Enduring or Fragile Cooperations

Complementary Medicine and Biomedicine in Healthcare Systems of Post-Soviet Kazakhstan and Kyrgyzstan

DANUTA PENKALA-GAWĘCKA

Abstract This paper focuses on relations between biomedicine and various segments of complementary and alternative medicine (CAM) in socio-economic and political contexts of post-Soviet Kazakhstan and Kyrgyzstan. While medical diversity was already present in Central Asia during Soviet times, the collapse of the Soviet Union has contributed to the further diversification of therapeutic options in this region. The author discusses changes in the official attitudes towards various non-biomedical forms of treatment, which reflect changing economic and political conditions. Initially, in the 1990s, the official support for traditional/folk medicine resulted mainly from the efforts of the newly independent states to gain legitimacy on the grounds of the cultural heritage of their titular nations. Such legitimisation is not needed anymore and, in effect, those CAM branches which are practised by healers, not biomedical doctors, have lost government backing. In this light, it seems that first attempts at cooperation between biomedical and complementary practitioners which had started in the 1990s turned out to be rather fragile. The boundary work, as the author's research revealed, is directed towards delimitation of what is perceived as scientific from methods and practices unconfirmed by "science." However, it should be stressed that despite such tensions various complementary therapies, including spiritual healing, enjoy great popularity among patients, which is partly due to the weakness of healthcare systems in Kazakhstan and Kyrgyzstan. The last part of the article addresses examples of cooperation between psychiatrists and healers in Kyrgyzstan, which proved to be fruitful in special circumstances.

Keywords medical diversity – complementary and alternative medicine – CAM – biomedicine – healing cooperation – boundary work – Central Asia – Kazakhstan – Kyrgyzstan

Introduction

In this article I focus on relations between biomedicine and various types of complementary and alternative medicine (CAM) in Kazakhstan and Kyrgyzstan, and pay particular attention to the attempts at cooperation between biomedical professionals and CAM practitioners, including "traditional"[1] healers. I show the dynamics of these processes, marked by changes in the official attitude to non-biomedical treatments and their practitioners. Using the concepts of medical diversity, legitimacy and authority, and boundary work in the analysis, I also discuss political, economic and social factors which strongly influence these interrelations.

The text is based on the longitudinal ethnographic research which I conducted in Kazakhstan during my five-year stay in Almaty between 1995 and 2000, and in Kyrgyzstan in the course of three fieldwork seasons in Bishkek between 2011 and 2013.[2] My study generally focused on urban medical diversity and the changing relationship between biomedicine and CAM in the context of particular healthcare systems. However, in Kazakhstan I was mainly interested in the role and position of CAM practitioners, while in Kyrgyzstan I concentrated on people's perceptions of health and illness, their health-seeking strategies and practices. During my fieldwork I employed typical ethnographic methods such as semi-structured interviews and numerous talks with "ordinary people," healers and other non-biomedical practitioners, doctors, pharmacists and officials working in healthcare management. An important part of my research was participant observa-

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tion—I was able to watch therapeutic encounters between medical practitioners and patients, and try some CAM therapies. In addition, I used scholarly literature, which is rather scarce on this topic, and materials from local newspapers, magazines and TV programmes. The studies in Almaty and Bishkek were conducted in different times—in Kazakhstan during the first decade of the state sovereignty and in Kyrgyzstan at the beginning of the third decade of independence. However, processes described here reveal considerable similarities in these two countries, which can be attributed, at least partly, to their common Soviet past (*cf.* HOHMANN & LEFÈVRE 2014—on post-Soviet health systems in the South Caucasus). Materials gathered in both fieldwork sites show such similarities and, at the same time, the impact of changing socio-political and economic conditions in Kazakhstan and Kyrgyzstan in the last decades on their healthcare systems, government attitudes to CAM, professionalisation of its practitioners and cooperation between biomedicine and some CAM branches.

I draw on the concept of boundary work, introduced by THOMAS GIERYN (1983, 1995) in reference to the attempts to demarcate "science" from "non-science". In GIERYN's words, boundary work can be characterised as "rhetorical games of inclusion and exclusion" (1995: 406); he points out the dynamics of these attempts, connected with "historically changing allocations of power, authority, control, credibility, expertise, prestige, and material resources among groups and occupations." This approach has been deployed to study relations between CAM and biomedicine in different contexts (*e. g.* SHUVAL & MIZRACHI 2004). What is important, researchers stress the need to examine not only the boundary work undertaken by biomedical professionals, but also CAM practitioners and patients, "in order to understand better the reasons why people are committed to boundary work" (BROSNAN *et al.* 2018: 11). It should be noted that social construction of these boundaries is closely connected with political and economic changes and power struggles, reflected in attempts to professionalise and regulate CAM. In addition, the concept of boundary work can be used to study not only conflict situations, but also inclusion and cooperation, as Gieryn's approach suggests.

In the analysis, I have also found useful the concept of legitimacy, grounded in the well-known Max Weber's typology of political power and developed in reference to the field of medical practice by GALINA LINDQUIST (2001, 2006). She discussed traditional, rational-legal (or bureaucratic) and charismatic legitimacy and showed how they may influence a healer's authority.[3] I understand authority as a dynamic relation based on respect and credibility, so it can be gained and lost, depending on many factors. Changing official attitudes to CAM have an effect on the ways of seeking legitimisation and building practitioners' authority and, in turn, their authority—sometimes grounded in great charisma—may help develop cooperation between them and medical professionals. In addition, the kind of achieved practitioner's legitimacy is important for drawing boundaries between different types of medical practice.

In this paper, first, I briefly describe the attitude of the Soviet regime to local traditional medicines and some new CAM forms arriving in Central Asia during the last decades of the USSR. The next section outlines an increasing medical diversity in Kazakhstan and Kyrgyzstan after the collapse of the Soviet Union and proclamation of independent republics. In the following chapters I present and analyse the changing position of CAM in Kazakhstan and Kyrgyzstan, describe differences in the official stance towards its various segments, and processes of professionalisation of its practitioners. The last section shows complicated relations between biomedical practitioners and healers and some attempts at cooperation between them in both countries, in different periods of their development. I focus on the case of psychiatric treatment in Kyrgyzstan, where efforts to collaborate with traditional healers can be observed. In conclusion, I discuss the specificity of boundary work in the presented contexts, the reasons for changes in the official policies and possibilities of further development of the relationship between biomedicine and particular CAM modalities.

Traditional healing and CAM in the Soviet era

It should be noted that in the Soviet Union folk healers and shamans, together with religious practitioners, for a long time were subject to per-

secution. Soviet regime banned traditional medical practices already in 1923 (STICKLEY *et al.* 2013) and the 1930s saw the beginning of a systematic anti-religious campaign accompanied by an intensive agitation against any forms of "backwardness" and "superstitions," including traditional healing. PAULA MICHAELS (2003: 48) writes that in Kazakhstan, "For the most part, agitation against healers meant trying to persuade the population to distrust them, but occasionally the state resorted to coercive methods, such as their arrest and imprisonment." Condemnation of healers' and mullahs' practices together with other habits of the local peoples deemed wild and backward, gave grounds for the Russian "civilising mission" (MICHAELS 2003, AFANAS'EVA 2008).

However, there were fluctuations in an official attitude towards folk medicine and other CAM practices during the seven decades of the Soviet Union, depending on many factors, such as deficiencies of the healthcare system, including insufficient medical personnel and infrastructure. More generally, the political changes induced waves of intensification or weakening of atheisation and "anti-superstition" programmes. There was a gradual relaxation observed after Stalin's rule, and then during "the late socialism" and perestroika some CAM disciplines, especially acupuncture and treatment with the use of "bioenergy" practised by *ekstrasensy*, were allowed on to the margins of the healthcare and gained popularity in the USSR. As ANDREW STICKLEY *et al.* (2013: 2) put it: "Official attitudes to non-biomedical forms of treatment softened somewhat in the later Soviet period with the recognition of some forms of CAM as a speciality in 1977 which stimulated a resurgence in alternative treatments in the 1980s." In light of this, it can be argued that there was de facto medical pluralism in those times, although some kinds of alternative medicine were practised underground or semi-underground (LINDQUIST 2006: 30). Despite a long-standing, strong anti-religious propaganda and efforts to eradicate traditional healing in Central Asia, healers, including shamans and mullahs, continued their practices, albeit usually in secret (MICHAELS 2003: 67, DUYSHEMBIYEVA 2005: 43, PELKMANS 2017: 153). My interlocutors in Almaty and Bishkek often assured me that it had been possible during Soviet times to find a good, strong shaman through informal connections. Importantly, various traditional remedies and therapies were widely used in self-treatment and illness prevention, and it was mainly women who practised such methods in the households.

Medical diversity in Kazakhstan and Kyrgyzstan since the 1990s

The collapse of the Soviet Union near the end of 1991 led to the further medical diversification in the newly independent Central Asian states. Although the concept of medical pluralism, introduced by Charles Leslie in the 1970s (LESLIE 1976) remains popular in medical anthropology, it has been criticised for many reasons (*e. g.* BAER 2004, HSU 2008) and several other terms were proposed. I prefer using here the notion of "medical diversity" instead of "medical pluralism," following DAVID PARKIN (2013: 125) who argues that the former term refers to more than the latter, as it implies not only coexistence, but also "mutual borrowings of ideas, practices and styles" between different medical traditions "and by implication more differentiated strategies adopted by patients in search of cure" (see also KRAUSE *et al.* 2012).[4] As ELISABETH HSU (2008: 320) points out, "Gone are the times where one could speak of a mosaic of clearly bounded, different medical cultures." Such a situation, leading to the considerable hybridisation of various kinds of medical practice, is observed in Kazakhstan and Kyrgyzstan. An increasing diversification of therapeutic options, enabled by the political and socio-economic transformation, is marked, on the one hand, by the revival of the local forms of traditional healing, and on the other—by opening up of Central Asian countries to the flows of various CAM ideas and products both from the West and the East.

Biomedicine undoubtedly occupies a dominant position in healthcare systems of Kazakhstan and Kyrgyzstan, but besides state healthcare and, increasingly, private biomedical institutions[5], a wide array of CAM therapies are available to the people. Based on free market conditions, various non-biomedical methods and techniques have been proliferating, especially in big cities such as Almaty and Bishkek. In rural areas the range of treatment options is not so wide and local, traditional healers play a stronger role, however, it is

not rare that people come from distant regions to visit the particular CAM centres or famous healers in the cities.

Among many CAM modalities in Kazakhstan and Kyrgyzstan, there are medical traditions of titular nations—Kazakhs and Kyrgyz, as well as other ethnic groups living in these multi-ethnic countries. Spiritual and religious healing are at the core of these traditions. Kazakh and Kyrgyz spiritual healers, in addition to healing, often practise fortune-telling with the use of 41 small stones or beans—such practitioners are known as *qumalaqshï* (Kaz.), *kumalakchï* (Kyrg.). Healers-clairvoyants, those who "can see," are called in Kyrgyzstan *köz achïk, közü achïk* ("with open eyes") (BIARD 2013, LOUW 2017). There are also specialists (Kaz. *täwip, emshi*, Kyrg. *tavïp, tabïp, emchi*) who use pulse diagnostics and herbs in the course of treatment, but similarly to the others they relate their abilities to the invisible world of spirits. The most respected albeit very rare are shamans (Kaz. *baqsï*, Kyrg. *bakhsï, bübü*).[6] Prayers from Qur'an and Muslim prayer beads (Kaz. *täspi*, Kyrg. *tespe*) are usually applied in spiritual healers' therapeutic sessions. It is important that such practices are commonly treated as part of the local, everyday Islam (PRIVRATSKY 2001, LOUW 2007), closely connected with culturally shaped identities of the Kazakhs and the Kyrgyz (*qazakhshïlïq* or *kïrgïzchïlïk*, respectively).[7] Religious practitioners—mullahs (*molda, moldo*) often help people who suffer from illness or other kinds of misfortune. They use Quranic verses for healing, but sometimes also utensils typical of traditional healers' practice, such as the knife (*cf*. BIARD 2013). However, the nomenclature used by healers (and patients) is not stable. MATHIJS PELKMANS (2017: 152–153), referring to Kyrgyz healers, rightly states that "many practitioners use more than one term to describe themselves, and in fact, their fields of practice overlap." Hybridisation of practitioners' practices is a common phenomenon, for instance methods and notions (*e. g.* bio-energy, bio-currents) which were applied by *ekstrasensy* during Soviet times, belong to the popular therapeutic repertoire nowadays. As I learned during my research, healers often avoided naming themselves and tended to describe their fields of competence in terms of afflictions which they could heal, and appropriate therapeutic practices. Besides spiritual healers there are various other practitioners of traditional kind, mainly bone-setters and herbalists—Kazakhs, Kyrgyz, Russians, Ukrainians, Tatars, *etc*.

Other popular therapies are derived from Eastern "great medical traditions" such as Chinese, Korean, Tibetan, Ayurveda and Unani. Perhaps the most popular among them are Chinese and Korean acupuncture, in several variants (PENKALA-GAWĘCKA 2002). And last not least, there are numerous new or relatively new treatments (*e. g.* homeopathy, known in imperial Russia, but then suppressed) which arrive from the former USSR, mainly Russia and Ukraine, from the West and East, or are locally invented (*e. g.* a particular version of ozone therapy developed in Kyrgyzstan). It is worth noting that various transnational CAM technologies have recently reached Kazakhstan and Kyrgyzstan thanks to the opening up of the country to the influences of globally operating corporations.

Generally, this non-biomedical sector briefly described above may be called "complementary medicine" in the discussed contexts, because of a positive and, from time to time, supportive governmental attitude to these therapies and a common pattern of patients' help-seeking strategies. It is striking that they often resort to both biomedical doctors and healers and do not treat their practices as contradictory.[8] Initially, in the 1990s, the newly independent Central Asian republics sought their legitimacy drawing on their history and cultural heritage. Since folk medicines of the titular ethnic groups were recognised as important part of this heritage, they received a strong support of the governments in Kazakhstan and Kyrgyzstan, as well as, for instance, in Uzbekistan (HOHMANN 2007, 2010; KEHL-BODROGI 2008).[9] Together with other CAM therapies, folk medicine was regarded as complementary to biomedicine. It should be noted, however, that the official attitudes towards these therapies have been changing depending on changes in political and socio-economic conditions. In addition, particular therapeutic methods were treated differently, which I discuss later as an example of boundary work, leading to worsening the position of folk healers. Such fluctuations can be generally considered a result of the attempts at modernisation, standing in opposition to traditional healing

which is viewed, from this perspective, as quackery and evidence of backwardness.

The changing status of complementary medicine and its practitioners in Kazakhstan

Nationalist tendencies which had already emerged before the proclamation of the independent Republic of Kazakhstan, favoured revalidation of Kazakh traditions, including folk medicine. In fact, it was treated then as one of the signs of the Kazakh cultural identity.[10] Subsequently, the Republican Centre of Folk Medicine was established as early as 1990 in Alma-Ata (then Almaty) under the auspices of the Ministry of Health, and later renamed the Republican Centre of Eastern and Contemporary Medicine. Two subsequent Acts of Parliament on healthcare in the Republic of Kazakhstan, issued in 1992 and 1997, approved and confirmed the position of "folk and traditional medicine" and pointed out the importance of their further development. The Centre established its branches in other big cities and many smaller, private CAM centres were opened, sometimes located in large state polyclinics or hospitals. In the second half of the 1990s some non-biomedical therapies and methods of self-treatment were included in the government programme promoting a "healthy lifestyle." Not only ideological, but also pragmatic reasons contributed to the official approval of complementary medicine. Because of a dramatic collapse of the previously socialist state healthcare system in the course of the country's political and economic transformation, marked by the introduction of free market economy, traditional therapies got support as inexpensive, effective and easily available. In the face of a severe crisis of healthcare, such methods were recommended as a valuable means to address the challenges of that time.

However, such initiatives were accompanied by the attempts to regulate and control the activities of non-biomedical practitioners. An official nomenclature classified a wide array of unconventional therapies into two categories: "folk medicine" and "traditional medicine." According to this division, folk medicine included, among others, spiritual healing together with shamanistic practices, herbal treatment, bone-setting, "folk massage" and "extrasensoric" treatment. The second category, traditional medicine, comprised such methods and techniques as Chinese and Korean acupuncture[11], homeopathy, manual therapies, hirudotherapy (treatment with leeches), apitherapy, iridology and magnetotherapy. Whereas "folk medicine" was understood, first of all, in terms of various forms of spiritual healing, "traditional medicine" referred primarily to the globalising Eastern "great medical traditions" and some other CAM branches which were acceptable, at least partly, from the biomedical perspective. Even if sometimes they might be more or less connected with local medical traditions (*e. g.* hirudotherapy or manual therapies) and the practitioners—mostly medical doctors—often combined them with some "folk" methods, they usually referred to the scientific authority as the most influential. Similarly, various CAM practitioners in the West often base their knowledge and practices on science "as a tool for claiming legitimacy" (HIRSCHKORN 2006: 548).

The measures described above served to construct or enhance boundaries between different CAM modalities, mainly on the grounds of their practitioners' sources of legitimacy and knowledge bases. Traditional medicine, in this understanding, lay—at least theoretically—within the competence of medical doctors having professional qualifications. It was in their interest to draw strict boundaries between their practices and "folk medicine," and protect them. Such demand was openly expressed, for instance, during the first Republican Conference on Traditional and Folk Medicine held in Almaty in 1997, which I was able to attend.

Traditional medicine received strong support from the government as a valuable complement to the official medicine. Some disciplines of this CAM segment were introduced to special post-graduate courses for doctors at the Department of Traditional Medicine of the Institute for the Advancement of Physicians, affiliated to the Medical University in Almaty.[12] In Turkestan, at the International Kazakh-Turkish University named after Ahmad Yasawi, the College of Eastern Medicine was opened in 1995, offering courses of Chinese, Tibetan and Arabic-Persian (Unani) medicine compiled with some basic knowledge of biomedicine. After six-year-studies a graduate received a title of the doctor of Eastern Medicine. In

addition, since 2004 a six-year course of traditional medicine (Chinese, Korean and some therapeutic methods of the Kazakh traditional medicine) had been taught at the Department of East Asian Medicine of the Kazakh Medical University in Almaty, but for various reasons it was changed into a shorter postgraduate course in 2010 (GRZYWACZ 2010: 39–40). Doctors practising particular CAM modalities, for example *soo-jok* (a version of Korean acupuncture), founded their own associations, however during the above-mentioned conference in 1997 they called for establishing an association for all traditional medicine practitioners, similar to such an organisation that gathered folk healers.

Thus, the process of professionalisation of "traditional medicine" practitioners, which had already started in the late 1980s, was well advanced near the turn of the centuries. Doctors who practised those therapies achieved legitimacy in a formal, bureaucratic way. However, with the aim to appeal to a wider circle of patients, they built their authority not only on such "scientific" credentials, but also on "tradition", albeit they seemed to refer more often to the "ancient medical wisdom of the East" than to the local medical traditions (*cf.* LINDQUIST 2006, PENKALA-GAWĘCKA 2017).

The Acts of Parliament mentioned earlier and further regulations introduced by the Ministry of Health gave grounds for institutionalisation of local medical practices and professionalisation of folk healers that I observed in Kazakhstan in the second half of the 1990s (PENKALA-GAWĘCKA 2002, 2013). A set of specific rules and instructions determined procedures of traditional practitioners' legitimisation at the Centre of Eastern and Contemporary Medicine in Almaty. As it was officially stated, the main goal of the Centre was to get rid of "charlatans" and to license activities of healers who would win the approbation. After a preliminary selection of candidates, they were obliged to attend special courses and practise under supervision of medical doctors working at the Centre. A special commission appointed by the Ministry was responsible for examination and certification of healers. After passing the final exams they received two certificates, first attesting their right to conduct healing, and second giving them a title of a "professional folk healer of the Republic of Kazakhstan." In addition, this document determined a healer's domain of competence—one of four available specialties: "bio-energy therapist," phytotherapist, bone-setter and "theopsychotherapist" (a specialist in spiritual healing). Although such an attestation was expensive and approved persons had also to pay for a licence to practise, many healers applied for approbation and between 1991 and 2000 about one thousand got certificates. However, numerous others continued to work without licences or did not fulfil the obligation to renew their attestation. Near the end of the 1990s, in view of a diminishing number of candidates, the fees were reduced and the rules of certification changed in order to make the procedure easier. At the same time bureaucratic control over healers' activities increased and a special inspection unit created at the Centre was charged with the task to trace unlicensed practitioners[13] and check if the licensed ones did not exceed their qualifications.

The process of healers' professionalisation was also visible in such endeavours as organisation of conferences and congresses, and many other activities of the Association of Professional Folk Healers of the Republic of Kazakhstan, founded as early as 1991. In 2008 there were already 32 branches of the Association, with five thousand members. It organised courses and schools for healers and published a journal (GRZYWACZ 2010: 37–39).

Despite the practical advantages of getting a certificate and a license, which allowed healers to work at biomedical institutions, such a bureaucratic legitimacy was not of primary importance for them. Although they eagerly displayed their credentials—certificates and diplomas or additional documents proving their membership of various "international academies of traditional medicine," it was not essential for enhancing their authority. As I learned, what remained crucial both for them and their patients was the traditional process of gaining legitimacy. Basic components of the "traditional way" of a spiritual healer were: receiving and approving the call of spirits (first of all—ancestor spirits, *ärwaq*), assisting an experienced healer during therapeutic sessions and pilgrimages to sacred sites, and, finally, getting a blessing (*bata*) from that practitioner and protecting spirits. A common feature was a kind of "initiation sickness" (similar to the shamanic one) experienced by a "chosen" person before ac-

cepting the healing gift offered by spirits. Healers' powers, their abilities to contact with the world of spirits, were additionally legitimised if they could demonstrate having strong healers or religious persons among their linear ancestors (PENKALA-GAWĘCKA 2013). Actually, some spiritual healers whom I met in Almaty maintained that while striving for certificates, they lost part of their inherited abilities. For example, an Uighur female shaman, popular not only among Uighurs and Kazakhs, but also patients of other ethnic backgrounds, told me that she had decided to apply for attestation against the will of her spirits and was punished by them—her spiritual development was slowed down.

Attempts to institutionally regulate and control the activities of healers expressed the government policy supporting folk medicine, but at the same time aspiring to comply with the standards of the modern country. The second direction became more important when the state got stronger and there was no need to seek its historical and cultural legitimacy any more. In Kazakhstan constraints on folk medicine increased at the beginning of this century, in line with the growing "anti-charlatan" discourse emanating from medical establishment and more and more often present in the media. According to the Act of Parliament from 2003 the use of folk and traditional methods of treatment should be, generally, restricted to medical doctors, and licences for treatment could be granted to persons without a professional training only in exceptional cases. These steps unveiled the boundary work directed towards further separation of the "traditional" segment of CAM from "folk" medicine. Moreover, in 2005 the procedures of healers' attestation were passed on to the Ministry of Health. The activities of the Centre were constricted and the Association of Professional Folk Healers took some of its obligations. However, the popularity of "folk" practitioners has not decreased during the last decades, which contributed to the development of courses for healers offered by the Association, as well as the emergence of new "healing specialties" (GRZYWACZ 2010: 46–47).

In fact, formally imposed restrictions on practising any types of CAM without biomedical training were not put into effect. Recent research conducted by ASKAR JUMAGELDINOV (2017) reveals the continuing popularity of spiritual healers in Kazakhstan and further government efforts to regulate their practices. According to JUMAGELDINOV's report (2017: 193–194), the regulations issued in 2011 oblige every healer to obtain a certificate and a licence delivered by the Ministry of Health after the procedure of attestation, which takes six months of practice at a state medical institution under supervision of medical doctors. It is striking that while trying to separate "charlatans" from those who "have a gift" and regulate the activities of the latter, the authorities left the door open for further development of a variety of non-biomedical practices, including traditional forms of healing. One of the reasons for this is, presumably, the situation of healthcare system in Kazakhstan, still facing a serious crisis and calling for effective reforms, despite general improvement in the country's economic conditions. State retrenchment in the public healthcare sector, as DINA SHARIPOVA (2015) argues, has had dramatic consequences for the provision of medical services and their quality, and has led to the increase in informal payments and reciprocal exchanges.[14] The author points out such grave problems of healthcare in Kazakhstan as the shortage of medical personnel in villages and the poor level of qualifications among doctors and other medical staff (SHARIPOVA 2015: 319–320). It may be assumed that the deterioration of healthcare delivery acts as a strong incentive for people to use the services of healers and other CAM practitioners.

The position of complementary medicine and its practitioners in Kyrgyzstan

The process of revalidation of the Kyrgyz folk medicine started as early as the late Soviet period. Similar to the Almaty Centre, a big, state-run institution called the Republican Scientific and Production Centre of Folk Medicine "Beyish" (which means "paradise") was established in Frunze, then renamed Bishkek, already in 1990. It was organised on the base of the Institute of Balneology and Physiotherapy which had been active since the middle of the 1980s. Both medical doctors and healers worked at the Centre, and among available services there were such treatment methods as phytotherapy, balneotherapy and mud baths, as well as "extrasensoric" and spiritual healing.

An important part of the Centre's activity was the production of medicines based on raw plant, mineral and animal materials. Its main aim was, according to Doctor OMORBAY NARBEKOV, the director, "to combine contemporary medicine with the experience of folk and Eastern medicine" and "to discover forgotten recipes of folk medicine."[15] During the 1990s the Centre invited practitioners of Chinese traditional medicine from Xinjiang who continued to work there for several years and offered treatment with acupuncture, Chinese massage and herbal medicines. In NARBEKOV's words, they managed to treat the "whole Kyrgyzstan" and to train about 70 local physicians in acupuncture and other traditional methods. In addition to Chinese specialists, also Ayurveda practitioners visited the Centre.

"Beyish" provided courses for healers and carried out their licensing. The process of healers' professionalisation was similar to what I observed in Almaty. As NARBEKOV claimed, over the course of five years about three thousand healers came to the Centre and a special commission involving, among others, a psychiatrist, a neuropathologist and representatives of the Ministry of Health, was created in order to check the abilities of the candidates. As a result, about 200–250 persons with some "gift" were selected. Among them were mainly *ekstrasensy*, clairvoyants, herbalists and bone-setters. Around a hundred healers from that group finished a two-year course of anatomy and physiology, which gave them the right to legally practise healing, for some preliminary period under supervision of medical doctors. A number of licensed healers began to work independently and the "most gifted" ("having the strongest gift") 50–60 persons continued to practise at the Centre.[16]

Various CAM branches, such as traditional Chinese medicine, Korean *soo-jok* acupuncture (known here since the 1980s), manual therapies and hirudotherapy gained an official acceptance and were introduced in the programme of postgraduate courses at the Kyrgyz State Medical Institute (later renamed: Academy) in Bishkek. Presently, physicians who choose the specialty of acupuncturist, hirudotherapist or manual therapist, receive professional training during four and half-month courses at the Department of Physiotherapy and Traditional Medicine of the Kyrgyz State Medical Academy. The position of those medical doctors who practise CAM and the others does not differ, at least such was the opinion of several physicians whom I asked about it. They maintained that there was no gap between "Western" and "Eastern" medicines; according to one of my interlocutors, "there is a kind of coalescence between them in Kyrgyzstan." This doctor, trained as a gynaecologist, after the basic course of acupuncture decided to continue education in this branch of CAM, which was possible at the Academy. Such specialists achieve bureaucratic legitimacy, based on the authority of science, but appeal to patients also by referring to the antiquity and richness of Eastern medicine or—as in the case of hirudotherapy—to the local folk traditions. Some of these doctors got certificates in Moscow, as a homeopath whom I met at a private CAM centre, yet others were educated in China or took an opportunity to receive training in Bishkek from, among others, osteopaths or acupuncturists coming from South Korea.

Whereas the position of CAM disciplines practised by medical professionals seems more or less secure, the status of "folk" healing is volatile. It has undergone changes that reflect revisions in the health policies connected with wider sociopolitical and economic transformations. According to a doctor who herself practised some CAM therapies, healers' attestation had been proceeded until 1996, then it was continued only on a small scale and recently abandoned. As a result—in her words—"contemporary healers are mostly charlatans, who can cheat and deprive patients of money," because there is no control instance supervising their activities. Two my interlocutors—doctors working in healthcare management who had been actively engaged in healthcare reforms in Kyrgyzstan, maintained that the efforts to regulate the healers' practices had been given up due to enormous challenges posed by implementing consecutive reform programmes.[17] In their opinion, the authorities are aware of the problem, but because of many other, more urgent tasks, this has to be left for the future.

Apparently, an official "anti-charlatan" discourse in Kyrgyzstan developed somewhat later than in Kazakhstan, but it also increased over the last decades. This change resulted in the closure of the "Beyish" Centre, whose activities had already

been constricted earlier, and founding the International Academy of Traditional and Experimental Medicine in 2011. As the acting Deputy Minister of Health, SARYBEK JUMABEKOV, put it:

> Such an Academy is necessary in the country. […] The Centre of Folk Medicine "Beyish" had not fulfilled its mission […]. Quacks, *ekstrasensy* and often common charlatans, *i. e.* people distant from medicine had worked here before. Therefore it was necessary to change the Centre's status, to channel its work into a scientific direction (NICHIPOROVA 2011).

The Head of the newly founded institution, OMORBAY NARBEKOV, said that they would experiment with the traditional pharmacology of Kyrgyz folk medicine, as well as Chinese and Tibetan medicines. It was also stated that the Academy would work in close cooperation with the Ministry of Health, Kyrgyz State Medical Academy, National Academy of Sciences and some universities in Bishkek.

In the following years the Academy, officially affiliated with the Ministry of Health, has continued testing various plant, animal and mineral substances, and production of "natural" medicines.[18] It has also engaged in healthcare programmes directed at prevention and eradication of several serious diseases. In addition, it provides diagnostics and services of physicians representing several biomedical specialties as well as some CAM branches, including acupuncture, reflexology and manual therapy. I do not know if any practitioners without medical education belong to the Academy staff, although when I talked with OMORBAY NARBEKOV in spring 2012, he claimed that some particularly gifted healers would be employed at his centre after careful selection and additional training.

This institution, as its website[19] suggests, has developed successfully and even opened its branch in Almaty. However, by the decision of the Prime Minister, in November 2017 the Academy was expelled from its premises. It was offered another venue, which—in NARBEKOV's words—did not meet their needs. He said: "This can destroy traditional medicine in Kyrgyzstan, since it is impossible to create such favourable conditions for treatment [anywhere—D. P.-G.] as here" (NICHIPOROVA 2017). The Director openly accused the government officials of an attempt to take over the part of the building occupied by the Academy[20], because of their particular interests. Actually, these steps can be seen as the efforts to install several government institutions in this huge and representative building, located just opposite the so called White House (home to the President, his offices and the Parliament), which had already served for offices of some ministries earlier. But it may be also assumed that recent developments are connected with changing attitudes not only towards traditional healing, but also other non-biomedical methods of treatment which did not fully succeeded in achieving scientific legitimation. Time will tell whether it is a reasonable supposition; throughout recent decades the position of CAM disciplines practised by medical doctors seemed quite stable in Kyrgyzstan.

As regards the healers, their position has significantly changed since the beginning of the last decade in consequence of the "anti-charlatan" discourses and actions described above. Their professionalisation was interrupted. In 2011 I did not meet any "folk" healers in "Beyish," however some who used to work there before, moved to another part of the same building. The healers told me that they had been "thrown out" from the Centre, but as I learned then, they had to leave because rent payments had significantly increased. Anyway, my interlocutors were annoyed and disappointed that soon after completing six-month courses and receiving nursing certifications demanded from them at "Beyish," they lost the institutional support and had to start off on their own. In fact, it was not bureaucratic but traditional legitimacy, based on the assumed close contacts with the world of spirits, which remained essential for a healer's authority and successful practice (PENKALA-GAWĘCKA 2107). In the new situation, marked by deprofessionalisation of healers, their certificates and diplomas lay hidden in a drawer, since they had been needed before only for bureaucratic reasons. While such certificates might have been sometimes useful in the cities, in villages and small towns healers were unconcerned about gaining that kind of legitimation (PELKMANS 2017: 162).

The apparent changes in the official policy towards folk healing did not diminish the popularity of healers among the people. This is also true of urban centres. Many people in Bishkek resorted

to healers' services and in common opinion there had been an enormous increase in their popularity since the 1990s. This concerns mainly spiritual healers of traditional background, who attract not only the Kyrgyz, but also patients from other ethnic groups. Although not abundant, ethnographic evidence confirms great popularity of healers in Kyrgyzstan (Heyat 2004, Duyshembiyeva 2005, Pelkmans 2017: 148–169, Strauch 2017).[21] In addition, there is some statistics available—a study of the use of folk medicine in eight post-Soviet countries, conducted in 2001, revealed the highest level of healers' popularity in Kyrgyzstan: 25 % of the respondents asked healers for help (the target sample was 2000), while in Kazakhstan 11 % (Stickley *et al.* 2013).

Obviously, such a high level of healers' popularity is largely connected with common dissatisfaction with the healthcare system and deep distrust of doctors, usually expressed by the people (Penkala-gawęcka 2016). Worth mentioning, in the opinions of international and local experts the reforms of healthcare system conducted in Kyrgyzstan, although not entirely successful, brought about positive changes and its situation is better than, for example, in neighbouring Kazakhstan (see Ibraimova *et al.* 2011). Despite this, people are mostly pessimistic about the reforms and do not trust doctors, discrediting their professional and moral qualifications. It should be admitted that such attitudes, based on my interlocutors' and their relatives' or friends' experience, but also on circulating rumours and terrible stories about doctors' misconduct, have quite reasonable grounds. Even these specialists who are generally enthusiastic about the progress in reforms, recognise several serious problems in the healthcare system. They refer to, among others, the underfunding of healthcare, an uneven regional distribution of medical facilities and doctors, poor quality of medical training and provided care. In addition, the mass economic migration of physicians and other medical staff to Kazakhstan and Russia, as well as widespread corruption (both in healthcare and educational institutions) belong to the most urgent problems. The persistence of informal payments for medical services is often mentioned as a great burden both by the officials and "ordinary" people. A gradual decrease in such payments has been noted, however, large sums are still being paid, especially to surgeons, anaesthetists and obstetricians (see Falkingham *et al.* 2010).

Doctors and healers—previous encounters, current experience and possibilities of further cooperation

In the literature, explanations of increasing healers' popularity in Central Asia refer mainly to the dramatic situation of healthcare systems in the region, briefly described in the previous sections, and to the overall socioeconomic crisis inducing "uncertainties of existence" (*e. g.* Heyat 2004, Pelkmans 2017). For example, Pelkmans (2017: 167) points out that in his research site in the southern Kyrgyzstan, Kokjangak, "the hospital was in disarray and, realistically speaking, hardly offered better medical care than some of the spiritual healers."

It should be noted, however, that these are not the only causes of the resort to healers' expertise and help. So, why do healers attract people, in addition to the aforementioned factors? As my studies revealed, the most important are, presumably, local perceptions of health and illness embedded in a wider worldview and inducing beliefs about healers' efficacy. Traditional ideas about health and illness, and especially the causes of illness, are widespread in Central Asia. They connect many afflictions with the influence of malevolent spirits and "evil eye" as well as black magic, whose particularly harmful kind is called, in Russian, *porcha*. Recognition of such etiological factors leads people to seek the help of healers, since in common opinion only they can effectively treat illness caused by this sort of agents. Pelkmans (2017: 160–161) also notices that determining the cause of a health problem has important consequences for seeking treatment, *e. g.* when the casting of a spell (Russ. *koldovstvo*) is suspected, a spiritual healer should be visited. Additionally, illness is treated as one of many kinds of misfortune and people often resort to healers in family problems or business failure. Notably, Kazakh and Kyrgyz ideas about health and illness are deeply rooted in their traditional beliefs about the world of spirits, ancestor spirits (Kaz. *ärwaq*, Kyrg. *arbak*) in particular, and their relations with the humans. A commonly shared belief that spirits actively interfere with people's lives influences health-seeking strategies and enhances the trust in the powers of

spiritual healers as mediators between different worlds. Traditional healing is strongly connected with religion, because—as it was mentioned earlier—in the popular view it is part of the "real," lived Islam, despite the negative attitude of orthodox Muslim leaders to such practices. This contributes, undoubtedly, to spiritual healers' authority. In addition, economic conditions play a great role in treatment choices. Healing and many other CAM therapies are generally perceived as less expensive than biomedical treatment, since patients often have to pay even for formally free public healthcare services.

In light of this evidence, attesting to the strong position of traditional healers in the society, it may be argued that since the 1990s they have become serious rivals to biomedical professionals on the market of medical services in Kazakhstan and Kyrgyzstan.[22] As a result of governmental attempts to professionalise and control healers' activities, discussed above, medical doctors got closer to their market competitors as their teachers and supervisors at the state-run centres in Almaty (then also in other cities in Kazakhstan) and Bishkek. Licensed healers were allowed to work at biomedical institutions, and I met such practitioners both at several private medical centres and big state clinics in Almaty. However, these encounters, initiated during the process of healers' professionalisation, did not lead to stronger, enduring cooperative endeavours, partly due to changes in the policy towards folk medicine described earlier.

In this section I focus on relations between biomedical professionals and traditional healers, leaving aside contacts between the former and practitioners of other CAM branches. In fact, the latter are usually medical doctors themselves and their practices are mostly regarded as a part of medicine or at least as "almost medicine." Thus, the boundary work or "closure strategies" (HIRSCHKORN 2006) did not concern "traditional medicine" practised by doctors, as it was officially called in Kazakhstan. Generally, in the case of such CAM disciplines as acupuncture, reflexology, homeopathy or hirudotherapy, therapeutic boundaries with biomedicine have become blurred (*cf.* NARAINDAS *et al.* 2014).

Of course, inclusion of CAM practitioners into biomedical institutions "does not imply equal status compared to other health care providers" and may result in their marginalisation, as JUDITH SHUVAL & NISSIM MIZRACHI (2004: 685) noticed in the Israeli context. The healers who worked together with medical doctors, obviously hold a subordinate position. Relations between the two parties were definitely asymmetrical. At the Republican Centre of Eastern and Contemporary Medicine in Almaty, where I observed interactions between doctors and healers, the former tended to show their superior status and stress the necessity to control the healers. They were very concerned about preserving the "proper" hierarchy. One of the doctors expressed her opinion in this way: "We are head and shoulders above healers." She added that doctors should "put them in their place" if they felt too strong. Physicians conducted courses for non-biomedical practitioners, supervised their practice, checked the results and participated in examination. They often pointed out the limits of healers' capabilities. Actually, some practices were excluded from their area of competence. In Kazakhstan healers could not deal, at least formally, with oncological, contagious and mental diseases, perform surgical procedures and apply pharmaceuticals. In addition, using "wild methods" in the course of treatment, such as butchering black hen or beating patients with a horse whip, was forbidden.[23] Which methods were considered wild, depended on the doctors' decision, and especially on the opinion of the head of the ward. Healers were allowed to indicate an afflicted organ, but making a diagnosis was forbidden. Generally, they were discouraged from gaining more biomedical knowledge than was offered to them during the courses. These are examples of the boundary work directed at designating limits for the practices of non-professionals. Such attempts were observable both in delimitation of knowledge claims and on the organisational and symbolic levels (*cf.* SHUVAL 2001, SHUVAL & MIZRACHI 2004). For example, whereas the doctors employed at the Centre wore white coats, the healers were prompted to dress in traditional Kazakh clothes, so as to separate them from medical professionals and at the same time demonstrate their commitment to the national, ancestral values.

Although the efforts to separate healers, who cannot ground their knowledge on the scientific base, from doctors were clearly visible at the Centre in Almaty, there were also some attempts at

cooperation between them. Their permanent contacts contributed to the hybridisation of practices, mentioned earlier. Presumably, the physicians borrowed some treatment methods from the healers, while the latter where not allowed to use biomedical techniques or pharmaceuticals in their practices. Several doctors from the Centre who combined various therapeutic methods with biomedical treatment, including folk healing or the use of bio-energy, expressed positive opinions about the abilities of certificated healers. The fact that those physicians practised some CAM therapies themselves certainly influenced their approach to traditional healers. Such was the case of a gynaecologist, an older woman, who used—besides biomedical methods—pulse diagnostics, bio-energy, purification with water, Tibetan massage, prayers and herbal treatment. These "open" doctors were eager to accept, for example, the "call of spirits," viewing it as a part of the Kazakh tradition. Moreover, some of them had experienced such revelations themselves, as the deputy director of the Centre who herself was a physician and a healer.[24] Several external members of the examination commission also praised healers' special abilities. A psychiatrist delegated by the Ministry of Health to the certification commission at the Centre admitted that after several years of contacts with healers her viewpoint had changed. This Kazakh woman, a professor of psychiatry, maintained that there were, albeit rarely, people with a special gift, such as clairvoyant powers. She claimed that mental health assessments might be mistaken and someone diagnosed, for instance, with schizophrenia, might be an "entirely normal" person whose behaviour should be taken as a sign of extraordinary abilities. She added, though, that her opinion was not shared by the majority of her colleagues from the psychiatric clinic.

Obviously, relations between medical personnel and local healers can get better or worse in particular settings. Interesting data about such interaction may be found in a report on one of the health programmes, implemented in Jambyl Region in the 1990s (KEITH 1997: 47–48). In one district of this region physicians had good contacts with healers and the latter often directed patients with serious health problems to medical institutions. However, in the other district hostility between the two groups was clearly visible. Doctors accused healers of being greedy charlatans who unscrupulously preyed upon people's credulity, while healers claimed that doctors were uneducated and could not deal with many diseases. It seems that such a situation, marked by unwillingness to cooperate or even hostility, especially on the part of medical personnel, is more common. As for Kyrgyzstan, a very negative attitude of doctors towards healers was documented, for example, by ELENA MOLCHANOVA *et al.* (2017: 8) who wrote that medical professionals "often claim that all healers are charlatans" and PELKMANS (2017: 167) who commented on Kokjangak hospital physicians' and head nurses' harsh criticism of the local spiritual healers.[25]

It can be assumed that healers employed in "Beyish" had been in a similar relationship to doctors as at the Centre in Almaty. The steps taken in Kyrgyzstan to "expel charlatans" from "Beyish" and change the name and status of this institution were described in the previous section. This kind of boundary work, however, did not reach the expectations of those medical professionals who, as one of my interlocutors—a doctor practising complementary methods—appealed for a rigorous control over healers who could work freely in the market, although deprived of the previous governmental support. This doctor claimed that the state should equally treat biomedicine and complementary medicine, but at the same time strictly monitor healers' activities. Because of the lack of such control, it is impossible, in her words, "to differentiate between a 'real' healer and a swindler."

Importantly, mental disturbances commonly were and are regarded as the result of black magic or evil spirits, therefore in Central Asia patients with psychic disorders are often treated by healers. BOTAGOZ KASSYMBEKOVA (2003) discussed complex factors which discouraged people in Kazakhstan and Kyrgyzstan from seeking professional psychiatric help. She wrote that many people in Shymkent, the "fairly traditional" city in southern Kazakhstan, turned to local healers when they suffered from mental health disorders. She added:

> Doctors and nurses may not have much faith in religious psychology, but they often shunt "no-hope cases" off to healers. They view *taeyips* as a cultural tradition that people in Shymkent and other communities created, protect, and are comforted

by. Some even suggest that *taeyips* should consider getting formal training, so they can offer more professional help (KASSYMBEKOVA 2003: 4).

Some statistics on psychiatric patients in Bishkek clinics is available. It was estimated that 80 % of the people who came to the psychotherapeutic clinic and nearly 100 % of the patients of other mental health wards at the Kyrgyz Republican Centre for Mental Health had visited traditional healers before searching for a psychiatrist's help (MOLCHANOVA *et al.* 2008). In the opinion of psychiatrists, there is evidence of increasing trust in folk practitioners who offer their help to people with mental disorders. Molchanova and colleagues argue that from the Kyrgyz point of view "an initial psychotic episode is usually considered a 'spiritual emergence' and a patient generally has to visit [...] a number of traditional healers before a psychiatrist takes care of him or her" (MOLCHANOVA *et al.* 2008: 68). Faced with such a situation, a group of psychiatrists in Kyrgyzstan started to appeal for cooperation with healers. They appreciate healers' social skills and cultural competence, and argue that their interventions have a real therapeutic value. These psychiatrists see their own role as specialists who work towards removing the symptoms of illness while healers can focus on its causes. It is stressed (MOLCHANOVA *et al.* 2008) that such traditional practitioners usually direct their patients to psychiatrists when they identify severe mental disturbances.

Noteworthy, the psychiatrists who try to develop, despite many obstacles, "community-based culturally sensitive mental healthcare services" in Kyrgyzstan (MOLCHANOVA 2014), recognise the importance of a good sociocultural expertise for their practice. They take into account, among others, traditional Kyrgyz family and clan relations, gender differences and prevailing attitudes towards people with mental disorders. They notice that "some patients with verbal hallucinations, might not only preserve their previous social status, but also acquire specific prestige in a Kyrgyz community as future-tellers (*kez-achyk*), shamans (*kuuchu*), and healers" (MOLCHANOVA 2014: 25).

In fact, first steps towards cooperation between psychiatrists and spiritual healers have already been done, with the aim to effectively help the victims of violence that occurred in 2010 during interethnic clashes in Osh. MOLCHANOVA *et al.* (2017: 8) claim: "We believe that psychiatry [...] might greatly benefit from cooperation with traditional healing, and patients with stress-related disorders can receive help from a wise traditional healer." Medical professionals—psychiatrists and psychologists from multidisciplinary mobile teams created after the conflict, established cooperation with the local healers, whose help, as it was admitted, turned out to be more effective for patients than that of psychiatrists. The authors present and discuss several cases where *bubu*—a traditional female healer—helped young women suffering from various stress-related disorders that resulted from rape. From the psychiatrists' perspective, *bubu* could effectively help a victim of gender-based violence because such a healer "can operate in the same cognitive schema as his/her patient by mixing traditional rituals, prayer, and cognitive behavioural techniques, even while a healer is unaware of using them" (MOLCHANOVA *et al.* 2017: 4). Healers know well local cultural values, hierarchies in the extended family and clan, norms of proper behaviour of the man and woman, *etc*. It seems important that psychiatrists working in these settings recognised the high position of experienced, esteemed healers in their communities and tried to gain a thorough knowledge about the cultural background, local social conditions and the barriers to psychiatric services. Moreover, a good communication between psychiatrists and healers could help the former win the trust of the people, usually distrustful of mental health specialists.

It might be interesting to compare these developments with ALISHER LATYPOV's (2010) remarks on the possibility of partnership between psychiatrists and healers in Tajikistan, in the face of the deep crisis of Tajik psychiatry. He claims that the healers he talked with were eager to cooperate with psychiatrists, but in their words, most doctors did not appreciate such traditional methods. The statements of the psychiatrists, quoted by LATYPOV (2010: 439), while revealing the popularity of healers, at the same time clearly illustrate the hostility of the former towards the latter and efforts to strengthen the borders.

As regards Kyrgyzstan, supposedly the activities of the Aigine Cultural Research Centre in Bishkek gave a stimulus towards building closer

connections between healers and medical practitioners, psychiatrists in particular. Since its foundation in 2004, The Aigine Centre has combined research with a cultural and educational mission, directed at preserving and reviving the Kyrgyz cultural heritage and "traditional wisdom." Within the frames of several projects researchers and practitioners—both biomedical and complementary—collaborated in order to investigate and assess the role of traditional healers as specialists dealing with health, family problems, social inadequacies of their patients, as well as providing them with spiritual assistance.[26] Participation in such projects undoubtedly helped psychiatrists and other medical professionals understand the importance and the reasons for tenacity of traditional healing. Moreover, a strong support that healers, as carriers of *kïrgïzchïlïk*, have received from several smaller organisations and associations involved in the revaluation of Kyrgyz culture might play a role.

Conclusion

Relations between biomedicine and different CAM disciplines in Kazakhstan and Kyrgyzstan may be analysed with the use of the concept of boundary work. This boundary work, understood as a dynamic process, has been shaped by political, economic and social changes following the collapse of the Soviet Union and emergence of independent Central Asian republics. During the 1990s both countries, similar to the other republics of the region, referred to the local cultural heritage in the need to legitimise the right to sovereignty. Together with a dramatic situation of post-Soviet healthcare systems, the revival of local cultural traditions contributed to the official acceptance and support for folk medicine, and CAM in general. Through the process of professionalisation, traditional healers could improve their position and work in public and private healthcare institutions.

The position of CAM specialties practised by medical doctors seems stable in Kazakhstan and Kyrgyzstan. They enjoy institutional support and have been included into educational systems of these countries. Although their knowledge bases sometimes clearly contradict biomedical knowledge, acquiring medical qualifications ensure those CAM practitioners acceptance. However, further studies could reveal if their position in biomedical institutions is equal to that of other doctors, or the boundaries are maintained.

Healers, in contrast, do not get an official backing anymore and their cooperation with doctors, formerly possible in such institutions as state-run centres of folk/traditional medicine, does not have much opportunity to develop. Changes in the official discourse and withdrawal of the support for folk medicine may be seen as boundary work, the efforts directed at separating what is perceived as scientific from methods of doubtful effectiveness, unconfirmed by scientific evidence. In this process not only epistemological, but also organisational boundaries between biomedicine and folk medicine are being enhanced (*cf.* Shuval & Mizrachi 2004). The boundary work has been strengthened by those medical professionals who themselves practise CAM therapies, but strive to expose their scientific legitimacy. However, whereas the process of healers' professionalisation in Kyrgyzstan has been interrupted, in Kazakhstan it still proceeds, although under stricter conditions.

Actually, contemporary Kazakhstan and Kyrgyzstan do not require justification of their sovereignty through appeals to "tradition" and "heritage," and their governments strive to present these countries as modern and "enlightened." Therefore in the official discourse healers are more and more often presented as charlatans. In addition, since purist trends in Islam have increased in Central Asia in recent decades, traditional spiritual healing may gradually loose its strength as condemned by Muslim religion. It ought to be remembered, though, that healing is commonly accepted as part of local, everyday forms of Islam.

Despite the changes in the official approach and enhancing the boundaries, practical reasons for acceptance or at least tolerance for traditional healing have not disappeared. Healthcare reforms in Kyrgyzstan, although well advanced, still have not led to fully satisfactory results, and in Kazakhstan the situation of state healthcare system seems even worse. Healers' great popularity among the wide public, which is in part due to these circumstances and in part to sociocultural factors, cannot remain unnoticed. Hence, such practitioners are allowed to work on the market of medical services. It should be noted that the dom-

inant critical official discourse on traditional healing is not entirely shared by biomedical professionals. A special case, which I described in more detail, is cooperation between psychiatrists and healers in Kyrgyzstan. However, the efficacy of the latter is especially valued in critical circumstances. In general, it may be argued that in today's Kazakhstan and Kyrgyzstan different modes of coexistence between biomedicine and CAM prevail, rather than the established cooperation.

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Notes

1 I put the word "traditional" in quotes since I recognise that healers' practices are highly hybridised, although they usually refer to local traditions. Having this in mind, for convenience I often omit quotation marks in the following text.
2 Part of this work involving research in Kyrgyzstan was supported by the Narodowe Centrum Nauki (National Science Centre, Poland), grant number N N 109 186440.
3 Lindquist added another type of legitimacy: "based on alterity," which appeals to "exotic" origins of CAM therapeutic methods. However, in my opinion it is rather a means of enhancing a healer's authority than a separate kind of legitimisation.
4 Another term proposed by medical anthropologists is "medicoscapes." It is mainly used in reference to the settings where transnational flows and globalisation processes are particularly strong (Hörbst & Wolf 2014). For a more extensive discussion on medical pluralism and connected notions see Hsu 2008, Penkala-gawęcka & Rajtar 2016.
5 Among private biomedical institutions there are small clinics for less affluent people as well as big, modern medical centres which offer, for example, cosmetic surgery for well-off patients.
6 According to Askar Jumageldinov (2016: 193) who studied Kazakh healers in Astana between 2013 and 2015, the term *baqsy* is rarely used today; healers are usually called *emshi*, and those who apply Quranic prayers—*täwip*. Pelkmans (2017: 152) notes that Kyrgyz healers avoid referring to themselves as *bakshi* mainly because they do not want to suggest that their powers "match those of the great *bakshis* of the past."
7 For similar observations on people's attitudes to healing as part of the local, everyday Islam in Uzbekistan, see Rasanayagam 2006, Kehl-Bodrogi 2008.
8 However, for convenience, I use the acronym CAM throughout the text.
9 Such a "medical revivalism," closely associated with nationalism, was also observed in other countries, for example in India and Indonesia (Lock & Nichter 2002: 7–8).
10 As Sophie Hohmann (2010) observed, similar strategies of "reconstruction of national identity" in Uzbekistan included, among others, the revival of traditional medicine based on Avicenna's (Ibn Sina) heritage.
11 Korean acupuncture was very popular in Almaty, especially its variant called *soo-jok* (*cf*. Penkala-gawęcka 2002).
12 Chinese acupuncture and manual therapy were included in the curriculum as early as the late 1980s.
13 They could be penalised, however inspectors usually tried to persuade them to apply for a license.
14 In Sharipova's (2015: 326) words, "the primary source of help in Kazakhstan is not impartial state institutions but friends and relatives who occupy various positions in the state apparatus and public organizations."
15 These and other citations of Narbekov's statements are derived from the interview that I conducted with him in Bishkek in 2012.
16 Healers did not form a large group in comparison with physicians. As Narbekov claimed, the number of employed doctors, together with technical staff and administration, had reached over a thousand. However, I am not sure if these numbers were not exaggerated.
17 When I was doing research in Bishkek in 2012, the third reform programme Den Sooluk ("Health") had just started.
18 A number of products, Narbekov's inventions bearing such intriguing names as "Great Diplomat" or "Shambala," are available for patients of the Academy and other customers—some of them are quite expensive (http://anon.kg/shop/, accessed: 5.11.2017).
19 On the Academy website (http://anon.kg/, accessed: 5.11.2017), named "Meditsinskiy tsentr Akademika Narbekova O. N." ("The Academician O. N. Narbekov's Medical Centre"), there are advertisements of the products, outline of the Academy activities, photos of certificates, awards and diplomas, and videos.
20 This institution had taken a part of the building on rent from the government, as the heir of "Beyish." Narbekov maintained that the Academy invested a good part of its profits in restoration of the premises.
21 Nevertheless, I often heard, both in Kyrgyzstan and Kazakhstan, that "there are no authentic, strong healers anymore," especially shamans. People tended to be sceptical about the abilities of contemporary healers, but despite of this they often tried to find a reliable practitioner. Pelkmans (2017: 154) quotes similar statements about *bakshis* with "real power," whose performances his interlocutors had witnessed in the 1950s or 1960s.
22 There is also a rivalry between healers themselves, which was discussed by Ildikó Bellér-Hann (2001) in her account of Uyghur healers in Almaty.
23 However, applying a whip was not forbidden—it could be used for expelling evil spirits.
24 Sergey Abashin in his book *Sovetskiy kishlak* (2016: 444–51) thoroughly discusses an interesting case of crossing knowledge and practice boundaries on the example of a medical doctor, ex-director of the hospital in Oshoba, Tajikistan, whom he met in 2010. This doctor had had positive experiences as a patient of traditional healers and started practising non-biomedical treatment himself, mainly with the use of bio-energy.

25 On the other hand, they did not entirely condemn healers' practices and "admitted that among the charlatans and impostors were those with real powers" (Pelkmans 2017: 167).
26 http://www.aigine.kg/?lang=en (12.11.2017). The Aigine Centre issued several publications presenting the results of cooperative work and views of numerous researchers and practitioners.

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DANUTA PENKALA-GAWĘCKA received her PhD and Dr. habil. degrees in ethnology and cultural anthropology and works as Associate Professor at the Department of Ethnology and Cultural Anthropology, Adam Mickiewicz University in Poznań, where she has organised the Medical Anthropology Research Group. She specialises in medical anthropology and Central Asian studies; her interests focus on medical pluralism, complementary medicine and people's health-seeking strategies in Kazakhstan and Kyrgyzstan. Her recent research in Kyrgyzstan was supported by the National Science Centre in Poland. She published books on transformations of traditional medicine in Afghanistan and on complementary medicine in Kazakhstan, and edited volumes on medical anthropology in Poland. Her articles appeared, among others, in "Anthropology & Medicine" and "Central Asian Survey." Between 2007–2016 she was Editor-in-chief of the oldest Polish journal of ethnology and socio-cultural anthropology *Lud* [People].

Adam Mickiewicz University in Poznań
Department of Ethnology and Cultural Anthropology
Umultowska Street 89D, 61–614 Poznań, Poland
e-mail: danagaw@amu.edu.pl