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Laurent Pordié

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Spaces of connectivity, shifting temporality.

Enquiries in transnational health

Laurent Pordié

(National Center for Scientific Research, CNRS/Cermes3, Paris)

This article examines the fabric of transnationalism in the health field through the prism of therapeutic travel and the transnational production of medical knowledge and practice. It takes travel, occasional and virtual contacts across international borders to be important forms of transnational encounters. For this purpose, the notion of “space of connectivity” is introduced to highlight the intersections of transnational networks and circuits and the myriad ways space and time deploy themselves. Circulations within these circuits converge in situated nodal points, such as clinics or (virtual) classrooms, where connectivity between geographically mobile and immobile agents intensifies. These nodal points result from the crystallization of transnational social, material and technological formations in a particular place and at a particular moment in time. They are stabilized by motionless actors. By examining spatiality and temporality in these contexts, this article frames this special issue while opening up research avenues in transnational (health) studies.

The expansion of transnationalism as a form of linkages between people, places and institutions across international borders has led to numerous and unpredictable social formations and cultural encounters. Studies by the social sciences of the effects of transnationalism in the health field have largely shed light on the health – and more widely caregiving – dimension of migration studies (Cognet *et al.* 2012; Elliott/Gillie 1998; Evans 1987; Huang *et al.* 2012; Stilwell *et al.* 2003; Zimmermann *et al.* 2011), medical and wellness travel (Hodges *et al.* 2012; Naraindas/Bastos 2011; Roberts/Scheper-Hughes 2011; Smith-Morris *et al.* 2010) and the international diffusion and transformation of medical practice and procedures (Alter 2005; Digby *et al.* 2010; Petryna 2009). A growing number of academic publications today explicitly overlap and compare these areas of study, aiming to enrich both empirical materials and theoretical options (Dileger *et al.* 2012; Knecht *et al.* 2012; Pordié 2011a). This special issue is an addition to this literature. It examines the shapes and shades of transnationalism in a single set of essays stemming from distinct fields of enquiry in the social study of health and healthcare.¹ The articles brought together in this collection take Asia as the port of entry to explore the social and cultural dynamics of transnational therapeutic itineraries, as well as the production, transmission and transformation of medical knowledge and practices, as they circulate transnationally and experience strong and decisive global influences. These issues are addressed for both biomedicine and Asian medicine in a variety of ways ranging from cultural translation to market construction, or again from therapeutic innovation to distance education. This issue aims to add complexity to current understanding of health and medical practice as they face a “mobility turn” in social science research (Sheller/Urry 2006). Conversely, it uses health and healing practices as a prism so as to offer a critical reflection of transnationalism itself.

By examining spatiality and temporality in transnational health, this paper underscores the points of convergence that bind the following articles together, while building on transnational studies. A transnational space is complex, multidimensional and multiply inhabited (Crang *et al.* 2003), and comes in all sorts of

¹ This issue stems from a series of gatherings held at the Cluster of Excellence ‘Asia & Europe’ at the University of Heidelberg between 2009 and 2011.

shapes. What then is the peculiarity and architecture of space and place in transnational health? How do the temporality and cadence of human encounters in this context help to expand the epistemological range of transnationalism? To answer these questions, I will address location and network, circulation and connectivity, mobility and motionlessness. For this purpose, I will rely on both material presented in this issue and on empirical data stemming from the transnational health industry in India². These are privileged sites from which to observe the nature, intricacies and implications of transnational encounters.

The crystallization of socio-material assemblages

Transnationalism brings together two forms of spatiality often mobilized in social theory – regions and networks. While they were initially focused on the diminished role of the nation-state in ordering the world, transnational studies however helped in “grounding globalization”, in Michael Burawoy’s terms (2000), by allowing territory, land and nations to express themselves in globalization processes, and by revising false and overarching assumptions of the global as a completely deterritorialized phenomenon. Indeed, regions (and their inhabitants) play an instrumental role in shaping the global, in diversifying and complexifying it. In fact, it is well-known that global processes are at all times local processes embedded in territories, communities, households, individuals and objects. They are therefore not uniform, nor are they simply elements of a context that determines local practices from the outside. The global may then be seen as small and diversified rather than big and homogeneous (Law 2005). In these regions people, objects, ideas, policies or institutions circulate around vast and highly heterogeneous networks which move across the borders of nation-states. They follow circuits, shift direction and change meaning, get connected and transformed, and are often appropriated. Being mobile

² I have been conducting fieldwork since 2008 in various structures that target foreign interest and clientele: biomedical hospitals involved in the medical travel industry, ayurvedic clinics adapting their services to international patients, spas chains geared toward Indian upper classes and foreigners, and ayurvedic pharmaceutical companies reaching global markets.

and fluid, these people, things or institutions move from one place to the other³; but they are always anchored in specific (but changing) grounded spaces, which play an important role in defining them. Objects, for example, are context-specific as studies in science and technology have taught us. The status of an ayurvedic drug is modified when the drug follows a circuit that leaves India to reach a country with a different legal environment; from being a medicine in India the drug becomes a food supplement in France. In this context, this shift in category (and meaning) is consubstantial to transnational mobility (Pordié 2008: 12). People experience translocality and transformation too when they go across international borders: these changes may bear on their subjectivity (Langford 2002) and on their biology and physiology, subject as they are to transport, jetlag, food intake, medicine, weather and pathogens. Travel and place help produce distinct corporalities: “diverse kinds of travel produce diverse kinds of *re-localized* (i.e. traveling) bodies and biologies,” write Roberts and Scheper-Hughes (2011: 21).

While studying networks is important to understand circulations, examining place highlights the way these networks overlap and collide; the two domains of enquiry should be examined concomitantly. Researching place is also crucial for anthropologists concerned with people’s perceptions, for there is a great deal of practical and emotional attachment to place (Jackson *et al.* 2004). However, in their analytic pursuits, specialists in transnational studies have mainly explored networks (including people, communities, economic enterprises, etc.) and overlooked both place (Gielis 2009) and space (Jackson *et al.* 2004)⁴. The fact that this domain of study has its roots in migration studies and has examined at length people mobility and agency perhaps explains this pitfall. For instance, in their landmark article Alejandro Portes and his colleagues introduced “the individual and his/her support network as the proper unit of analysis” in transnational studies, as “the most viable point of departure” (1999: 220) before delving into more complex stages of enquiry. These methodological assertions do not transpose well to transnational health, as in the

³ For James Clifford, this situation makes location “an itinerary rather than a bounded site – a series of encounters and translations” (1997: 11).

⁴ On the articulation between place and space in transnational settings, see, for example, Yoshihara (2010).

case of medical travel or the circulation and transformation of therapeutic knowledge, quite on the contrary. In order to understand the fabric of transnationalism in these situations, I propose to start by examining the conjunction of locations and space, the way they are socially, culturally and materially produced, transformed and inhabited, by what, by who, and for how long. We should look at processes.

Let us take the case of a high standard wellness center in Southern India, where almost all of the clients are foreigners. None of them reside locally and the average stay within the spa premises amounts for a couple of hours. However, they circulate in a transnational space that includes the wellness center as the nodal point of several networks. What actually bring stability to this space are the Indians. Although some may come from national states located hundreds of miles away to seize a job opportunity, once at work they become immobile, stabilizing agents. These agents (management, therapists, cleaners, gardeners, accountants) form the backbone of the transnational space; they largely allow for its functioning and sustainability. In this case, the suggested unit of analysis is the space itself, and everything that makes it – from the geographically immobile people, institutions, objects and technologies to the international clients and their means of mobility (such as cars, airplanes and credit cards). While the dialectical interaction between national territory and transnational space must of course be acknowledged and closely examined (Robinson 1998), the significance of the local in transnational phenomenon here is exemplary, as it is in general in the medical travel industry: it is a national construct with cross-border appeal and global aspirations, as shown by the case studies of Malaysia (Toyota *et al.*, this issue) and Thailand (Bochaton: this issue; Wilson 2011). Indeed, “the nation-state continues to play a key role in defining the terms in which transnational processes are played out” (Jackson *et al.* 2004: 4). These considerations together form an invitation to turn upside down Arjun Appadurai’s notion of the production of locality in global flows (1996) and stress instead the local production of transnationality.

To be effective and operational, the transnational health space must of course be embedded in networks that extend beyond international borders and must comprise circuits (which may involve new territorial arrangements) that converge within definite places such as hospitals and clinics. Such places are situated contexts which specify transnational activities⁵. These regions and these networks both result from and produce specific “global assemblages” (Ong/Collier 2005), which crystallize in a particular place and at a particular moment in time. This does not preclude the fact that these socio-material and technological assemblages are fluid⁶; they may change patterns and content, while at the same time being prone to a relative time- and space-bound stability, however precarious it might be. This merging of regions and networks, mobile and immobile agents, technologies and materials plays an instrumental role in the making of transnationalism.

Spaces of connectivity

A network is qualified by both circulations and connectivity, each of which present different problems. Circulations are plural in form; the nature of the circuits they follow varies according to what circulates and where it goes to and comes from. Thus, ayurvedic drugs follow different circuits than siddha medical knowledge, Cambodian pepper, or Japanese mangas. The same heterogeneity applies to connectivity. Of particular interest for this paper is that connectivity happens and intensifies in specific spaces that result from the crystallization evoked above, whether it is a hospital, a cyberspace, a teaching center or a multilateral health institution. These are ‘spaces of connectivity’. These spaces allow transnationalism to actually take *place*.

They may take various shapes. In the case of distance education (Sieler, this issue), connectivity is exercised in cyberspace. Siddha therapeutic knowledge is transmitted from India through the internet to international students located anywhere in the

⁵ On the ways migrant transnational practices are, in practice, relatively contained and limited to specific contexts, see Gielis (2009).

⁶ I refer to the notion of fluid as given by Mol and Law (1994).

world. It is a form of transnationalism where all human actors are geographically immobile; none of them embody the transnational the way a migrant would do, but all have the possibility to extend into other places and other times through their virtual modes of communication. There is an “in-betweenness of social practices linking different local contexts, but not strictly reducible to any of them” (Boccagni 2012: 120). Here virtual contacts within a virtual space – which comprises concrete people and things, such as the teacher, his house, the students and their place, computers, satellites, snail mail, etc. – take a tangible form in transnational knowledge transmission, in the granting of certificates and ultimately, in newly acquired therapeutic practice. Elsewhere in Thailand, connectivity in the space in question culminates in a clinic or a classroom where international students learn the basics of Thai massage (Iida, this issue). Once established and stabilized, the space of connectivity fosters these (transnational) exchanges. In these cases, these spaces and the exchanges that take place within them contribute to the production of therapeutic knowledge and practices⁷: siddha medicine is adjusted and transformed *in order to* be trans-nationalized (by withdrawing sensory experiences and oral knowledge); Thai massage is transformed *through* relationships involving Thais and foreigners (by making it a holistic practice in tune with global expectations reflecting trends in complementary and alternative medicine).⁸ These forms of transnational productions involve creativity and imagination – a social practice characteristic of globalization (Appadurai 1996). In each of these cases, however, the imagination is not only affected by the desires of those at great social, cultural and geographic distance, but also by linkages in the form of contacts, discussions and interactions between individuals and across the borders of nation-states – be it through the internet, repeated phone calls, therapeutic interventions or teachings in a classroom. As shown in the articles by Sieler and Iida, these transnational relationships also offer a

⁷ For other examples on the transnational production of medical knowledge and practice, see Pordié (2011a,b) and Zhang (2009).

⁸ The distinction made between the transformation of therapeutic knowledge and practice *prior to* international diffusion and *through* transnational exchanges may appear to be overly clear cut. In practice, these are trends, sometimes simply intentions, and in the former case further transformation occurs when the knowledge, practice or product has reached the global arena, just as transformation through transnational relations does not preclude the fact that change may have taken place, deliberately or not, before diffusion.

grid from which to read “the cultural specificities of global processes” (Ong 1999). (Medical) culture is reorganized across space and time, and contributes to the formation of new, “translocal cultures” (Clifford 1997; Gupta/Ferguson 1992).

This is not to say that the space of connectivity is stabilized forever. In fact, all attempts are made to increase the level of connectivity in a particular transnational health space with the aim of promoting commercial development. Examples abound. One evident situation is branding and marketing in the medical and wellness travel industry (Crooks *et al.* 2011; Pordié 2011a). “The biggest hurdle that medical tourism has had to face, and continues to face, is the challenge of convincing distant potential visitors that medical care in relatively poor countries is comparable with that available at home, in outcome and safety (...) This has been especially so when medical care systems, in countries such as India, have been conventionally regarded in the west as inadequate, ‘even’ for India itself” (Connel 2006: 1094). A variety of strategies has been deployed to counter this perception in most Asian countries, from drafting and implementing specific national policies to establishing international accreditations and certifications for health institutions, or from door to door publicity conducted by private firms (see Bochaton in this issue on the Thai marketing strategies in Lao PRD) to international marketing approaches (as exemplified by the pan-Asian study presented by Toyota *et al.* in this issue). In general, medical institutions rely on a growing global awareness of the hospital brand and the reputation of the country (such as Singapore for Indonesian patients) or of the city – for example, hospitals in Bangalore are trading on the city's reputation as “India's silicon valley,” and thus a hub for the knowledge-based service economy and scientific expertise. In other places, the context of medical and wellness tourism is significantly different. Kerala has a well-established tourism industry and is a major center for Ayurvedic tourism. Recently, this has allowed the Indian state to create the brand “Kerala Ayurveda” in an attempt to attract an increasing number of patients/clients. In the wake of the growing popularity of medical travel worldwide, the success of Ayurvedic tourism and the high volumes of tourists who were already coming to India, various cities and states, such as Kerala, have also sought to expand the “biomedical tourism” industry. This has led to collaboration between leading

entrepreneurs and state governments in many places in India as efforts are made to re-brand the country as a global health care destination. Specialized travel agencies (Planet Hospital, IndUSHealth, Taj Medical Group) and guidebooks, as well as medical structures in the West and health insurance companies in Asia and abroad work together to reinforce not only circulations but also and most importantly connectivity. Largely under-researched to date is the role of brokers and intermediaries (see Bochaton, this issue), who are also instrumental in the transnational chain of activities aiming at building spaces of connectivity.⁹

Efforts directed at increasing connectivity have also entailed a profound reorganization and transformation of the medical and wellness infrastructures (Bochaton, this issue). Corporate hospitals have opened specialist accommodation wings, providing rooms equipped with cable television, telephones, sofas, fridges and air-conditioning, modifying the esthetics and functionality of medical space (Evans *et al.* 2009). Ideally, medical travel involves the rapid transfer of people from the airport to the hospital – which, interestingly, often shares some characteristics with new airports lobbies such as cleanliness, impersonality and freezing temperatures – and the provision of foodstuffs from people’s country or place of origin, to make them as comfortable as possible. Some of the leading staff working in “medical tourist wards” have experience working overseas, some are well versed in foreign languages, and they claim to be more aware of cultural considerations. The industry has realized that it needs to adapt and learn from patient responses to inter-cultural differences – and to use this knowledge to minimize cultural difference and practices in the future.

The spaces of connectivity may shift between cultural insulation and immersion. As far as biomedical travel is concerned, people are realizing it is necessary to promote a generic, sanitized, pristine medical environment of international standards and the qualifications, expertise and international experience of doctors. Biomedical travel is therefore based on a principle of “cultural insulation.” Health care

⁹ For a study focused on the intermediaries of medical travel, see Baujard (2012).

professionals are trying to create a globalized, culturally neutral space that will be familiar to all, in order to develop a better connectivity between the visiting patients and the host hospital. Although more research is required on this subject, it is apparent that many medical care seekers do not feel comfortable travelling to another country for treatment, that some have never traveled overseas before, and therefore minimizing cultural difference is extremely important to the success of medical travel ventures. On the Indian subcontinent, such efforts produce what Mark Nichter calls “accessible India”; that is, a place where foreigners and the Diaspora Indians will be keen to visit or return to, without facing what they perceive to be the burden of dirtiness and poverty of the country at large. Biomedical entrepreneurs are increasingly learning to de-couple the word “medical care” from “tourism,” preferring to frame their clients as “international patients”. These international patients may not be interested in the local culture or place, so providers seek to insulate them as much as possible from it, perhaps only offering an optional, one-day trip to a famous and easily accessible temple or monument. Practitioners also appear to prefer to learn and work within the common globalized language and practice of biomedicine, where cultural differences are recognized, and removed. Here, a form of universality through therapeutic practices is sought after to ease connectivity.¹⁰

While local culture is played down in biomedical hospitals, it is emphasised in other forms of therapies. But what kind of “culture” are we speaking about? Ayurveda or Thai massage, for example, is perceived to be based on tradition, heritage and nature and the corresponding centers or clinics are more often than not located in pleasant restorative, nurturing, tropical environments. Interior design, furniture, music and atmosphere are chosen in relation to healing and traditions, and form an integral part of the therapeutic service and experience. In these contexts, the visitor’s ability to learn about the place and interact with the local culture is of significant importance. However, issues of translation are ever present in that the

¹⁰ The quest for universality, as a means to gain legitimacy and credit on the market, also concerns traditional therapies. On the dialectic between the universal significance of a traditional treatment that may be granted by science (through clinical trials) and its cultural embeddedness, see Pordié (2010, 62). More generally, on the way universal knowledge may come into being at particular times and places, see Tsing (2004).

“cultural experience” and place are represented, adapted and translated (such as the teachings manuals in Iida’s article) to meet the needs, demands and expectations of foreigners, including their cultural conceptions of the body, wellness, “traditional medicines”, age or gender.¹¹

The space of connectivity could be fruitfully articulated to the significant implications of architecture for cultural practices associated with health and health care (Gillespie 2002) and more generally, with the notion of therapeutic landscapes (Buzinde/Yarnal 2012; Conrad 2005; English *et al.* 2008; Gesler 1992; Gesler *et al.* 2004, Smith 2005). While these authors emphasize that the natural and material environment (aesthetics, architecture, configuration, ornamentation, etc.) combined with social organization, people perceptions or ideas of territoriality have a role to play in the pragmatics or the symbolism of health and healing processes, it may be suggested that the making of a “therapeutic place” also works on the dynamics of relationships, that is, on connectivity.

Transnational encounters and their temporality

We shall now look at the temporal dimension of connectivity. Transnationalism is broadly defined as the *sustained* linkages between people, places or institutions across the borders of nation-states (See, for example, Faist 2010; Vertovec 1999, 2009). These linkages are presented as continued contacts between any of these entities, as is the case with so-called “transnational communities” (Levitt 2001). The individuals concerned live in a social world that includes various places and communities which stretch between two or more nation-states (Vertovec 2010). A different situation is revealed in transnational health. Take a hospital in Malaysia, a reproductive clinic in Singapore, a teaching center in Thailand or an Ayurvedic spa in India. In each of these cases, the linkages between the foreign patient/client/student and her local doctor/therapist/teacher or her host place are certainly intense but relatively short,

¹¹ One would never see an Indian man giving an oil massage to an Indian woman, although this happens with tourists in South India, and, as I have observed, often according to the tourist’s demands.

and very rarely sustained – unless we consider that the presence of past experiences, which include encounters within and beyond the human realm, remain as a form of connection. How true this view might be, it would perhaps push the idea of transnational connections a bit too far for our purpose. From the perspective of the people themselves, their respective social worlds collide but they find themselves quickly unconnected. As said earlier, those actually living in the nodal points of these transnational spaces are the geographically immobile agents, the vast majority of whom never cross international borders. Their community is local, and if they do have interactions with foreigners, the latter are not considered to be part of the local community. The foreigners' ties to locality are limited to ephemeral forms of businesses, intimacies and emotions that involve therapeutic encounters or teacher-student relations. However, this does not disqualify such situations from being defined as transnational, with particular forms of cross-border relations that present, on one side, important resources for welfare – as in the case of Diaspora (Clifford 1997: 256) –, and on the other, valued resources for health, well-being or learning. In fact, proximity and distance, presence and absence do not need to be opposed, but should be understood as manifestations of the ways space and time deploy themselves (Callon/Law 2004).

Let us take some ethnographical examples. Christoph is a German national that needed a hip resurfacing intervention, which is a technique developed as a surgical alternative to total hip replacement. A pro-active man in his mid-forties, Christoph found out that one of the best specialist surgeons was located in a reputed private hospital in Chennai, South India. Aware that the outcome of the operation was dependent on the surgeon's experience (cf. Shimmin *et al.* 2010), the patient was ready to forgo his medical insurance in Germany and to pay the price in order to be operated on by the famous doctor. He entered into contact with the corresponding hospital service in Chennai through the internet, arranged a date for the intervention, managed to obtain a "medical tourist" visa and flew to India – an unknown country to him. In less than a month his connection to the country, the hospital and the

surgeon became a palpable reality.¹² Christoph stayed for nine days in India. He did not see any of the tourists' attractions and spend his last three days in a resort by the beach about an hour from Chennai to indulge himself with some gentle spa treatments and massages. He came back to Germany satisfied but stopped all form of contact with the people he had met in India. This situation is not uncommon. In my experience, it is in matters relating to reproductive health that the interaction between international patients and the local doctors and clinics is the most sustained. This is especially true for those couples seeking a surrogate mother, since most follow the pregnancy from a distance, visit the country at least twice (to establish the contract and to take part in necessary medical tests and interventions and, at the very end, to take the baby), and often keep a link with the surrogate once they are back in their country with the child¹³. On the other end of the health travel spectrum lie the spas and wellness centers. As said above, the linkages there are established for a few hours at the maximum. Elsewhere, students in Thai massage take a few weeks course at most, feeding the transnational classroom with their presence until a new batch comes in. Indeed, from the perspective of the geographically immobile people in either of these health infrastructures, they see an unending series of international people visit their clinic, ward or school, and each new patient, guest, client or student replaces the other. Local people's experience of transnationality takes place within the physical boundaries of their work place, itself located within the national boundaries of their country. However, they do indeed spend most of their days in a transnational space.

What defines the transnational here is *the sum of intermittent connections and bodily co-presence* between (changing, residing or transient) people that belong to different nations and find themselves together at a particular moment in time in a space of connectivity – a transnational space that coalesces in a hospital, in cyberspace or in a

¹² I have chosen this example among many because it shows a case rarely, if at all, described in the literature in “medical tourism”, where an international patient seeks healthcare abroad for a different reason than economic value, technological advancement, long waiting lists or lack of insurance. Here it is the perceived quality of the medical practitioner that was sought after. However, this example mirrors the organizational logic of most cases.

¹³ On the new forms of kinship stemming from transnational surrogacy, see the work by Pande (2009).

classroom. This involves temporality. The cross-border linkages do not need to last very long to fall under the purview of transnationalism as long as they are repeated and maintained across time. This understanding of transnationalism follows the criticism expressed by some authors about the disengagement of the social sciences – and of transnational studies for that matter – regarding the role of “distance contacts” such as travel and occasional encounters in holding social life together (Urry 2004). These kinds of contacts are vital forms of transnational exchanges. In our case, it is the space that is transnational, and not necessarily the individuals and objects that make this space. This situation echoes what I have described above for the virtual students of siddha medicine and their virtual connectedness to their teacher. These are firm and concrete transnational relations. The actors make use of technologies that make them present to one another, in an eloquent example of the “time-space compression” (see Harvey 1989; Urry 1995).

The very nature of medical space determines temporality. Therapeutic interventions and medical courses are time constrained. Treatments generally address acute problems and the teachings are adapted and shortened for foreign students. These configurations prevent long term exchanges, although these may happen according to individual preferences and commitment. On the other hand, individual time constraints are balanced by a high turnover of people accessing these spaces of connectivity, therefore allowing for the multiplication and repetition of transnational exchanges. These considerations may be helpful to revise static conceptualization of transnationalism and to expand its epistemological range.¹⁴

Conclusion

Recent critical scholarship in transnational studies has encouraged further elaboration on the reference points of transnational ties (Boccagni 2012). Based on

¹⁴ In the same vein, Philip Crang and his colleagues (2003: 446) have studied “transnational commodity culture” to provide “a particularly productive entry point into [a] wider conceptualization of transnational space. The study of transnational commodity culture widens the field of study to encompass a range of activities, goods, people and ideas that would not qualify as transnational [otherwise]”.

migration studies, the proposition recognizes its own actor-centered view (*ibid.* p. 119). This article took a different route. It introduced the notion of “space of connectivity”, a methodological device, which highlights the crossing points of transnational circuits. Circulations in these circuits converge in specific places, such as a hospital, a wellness center or a (virtual) classroom, where connectivity deepens. However, a locality is not a given; it is *made* through an array of social and cultural relations and perceptions, natural and material arrangements. These places are seen by the actors as a reference point for transnational relations. In other words, studying spaces of connectivity allows us to concentrate on both networks and place: the former helps to unpack the “internal complexity of cross-border social networks” while the latter is useful to understand their “external complexity”; that is, the ways these networks relate to each other (Gielis 2009).

Spaces of connectivity are not fixed entities; their spatial and temporal attributes are fluid and shifting. The spatiality and temporality of transnationalism are manifold. There are cases where all human actors are immobile and enter into a transnational space through ICTs. Technology therefore renders immobility and transnationalism compatible. In other instances, physical encounters do exist but they are limited by distance and costs, the nature of medical practice and the adjustments made to cater to the needs of foreign patients, clients and students. In each of these configurations, circuits and circulations congregate at the networks’ nodal points. Although they are located at the epicenter of transnational forces, these nodal health infrastructures mostly rely on motionless stabilizing agents. In the health field, the non-transnational takes precedence in the making of a transnational space. If the transnational space is sustained by immobile agents who inhabit the sites of coalescence in this space, mobile agents are free to join in, to plug themselves into the right network, follow the circuit and experience transnational connectivity. This is not small thing: those seeking healthcare offer and immerse their body in the space of connectivity in the hope of being taken care of and, for some, possibly cured. The transnational space is there embodied.

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