Introduction

Andrea Pieroni and Ina Vandebroek

Ethnobiology as a Contested Discipline: From the Exotic and Remote to Urban Studies in Our Own Backyard

The research area that represents the lynchpin of this book is situated between *transcultural health studies* and what we call today *urban ethnobotany* (Balick et al. 2000). In the late 1990s, ethnobotanists became interested in urban ethnobotany when they began to realize that biocultural diversity (Maffi 2001) is not restricted to dispersed and marginal communities of the planet; it is also very much a part of metropolitan areas. Young ethnobotanists often talk of their dream to "boldly go" in the tradition of Star Trek, where no man (or woman) has gone before, to some remote and exotic tropical place where they can study peoples and their knowledge, beliefs, and practices, including their use of plants. Many young ethnobotanists would prefer to work with indigenous tribes in tropical rainforests, because there is a notion deeply rooted in Western public opinion that a wealth of ethnobotanical knowledge is hidden away in some far-off jungle just waiting to be uncovered (Voeks 2004). They do not seem to be aware of the fact that ethnobiology and ethnobotany can be studied just as effectively in immigrant communities who live, literally speaking, in our own backyard. Indeed, no passport or airplane ticket is required to study exotic plants and the traditional beliefs surrounding their use in multicultural, urban settings. One could stubbornly insist, of course, that this kind of urban ethnobotany will probably be "minimal" compared to the "original" wealth of knowledge held by remote indigenous forest tribes. It is true that urban ethnobotany is still in its infancy, and as yet no extensive studies have been conducted that would allow us to compare the breadth of plant knowledge in rural, tropical study areas with urban temperate study areas. Or to put it another way, there still is very limited data available to make comparisons *in situ* (in immigrants' country of origin) with *ex situ* (in immigrants' host countries).[1]

Nevertheless, the dynamic and challenging subfield of urban ethnobotany is rapidly gaining attention worldwide, and on-going studies are already providing a surprising amount of ethnobiological and ethnopharmaceutical data from immigrant communities in urban settings (e.g., Balick et al. 2000; Corlett et al. 2003; Pieroni et al. 2005; Sandhu and Heinrich 2005; Johnson et al. 2006; Waldstein 2006).

Migrants' Health

The growing interest of medical anthropologists and other social scientists in ethnicity and health studies in multicultural societies parallels an increasing awareness that the meaning of health in multicultural societies is often broader and more complex than what is understood in classical Western biomedical terms. In order to understand human well-being, we need to take into consideration *emic* or insiders' health perceptions, beliefs, and practices (Balarajan 1996), instead of focusing merely on the *etic* or outsiders' approach. This is significant given the contested nature of the concepts "ethnicity" and "health" (Anand 1999; Bradby 2003). *Emic* approaches to migrants' health studies represent important turning points in public health discourses aimed at improving interventions devoted to ethnic "minority" groups in Western countries (Trevino 1999; Mackenbach 2006). For instance, it has been shown that immigration to Western metropolitan areas has a significant impact on migrants' experience and meaning of illness, and on their health care-seeking strategies (Papadopoulos et al. 2004; Owusu-Daaku and Smith 2004; Gilgen et al. 2005; Belliard and Ramírez-Johnson 2005).

Research on transcultural health also includes studies conducted on migrants' dietary habits (Jonsson et al. 2002; Burns 2004; Cwiertka 2005), as nutrition and health are closely intertwined (Etkin 2006; Pieroni and Price 2006, and chapters in this volume).

Open Questions

Several scientific questions remain open for investigation in the field of ethnobotany and transcultural health. They include the following:

- Do migrants still depend on their own health care strategies within the domestic domain, including the continued use of food and medicinal plants brought over from their home countries or purchased in local shops in the host society for common, chronic, and/or culturally important health conditions? If so, why is this the case?
- In what ways do migrants' health care-seeking strategies change over time, in response to "internal" dynamics of identity and representation within the migrant community, and to external environmental, cultural, social, and political changes in the host country, including public health care policies?

- What are the existing articulations between migrants' own health care systems and the biomedical system?
- To what extent are institutional health actors in the host country aware of these strategies?

Mobility in Urban Environments

Mobility is a key factor in shaping human history (Sanjek 2003). Over the past several decades, national and transnational migrations have gained momentum so that they now take place on a large scale in an increasingly urbanized and "globalized" world. Plural societies are as much a part of our reality today as the Internet, with some 140 million persons living outside their country of birth. Ethnic diversity is a hallmark of large metropolitan areas such as New York City and London. Furthermore, by 2007, the majority of the world's population will live in urban areas; hence migration is now considered to be a primarily urban phenomenon (Galea et al. 2005).

Migration and cities appear to be intrinsically linked within most immigrants' countries of origin, where people tend to move away from rural areas toward urban centers. Transnational migration is responding to the same tendency, and usually involves settlement in large urban areas upon arrival in the host country. Immigration is also intertwined with health and health care, as many immigrants often lack health insurance coverage, or face linguistic, cultural, or legal barriers to biomedical care. The usual result is in an underutilization of the official, biomedical health care system in the host country. On the other hand, people who cross borders and arrive in new societies do not come empty handed. They bring along their own traditions, lifestyles, world and health views, as well as their own support systems, which include knowledge about plants for health care and nutrition. These attitudes and practices are maintained to varying extents in the host society (e.g., Gomez-Beloz and Chavez 2001, Nguyen 2003).

This volume is a compilation of studies that deal with transnational movements, urban living, health and health care, biocultural adaptation, and past and present interactions between people and plants for health, food, well-being, and identity. Each chapter explores different dimensions that exist between immigrants, health, well-being, disease and illness, plants, and/or identity by drawing examples from different continents at different moments in time, and addressing the dynamics that occur between immigrant groups and host societies.

Strengthening or Adapting Cultural Identities?

Biocultural adaptation, cultural negotiation, and identity are key issues for anthropological discourses on displacement and migrations (Janes and Pawson 1986; Belliard and Ramírez-Johnson 2005). Research in culturally homogenous and/or

non-urban environments has shown that to follow the pattern of change in traditional knowledge and use of plants among migrants implies the analysis of acculturation processes (Bodeker et al. 2005; Nesheim et al. 2006). Acculturation has been identified as one of the explanatory concepts that encompass the complexity of migrant adaptation (Janes and Pawson 1986). Acculturation has been discussed in communication sciences as being the result of two simultaneous processes: one involving deculturation from the original culture, and the other enculturation toward the host culture (Kim 2001). The old model of cultural adaptation is quite problematic, since it is highly unlikely that a culture, after moving, simply "adapts" to the new autochthonous culture. There are at least two reasons for this:

- Adaptation does not represent a sort of "destiny". On the contrary, it is only one of many diverse possibilities that migrants have in their interface with the host culture. Adaptation is, in fact, the result of cultural negotiations.
- The host environment is not always culturally homogenous. Indeed, Western metropolitan milieus are never culturally homogenous.

Often migrants may choose other strategies, those aimed at strengthening their cultural identities, for example, in a process that is similar to what other scholars in ethnoecology define as "resilience" at ecological and cultural edges (Turner et al. 2003). Strengthening their own identities in the midst of autochthonous/host populations means that migrants may want deliberately to retain their traditional knowledge and practices, in order to affirm their distinct cultural identity. In other words, they may wish to say, "I am different from you, and I am proud of it!" The strategy of "strengthening identities" and the cultural adaptation model are theoretical opposites; what migrants do in reality probably lies somewhere in between the two. The exact location depends very much on the dynamics in the migrants' changing interface with their host cultural context. Moreover, since ethnicity is the complex result of social processes too (Barth 1969; Baumann 1999), and cultural boundaries are very dynamic (and may even be seen as constructs that are created by our own processes of representation, see Clifford and Marcus 1986; Marcus 1998), plant uses, and especially their representations, may change rapidly in response to continuously shifting cultural negotiations.

The Chapters in This Book

This volume is partially based on papers presented by the panel, "Ethnopharmacy and Migration", at the 9th International Congress of Ethnobiology (organized by the International Society of Ethnobiology at the Department of Anthropology, University of Kent at Canterbury, UK, 14–17 June 2004). It is an attempt to offer an overview of diverse approaches and research questions, all of which

focus on "traveling" plants for food and medicine, and transcultural health and diet studies. This book is organized according to immigrant group and continent. The first three chapters look into Latino immigrants in New York City; chapters 4 and 5 give an account of Asians in the United States and Europe; chapters 6 to 9 deal with immigrants in Western Europe, ranging from Surinamese immigrants in Amsterdam, to Latino, Kurdish, and Somali immigrants in London; and the last three chapters focus on plant uses and historical migrations and/or cultural exchanges in Northern and Southern Europe, and Northwestern Africa, respectively.

Latino Immigrants in New York

In the first chapter, Andreana Ososki and coworkers present an overview of ethnobotanical research on medicinal plant knowledge pertaining to women's health conditions among rural and urban communities in the Dominican Republic, and Dominican healers in New York City. The work of Ososki et al. shows that Dominican traditional medicine is not confined within the borders of the Dominican Republic. On the contrary, Dominican healers in New York City have retained and adapted their plant knowledge according to the local prevalence of women's health conditions and the availability of plants. The authors also demonstrate that selected Dominican rural study sites hold a greater amount of general medicinal plant knowledge than urban sites for most of the women's health conditions that were surveyed, with the exception of uterine fibroids (benign tumors that develop within the wall of the uterus or attached to it). The rural-urban disparity in plant knowledge for uterine fibroids in the Dominican Republic is further pronounced by a transnational comparison between the Dominican Republic and New York City. In the latter environment, a higher number of distinct plant species was reported as compared to the urban and rural Dominican Republic study sites. This may be because women in urban settings are more familiar with the diagnosis of uterine fibroids, especially in a metropolis with modern screening facilities like New York City. Furthermore, in New York City, several plant species were substituted. Sometimes, but not always, these plant species were closely related to the species used in the Dominican Republic. This example nicely illustrates how the dynamics of medicinal plant knowledge and use are triggered by migration. The authors call for continued research that addresses cultural variation and change by examining the distribution of intracultural plant knowledge across rural, urban, and transnational landscapes.

Chapter 2 presents the results of a survey conducted by Ina Vandebroek and coworkers with Dominican immigrants in New York City, who self-medicate with medicinal plants (non-specialists or laypeople). Plant remedies reported by Dominican participants as "used in New York City only" (and hence not used in the Dominican Republic, nor used in both countries) were compared with Domini-

can and Caribbean plant-use data from scientific literature. The results demonstrate that there exists a high correspondence of plant remedies used for flu, common cold, and respiratory disorders between New York City and the Dominican Republic. On the other hand, plants used in New York City to treat high cholesterol and diabetes are not corroborated by the reviewed literature from the Dominican Republic. These results lead to a new research question: Are plant remedies for high cholesterol and diabetes "exclusive" to New York City because of a higher prevalence of these health conditions or better screening facilities, or did former inventories in the Dominican Republic simply not record data on diabetes and cholesterol?

In the third chapter, Anahí Viladrich approaches Latino immigrants' healing practices in New York City from a different angle. She describes New York City *botánicas* (ethnic healing stores annex plant pharmacies that sell religious and ritual items, and/or dried and fresh medicinal plants) as focal points that maintain connections between a dispersed immigrant community of practitioners (healers) and followers (clients) of spiritual, religious, and physical healing. These *botánicas* are culturally grafted entities that resemble *botánicas* in immigrants' home countries. However, the multicultural urban setting in New York City allows immigrant healers to experiment, interchange, disseminate, and gain profit from their knowledge on a larger scale than in their country of origin. At the same time, Viladrich points out that the widening and blending of different spiritual and religious healing practices such as *Santería*, *Espiritismo,* and Yoruba are compromised by serious limitations on plant availability in the host country. The United States government strictly regulates plant species allowed into the country; hence rituals that originally require 100 to 200 different plants have been adapted so that only 21 herbs are needed. In New York City, healing has shifted on a continuum from informal exchange towards a profit making enterprise. Plants are not only remedies for clients' relief of spiritual, emotional, or physical complaints, but also a concrete means of survival for healers.

Asian Migrants in the United States and Sweden

In Chapter 4, Usha Palaniswamy presents a study that focuses on Indians in the United States and their knowledge, beliefs, and preventive practices in relation to diabetes. Palaniswamy reveals that dietary modifications have occurred within the participating Indian groups, which have different levels of acculturation. Some groups, for example, have reduced their intake of traditional foods that contain plant species with known hypoglycemic potential. Reasons for no longer using these species included a lack of knowledge about these plants' health benefits and non-availability of these plants at neighborhood grocery stores in the United States. Interestingly, neither Indian immigrants who already lived for more than ten years in the United States, nor second-generation immigrants born in the

United States, have abandoned traditional diets completely. Furthermore, the immigrants in this study indicated that they were growing specific plants from India in their home gardens, despite difficulties in procuring plants from India or other sources and/or growing these plants in a temperate climate. Palaniswamy urges that health promotion programs for Indian immigrants incorporate education about the benefits of traditional diets.

In Chapter 5, Pranee Lundberg explores the knowledge, beliefs, and practices of Thai immigrant women in Sweden in relation to medicinal plant use, and identifies the following contexts: (1) Thai immigrant women's belief that certain plants will help users become or remain strong, healthy, and free from disease; (2) medicinal plants can be used in the treatment of common health conditions; and (3) traditional health beliefs and practices such as Thai massage and puerperium rituals are used in an effort to regain health or avoid ill health. Lundberg found that medicinal plants were administered as condiments and spices, and as teas or health drinks, either in response to illness or for illness prevention. Furthermore, the Thai women who were interviewed described how they used plants curatively to treat common illnesses, such as colds, cough, sore throat, and stomachache, as well as chronic health conditions such as menopause, hyperglycemia, and hypertension. The study also found that Thai immigrant women in Sweden combine biomedical health care with traditional Thai herbal remedies for diseases such as cancer. Lundberg's interviewees reported, not only about herbs, but also about *emic* holistic views related to health. Lundberg believes that recording these practices is important for health care providers working with Thai immigrants in Sweden, because the information will enable them to deliver culturally appropriate health care.

Surinamese in Amsterdam

In Chapter 6, Tinde van Andel and Charlotte van't Klooster give an account of their urban ethnobotany research on Surinamese immigrants in Amsterdam. Their study shows that a wide variety of Surinamese medicinal plants is offered for sale in Amsterdam, many of which are imported from Surinam where most are harvested in the wild. Hence, in spite of the fact that in The Netherlands most legal immigrants have health insurance and access to modern health facilities, medicinal plants still play an important role in the well-being of Surinamese immigrants. The medicinal plants listed during the survey were most frequently used for gynecological problems and rituals for psychosocial ailments. This observation has led the authors to conclude that gynecological and psychosocial ailments must be perceived as culturally important by the Dutch Surinamese community. They point out that it is quite easy to import medicinal plants from Surinam to The Netherlands. No permit is needed for personal use as long as no endangered species are involved. This situation is in sharp contrast with the strict

customs regulations described for Colombians in London (chapter 7) and for Latinos in New York (chapters 1 and 2), and might help explain the higher number of local/"exotic" versus common/"globalized" plant species in the urban pharmacopoeias of The Netherlands compared with the United Kingdom and the United States.

Migrants in Urban United Kingdom

In chapter 7, Melissa Ceuterick and colleagues explore the use of home remedies by Latino immigrants in London, and demonstrate that immigrants' actual use of particular plant species for health care and well-being is a practical matter of plant availability in the host country. The United Kingdom's harsh importation laws make it difficult for herbal material from non-European Union countries to enter the country. Ceuterick et al. argue that, as a consequence, Latino immigrants in London restrict their plant use to commonly known and "globalized" species such as garlic, chamomile, mint, eucalyptus, *Aloe vera,* and citrus fruits. The authors also offer practical methodological lessons drawn from their research. For instance, querying participants for "plants to treat disease" yielded very few answers. This may be because in the Latino view of health, self-medication with home remedies is linked to discomfort and the re-establishment of well-being rather than disease. Furthermore, querying participants about "plants" can cause confusion because this term is culturally interpreted as "herbs", hereby ruling out a range of health foods and food medicines.

In chapter 8, Sarah Keeler focuses less on plants and plant uses, and more on local food culture and the articulation of cultural identity. Keeler's study was conducted among the Kurdish community in Hackney, London, and her core question was: "In what ways do the *how*, *where,* and *with whom* of eating habits contribute to the sense of self and other?" Her paper is based on fourteen months of fieldwork with Kurdish migrants and refugees in a multiethnic London community and looks at food culture from this perspective. In particular, it explores the ways in which food becomes a marker of ethnic difference, and a means of imagining and maintaining identity boundaries within the Kurdish diaspora, and as a consequence of narrating their history and migratory experience, including the changing contours of social relations in the diaspora. Of particular significance for the Kurdish community is the way these processes are played out with regard to their relations with the sizable Turkish community, with whom they coexist in the same inner-city area of London. The study reveals how foodstuffs and cuisine culture become, within these narratives, emblematic of a politico-historical experience in the homeland, in which Kurdish ethnic identity was perceived as being obscured, and aspects of Kurdish culture appropriated by Turkish antagonists, and how this experience is reproduced in local political economic relations in the position of exile. Keeler also looks at how the reclamation of this

"stolen" and degraded identity is enacted through foodways that memorialize imaginings of the homeland and assert a continued presence and resistance through embodied practices of food production and consumption. In exploring these questions, the author considers the traditional concepts of use value and exploitation of resources in symbolic rather than material terms, and more specifically, how this exploitation of resources within public space is used as a means of managing expressions of identity. For Kurds embedded within the local ethnic economy of Hackney, and often identified from an external perspective as "Turkish speakers" or even Turks, there is a considerable degree of ambivalence toward the many factors that shape their identification. These factors include a sense of responsibility to and pride in maintaining a distinct ethnic identity; the desire to integrate socially into the local culture; and the very pragmatic economic interests met by the essentializing expressions of ethnicity in the commercial arena. Keeler suggests that it is perhaps because of this ambivalence, and the relative fluidity of ethnic identifications at the local level (particularly within the economy and public space), as familiar social relations are juxtaposed, reconfigured, and rendered unfamiliar in the multicultural metropolis, that foodways become more salient as signifiers of historical experience, ethnic integrity, and purity. In the case of food culture in Hackney's "Little Turkey", the consciousness of ethnic identity and its expression through food is informed by wider economic, political, and social discourses at local and transnational levels.

In chapter 9, Neil Carrier focuses on khat consumption within the Somali diaspora in the United Kingdom. Carrier emphasizes khat's social and cultural importance in the life of Somalis, and also its reception in the West, as well as its glib absorption into debates concerning substances with very different cultures of consumption. The spread of khat and khat consumers to the Western countries has raised major public health concerns for the migrant communities involved. Carrier criticizes the approach the media and diverse stakeholders are taking on this issue and writes of their "demonization" of such practices. He explains that, despite these reactions, khat consumption is probably not going to disappear in the near future, as the use of a plant means much more to an immigrant community than its taste or effect.

Non-urban Historical Migrations in Europe

In chapter 10, Cassandra Quave and Andrea Pieroni offer a cross-cultural comparison of traditional medical practices, botanical remedies, and foods in a small, ethnic Albanian Arbëreshë community and in an autochthonous Italian village in Lucania, southern Italy. Despite the fact that the two communities share similar sociodemographic, economic, and geographic characteristics, they differ considerably in the way they use plants for food and medicine. Not only are the autochthonous Italians familiar with a much larger botanical pharmacopoeia

than the Arbëreshë, but they also follow a different medical framework. The authors suggest that the lower number of medicinal plants known to the Arbëreshë is due to their heavy reliance on a ritualistic or spiritually based system of complementary medicine. In the Arbëreshë system, plants serve an underlying role as spiritual objects and are not necessarily associated with being the source of a cure. With regards to wild food botanicals, the Arbëreshë more frequently integrate *liakra,* or wild/weedy greens, into their daily diet. While their cuisine has certainly grown due to an informational flux with neighboring Italian communities, this exchange of culinary knowledge has probably not been a mutual phenomenon, as the authors have not been able to clearly trace Albanian food plants and food plant uses in the surrounding South Italian culinary traditions. The multifaceted picture provided in this study demonstrates the complexity of comparative ethnobiological studies on migratory populations, and how these are influenced by social processes that are very rarely mutual. This study also illustrates how "traveling plants" and their related uses can be more obscure than first impressions would suggest.

In chapter 11, Ingvar Svanberg gives another perspective on historical migration and cultural exchange trajectories in his research on plant knowledge and historical cultural contacts in the Atlantic Fringe. Svanberg's case study focuses on tormentil (*Potentilla erecta* L.), which until the end of the nineteenth century was used as a source of tannins within the household economy of Atlantic islands where trees are lacking or scarce. Svanberg shows that when the local ecology restricted the amount of available tanning plants, as in the case of the Hebrides and the Orkney, Shetland and Faroe Islands, tormentil was found to be a good substitute. Svanberg suggests that the islanders' knowledge of *Potentilla erecta* uses was probably not brought by the Vikings from Norway, but was more likely to have been discovered locally either in the Faroes, Shetland, or Orkney Islands and then spread to the other islands. This has been confirmed using ethnolinguistic analysis and clearly demonstrates how plant knowledge has been exchanged among populations since ancient times, and how the cultural history of plant uses—along with archaeobotany and the history of Materia Medica/pharmacognosy—could represent interesting arenas for studying the dynamics of ethnobiological knowledge in human societies that are fortunate enough to retain a relevant heritage of historical texts or written sources.

Displacements in Northwestern Africa

In Chapter 12, Gabriele Volpato and colleagues focus on the procurement of traditional remedies and the transmission of medicinal plant knowledge among Sahrawi people displaced in southwestern Algerian refugee camps. The authors suggest that Sahrawi refugees have preserved the use and knowledge of traditional medicinal remedies in the camps, and have established a variety of networks in

order to obtain these remedies. The authors have recorded mostly wild plants gathered in the part of western Sahara controlled by the *Polisario,* the political and military organization that represents the refugees. They found that soldiers stationed there play an important role in the procurement of these remedies for refugees' families. The detailed study by Volpato et al. shows how the conservation of traditional medicine in this kind of context represents a means of maintaining cultural identity, and that the procurement of remedies from the "liberated territories" in western Sahara allows refugees to maintain ties with their place of origin. The conservation of traditional knowledge and practices also represents resistance to acculturation and a way of alleviating despair. Many refugees report feeling that their lives have been wasted. When they emigrate, they abandoned hope of ever returning to western Sahara. This, and the influence of different host cultures on the Sahrawi who have studied abroad, inevitably leads to younger generations losing out on traditional knowledge and breaking ties with western Sahara.

Concluding Remarks

The chapters in this volume bring to our attention that there exists a challenging dynamism in what migrants consciously or subconsciously choose to retain, abandon, and/or acquire while being exposed to host societies. For instance, migrants may retain the use of particular plant species, health beliefs, or traditional practices in host societies because of their perceived shared cultural importance or because their continued use reinforces migrants' cultural identity. In the latter case, these species, beliefs, or practices become salient markers of *identity* that express "tell me what you eat/consume, or what you use to cure yourself, and I will tell you who you are." On the other hand, the plant uses or practices that people abandon or newly acquire after they migrate may well become a marker of the immigrant *experience.* Shifting health conditions and changing folk pharmacopoeias can inform us about the new realities migrants are confronted with. Health conditions that were prevalent in immigrants' area of origin may become replaced with (a set of) different health conditions that are very much a part of the reality of life in the host society. This dynamic interaction between migrants and host societies may result in shifting pharmacopoeias adapted with substituted plant species. Likewise, changes in pharmacopoeias can be triggered by the availability of particular plant species in the host society, or by contact with different kinds of (traditional) healing systems that coexist within multicultural urban spaces. Further studies may wish to address these themes more in detail, either by looking at the knowledge, beliefs, and practices that have been retained or abandoned by migrants, or alternatively, by focusing on those that are newly acquired. Continued research is also needed on the underlying reasons for these changes. In addition, by comparing healing pharmacopoeias between immigrant groups

from diverse cultural backgrounds in different host societies, it may become clear if and to what extent globalization has had an impact on these pharmacopoeias by substituting the original "exotic" plant species by common "globalized" species.

Notes

1. Often the country of origin represents a tropical, or subtropical, developing country and the host country an industrialized country.

References

Anand, S.S. 1999. "Using ethnicity as a classification variable in health research: perpetuating the myth of biological determinism, serving sociopolitical agendas, or making valuable contributions to medical sciences?" *Ethnicity & Health* 4: 241–244.

Balarajan, R. 1996. "Editorial." *Ethnicity & Health* 1: 3–5.

Balick, M.J., F. Kronenberg, A.L. Ososki, M. Reif, A. Fugh-Berman, B. O'Connor, M. Roble, P. Lohr, and D. Atha. 2000. "Medicinal plants used by Latino healers for women's health conditions in New York City." *Economic Botany* 54: 344–357.

Barth, F. 1969. *Ethnic groups and boundaries. The social organization of culture difference.* Long Grove (Illinois): Waveland Press.

Baumann, G. 1999. *The multicultural riddle: Re-thinking national, ethnic and religious identities.* London: Routledge.

Belliard, J.C., and J. Ramírez-Johnson. 2005. "Medical pluralism in the life of a Mexican immigrant woman." *Hispanic Journal of Behavioral Sciences* 27: 267–285.

Bodeker, G., C. Neumann, P. Lall, and Z. Min Oo. 2005."Traditional medicine use and health worker training in a refugee setting at the Thai-Burma border." *Journal of Refugee Studies* 18: 76–99.

Bradby, H. 2003. "Describing ethnicity in health research." *Ethnicity & Health* 8: 5–13.

Burns, C. 2004. "Effect of migration on food habits of Somali women living as refugees in Australia." *Ecology of Food and Nutrition* 43: 213–229.

Clifford, J., and J. Marcus, eds. 1986. *Writing culture: the poetic and politics of ethnography.* Berkeley: University of California Press.

Corlett, J.L., E.A. Dean, and L.E. Grivetti. 2003. "Hmong gardens: botanical diversity in an urban setting." *Economic Botany* 57: 365–379.

Cwiertka, K.J. 2005. "From ethnic to hip: circuits of Japanese cuisine in Europe." *Food & Foodways* 13: 241–272.

Etkin, N.L. 2006. *Edible medicines. An ethnopharmacology of food.* Tucson: University of Arizona Press.

Galea, S., N. Freudenberg, and D. Vlahov. 2005. "Cities and population health." *Social Science & Medicine* 60: 1017–1033.

Gilgen, D., D. Maeusezahl, C. Salis-Gross, E. Battegay, P. Flubacher, M. Tanner, M.G. Weiss, and C. Hatz. 2005. "Impact of migration on illness experience and help-seeking strategies of patients from Turkey and Bosnia in primary health care in Basel." *Health & Place* 11: 261–273.

Gomez-Beloz, A., and N. Chavez. 2001. "The botánica as a culturally appropriate health care option for Latinos." *Journal of Alternative and Complementary Medicine* 7: 537–546.

Janes, C.R., and I.G. Pawson. 1986. "Migration and biocultural adaptation: Samoans in California." *Social Science & Medicine* 22: 821–834.

Johnson, L., H. Strich, A. Taylor, B. Timmermann, D. Malone, N. Teufel-Shone, R. Drummon, R. Woosley, E. Pereira, and A. Martinez. 2006. "Use of herbal remedies by diabetic Hispanic women in the Southwestern United States." *Phytotherapy Research* 20: 250–255.

Jonsson, I.M., H.R.M. Hallberg, and I.B. Gustafsson. 2002. "Choice of food and food traditions in prewar Bosnia-Herzegovina: focus group interviews with immigrant women in Sweden." *Ethnicity & Health.* 7: 149–161.

Kim, Y. 2001. *Becoming intercultural. An integrative theory of communication and cross cultural adaptation.* Thousand Oaks, California: Sage.

Mackenbach, J.P. 2006. "Migrant health: new challenges for European public health research (Editorial)." *European Journal of Public Health* 16: 345.

Marcus, G. 1998. *Ethnography through thick and thin.* Princeton: Princeton University Press.

Maffi, L., ed. 2001. *On Bio-Cultural Diversity. Linking Language, Knowledge and the Environment.* Washington D.C.: Smithsonian Institution Press.

Nesheim, I., S.S. Dhillion, and K.A. Stolen. 2006. "What happens to traditional knowledge and use of natural resources when people migrate?" *Human Ecology* 34: 99–131.

Nguyen, M.L.T. 2003. "Comparison of food plant knowledge between urban Vietnamese living in Vietnam and in Hawai'i." *Economic Botany* 57: 472–480.

Owusu-Daaku, F.T.K. and F.J. Smith. 2004. "Health-seeking behavior: perspective of Ghanaian women in London and Kumasi." *International Journal of Pharmacy Practice* 13: 71–76.

Papadopoulos, I., S. Lees, M. Lay, and A. Gebrehiwot. 2004. "Ethiopian refugees in the United Kingdom: migration, adaptation, and settlement experiences and their relevance to health." *Ethnicity & Health* 1: 55–73.

Pieroni, A., H. Münz, M. Akbulut, K.H.C. Baser, and C. Durmuskahya. 2005. "Traditional phytotherapy and transcultural pharmacy among Turkish immigrants living in Cologne, Germany." *Journal of Ethnopharmacology* 102: 69–88.

Pieroni, A., and L.L. Price, eds. 2006. *Eating and healing. Traditional food as medicine.* Binghamton, New York: The Haworth Press.

Sandhu, D.S., and M. Heinrich. 2005. "The use of health foods, spices, and other botanicals in the Sikh community in London." *Phytotherapy Research* 19: 633–642.

Sanjek, R. 2003. "Rethinking migration, ancient to future." *Global Networks* 3: 315–336.

Turner, N., I.J. Davidson-Hunt, and M. O'Flaherty. 2003. "Living on the edge: ecological and cultural edges as sources of diversity for social-ecological resilience." *Human Ecology* 31: 439–461.

Trevino, F.M. 1999. "Quality of health care for ethnic/racial minority populations." *Ethnicity & Health* 4: 153–164.

Voeks, R.A. 2004. "Disturbance pharmacopoeias: medicine and myth from the humid tropics." *Annals of the Association of American Geographers* 94: 868–888.

Waldstein, A. 2006. "Mexican migrant ethnopharmacology: pharmacopoeia, classification of medicines, and explanations of efficacy." *Journal of Ethnopharmalogy* 108: 299–310.