We'd spend years attending meetings, sometimes

every week, simply because it was expected of us. Most of this wasn't paid, and often, it wasn't even clear what we were really there to decide.

These arrangements often reproduce vertical structures: the ministry defines certain priorities, national institutes relay them to regional ones, and collaboration becomes a procedural checkbox rather than a meaningful exchange. A specialist of social medicine from Novi Sad noted wryly: "It's not collaboration, it's compliance."

Such enforced, hollow collaboration, marked by formal participation without genuine dialogue or decision-making, can have serious consequences, especially during crises like the Covid-19 pandemic. When collaboration becomes a performance rather than a space for debate, it fosters an environment of silence and conformity. Fearful of political repercussions, experts avoid open criticism, and necessary disagreements are pushed into private conversations. In these conditions, institutions prioritise activities that are politically safe over those that are evidence-based or effective. As a result, public health measures may appear active on paper but lack substance or impact, leaving systems poorly equipped to respond to emergencies. This type of collaboration erodes trust, limits innovation, and ultimately undermines the very goals it claims to serve. A doctor from the Teaching Institute of Public Health "Dr. Andrija Štampar" told us that raising concerns about failures in public health often carries the risk of being branded unpatriotic or disloyal:

There's a clear pattern: first, deny there's a problem, because admitting it would be seen as disloyal. Speaking openly about issues in public health is risky; it's easier to stay silent, and most do. Even during Covid, when I raised concerns in mass emails, no one responded publicly. Yet privately, people would message me saying they agreed but wouldn't say so aloud. It's a system where pretending everything is fine and performing activity [Croatian: *glumljenje aktivnosti*], launching superficial measures with no real impact, takes priority. The goal isn't actual prevention, but actions that won't upset anyone politically or economically. This kind of false activity leaves us with some of the worst health indicators in the EU, yet the system still pretends to function.

Closely related to bureaucratic collaborations are (2) *policy-oriented collaborations* that reflect a form of knowledge production that is deeply tied to policy processes but often remains outside academic or public scrutiny. Unlike purely research-driven collaborations, this model is focused on producing reports, recommendations, and technical documents intended to inform government decisions, legislation, or institutional strategies. We distinguish between bureaucratic and policy-oriented collaboration on the basis of power relations. Unlike bureaucratic collaboration, where little to no input is asked of collaborators, policy-oriented collaboration means professionals are actively engaged, often as experts tasked with producing evidence or shaping recommendations, but within predefined policy frameworks and timelines that limit broader reflection or long-term impact. While such collaborations are typically methodologically rigorous and often involve cross-institutional teams, they prioritise applicability and policy relevance over academic contribution.

Our interlocutors described how many public health projects in Serbia and Croatia are designed primarily to generate actionable recommendations for ministries or international organisations, rather than to produce academic publications that advance scientific

progress. Reports are written, presented to stakeholders, and sometimes discussed publicly, but they rarely enter the scientific literature. As a professor of social medicine explained, the process of turning these reports into journal articles demands additional time, resources, and often steep publication fees, which are difficult to justify when the research already fulfils its intended policy purpose. This creates a large body of “grey literature”, research that informs decisions but remains largely invisible to the academic community and disconnected from broader debates. She adds: “Turning them into academic articles takes extra effort, funding, and time, which we often don’t have or prioritise.”

(3) *Rational-scientific collaboration* would represent a sort of knowledge without context. Many professionals in public health come from clinical or scientific backgrounds, and interinstitutional collaboration often occurs around research projects, data-sharing, or knowledge production. This is the domain of what we term rational-scientific collaboration: efficient, goal-oriented, methodologically rigorous, but often abstract and removed from lived realities. While such collaborations can produce valuable insights, they can also marginalise experiential or qualitative knowledge. As a social medicine specialist from the Institute of Public Health of Vojvodina told us, “We get called to collaborate when there’s a need for numbers. But when we start to talk about the social side of health, poverty, stress, family violence, there’s no space for that.” In this model, disciplines like anthropology or social work are often sidelined unless they can produce policy-friendly outputs. The result is a narrowed understanding of collaboration, one that favours standardisation over adaptability and measurable outcomes over messy realities.

The fourth model we can extrapolate relates to (4) *charismatic collaboration*, where the focus is on specific people that can push forward topics and collaborations, not pre-imagined programs. In both Croatia and Serbia, some of the most vibrant collaborations we have encountered were rooted not in institutional mandates but in the personal energies, networks, and convictions of individual professionals. These we call charismatic collaborations as they are initiatives made possible through trust, long-term relationships, and shared commitment. What struck us was that even interlocutors who didn’t know each other often mentioned the same people, across both Croatia and Serbia, as key collaborators and drivers of change. These were individuals who seemed to carry public health initiatives forward not because of their official roles, but because of their personal energy, networks, and long-standing commitment to collaboration. In fact, nearly everyone we spoke to seemed to circle back to certain individuals, people we haven’t yet interviewed ourselves but who clearly play a central role in the region’s public health networks. It’s through these personal connections that projects get made, a professor of social medicine from the Medical Faculty in Belgrade tells us:

Recently, we’ve been involved in a few projects with colleagues from Croatia through the university, three of them, I think, but honestly, those collaborations are more about personal connections than formal partnerships.

However, this mode of collaboration is fragile. It relies on the time, labour, and affective investment of individuals, very often women, often underpaid and overworked, who

carry the burden of sustaining cooperation in their “free time”, outside project cycles or institutional recognition. When such individuals retire, move, or burn out, the collaborative structure often collapses. It is intensely meaningful, but rarely sustainable.

The next model is (5) *participatory collaboration*. Participatory collaboration, especially with communities or non-medical professionals, is often named in policy documents and international guidelines. In practice, however, it remains difficult to enact. Some practitioners spoke of sincere efforts to involve citizens in health promotion programs or needs assessments, only to encounter logistical, political, or methodological barriers. Others described participatory frameworks imposed by donors without regard for local trust networks, language barriers, or political sensitivities. Some, like our interlocutor from the Department of Social Medicine and Epidemiology, Faculty of Medicine, University of Rijeka, noted that there simply aren't enough medical practitioners to enact these changes:

One of the biggest challenges in making participation work in practice is the lack of healthcare workers, especially in rural areas and on islands. While policies might promote community-based care or citizen involvement, the reality is that many communities don't even have enough doctors or basic services, particularly in primary care. It's hard to engage communities meaningfully when basic needs aren't being met.

The sixth tentative model is (6) *globalised collaboration*. A sort of funding-with-strings, an increasingly common form of collaboration is that which occurs through international projects, regional networks, or externally funded initiatives. EU programs, WHO frameworks, and donor-funded public health campaigns enable forms of cross-border collaboration that bring new resources, visibility, and exchange. Some of the rare examples of cross-border collaboration we heard about were tied to IPA projects, EU-funded programs designed to support cooperation and development in candidate and neighbouring countries. However, even these collaborations were often described as highly technical and driven by external agendas, with little direct involvement from social medicine professionals.

An interlocutor from the Institute of Public Health of Vojvodina said that their institution had recently been involved in several IPA projects focusing on environmental health issues, such as mosquito control and microplastics in water, with partners from Hungary and Croatia. The mosquito project, for example, involved releasing modified mosquitoes to reduce disease risks, a project framed under the One Health model, which links human, animal, and environmental health. Yet despite its scale and technical complexity, said our interlocutor, the project had limited relevance to their everyday work:

We've had some IPA projects with partners from Croatia and Hungary, like one about microplastics in water with Baja and the Institute of Public Health in Sombor. But honestly, we aren't really involved beyond some minor roles, these projects are mostly handled by hygiene specialists, not us. They're very technical, focusing on things like reducing pollution at the source, recycling, or preventing synthetic fibres from reaching waterways. It's important work but not really connected to what we do in social medicine. In fact, we rarely participate in such projects because they require enormous administrative effort, extra staffing, paperwork, and time that we simply don't have. Our work schedules are already overloaded, and we don't have anyone who could take on that kind of project management.

Others noted how donor dependence creates a cycle of short-termism, where institutions chase grants not for content alignment but simply to stay afloat. As an epidemiologist from Belgrade summarised: “The project is over. The collaboration is over.”

Finally, we observed a mode of collaboration that was perhaps the most cynical and this is why we refer to it as (7) *coerced collaboration*. This describes arrangements where collaboration is mandated not to generate meaningful partnerships, but to perform institutional alignment, satisfy funding conditions, or avoid conflict. In some cases, public health professionals were included in working groups for projects whose content they fundamentally disagreed with but could not afford to refuse. In other cases, “interdisciplinary collaboration” was simulated for a report or an evaluation, only to be ignored in practice. This is another side of the collaboration discourse: a performance of unity masking deep epistemic or political divisions. A doctor and professor from the Medical Faculty, University of Belgrade, explained:

We have this mandatory collaboration with the Faculty of Organisational Sciences. Honestly, we are structured completely differently, and there are many misunderstandings, differences in sensitivity, research approaches, and ways of thinking. They are extremely pragmatic, focused on cost-benefit analysis, and often ignore our professional and scientific standards. It’s very frustrating. I haven’t worked with them much myself, but my colleagues often come back from meetings completely drained. At one point, I was asked to join their advisory board, but I refused, there’s just too much of a gap in understanding. They can also be very arrogant, even aggressive in their ignorance. Some of them have said things like, ‘I could easily give a lecture on surgery,’ which left everyone in shock. We still quote that as a prime example of their overconfidence.

Taken together, these seven tentative modes reflect a broader tension in the way collaboration is imagined and enacted in public health. On paper, collaboration is everywhere. In practice, it is often a site of contradiction, ambivalence, and exhaustion. And yet, within and between these forms, we also encountered moments of creativity, improvisation, and care, often hidden in the margins of institutions or nurtured within fragile interpersonal constellations.

Our own collaboration, as anthropologists navigating these systems, sits uneasily within this terrain. We rely on charismatic and participatory models but are often pulled into bureaucratic or project-based frames ourselves. This friction is productive: it reminds us that collaboration is never neutral. It is always shaped by histories, hierarchies, and the labour of those who choose to remain engaged, even when there is little recognition or reward.

## INSTITUTIONAL ENCOUNTERS

As we moved from fieldwork research to conceptual mapping and back, the abstract forms of collaboration we had identified began to take on embodied, affective, and often contradictory shapes. Institutions, named, historical, and seemingly solid entities like the Institute for Public Health “Milan Jovanović Batut” in Belgrade, or the School for Public Health “Andrija Štampar”, at first appeared as static nodes. But what we found were not unified actors, but entangled assemblages of individuals, legacies, aspirations, and bureaucratic fatigue. These

were not simply “sites” of public health knowledge, they were spaces of encounter, negotiation, silence, and sometimes quiet refusal. We present here a series of situated vignettes drawn from our interviews and field visits, what we might call institutional voices, though they are often polyphonic and unsettled. These fragments do not aim to represent the institutions as wholes, but to open windows into the lived experiences of the public health professionals who inhabit them.

We go back to one of the most frequently repeated refrains in our fieldwork, the overwork of public institution employees and the absence of continuity. These are connected issues that come from the multiplicity of proscribed roles the experts in these institutions have and the project logic that needs to be satisfied in a timely manner. In a conversation at the Institute for Public Health in Vojvodina, a senior physician with over two decades of experience put it bluntly:

There is no continuity, let me tell you that right away. I've been in this field for over 25 years, and the biggest problem in our country is the lack of continuity within the Ministry of Health. Most initiatives are tied to project-based funding, and once the project ends, everything stops. Very little actually takes root. Those are the main problems.

This lack of continuity extended not only to programming and policy but to collaboration itself. Initiatives born out of urgent needs or shared crises, like Covid-19, disintegrated once the funding had run out. Collaborative efforts had to be maintained in the crevices of official working hours, sustained by goodwill and, quite literally, days off.

“Most colleagues will write their papers during holidays,” another doctor added, half-laughing. “It’s not funny.” Some recalled the days when public health education included fieldwork, community-based campaigns, and interdisciplinary cooperation. Others, particularly younger colleagues, had entered institutions already defined by audit culture, short-term grants, and shifting EU benchmarks. One of our interlocutors, a psychiatrist from Zagreb, paused before answering our question about the current state of public health:

What stands out here is the deliberate and continuous dismantling of the healthcare system, not just an effort to break with the communist legacy of public health, but an ongoing process of erosion. In Croatia, this really happened. In the 1990s, certain medical fields were intentionally discarded, treated as mere remnants of collectivist ideology, rather than recognised as essential parts of the healthcare system. Yet these fields had once been a strength, as shown during the 1972 epidemic<sup>7</sup>, which, despite its oppressive aspects, demonstrated how an organised state could effectively respond to a crisis. Today, we clearly see the consequences of losing that kind of institutional capacity.

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The reference is to the 1972 smallpox epidemic in Yugoslavia, the last major smallpox outbreak in Europe. The epidemic started in Kosovo and spread to other parts of the country, leading to a swift state response involving strict quarantines, mass vaccinations, and travel restrictions. While the measures were seen by some as repressive, the outbreak is often cited as an example of an effective, centralised public health intervention under Yugoslavia’s system of social medicine. For more on this topic, see Radina Vučetić (2022), *Nevidljivi neprijatelj: Variola vera 1972*.

This wasn't said with anger or resignation, but with a quiet sense of mourning. Later in the conversation, the same person pointed to the paradox that while public health discourse is ubiquitous, especially in crisis, its institutional foundations are eroding.

These institutional encounters were never neutral. Often, they mirrored broader patterns of fragmentation, precarity, and political exhaustion. Yet they also revealed the continued desire for something else: for "real" transformative collaboration, for mutual recognition, for spaces where public health could once again mean not just services and statistics, but care, prevention, and solidarity. What these voices make clear is that collaboration in public health is not only about institutional design or professional will. It is about power, positionality, and endurance. It is about who has the time to meet, who has the authority to speak, and who is allowed to act. Most importantly, it is about who still believes that something better is possible.

In our next section, we reflect on how these voices and experiences shaped our own research practice, and what it has meant to pursue "collaborative ethnography" in such a fractured institutional landscape.

#### BETWEEN ASPIRATION AND CONSTRAINT: RETHINKING COLLABORATION IN PRACTICE

As we moved through institutions and conversations, crossing administrative levels, disciplinary languages, and personal biographies, one thing became increasingly clear: collaboration is both deeply desired and structurally obstructed. The concept appears everywhere in public health discourse, in policy documents, mission statements, and grant calls. But its enactment, at least in the public health systems of Croatia and Serbia, is fraught with constraint. And yet, people try. They keep trying, often against their better judgment, often with full knowledge of the likely limits. This persistence, this refusal to fully give up on collaboration, is what we want to pause on here.

We began our project with an open question: What does collaboration mean in post-socialist public health institutions today? And how might anthropologists, not just as critics or observers, but as potential partners, contribute to its reimagination? These questions were never abstract for us. Our own research is collaborative in intention and in structure: it is the product of our mutual curiosity, our institutional affiliations, and our overlapping yet distinct ethnographic trajectories (Kupsjak 2022; Pantović 2022; Radovanović, Kupsjak and Pantović 2024). But this very collaboration has constantly required negotiation – with funders, with administrative systems, with disciplinary expectations, and with our own capacities and limits.

In many ways, our project is caught in the same binds as the public health professionals we spoke to. Like them, we work across institutional systems that reward individual achievement, not shared labour. Like them, we try to carve out time for dialogue and trust-building in systems that prioritise short-term deliverables. More often than we expected, we are, like them, writing grey literature and sitting in meetings with no goal or end in sight. And like

them, we find ourselves wondering: What counts as meaningful collaboration? What kinds of work are visible, valuable, and sustainable, and what kinds are quietly rendered invisible?

One recurring theme in our research is the emotional and temporal labour required for collaboration. “True collaboration,” as a doctor from Belgrade said, “takes time, energy, and vulnerability. But we don’t have the time anymore.” Many of the professionals described a desire for collective work across institutions, sectors, or disciplines, but pointed to time poverty, administrative overload, and lack of institutional support and funding as persistent obstacles. Collaboration is also risky. In hierarchical institutional cultures, inviting others in can mean losing control over projects, credit, or authority. Several people spoke of being burned by past experiences, excluded from publications, their contributions minimised, their expertise treated as secondary. This makes trust-building slow and sometimes painful, especially in contexts where professional mobility is limited and where “burnout” is no longer an exception but a normalised condition.

We also encountered what we might call (8) *aspirational collaboration*: partnerships imagined or planned but never fully realised. This includes memoranda of understanding between faculties, multi-stakeholder committees that rarely meet, or working groups whose work remains locked in unpublished reports. These moments were not failures in any simple sense; they often contained important conversations, flashes of mutual recognition, but they did not live on in practice. They are the ghosts of collaboration: real, remembered, but structurally foreclosed.

Throughout this project, we found ourselves repeatedly returning to a deceptively simple question: What counts as collaboration? Is it shared authorship? Co-writing a grant proposal? Organising a conference together? Having coffee every month to talk through work frustrations and ideas?

If we adopt an expansive, situated definition, one that includes informal networks, affective labour, care work, and knowledge exchange not formally recognised by institutions, then transformative collaboration is alive and well. But it is happening under the radar, in side rooms and WhatsApp and Viber groups, in conversations that are not transcribed or logged. One senior expert of social medicine from Serbia described this as “a different kind of system, one that isn’t rewarded, but that keeps us going.”

This “different system” often overlaps with what Tsing (2015) calls “contamination”: a mode of encounter in which divergent life worlds intersect, not seamlessly but generatively. Collaboration, in this view, is not necessarily harmonious or planned. It may be awkward, unfinished, and provisional. But it still matters.

When we presented ourselves to public health professionals as anthropologists conducting research on collaboration, we were sometimes met with confusion (“So you’re studying us?”), curiosity (“What exactly do anthropologists do again?”), or relief (“Finally, someone who wants to listen”). We were also frequently asked if we had concrete outputs or recommendations to offer, if our collaboration would be useful in the instrumental sense. Here, if we are fully truthful, we used our project funding as an external validation source. External both to us, but also to the region, thus relying on the symbolic geographies and imaginaries of Western

Europe and Germany (Pantović and Čeriman 2024). This is the double bind of collaborative ethnography in institutional settings: to be a good partner, one must be legible to the system, but legibility often requires surrendering the very critique and relationality that ethnography makes possible. The more we tried to “collaborate”, the more we encountered these frictions: between slowness and speed, between situated knowledge and standardised outcomes, between openness and expectation. In many cases, rather than securing access through formal institutional channels, we ultimately relied on what we term charismatic collaborations. Despite sending numerous official emails to institutional leaders to express our interest in establishing communication and conducting interviews, these formal approaches were often unsuccessful. Instead, access was frequently facilitated through personal networks, colleagues, friends, and friends of friends, who were able to open doors that official correspondence had left closed.

Rather than resolving this bind, we have come to see it as generative. Collaboration, in our experience, is less a stable method than a set of ongoing negotiations. It requires humility, attentiveness, and a willingness to be changed by the encounter (Tsing 2015). Sometimes this means showing up repeatedly with no clear outcome. Sometimes it means accepting that not everyone wants to collaborate or can afford to.

#### STAYING WITH THE TROUBLE:<sup>8</sup> RETHINKING COLLABORATION FROM WITHIN THE FRICTIONS

The language of collaboration in public health is often technocratic, abstracted from the lived worlds of the people who are supposed to enact it. Our work, we hope, opens a space to rethink this language, to ask what collaboration looks like from below, in practice, and what it demands of those who engage in it. Between aspiration and constraint lies a wide terrain of improvisation, care, frustration, and quiet persistence. It is this terrain we seek to make visible, not to offer definitive answers, but to better understand what it means to work together when the structures around us are designed for separation.

In our conclusion, we turn to these structural dynamics and the political conditions under which collaboration can be reimagined not as a managerial buzzword but as a form of relational and epistemic commitment.

This article has emerged from our attempt to think and work collaboratively in a space where collaboration is both urgently needed and deeply constrained. Drawing on our research across public health institutions in Serbia and Croatia and grounded in our own cross-border, cross-institutional collaboration as anthropologists, we have tried to trace the complex terrain in which public health collaboration is imagined, practiced, desired, and resisted.

We began with the historical legacy of social medicine in Yugoslavia, not to idealise a lost system but to better understand the infrastructures and imaginaries that continue to shape public health today. From this legacy, we followed the institutional ruptures and

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Donna Haraway (2016) has also been an inspiration, even if we don't cite her directly, except in this heading.

policy realignments that have marked the post-socialist transition, especially the shift from sustained public investment to short-term, externally funded project logics. In doing so, we encountered professionals who continue to work under conditions of fragmentation, burn-out, and institutional inertia, yet who also carry with them visions of public health as an interdependent, care-based, and community-attuned practice.

By identifying eight provisional types of collaboration – bureaucratic, policy-oriented, rational-scientific, charismatic, participatory, globalised, coerced, and aspirational – we offer a heuristic for navigating the forms and frictions that characterise the current landscape. These modes are not fixed categories but points of tension where collaboration becomes visible as a lived relation, a risk, and at times, a form of quiet resistance. Across the interviews and institutional encounters we explored, collaboration was rarely what it claimed to be on paper. Instead, it was often improvised, informal, deeply personal, and at odds with institutional incentives. It required time people didn't have, energy they weren't paid for, and care that wasn't recognised. And yet, it happened. It happened over coffee during holiday time, in moments of solidarity between exhausted professionals who still believe in the value of their work.

We have argued that to understand collaboration in public health today, we must look beyond formal structures and institutional declarations. We must attend to the affective and temporal dimensions of collaboration: to how it is felt, sustained, and sometimes lost. We must consider the political conditions, both within institutions and across regional and global governance, that shape what forms of knowledge and partnership are possible, and for whom.

As anthropologists working within and alongside public health institutions, we do not claim neutrality. Our collaboration, this article included, is also part of the field we are trying to understand. We write not as observers from the outside but as participants entangled in the very constraints we analyse. Our hope is that by documenting these frictions and by refusing to reduce collaboration to a managerial buzzword, we can open space for a more reflexive and politically attentive understanding of what it means to work together.

Collaboration is a fragile achievement, sometimes hopeful, sometimes heartbreaking. But if we are to reimagine public health as something more than crisis response and fragmented programming, then we must start from these frictions. We must take seriously the everyday labour of those who, despite everything, still try to collaborate, not because they are told to, but because they believe something better is possible.

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Prispevek preiskuje pomene in načine sodelovanja v sistemih javnega zdravstva v Srbiji in na Hrvaškem, s poudarkom na tem, kako politični, institucionalni ter epistemološki obrati krojijo možnosti skupnega dela. Na podlagi sodelovalnega etnografskega projekta dveh medicinskih antropologinj raziskuje, kako sodelovanje hkrati deluje kot predmet proučevanja in metodološki izziv.

Z analizo gradiva, dobljenega s terenskim delom ter intervjuji s strokovnjaki in strokovnjakinjami, izvedenimi v osrednjih ustanovah v Beogradu, Novem Sadu, Zagrebu in na Reki, je bilo opredeljenih več oblik sodelovanja: birokratsko, javnopolitično usmerjeno, racionalno-znanstveno, karizmatično, participativno, globalizirano, prisilno ter aspiracijsko. Ti načini soobstajajo in trkajo eden ob drugega v razdrobljeni institucionalni krajini, ki jo zaznamujejo varčevalni ukrepi, projektizacija in politični pritiski. Prispevek sodelovanja ne obravnava kot inherentno pozitivno vrednoto, temveč ga razume kot situacijski, kočljiv in z močjo prežet proces, ki omogoča ter obenem ovira delo v javnem zdravstvu.

Z orisovanjem kontinuitet in prelomov z jugoslovansko socialnomedicinsko dediščino, ki je svoj čas poudarjala pravičnost, participativnost in decentralizirano nego, članek razkriva, kako se je ta dediščina obdržala v spominih, frustracijah ter profesionalnih idealih, četudi se institucionalne kapacitete razkrajajo. Sodelovanje, nekoč utemeljeno na kolektivni odgovornosti, postaja vse bolj birokratizirano, kratkotrajno in poganjano od zunaj. Kljub temu pa pristni trenutki partnerstva ne izginejo, po navadi se ohranjajo v neformalnih mrežah, z osebno predanostjo in afektivnim delom.

Avtorici s pomočjo refleksije lastnih poskusov vključevanja v javnozdravstvene institucije osvetlujeta trenja, asimetrije in čustveno delo, ki jih zajema sodelovalno raziskovanje. Trdita, da transformativno sodelovanje zahteva refleksivnost, čas in zavedanje razmerij moči. Prispevek zaključujeta s premislekom: da bi si bili zmožni na novo zamisliti javno zdravstvo, zunaj okvirov upravne retorike, moramo sodelovanje razumeti ne kot sledenje navodilom ali stvar učinkovitosti, temveč kot krhko in etično prakso deljene odgovornosti ter skrbi.