Medical pluralism reloaded

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Medical pluralism plays a role in many people's lives. In the existing body of literature, it is described as the «co-existence of ideas and practitioners from several traditions occupying the same therapeutic space in society» (Janzen 2002: 234). And although anthropologists have long written about the influence of distance on the assumed efficacy of therapeutic traditions, as well as the crossing of cultural/linguistic borders and the movement of patients/practitioners (Parkin forthcoming), the conceptualisation of medical pluralism has suffered from what scholars have called "methodological nationalism" (Wimmer & Glick Schiller 2003; Beck 1997): namely, that medical pluralism has been primarily envisioned as occurring within one nationally bound space. 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. But their technologically-driven intensification and expansion in tandem with increased opportunities for travel has lead anthropologists to study these occurrences as examples of globalisation and transnationalism. We do not attempt to exhaustively cover these research areas in this chapter; rather, we want to explore how we can rethink classical concepts of medical pluralism via a critical reading of transnationalism and spatial theorisation.

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Our starting point is thereby the observation that new opportunities and restrictions emerge 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 (Tarrow 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 nonstate actors (*ivi*: 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).

Thus, one of the questions we wish to explore in this chapter is what happens to classical concepts from the study of medical pluralism when we re-think the therapeutic space[1] in which «ideas and practitioners from several traditions co-exist» as an *opportunity space* that spans more than one national border and emerges through the relations created by people's activities, the agency of medical products/technologies, and various national regulations, meanings and moralities.

Among the key concepts from the research on medical pluralism that, in our view, require redefinition in light of the transnationalisation of medical spaces are "therapy management group" (Janzen 1987), "health-seeking behaviour" (Fabrega 1974), and the related "hierarchies of resort" (Romanucci-Schwartz 1969). These three concepts are used to describe how events of sickness are embedded in social relations, imbued with specific meanings, unfold over time, and how they are shaped by particular local contexts, including socio-economic conditions and power relations. What happens to these processes in a transnational context? What changes? 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 a therapeutic pluralism spanning different national contexts?

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: "reproductive travellers" (Zanini 2011) in Europe, migrants who send medicine within their personal networks, and the impact of NGOs on traditional practitioners in India. Pluralism, as we will show, evolves in these cases not only from the co-existence of different therapeutic traditions, but also from diversity within one system (for example, biomedicine) emplaced in different national contexts. Likewise, pluralism stems from and is affected by synergies, frictions and loose fits between global models and local forms. While the aforementioned examples derive from our own research interests, they represent three key areas in which the emergence of transnational medical opportunity 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. Combined with transnational medical opportunities, reproductive travellers, therapy networks of migrants and traditional Indian practitioners point to the extent to which different kinds of pluralities emerge. They demonstrate how people and organisations are exposed and contribute to building up a global assemblage[2] of health care, which cannot be grasped in a simple juxtaposition of different medical traditions, but must rather be conceptualised in terms of heterogeneous needs and possibilities of access, moralities, regulations, practices, procedures and the scopes of people and institutions.

The choice of which medicines are sold over the counter, which procedures are available in fertility clinics, which therapeutic knowledge is considered worthy of support by NGOs, and how much treatment costs 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 while searching for recognition and the treatment perceived as appropriate. Medical pluralism going transnational can thus be seen as *a transnational medical space of agency*. This space is 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 (and as a way of introduction), we will clarify the background of the two terms at the centre of this chapter: 'medical pluralism' and 'transnationalism'.

Medical pluralism and transnationalism: the opening up of transnational therapeutic spaces

Both medical pluralism and transnationalism denote very influential fields of inquiry within anthropology and beyond: medical pluralism, now an "old-fashioned topic", has been a powerful catalyst for the exploration of salient themes, including the question of alternative modernities (Knauft 2002; Stollberg & Hsu 2009; Raffaetà 2013a), the politics of cultural heritage, and the extent to which medical anthropology itself can be appropriated by powerful discourses (Brodwin 1996) such as that surrounding biomedicine (Baer 2001; Han 2002). The study of the co-existence of different therapeutic traditions has thereby resonated with many other attempts to study everything from multiplicity and heterogeneity to appropriation processes and affiliated power relations in phenomena of syncretism.

Early debates about the co-existence of different medical traditions[3] tended to describe therapeutic knowledge as constituting separate cultural systems, emphasising their seclusiveness and difference. In his study on the Hausa, Murray Last (1981: 388) distinguishes 'medical systems' from "medical culture", defining the latter as "all things medical that go on within a particular geographical area". A medical culture in this view can be best understood as being «composed of competing systems derived from distinct cultural groups» (*ivi*: 392). Following this approach, anthropologists studying therapeutic practices in exotic places described a strong and univocal relationship between medical systems and culture, assuming either different cognitive repertories (Fabrega 1971), etiologic patterns (Foster 1976) or cultural traditions and institutions (Foster & Anderson 1978). The image of bounded medical systems did not, however, survive for long (Pool 1994). Due to the influence of post-structuralist thinking, the research questions no longer revolved around identifying cultural logics, but instead required investigating the hierarchy of different knowledge traditions, including when and how they can be described as "interlatticed" (Parkin 1995).

Scholars demonstrated that most national health systems incorporated different therapeutic traditions and pointed to the inherent multiplicity

of medical knowledge (Kleinman 1978; Leslie 1975). The goal was to move away from dichotomist categories, such as folk medicine versus cosmopolitan medicine, and to instead indicate convergence between different medical traditions. Medical knowledge was then considered the product of interactions (Fassin 1987), emphasising the negotiated nature of the medical encounter (Benoist 1993; Last 1981; Parkin 1995; Pool 1994) and its historic specificity (Feierman 1985). However, although temporality was added to the frame of systems, the spatial theorisation of medical pluralism was until recently left largely untouched[4].

The other central term of this chapter, 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 & Blanc 1994; Levitt & Glick Schiller 2004). Transnational approaches developed into productive interventions which challenged common understandings of bounded concepts such as the nation, community or society (Wimmer & 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 look at 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 notion "international" takes the state and the state's bounded space as it's starting point and is mainly used to describe organisational bodies that are created through agreements between states (*ivi*: 3). In contrast, transnationalism signifies on-going connections by non-state actors whose relationships are constantly in progress, as they are made and remade by people's and organisations interconnectivity (DeVereaux & Griffin 2006; Vertovec 2009: 3). Transnationalism is simultaneously concerned with the changing roles and nature of the state

The term globalisation highlights the decentered 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 (*ivi* and Tsing 2004: 4). Various authors have emphasised the rooted features of globalisation (Friedman 1997; Fog Olwig & 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 (*ivi*: 45).

This conceptualisation is consistent 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 Keeping this idea of space in mind helps us to retain sight of the fact that global and transnational processes are always grounded in concrete sites. We therefore acknowledge that in the literature on medical pluralism the terms "medical landscapes" or "therapeutic landscapes" have been used to include the spatial expressions of power relations in describing diverse medical practices and patient-practitioner relations (Hörbst 2008; Hsu 2008; West & Luedke 2006). Based on Arjun Appadurai's (1990) conceptualisation of different scapes, which characterise the situation of globality, Viola Hörbst and Angelika Wolf have suggested using the term "medicoscape" to refer to

> landscapes of individuals as well as national, transnational, and international organisations and institutions, and heterogeneous practices, artefacts and things, that are connected 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 & Wolf 2012: 4).

We find the notion of medicoscapes helpful in thinking about medical pluralism and globalisation on a more general level, as for instance with the term "reproscapes" (Inhorn & Shrivastav 2010), which denotes the transnational field of institutions and practices related to reproductive medicine. Similarly inspiring is Stefan Beck's suggestion to consider medical mobilities as a "networked topography" (Beck 2012: 362) arising from biomedical platforms (Keating & Cambrosio 2000) operating on a global scale.

We thereby depart from looking at space and place as bounded entities and instead regard them as socially produced and emerging

from networks of interactions (Massey 2005: 99). Transnational medical opportunity spaces and the resulting specific agency 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 (Massey 1996; Smith 2001: 106ff; Hörbst & Wolf 2012). Attention to specific spatial constellations understood in this way can help describe the concrete "transnational therapeutic itineraries" (Kangas 2010) of people in search of care. Various phenomena, such as people searching for cures in health facilities located abroad (Sobo 2009), or the role of transnational expert advice through telemedicine services (Cartwright 2000), can been grouped under this term. Transnational therapeutic itineraries include new possibilities for work and cure but also rest upon and deepen socio-economic stratifications within and among countries (Langwick *et al.* 2012; Sobo 2009; Whittaker, Manderson & Cartwright 2010), as the following examples from Giulia Zanini's research show.

Transnational reproductive opportunity spaces

Caterina and Mario are an Italian couple who have experienced reproductive disruption due to particular medical conditions: Caterina was diagnosed with severe endometriosis[5] at the age of 21, while her husband was found to have a chromosomal translocation[6]. They underwent many attempts of assisted reproduction before Caterina became pregnant in the Czech Republic via a 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 locations: pre-implantation genetic diagnosis (PGD)[7], sperm donation[8], sperm and egg donation in Belgium, embryo donation[9] 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 donor conception 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 astudy conducted by the Observatory of Procreative Tourism (2012)[10] showed, almost half of the Italian residents seeking reproductive assistance abroad were currently undergoing treatments that were not officially banned within their national territory; rather, these residents perceived the reproductive care abroad to be better. Indeed, Italian couples reacted 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.

Caterina and Mario's reproductive trajectory provides insight into what health-seeking behaviour means in a transnational context: their "transnational quests for conception" (Inhorn & 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 of medications, communication with practitioners, and accommodation – are taken into serious account and often make the resulting choice extremely arduous (Inhorn & Patrizio 2012). It is through these intersecting arrangements, which represent more than just the addition of diverging options in different countries, that the transnational space of therapeutic agency evolves. 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[11].

Therapy networks and medical remittances

Transnational migrants and their usage of multiple health systems and personal networks reveal other aspects of transnational medical pluralism, as found by Raffaetà's research on Morroccan and Ecudaorian families in Italy and Krause's fieldwork on therapy networks among Ghanaians in London. We use the term "therapy networks" rather than "therapy management group", since "network" better expresses the situational character of the support received without pre-supposing a bounded community[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 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 & 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 & Castaneda 2009), and migrants' "nostalgic" yearning for particular practices (e.g. Bergmark, Barr & Garcia 2008). Recent studies (Horton & 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 too expensive for most Mexicans living in the US are affordable in Mexico.

This 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. In their study on the treatment of eye diseases in Egypt, Lane and Inhorn argue against the idea that cognitive models and belief systems determine hierarchies of resort, but instead note that such hierarchies are established in belonging to a specific position in the class structure of Egyptian society. Within the context of transnational migration, this means that transnational structures of agency are brought about by what Boris Nieswand (2011: chapter 5) has called the "status paradox" of transnational migration: by using income obtained through low-status work in high-income settings, migrants are able to gain a higher status in

the original home context, which allows them to do such things as consult private medical care.

Along with people, medicine travels too. Similar to money and other goods journeying along transnational pathways, medicines can be considered a special kind of remittances. "Medical remittances" (Pribilsky 2008) circulate within personal networks, and are part of a multidirectional exchange flows back and forth between the home and the host country but also encompassing the migrants' previous destinations (Beijers & de Freitas 2008; Krause 2008). Roberta Raffaetà (2013b, 2016) drawing on her research in Italy with migrants from Morocco and 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 found that migrants evaluate the disparity in costs for drugs and medical interventions and buy medicine 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 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. 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 (*ivi*), as opposed to being limited to one nation-state.

Another interesting finding from Raffaetà's and Krause's research with migrants 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 become included in migrants' networks as advisors and facilitators in therapeutic decisions. Raffaetà (2016) 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 visit 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 flying 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 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 takes 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 and put 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 cases of transnationally arranged therapy networks and reproductive travellers show how people make use of the interstices created by economic inequality among countries, and taking advantage of gaps between regulations in order to keep their heads above water most effectively.

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 both 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 context and efficacy is the idea of modernity, as demonstrated in the case of Ecuadorians who send drugs from Italy to relatives in the southern coastal region of Ecuador on the basis 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 (2008) has termed «the social efficacy of traveling medicines», this 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 (2008: 13) 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. He regards medicines as reciprocal gifts from those who stay behind and receive money from family members living abroad (*ivi*: 14). The unidirectional sending of money is thereby embedded «in a more affective exchange» (*ivi*), 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 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 the specific medical needs of migrants, 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 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 (van der Geest & Whyte 1989; Whyte *et al.* 2002; Krause 2008, 2013).

Transnational institutionalisation and its entanglements

Instances of transnational medical pluralism, like reproductive travel and the transnational health-seeking behaviour of migrants, must also be analysed in light of economic, political and legal agreements between states.

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 1851 in Paris. 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 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]. 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 the 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 the directive 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 provisions 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 recognise 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 (2008) found in her research in London.

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 2012). She describes how medical know-how and skills as well as technological and pharmaceutical equipment are introduced into the transnationally spanning medicoscapes 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 Viola 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 globe-spanning medicoscapes, 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, Roman Church's special influence on reproductive policieshas 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[20], gamete and embryo donation and surrogacy[21]) (Fenton 2006; Hanafin 2007). Interestingly enough, a very 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 one of the most liberal sets of laws in Europe[22]. This clearly shows how the impact of transnational organisations such as the Roman Catholic Church[23] can be evaluated

only in concrete local configurations and not generalised on a global scale. Depending on the country's history of church/state entanglement and the political constellations in the specific social sites, both different opportunity structures and different moral evaluations evolve regarding issues like assisted reproduction.

Italian reproductive travellers' health-seeking strategies and tactics are not about the choice between different therapeutic systems, but between different biomedical fertility centres that offer particular services on a global market. Here we can not only see how hierarchies of resort in a transnational framework do concern the economic status of people, which may vary in different national contexts as argued above, but also how the various national health systems are associated with different meanings and values. As already shown by Romanucci-Schwartz (1969), "hierarchy of resort", the temporal order in which people adhere to different therapeutic options, is influenced by socio-moral functions ascribed to the treatments'. The case of reproductive travellers indicates that these influences are even greater: the difference in legal regulations, together with the perceptions that patients have of local offers and existing options, create the preconditions for transnational therapeutic itineraries.

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 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 portrays 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), where in the 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 conditioned upon being able 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 (2013a) 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 & 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 "opportunity space" with huge potential to "reload" health-seeking behaviour and therapy management. Various studies, however, have shown that people's imaginations and prior knowledge direct their online search for support and information (Gherardi 2009; Brijnath 2010; 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.

Similarly, in the case of 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 opportunity spaces. Local power articulations and local meanings/imaginations constrain both the possible choices available in a transnational opportunity space and the way in which concepts like "therapy management group", "hierarchies of resort" and "health-seeking behaviour" are reloaded.

Conclusion

The idea of medical pluralism was from its very beginning about multiplicity, but initially thought about mainly in terms of closed systems within national boundaries. This was challenged by poststructuralist thinking, theories of globalisation and insights gained from the study

of transnational phenomena. Together with actions within transnational dimensions (such as the internet) and transnational institutes (such as the EU, Catholic Church and NGOs), the different ethnographic fields covered in this article (reproscapes, medical tourism and the migration of people, medicines and technologies) show how medical pluralism can no longer be considered without reference to the interactions between national and transnational fields. Such interaction, however, is far from predetermined; many elements (legal, symbolic, moral, economic, social) contribute to shaping it along the way. More systematic research into the transnational medical opportunity spaces is needed and while there are likely other methods of doing so, ethnographies are particularly well-suited to the task.

In this chapter, 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 not only associated 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 health-seeking strategies? 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 & 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. We have therefore sought to "reload" the debate about medical pluralism by thinking it through transnational spaces. 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[24]. 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 medical pluralism. Therapeutic landscapes today are characterised by disparities in health systems which open up opportunities for people, creating spaces for care that are simultaneously concrete and potential.

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Notes

1. We use in this paper the terms transnational medical or therapeutic space interchangeably. Whereas "therapeutic" has the advantage of including religious and other forms of 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, not a real therapy 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.

2. Collier & Ong (2005) suggested this term to overcome the dichotomist view of global forces that impact locally and to capture the complex interplay of heterogeneous actors, including regulations, laws, physical infrastructures, organizations.

3. The study Medicine, Magic and Religion from 1924 by William Hals Rivers and Evan-Pritchard's book *Witchcraft, Oracles and Magic* from 1937 can be seen as examples of these earlier studies.

4. Great exception are the writings of Leslie (1980, 1992) and Young (1990), who explored the articulation between local medicine and the world system.

5. 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", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. <http://www.oxfordreference.com.ezproxy.eui.eu/views/ENTRY.html?subview=Main&entry=t60.e3153>,[12/06/2012]).

6. 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", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. [last accessed 18 June 2012]).

7. 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", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. [last accessed 18 June 2012]).

8. 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.

9. 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.

10. 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 in terms of cross-border reproductive care.

11. De Certeau regards tactics as the "art of the weak" and strategies as the instruments of the powerful (de Certeau 1984: 36f). Strategies require an institutionalised space of power from where objectives are targeted. In contrast, a tactic «is a calculated action determined by the absence of a proper locus» (*ivi*: 37). In our view this distinction should be applied to positions actors can inhabit rather than to real actors (the ones who are powerful enough to employ strategies and the weak ones who are left with tactical manoeuvres): a strategic position is inhabited by the subject if she can act from a clearly demarcated position, while a tactical position consists of "poaching" in the terrain of others.

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

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", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. <http://www.oxfordreference.com.ezproxy.eui.eu/views/ENTRY.html?subview=Main&entry=t60.e5160>[18/06/2012]).

14. Egg-donation or oocyte donation is «the transfer of secondary oocytes from one woman to another». ("Oocyte donation", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. <http://www.oxfordreference.com.ezproxy.eui.eu/views/ENTRY.html?subview=Main&entry=t60.e7027>[18/06/2012]).

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

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).

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.

19.< http://ec.europa.eu/health-eu/news/streaming/crossborder/crossborder_en.htm> [24/06/2012].

20. 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", *Concise Medical Dictionary*. Oxford University Press, 2010. *Oxford Reference Online*. Oxford University Press. European University Institute Library. 18 June 2012 <http://www.oxfordreference.com.ezproxy.eui.eu/views/ENTRY.html?subview=Main&entry=t60.e5160>).

21. Surrogacy refers to «an arrangement in which a woman ("the carrying mother") agrees to bear a child and to hand over that child, on birth, to another person or persons ("the commissioning parents"). The carrying mother may have been artificially inseminated 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", *A Dictionary of Law*. by Jonathan Law and Elizabeth A. Martin. Oxford University Press 2009 *Oxford Reference Online*. Oxford University Press. European University Institute Library. <http://www.oxfordreference.com.ezproxy.eui.eu/views/ENTRY.html?subview=Main&entry=t49.e3885>)[18/06/2012].

22. The current law was passed in 2006.

23. We are here 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, pope's writings to faithful people etc).

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

References

Alex, G. 2009. *Folk healing and the negotiation of shifting social identities in Tamil Nadu, India*. Max Planck Institute for the Study of Religious and Ethnic Diversity.

Amselle, J.-L. 2001. *Branchements. Anthropologie de l'universalité des cultures*. Paris: Flammarion.

Appadurai, A. 1990. Disjuncture and difference in the global cultural economy. *Public Culture*, 2, 2: 1-24.

Appadurai, A. 1996. *Modernity at large. Cultural dimensions of globalization*. Minneapolis: University of Minnesota Press.

Arnold, D. 1996. *Colonizing the body. State medicine and epidemic disease in nineteenth-century India*. Berkeley: California University Press.

Baer, H. A. 2001. *Biomedicine and alternative healing systems in America: Issues of class, race, ethnicity, & gender.* Wisconsin: Wisconsin University Press.

Basch, L. G., Glick Schiller, N. & C. S. Blanc 1994. *Nations unbound: Transnational projects, postcolonial predicaments and deterritorialized nation-states*. London and New York: Routledge.

Beck, S. 2012. "Biomedical mobilities: Transnational lab-benches and other space-effects". In *Reproductive technologies as global form. Ethnographies of Knowledge, practices and transnational encounters*, pp. 357-374. Frankfurt am Main and New York: Campus.

Beck, U. 1997. *Was ist Globalisierung? Irrtümer des Globalismus – Antworten auf Globalisierung.* Frankfurt am Main: Suhrkamp.

Beijers, Huub & C. de Freitas 2008. "Cape Verdeans' pathways to health: Local problems, transnational solutions", in *Transnational archipelago. Perspectives on Cape Verdean migration and dias-pora*, edited by Batalha, L. & J. Carling, pp. 237-254. Amsterdam: Amsterdam University Press.

Benoist, J. 1993. *Anthropologie médicale in société crèole*. Paris: Presses Universitaires de France.

Bergmark, R., Barr, D. & R. Garcia 2008. Mexican immigarnts in the US living far from the border may return to Mexico for health services. *Journal of Immigrant and Minority Health*, 98, 11: 1987-1995.

Brijnath, B. 2010. *Four days of light and then it's dark again: Dementia care in India*. PhD thesis, Medicine, Nursing and Health Sciences, Monash University.

Brijnath, B. & T. Ahlin 2011. *Online idioms of distress in biomedicine and ayurveda*, American Anthropological Association, 16th-20th November, Montréal, Canada.

Brodwin, P. 1996. *Medicine and morality in Haiti*. Madison: University of Winsconsin Press.

Butler, J. 1997. *The psychic life of power. Theories of subjection.* Stanford: Stanford University Press.

Cant, S. & U. Sharma 1999. *A new medical pluralism? Alternative medicine, doctors, patients and the state*. London: Routledge.

Cartwright, L. 2000. Reach out and heal someone: Telemedicine and the globalization of health care. *Health*, 4, 3: 347-377.

Chavez, L. R. 1984. Doctors, curanderos, and brujas: Health care delivery and Mexican immigrants in San Diego. *Medical Anthropology Quarterly*, 15, 2: 31-37.
Collier, S. J. & A. Ong (eds.) 2005. *Global assemblages: Technology, politics and ethics as anthropological problems*. Malden (MA): Blackwell.
Comaroff, J. 2010. "Beyond bare life: AIDS, (bio)politics, and the neo-liberal order", in *Morality, hope and grief. Anthropologies of AIDS in Africa*, edited by Dilger. H. & U. Luig. London: Berghahn Books.
Corsin Jiménez, A. 2003. On space as capacity. *Journal of the Royal Anthropological Institute*, 9: 137-153.
Crandon-Malamoud, L. 1991. *From the fat of our souls: Social change, political process, and medical pluralism in Bolivia*. Berkeley: University of California Press.
de Certeau, M. 1984. *The practice of everyday life*. Berkeley, Los Angeles and London: University of California Press.
DeVereaux, C. & M. Griffin,+ 2006. *International, global, transnational: Just a matter of words?*. Paper presented at the 4th International Conference on Cultural Policy Research, iccpr 2006. Vienna.
Dodier, N. 2005. Transnational medicine in public arenas. Aids treatments in the South. *Culture, Medicine and Psychiatry*, 29, 3: 285-307.
Fabrega, H. Jr. 1971. Some features of Zinacantecan medical knowledge. *Ethnology*, X, 1: 25-43.
Fabrega, H. Jr. 1974. *Disease and social behaviour: An interdisciplinary perspective*. Cambridge: The MIT Press.
Faist, T. 2000. *The volume and dynamics of international migration and transnational social spaces*. Oxford: Oxford University Press.
Fassin, D. 1987. La santé, un enjeu politique quotidien. *Politique Africaine*, 28: 2-8.
Feierman, S. 1985. Struggles for control: The social roots of health and healing in modern Africa. *African Studies Review*, 28, 2/3: 73-147.
Fenton, R. 2006. Catholic doctrine versus women's rights: The new Italian law on assisted reproduction. *Medical Law Review*, 14, 1: 73-107.
Fog Olwig, K. & K. Hastrup (eds.) 1997. *Siting culture. The shifting anthropological object.* London and New York: Routledge.
Foster, G. M. 1976. Diseases etiologies in non-western medical systems. *American Anthropologist*, 78: 773-782.
Foster, G. M. & B. G. Anderson 1978. *Medical Anthropology*. New York: John Wiley.
Friedman, J. 1997. "Simplifying complexity. Assimilating the global in a small paradise", in *Siting culture. The shifting anthropological object*, edited by Fog Owig, K. & H. Kirsten, pp. 268-291. London and New York: Routledge.
Gherardi, S. 2009. Telemedicine: A practice-based approach to technology. *Human Relations*, XX, X: 1-24.
Giddens, A. 1997. *Central problems in social theory: Action, structure, and contradiction in social analysis*. Los Angeles: University of California Press.
Glick Schiller, N. 2005. Transnational social fields and imperialism: Bringing theory of power to transnational studies. *Anthropological Theory*, 5: 439-461.
Guendelman, S., & M. Jasis 1992. Giving birth across the border: The San-Diego-Tijuana connection. *Social Science and Medicine*, 34, 4: 419-425.

Han, G. S. 2002. The myth of medical pluralism: A critical realist perspective. *Sociological research online*, 6, 4.

Hanafin, P. 2007. *Conceiving life: Reproductive politics and the law in contemporary Italy*. Aldershot and Burlington: Ashgate.

Hörbst, V. 2008. *Heilungslandschaften – Umgangsweisen mit Erkrankung und Heilung bei den Cora in Jesús María, Mexiko*. Münster: LitVerlag.

Hörbst, V. 2012a. "Assisted reproductive technologies in Mali: Asymmetries and frictions", in *IVF as global Form. Ethnographies of Knowledge, Practices, and Transnational Encounters*, edited by Knecht, M., Klotz, M. & S. Beck, pp. 120-148. Frankfurt am Main and New York: Campus.

Hörbst, V. 2012b. "IVF in Bamako: Globalizing technology, mobile knowledge, reinterpreted practice?", in *Transnational medicine, mobile experts: Globalization, health and power in and beyond Africa*, edited by Dilger, H., Kane, A. & S. Langwick, pp. 163-189. Bloomington: Indiana University Press.

Hörbst, V. & A. Wolf 1995. "Globalisierung der Heilkunde: eine Einführung", in Wolf, A. & V. Hörbst (eds.), *Medizin und Globalisierung. Universelle Ansprüche – lokale Antworten*, pp. 3-30. Münster: LitVerlag.

Hörbst, V. & A. Wolf 2012. *ARVs and ARTs: Unequal flows to sub-Saharan Africa*. Unpublished article, currently under review.

Horton, S. & S. Cole 2011. Medical returns: Seeking health care in Mexico. *Social Science and Medicine*, 72: 1846-1852.

Howard-Jones, N. 1975. *The scientific background of the international sanitary conferences 1851-1938.* World Health Organisation.

Hsu, E. 2008. "Medical pluralism", in *International encyclopedia of public health* 4., edited by Heggenhougen, K. & S. Quah, pp. 316-321. London: Elsevier Science & Technology Books.

Ingold, T. 2011. *Being alive. Essays on movement, knowledge and description*. London and New York: Routledge.

Inhorn, M. & P. Patrizio 2009. Rethinking reproductive "tourism" as reproductive "exile". *Fertility and Sterility*, 92: 904-906.

Inhorn, M. & P. Patrizio 2012. Assisted reproductive technologies and fertility "tourism": Examples from global Dubai and the Ivy League. *Medical Anthropology*, 31, 3: 249-265.

Inhorn, M. & P. Shrivastav 2010. Globalization and reproductive tourism in the United Arab Emirates. *Asian Pacific Journal of Public Health*, 22, 3: 68S-74S.

Janzen, J. M. 1987. Therapy management: Concept, reality, process. *Medical Anthropology Quarterly*, New Series, 1, 1 (Mar., 1987): 68-84.

Janzen, J. M. 2002. *The social fabric of health. An introduction to medical anthropology.* Boston: McGraw Hill.

Kangas, B. 2010. Traveling for medical care in a global world. *Medical Anthropology*, 29, 4: 344-362.

Keating, P. & A. Cambrosio 2000. Biomedical platforms. *Configurations*, 8, 3: 337-387.

Khare, R. S. 1996. Dava, daktar, and dua: Anthropology of practiced medicine in India. *Social Science and Medicine*, 43, 5: 837-848.

Kleinman, A. 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science & Medicine*, 12: 85-93.

Knauft, B. 2002. "Critically modern: An introduction", in *Critically modern: Alternatives, alterities, anthropologies*, edited by B. Knauft, pp. 1-56. Bloomington: Indiana University Press.

Krause, K. 2008. Transnational therapy networks among Ghanians in London. *Journal of Ethnic and Migration Studies*, 34, 2: 235-251.

Krause, K. 2013. Pharmaceutical potentials: Praying over medicines in Pentecostal healing. *Ghana Studies*, 15-16: 223-250.

Lane, S. & M. Inhorn 1987. The hierarchy of resort reexamined: Status and class differentials as determinants of therapy for eye disease in the Egyptian delta. *Urban Anthropology*, 16, 2: 151-182.

Langwick, S. A., Hansjörg, D. & K. Abdoulaye 2012. "Medicine, mobility, and power", in *Medicine, mobility and power in global Africa. Transnational health and healing*, edited by Dilger, H., Kane, A. & S. A.Langwick. Bloomington: Indiana University Press.

Last, M. 1981. The importance of knowing about not knowing. *Social Science and Medicine*, 15B, 3: 387-392.

Leslie, C. 1975. "Pluralism and integration in the Indian and Chinese medical systems", in *Medicine in Chinese Cultures*, edited by A. Kleinman, pp. 401-417. Washington DC: U.S. Government Printing Office.

Leslie, C. 1980. Medical pluralism in a world perspective. *Social Science & Medicine*, 14B: 191-195.

Leslie, C. 1992. *Paths to Asian medical knowledge. Interpretations of illness: syncretism in modern ayurveda*. Berkeley: University of California Press, pp. 177-208.

Levitt, P. & N. Glick Schiller 2004. Conceptualizing simultaneity: A transnational social field perspective on society. *International Migration Review*, 38, 3: 1002-1039.

Markowitz, L. 2001. Finding the field: Notes on the ethnography of NGOs. *Human Organisation*, 60, 1: 40-46.

Massey, D. 1996. "Power-geometry and a progressive sense of place", in *Mapping the futures: Local cultures, global change*, edited by Bird, J., Curtis, B., Putnam, T., Robertson, G. & L. Tickner, pp. 59-69. London and New York: Routledge.

Massey, D. 2005. *For Space*. London: Sage.

Mata Codesal, D. 2008. *Rice & coriander. Sensorial re-creations of home through food: Ecuadorians in a northern Spanish city*. University of Sussex, Sussex Center for Migration Research, WP 50.

Menniti-Ippolito, F., Gargiulo, L., Bologna, E., Forcella, E. & R. Raschetti 2002. Use of unconventional medicine in Italy: A nation-wide survey. *European Journal of Clinical Pharmacology*, 58, 1: 61-64.

Mosse, D. 2005. *Cultivating development: An ethnography of aid policy and practice*. London and Ann Arbour (MI): Pluto Press.

Mosse, D. (ed.) 2011. *Adventures in Aidland: The anthropology of professionals in international development*. New York and Oxford: Berghahn Press.

Nieswand, B. 2011. *Theorising transnational migration: The status paradox of migration*. London and New York: Routledge.

Parkin, D. 1995. "Latticed knowledge: Eradication and dispersal of the unpalatable", in *Islam, medicine and anthropological theory. Counterworks:*

Managing the diversity of knowledge, edited by R. Fardon, pp. 143-164. London: Routledge.

Parkin, D. 2014. Forthcoming pathways to healing: Curative travel among Muslims and non-Muslims in Eastern East Africa. *Medical Anthropology*, 33: 21-36.

Pool, R. 1994. *Dialogue and interpretation of illness. Conversations in a Cameroon village*. Oxford: Berg Publisher.

Pribilsky, J. 2008. Sending energías from the Andes: The social efficacy of travelling medicines. *Anthropology News*, 49, 5: 13-14.

Raffaetà, R. 2013a. Allergy narratives in Italy: 'Naturalness' in the social construction of medical pluralism. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 32, 2: 126-144.

Raffaetà, R. 2013b. "Famiglie immigrate e accesso ai servizi sanitari di pediatria nella Provincia di Trento: una ricerca antropologica", in *L'immigrazione in Trentino – Rapporto annuale 2012*, a cura di Ambrosini, M., Boccagni, P. & S. Piovesan, pp. 145-162. Trento: Pubblicazioni della Provincia Autonoma di Trento.

Raffaetà, R. 2016. "Itinerari medici transnazionali come pratiche d'appartenenza. Curare i propri figli tra Italia, Ecuador e Marocco", in *Salute e inclusione sociale degli immigrati: la sfida dell'accesso ai servizi sanitari*, a cura di Tognetti Bordogna, M. & P. Rossi, pp. 184-197. Milano: Franco Angeli.

Roberts, E. 2006. God's Laboratory: Religious rationalities and modernity in Ecuadorian in vitro fertilization. *Culture, Medicine and Psychiatry*, 30, 4: 507-536.

Romanucci-Schwartz, L. 1969. The hierarchy of resort in curative practices: The Admiralty Islands Melanesia. *Journal of Health and Social Behavior*, 10: 201-202.

Seid, M., Castañeda D., Mize R., Zivkovic M. & J. W. Varni 2003. Crossing the border for health care: Access and primary care characteristics for young children of Latino farm workers along the US-Mexico border. *Ambulatory Pediatrics*, 3, 3: 121-130.

Shenfield, F., De Mouzon, J., Pennings, G., Ferraretti, A. P., Andersen, A. N., de Wert, G., Goossens, V. & the ESHRE Taskforce on Cross Border Reproductive Care 2010. Cross border reproductive care in six European countries. *Human Reproduction*, 25, 6: 1361-1368.

Shenfield, F., Pennings, G., De Mouzon, J., Ferraretti, A. P., Veerle, G. & on behalf of the ESHRE Task Force 'Cross Border Reproductive Care' (CBRC) 2011. ESHRE's good practice guide for cross-border reproductive care for centers and practitioners. *Human Reproduction*, 1-3.

Smith, M. P. 2001. *Transnational urbanism. Locating globalization*. Oxford, Malden: Blackwell.

Sobo, E. J. 2009. Medical travel: What it means, why it matters. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 28, 4: 326-335.

Stollberg, G. & E. Hsu 2009. Introductory note. Globalizing Chinese medicine. Special Issue. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 28, 2: 109-110.

Storrow, R. F. 2011. Religion, feminism and abortion: The regulation of assisted reproduction in two catholic countries, *Rutgers Law Journal*, 42, 3: 725-764.

Tarrow, S. 2005. *The new transnational activism*, Cambridge: Cambridge University Press.

Tishkov, V. 2005. An Anthropology of NGO, in *Eurozine*. <http://www.eurozine.com/articles/2005-06-01-tishkov-en.html>.

Tsing, A. 2004. *Friction. An ethnography of global connection*. Princeton: Princeton University Press.

Turismo procreativo: la fuga continua, anche senza indicazione medica. 2012. Osservatorio sul turismo procreativo.

Van der Geest, S. & S. Reynolds Whyte 1989. The charms of medicines: Metaphors and metonyms. *Medical Anthropology Quarterly*, 3, 4: 345-367.

Van der Geest, S., Reynolds Whyte, S. & Hardon A. 1996. The anthropology of pharmaceuticals: A biographical approach. *Annual Review of Anthropology*, 25: 153-178.

Vertovec, S. 2009. *Transnationalism*. London and New York: Routledge.

Young, A. 1990. (Mis)applying medical anthropology in multicultural settings. *Santé Culture Health*, VII, 2-3: 197-208.

Wallace, S. P., Mendez-Luck, C. & X. Castaneda 2009. Healing south: Why Mexican immigrants in California seek health services in Mexico. *Medical Care*, 47, 6: 662-669.

West, H. & T. J. Luedke 2006. "Healing divides: Therapeutic border work in Southeast Africa", in *Borders and healers. Brokering therapeutic resources in Southeast Africa*, edited by West, H. & T. J. Luedke. Bloomington and Indianapolis: Indiana University Press.

White, S. 2001. "Medicines and modernities in socialist China: medical pluralism, the state and naxi identities in the Lijang Base", in *Healing powers and modernities. Traditional medicine, shamanism, and science in Asian societies*, edited by Connor, L. H. & G. Samuel, pp. 173-194. London: Bergin and Garvey.

Whittaker, A., Manderson, L. & E. Cartwright 2010. Patients without borders: Understanding medical travel. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 29, 4: 336-343.

Whyte, S. R., van der Geest, S. & A. Hardon 2002. *Social lives of medicines*. Cambridge: Cambridge University Press.

Wimmer, A. & N. Glick Schiller 2003. Methodological nationalism, the social science, and the study of migration: An essay in historical epistemology. *International Migration Review*, 37, 3: 576-610.

Zanini, G. 2011. Abandoned by the State, betrayed by the Church: Italian experiences of cross-border reproductive care. *Reproductive BioMedicine Online*, 23: 565-572.

Abstract

This article examines if and how medical pluralism can be reconceptualised in light of the expansion of the borders of care, where people do not simply seek care nationally but transnationally. We draw on our own research on reproductive travels, medical remittances, the circulation of medicines in migrant's personal networks and the revitalization of local healing traditions through globally active NGOs to shed light on the emergence of what we call a transnationally opportunity space. The article focuses on the analysis on new opportunities and restrictions which emerge through the existing global economic stratification, the diverging legal frameworks and regulations in different nation states and locations, and the different levels of health care governance.

Key words: transnational opportunity space, medical mobilities, medical travel, medicoscapes, reproscapes.

Riassunto

Questo articolo riflette su come e se il pluralismo medico può essere riconcettualizzato alla luce dell'espansione dei confini della cura, in cui gli individui non cercano forme di cura semplicemente su scala nazionale, ma transnazionale. Gli autori configurano la loro ricerca sui viaggi riproduttivi, le rimesse mediche, la circolazione di medicine tra i network personali dei migranti e la revitalizzazione delle tradizioni di cura locali compiuta da ONG attive globalmente, per fare luce sull'emergere di ciò che gli autori chiamano uno spazio transnazionale di opportunità. L'articolo si concentra sull'analisi di nuove opportunità e limitazioni che emergono dalla stratificazione economica globale, i divergenti quadri normativi nei differenti Stati e i diversi livelli di governance *della cura.*

Parole chiave: spazio di opportunità transnazionale, mobilità medica, viaggio medico, *medicoscapes*, *reproscapes*.