

Introduction

Healthcare in Motion

*Cecilia Vindrola-Padros, Ginger A. Johnson,
and Anne E. Pfister*

(Im)mobilities permeate every aspect of our daily life, including our opportunities, lifestyle choices, well-being, and access to healthcare. The scale of movement associated with obtaining health services is increasing, with an estimated five million people traveling to obtain medical care in another country (Horsfall and Lunt 2016). Healthcare professionals are also increasingly mobile, and it is estimated that low- and middle-income countries (LMICs) contribute between 40 and 75 percent of medical graduates to high-income countries (HICs), a phenomenon leading to “brain drain” in areas of the world with the highest levels of disease burden (Bradby 2014; Humphries et al. 2015; Mackey and Liang 2012; Mpofu, Sen Gupta, and Hays 2016). Healthcare practice is also becoming mobile with the incorporation of new technologies that adjust to patients’ mobility trends through the use of devices (e.g., mHealth, or “mobile health”), in some cases, allowing the delivery of services without being in the same location (e.g., virtual healthcare services) (Fiordelli, Diviani, and Schulz 2013). In 2013 alone, approximately one thousand mHealth projects were implemented across the globe, and 65 percent of those were taking place in developing countries (Al Dahdah, Du Loû, and Méadel 2015; GSMA 2013).

The current state of movement of patients, healthcare professionals, and medical services opens opportunities to new forms of healthcare or higher quality of services for some populations, but limits access to care for others (Chen and Flood 2013; Whittaker, Manderson, and Cartwright 2010). As some populations become more mobile, others might face restrictions in movement as borders solidify, political tensions between “citizens” and “migrants” erupt, and policies dictating “deservingness” to public services are enforced (Messina 2011; Winton 2015). Technologies designed to empower healthcare users and disseminate health information to a wider range

of stakeholders might remain available to the few groups able to access them (Al Dahdah et al. 2015). These differences in capacities for movement are the product of larger social, political, economic, and cultural factors that contribute to inequalities in the distribution of health services, and differences in the quality of available healthcare (Lee, Kearns, and Friesen 2010).

The turn toward a focus on mobilities in the social sciences has demonstrated the centrality of mobilities in our everyday lives (Salazar 2016) and draws our attention to the multiple ways in which being mobile (or immobile) is the product of individually negotiated social, cultural, economic, and political processes (Büscher and Urry 2009; Urry 2002; Urry 2007). As D’Andrea, Ciolfi, and Gray (2011: 150) have argued, “mobilities deserve to be examined in their own singularity, centrality and contingent determination, as they may destabilize and recode social and natural formations in ways that cannot be properly understood through the lenses of classical (sedentary) social theory.” Movement and stasis can therefore be used as a window into social constructions of gender, class, ability, ethnicity, the cultural meaning of place, and identity formation, as well as experiences of delivering and obtaining health services and other forms of care.

Not all movement is the same and not all movement is voluntary (Hannam, Sheller, and Urry 2006). The analysis of the restriction or promotion of movement by healthcare policies and practices and the new modalities of healthcare that are shaped by emerging mobility forms allows us to explore the social and cultural construction of both mobility and healthcare. The movement required for obtaining health services can therefore take on different meanings than movement used for other purposes, as these journeys might be perceived and experienced as “healing,” “restorative,” and even “life-sparing.” The geographies of medical spaces can simultaneously welcome or deter patients (Neuwelt, Kearns, and Browne 2015) and ultimately shape individual experiences of receiving health services and other forms of care in material (e.g., physical access) as well as emotional ways (Ergler et al. 2011). Clinical spaces can also function in both effective and affective ways, becoming places of treatment (focused on clinical outcomes), as well as therapeutic landscapes (focused on offering comfort and tranquility that may facilitate healing and well-being) (Lee et al. 2010). In the process of entering and navigating these medical spaces, people acquire additional roles (patient, healthcare professional, carer, etc.), and their movement might be organized in relation to predetermined clinical pathways that can be flexible and negotiated to some extent, but nonetheless set the roadmap for patient flows.

In the same way that healthcare policies and institutions shape mobility forms, new trends in (im)mobility redefine healthcare systems and what

it means to be a patient, a carer, or a healthcare professional. As Kangas (2010: 357) has argued, “care takes on new meanings and obligations in today’s interconnected world when consciences cannot settle for what is available locally.” Treatment and health service labor mirror global capital flows as new and less expensive forms of travel can expand an ill person’s sense of viable treatment options, leading them and their family to travel great distances to access what they consider to be the best type of care (Kangas 2007, 2010; Vindrola-Padros and Brage 2017). Potential employment opportunities located elsewhere in the world can foster the migration of healthcare professionals seeking better jobs and chances for career development. In the era of increasingly mobile healthcare, new actors—such as mobile network operators, technology developers, data management companies, and medical-tourism marketing experts—come into play and influence how health services are designed and delivered. Physical proximity is replaced by virtual platforms, potentially redefining the ways in which medicine is conceived and practiced (Ahlin 2013; Al Dahdah et al. 2015) and expanding our traditional notions of the need for co-presence (Urry 2002) in clinical encounters to include more remote ways of knowing and healing.

A significant amount of research has examined the migration of patients, health workers, and mobile health technologies, but further work needs to be carried out to understand processes of healthcare delivery within the context of (im)mobilities. *Healthcare in Motion* seeks to explore the dynamic interrelationship between mobility and healthcare by analyzing how gradients of movement and stasis interact to engender multiple forms of travel as people seek or deliver health services. The book is guided by the following questions: (1) How does the need to obtain and deliver health services engender particular (im)mobility forms? (2) How is mobility experienced and imagined when it is required for healthcare access or delivery?

The focus on ground-level, subjective experiences of mobility and healthcare allows the authors in this volume to study and understand mobility as a social practice imbued with cultural meaning, thus gaining insight into the social, cultural, political, and economic processes that make mobility possible as well as those that restrict movement. Most of the authors apply frameworks and perspectives stemming from the social sciences, but several are also practitioners who design or deliver health services on the ground and can shed light on the day-to-day practices of moving health services closer to the people who need them. Mobility and healthcare are represented as complex cultural and political processes, which are not only influenced by global policies and structures, but also shaped daily by individuals and their local communities.

Structure of the Book

The book is divided into three main sections: (1) Healthcare and differential mobility empowerments; (2) Mobility as a resource in the search for care and caring; and (3) Patient navigation and mobile technologies of care. The three sections cover important areas of health and healthcare understood in relation to different types of mobility forms. Each section contains a short preface that serves as an introduction to the main concepts and approaches discussed in the chapters in the section. The chapters—written by authors from various disciplines, including anthropology, social policy, philosophy, nursing, pharmacy, public health, and neuroscience—draw from experiences and case studies taking place in geographical and cultural contexts such as the United States, Mexico, Kenya, South Africa, Myanmar, Slovenia, and the Czech Republic.

Healthcare and Differential Mobility Empowerments

Not everyone who wants to use mobility as a resource is able to do so (Morley 2002; Skeggs 2004). As Tesfahuney (1998: 501) has argued, “differential mobility empowerments reflect structures and hierarchies of power and position by race, gender, age and class, ranging from the local and the global.” This section engages explicitly with the ways in which public policies create and reproduce these “differential mobility empowerments,” where some groups are represented as “deserving” of free movement and access to public services, while others are contained and not considered eligible for services as essential as healthcare.

The chapters by Nolan Kline and Heide Castañeda address this topic in the United States. Kline explores the relationship between immigration policies, mobility, and healthcare, demonstrating the effects of immigrant policing on health-seeking behaviors and access to medical services. In his ethnographic research in Atlanta, Georgia, Kline found that undocumented immigrants avoid visiting medical facilities due to the fear of deportation. The risk of deportation is perceived not only in clinics, but also while driving to obtain medical services or participate in daily activities, such as commuting to work. Migrants thus perceive and experience constant threats to their lifestyle and well-being and adapt their mobility accordingly. While exploring these processes through the lens of automobility, Kline argues that current US immigration policies underlie health inequalities by creating structural vulnerabilities and inequalities in movement that prevent undocumented migrants from maintaining their health and seeking medical attention.

Castañeda’s chapter deals with undocumented migrants’ experiences of accessing health services in the Texas/Mexico borderlands, arguing that

they are “stuck in motion.” Bordering processes in the United States constrain the movement of undocumented migrants to the extent that they feel in a constant state of “stuckness.” This idea alludes to both fixity and motion, and is an attempt to consider the coexistence of mobility and immobility without succumbing to the restrictions of the movement/stasis dichotomy (Khan 2016). Mobilities and moorings intertwine to produce instances of stillness, fixity, and restraint (Hannam et al. 2006), but being stuck does not mean being immobile. The migrants Castañeda worked with shared the diverse strategies they use to negotiate borders, both lived and imagined, and restrictions in movement to obtain medical services, restore their health, and, in some cases, save the lives of their children. According to Castañeda, if we shift our conceptualization of borders from a fence or a wall to the stillness of people, we might be able to rethink borders as dynamic and inhabited places, places that change, have meaning, and matter.

Uršula Lipovec Čebren and Sara Pistotnik also explore the relationship between public policies and healthcare access by discussing the case of “the erased” in Slovenia. The erased were citizens of former Yugoslav republics who either did not apply for residency after the Slovenian independence or had their applications rejected. Despite former residence in the country, they were erased from national registries and lost access to public services, including most healthcare services, equating their status with that of undocumented migrants. They became classified as an “undeserving population” and entered a state of liminality, where they remained fixated in the same physical space but without being able to enforce their social and political rights. As Khan (2016: 98) has argued, “liminality is inflected in the broader political-economic condition of not moving, and never arriving,” and thus, as a concept, allows us to glimpse the experience of being and feeling immobile. These new health policies first excluded “the erased” and other migrants, but different forms of restricted access to health services are experienced contemporarily by a rising number of residents, especially after the 2008 economic crisis.

Mobility as a Resource in the Search for Care and Caring

Experts studying mobility among human populations expose a provocative juxtaposition regarding who travels and why. Scholars agree that mobility is not a new phenomenon among humans (Urry 2002; Salazar and Smart 2011), that mobility is “basic to human social life” (Glick Schiller and Salazar 2013: 184), and that, for many, being on the move has become a way of life (Urry 2000; Urry 2002). Yet scholars increasingly recognize the inequity of *motility*, or the ability or potential to move (Kaufmann, Bergman, and Joyce 2004; Leivestad 2016). Research in many disciplines reveals stark

and subtle ways that motility, as a potential resource employed to solve basic human problems, is not equally accessible to all members of societies, nor equitably distributed globally (Salazar and Smart 2011). Capacities for movement are framed by global policies and the local context, but also negotiated by individuals in their daily practices.

The endeavor of section two is the exploration of these individual experiences of movement and the corresponding narratives revealing why people seek movement as a resource. The authors in this section explore physical acts of movement as well as what Lean, Staiff, and Waterton (2014) have referred to as “imaginaries” of travel—or the effect of imagination on potential and performed travel experiences. Attention to these imaginaries of travel reveals the creativity that people employ as they seek mobility as a resource to solve problems related to health and healthcare.

Anne E. Pfister and Cecilia Vindrola-Padros describe the movement of families of deaf children in and around Mexico City. The journey upon which these families embarked following deaf diagnoses compelled them to find ways of understanding their children’s deafness, and as they did, their identities were refashioned in ways they could not have imagined. These families, in their quest for information and assistance, engaged in what Urry (2002) refers to as *corporeal* travel, or movement that explicitly involves bodies in motion. The physical movement of these families as they sought care is the most obvious component of their mobility. However, their simultaneous movement through stages of identity formation—how they imagined and reimagined themselves as parents of deaf children—accompanied and, in some cases, transcended physical movement and was ultimately the most transformational component of their travel.

Amy Speier explores the experiences of women who participate in the reproductive travel industry in the Czech Republic. This study is part of a growing body of literature documenting the expansion of the medical-tourism industry and scholarly contemplation of its potential implications (Chen and Flood 2013; Kangas 2010; Whittaker and Speier 2010). Through careful contextualization and the honesty of her ethnographic participants, Speier reveals how regional, social, economic, and imagined movements impact young, childless Czech women and women on maternity leave. Her exposition links the accessibility of new and flexible types of financial gain—via egg donation—with the perception among this population of social and cultural mobility through their reproductive choices. Again, physical movement (of intended parents as tourists, of egg donors) becomes the backdrop as we learn about the complex inner negotiations of the egg donors and consider the consequences of the services they offer.

Evgeniya Plotnikova explores the global mobility of health workers by drawing our attention to the interaction of economic factors, policy and

regulation, and individual practices impacting their mobility. She offers insight into the challenges of regulating health worker mobility, offering examples of the “complex and multilevel character of contemporary migration,” composed of multisited migration routes with a final desired (and ultimately imagined) destination to which individuals cling throughout these extended journeys. Plotnikova asks: What policies can adequately manage health worker migration, secure access to health services in source countries, and protect migrant health workers from the risk of exploitation and from racial and gender discrimination in receiving countries? Policy tools attempting to regulate cross-border health workers are the focus of this chapter, yet we are drawn into the examples Plotnikova provides and are reminded that global policies are not always attuned to the individual creativity and imaginaries of health workers that ultimately affect their mobility.

Patient Navigation and Mobile Technologies of Care

In global context, health disparities between rural and urban populations are stark and this gap continues to widen, with rapid social and economic transformations creating adverse effects in health that “disproportionately affect the poorest and most disadvantaged” (UNICEF 2015: 3). However, utilization of healthcare services is not only about “getting there,” but also about how patient-provider interactions are guided (or not) once “there.” As stated above, mobilities literature focuses not only on the barriers that may (im)mobilize patients and healthcare providers, but also on the quality of available healthcare services and how that care affects patient and user experiences. These barriers might deter patients from obtaining treatment or effectively adhering to medical advice (Ensor and Cooper 2004).

In low- and middle-income countries, these barriers are more likely to affect the poor, while in wealthier nations they are most pronounced among socially vulnerable and marginalized groups (Ensor and Cooper 2004). Mobile healthcare solutions, including mHealth initiatives, have the potential to address many of the challenges faced by under-resourced health systems, particularly with regard to linking rural and hard-to-reach populations with health facilitators (e.g., community health workers) and urban health professionals (Marshall, Lewis, and Whittaker 2013; Mishra and Singh 2008).

The authors in this section seek to describe and critically examine the implementation of health interventions aimed at addressing barriers to healthcare access. The chapters in this section cover three continents and a range of health issues, from HIV/AIDS among the deaf and hard-of-hearing in Kenya to family planning and reproductive, maternal and child health services in Myanmar. Yet, the common thread throughout each of the

unique ethnographic case studies presented here are descriptions of health interventions that seek to (1) utilize new or existing infrastructures to bring patients and healthcare providers together and (2) guide the appropriate translation of health information from provider to patient.

The chapter by Alina Engelman discusses the barriers to HIV/AIDS education and services in receiving care that are faced by deaf and hard-of-hearing Kenyans who are HIV-positive or living with AIDS—a population often immobilized by the inability to effectively communicate with family, friends, peers, and program staff. LVCT Health is an indigenous nonprofit, nongovernmental organization in Kenya serving at-risk populations including men who have sex with men, prisoners and sex workers, and the deaf. Its programming includes community-based mobile voluntary counseling and testing (VCT) outreach services and participatory theater in rural areas. After mobilizing VCT units to reach populations in need, three critical components of the deaf program trained members of the deaf community to provide peer-based HIV/AIDS education and services, putting deaf Kenyans in key leadership roles in VCT sites throughout Kenya, and teaching hearing HIV and sexual health service providers basic Kenyan Sign Language to enable their effective communication with patients. Engelman’s chapter describes a program evaluation and needs assessment of LVCT Health to provide recommendations for program improvement and, ultimately, to demonstrate “the empowering nature of community-driven healthcare delivery.” The author concludes by exploring the ways in which mHealth can enhance the mission of LVCT Health.

Sunitha C. Srinivas and Sharli A. Paphitis describe the physical and informational barriers to basic healthcare services that affect patients in impoverished areas of rural South Africa. Two South African trains currently operate as mobile clinics to increase patient access to basic healthcare in underserved rural areas. To increase the rational use of medicines among the illiterate populations served by the mobile clinic, South African education institutions such as Rhodes University provide service-learning opportunities for pharmacy students to design medicine information leaflets that embody cultural appropriateness, readability, and understanding for a low-literate population. Service-learning opportunities serve to introduce students to the challenges healthcare workers face in delivering healthcare and the challenges patients face in attempting to comply with medical advice. Ultimately, this opportunity serves to train a future generation of healthcare professionals “to be more aware of and responsive to a broader range of societal health care needs.”

The chapter by E. Kale Edmiston explores the health and healthcare inequalities experienced by transgender persons living in the US South. These inequalities include discriminatory (and potentially dangerous) politically

partisan legislation that restricts movement in public spaces, higher rates of violence (including murder), higher rates of HIV/AIDS, and mental health concerns. In response, the Trans Buddy Program is a unique program founded in Nashville, Tennessee, to improve mobility of and healthcare access by transgender persons by providing volunteer peer advocates. These “buddies” offer phone support, including health referrals and resources, and may provide in-person support by, for example, attending healthcare appointments with patients. Because many transgender persons in the South have limited access to local care and may have limited mobility, the Trans Buddy Program helps to circumvent some of their needs for physical mobility by providing support services over the phone (a deliberately low-tech solution) and, when requested, by supporting transgender patients in navigating rigid healthcare systems that often do not take into consideration the unique health needs of transgender identities and bodies.

Perrie Briskin and Sara Lucía Gallo discuss new technological channels for virtually reaching out to women of reproductive age in Myanmar—a country with low contraceptive use and high maternal mortality—with key messages on family planning and reproductive, maternal, and child health. Within this context, Population Services International launched the first-ever maternal health mobile smartphone app in Myanmar (called “maymay”) in recognition of the country’s rapidly changing digital landscape. The maymay app (downloaded more than sixty thousand times as of May 2016) allows women to privately access key family planning and reproductive health messaging, in addition to an extensive medical provider network. The multiple rounds of testing, modifying, and evaluating the app for user acceptability that maymay has undergone since its early development and initial launch in 2014 serve as an important reminder that the delivery of health information—whether virtually or in person—must be responsive to the needs of its intended audience. As stated by the authors, digital health initiatives must seek to “ensure that messages remain relevant and that target populations remain tuned in.”

Concluding Remarks

Health, healthcare, and the practice of caring are currently being reconfigured by increased flows of patients, healthcare workers, and medical technologies. In response to this increased mobility, scholarly attention turns toward related stigmas, inequities, political ideologies, and policies that delineate populations as “deserving” and “non-deserving” of health-related services. The interconnection between (im)mobilities and healthcare is therefore an area ripe for analysis and critical exploration. The chap-

ters within this book highlight the need to focus on the particularities of the experiences of movement and stasis when attempting to explore the broader interconnection between (im)mobilities and healthcare. As people move, their bodies (racialized, gendered, aged, classed, impaired, sexualized, or (un)healthy) shape how, when, where, and if they move (Büscher and Urry 2009). This book is a pioneering attempt that acknowledges these particularities while exploring the experience of movement in the context of healthcare access and delivery. Collectively, these chapters contribute to mobility studies, as an emerging field of inquiry, and prompt further exploration of healthcare (im)mobilities.

Cecilia Vindrola-Padros, PhD, is a research associate in the Department of Applied Health Research, University College London, UK. A medical anthropologist, she has researched the experiences of children and families who relocate to access medical treatment. Recent publications on mobility include the book chapters “Children Seeking Health Care: International Perspectives on Children’s Use of Mobility to Obtain Health Services” (with Ginger Johnson), in *Movement, Mobilities, and Journeys: Geographies of Children and Young People* (Springer, 2017), and “Child Medical Travel in Argentina: Narratives of Family Separation and Moving Away from Home” (with Eugenia Brage), in *Children’s Health and Wellbeing in Urban Environments* (Routledge, 2017).

Ginger A. Johnson, PhD, is a visiting assistant professor at Southern Methodist University. She holds a PhD in medical anthropology and a master’s degree in global public health from the University of South Florida and a master’s degree in international law from the United Nations Interregional Crime and Justice Research Institute. Recently, she was embedded in West Africa conducting Ebola-related research with the International Federation of the Red Cross. A selection of her current research projects includes addressing adolescent nutritional needs in Cambodia, for the World Food Programme, and ensuring social accountability for maternal and child health in Malawi, for UNICEF.

Anne E. Pfister, PhD, is assistant professor of anthropology at the University of North Florida. Her research investigates how deaf youth and their families experience deafness in Mexico City, by integrating sociocultural linguistic theory with biocultural medical anthropology analyses. Her current project utilizes visual methods, including “photovoice,” to actively engage participants as co-researchers. She has been involved with the Mexican deaf community for over ten years. Her research interests include disabilities studies, language socialization, and medicalization; her work has been pub-

lished in *Ethos*, *Visual Anthropology Review*, *Behavioral and Brain Sciences*, *Collaborative Anthropologies*, and *Annals of Anthropological Practice*.

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