Title

Cross-Border Therapeutic Itineraries: Towards the Study of Medical Pluralism and Cross-Border Human Mobility

Authors

Piñones Rivera, Carlos
Liberona Concha, Nanette

Publication Date

2018-11-19

ISSI VISITING SCHOLAR WORKING PAPER SERIES 2018-2019.01

Cross-Border Therapeutic Itineraries: Towards the Study of Medical Pluralism and Cross-Border Human Mobility

by Carlos Piñones Rivera and Nanette Liberona Concha

Institute for the Study of Societal Issues
University of California, Berkeley
November 19, 2018

Institute for the Study of Societal Issues

Cross-Border Therapeutic Itineraries: Towards the Study of Medical Pluralism and Cross-Border Human Mobility

Carlos Piñones Rivera, Ph.D.
Instituto de Estudios Internacionales (INTE), Universidad Arturo Prat, Chile
and Visiting Scholar, Berkeley Center for Social Medicine, Institute for the Study of Societal Issues, UC Berkeley

carlospinonesrivera@gmail.com

Nanette Liberona Concha, Ph.D.
Instituto de Estudios Internacionales (INTE), Universidad Arturo Prat, Chile

nliberonac@gmail.com

The article[1] addresses the obstacles to the study of the relationships between Medical Pluralism and human mobility. We critically review the existing literature on Medical Pluralism and Mobility, showing how the classic studies of medical pluralism neglected three fundamental aspects that make up what we call non-situated Medical Pluralism: mobility, space, corporality. A critical review of these aspects in contemporary studies of medical pluralism led us to formulate a framework that seeks to integrate the main contributions of the studies of medical pluralism from Critical Medical Anthropology (Menéndez) with the Mobility Paradigm (Tarrius). This framework is presented, and the paper concludes by underlining its main contributions to the contemporary discussion in the field of Medical Pluralism and mobility.

[1] This is the translation of a paper to be published in *Si Somos Americanos, Revista de Estudios Transfronterizos*.

Introduction

Medical pluralism is an important field of study, shared by disciplines such as medical anthropology, medical sociology, public health, health sciences, etc. (Cant & Sharma, 1999; Crandon-Malamud, 1986; Hampshire & Owusu, 2013; Lambert, 2012; Macartney & Wahlberg, 2014; Miles & Leatherman, 2003). Medical pluralism is an unavoidable consequence of the history of colonization and globalization processes (Baer, 2011; Knipper, 2006). These, together with the expansion of medical care, the commodification of health, increased flows of human mobility, as well as the apparent valorization of so-called alternative and complementary medicines (among other processes), have contributed to the proliferation in every corner of the globe of complex healthcare systems. In them, different types of medical knowledge[2] coexist and are articulated in multiple ways, transforming the contemporary panorama of health care and the exercise of the right to health.

Medical pluralism is, therefore, the concrete framework in which Health/Disease/Care processes occur in Latin America, so it is worrisome that a pronounced monist bias has led researchers to conceive of medical knowledges in a unitary and isolated manner, making the contribution of medical pluralism[3] to the health of people invisible.

[2] In Spanish, *saberes médicos* is a plural concept that does not have a strong translation in English. Throughout the paper, we consistently use *medical knowledges*, when we want to point out this plural condition.

[3] Throughout the paper we will use "medical pluralism" to refer to the reality of people living in complex worlds with multiple medical knowledges (a result of colonialism, mobility, etc.), and "Medical Pluralism" to refer to the scholarly approach to the study of that reality.

This erasure has served to reproduce biomedical hegemony, which proclaims itself as the only valid knowledge and relegates the rest of the medical knowledges to non-existence [*no-existente*], a concept elaborated by De Sousa Santos (2010).

Our work on Medical Pluralism in an Aymaran community showed us the need to understand and make visible the processes of articulation of medical knowledges, as well as the production of relations of hegemony/subalternity that occur within the community (Piñones Rivera, 2015). This awareness, in confluence with our work based on the study of health and immigration processes (Liberona Concha, 2012), has led us to note that there is a gap when thinking about Medical Pluralism in relation to the complexity of the Human Mobility processes (Tarrius, 2000), and this gap is more pronounced when such mobility involves the crossing of borders.

In the theoretical dimension, it seems necessary to problematize the reasons for this gap. There are no studies that synthesize the main theoretical approaches to medical pluralism and seek to understand the reasons for this theoretical impasse. In this article, we will try to contribute to this broad problem through a critical review of the existing literature on Medical Pluralism, but we will also propose the main outlines of our proposed framework called Cross-Border Therapeutic Itineraries, which seeks to integrate Medical Pluralism and Human Mobility in cross-border contexts. Our reflection is nourished from the perspective of Latin American Critical Medical Anthropology developed by Eduardo Menéndez, from the Tarrius Mobility paradigm (2000), but above all from learning from Aymara and migrant communities struggling to claim their right to life, housing and health in the historical territory of Tarapacá, Chile.

On Methods

The article consists of a critical analysis of the main theoretical works on Medical Pluralism. The compilation of the sources results partially from the doctoral thesis "La Mala Hora" (Piñones Rivera, 2015), complemented by a recent thorough search of books, scientific articles, and theses on this topic, published in Spanish, English, and French until March 2017. The common factor in the bibliographic search was the concept of Medical Pluralism, but by virtue of the interest in analyzing the relationship between Medical Pluralism and Cross-border Mobility, within said bibliography, the following searches were also carried out: Health-Migration; Health-Mobility; Border-Medical Pluralism; Territory-Medical Pluralism; Corporality-Medical Pluralism.

Given that every theory about Medical Pluralism supposes at least a conceptualization of medical knowledges/systems, of the relationship between them, of the social actors that participate in said pluralism and of the dimensions involved, our critical analysis was done through a grid based on the following axes:

> -The conceptualization of medical systems and their relationships. We ask: what is the author's understanding of medical knowledges/system? How many forms of medical knowledge [*saberes médicos*] do they consider in their analysis? How do they conceive the relationships between such medical knowledges? With these inputs, we reflect on their implications in the construction of Medical Pluralism as a research object.
>
> -The dimensions included in Medical Pluralism. We ask which dimensions the authors include and which ones they exclude in their theorization about Medical Pluralism so we can answer the questions: how complex is the conceptualization of medical pluralism? Which dimensions do they emphasize in their conceptualization?

In the remainder of the paper, we will first present the initial work on Medical Pluralism in a section called "classical contributions," then we will review the critical approaches, finally taking stock of the main elements left out of the work that seems relevant to us in thinking about the problem of cross-border mobility, namely: space, mobility, and corporality. In a second section, we will review the limited scholarship in the field of Medical Pluralism that has addressed these excluded dimensions, and we will make a critical assessment of how Medical Pluralism has been approached in relation to Cross-Border Mobility. In the third section, we will explicate the main features of our framework called Cross-border Therapeutic Itineraries, showing its contribution in the context of the previous studies on Medical Pluralism.

The First Works on Medical Pluralism: From the Invisibility of Pluralism to the Invisibilization of Power

Although the colonial reality in which anthropology was initially deployed allows one to suppose the heterogeneity of different medical knowledges in the places in which ethnography was carried out, the studies that respond to what Martínez-Hernáez (2008) has called the "classical model" of medical anthropology systematically omitted this plural condition. Far from problematizing the colonial condition, these works presented local medical knowledge as isolated, making invisible the presence and impact that the imposed medical systems were having. Only later did scholarship emerge that analyzed the coexistence of medicines, for example, the pioneering work of Holland (1963) or the functionalists of Press (1969) on the "dual use" that the urban population made of "doctors" and "curers."

According to several authors (Baer, 2011; Hsu, 2008; Stoner, 1986), it was not until 1971 that a first systematic approach to the study of Medical Pluralism was established around the figure of Charles Leslie. In his *Asian Medical Systems: A Comparative Study* (1976), some of the main ideas that have become canonical in the study of Medical Pluralism are presented, including Dunn's (1976) classification of medical systems according to geographical and cultural disposition as "local systems," "regional" or "cosmopolitan." Foster (1970) was also influential; based on an etiological criterion, he classified "non-western medical systems" into "personalist" and "naturalistic" systems.

In these first works, two of the central lines of analysis present in the scholarship are established: one that focuses on the characterization and analysis of medical systems and their relationships; and another that conceives of Medical Pluralism as underlining the role played by social actors through the search for health care. Regarding the first line, in analytical terms, they tried to make visible the plural reality of medical knowledge, through eminently classificatory approaches such as those of Dunn. The first defining exercises on what was to be understood as a "medical system" (Dunn, 1976, Foster, 1970) were carried out, as cultural systems constituted by beliefs or practices based on beliefs. When this anthropological perspective was combined with a more sociological perspective, people talked about socio-cultural systems.

Regarding the second line of inquiry, a series of works was developed based on the concepts of "therapeutic itinerary" (linked to French anthropology)[4] and "health seeking behavior" (pre-eminent in English-speaking environments), work that developed thanks to Chrisman's pioneering work on Health Seeking Behavior (Perdiguero-Gil, 2006). In these works, medical

[4] Cfr. Augé (1986), Zempleni (1985), Sindzingre (1985).

pluralism was made visible by showing how, as social actors search for an answer to their health problems, they draw upon a heterogeneity of medical knowledges. The analyses sought to reveal the patterns present in these itineraries, as well as the underlying rationality.

Other scholars raised the need to study the relationships between different medical systems. Thus, Kleinman (1978), from an interpretative paradigm, proposed to study Explanatory Models (EM), which are models that explain the disease in terms of its symptoms, causes, treatment, etc. taking elements from different sectors (folk, professional and popular). This articulation of medical systems was conceived by Kleinman as a process of translation between different languages (Kleinman, 1978, p.88).

Whether the works are focused on knowledge or actors, in this period the coexistence of medical knowledges denied by colonial approaches is made visible, and the first theoretical elements are contributed that allow us to think about a new field, defined mainly by the cultural and social dimensions elucidated by Medical Pluralism. These early stages have been critiqued (Hsu, 2008, Perdiguero-Gil, 2006). Two of the most significant criticisms are: 1. That people do not make decisions in a rational manner as assumed by the model and 2. That this type of approach is less sensitive to historical, sociological and political dimensions, as well as to power issues (Hsu, 2008). These criticisms were further developed by the critical approaches to Medical Pluralism, which we will now review.

Critical Contributions: Making Power Visible

In response to the work already reviewed, with their functionalist, cognitivist, socioculturalist or clinical emphases, a series of critical approaches were developed. Most of them aligned with Critical Medical Anthropology (CMA) (Baer, 1989, Menéndez, 1983, Singer, 1990). Others, although they did not define themselves in this way, similarly sought to reestablish the missing link of economic-political determination (Crandon-Malamud, 1986, Knipper, 2006). Since Latin American approaches have been systematically invisibilized in English and French scholarship, we will focus our analysis on the approaches of Baer, Crandon-Malamud and Menéndez.

The focus of Hans Baer's approach is to give the studies on Medical Pluralism a Marxist perspective. His diagnosis is clear: except for a few exceptions, Marxists have not addressed Medical Pluralism, so it is necessary to investigate the extent to which Medical Pluralism reflects inequalities in the broader society, in terms of class, ethnicity, and gender (Baer, 1989, p.1031). What interests Baer is the stratified relationships established between medical systems. He introduces the concept of Dominative Medical System by characterizing the American system and showing the trajectory through which it stopped being pluralistic and became hierarchical and exclusionary. Biomedical hegemony, according to Baer, was achieved mainly through the inclusion of non-biomedical practitioners in medical societies.

Allopathy would have received the support of economic groups, remaining at the top of the dominative system, because their interpretation of the disease ignores social causes (Baer, 1989). This hierarchy is interpreted as the result of a historical economic-political process, in the

passage from a competitive capitalism to a monopolistic one, in the scope of the “modes of medical production.”

A. Biomedicine
B. Osteopathic Medicine as a Parallel Medical System Focusing on Primary Care
C. Professionalized Heterodox Medical systems
   1. Chiropractic
   2. Naturopathy
D. Anglo-American Religious Healing Systems (e.g. Christian Science, Spiritualism, evangelical faith healing)
E. Ethnomedical Systems (e.g. Black ethnomedicine, *curanderism*, *espiritismo*, *santeria*, Asian ethnomedicine American healing systems)

Figure 1. The American “dominative system” (Baer, 1989, p.1017)

This type of analysis is found in the work of Libbet Crandon-Malamud but with greater complexity. Indeed, Crandon-Malamud’s work has been recognized retrospectively as one of the precursors of CMA through his study on Medical Pluralism in Bolivia (Baer, 2003). His approach is consolidated with the publication of *From the Fat of Our Souls* (1991) where, following Unschuld (1975), he conceptualizes medicine as a primary resource, that is, one that being fungible has the peculiarity of allowing access to secondary resources (specifically ethnic and religious identity). Through his field material, Crandon-Malamud shows how in certain contexts, the choice of a type of medical care (indigenous, Methodist or domestic) can be a way to validate access to a new identity (religious or ethnic), and in this way access certain material and non-material benefits, a matter of vital importance within a framework of "social crisis" such as the revolutions that took place in Bolivia during his research and that permanently called into question and forced the redefinition of the social position of the inhabitants (Crandon-Malamud, 1991). Thus, Crandon-Malamud offers a theory of how medicine restructures social relations, contributing to the creation of social change, reversing the direction in which we usually think about the relationships between the medical and “meta-medical” fields in the Critical Medical Anthropology of Baer.

Although the contributions of Crandon-Malamud founded a visionary critical approach to Medical Pluralism, Latin American scholars developed a similar approach even earlier. One of Eduardo Menéndez's key texts, *Poder, Estratificación y Salud* [*Stratification, Power, and health*], was published in 1981, ten years before *From the Fat of Our Souls* and only five years after Leslie's "Asian Medical Systems" symposium. We discovered that when faced with the task of analyzing Medical Pluralism power relations, the CMA of the U.S. (Baer, Singer, & Johnsen, 1986) was outdated and problematic in several aspects when compared to that of Menéndez's contributions a decade prior.

It would be too ambitious to synthesize Eduardo Menéndez's contributions over four decades regarding Medical Pluralism. However, we can acknowledge him as an heir to the work of Ernesto De Martino, as he recovers the main elements of the Gramscian conception, namely, an emphasis on the ideological process in their indissoluble relationship with those of economic infrastructure, as well as the systematic reflection on how, within the Health/Disease/Care Process, we are permanently creating and recreating Hegemony/Subalternity Relationships (Feixa, 2008, Menéndez, 2012).

Menéndez has contributed at least three main lines of analysis that allow thinking about the production of Hegemony/Subalternity Relations within the Health/Disease/Care Process:

1. The illumination of forces in the ideological space, at the micro, meso and macro levels. Of special importance are his historical analyses of the process of medicalization, the critique of the assumptions of positivist epidemiology, the racism in the biomedical ideology, etc. (Menéndez, 1984, 2002).
2. The analysis of the relationships between Medical Knowledges, where the emphasis is

on the identification of the structural features of knowledge, from there to understand their participation in social stratification (Hegemony / Subalternity Relationships) (Menéndez, 1984).

3. The dynamic process of articulation of knowledges, where the emphasis is on the reciprocal transformation of knowledges in articulatory processes within Hegemony/Subalternity Relations and their contribution to their maintenance or transformation (Menéndez, 1996, 2005).

How is medical knowledge understood in this perspective? It constitutes those instances from which it is signified and acts with respect to health, illness, death, the normal and the deviant, and everything that can be included within their domains. Medical Knowledges are not entities, but processes of transformation (Menéndez, 1996), so they consist of an incessant structuring of representations and practices in the ideological field. Being productions of social groups, they are not reduced to the knowledge produced by specialized actors; one of the emphases in his work is that every social group articulates knowledges within the domestic space giving rise to the Self-Attention Knowledge (Menéndez, 1994). All medical knowledge has, in addition to the therapeutic function assigned to it, functions of social control, of regulation, and of production of subjectivity, as well as collective meanings. These functions are overshadowed by the therapeutic function that appears to be the exclusive one.

Then, how does this perspective understand the processes of articulation of medical knowledges? We cannot go into detail here (Cf. Piñones Rivera, 2015), but we can point out that speaking of articulations between medical knowledges (and not of transactions between strata) implies a double movement that emphasizes the historical, dynamic, procedural and transformative traits

of medical knowledge, besides its structural features (*ideal type*), while focusing the interest in the processes that occur *between* forms of medical knowledges.

Now, in an effort to synthesize critically, we can point out that although the theories about medical pluralism have progressively tackled the problem of its own political-economic determination, the panorama analyzed here reveals that no tools have been developed to satisfactorily address the problem of Cross-Border Mobility.

In this difficulty, we discover the confluence of several theoretical-epistemological elements that we could situate as the problem of a "non-situated Medical Pluralism" based on three systematic exclusions: mobility, space, and corporality. The authors of the first work on Medical Pluralism only addressed the problem of mobility present in the "therapeutic itineraries," that is, the one that actors perform between one medical knowledge and another, and reduced this mobility to the cognitive process of choice between medical knowledges. This body of work does not address the way mobility occurs in a specific space, such that the itinerary drawn between one knowledge and another can be influenced, not only by the cognitive process of choice but also by territorial processes and the conditions for mobility in said territory.

This absence in the field of Medical Pluralism reveals that there are problems both with respect to the ways in which spatiality is conceived (the relation between Medical Pluralism and Space) and the ways in which mobility has been conceived (Medical Pluralism-Mobility). A third systematically excluded element is the body. In the works reviewed, it seems that the medical knowledges, studied as practices and representations, were external to the bodies on which they operate. And it seems as if social actors are purely cognitive subjects, not bodies. Thus, we also intend to review the theoretical relations between Medical Pluralism and Corporality. Given that

the approaches to these dimensions are incipient and unsystematic, in the next section we will make a brief critical analysis of the existing literature.

Mobility, Territoriality, and Corporality: Prolegomena for a Study of Cross-Border Therapeutic Itineraries

Mobility and Health

As one of the main advances in the study of Medical Pluralism took place thanks to the incorporation of the economic-political dimension, we believe that one of the main contemporary challenges that will make it progress further is to bring in Cross-border Mobility processes. We can sketch a panorama that goes from the classic studies of Migration and Health to the contemporary conceptualizations of Mobility for health.

We observe four dominant approaches. The first is that of organizations such as the United Nations (UN), the International Organization on Migration (IOM), and the World Health Organization (WHO), which are interested in the repercussions of international migration on health, with a strong emphasis on the epidemiological surveillance of infectious and contagious diseases (WHO, 2003). Thus, AIDS, reproductive and sexual health, and tuberculosis (Molina-Salas, Lomas-Campos, Romera-Guirado, & Romera-Guirado, 2014), have been topics addressed especially in the studies on Migration and Public Health (CENSIDA/INSP, 2006).

The main conclusion of these studies is that both people and diseases cross national borders despite the political-administrative limits, establishing epidemiological comparisons between the local population and the migrant population, which is mainly conceived as a vector of diseases

(Piñones Rivera, 2015). Thus, risk behaviors of migrants are one of the main variables of analysis. Research is concentrated in border areas and in places where the migrant population is especially vulnerable, both for the health status in the countries of origin, and for the conditions of overcrowding and poverty in the host country (Cabieses, Bernales, & McIntyer, 2017).

The second approach is concern about the access and use of health services (Jelin, 2007), which includes the issue of financing that appears as a difficulty to overcome (Arredondo López, Orozco Núñez, Wallace, & Rodríguez, 2013) and the issue of the rights of foreigners, as opposed to the rights to health of local/native citizens. In these works, we also find discrimination and mistreatment directed towards the foreign community, suggesting that the causes lie in a structural deficiency of the system (Liberona Concha & Mansilla, 2017; Waldman, 2011).

The third approach focuses on the patient/therapist relationship as a social relationship, in which the professional models are the referents of the clinical encounter (Fassin, Costa-Lascoux, & Hily, 2017; Fortin & Laprise, 2007). Scholars in this sub-field state that clinical relationships are power relations, where immigrants find themselves in an unequal position, in which their explanation of the disease is not considered. When introducing the border dimension, the studies could cover some of the criteria that we are interested in investigating. However, we see that health issues have been under-studied, and the focus has been on border health control, strongly marked by the separation of nation-states and the pressure posed by the free transit agreements of people between nation-states, due to which the right to health is put into practice (Courtis, Liguori, & Cerrutti, 2010; Izerrougene, 2008).

A fourth approach is one that has addressed mobility motivated exclusively by the search for health. This field has been defined as “medical tourism” (Connell, 2015), “cross-border patient mobility” (Glinos, 2010) or “mobility for health” (Tapia Ladino, Liberona Concha, & Contreras,

2017). These are informal mobilities that have increased in the face of unmet demand or care not covered by national health systems (Bell, Holliday, Ormond, & Mainil, 2015), due to the privatization and commodification of health systems, low social coverage etc. (Glinos, Baeten, Helble, & Maarse, 2010). These studies show an increase in the search for cross-border health and the growth of a privatized, competitive and consumer-oriented health industry.

While these studies address different dimensions of the Health/Disease/Care Process, we can see that in all cases a state-centric conception of the problem has been adopted. The border is thought of restrictively in a juridical-administrative key: it is a control space, pivot of the asymmetry between health systems, or liminal space where rights are violated. It's never seen as the starting point of the creative practices that the actors produce in the search for care to their health problems. However, far from the State, the social actors have experiences and use medical knowledge to solve their health problems concretely, processes that none of these works investigate, contributing to the maintenance of the strategic alliance between the state apparatus and biomedical knowledge as hegemonic knowledge (Cant & Sharma, 1999; Piñones Rivera, 2015).

The tacit solidarity with this alliance can be seen when talking about "mobility for health" without questioning what the specific medical knowledge is from which the term "health" is implicitly or explicitly understood. In general, studies have assumed the biomedical perspective as evident, making invisible the fact that the problem can be addressed by including the heterogeneity of medical knowledges. On the other hand, and with the exception of the last approach, the mobility process is largely restricted to migration, reducing the possible spectrum as well as any systematic study of circulatory mobility.

In our extensive review, one of the few approaches that has problematized mobility while incorporating Medical Pluralism is that of Dilger, Kane, & Langwick (2012). The authors explicitly state that while health interventions are often initiated by national governments and global health institutions, these large-scale actors are only part of the total picture. However, this work is an exception to the various studies on Mobility and Health that we have reviewed since many exclude Medical Pluralism and limit their focus on mobility (including cross-border) to the itineraries within biomedical care spaces.

Space and Health

Thinking about mobility means thinking about the space in which it occurs. There is a whole field of studies that analyze the relationship between space and health (Cummins, Curtis, Diez-Roux, & Macintyre, 2007, Rainham, 2009, Thorsen, 2015, Wilson, 2003). Now, how many have thought about this relationship with Medical Pluralism? In what follows, we will analyze four paradigmatic approaches in the reflection on space and Medical Pluralism: that of the therapeutic landscape, that of the healthscape, the current socio-territorial approach to the study of health (Vialard, Squiban, Fournet, Salem, & Foley, 2017), and the approaches of Baud. While the first three have addressed health and Medical Pluralism from a consideration for space, the latter we chose as a good example of the treatment that a researcher on Medical Pluralism makes of the spatial dimension.

The study of the relations between Health and Space is recent, and the first approximations were static (Vialard et al., 2017), until the emergence of the approach of the Therapeutic Landscapes (Gesler, 1992). Starting from the assumption that every therapeutic process is always deployed in

space, Gesler set out to analyze this relationship, overcoming a purely physicalist conception towards one that integrates physical and constructed environments, as well as actions, intentions, constrictions and social structures (Gesler, 1992). Through the concept of the landscape taken from the "New cultural geography," the ambitious task of integrating the study of structure, agency, and time-geography was proposed when addressing health-seeking behavior in particular places and environments (Gesler, 1992). Gesler's approach is interesting because it shows that the incorporation of the concept of health seeking behavior can result in medical monism when the integration of Medical Pluralism is neglected: the search for care is analyzed only inside the space of biomedical knowledge.

This medical monism has as a correlation a concept we refer to as *space monism*, as Wilson (2003) has shown, by making a critical analysis of the use of the concept of Therapeutic Landscapes with native peoples, revealing the insensitivity of Therapeutic Landscapes to the culturally specific dimensions of the territory. To counteract this, Wilson proposes to overcome the emphasis on exceptional territories (e.g. pilgrimages) by focusing on "everyday geographies" (Wilson, 2003, p.85) and specifically on conceptions of health, the relationship between territory and identity, the contribution of land to holistic health and the importance of certain specific aspects of the landscape in health (e.g. the symbols of cultural identity).

We will have to wait for research based on the Healthscape concept (Gold & Clapp, 2011; Rainham, 2009; Rainham, McDowell, Krewski, & Sawada, 2010), to have a properly spatial approach to Medical Pluralism. Initially developed by Rainham in dialogue with and critique of the previously revised approaches, he makes explicit how the study of the relations between health and place is enriched through the study of Mobility, allowing us to study the diversity of places that influence health, including those that are distant in space and time, as well as the

heterogeneity of contexts associated with these movements (Rainham et al., 2010, p. 669). Rainham's study proposes to understand interaction as a spatial process, locations, and movements as paths, and grants an important place for both agency and social structure (Rainham et al., 2010).

This prepares the ground for the first approach that thinks about mobility in the context of Medical Pluralism, that of Gold & Clapp (2011). In line with the approaches of the CMA, its focus is on the interactions between medical systems (Gold & Clapp, 2011, p.97). From there, they analyze global power relations (Gold & Clapp, 2011, p.94), through the duality between the modern and the traditional, identifying biomedicine with the modern pole and locating it as a source of acculturation of indigenous medical knowledge. As a first approach to the problem of mobility in the context of Medical Pluralism, it seems valuable insofar as it incorporates in its analysis the economic-political dimension and aims to overcome a monistic view of the territory through the concept of Healthscape. However, several elements of their proposal seem insufficient:

1. The reduction of reflection on the relationship between medical knowledges to the traditional/modern duality, which has been systematically criticized by Menéndez since its inception (Menéndez, 1981). Biomedicine is not pure modern rationality, just as it is not true that other knowledge is devoid of "modernity," after centuries of colonization, accentuated by current globalization.
2. Although the work aims to analyze medical pluralism, what they analyze is a medical dualism, an issue that Crandon-Malamud (1991), whom they cite, insisted on problematizing. This is relevant because the introduction of other medical knowledge, like the evangelical one, unbalances the dichotomous analysis.

3. The great distance that exists between the theorizing about space in the concept of Healthscape and its concrete application in this work is noteworthy, in that the territory is reduced to being the scenario in which medicinal plants are found, as inputs for the Andean Medical Knowledge.

Recently, and in line with studies of medical pluralism, a socio-territorial approach to the study of health has been proposed, which recognizes the work of Gold and Clapp as a direct antecedent (Vialard et al., 2017). Vialard and colleagues propose to examine the potential influence of space (place) in the search for health, access to care and therapeutic strategies (Vialard et al., 2017, p.2). When questioning the relationship between urban populations, urban spaces, and health, they analyze both how societies manage space and how space influences society and social organization. Through the concept of territory, they emphasize the political and administrative sense of space, at the same time that they incorporate the social, cultural and historical meanings at the local level. In this way, space is understood as consisting of social strategies and territorial control, allowing them to examine the ways in which policies take material form in a specific space, and how this materiality of policies can influence inequities in health (Vialard et al., 2017). Thus, they define a study of health inequity that considers not only the physical environment, but also the social and environmental forces resulting from political management in its historical dimension, establishing -as a heuristic tool- that the way people move in the territory reflects power relations (Vialard et al., 2017, p.2).

All these elements of the socio-territorial approach seem to us significant contributions towards thinking about mobility in cross-border contexts, however, several criticisms can be raised from the perspective of Medical Pluralism:

1. By adopting the neighborhood scale as the main scale of analysis, the processes inherent to therapeutic itineraries that transcend this scale are rendered invisible.
2. The choice of the type of health problem addressed (diabetes, hypertension, and overweight) has been made from a biomedical point of view that is never problematized. This, which should be central to a study of Medical Pluralism, leads to many of the blind spots in the study.
3. The urban approach used in the article allows focusing on the level of neighborhoods without problematizing local conceptions and experiences of space as explored by Wilson (2003). The concept of territory used is too congruent with the governmental conception of territory, and thus does not allow one to think about cultural specificity.
4. In view of Rainham´s extension and clarification of the Healthscapes, the conception presented here appears limited, since it only conceives of the territory as a space for the availability of resources when referring to it as a place of "therapeutic options".
5. Although it constitutes a contribution to Rainham by incorporating Medical Pluralism as a study of Health Seeking Behavior and Therapeutic Itineraries, it does so in a homogenizing way, contravening one of the most radical elements of the studies of Medical Pluralism.

Finally, the work of Baud (2005) shows a magnificent example of a study of Medical Pluralism located in a specific space. The author shows with great ethnographic detail both Medical Pluralism and its dynamic interrelation with the territory. Starting from the hegemonic conception that situates the efficacy of Andean medical knowledge in the restoration of equilibrium or reciprocity, Baud develops a dynamic conception of the *mesas* (Baud, 2005, p.28) which are observed operating through the intervention of the territorial entities (here conceived

as “personifications of the landscape”), a clearly articulated Medical Pluralism. The *mesas*, typical of the Andean medical knowledge, serve to treat an infinity of health problems of biomedical nature (tuberculosis, blocked arteries, kidney problems), which, according to Baud, is due to the fact that the same territorial entities have learned and specialized in the treatment of certain organs or conditions defined in biomedical code. Thus, for example, Apu Wamansinchi is a specialist surgeon in the heart or brain (Baud, 2005, p.28); and Pachamama prescribes patent medicines that must then be purchased in pharmacies (Baud, 2005, p.28).

However, while Medical Pluralism is thought of in its Andean territorial dimension as a territory that, taking the expression of Duviols (1976), “*litomorphoses*” biomedicine, the relationship is thought of in the opposite sense only marginally: the territory is not the territory that observes the physicalist canon nor the one affected by the extractive industry, as presented by Baud. Indeed, only at the end of the article does the author point out that the same territory that humans destroy is the one that is symbolically handled from the *mesas*. This unidirectional approach makes us realize that in his work we find the socioculturalism criticized by Critical Medical Anthropology, since it does not situate cultural processes, such as those of the *mesa*, in their economic-political context: the environment to which he alludes is that of the litomorphized entities, but not that of their extractive destruction.

Medical Pluralism and Corporality

The last dimension that we are interested in addressing in our analysis, and that we have rarely found present in the studies on Medical Pluralism, is the corporal dimension. In our search, we

found two models that seem paradigmatic of the problems that the relationship between Medical Pluralism and Corporality exposes: those of Baud (2005) and Marion Cipriano (Cipriano, 2013).

In the work of Baud previously outlined, he clearly contrasts the development referred to the space with the one that makes the body. When we question his conception of the body we see that there is no specific problematization because while the *mesa* is a dynamic system in which the Andean and biomedical medical knowledges are articulated, it seems that the body is not. This continues to operate according to the reference of Andean medical knowledge: it is a body composed of Andean elements, whose proper functioning depends on not violating the cultural norms of Andean reciprocity, in which case it is penetrated by "beings of nature" or "personifications of the Andean landscape" (Baud, 2005, p.21). The uniformity of the Andean reference in thinking about the body is surprising when the *mesa* and the territorial entities incorporate medicines and injections specific to biomedicine. Therefore, the articulation of knowledges with an articulation of corporalities does not correspond. Only one body, the Andean body, is the one in which the articulation of medical knowledge operates through the *mesas*. Again then, the proposal does not manage to integrate the Medical Pluralism with a coherent conception of the involved corporalities, and even less, of the articulatory character of them.

The work of Marion Cipriano, on the other hand, contributes some elements of interest for our reflection, since it analyzes Medical Pluralism under the "focus of power." Her work mentions the "feminine care in the domestic sphere" and the existence of a medical pluralism "composed of a certain diversity of healers" (p.16), who join the institutional actors, denouncing a hierarchy of medical knowledges.

Cipriano analyzes the transformations produced by the installation of a health post in a Quechua village in Peru, based on the representations the population has of their bodies. The author raises the existence of a Quechua physical body that would be more adapted to herbal remedies than those delivered to the public health post. These remedies are considered by the Quechua community as maladjustments, of low or no effectiveness and even risky. However, she argues that some bodies will gradually become accustomed to these treatments, particularly the bodies of children and young women, who are more likely to see urban doctors. Given the multiple coercions that the biomedical system imposes on women, some of them claim the freedom to care for their own bodies and take care of their children and affirm their own identity through domestic care practices (Cipriano, 2013, p. 264).

She concludes that public health acts under a dynamic of control and normalization of bodies when there is a significant transformation of care practices. This will result in the transformation of individual bodies and the social body so that generational change would involve the passage "from one body to another:" the introduction of biomedical knowledge generates a different corporality, to which some women resist, maintaining their practices in the domestic space.
To close this section, we must point out that, in Cipriano's reflection on the body in Medical Pluralism, the existence of plural bodies or an articulation of corporalities is not sustained: they are unitary bodies that are politically transformed from an "Andean body" to a "biomedical body" through political transformations. Therefore, there are no Andean-Biomedical bodies, nor Andean-Biomedical-Pentecostal bodies. The plural conception of medical knowledges does not relate to a plural conception of corporalities.

Cross-Border Therapeutic Itineraries

Our framework for the study of mobility in the context of Medical Pluralism, for which we have coined the term Cross-Border Therapeutic Itineraries, is based on the main approaches of Latin American Critical Medical Anthropology to Medical Pluralism (*sensu* Eduardo Menéndez), as well as those of the Paradigm of Mobility (Tarrius, 2000). In this sense, it seeks to understand the therapeutic itineraries as processes of mobility of social actors within medical pluralism and in a dynamic relationship with a circulatory territoriality typical of the dynamics of cross-border mobility. Therapeutic itineraries are the ways in which social actors exercise their right to health on a daily basis, guided by the common sense understandings that arise from and produce processes of articulation of medical knowledges, guided by the practical need to take care of life. This pragmatic motive transgresses the imaginary frontiers of medical knowledges, generating new forms of articulatory efficacy that constitute an intercultural collective heritage. Given that itineraries are practices for exercising the right to health, any obstacle to their development constitutes a violation of this right and a form of structural violence (Baratta, 1990; Galtung, 1969); at the same time, any facilitation of such creative mobility constitutes a form of resistance to such violence.

Therapeutic itineraries produce, through the articulation of medical knowledges, new circulatory territorialities based on a circulatory knowledge that gives rise to "cross-border everyday geographies," paraphrasing Wilson (2003), being a new way of approaching the problem of mobility for health. Finally, the emphasis placed on the social actors, and not on the specialized agents of a medical knowledge, allows us to visualize the contribution that self-care *[autoatención]* makes to collective health, as a reference for pragmatic articulation on which

most of the health problems are resolved (Menéndez, 1994). The notion of mobility (especially across borders) allows us to overcome a conception that places this self-care *[autoatención]* too insistently within the domestic space, since it expands the processes of articulations to all the relational spaces between medical knowledges and locates them in a dynamic territorial dimension as is that of the cross-border circulatory territory thus constituted. Since our territorial conception is based on Tarrius, it is assumed that territory is defined from knowledge, so it validates the popular, indigenous, subaltern knowledge, not restricted to the hegemonic view.

Our research framework for therapeutic itineraries is multidimensional in that it includes:

a) The dimension of human mobility. For this we redefined the concept of the therapeutic itinerary from the Tarrius Mobility paradigm (2000), emphasizing the following points: 1. Mobility is based on circulatory knowledge by universes of local norms; 2. Mobility establishes social legitimacies; 3. Circulatory Knowledge is the result of negotiation processes; 4. Circulatory mobility produces territorialities. When studying Cross-Border Therapeutic Itineraries, we will try, therefore, to assess the social senses associated with human mobility, to the extent that these meanings constitute a circulatory knowledge in the search for health. Said circulatory knowledge, the collective memory that is configured there and the processes of negotiated legitimation will be the references to think about the production of a specific territoriality through which the fulfillment of the right to health for migrants is (or is not) given.

b) The ideological (cultural) dimension. Our focus will be placed on the articulation of medical knowledges, because ultimately, we understand that what operates in the definition of cross-border therapeutic itineraries is *common sense* (Gramsci, 1986) as articulations of ideological fragments that participate in the production of relationships of

hegemony/subalternity and operate as concrete ideological support of the practices that are deployed in the exercise of the right to health. While this is our focus, our consideration of the ideological dimension will not be restricted to medical knowledge, since the analysis of ideological processes is indispensable for all areas of social life, from the point of view of Critical Medical Anthropology.

c) The economic-political dimension. We understand it as the processes in which the material conditions of existence are defined within a certain mode of production. It includes the processes of production, distribution, and consumption of goods and subjectivities and is therefore intimately linked to the processes of stratification by social class. In the case of cross-border therapeutic itineraries, the economic-political dimension corresponds to the role played by the modes of production in the definition of at least the following topics: the organization of national health systems; the economic status that is given to the goods necessary to take care of health; the impact on health of development models; etc. The economic-political dimension participates, therefore, as an important determination of concrete therapeutic itineraries, since it constitutes the infrastructure for the ideological processes already mentioned.

d) The territorial dimension. In its specific sense, we are interested in knowing the territoriality that is produced through circulatory knowledge, in the use of different medical knowledges and in the exercise of the right to health. Thus, following Tarrius, we take the concept of territoriality in a dynamic relationship with human mobility, and since we define it from the production of knowledge, we give space to the cultural specificity of the relationship of every human group with the territory, in the sense already problematized by Wilson (2003).

e) The corporal dimension. If it has been argued that the concept of therapeutic itinerary overcomes the body/society distinction (Augé, 1996), we are interested in exploring this heuristic potential by questioning the extent to which the body is constructed through therapeutic itineraries and their circulatory territorialities. In this respect, our non-essentialist conception of the Health/Disease/Care Process allows us to think that the body is not constituted as a substance, nor is the disease already pre-defined essentially in its forms. Thus, the beginning of the health search process is not a biological body already sick, since the itinerary is not a socio-cultural and economic-political process that is added externally and subsequently to the disease and the body.

f) The dimension of rights. Finally, we conceive of Cross-Border Therapeutic Itineraries as ways of exercising the right to health. We are interested in seeing them as indicators of compliance with the rights and popular exercise of citizenship (Naranjo Giraldo, 2008). Thus, any limitation to mobility can be understood as a violation of rights, and therefore, as a form of Structural Violence (Baratta, 1990, Galtung, 2009).

These dimensions are not exclusive or exhaustive, but they allow us to define certain indispensable foci for the analysis of Cross-Border Therapeutic Itineraries. One of the ways to study them is based on the identification of certain mobility patterns. These patterns do not result from a rigid sequence but are discovered in a complex relationship between the characteristics of the social actors (their affiliation to native peoples, gender, age, educational level, ideological characteristics, etc.) and certain elements of the itinerary that function as *nodes*. The nodes are not predefined but are emerging from the process of the therapeutic itinerary, which does not mean that there are no conditions or determinations; said conditions and determinations should be studied through each social actor, not each individual.

Thus, the pattern in the itinerary is discovered in the recurrence of the dynamics of displacement and can be evaluated in terms of *facilitation and obstacles to mobility*, depending on the obstacles that hinder the exercise of the right to health. What appears is a complex of movement flows, in which different processes, institutions, actors or conditions of all kinds (including the so-called "spiritual," non-human agents and the materiality of public policies, for example), participate as obstacles or facilitators of the movement in their production of an itinerary.

Conclusion

We have provided an overview of the studies on Medical Pluralism and mobility showing a series of reductionisms: mobility is reduced to migration or to intra-border therapeutic itineraries; when the border is approached, it is only in a state-centric way, making the practices of cross-border mobility invisible; pluralism is reduced to a monism or to dualisms of medical knowledge and is not located in a territory, nor in a movement, nor in a corporality; when it is situated, it does not consider the coexistence of corporalities, territories or movements; finally, pluralism is understood primarily in socio-cultural terms, leaving aside the economic-political dimension.

The multiple obstacles that we have found have made us propose a new approach for the study of the relations between Medical Pluralism and Human Mobility in cross-border contexts. Its novelty and usefulness lie in the production of a new framework that is critically developed to address the main epistemological obstacles found in this field. We want to highlight as one of our main contributions the relationship that we define between Medical Pluralism, mobility, and corporality. We are interested in using the theoretical-methodological approach to corporality as a process that does not precede itinerary. That is to say, the therapeutic itinerary, as a whole,

through its wandering of spatialized Medical Pluralism will make up in different moments, and in a projective and retroactive way, healthy bodies, diabetic bodies, frightened bodies, sinful bodies, etc., according to the specific drifts of the actors through medical knowledge.

One of the main challenges consists in thinking about these bodies in a non-disjunctive way, but as a process of production/articulation of corporalities. Another is to think of them as corporalities proper to social actors, without reducing them to individual corporality. The reference to knowledge as ideological processes, in its irreducibly articulatory and collective character, constitutes one of our contributions towards the confrontation of these challenges, in the theoretical trajectory that goes from the conception of the body as biological essence, to one of the plural corporalities as a network of dynamic social, cultural, economic-political and territorial determinations.

References

Arredondo López, Armando., Emanuel Orozco Núñez, Steven Wallace, & Michael Rodríguez. 2013. "Indicadores de Gobernanza para el Desarrollo de Estrategias Binacionales de Protección Social en la Salud de los Migrantes." *Saúde e Sociedade* 22 (2): 310–327.

Augé, Marc. 1996. *El Sentido De Los Otros*. Buenos Aires: Paidós.

Baer, Hans, Merril Singer & John Johnsen. 1986. "Toward a Critical Medical Anthropology." *Social Science & Medicine* 23 (2): 95–98.

Baer, Hans. 1989. "The American Dominative Medical System as a Reflection of Social Relations in the Larger Society. *Social Science & Medicine*, 28 (11); 1103–12.

_____. 2003. "Contributions to a Critical Analysis of Medical Pluralism. An Examination of the Work of Libbet Crandon-Malamud." In *Medical Pluralism in the Andes*, edited by Joan D. Koss-Chioino, Thomas Leatherman, & Christine Greenway, 42-60. London: Routledge.

_____. 2011. "Medical Pluralism: An Evolving and Contested Concept in Medical Anthropology." In *A Companion to Medical Anthropology*, edited by Merril Singer & Pamela Erickson, 405-423. Oxford: Willey-Blackwell.

Baratta, Alessandro. 1990. "Derechos Humanos: entre Violencia Estructural y Violencia Penal." *Revista Del Instituto Interamericano de Derechos Humanos* 11: 11–28.

Baud, Sébastien. 2005. "Esprits Sauvages, Citadins et Maladie, Quand la Nature s' en Mêle." *Bulletin-Société Suisse Des Américanistes* 69: 21–33.

Bell, David, Ruth Holliday, Meghann Ormond, & Tomas Mainil. 2015. "Transnational Healthcare, Cross-Border Perspectives." *Social Science and Medicine* 124: 284–289. http://doi.org/10.1016/j.socscimed.2014.11.014

Cabieses, Báltica, Margarita Bernales, & Ana McIntyer. 2017. *La Migración Internacional como Determinante Social de la Salud en Chile: Evidencia y Propuestas para Políticas Públicas*. Santiago: Universidad del Desarrollo

Cant, Sara, & Ursula Sharma. 1999. *A New Medical Pluralism? Alternative Medicine, Doctors, Patients and the State*. London: Routledge.

CENSIDA/INSP. 2006. *Sida: Aspectos de Salud pública*. México: CENSIDA.

Cipriano, Marion. 2013. *D'un Corps à l'Autre: les Corps à l'Épreuve de la Santé Publique: Représentations et Pratiques Relatives aux Corps et aux Soins dans un Village des Andes Sud-Péruviennes*. Université Montpellier 3.

Connell, John. 2015. "From Medical Tourism to Transnational Health Care? An Epilogue for the Future." *Social Science and Medicine* 124: 398–401.

Courtis, Corina, Gabriela Liguori, & Marcela Cerrutti. 2010. *Migración y Salud en Zonas Fronterizas: el Estado Plurinacional de Bolivia y la Argentina*. Santiago: CEPAL.

Crandon-Malamud, Libbet. 1986. "Medical Dialogue and the Political Economy of Medical Pluralism: A Case from Rural Highland Bolivia." *American Ethnologist*, 13 (3): 463–476.

_____. 1991. *From the Fat of our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia*. Berkeley: University of California Press.

Cummins, Steven, Sarah Curtis, Ana V. Diez-Roux, & Sally Macintyre. 2007. "Understanding and Representing 'Place' in Health Research: A Relational Approach." *Social Science and Medicine*, 65 (9): 1825–1838.

De Sousa Santos, Boaventura. 2010. *Para Descolonizar el Occidente*. Buenos Aires: CLACSO.

Dunn, Frederick. 1976. "Traditional Asian Medicine and Cosmopolitan Medicine as Adaptative Systems." In *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie, 133-158. Berkeley: University of California Press

Duviols, Pierre. 1976. "Un Symbolisme Andin du Double: la Lithomorphose de l'Ancêtre." *Actes du XLIIe Congrès International des Américanistes* 4: 359–364.

Fassin, Didier, Jacqueline Costa-Lascoux, & Marie-Antoinette Hily. 2001. "L'Altérité de l'Épidemie. Les Politiques du Sida à l'Épreuve de l'Immigration." *Revue Européenne Des Migrations Internationales*, 17 (2): 139–151.

Feixa, Carles. 2008. "Más allá de Éboli: Gramsci, De Martino y el Debate sobre la Cultura Subalterna en Italia." In *El Folklore Progresivo y otros Ensayos,* edited by Carles Feixa, 13–66. Barcelona: MACBA.

Fortin, Sylvie & Elisha Laprise. 2007. « L'Espace Clinique comme Espace Social. » In *Éthique de l'Altérité. La Question de la Culture dans le Champ de la Santé et des Services Sociaux,* edited by Marguerite Cognet & Catherine Montgomery, 191–214. Montréal: Les Presses de l'Université Laval.

Foster, George. 1970. "Disease Etiologies in Non-Western Medical Systems." *American Anthropologist* 78 (4): 773–782. http://doi.org/10.1525/aa.1976.78.4.02a00030

Galtung, Johan. 1969. “Violence, Peace, and Peace Research.” *Journal of Peace Research* 6 (3): 167-191.

Gesler, Wilbert. 1992. “Therapeutic Landscapes: Medical Issues in Light of the New Cultural Geography.” *Social Science and Medicine* 34 (7): 735–746. http://doi.org/10.1016/0277-9536(92)90360-3

Glinos, Irene, Rita Baeten, Matthias Helble, & Hans Maarse. 2010. “A Typology of Cross-Border Patient Mobility.” *Health and Place* 16 (6): 1145–1155. http://doi.org/10.1016/j.healthplace.2010.08.001

Gold, Catherine Leah, & Roger Alex Clapp. 2011. “Negotiating Health and Identity: Lay Healing, Medicinal Plants, and Indigenous Healthscapes in Highland Peru. *Latin American Research Review* 46 (3): 93–111.

Gramsci, Antonio. 1986. *Cuadernos de la Cárcel. Edición Crítica del Instituto Gramsci a cargo de Valentino Gerratana. Tomo 4*. México: Ediciones Era.

Heyman, Josiah. 2012. “Construcción y uso de Tipologías: Movilidad Geográfica Desigual en la Frontera México-Estados Unidos.” In *Métodos cualitativos y su aplicación empírica. Por los caminos de la investigación sobre migración internacional*, edited by *Marina Ariza* & *Laura Velasco,* 419-454. México: Universidad Nacional Autónoma de México-El Colegio de la Frontera Norte.

Holland, William Robert. 1963. *Medicina Maya en los Altos de Chiapas: un Estudio del Cambio Socio-Cultural*. México: Instituto Nacional Indigenista.

Hsu, Elisabeth. 2008. Medical Pluralism. In *International Encyclopedia of Public Health Vol. 4*, edited by Harald Kristian Heggenhougen, 316–321. New York: Academic Press.

Izerrougene, Bouzid. 2008. “O desafio da Integração Social no Mercosul.” *Cadernos PROLAM/USP* 7 (13): 100–112.

Jelin, Elizabeth. 2007. *Salud y Migración Regional. Ciudadanía, Discriminación y Comunicación Intercultural*. Buenos Aires: IDES.

Kate Hampshire & Samuel Asiedu Owusu. 2013. “Grandfathers, Google, and Dreams: Medical Pluralism, Globalization, and New Healing Encounters in Ghana.” *Medical Anthropology* 32 (3): 37–41. http://doi.org/10.1080/01459740.2012.692740

Kleinman, Arthur.1978. “Concepts and a Model for the Comparison of Medical Systems as Cultural Systems.” *Social Science & Medicine* 12 (2B): 85–95.

Knipper, Michael. 2006. “El reto de la ‘medicina intercultural’ y la historia de la ‘medicina tradicional’ indígena contemporánea.” In *Salud e Interculturalidad en América Latina: Antropología de la Salud y Crítica Intercultural*, edited by Gerardo Fernández Juárez, 413–432. Quito: Abya-Yala.

Lambert, Helen. 2012. “Medical Pluralism and Medical Marginality: Bone Doctors and the Selective Legitimation of Therapeutic Expertise in India.” *Social Science & Medicine* 74 (7): 1029–1036. http://doi.org/http://dx.doi.org/10.1016/j.socscimed.2011.12.024

Leslie, Charles. 1976. *Asian Medical Systems: A Comparative Study*. Berkeley: University of California Press.

Liberona Concha, Nanette. 2012. “De la Alterisación a la Discriminación en un Sistema Público de Salud en Crisis: Conflictos Interétnicos a propósito de la Inmigración Sudamericana en Chile.” *Revista de Ciencias Sociales* 28:1-38.

Liberona Concha, Nanette., & Miguel Ángel Mansilla. 2017. “Pacientes ilegítimos. Acceso a la Salud de los Inmigrantes Indocumentados en Chile.” *Salud Colectiva* 13 (3): 507-520.

Lomas-Campos, María de las Mercedes, Francisco José Romera-Guirado, & María Jesús Romera-Guirado. 2014. “Influencia del Fenómeno Migratorio sobre la Tuberculosis en una Zona Semiurbana.” *Archivos de Bronconeumología* 50 (8): 325–331. http://doi.org/10.1016/j.arbres.2014.01.009

Macartney, John, & Ayo Wahlberg. 2014. “The Problem of Complementary and Alternative Medicine Use Today: Eyes Half Closed?” *Qualitative Health Research* 24 (1): 114–23. http://doi.org/10.1177/1049732313518977

Martínez-Hernáez, Ángel. 2008. *Antropología Médica: Teorías sobre la Cultura, el Poder y la Enfermedad.* Barcelona: Anthropos.

Menéndez, Eduardo Luis. 1981. *Poder, Estratificación y Salud: Análisis de las Condiciones Sociales y Económicas de la Enfermedad en Yucatán*. México: Ediciones de la Casa Chata.

_____. 1983. *Hacia una Práctica Médica Alternativa: Hegemonía y Autoatención (Gestión) en Salud*. México: CIESAS.

_____. 1984. “El Modelo Médico Hegemónico: Transacciones y Alternativas hacia un Modelo de Autoatención en Salud. *Arxiu D’etnografia de Catalunya*, 3: 85-119.

_____. 1994. “La enfermedad y la curación ¿Qué es medicina tradicional?” *Alteridades* 4 (7): 71–83.

_____. 1996. “El Saber Popular como Proceso de Transformación: Tipos de Articulación entre la Biomedicina y la Medicina Popular.” In *Creer y Curar: la Medicina*

Popular, edited by José Antonio González Alcantud y Salvador Rodríguez Becerra*,* 31–63. Granada: Diputación Provincial de Granada.

_____. 2002. *La Parte Negada de la Cultura*. Barcelona: Bellaterra.

_____. 2005. "Intencionalidad, experiencia y función: la articulación de los saberes médicos." *Revista de Antropología Social* 14: 33–69.

_____. 2012. "Antropología Médica. Una genealogía más o menos autobiográfica." *Gazeta de Antropología* 28 (3).

Miles, Ann, & Thomas Leatherman. 2003. "Perspectives on Medical Anthropology in the Andes." In *Medical Pluralism in the Andes*, edited by Joan D. Koss-Chioino, Thomas Leatherman, & Christine Greenway, 3-15. London: Routledge.

Naranjo Giraldo, Gloria. 2008. "Migrantes y Desplazados en las Fronteras Culturales y Políticas de la Ciudad… ¿Cuál Ciudadanía?" *Cultura Urbana*, 1–14.

OMS. 2003. Migración Internacional, Salud y Derechos Humanos. Ginebra: OMS.

Orlove, Benjamin. 1977. "Inequality Among Peasants: The Forms and Uses of Reciprocal Exchange in Andean Peru." In *Peasant livelihood: Studies in Economic Anthropology and Cultural Ecology*, edited by Rhoda H. Halperin & James Dow, 201–226. New York: St. Martin's Press.

Perdiguero-Gil, Enrique. 2006. "Una Reflexión Sobre el Pluralismo Médico." In *Salud e Interculturalidad en América Latina: Antropología de la Salud y Crítica Intercultural*, edited by Gerardo Fernández Juárez, 33-49. Quito: Abya-Yala.

Piñones Rivera, Carlos. 2015. *La Mala Hora. Articulaciones en el pluralismo médico de agricultores precordilleranos aymaras chilenos*. Universitat Rovira i Virgili.

Press, Irwin. 1969. "Urban Illness: Physicians, Curers and Dual Use in Bogota." *Journal of Health and Social Behavior* 10 (3): 209–218.

Rainham, Daniel, Ian McDowell, Daniel Krewskic, & Mike Sawada. 2010. "Conceptualizing the Healthscape: Contributions of Time Geography, Location Technologies and Spatial Ecology to Place and Health Research." *Social Science and Medicine* 70 (5): 668–676. http://doi.org/10.1016/j.socscimed.2009.10.035

Rainham, Daniel. 2009. *Human Healthscapes as an Approach to Measuring Context in Research on Place and Health*. University of Ottawa

Sindzingre, Nicole. 1985. "Présentation: Tradition et Biomédicine." *Sciences Sociales et Santé* 3: 9-26.

Singer, Merril. 1990. "Reinventing Medical Anthropology: Toward a Critical Realignment." *Social Science & Medicine* 30 (2): 179–187. http://doi.org/10.1016/0277-9536(90)90078-7

Stoner, Bradley. 1986. "Understanding Medical Systems: Traditional, Modern, and Syncretic Health Care Alternatives in Medically Pluralistic Societies." *Medical Anthropology Quarterly*, 17 (2): 44–48.

Tapia Ladino, Marcela, Nanette Liberona Concha, & Yasna Contreras. 2017. "El Surgimiento de un Territorio Circulatorio en la Frontera Chileno-Peruana: Estudio de las Prácticas Socio-Espaciales Fronterizas. *Revista de Geografía Norte Grande*, 66:

Tarrius, Alain. 2000. “Leer, Describir, Interpretar. Las Circulaciones Migratorias: Conveniencia de la Noción de “Territorio Circulatorio”. Los Nuevos Hábitos de la Identidad. *Relaciones* XXI (83): 38–66.

Thorsen, Rikke Stamp. 2015. “Conceptualizations of Pluralistic Medical Fields: Exploring the Therapeutic Landscapes of Nepal.” *Health and Place* 31: 83–89. http://doi.org/10.1016/j.healthplace.2014.11.004

Vialard, Lucie, Clara Squiban, Gilles Riveau, Emmanuel Hermann, Doudou Diop, Florence Fournet, Gérard Salem, & Ellen E. Foley. 2017. “Toward a Socio-Territorial Approach to Health: Health Equity in West Africa.” *International Journal of Environmental Research and Public Health* 14 (1): 106. http://doi.org/10.3390/ijerph14010106

Waldman, Tatiana Chang. 2011. “Movimentos Migratórios sob a Perspectiva do Direito À Saúde: Imigrantes Bolivianas em São Paulo.” *Revista de Direito Sanitário* 12 (1): 90–114.

Weiner, Annette. 1992. *Inalienable Possessions*. Berkeley: University of California Press.

Wilson, Kathleen. 2003. “Therapeutic Landscapes and First Nations Peoples: An Exploration of Culture, Health and Place.” *Health and Place* 9 (2): 83–93. http://doi.org/10.1016/S1353-8292(02)00016-3

Zempleni, Andreas. 1985. “La Maladie et ses Causes.” *L’Etnographe* 96-97 (2-3): 13-43.

Institute for the
Study of
Societal Issues

2420 Bowditch St. # 5670
Berkeley , CA 94720-5670

tel: 510-642-0813
fax: 510-642-8674

email: issi@berkeley.edu
web: http://issi.berkeley.edu