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Transnational medical spaces: Opportunities and restrictions[1]

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Abstract

How can we understand health-seeking behaviour, if the space in which this behaviour takes place stretches across borders? Is there more happening than just the increase in options? Based on examples from research on reproductive travels, medical remittances, the circulation of medicines in migrants' personal networks, and the revitalisation of local healing traditions through globally active NGOs, in this working paper we attempt to elaborate upon medical practices and therapeutic itineraries in a transnational framework. By looking at how people take advantage of different regulations and procedures in different national frameworks, we propose to think along the lines of therapeutic opportunity structures in order to bring in spatial theory as well as draw attention to new forms of exclusion and agency.

Key words: transnational spaces, therapeutic itineraries, health-seeking behaviour, reproductive travel, traditional medicine in India, medical remittances, medical travel, medical mobility, medicoscapes, reproscapes

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Contents

The travel of patients in search of affordable and appropriate treatment, the circulation of pharmaceuticals within personal networks, the spread of technologies and knowledge to different contexts, and the institutionalisation of international legal frameworks to regulate issues of health and healing are not new phenomena. However, their technology-driven intensification and expansion in tandem with increased opportunities for travel has led anthropologists to study these occurrences as examples of globalisation and transnationalism. We do not attempt to exhaustively cover these research areas in this paper; rather, we want to explore how we can think about therapeutic itineraries as well as medical opportunities and restrictions in transnational spaces, while most public health systems are organised at the national level.

Our starting point is the observation that new opportunities and restrictions are emerging through both the existing global economic stratification and the diverging legal frameworks and regulations in different nation-states: What is illegal and expensive in one national context is legal and affordable in another. Thus, national borders and regulations play a crucial role in creating new therapeutic opportunities and restrictions. The sheer existence of different regulations and economic disparities is, however, not enough. Patients and practitioners alike need to be aware of different options to develop imaginations and ideas about different national contexts. Here we take inspiration from political scientist Sidney Tarrow's definition of 'transnational opportunity space' as 'a dense, triangular structure of relations among states, nonstate actors, and international institutions, and the opportunities this produces for actors to engage in collective action at different levels of this system' (2005: 25). He describes the transnational as a complex space that consists of not only relations between states (horizontal relations), but also vertical relations between national, subnational, international, and non-state actors (2005: 8). Another source of inspiration comes from Stefan Beck's STS (Science and Technology Studies) approach, in

which he defines 'medical mobilities' as 'civil as well as scientific practices in the medical domain that *do relations* beyond the boundaries of states, societies or institutions by moving people, knowledge, ideas as well as biomedical "things" [*emphasis added*]' (Beck 2012: 357). Whereas transnational formations enable new forms of agency, we know for instance from research on surrogate mothers (Bharadwaj 2012), transnational care chains (Raghuram 2012), and pharmaceutical trials (Petryna 2007), how opportunities and mobilities are closely intertwined with exclusions and restrictions.

The central question we want to explore in this paper is what happens if we consider medical space[2] as a global assemblage of health care: a combination of opportunity structures of different therapeutic and medical options, and structures of exclusion, spanning national borders, emerging through the relations created by people's activities, the agency of medical products/technologies, and various national regulations, meanings and moralities. What role do national borders and regulations play? What remains the same, intensifies or decreases? How do global power geometries—the ways in which people are enabled or restricted by the effects of globalisation, depending on how they are positioned and situated (Massey 1996: 62)—impact therapeutic spaces spanning different localities? Of the many possible examples with which to discuss these questions, and in order to illustrate how people create and navigate transnational medical spaces, we have selected the cases of 'reproductive travellers' in Europe (Zanini, 2011; 2013), migrants who send medicine within their personal networks (Krause 2008; Raffaetà 2013a, in press), and the impact of NGOs on traditional practitioners in India (Alex 2010; 2012).

While these examples derive from our own research interests, they represent three key areas in which the emergence of transnational medical spaces is salient: new technologies; migration; and global organisational forms. Transnational spaces created by new medical technologies are the condition for, and the result of, medical mobilities (Beck 2012); transnational personal networks of migrants become channels for the circulation of medicines; and globally active NGOs revitalise local therapeutic traditions. The selection of medicines available over the counter, the procedures available in fertility clinics, the therapeutic knowledge considered worthy of support by NGOs,

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2 In this paper we use the terms transnational medical or therapeutic space interchangeably. Whereas 'therapeutic' has the advantage of including non-biomedical healing, it has the disadvantage of pre-supposing that somebody is 'sick' and in need of therapy. For many issues, such as reproductive problems, it is not a real therapy that is sought after, but a medical intervention. Drawing on the broad understanding of 'medicine' within medical anthropology, we refer in most cases to 'medical' spaces.

and the cost of treatment in one place compared to another, are all examples of and contingent upon the legal and economic make-up of these transnational therapeutic landscapes. Within the interstices of these spaces, people find room for agency, even though these spaces are structured by inequalities. We draw on De Certeau's work (1984: 36f) in suggesting that health-seeking behaviour is therefore best expressed as tactics or strategies in order to capture the highly situational character of people's attempts to find appropriate solutions (Last 1981) for their problems. Transnational medical spaces can therefore be perceived as being composed of both the agency of people looking for care and the specific opportunity structures that evolve from economic disparities (e.g. migrants can afford private treatment in one national context through money they have earned in another), differences in legal regulations (e.g. egg donation is legal in one state but not in another), and notions people have about particular nation-states (e.g. the orientalist imagination connected with Indian medicine as being closer to nature). Before we explain this in more detail, we will clarify the background of the terms at the centre of this paper.

The opening up of transnational medical spaces

The term transnationalism originally stems from the field of economics and was used to describe companies that act across national boundaries. It became a very successful line of research in the 1990s after being employed by anthropologists studying migration to describe how migrants maintain social bonds across borders (Basch, Glick Schiller and Blanc 1994; Levitt and Glick Schiller 2004). Transnational approaches challenged common understandings of bounded concepts such as the nation, community or society (Wimmer and Glick Schiller 2003). Notions of 'transnational social fields' and 'transnational spaces' (see Vertovec 2009) thereby denoted that this shift in perspective achieved more than just looking at different national contexts, but in fact enabled researchers to take into account the configurations of new forms of interaction beyond nation-states. In this vein, the term is often used interchangeably with 'global' and 'international'. Whereas all three terms are concerned with activities between and beyond states, they highlight different aspects of border-crossing activities and should be differentiated.

The concept of 'international' takes the state and the state's bounded space as its starting point and is mainly used to describe organisational bodies that are created

through agreements between states (Vertovec 2009: 3). By contrast, transnationalism signifies on-going connections between non-state actors whose relationships are constantly in flux, as they are made and remade by people's and organisations' interconnectivity (DeVereaux and Griffin 2006; Vertovec 2009: 3). Transnationalism is thus simultaneously concerned with the changing roles and nature of the state.

The term globalisation highlights the decentred and deterritorialised features of interconnectivity (Faist 2000: 210) and is often used to describe 'phenomena that affect the planet' (Glick Schiller 2005: 440). Capitalism as a global system is one example of such phenomena in that it is both the context and the medium of human relationships (ibid.; Tsing 2004: 4). Various authors have emphasised the rooted features of globalisation (Friedman 1997; Fog Olwig and Hastrup 1997) through the metaphors of friction (Tsing 2004), connection (Amselle 2001), disjuncture (Appadurai 1990) or ethnoscape (Appadurai 1996). Yet in discussing therapeutic opportunity spaces, we find it useful to follow authors who speak of 'transnational spaces' rather than global flows. In Thomas Faist's (2000) conceptualisation, 'transnational spaces' anchor experience to specific places but at the same time emphasise connectivity to other places, global meanings, and political regimes:

> Space here does not only refer to physical features, but also to larger opportunity structures, the social life and the subjective images, values and meanings that the specific and limited place represents […] Space has a social meaning that extends beyond simple territoriality (2000: 45).

This conceptualisation resonates with Massey's (2005) description of space as a lively and open-ended 'space-time' (see also Ingold 2011: 14) rather than a lifeless and abstract dimension, and with her understanding of localities as emerging from intersecting trajectories. Localities and places, in this understanding, gain their specific quality through their relations to other places. This idea of space as intersection and as not opposed to networks and flows is, in our view, helpful in thinking about global and transnational medical processes as grounded in concrete sites.

Different attempts have been made to come up with terms that capture these aspects in regard to medical knowledge and therapeutic practices. They can be grouped under three different perspectives. The first one follows thinking in landscapes, inspired by Appadurai's notion of scapes (1990). In one of the first definitions of 'medicoscapes', Viola Hörbst and Angelika Wolf described these as:

> […] landscapes of individuals as well as national, transnational, and international organisations and institutions, and heterogeneous practices, artefacts and things, that are con-

nected to different policies and regimes of medical knowledge, treatments, and healing all around the world. While concentrated in certain localities, medicoscapes connect locations, persons, and institutions via multiple and partially contradicting aims, practices and policies (Hörbst and Wolf 1995; Hörbst and Wolf 2012: 4).

Other terms include 'healthscapes' (Clarke 2010a: 105-106; 2010b)[3] or 'reproscapes' (Inhorn and Shrivastav 2010), denoting the transnational field of institutions and practices related to reproductive medicine.

Another strand of research foregrounds the connections created by activities of people and the different medical mobilities resulting from transnational spaces. Phenomena such as people searching for cures in health facilities located abroad or the role of transnational expert advice through telemedicine services (Cartwright 2000), have been grouped under terms such as 'medical tourism' (Connell 2006, 2011; Mainil 2010),[4] medical 'exiles' (Inhorn and Patrizio 2009), 'transnational therapeutic itineraries' (Kangas 2010), transnational health care (Mainil 2012), cross-border patient mobility, cross-border health care (Glinos et al. 2010), or transnational health (Thomas 2010). Similar terms are medical travel (Sobo 2009), or 'healing holidays' (Naraindas and Bastos 2011).

A third perspective focuses on practices, procedures and protocols that bring together heterogeneous elements, as expressed in the Deleuzian notion of 'assemblages' (Deleuze and Guattari 1987: 71). Drawing on Karen Knorr-Centina (2009), Aihwa Ong and James Collier (2005), Michi Knecht, Maren Klotz and Stefan Beck prefer thinking along the lines of 'global forms' (2012: 15ff)[5] over scapes, because in their view the 'spatial colouring' (2010: 17) of scapes evokes coherence and does not capture the dynamic of decontextualisation and recontextualisation of medical knowledge around the globe. However, this assessment might be due to a too static understanding of space.

Beck's suggestion to consider medical mobilities as a 'networked topography' (Beck 2012: 362) arising from global biomedical platforms (Keating and Cambrosio 2000), is much closer to an understanding of space that departs from looking

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3　Gold and Clap use the term healthscape but refer to an 'individual's subjective vision of a landscape's medical resources and institutions' (2011: 93). See also Hörbst's earlier writings on medical landscape (2008).

4　The term 'medical tourism' has been criticised as trivialising socio-economic inequalities that underpin most transnational movements related to health problems.

5　Global forms refer to knowledge formations that affect everybody around the globe, see e.g. Sarah Franklin's 'global biological' (2012).

at space and place as bounded entities and instead regards them as emerging from networks of interactions (Massey 2005: 99). Transnational medical spaces and the resulting opportunities and restrictions are thus not only about patient-practitioner interactions across borders and the exposure to global therapeutic knowledge, but also about their situatedness in concrete places within nation-states and global power geometries (Hörbst and Wolf 2012; Massey 1996; Smith 2001:106ff).

Drawing on these various attempts to rethink the localisation of medical knowledge and practice, we propose an understanding of transnational medical spaces that acknowledges the pertinence of global forms but emphasises the horizons of different actors in specific localities. Attention to the specific spatial constellations can help to describe the concrete transnational therapeutic itineraries of people in search of care (Kangas 2010). We need to keep in mind, though, that transnational medical spaces include new possibilities for work and cure but also rest upon and deepen socio-economic stratifications and emphasise legal distinctions between countries (Langwick et al 2012; Sobo 2009; Whittaker, Manderson and Cartwright 2010), as the following examples from Giulia Zanini's research show.

Transnational reproductive spaces

Caterina and Mario are an Italian couple who have experienced reproductive disruption due to particular medical conditions: Caterina was diagnosed with severe endometriosis[6] at the age of 21, while her husband was found to have a chromosomal translocation.[7] They underwent many attempts of assisted reproduction before Caterina became pregnant in the Czech Republic via a third-party sperm and egg donation treatment.

Feeling abandoned by the Italian state (Zanini 2011), which forbade the reproductive practices that might fulfil their parental project, Caterina and Mario eventually built their own dynamic reproductive trajectory beyond national borders which, before the last successful treatment, included various procedures in different loca-

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6 Endometriosis is 'the presence of fragments of endometrial tissue at sites in the pelvis outside the uterus or, rarely, throughout the body (e.g. in the lung, rectum, or umbilicus).' ('Endometriosis', Martin, 2010).

7 Chromosomal translocation refers to 'a type of chromosome mutation in which a part of a chromosome is transferred to another part of the same chromosome or to a different chromosome. This changes the order of the genes on the chromosomes and can lead to serious genetic disorders.' ('Translocation', Martin, 2010).

tions: pre-implantation genetic diagnosis (PGD),[8] sperm donation,[9] sperm and egg donation in Belgium, embryo donation[10] in Spain, and sperm and egg donation in the Czech Republic. The fertility centre in Belgium was initially selected after an intense evaluation of possible options abroad on the basis of information acquired through informal channels like patient associations, websites and online communities as well on the suggestion of Italian doctors and after direct contact with centres. The motives that led Caterina and Mario to change reproductive procedures and destination countries included unsuccessful treatments and low chances of success, mistrust in the fertility centres, waiting lists, costs, and a varying understanding of reproduction in each respective location.

Caterina and Mario chose to be treated outside Italy after having been told that their medical conditions would require either a PGD or third-party donation for the reproductive process to be successful. In 2005, when they began their assisted reproductive experience, these procedures were forbidden in Italy. Like many other Italian reproductive travellers, who constitute one-third of the overall reproductive travellers in Europe (Shenfield et al. 2010), Caterina and Mario mentioned legal reasons as the primary motivation for crossing national borders. Nevertheless, as the last study conducted by the Observatory of Procreative Tourism (Osservatorio sul turismo procreativo, 2012)[11] shows, almost half of the Italian residents seeking reproductive assistance abroad are currently undergoing treatments that are not officially banned within their national territory; rather, these residents perceive the reproductive care abroad to be better. Indeed, Italian couples react not only to an ambiguous legal situation in Italy, but also to both a distrust of local reproductive care and feelings of non-recognition of their reproductive health needs by the Italian state, the Catholic Church, and the public discourse in their home country.

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8 Pre-implantation genetic diagnosis (PGD) is 'a diagnostic procedure carried out on embryos at the earliest stage of development, before implantation in the uterus.' ('Pre-implantation genetic diagnosis', Martin, 2010).

9 Sperm donation refers to the use of sperm from a donor who does not play a role as an intended legal parent to the resulting child.

10 Embryo donation refers, in this case, to the transfer of an embryo that was produced during previous treatments by other patients and then left for donation. In contrast to double-donation, in embryo donation the embryos are always cryo-preserved.

11 The Observatory of Procreative Tourism (Osservatorio sul Turismo Procreativo) is a project started in 2005 by the Italian CECOS, Centre d'Etude et de Conservation des Oeufs et du Sperm (Centre for Study and Preservation of Eggs and Sperm) that aimed to monitor the effects of law 40/2004 in terms of cross-border reproductive care.

Caterina and Mario's reproductive trajectory provides insight into what health-seeking behaviour means in a transnational context: Their 'transnational quests for conception' (Inhorn and Patrizio 2009; 2012) are shaped by legal, medical, economic, pragmatic and cultural matters. The couple's experience demonstrates the on-going negotiation of needs and offers, which does not end until reproductive plans are either fulfilled or abandoned. In entering differing legal contexts, reproductive travellers also resort to various reproductive procedures which address the many aspects of their reproductive trajectories, including legal restrictions and choices about how to conceive (first considering sperm donation, then sperm and egg donation). When trust in a given foreign fertility centre turns into distrust, as in the case of Caterina and Mario, reproductive travellers must again analyse all possible options in order to find a new, suitable reproductive solution. Both the costs and the pragmatics of reproductive travels—including geographical distance, waiting lists, transporting medications, communication with practitioners, and accommodation—are taken into serious account and often make the resulting choice extremely arduous (Inhorn and Patrizio 2012). It is through these intersecting arrangements, which represent more than just the addition of diverging options in different countries, that transnational medical spaces, enabling new therapeutic agencies, evolve.

Therapy networks and medical remittances

Transnational migrants and their usage of multiple health systems (Kane 2012; Murphy and Mahalingam 2004; Tiilikainen and Koehn 2011), relying on their personal networks and their knowledge about, and entitlement to, more than one national health system, reveal other aspects of transnational medical spaces. We use the term 'therapy networks' because the concept of network expresses the situational character of the support received, without pre-supposing a bounded community (Krause 2008).[12]

A rich literature on this topic has evolved, particularly in regard to Mexican migrants in the US. Chavez (1984) described how Mexicans living in the US cross the border into Mexico from San Diego in order to consult familiar medical doctors or buy medicine, mainly biomedical, which they carry back to the US. The author points out, however, that this health-seeking behaviour is only open to those

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12 The term is equally useful for therapeutic trajectories that do not entail the crossing of borders.

migrants who can cross the border with regular papers. Subsequent research has focused on Mexicans living in the US crossing the border into Mexico to give birth (Guendelman and Jasis 1992), the strategies migrants employ to circumvent a lack of insurance and the high cost of medical care in the US (Seid et al. 2003; Wallace, Mendez-Luck and Castaneda 2009), and migrants' 'nostalgic' yearning for particular practices (e.g. Bergmark, Barr and Garcia 2008). Recent studies (Horton and Cole 2011) confirm that, in particular, it is the disparity between the costs of private health care in Mexico and the US that causes people to cross the border: Private services that are too expensive for most Mexicans living in the US are affordable in Mexico.

These example provides further evidence that, similar to what we have discussed above in regard to reproductive medical migration, health-seeking tactics become redefined in regard to politics in each locality. Reproducing an argument brought forward by Lane and Inhorn (1987) decades ago, albeit in a slightly different form, we posit that it is not explanatory models that drive people to adhere to specific practices, but questions of status reproduction and access based on economic means. Within the context of transnational migration this means that transnational structures of agency are brought about by what Boris Nieswand has called the 'status paradox' of transnational migration (Nieswand 2011: chapter 5): People gain a higher status in the home context, which allows them, for instance, to consult private medical care, through the income they gain with dirty and dangerous work in the migration context.

Along with people, medicines travel too, and can be considered a special kind of remittance, or, more properly, 'medical remittances' (Kane 2012; Pribilsky 2008). This term indicates the circulation of medicines within personal networks, which also rely on the disparities in income and different therapeutic options available in the respective national and social context. The sending of medicines is part of a multi-directional exchange that flows back and forth between the home and the host country, but also encompasses previous destinations of migrants (Beijers and de Freitas 2008; de Freitas 2005; Krause 2008; Thomas 2010). Roberta Raffaetà, drawing on her research in Italy with migrants from Morocco and from the southern coastal region of Ecuador, suggests clustering the trajectories of the flows according to the different needs they meet: cost, efficacy, and care.

In her research, Raffaetà (2013a) found that migrants evaluate the disparity in costs for drugs and medical interventions and buy medicines where the prices are most reasonable. Moroccans and Ecuadorians interviewed by Raffaetà bring generic drugs, such as pain-killers or anti-inflammatory medicines, from their holidays in

their home country back to Italy, or ask relatives to send such drugs because they are much cheaper there. Similarly, Krause (2008) found in her research with migrants from Ghana in London that people without legal status rely on antibiotics and other pharmaceuticals sent from their home country, in case such drugs are not available over-the-counter in Europe (see also Thomas 2010 for similar results). Furthermore, when migrants with secured status travel home or are visited by relatives (such as in the case of people travelling between Morocco and Italy as well as between Ghana and London), bags and suitcases are filled with essential oils, soap and creams, used for the treatment of skin and hair problems. These examples indicate the need to conceive of therapy networks as spanning national borders (Krause 2008), as opposed to being limited to one nation-state.

Another interesting finding from Raffaetà's and Krause's research concerns the incorporation of different therapeutic professionals based in various national contexts within therapy networks. Spiritual experts, as well as biomedical doctors, pharmacists and herbalists, procure medicine and are incorporated into migrants' networks as advisors and facilitators in therapeutic decisions. Raffaetà found that Ecuadorians and Moroccans not only consult their doctors in Italy about the health problems of family members in their home country, but also arrange for these relatives to see the doctor in person when they come for visits. Depending on the trust between the doctor and the migrant, this caring relationship can extend through time and space. Some Italian doctors continue to provide drug prescriptions for returned relatives that are then sent to Ecuador or Morocco, as in the following case:

> Carla is originally from Ecuador and has lived in Italy for 13 years. She is married to an Italian man with whom she has a child. She is well integrated into the life of the village, nestled in the Italian Alps, and was one of the leaders of the local association of Ecuadorians. When she gave birth, her mother came for a visit. Carla's mother has had a problem with a varicose vein in her leg for many years, but never thought to seriously take care of it. Once, while accompanying Carla to the general practitioner (GP) for a regular visit, the doctor also had a look at her leg. Carla's GP prescribed a visit to a specialist for the mother, who, one year later, had surgery on that leg in the local hospital in Italy. Now, Carla's mother is fine and back in Ecuador but must follow up the surgery by taking a specific kind of medicine. Carla's GP prescribes the appropriate drugs, Carla buys them in Italy, and then sends them to her mother in Ecuador.

Two distinct and opposite flows are at work in this vignette: The first is from a global south country to a global north one (the Ecuadorian woman seeking help for her leg in Italy), and the second is from a global north country to a global south one

(medication being transported from Italy to Ecuador). A similar pattern, although in the realm of reproductive travel, can be found in Zanini's work on reproductive travellers:

> Ariella, a 40-year-old Italian woman, had been married to Marcello for many years when they decided to have a child together. After an unsuccessful IVF[13] treatment in Italy, they tried third-party egg donation[14] in the Czech Republic. Ariella's Italian gynaecologist was critical of the way in which the embryo transfer was being prepared by the Czech specialist and proposed that she herself take responsibility for the preparatory treatment for transferring the remaining frozen embryos before Ariella left for the Czech Republic. Ariella accepted this and negotiated with the Czech fertility centre to undertake the preparatory treatment in Italy, before leaving for the transfer.

By negotiating a tailored service with the fertility centre in the Czech Republic, Ariella built her own reproductive trajectory by putting her therapies and reproductive experience in the hands of different doctors in different countries at different moments in the process. Her entire reproductive experience can therefore be regarded as a self-arranged, creative combination of national and transnational reproductive care.

These examples of transnationally arranged therapy networks show how migrants and reproductive travellers make use of the interstices created by economic inequality between countries, navigate among different degrees of trust in practitioners, and take advantage of gaps between regulations. Flows can thus be multidirectional, which also applies to the *perceived efficacy* of drugs. A common explanation for justifying the transnational movement of drugs, irrespective of their origin, is that they are identified as 'more powerful'. This happens even when the active ingredient in the medication is exactly the same in the sending and receiving countries, or when the medicine differs only in name, packaging, and shape (pills, drops, powder). The assumed difference in efficacy is thereby often related to the national or cultural context in which a drug is produced.[15] One such association between production

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13 In vitro fertilisation (IVF) refers to the 'fertilization of an ovum outside the body, the resultant zygote being incubated to the blastocyst stage and then implanted in the uterus. […] The ova are mixed with spermatozoa and incubated in a culture medium until the blastocyst is formed. The blastocyst is then implanted in the mother's uterus and the pregnancy proceeds normally.' ('In vitro fertilization', Martin, 2010)

14 Egg-donation or oocyte donation is 'the transfer of secondary oocytes from one woman to another.' ('Oocyte donation', Martin, 2010).

15 On the relation between assumed efficacy and meaning, see the classical studies on the biographies of pharmaceuticals, Van der Geest and Whyte (1989); Van der Geest, Whyte and Hardon (1996).

context and efficacy is the imaginary of modernity, as in the case of Ecuadorians who send drugs from Italy to relatives in the southern coastal region of Ecuador with the assumption that biomedicine from Europe is more powerful than locally available drugs. The reverse is also true; for example, many Moroccans who have experienced severe discrimination in Italy consider Moroccan medicines to be more powerful than Italian drugs, because these Moroccan treatments are grounded in a context familiar to them, one rich in trust-based relationships that give patients the perception of being cared for.

Indeed, the desire for the best possible *care* is a crucial aspect that determines from where to where drugs will move. The emotional attachment to medicine representing the home context is expressed in what Jason Pribilsky has termed 'the social efficacy of traveling medicines' (2008), which is analogous to other expressions of feelings of belonging, such as cooking (Mata Codesal 2008). In his research on remittances among people from the south-central Ecuadorian Andes who live in the US and Western Europe, Pribilsky found that *energías*, which include mass-produced natural medicines, locally gathered herbal bundles, homemade syrups and biomedical pharmaceuticals, are among the items most commonly sent from the Andes to individuals in other countries (2008: 13). He regards medicines as reciprocal gifts from those who stay behind and receive money from family members living abroad (2008: 14). The unidirectional sending of money is thereby embedded 'in a more affective exchange' (2008: 14), and the *energías* become tokens of care and love.

In the context of discrimination, as experienced by West and North African migrants in Europe, the meaning of the national context from which care or medicine stems and the assumed efficacy of medication can become highly charged. In interviews Raffaetà conducted with Moroccan migrants, her interlocutors reported experiences of racial discrimination and non-understanding by Italian medical staff. One woman told Raffaetà of a traumatising medical encounter in which she, as a Moroccan, was clearly negatively regarded by medical staff as part of a certain group of women, all of whom are perceived as veiled, overweight, ignorant and entirely submissive to their husbands. She did not feel as though her identity was recognised or welcomed. Moreover, according to these interviews, the Italian health system does not take into proper account specific medical needs of certain groups, like circumcision. Given that this practice is rather rare among Italians, Moroccans wishing to circumcise their children may have to wait up to a year before being called in for the medical procedure. As a result, some Moroccans decide to circumcise their children while visiting the home country, thereby adding the advantage of a short waiting list

to the familiarity with the medical staff and the mutual implicit understanding of gender and body conventions that the home context brings with it.

These snapshots from our fieldwork show the complex interplay between cost, efficacy, care, and the different perceptions expressed by the various actors. They further highlight that it is the very specific meaning embodied in medicines within a particular health situation and geographic context and the sociality attached to them that make medicines or medical practices important for people (Krause 2008; Thomas 2010; Van der Geest and Whyte 1989; Whyte et al. 2002).

The examples presented in this section furthermore show how situatedness in transnational therapeutic opportunity spaces defines not only the resources and structures available in places, but also the different kinds of medical issues that are brought forward. Transnational medical spaces are inhabited by actors who may be related to each other according to different power and economic relationships. People may enter transnational trajectories as patients and/or clients, according to the type of services they seek and the way in which cultural, political, social and economic resources are mobilised by different actors who participate in providing and approaching them.

Inspired by Annemarie Mol's compelling rehabilitation of the figure of the patient as someone looking for care in biomedical contexts (Mol 2008); by Linda Hogle's elaborations about patients being transformed into health and drug consumers (Hogle 2002); and by Charis Thompson's sketchy distinction between ' "client" patients' and ' "employee" patients' in fertility clinics (Thompson 2005), we acknowledge the complexity of people's economic, social, cultural, political and emotional positioning within health care global services. The very nature of the embodied condition which people deal with when accessing transnational medical opportunity spaces affects the way in which they approach healing practices, pharmaceuticals, and medical technologies as patients, clients and/or consumers. The examples that we offer in this paper show how very different medical and health conditions and needs may lead people to find different kinds of responses in specific self-defined transnational medical and healing spaces, where the existence of given national medical and healing structures encourages people's engagements across borders.

Transnational institutionalisation and its entanglements

Instances of transnational medical spaces, like reproductive travels and the transnational health-seeking behaviour of migrants, have to be analysed in light of economic, political, and legal transformations. Interestingly, some of the first agreements between the institutions of national governments were closely connected to the realm of health. Early forms of international health policies began in the middle of the 19th century with the first sanitary conference in Paris in 1851. Eleven such conferences had been held by1903, originating in a growing state consciousness of the need to monitor communicative diseases beyond and across borders by establishing 'a unique forum for the international exchange of ideas between medical administrators and medical scientists of different nations and cultures' (Howard-Jones 1975: 9). Following worldwide outbreaks of cholera and the discovery of the contamination routes of diseases in the movements of pilgrims or colonial staff and animals (Arnold 1996: 286; Dodier 2005), international bodies were established at the beginning of the 20th century, effectively bringing forward an early version of global health policies.

Much has happened since then, including the founding of the World Health Organization (WHO). Recent transformations have set the stage for the current trend towards health commodification on a global scale. Whittaker, Manderson and Cartwright (2010: 338) observe that the involvement of the United Nations Conference on Trade and Development within the General Agreement on Trade in Services (GATS), approved in 1995 by the World Trade Organization (WTO), provided the legal framework for the liberalisation of health care in an international arena. Since then, several international accreditation schemes have gained prominence.[16] These international schemes grant credibility to various health facilities located around the globe, assuring the quality of their services in combination with lobbying bodies uniting diverse stakeholders, such as insurers, policy-makers, and the tourism/service industries.[17]

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16 Whittaker et al. (2010: 338) list, for example, the Joint Commission International (JCI), the Australian Council on Healthcare Standards International (ACHSI), DNV Healthcare Inc., Accreditation Canada International (ACI), the Trent Accreditation Scheme (TAS), and the International Organization for Standards (ISO).

17 The Medical Tourism Association, the International Medical Tourism Association and HealthCare Tourism International (cf. Whittaker et al. 2010: 338).

The increasing number of reproductive travellers across Europe has recently spurred an attempt at transnational praxis and policy harmonisation. The Good Practice Guide (GPG), developed in April 2011 by the European Society for Human Reproduction and Embryology (ESHRE) for health professionals dealing with cross-border reproductive patients, was considered necessary on the assumption that cross-border reproductive care will eventually have very important local consequences. For instance, if a treatment abroad is not conducted well, the side- and long-term effects are usually treated in the home context. Nationally organised health-care bodies are therefore very interested in securing transnationally valid standards. The GPG provides suggestions for centres and physicians treating reproductive travellers and helps 'regulators and policy-makers create a framework to enable centres to abide by these rules' (Shenfield et al. 2011).

In more general terms, the European Commission presented a proposal in July 2008 which eventually turned into a *Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare*, issued on 9 March 2011 and which EU countries must nationally implement by 25 October 2013. The proposal followed a discussion on 'patients' mobility' that started around 1998, when the European Court of Justice (ECJ) added several principles to the already existent Regulation (EEC) No 1408/71 from the 14 June 1971 Council on the application of social security schemes to employed persons and their families moving within the Union. This regulation stated that patients treated during their stay in another Member State should be entitled to the same benefits as patients insured in the host Member State. The ECJ recognised that health care, being subject to remuneration, was to be considered a service and that EU provision of free movement of services therefore applied to health care as well.

This directive aims to regulate the flow of patients, technologies, doctors, money and information within EU territory, particularly focusing on the need to protect patients' right to access health care in EU countries, coordinate reimbursement policies, and improve cooperation among health professionals. The last point also includes the promotion of e-health services, which allow health professionals in the same field to establish close networks in order to improve reciprocal knowledge and cooperate in both diagnostic and therapeutic acts. The appearance of such a directive demonstrates that supranational[18] institutions like the EU feel prompted to rec-

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18 'Supranational' is a legal term that refers to the existence of a regulation or a body which has more power than states and that nation-states have agreed to respect.

ognise the growing tendency of seeking health care in other EU countries and to respond by providing common measures for Member States.

The intervention of the EU in the management of cross-border health care thus provides regulation concerning a phenomenon arising from an existing geopolitical and economic setting that favours the transnational flow of people and services among Member States. Nevertheless, as Commissioner of Health Androulla Vassiliou promptly emphasised in her video presentation of the directive, such a provision does not aim to constitute a unified health care system, but rather to provide a legal framework that allows European patients to move and seek treatments within EU territory by respecting the variety of national health care systems. In particular, the Commissioner of Health underlined that Member States 'remain fully responsible for organising and financing their home system in accordance with their traditions and their needs.'[19] This last statement reveals the difficulty inherent in any attempt to transnationally regulate a sphere so dominated by national interests.

Transnational institutionalisation processes are also embedded in wider interests, such as those of the global pharmaceutical industry complex. Lobby groups of CAM (complementary and alternative medicines) have pointed to this fact in regard to requests by national governments and the EU to test alternative medicines for their efficacy according to biomedical standards. Following the European Directive 2004/24/EC on traditional herbal medicinal products, all traditional and herbal medicines sold in the EU since 2011 must be fully licensed, a very expensive process which cannot necessarily be instituted by smaller companies. The directive was initially developed due to concerns about patient safety and the fact that many products were sold as foodstuffs. Until now, many EU Member States have had pragmatic national arrangements permitting herbal medicines to remain on the market, especially when their purveyors can provide evidence of 'traditional use'. This leaves room to manoeuvre, in particular when it comes to medicines sold as food supplements in shops set up by migrants, as Krause found in her research in London (2008; 2011).

It is against such a backdrop that ethnographic research is needed in order to describe how transnational agreements and legal treaties concretely play out in local dimensions and the frictions that arise in these global assemblages. Recent work by Viola Hörbst on the introduction of assisted reproductive technologies (ARTs) in West Africa, for instance, highlights the importance of professional transnational networks in bringing these technologies to the region (Hörbst 2012a; 2012b). She

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19 **http://ec.europa.eu/health-eu/news/streaming/crossborder/crossborder_en.htm**
   (Last accessed 24/06/2012).

describes how medical know-how and skills as well as technological and pharmaceutical equipment are introduced into the medicoscapes with transnational reach of Bamako via the personal networks of one Malian doctor who studied abroad. In Mali, there is a high demand for fertility treatments but no national regulation of ARTs, and it is difficult for patients to obtain such treatments. Moreover, the topic does not attract philanthropic organisations, political activists or multilateral governmental programs. The introduction of ARTs in Mali is therefore left up to individual doctors. Through a transnational lens, Hörbst is able to show the concrete ways in which biomedical procedures are entangled with national and transnational regulations and moral evaluations, and how local reproductive policies depend on, and enter into friction with, transnational and international reproductive governance.

In a jointly written article Angelika Wolf and Hörbst (2012) emphasise this point even more clearly by comparing ART and HIV-related anti-retro-virus treatment (ARV) provisions in Africa. The treatments respond to two very different moral and legal dimensions which both express the perspective of transnational entities and their local counterparts. The distribution of ARVs is transnationally well structured and involves institutionally organised transnational groups, the pharmaceutical industry, multilateral governmental programs and activists, while ART distribution in comparison is loosely organised and relies on individual initiative. The different forms of the interactions within a transnational medical space, in the end, have very practical consequences for the people in Mali.

Power, meaning and imaginations

As the comparison of ART and ARV shows, meanings are linked to specific cultural domains, supported by different actors and are thus entangled in legal regulations and transnational flows. Research by Roberts (2006) and Storrow (2011), among others, demonstrates the differences in the impact the Catholic Church has on ART depending on the national context. In Italy, the Church's influence has resulted in one of the most restrictive perspectives on ARTs in the world. Assuming that life starts with conception, the Roman Catholic Church condemns reproductive technologies of any kind (including contraception, abortion, IVF, gamete and embryo donation, and surrogacy[20]) (Fenton 2006; Hanafin 2007). Interestingly enough, a very

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20 Surrogacy refers to 'an arrangement in which a woman ("the carrying mother") agrees to bear a child and to hand over that child, at birth, to another person or persons ("the commissioning parents"). The carrying mother may have been artificially inseminated

different approach characterises other countries in which the majority of citizens declares themselves to be Catholic. One case in point is Spain, which, contrary to Italy, issued its first law permitting and regulating assisted reproduction in 1986 and boasts of of one of the most liberal sets of laws in Europe.[21] This clearly shows how the impact of transnational organisations such as the Roman Catholic Church[22] can be evaluated only in concrete local configurations and not generalised on a global scale. Depending on athethe country's history of church/state entanglement and the political constellations in the specific social sites, different opportunity structures and different moral evaluations evolve. Transnational therapeutic itineraries are thus subject to situated evaluations of differences in legal regulations and by the perception that patients have of the local offer and the other existing options.

The production of meanings and imaginations by transnational actors, such as faith-based organisations, can be further illustrated by the case of Traditional Medicines from Asia and the role played by transnationally operating NGOs. In her work, Gabi Alex (2009) shows that NGOs set their own health projects according to their organisation's economical and ideological orientation (see e.g. Markowitz 2001; Mosse 2005, 2011; Tishkov 2005). By communicating and mixing with the facilities and practices of the area in which they establish themselves and by bringing along biomedical equipment and infrastructure, the NGOs contribute to the formation of therapeutic syncretism. They also take part in re-evaluating marginalised forms of therapeutic knowledge. Alex (2009) found how the globally circulating rhetoric of tradition and modernity reifies common-sense concepts about what it means to be modern or traditional in the countries these NGOs operate in. NGOs that intend to strengthen traditional practices and values of disadvantaged autochthonic communities (or even defend them against a hegemonic culture) focus on so-called indigenous groups and emphasise the field of traditional knowledge and skills of which medical knowledge, such as the medical properties of plants or minerals, forms an important part. Medical practices in many areas of the world are conceptually linked to ethnic

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with the sperm of the commissioning father or donated gametes from the commissioning parents may be used to create an embryo that is then carried to term by her.' ('Surrogacy', Law and Martin. 2009)

21 The current law was passed in 2006.

22 Here we are speaking about the Roman Catholic Church as a religious institution and not looking at its peculiarities as a religious state (the Vatican). Surely the power of the Vatican depends also on its power as an independent state, but the way in which it intervenes in reproduction does not always pass through its national institutions (i.e the diplomats) but rather through other channels (i.e. priests, important bishops, the pope's writings to the faithful, etc).

or religious groups from which particular forms of authority and knowledge are deduced; these practices serve as a kind of platform where all kinds of identities can be expressed and negotiated (Crandon-Malamoud 1991; White 2001).

Alex (2009) demonstrates how in Tamil Nadu, South India, the figure of the healer and the symbolism and cosmology of the medical ideology is linked to wider discourses in which powerful dichotomies such as tradition and modernity, nature and culture, past and present are evoked and used to make statements about the relationships between individuals and groups. Alex describes how healers from the peripatetic community of the *Narikuravar* have offered their services as wandering healers for many decades, but some have recently begun to work full-time as professional healers, treating their patients in elaborately decorated healer shops. These shops are organised in the fashion of a doctor's practice and are advertised through mass media, such as local TV channels or newspapers. Even though a considerable number of these healers have started to attend Siddha or Ayurveda courses on the private education market and have further adapted and borrowed elements from other healing practices and traditions, their self-representation stresses the inherited traditional character of their skills as well as their strong connection to the 'forces of nature'. This is accomplished by drawing on images from a romanticised past which portray the *Narikuravas* as hunters living in the forest and leading a simple natural life.

By means of a re-evocation and representation of a lost tradition through both material culture and a therapeutic logic that is legitimised with the traditional knowledge of the healing powers of nature, the healers posit themselves in contrast to images of modernity. The reification of tradition and folklore provides a wider context and movement within India in which this can be seen; communities and groups are beginning to dig out their traditions and display them in museums or archives, often with the support of NGOs or folklore institutions. This self-representation as a 'tribal community' can be seen as part of the much wider identity politics of the *Narikuravas* (as well as of numerous other communities in India). In this context of state-based positive discrimination policies for disadvantaged groups and development schemes from NGOs, claims of indigenousness and eligibility for support are not accepted per se, but are dependent upon the ability to demonstrate a specific group status, in this case that of the 'scheduled tribe'. Returning to Tarrow's idea of an 'opportunity space' (2005), medical traditions are shaped in a field where medicine as a cultural property also becomes a cultural characteristic distinguishing communities from the mainstream society and might thereby be able to contribute to the recognition of the status of a tribal or indigenous community in the political field.

A similar process is illustrated by Raffaetà (2013b) regarding how complementary and alternative medicines (CAM) are interpreted in Italy. In the second half of the 20th century, Italy, like other European countries, embraced a 'new medical pluralism' (Cant and Sharma 1999), described as a state-led system of legal CAM services, even if CAM were mostly provided by private practitioners and only constituted a part of the public health system in some regions. Since 1991, CAM use in Italy has doubled (Menniti-Ippolito et al. 2002). CAM's global spread, however, displays specific features in the Italian context, where the diversity offered by CAM is perceived as stemming from the concept of 'naturalness,' romanticising the past and valorising fixed gender roles, folk wisdom, and socio-biological authenticity. The concept of 'naturalness' is used by health-seekers to bring together different understandings of health and healing practices, thus providing a symbolic and idealised resource by which to orient themselves among global flows of therapeutic traditions and face an uncertain and rapidly changing present.

The commodification of pharmaceuticals and therapeutic traditions as ethnically or regionally marked products is even more apparent in the emerging medicoscape of the internet. In online marketing for medicines and medical practices, cultural meanings and imaginations are alluded to in order to convince shoppers of the power of a drug or treatment. The internet, indeed, represents a wide 'medical space' with huge potential to 'reload' health-seeking behaviour and therapeutic trajectories. Various studies, however, have shown that people's imaginations and prior knowledge direct their online search for support and information (Brijnath 2010; Gherardi 2009; Khare 1996). For instance, Brijnat and Ahlin (2011), comparing an Indian and a Slovenian online health forum, observe that people draw on their offline experiences when accessing the internet (see also Gherardi 2009). Global platforms, such as online health forums, are shaped and constrained by a stereotypical and essentialising appropriation of what counts as local and national culture. People accessing the Indian online health forum, for example, are either Indian or attracted by India's history of medical pluralism and disillusioned or sceptical about biomedicine (see also Brijnath 2010; Khare 1996). Similarly, in the case of transnationally travelling to access reproductive technologies, people's movements can be regarded as grounded in '[the] expression of fantasies regarding foreign lands, nature, friendly locals, and even gendered interaction patterns in consuming offshore care' (Sobo 2009: 333). These examples point to some important factors which limit the potentiality of transnational medical spaces. Local power articulations and local meanings/imaginations constrain the possible choices.

Conclusion

Poststructuralist thinking, theories of globalisation, and insights gained from the study of transnational phenomena challenged previous approaches to multiplicity, which tended to identify separate closed systems within national boundaries. The different ethnographic fields covered in this article—reproscapes; medical travels; and the migration of people, medicines and technologies, together with the action within transnational dimensions such as the internet and of transnational institutions such as the EU, the Catholic Church, and NGOs—show how therapeutic trajectories and health-seeking behaviour are to be analysed as taking place within transnational medical spaces of opportunities and exclusion, describing many different ways of being patients or clients.

The interaction between national and transnational fields, however, is far from predetermined: Many elements contribute to forging its shape along the way (legal, symbolic, moral, economic, social), and only thick layered ethnographies can reveal the specific political configurations implied. In this paper we have attempted to point to aspects of global assemblages of health care, revealing the 'power geometry of time-space compression' (Massey 1994: 148), because actors and social groups are differently positioned and therefore have unequal control and access in relation to flows and interconnections.

In this working paper we could only present snapshots from the research we have undertaken. But the variety of examples from our respective fieldwork has shown that therapy networks gain a transnational dimension and must therefore include a mixture of people, not only close kin and friends but doctors and health professionals as well. This is also true for locally restricted therapy management groups. But our examples highlight how the embeddedness of people in more than one national context and their knowledge of diverging regulations in different health systems can be best captured through spatial analysis.

Beyond the simple facts that medical mobilities 'do relations' (Beck 2012: 357) and health-seeking tactics/strategies stretch across national boundaries and include therapies in different countries, the instances of reproductive travellers, migrants and practitioners from low-status castes in India have furthermore demonstrated that meaning is associated not only with specific therapeutic knowledge systems, but with different national versions of it as well. Coupled with the fact that health care provision is strongly associated with the nation-state, this leads to an interesting entanglement of health-seeking, therapy management and representations of identities with

questions of political subjectivity and belonging: What kind of emotional bonding do people develop via therapeutic trajectories? Where do they feel cared for, and when and how do they agree to be submitted to specific regimes of control? How is perceived efficacy rethought transnationally? What kind of body politic emerges and how is it related to nationally bound forms of biopolitical governance? How do imagined geographies play out in the commodification of therapeutic practices associated with particular localities?

These questions point to the importance of unpacking the global assemblage of health care (Collier and Ong 2005) and revealing the 'power geometry' (Massey 1996: 62) underlying global platforms of medical knowledge and technologies. Actors and social groups are differently positioned and thus have unequal control and access in relation to flows and interconnections.

Drawing on Massey's suggestion that 'space and place emerge through active material practices' (2005: 118), we have explored the theoretical—and practical—relevance of transnational medical spaces as 'transnational medical structures of agency'. Through spatial theorisation we can capture the structures of existing power geometries, regulations and moralities that impinge upon people and their agency. Putting these two apparently antithetical terms (structure and agency) together in our conceptualisation of opportunity space enables us to revisit agency in stressing that the political and economic structure is the inescapable framework within which subjectivities can act.[23] In other words, from the critical engagement with structure, unexpected forms of action and new forms of health-seeking tactics can emerge (Comaroff 2010). Both agency and structure imply spatiality because space is not a given, but is always performed: Space is not only in structures, it is a dimension of being, of doing (Corsin Jiménez 2003), of agency. The bounding of agency and structure into the concept of space helps to concretely chart transnational flows without letting them free-float in an empty global space. We have therefore given special concern to the concept of space as 'forever incomplete and in production' (Massey 2005: 100), identifying in *space's mixture of openness and closure* its challenge, its ability to inform current understandings of how people find solutions to their health problems. The borders of nation-states thereby remain crucial, although so much is happening across, between and beyond them.

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23 We hereby draw eclectically from understandings of subjectivity, agency, and structuration as they have been formulated by Judith Butler (1997) and Giddens (1997).

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