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Temporality and Discontinuity as Aspects of Smallpox Outbreak in Yugoslavia*

The paper demonstrates interconnection and role of certain social, political and cultural factors in 1972 Yugoslavian smallpox outbreak. It focuses on a cultural concept of time, denoted as temporal distance, and discontinuity between pre-socialist and socialist period in Yugoslavian history, as determinants that shaped the understanding of smallpox, risk perception and behavior with regard to the disease. The argument is that those two factors caused forgetting and disregarding of smallpox and thereby contributed to its abrupt distribution in the beginning of the outbreak. In the end are considered contemporary epidemiological implications of the reasoning that relies on the cultural notions of temporal distance and discontinuity.

Key words: culture, discontinuity, temporality, memory, smallpox, Yugoslavia.

Темпоралност и дисконтинуитет као аспекти избијања епидемије великих богиња у Југославији

Рад показује повезаност и улогу одређених друштвених, политичких и културних фактора у избијању епидемије великих богиња у Југославији 1972. године. Како је акценат првенствено стављен на биокултурни аспект ове епидемије, теоријски приступ је постављен у оквиру културне епидемиологије. Тумачење је усмерено на темпоралну удаљеност, као културну концептуализацију времена, и на перцепцију дисконтинуитета између два социо-политичка система, оличена у предсоцијалистичкој и социјалистичкој Југославији. Аргументује се да су ова два фактора утицала на формирање значења која су приписивана великим богињама, перцепцију ризика и понашање по питању ове болести, што је заједно узроковало њено заборављање и занемаривање, те допринело њеном нагом ширењу у почетку епидемије. У социо-културном погледу, ова епидемија разоткрила је занимљиве односе између идеологије, социјалне структуре и схватања о неподложности обољењу. На крају су размотрене савремене епидемиолошке импликације резоновања које се ослања на културне концептуализације темпоралне удаљености и дисконтинуитета.

Кључне речи: култура, дисконтинуитет, темпоралност, сећање, велике богиње, Југославија.

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As an important part of human life and death, infectious diseases have deservedly occupied the attention of medical anthropologists, who have insisted on their socio-cultural reality beside a well-known biological one. In linking tiny, pathogenic microbes to social structure, cultural conceptualizations, political and economic context, several theoretical perspectives have surfaced as particularly relevant, among which are phenomenological and related meaning-centered approaches (see Singer 2015). These primarily refer to cultural patterns of behavior, beliefs, ideas, values, illness labels, norms and representations, all of which are emphasized in Cultural Epidemiology – an approach that advocates for introducing culture as a complementary alternative to social epidemiology and its orientation towards health effects of structural factors and social organization (see Trostle 2005). According to Trostle, emphasizing culture means focusing attention on disease classification, meaning, risk, and behavior in addition to social variables such as income, marital status or occupation (Trostle 2005, 5).

In this paper, I wish to apply such approach in interpretation of a temporal aspect of smallpox outbreak in 1972, in what was then the Socialist Federal Republic of Yugoslavia. More specifically, the aim will be to address meanings attributed to this disease, perceptions of risk and behavior as influenced by a cultural concept of time which could be denoted as temporal distance, and associated with a particular historical context that implied dissociation between pre-socialist and socialist socio-political systems. I argue that these two factors shaped to a certain degree the understanding of smallpox and, consequently, behavior regarding the disease, which altogether contributed to its abrupt distribution in the beginning of the outbreak, making it the largest post-war smallpox epidemic in Europe (Litvinjenko et al. 1973). Moreover, it seems that the ideas about smallpox and related perceptions of risk also partially underlay social organization in terms of this communicable disease.

What happened in Yugoslavia at that time was that smallpox dropped out of collective memory and was disregarded, since the last previous outbreak had occurred forty-two years before in completely different political and social circumstances. This manifested in irregular vaccination, but also in a failure of the state apparatus to provide satisfying vaccination rates, its unpreparedness to confront the disease effectively upon the outbreak, as well as in physicians' failing to recognize and diagnose it at first. All of these setbacks were documented in subsequent reports about the epidemic from international organizations and domestic physicians who had been involved in its confining. On the other hand, their explanations of these failures usually came down to a long absence of the disease, without further elaborations (See Litvinjenko et al. 1973; Lalević et al. 1972). I consider the long absence of smallpox as an outcome of the specific socio-cultural, economic and political circumstances, which also produced perception of discontinuity between two different periods in Yugoslavian history.

In the analysis, I will try to show how this discontinuity influenced collective memory and attitude towards events that were perceived as temporally distant, among which were smallpox epidemics. This means that the two specific socio-political contexts of pre-socialist and socialist Yugoslavia need to be considered,

with a special reference to socialist regime's endeavors to distance itself from the previous system and prove its worth against it. I will investigate how the success in this dissociation had a role in disregarding of smallpox – the disease that up until the year of 1972 had not been a part of then living reality for a long time and was thus perceived as belonging to the pre-socialist past. Finally, I will consider contemporary epidemiological implications of reasoning that relies on the cultural notions of temporal distance and discontinuity.

Epidemiological time and socio-cultural time

Time is both an important category in epidemiology and one of the essential categories according to which different cultures define and conceptualize their reality. In epidemiological sense, time could be measured through variables such as an incubation period (the time between moment of exposure and onset of clinical symptoms) and a latent period (the time between infection and infectiousness). Time is also relevant in characterizing disease occurrence and in noting variations in disease frequency – if incidence rates notably increase or decrease over a certain period of time, if there is a seasonal causality associated with biological factors such as variations in number of arthropod vectors, like ticks or mosquitoes, etc. On the other hand, the effect of socio-cultural time on disease dispersal is equally significant, although not often acknowledged.¹

Along these lines, different time variables have a significant role in disease dispersal, but the overlapping cultural conceptualizations of time also influence disease distribution, because people organize their behavior according to the meanings attributed to certain time periods. This means that time variables potentially represent multiple underlying processes (Trostle 2005, 43). Trostle also points out that without explicit theories relating these underlying processes to measured causal variables, the category of time is meaningless, and studies linking it to health outcomes are difficult to understand and compare (Trostle 2005). He concludes that if time allocation studies could be better associated with exposure to disease risk, anthropologists might make a significant contribution to the studies of time as causal agent (Trostle 2005, 68).

Theories developed within anthropology understand time primarily through the socio-cultural dimension, although Gell distinguishes objective, "real" time which is outside the domain of human agency, and a subjective notion that implies human perception (Gell 1992, 151). The latter perspective is taken by Munn who sketches the notion of "temporalization" that views time as a symbolic process continually produced in everyday practices. In other words, socio-cultural time consists of multiple dimensions that in any instance can be in the focus of attention, and are

¹ A very indicative example of this is demonstrated in a study about the local definitions of seasons, perceptions of seasonal variation in mosquito populations and incidence of febrile illnesses in Tanzania. The study showed that the transmission of febrile illnesses, like malaria, is very much related to the people's ideas about what illnesses are common in particular season and to the perceptions of mosquito densities. For more details see: Winch et al. 1994.

apprehended through various relationships among people, objects and space in the everyday life (Munn 1992, 116). The socio-cultural time dimension, or temporalization, considered in this paper is the notion of temporal distance, best depicted in a phrase "a long time ago". This time conceptualization translates into people's relations towards events that are perceived as belonging to the past for some particular reasons, and therefore cannot be easily associated with contemporary period.

It could be said that the cultural concept of temporal distance and relation toward past occurrences are closely linked to the processes of remembering and forgetting, or in short – memory (compare with: Assmann 2008). According to Halbwachs, memory is always collective because it is a socially constructed notion peculiar to different social groups who all share distinctive memories that their members have constructed, usually over long time periods (Halbwachs 1992; see also: Sládeček et al. 2015). Connerton adds to this that the images of the past and recollected knowledge are conveyed and sustained mostly by ritual performances, as acts of transfer that make remembering in common possible (Connerton 1989; compare with: Assmann 2008). Likewise, memory work, or social practices that create memories, can generate new interpretations of past, but also induce forgetting by suppression, hiding, destruction, etc. (see Mills et al. 2008). In keeping with all this, it is reasonable to assume that memory tends to fade away if there has been a long-time period during which the group members have not had any contact with a specific set of associations. It could be said that this particularly happens if there has been a discontinuity between different "eras", as was the case with pre-socialist and socialist Yugoslav periods.

"Era shifts" are the points when a social group² conceives a whole new historical beginning and willingly makes an effort to start anew. It is a kind of transformation that is similar to Das' concept of critical event after which new modes of redefining actions are enacted, cutting across social organization, institutions, structure, ideas, etc. (see Das 1995). In such starting afresh process, the whole history tends to be re-written, which also reflects in the reconstructions of collective memory and in eliminating the idea of continuity with the old. However, Connerton stresses the complexity of this issue, as the absolutely new is inconceivable because people base their experiences on a prior context in order to ensure that those experiences are intelligible at all (Connerton 1989). This means that the attempt to break with an older social order encounters a kind of historical deposit and threatens to founder upon it (Connerton 1989, 12).

Although Connerton concludes that a radical beginning is inconceivable without its element of explicit and implicit recollection, it could be assumed that this process of thorough systemic dissociation has a special impact on collective attitude towards temporally distant events, especially if those do not fit easily into the new order and are considered outdated. As already stated, smallpox was a disease that up to the year of 1972, had never occurred during the socialist Yugoslav period

² Connerton uses the notion of social group to refer to both small-scale societies (villages, clubs), and large-scale industrial societies (nation-states), (Connerton 1989).

due to the new socio-political system and overall circumstances in the world scene that affected its distribution at the time. The disease was therefore regarded as a matter of past and, also for ideological reasons, classified as belonging to a long-gone period, that was in so many ways different from the new one. This consequently reflected on risk perception and led to disregarding smallpox, which could be observed as a culturally constructed response to the disease that had not been eradicated at the time.

The outbreak and forgetting/disregarding smallpox

In 1967 the World Health Organization initiated smallpox eradication campaign, focusing on mass vaccination, surveillance and containment (Green et al. 2013). By the year of 1971, the endemic areas were significantly reduced to some regions of Africa, South America and Asia (Green et al. 2013; see also: Kotar et al. 2013; Fenner et al. 1988). However, in the first half of 1972 there was an unexpected increase in registered smallpox cases, when the disease was imported in countries like Iran, Iraq, and the Syrian Arab Republic (Fenner et al. 1998). This outbreak overlapped with the great pilgrimage to Mekka and Medina, when about 2700 Yugoslavian Muslims traveled to these destinations in January and February 1972 (Čobeljić 2004). One bus with pilgrims from Kosovo also visited holy places of Dervish Muslims near Basra and Baghdad in Iraq between February 2 and 6, returning to Yugoslavia on February 15. Soon upon the arrival, one of the pilgrims fell ill with non-specific symptoms and the disease ended fast with no typical clinical manifestations of smallpox. Later investigation identified this person as the index case (Čobeljić 2004, 569). Smallpox spread rapidly in Kosovo and Serbia, infecting in total 175 individuals, out of which 35 or 20% died within three months that took the epidemic to end. The distribution of the disease was very much facilitated by its disregarding, which reflected in misdiagnosis, unpreparedness of the state apparatus to confront the disease and its failure to provide satisfying vaccination rates.

Repeated misdiagnosis was first in the chain of events that led to the disease dispersal in Serbia and Belgrade. This was the case of a teacher from a town in Serbia who had a contact with the index case when traveled to Kosovo. In different hospitals where he was admitted, his condition was consistently attributed to a severe reaction to penicillin that he was treated with for a febrile illness. This person infected a total of 38 individuals mainly in these hospitals, which was a unique example of smallpox transmission ever registered (Čobeljić 2004). Various reports state that during all this no one ever thought of smallpox (Litvinjenko et al. 1973; Šuvaković 2014; Bura 2012). This was not the only case of misdiagnosis, but was certainly the most extreme one. It should be noted that importation of smallpox virus into a population that obtained a relative immunity provides basis for the emergence of all smallpox types, which causes diagnostic difficulties. The outbreak in Serbia and Belgrade was probably initiated by the most severe type, *Purpura Variolosa*, with mortality rate of 100%, which was very hard to identify by inexperienced physicians. Also, different stages of the disease influence its identification and con-

fusion with other diseases (Perišić et al. 1972; Pavlović et al. 1972). This led a group of physicians to conclude that long absence of smallpox and lack of physician's practical experience were the reasons for diagnostic difficulties (Perišić et al. 1972). On the other hand, a very indicative statement was given by another group of physicians, who wrote: "Doctors in Yugoslavia were not accustomed to think of a possibility of smallpox emergence" (Pavlović et al. 1972, 143; italics V.T.). According to this, the misdiagnosis was not just based on the real diagnostic difficulties, but was as well under the significant influence of socio-cultural factors that caused disregarding of the disease.

Taking into account smallpox epidemiological situation in the world at the time, intensive mobility and relations with endemic countries, importation of the disease would not had been unexpected (Antić et al. 1972a). At first glance it would seem that geographical distance from the endemic areas also created a false sense of being protected against the disease, which resulted in its disregarding. However, there had been occasional importations of smallpox in Europe from 1950-1977.³ Because of this, it is curious that smallpox was disregarded to the point that the state apparatus was not even prepared to confront it. According to the report of the Agency for International Development, health authorities were unprepared for rapid vaccination, there were only 1 000 000 doses of high quality lyophilized vaccine on hand, of which 100 000 doses were in Serbia at the time of the outbreak. The vaccine used in Kosovo was old and of poor quality, the vaccinators were not trained for mass vaccination and there was shortage of vaccinating instruments.⁴

Previous vaccination rates also reflected very well the overall disregarding of the disease. Amid the outbreak, The Epidemiological Institute conducted a research about immunization status of Belgrade population and ascertained a large number of those who had not been vaccinated years before the epidemic, which was against the immunization law (Krajinović et al. 1972). Likewise, an unexpectedly large number of unvaccinated children was revealed, which was related to a long list of contraindications that physicians followed (Čalić-Perišić et al. 1972). It was also discovered that a significant number of healthy children remained unvaccinated in the first year of life, because their parents were reckless towards vaccination or even deliberately avoided it (Barjaktarević-Nikolić et al. 1972). Low immunization status was detected even among hospital staff, which meant that the policy of medical workers' vaccination at frequent intervals was not enforced (Lane 1972). What also surfaced was that the data of previous vaccinations were not complete since the whole matter was approached more formally than essentially, without details, control and repeated vaccination (Miletić et al. 1972).

All of this indicates that smallpox was disregarded not just by ordinary people, but also at the level of the state apparatus and by health authorities. That is to say, the idea about the disease as temporally distant, which induced perceptions

³ See: The global eradication of smallpox: final report of the Global Commission for the Certification of Smallpox Eradication, Geneva, December 1979: 50

⁴ Case report: Yugoslavia – Smallpox Epidemic March, 1972. Office of the Foreign Disaster Coordinator, Agency for International Development, Washington D. C.

of low risk, was so widely disseminated that it even altered social organization regarding smallpox. In the following section, I will try to show how this idea emerged and was strengthened by the (notion of) discontinuity between pre-socialist and socialist era in Yugoslavian history. Such perspective should also assert the significance and interconnection between social, political and cultural factors in this outbreak.

The effects of historical dissociation and the idea of discontinuity

Following the end of the First World War, the Ministry of National Health in the Kingdom of Serbs, Croats and Slovenes set off to fight epidemics of communicable diseases and to generally achieve better results in the field of public health. This struggle was confronted with different obstructions that ranged from ethnic, political, economic and infrastructural, to overall devastating health conditions in the field. The period was marked by underdeveloped and inefficient network of healthcare institutions (Pavlović 2007), poor nutrition, hygiene, living and health conditions for the majority of population that consisted mostly of small peasants (80%), high morbidity and infant mortality, all of which were even more incited by war, great human and material losses. Peasant population was too poor to afford medical services, did not have any kind of health insurance or possibility of free medical treatment, and it was basically left to itself (Žarković 2003).

Smallpox had been present in this region since the Middle Ages, affecting all age groups, with lethal outcome for almost 30% of the whole population. After Edward Jenner's discovery of vaccine in 1796, vaccination against smallpox soon became mandatory in different countries⁵ (Ćurčić et al. 2000). Notwithstanding, according to the existing data, since 1896 up until 1910, 38 953 people died just in Serbia during smallpox epidemics. The last case of smallpox, before the eradication campaign that started in 1967, had been registered in 1930 in Serbia (Kuljić-Kapuljica 2004; Kotar et al. 2013, 349), which was then a part of the Kingdom of Yugoslavia. At that time, due to the aforementioned reasons, the fight against communicable diseases yielded modest results which were downgraded during the World War II (Petrović-Todosijević 2007).

In the aftermath of the World War II, a whole new socio-political regime based on a communist doctrine was inaugurated, which was directly opposed to the previous system. This implied a thorough economic and political transformation that was especially reflected in the creation of a new social structure, administrative apparatus, educational and health care system, etc. In short, that meant a radical split with the old establishment and a dominant sense of starting anew. In the field of public health, the new regime proclaimed as its revolutionary objectives comprehensive health enlightenment, as well as the reduction of mortality and morbidity

⁵ In Serbia, the law on mandatory vaccination against smallpox was passed in 1839 (Dimitrijević 2011). Furthermore, inoculation had already been known before Jenner's discovery in India and China, but also in this region's traditional medicine (see Jeremić 1935; Kotar et al. 2013; Knežević 1989).

(see Petrović-Todosijević 2005). Pre-war state policy was mainly blamed for the existing wretched health conditions (see Bondžić 2007). Hence, fighting communicable diseases was especially challenging for the new regime, because winning that battle meant that the old system had deservedly failed and that the new one was on the right path (Petrović-Todosijević 2007).

During the first decade after the war, the communist party started working on new health policy and service, with emphasized prevention and education. Yet, health improvement endeavors encountered many difficulties – local officials generally ignored and underestimated health service, and journalist propaganda was more inclined to report about alleged successes of health service, than to publish informational texts on hygiene, contagion prevention and the like (Dobrivojević 2007). Communicable diseases were on the rise and present in different parts of the country due to extremely low health education among the impoverished population. Socialist Yugoslavia also experienced shortages in professional medical staff and poor situation in hospitals (see *ibid.*). In that sense, there was rather a continuity with social and cultural conditions of the previous period that generally reflected on population's health. The breakaway in these terms was prompted by new political circumstances at the end of 1940s that provided more solid basis for implementing long needed health measures.

Systematic eradication of communicable diseases begun in the first half of the 1950s with a considerable help of UNICEF and the World Health Organization, which was in direct relation to Yugoslavia's political split with the Soviet Union and opening towards Western Europe and the United States (see Petrović-Todosijević 2006). The geo-political significance of the separation from the Soviet influence provided generous grants from the West, helping Yugoslavia experience a remarkable development and spirit of modernization. The results, in comparison to the previous circumstances, were a notably elevated living standard, advanced health and hygienic awareness, population's higher educational level, training of new medical staff, developing network of clinics and hospitals, introduction of mandatory physical examinations and the right to free social care for all citizens.⁶ All of this induced normalization of health conditions in 1960s, which could be taken as a period when Yugoslavia went through a second epidemiological transition, like other high and middle income countries earlier, when mortality from communicable diseases significantly declined due to improved nutrition, living and health standards, invention of antibiotics, etc. (see Brown et al. 2011). Also, in this period smallpox was excluded from the list of current communicable diseases in Europe (Krajinović et al. 1972). It was these political and economic conditions and the following changes at the socio-cultural level that reduced the burden of communicable diseases, had a role in smallpox absence and, most importantly, produced the idea of discontinuity between two different periods in Yugoslavian history.

⁶ This also means that the subsequent disregarding of smallpox at the level of the state apparatus was not caused by structural disadvantages, like a lack of funding, but that it could be rather viewed in cultural and ideological terms.

By these accomplishments, the new system successfully distanced from the old one, and smallpox, along with other ravaging infections, became a symbol of disadvantages of the pre-socialist era. In that sense, disregarding smallpox demonstrated a high level of confidence in breakaway with the past, which eventually led to not thinking anymore of a possibility of its emergence. The perception of discontinuity also affected attitudes towards the events that were perceived as temporally distant, or belonging to the pre-socialist period, among common people. In the new context of significantly improved health quality and healthcare system, devastating epidemics were a matter of bygone times and could not be easily associated with current period. According to Halbwachs, the most painful aspects of yesterday's society are forgotten because constraints are felt only so long as they operate and because, by definition, a past constraint has ceased to be operative (Halbwachs 1992, 51).

Collective behavior, ideas and perceptions of risk were also under the influence of meanings attributed to modern socialist period (without a doubt supported by political propaganda), that was regarded as advanced in many respects, which made it seem that smallpox outbreak was unlikely to happen again. In addition to this, the majority became accustomed to a paternalistic state and party, and felt that they were supposed to solve every problem (Golubović 2007). Hence, the public was largely carefree in terms of outer health threats, as it was the state's duty to take care of its people and make sure those threats didn't reach them.

New circumstances also oriented collective attention towards present and future that probably seemed much more alluring than a grim past, marked by poverty and miserable health conditions. The rapid process of modernization and industrialization put in the forefront a linear apprehension of time characteristic for modern societies, which entailed continuous advancement into an unknown future (see Rot 2000). This is not to say that the other time conceptualizations typical for Balkan settings, like cyclical or liminal (ibid), ceased to exist, but that the linear perception became dominant with regard to the emerging social structure, which was characterized by a significant diminishment of agricultural population and simultaneous enhancement of working and middle class (see Petranović 1988; Pečujlić 1979). The period became known as the communist welfare state, when people finally started living good lives, which reflected in prevailing value orientations with emphasized material standard, pragmatism and utilitarianism (Golubović 2007). Thus, temporal perspective shifted when people became mostly occupied with better living standard in present and focused on maintaining it in future, rather than looking into past (compare with: Guyer 2007). In Halbwachs' words, absorbed with everyday preoccupations, people are not interested in occurrences from the past that are irrelevant to these preoccupations in present (Halbwachs 1992, 47). With the new context of modernized society, its prevailing orientation towards present and future, significantly reduced communicable diseases, and the fact that smallpox was associated with a completely different and long gone era, it is reasonable to assume that the recollections of the disease gradually faded away. Also, it could be said that disregarding smallpox was partly the consequence of assurance in discontinuity

with the past, and of confidence in advances and advantages of the new social system.

The regime's insisting on discontinuity with the previous socio-political arrangement could be also considered as having a certain part in physicians' failure to think of smallpox in the beginning of the outbreak. Although the creators of the new health policy wished for utter break with the preceding system, the health service of socialist Yugoslavia inherited both institutions and people on which the previous health care rested (Petrović-Todosijević 2007; compare with: Connerton). Hence, in the years following the end of the World War II, the efforts of the socialist regime to dissociate from previous system reflected quite harshly on already scarce staff of the Medical School which mostly belonged to the much-despised bourgeoisie and vigorously resisted the new order. Great importance was given to the ideological profile of professors, who were not just supposed to educate experts, but also to help create a new type of socialist physicians who would link Marxist doctrine with their work (Bondžić 2007). A physician was expected to become a folk doctor with a vision and developed sense of new, as well as a health worker that actively participated in building a new socialist society (Dobrivojević 2007, 141). It never occurred to the policy makers that this kind of discontinuity between different generations of physicians might interrupt the transfer of memory and experience about certain forgotten diseases such as smallpox, and that this could have real consequences in a new historical era.

While it is a fact that the regime adopted pragmatic solution, and tolerated older cadre until they could be replaced (*ibid*), an insurmountable ideological gap was fostered among old and new generations of physicians. Thus, the discontinuity between these generations was also ideational – it implied differences in ideas, concepts and meanings that were expressed in their relations towards past and present. According to Connerton, images of the past commonly legitimate a present social order, and to the extent that the people's memories of society's past diverge, to that extent they can share neither experiences nor assumptions (Connerton 1989, 3; compare with: Asman 2015). In other words, communication across different generations can be impeded by different sets of memories, so that although physically present to one another in a particular setting, the different generations may remain mentally and emotionally insulated (Connerton 1989, 3). If the majority of new doctors, educated as communist intelligentsia, accepted the prevailing notion that modern and advanced socialist system successfully distanced from the previous wretched health conditions, they would not had been accustomed to think of a possibility of smallpox emergence, which was symbolically linked to a period conceptualized as “a long time ago”, a different social system, and faraway, mostly poor, world regions.

It could be said that the dissociation between two eras largely produced such cultural conceptualizations in places where the discontinuity with the old was most noticeable – in urban and economically developed settings where most of the consulted physicians were stationed. Such gap was not that much visible in parts of the country that still had to catch up with social and economic advances, like Kosovo, which was one of the most underdeveloped regions of the socialist Yugoslavia.

It is interesting that smallpox was actually first recognized there by some old Albanian woman⁷, who called it Arabic pox⁸. It appears that the recollections of smallpox were much stronger in communities that didn't experience thorough discontinuity with the past, and where continuity with the old traditions was cultivated instead. In those circumstances, people seemed more prone to base their experiences on the prior context, so smallpox outbreaks, that used to happen a long time ago, were not that hard to imagine in present. This also supports Halbwachs' thesis that recollections vary from group to group, depending on the context in which those groups find themselves.

The belated smallpox diagnosis and generally reluctant authorities' response to the outbreak could be also attributed to socio-cultural and political factors. According to Rosenberg, most communities are slow to accept and acknowledge an epidemic when it occurs, because it poses a threat to specific social, economic and institutional interests (Rosenberg 1989). This author notes a repeating pattern over centuries, with the first stage of an outbreak acting itself out in predictable fashion: physicians find a few "suspicious" cases and then either suppress their own anxiety or report their suspicions to authorities, who are usually unenthusiastic about publicly acknowledging the presence of so dangerous an intruder (Rosenberg 1989, 4).

The same scenario happened in Yugoslavian smallpox epidemic. Many physicians criticized the authorities for stalling to proclaim the outbreak (see Antić et al. 1972b; Dovijanić 1972). On the other hand, reading some physicians' testimonies reveals that their first response upon encountering smallpox cases was precisely to suppress their anxiety. One of them said: "I startled and discarded the thought [that it could be variola]" (Bura 2012, 32), and another statement reads: "Nonetheless, I still didn't have the courage to say it out loud that it was variola, and call on the authorities to signal emergency" (Bura 2012, 38). Surely these were not responses typically ascribed to physicians who are often thought of as rational and objective in any kind of a situation. Given the seriousness of the disease, the fear expressed in these statements is understandable, but taking prompt action was a logical and expected step as well.

However, the expressed fear also reveals another, more "human", side of these physicians, which is above all shaped by cultural conceptualizations and under the influence of socio-political factors. First of all, smallpox was out of its place – in people's minds it belonged to a long gone past or remote and underdeveloped world regions. Its occurrence was an offence against the conceptually established order, a contamination of present with the past, a corruption of advanced and well-known with backward and unfamiliar, all of which led to the established boundaries

⁷ Prof. Dragan Mikić, the head of the first department of the Clinic for Infectious and Tropic Diseases, of the Military Medical Academy in Belgrade, states this in a recent interview to the press. See: <http://www.vesti-online.com/Vesti/Srbija/211222/Variola-vera-i-dalje-preti>

⁸ There was a plethora of diverse folk terms used to denote smallpox in these regions. Arabic pox was mostly remembered among older generations, and the term preserved the memory of who brought the disease to Europe (see: Knežević 1989).

appearing blurry. Hence the initial paralyzing anxiety and surprise.⁹ Furthermore, officially recognizing the first smallpox cases meant admitting that something went terribly wrong in the alleged clockwork of the Yugoslavian socialist system. It implied that the paternalistic state, on which everybody heavily relied on, failed. This was probably especially hard for physicians to acknowledge because they were among the intelligentsia that was supposed to lead in building and preserving the new order.

It could be said that in this outbreak the socialist Yugoslavia fell victim of its own success in distancing from the previous system, both in historical and in conceptual terms. Improved life and health standards and overall modernization, developing at a quick pace, induced an impression of safety and a sense that those bad things, like smallpox, happen to someone else, less fortunate and poor. Those less fortunate and poor were not only populations living in then endemic areas, but also the predecessors of socialist Yugoslavs. In a nutshell, this epidemic revealed a peculiar relation among ideology, social structure and constructions of selves as no longer susceptible to smallpox (see Rosenberg 1989).

Concluding remarks

“The history of tuberculosis control is really one of forgetting.”

Paul Farmer

A forgotten or neglected disease is a well-known concept, usually applied to certain communicable diseases. The concept itself testifies to the inherent biocultural and biosocial nature of infections (Singer 2015) – forgetting and disregarding are indisputably cultural responses, generally entwined with social and political processes. There are different factors at work that cause such a relation towards some diseases, often recognized as structural. The World Health Organization identifies a group of diseases that have received insufficient attention from governments and health agencies, and that affect people who live in low-income, remote, rural areas or urban slums, and in tropical and subtropical regions. These are classified as Neglected Tropical Diseases (NTDs) and are also known as the forgotten diseases.¹⁰ Such maladies are not disregarded because they are insignificant or rare – in fact, they affect and disable more than a billion people in 149 countries and financially exhaust developing economies.¹¹ The cause of their neglect lies in a lack of strong political voice, a low profile and status in public health priorities of impoverished populations in the developing world.¹²

⁹ Mary Douglas had mumps when she wrote “Purity and danger”. She pointed out: “there was an immediate connection with contamination and infection” (<http://www.haujournal.org/haunet/douglas.php>).

¹⁰ See: Neglected tropical diseases http://www.who.int/neglected_diseases/diseases/en/

¹¹ See: Ibid.

¹² See: <http://www.who.int/features/qa/58/en/>

This paper demonstrated that forgetting or disregarding a certain disease does not have to be based exclusively on weak political influence of the so-called forgotten people and poverty as structural barriers to good health. Quite the opposite, forgetting and disregarding of smallpox in the socialist Yugoslavia happened in a period when people, relying on paternalistic state, mostly felt secure and were preoccupied with living much better lives than they used to in the past. In this case, the disease was neglected and forgotten by the state apparatus, health authorities and ordinary people primarily for biocultural reasons, reflected in the cultural notion of temporal distance and the idea of discontinuity between two different eras and socio-political systems associated with them.

Cultural notions of temporal distance and discontinuity are still important determinants in people's reasoning about infectious diseases. Some maladies are often conceptually related to poor living conditions and impoverished populations who are at a larger risk of contagion, but also to the past. Plague instantly comes to mind as a disease that remains endemic in the tropics and subtropics but, from the Western point of view, it is mostly memorized as a scourge in the Middle Ages period, and is hard to conceive as a cause of great affliction in present-day developed countries. As Rosenberg notes, we have become accustomed in the last half century to thinking of ourselves as no longer subject to fulminating infectious diseases, and death from them seems, like famine, limited to the developing world (Rosenberg 1989, 2). I would add that this kind of reasoning could be related to the (idea of) discontinuity with the period when such diseases posed a great threat.¹³ Yugoslavian smallpox outbreak shows how this logic can be misleading, and how because of it an epidemic can easily become a reality of modern countries with significantly improved living conditions. It seems that the occurrence of smallpox came as quite a shock not only in Yugoslavia, but also in other European countries where importations of the virus were registered around that period. These outbreaks could be described as extraordinary events in a promising context that such scourges would never happen again. Perhaps hence the marking of their anniversaries even decades after the disease had been eradicated.¹⁴ In other words, these outbreaks were so striking that their recollections have transformed over time from informal, communicative memory (the knowledge communicated in everyday interaction) into cul-

¹³ Epidemiological transition theory argues that some populations in high and middle income nations underwent a second epidemiological transition about 150 years ago, when improved nutrition, basic public health measures and medicine led to a decline in mortality from infectious disease and a rise in noninfectious, chronic, and degenerative diseases. This transition was accelerated by the invention of antibiotics, which even made some scientists predict the end of infectious diseases (Brown et al. 2011, 257).

¹⁴ 50 years in Britain (<https://smallpox1962.wordpress.com/>); 40 years in Serbia (<http://www.vreme.co.rs/cms/view.php?id=1041070>); 50 years in Poland (<http://www.n7ewsweek.pl/historia/ospa-we-wroclawiu--jak-piecdziesiat-lat-temu-zabijala-czarna-pani,95724,1,1.html>).

tural memory objectified in media texts, internet pages, movies¹⁵, etc. (see Assmann 2008).

According to Brown et al. history is now marked by the third epidemiological transition, in which many humans face a resurgence of infectious diseases previously thought to be under control (Brown et al. 2011). These authors primarily refer to (multi)antibiotic resistant pathogens and novel infectious disease that have been identified, as was the case with AIDS in 1980s in the United States. However, it should be noted that the third epidemiological transition could be also marked by re-emergence of infections like measles, whooping cough or polio. These are called forgotten diseases because they have been successfully kept under control by regular vaccination, especially in developed countries. Their re-emergence is particularly associated with human behavior which is influenced by similar set of cultural conceptualizations that were at work in Yugoslavian smallpox outbreak. Those imply people's ideas about what illnesses are common in contemporary developed countries, which shape risk perception, and lead to disregarding a certain communicable disease on the basis of its long absence. The best examples of how these ideas reflect in people's behavior are vaccine hesitancy and vaccine refusal. Beside vaccine safety concerns, assumptions underlying long absence of a disease seem to be an important factor that may influence a negative decision about vaccination.¹⁶

Discontinuity has an important part in a transitional process, be it epidemiological, socio-political or economic, as well as in many other aspects of social life. It is primarily an ideational process that marks a conceptual split with previous arrangement, whatever that might be. Thus, once the second epidemiological transition was in full swing, people felt that there had been a discontinuity with the period when death from some infectious diseases was almost certain. As shown in this paper, the effect of this idea is materialized in people's behavior, like disregarding and forgetting diseases, and in consequences that such behavior produces. If we accept this argument, a legitimate question arises: does this mean that the third epidemiological transition will produce a perception of discontinuity with the period when infections were not a significant menace and, more importantly, will that make people in developed countries more on the alert when it comes to communicable diseases? Not very optimistically, my guess is that the reasoning leading to significant changes in behavior would ensue only after infections, new and old, have persuasively demonstrated their ferocity. Either way, the bottom line is that culture, comprising conceptualizations, ideas and meanings, should be acknowledged as equally

¹⁵ "Variola Vera" is a Yugoslavian movie from 1982 that featured events in the 1972 outbreak (<http://www.imdb.com/title/tt0083275/>).

¹⁶ According to SAGE working group's report on vaccine hesitancy, vaccine complacency exists where perceived risks of vaccine-preventable diseases are low and vaccination is not deemed a necessary preventive action, see: Report of the SAGE working group on vaccine hesitancy 2014. Vaccine refusal has been around ever since the first vaccine was invented (which was Jenner's smallpox vaccine). However, it could be said that in the second half of the 20th century, the issue was influenced by the golden era of novel antibiotics, which provoked the idea of discontinuity with previous infection threats during the second epidemiological transition in developed countries.

important as historical and social factors for pondering and explaining shifts in the prevalence of epidemics and communicable diseases.

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