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Intertwined Therapeutic Mobilities: knowledge, plants, healers on the move between Laos and the U.S.

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Abstract: We investigate the notion of therapeutic mobilities through the case study of transnational health care practices and medicinal flows within the Hmong diaspora between Laos and the U.S. Drawing upon narratives of traditional healers, pickers, and plants sellers as well as a collection of postal registers, we highlight how therapeutic mobilities follow the routes of migration and organize the practices of healing among Hmong in receiving countries, particularly in the U.S. Through the different and multidirectional aspects of therapeutic mobilities, we illustrate how transnational healing touches upon questions of cultural identity within the Hmong diaspora. Therapeutic mobilities not only involve border-crossing, they also strengthen existing bonds within the Hmong diaspora. Similarly, herbal treatments not only achieve a therapeutic function, they also represent a range of meanings and values for patients. We explore the fabric of therapeutic mobilities through the prism of translocality and medical pluralism.

Keywords: therapeutic mobilities; medicinal plants; translocality; medical pluralism; migration; diaspora; Hmong; Laos; U.S.

Introduction

Mobility has become one of the predominant characteristics of our time (Appadurai 2001) and an evocative keyword for the twenty-first century (Hannam et al. 2006). If “*mobilities are centrally involved in reorganizing institutions, generating climate change, moving risks and illnesses across the globe...*” (ibid), they also transform health practices large scale by easing access to health facilities, remedies, and diagnoses. At the same time, over the last decade, a common idea associated with neoliberal policies is that individuals take increasing responsibility for their health conditions and become consumers making choices in a global marketplace (Kearns and Moon 2002). With the multiplication of healthcare options and the ease of traveling, patients have therefore the opportunity to select from a wide range of medical services and facilities inside or outside their country of residence. This observation made in the health sector overlaps the new mobilities paradigm (Sheller and Urry 2006) and the attempt to conduct research that goes “beyond the imagery of ‘terrains’ as spatially fixed geographical containers for social processes” (ibid, 209). Medicine and healthcare practices are embedded into circulations of knowledge, persons (practitioners and patients), products and standards that produce multiscale movements. Medicinal materials, therapeutic practices and healing practitioners circulate and transform infinite aspects of social, cultural, economic and political life. These circulations connect multiple places (nearby or far away), expand opportunities of access to different types of treatments and increase healthcare consuming patterns. In this context, international medical travel has expanded considerably since the beginning of the 21st century and given rise to a rapidly growing number of studies on cross-border and transnational practices regarding health issues (Kangas 2010; Connell 2015; Bell et al. 2015; Lunt et al. 2015; Bochaton 2015).

In this paper, we address the notion of therapeutic mobilities through the case study of transnational health care practices and medicinal flows within the Hmong diaspora between Laos and the U.S. As mentioned in the introduction of this issue, therapeutic mobilities combine movements of things as well as humans that travel to unfold therapeutic capacities or to provide or receive therapy. This case study brings together the transfer of non-manufactured products (dried or fresh plants), the transnational movements of Hmong healers as well as returning mobilities of Hmong Americans to Laos. Through these different and multidirectional aspects of therapeutic mobilities, we propose to explore how transnational healing touches upon questions of cultural identity of the Hmong diaspora. We will see how the plants, the figures of the traditional therapists, the mountain landscapes of Northern Laos (the landscapes of origin) all participate to the Hmong identity and open up beneficial therapeutic perspectives.

The Hmong are an ethnic group from South China and Southeast Asia with a long tradition of migration and are spread among several countries of the world (China, Laos, Thailand, Vietnam, France, U.S., Australia, etc.) following historical events that occurred in the second half of the 20th century. The aim of this paper is to highlight how therapeutic mobilities follow Hmong migration routes and organize the practices of healing among Hmong in receiving countries, particularly in the U.S. How does the transnational identity of Hmong materialize through therapeutic mobilities? How do sale networks operate between the forests, where the plants are picked, the local markets where they are sold, and the post offices that form nodes of this transnational economy? What are the economic, cultural, environmental impacts of these therapeutic mobilities in Laos, the place of origin?

A vast body of research has emerged around migration and health. Surveys of migrants' health care patterns show that individuals often carry health-related knowledge with them as they migrate: such knowledge is borrowed from their native country's medical

tradition and channelled via transnational networks linking patients, practitioners, and remedies. Many studies on Canadian and American Asian communities have shown the reality of this transfer (Monnais 2012; Roth and Kobayashi 2008; Ahn et al. 2006). In her study on Vietnamese population based in Montreal, Laurence Monnais established that the pluralist practices are not only related to issues of “cultural barriers” meaning the difficulty of access to conventional health care services in the host country and therefore its under-utilisation. Conversely, the pluralist practices appear as the rational product of previous representations and experiences of illness and care. Felicity Thomas (2010) conducted a study in London where she examined how transnational health networks strongly influence treatment seeking decisions of migrants from southern Africa and provide help and support in times of ill health. Similarly, research carried out with Chinese migrant women living in England (Green et al 2006) shows that most of them engage both with Western and Chinese healthcare leading to a dual medical systems pathways; their choices vary according to health beliefs, treatment failures and financial capacity of the patients and their household.

According to another study by Grace Xueqin Ma (1999), concomitant use of Western and traditional Chinese health practices is usual among Chinese immigrants in the U.S. and 32% of them travel to China or Taiwan for care. This interweaving between medical knowledge from home and health systems existing in host countries is much investigated through many cases studies in medical anthropology: Ghanaians in London (Krause 2008), Somali diaspora in Finland and different European countries (Tiilikainen 2012), Haalpulaar migrants in France returning back to Senegal for healthcare (Kane 2012) are some examples exploring the numerous ways traditional medicine is integrated and/or in tension with western medicine among the migrant communities studied (Grønseth and Oakley 2007; Dilger et al. 2012). However, other studies have shown that, in some contexts, traditional medicines take the form of ‘ethnic’ commodities mostly targeted at American or European consumers (Bode 2006)

and to a much lesser extent at migrants as in the case of Ayurveda medicine in the French context (Hoyez 2012).

The notion of therapeutic mobilities allows us to consider therapeutic practices that are expressed simultaneously in distant but interconnected places. As ‘migrants conduct their lives simultaneously across multiple spaces and via multi-layered and coexisting networks, linkages and connections’ (Thomas 2010), they tend to seek out different forms of treatment (biomedical pharmaceuticals, plant-based treatments, spiritual practices from various areas according to patients’ needs, accessibility and beliefs). In this paper, we propose to explore the fabric of therapeutic mobilities through the prism of translocality and medical pluralism (Benoist 1996). The term translocality, “being identified with more than one location” (Oakes and Schein 2006), usually describes a space in which new forms of identity are constituted. Translocality approaches aim to study the role of socio-spatial interconnections and in-between places in the construction and re-construction of identities. Traveling, exchanging information and staying in touch with relatives and friends in the country of origin appears as acts of ‘homing’ (Brah 1996) and ‘regrounding’ (Ahmed et al. 2003) which illustrate the complex interaction between travel and dwelling, movement and sedentarity (Scheller, Urry 2006). In this paper, emphasis will be put on the fabric “here and there” of the therapeutic identity of Hmong Americans between “therapeutic acculturation” (Monnais 2012) on one side—a process through which they adapt themselves to the practices of medicine consumption of the host country—and therapeutic traditions linked to the country of origin on the other side. In this in-betweenness, we will observe how the notion of medical pluralism, meaning the coexistence of conventional, complementary and alternative medicine, is transformed and enriched. This notion of medical pluralism itself appears to be translocal as circulations and interconnectedness blur the borders not only between different health care sectors but also between countries. Following the therapeutic mobilities ‘here and there’, we

will see that the mobility itself can be therapeutic for Hmong American who choose to return to their country of origin to find a state of health from before migration. The concept of medical pluralism incorporates here a new dimension, the one of place, environment and lifestyle attached to this place, which goes beyond the classic approach of medical pluralism between biomedicine and alternative remedies.

A preliminary approach to the study of therapeutic mobilities, its origins and processes, is to focus on the notion of networks. In this case study, networks are an essential link between herb gathering areas, healers and sellers in Laos and patients and consumers of the Hmong communities living overseas. Kristine Krause elaborates the helpful concept of ‘transnational therapy networks’ to grasp the ‘interlaced situational, formal and informal contacts between people, which become meaningful in the event of sickness, providing financial and practical support and help in finding the right treatment’ (2008, 235). Her study among Ghanaians in London shows how sickness can activate intensive exchange between friends and family members. We will examine to what extent this concept is relevant in the context of Hmong diaspora and how the therapeutic mobilities described in this case bring new insights to the ‘transnational therapy networks’. From a spatial perspective, the transnational diasporic networks show how some remote mountainous villages in Laos are well connected to some distant cities in the U.S. This observation feeds Charles Piot’s idea of a ‘remotely global’ place, a term he used to highlight the strong connections interwoven by traveling villagers between African villages and faraway places (1999). Because of the particular social position of the Hmong as relatively distant from the rest of the Laotian society, we will investigate how mountain villages, where medicinal plants are gathered, finally appear as better interconnected to the U.S. Hmong market than to neighbouring villages and local consumption markets.

While there is a kind of novelty in the therapeutic mobilities described in this paper, yet we will demonstrate how these processes are embedded in a long-standing history of health care, and geopolitics in Southeast Asia. Indeed, understanding therapeutic mobilities requires studying the broader historical, cultural and economic background of Hmong's health seeking behaviours in Laos as well as in host countries. This paper is structured as follows: after a historical frame of Hmong immigration to the U.S. (section 1), we will see how the therapeutic practices of this community have been built up over time and migrations (section 2). These contextual elements lead to understanding of the emergence of multidirectional therapeutic mobilities between Laos and the U.S. today (section 3). Finally, we will examine and evaluate the social, economic and environmental impacts of therapeutic mobilities mainly in the country of origin (section 4).

Method

This paper is based on a multi-sited ethnography carried out in Laos during 4 months (between 2010 and 2011) with an ethno-botanist Jean-Marc Dubost. Our initial investigations took place in some herbal medicine markets in Vientiane, the capital of the Lao PDR and in a Hmong community called 'kilometer 52 village' (meaning 52 kilometers north of Vientiane) where a medicinal plants market arises between 2000 and 2004. These first investigations eventually led us to focus on data collection in Xiengkouang province in the north-east of Laos, specifically in Phonsavan and Nong Hed district, a mountainous and remote area along the border with Vietnam. The data was gathered by ethnographic methods and consists of interviews and field notes. Interviews were conducted with some officials at the Ministry of Health and the traditional Medicine Research Center in Vientiane, with traditional healers, and with plants sellers in the different areas covered by our study. It also includes observation and gathering of medicinal plants with several healers in Nong Hed district and its surroundings. Moreover, records from the Lao Post Office were collected as they contain

information concerning the content and value of packages sent abroad. The postal registers from Vientiane, ‘kilometer 52’ village, and Phonsavan have been obtained to determine the volumes of herbal medicine sent abroad and to which countries. Finally in March 2012, I had the opportunity to visit and to have informal discussion with vendors of medicinal plants in a Hmong market in Saint Paul, U.S.

The Hmong diaspora: exile and transnational ties

From China... to a worldwide diaspora

Originating from China, the Hmong are an ethnic minority which, throughout its history, has often experienced migration and cohabitation with larger populations and cultures. During the five thousand years of their history, they migrated from Southeast China to the central plains, and to south-central and southwest China. As a result, they are known as the ‘roaming minority’ or the ‘Gypsies of the Orient’ (Yun 2010). Hmong community members first settled in Laos, as well as in Vietnam and Thailand, in the 19th century.

During the Vietnam War, a sizable number of Hmong furnished military intelligence and guerrilla support to the American troops who themselves supported the royal Lao Government in Laos. As US troops withdrew from the country, Laos embraced communism and this in turn caused the fall of the Lao royal regime in 1975. Since the Laotian Hmong opposed the communists, they faced an uncertain future and many fled to Thailand where over 100,000 of them applied for political asylum. Many Hmong have spent years in refugee camps, waiting to be resettled or expecting better prospects to return to their homeland. These dramatic events have greatly influenced Hmong lives. They faced death and disability; they lost family members and saw some of them being killed; they faced possible capture, torture, and imprisonment as they fled Laos, as well as harassment and robbery in refugee camps in Thailand (Culhane-Pera et al. 2003). Many Hmong therefore suffered from depression, post-

traumatic stress disorder, and culture shock. They still share a sense of vulnerability and powerlessness often translated into a self-protective mistrust of others' intentions (Culhane-Pera et al. 2003) which can partly explain mistrust towards Western medicine and towards U.S. healthcare particularly after desertion.

From refugee camps, a large number of them were given permission to settle in the U.S. in return for their support to American military efforts during the Vietnam war: the US government allowed for 65,000 Hmong migrants to settle in the U.S. during the 80s-90s (Hassoun 1997) and in 2003 they were 15,000 more (Grigoleit, 2006). Like all other diasporic groups, Hmong integrated in these host countries but they still remain connected to Laos and relatives they have left behind. These transnational links are not new, but in the era of globalization the ties between migrants and their homelands are more acute than before: the various means of communication and the quality of international transport facilitate long-distance and frequent contacts between the members of transnational families.

The Hmong who stayed in Laos after 1975 faced mistreatment and abuses from the Lao People's Democratic Republic: torture, forced displacement, starvation, and many of them opted to hide in Laos in order to escape the brutality of the dictatorial communist government (Hamilton-Merritt 1993). As a result, The Hmong have remained and still remain today at the margins of Laotian society, with limited integration. Besides linguistic and religious differences, Hmong community is apart in Laos and keeps strong and privileged links with the members of the diaspora.

With the opening of Lao PDR since the early 1990s, many Hmong people based abroad regularly come back to Laos, especially for cultural events such as the Hmong New Year. 'Hmong Americans are maintaining a strong sense of identity with Hmong in Southeast Asia and China and are continuing their relationships with Hmong throughout the world by letters, audiotapes, videotapes, newsletters, e-mail messages, and visits' (Culhane-Pera et al.

2003). The contacts are thus sustained through visits, sending money and other items, telephone calls, and internet. The transnational networks with relatives living overseas also create pathways for information flows, and this in turn encourages Hmong entrepreneurship in Laos by providing external sources of capital and advice, as observed in development of rubber plantations by members of the Lao Hmong community development (Baird and Vue 2015).

Traditional remedies & biomedicine: Hmong's health practices

The histories of traditional medicine and biomedicine are intertwined in the case of the Hmong trajectory.

Traditional therapeutic practices

In Laos, traditional practices in medicine has been used for centuries by Hmong people and other ethnic groups living in remote and mountainous areas and has played a crucial role in maintaining local populations in good health in the past (Pottier 2004; Ngaosyvathn 1983; Westermeyer 1988; Sydara 2005; Soejarto 2006). These traditional practices include home therapies which are mainly based on the family's knowledge of plants; draw on the knowledge of 'medicine doctors' who heal with herbal remedies; use ritual or magical practices through soul callers and shamans.

Traditionally, family members perform a vast array of healing modalities, including ritual healing and administering herbal medicines. Our research interviews supported Pake's (1987) observations that women in particular know about medicinal plants—for example, fresh herbs and dried barks and roots that are made into teas for internal ailments or poultices for skin and musculoskeletal problems. Traditionally, Hmong women are responsible for growing herbal plants, for preparing and prescribing the use of herbal medicines. These herbal therapies are performed for the relief of many types of common ailments, such as colds,

coughs, abdominal pains, and diarrhoea (ibid). If, however, the problem is unusual, seems to be serious, or does not respond to home therapies, then family members seek out the assistance of a medicine doctor. Usually a woman, a medicine doctor examines the patient's body, diagnoses the condition, and gives medicinal treatments she has harvested from the forest or from her own medicinal garden. Her knowledge comes from apprenticing with an older medicine doctor and from her helping spirits whose wisdom guides her as she examines, diagnoses, and prescribes. People may consult them for a wide range of physical ailments, including fevers, headaches, wounds, abdominal pains, menstrual irregularities, infertility, impotence, prolonged labor, fetal malpositions, and many others. People usually pay a nominal fee for their services, although the medicine doctors may give free treatments to those who ask graciously. Many medical anthropological works have been published on the Hmong medicinal uses of flora (Geddes 1976; Chindarsi 1976; Lemoine 1972; Vidal 1969; Kunstadter 1985; Vidal and Lemoine 1970).

Hmong experiences with Western medicine

The French colonial administration (1893-1954) laid the foundations of western medicine in Laos as public health was considered as one of the pillars of the "civilizing mission" (Mignot, 2003, 22). A network of healthcare facilities developed to legitimize colonial power and to demonstrate the superiority of Western medicine over local therapies used by the multi-ethnic population (Mobillion 2010). However, the hospitals and dispensaries built were mainly concentrated in the most accessible areas of the lowlands of the Mekong Valley. For this reason, the provision of care introduced by the French protectorate did not benefit at all the mountain communities to which the Hmong belong. Because of this context, Hmong in Laos had little access to Western-trained health care providers and western medicine until the USAID-sponsored medical relief efforts were established in the 1960s (Weldon 1999). From 1975, the People's Democratic Republic expanded the healthcare network all over the country

through a pyramidal scheme: health volunteers in the villages, dispensaries at the sub-district level, district hospitals, provincial hospitals and central hospitals in Vientiane. However, the insufficient level of training of doctors and their short daily presence in public facilities contributed to a crisis of confidence of Laotians with regard to the public health care system and consequently its underutilization (Hours & Selim, 1997; Pottier, 2004). A study conducted in Laos in the '90s shows that Hmong people were reluctant to seek health care in health centers (Mignot 2003).

The official policy of the socialist state was also to promote the use of medicine remedies as one of the key components of a nation building project, alongside its neighbour and political ally Vietnam (Monnais et al 2012). In 1976, the Institute of Medicinal Plant Research was created in Vientiane as well as 12 provincial centers of traditional medicine, and these were charged with gathering and transmitting local therapeutic knowledge towards Vientiane. However, field observations revealed the very weak activity of these facilities because of insufficient allocated budgets but also due to the resistance of traditional healers to communicate their knowledge to official authorities, partly due to of the ill-treatment suffered by the Hmong and other ethnic groups. As a result, the knowledge of remedies remains quite compartmentalized between the different ethnic communities in Laos and in particular among the Hmong where knowledge circulates exclusively within the community. Exclusive Hmong knowledge is associated with the interconnectedness of the diaspora, which accounts for its translocal dimension.

Most of the Hmong who fled from Laos after 1975 had their first contact with allopathic medicine in the Thai refugee camps in the 1970s and 1980s (Wright 1986). Hmong people had mixed reactions to Western medicine; 'They were impressed with the efficacy of intravenous fluids, blood transfusions, antibiotics, and operations that repaired war wounds. But they also were concerned about the adverse effects of Western therapies' (Culhane-Pera

et al. 2003). Moreover refugees were wary of physicians' procedures and motives: religious proselytizing was connected with health care, and Hmong refugees associated deaths and medical complications with the unfamiliar healthcare practices (Wright 1986). Some of them assumed that improper medicines were being given to them.

Ever since Hmong refugees started to settle in the US, numerous documents show that Hmong Americans experienced 'culture shock' when faced with conventional health care professionals because of differing perceptions of appropriate health treatment procedures (Fadiman 1998; Dia 2003). These studies have shown that many Hmong Americans rely upon traditional healing practices before they will consult conventional health care professionals. This situation points to conflicting values between Hmong families and U.S. healthcare providers and this can be related, as mentioned before, to a wider feeling of suspicion and distrust developed by the Hmong when they felt deserted by the Americans in the wake of the Vietnam War.

Among the Hmong seeking health care in US facilities, many complained that physicians were unable to diagnose any disease or prescribe appropriate medicines to relieve symptoms. They shared two major concerns regarding American medicines: physicians did not give the best medicines to Hmong people and kept them for the Americans; and, Western medicines were too strong for Asian people (Culhane-Pera et al. 2003). The attitude of Hmong toward Western medicine is characterized by both fascination and mistrust, an ambivalent feeling that has already been observed in other contexts, for example within the Vietnamese community in Canada (Monnais 2012). Western pharmaceuticals are seen as very efficient and quick-acting that some raise doubts about their harmful effects on the body. However this situation has changed since the late '70s: the bulk of the first generation still hold strongly to traditional Hmong therapies, while the younger members, educated in the U.S. school system, tend to adjust more biomedicine and tradition thus giving full meaning to

the notion of medical pluralism. Young American Hmong do not relinquish herbal remedies, which explains the sustained imports from Laos.

The age-old tradition of herbal therapeutic uses on the one hand and mistrust towards Western medicine on the other hand both explain the use of traditional healing in the receiving countries (particularly in the U.S.) and the emergence of the transnational healing trade between Laos and the US.

Multiple therapeutic mobilities: medicinal flows, returning migration, healers' movements

The Hmong diaspora is known for maintaining very strong relations with their families and communities left behind. Therefore they maintain a strong sense of cultural identity, and in the medical area they continue to invest in their traditional systems of understanding illness and healing. Traditional Hmong therapies have persisted in the migration and still prevail today in the United States through ritual healings and herbal medicines uses. Medicinal herbal knowledge is still intact and actively practiced especially among older Hmong. 'Use of traditional herbal medicine has remained part of the world of Hmong women in the United States, where gifted elders have continued to teach female relatives and trusted friends' (Corlett et al. 2003).

This feature was already noticed in refugee camps in Thailand by Western health personnel; indeed, they observed that the Hmong heavily relied on their herbal medicine and hardly used the available Western medical services. 'In comparison to refugees of other ethnic groups, the Hmong have the lowest per capita rate of visits to Western clinics' (Pake 1987). This situation was made possible because many Hmong had carried their collections of plants on the long journey from the northern highlands of Laos to the lowland refugee camp. However the amount of plants was low because of the heat and of the long distance covered on foot.

In the U.S., women mostly grow plants in summer gardens or in winter greenhouses. In Sacramento (California), for example, ‘the Hmong continue their agrarian traditions by creating urban gardens where they grow traditional plants either for food or medicinal use’ (Corlett et al 2003). But, as tropical plants can be difficult to obtain or to grow, exchange and trade networks exist within the American Hmong community: for example, they send fresh plants from warmer to colder parts of the country. Nevertheless, some herbs cannot be grown anywhere in the U.S., which makes the continuation of traditional herbal healings difficult. This ‘lack of familiar plants has led to the importation of traditional Hmong herbs to California whether through covert commercial exchange or through covert personal transportation’ (Corlett et al 2003, 366).

Based on the analysis of the Lao Post Office records in 2010-2011ⁱ, the U.S. is the main destination for exports of herbal medicine gathered in Laos: 94% of the packages sent abroad go to the U.S. 408 packages were sent from Phonsavanh to the U.S. between January 2010 and July 2011 (monthly average: 22 packages); 260 packages were sent from km52 to the U.S. between January 2010 and August 2011 (monthly average: 14.5 packages); 81 packages were sent from Vientiane to the U.S. between October to December 2010 (monthly average: 27 packages). France comes in second for herbal medicine exports with 3.7% of international shipments and Australia comes third with 1%. This considerable gap actually reflects the unequal distribution of Hmong people between the three receiving countries: estimates of Hmong populations in the US are 278,871 (U.S. Census Bureau 2016), while around 16,500 lived in France in 1999 and 2,000 in Australia (Lemoine 2005).

In addition to the demographic factors, the differences may also reflect contrasting customs regulations regarding the import of natural goods and access to health-care systems in host countries. The major differentials in the volumes of herbal healing products shipped towards host countries thus underline differing use patterns for herbal medicines from Laos

by Hmong community members depending on migration backgrounds. All members of a group do not have the same access or relationship to the medicines coming from their original country and the use of different healthcare practices depends on several factors related to social and economic environments, health values, medical systems available, etc.

For the U.S., parcel shipments to different states are broken down as follows: the state of Minnesota (and especially the city of Saint Paul) comes first, followed by California where Fresno and Sacramento get most of the packages. These numbers clearly match the distribution of Hmong community members in America: nearly 30,000 Hmong people live in Saint Paul, 25,000 in Fresno, and almost 17,000 in Sacramento.

This brief depiction of medicinal flows shows that, apart from the plants grown in urban gardens in the U.S., Hmong Americans use their transnational linkages to find the right treatment for their sickness. The example of parcel shipments described above illustrates well these medicinal flows which tend to fill the gaps of the U.S. health system. The plants sent abroad are usually dried before being prepared for transportation in plastic bags. Although some plants are ideally used fresh, most of the remedies sold in Laos markets and consumed locally are dried. There is thus no special preparation of plants before sending them abroad.

In addition to these large scale medicinal movements from Laos to the U.S., therapeutic mobilities also happen in suitcases through personal travel of Hmong Americans on their way back to their host country. Several plants sellers met in km52 and Phonsavanh markets reported that American Hmong sometimes came to buy plants to bring home; these purchases are usually made in December at the time of Hmong New Year which attracts many members of the diaspora. Very few reported purchases made by Hmong living in other host countries.

Therapeutic mobilities take shape as well through the circulation of some healers who travel to the U.S. mainly through family networks and bring with them luggage full of freshly collected medicinal plants.

I went twice to the U.S. in 2006 and 2007 to visit but also to sell medicinal plants (about 60kg of goods each time). Three of my daughters live in Oklahoma and Michigan. I went to the U.S. with my husband and I sold to relatives and acquaintances there (healer in Nong Hed district).

This healer met in Nong Hed brought with her a document prepared by Phonsavanh hospital allowing her to leave Laos with the plants and take them through the U.S. customs. She explained she earned about US\$3,000 each time.

Therapeutic mobilities also include the transfer of advice through telephone calls and internet. A man was about to send a parcel to his brother-in-law when we met him at the Post Office in the km52 village.

This is the first time I send plants to Fresno (California), however I regularly send traditional clothes and embroidery. My brother-in-law called me several times because he has a stomach ache; he described his symptoms and asked me to send him treatment (farmer in km52 village).

During the interview, he explained how he learned to cure with plants by his mother and repeated several times that he did not understand why his brother-in-law in the U.S. needed these plants for treatment. After several phone calls, he finally went to collect the plants himself in the province of Xiengkhouang because the ones he was looking for were not available at the market at km52. This example emphasizes that, from the point of view of the Hmong who remain in Laos, it is not necessarily easy to understand why the Hmong abroad ask for medical advice from their relatives and still use herbal medicine from Laos while they have access to a modern health care system and well trained doctors. Moreover, in this case, the transnational healing process tends to strengthen the unity of the family and serves as a reminder of the importance of close family ties.

However these circulations of medicine, healers and advice are far from unidirectional. They travel both ways. The dynamics of migration between Laos and the U.S. have given rise to multidirectional flows of medicines, knowledge and individuals between the two countries. Medicine and other medical supplies are also frequently sent from the U.S. to Laos, but the types of medicines are different. Family members in Laos commonly receive painkillers, complementary health products and dietary supplements such as vitamins and minerals found in U.S. food supplement stores, as well as devices to measure bloods pressure and sugar.

It is also familiar for migrants returning to Laos for a family and tourist trip to seek alternative treatments and medications or to consult local healers during their stay when they wish to find a cure for serious illness. Based on an anthropological study on the perceptions and health practices of Hmong with type 2 diabetes in the U.S., Mai See Thao (2015) highlights the existence of return migration to Laos and shows how these mobilities provide relief to the patients concerned: ‘Yes, the weather fits our bodies. The food is natural, grown in the countryside. There we are better, there we have no more diabetes.’ In most cases, these returning patients use biomedicine in their host country, and when the researcher asked a Laotian Hmong if the Hmong from America come to Laos for medical treatment, the woman answered, ‘We all know that they are not here for medical treatment because the United States has the best of medicines in the world. They are here to be happy, and to live like they did in their old country.’ Many exiled Hmong perceive Laos as their ideal home to which they wish to be able to return. Therefore, traveling home to a socially, culturally, and religiously familiar environment is itself often experienced as therapeutic and healing. Hmong-Americans interviewed in Laos by Mai See Thao explained to her that rather than seeking a miracle cure, they came back to Laos to enjoy the way of living. The cure is materialized in the sense of seeing their old country, their relatives, and moving freely through the land that once was home. For the anthropologist, the desire for cure is rooted in the desire to return to

pre-diabetic self, a young youthful self that had always continued to live in Laos. Embodying the landscapes and social relations in Laos constitutes therefore a form of healing which works as a memory of what it means to be Hmong. These return migrations prove that ‘medical pluralism’ can be expressed in many ways without necessarily receiving care or medicine, but also by going and moving in places that are good for the body and the mind. Returning home appears as an alternative practice of care within a classic therapeutic itinerary and it echoes the notion of ‘therapeutic landscapes’ developed by Gesler (1992) and briefly defined as ‘places that have achieved lasting reputations for providing physical, mental and spiritual healing’ (Kearns and Gesler 1998, 8). These returning migrations also involve a strong element of hope and touch upon questions of cultural identity among the Hmong diaspora.

The previous examples show the therapeutic mobilities between Laos and the U.S. are multifaceted and multidirectional connecting back and forth the two countries. Not only capital exchange for health goods, but also health care workers, health products, and medical knowledge are on the move in both directions. The circulations of biomedicine and traditional medicine between the two spaces, traditional healers one way and patients the other, indicates that exiled Hmong as well as Hmong left in Laos want to take advantage of both systems.

While these mobilities have consequences in both environments and societies, we mainly focus on the ambivalent impacts of these therapeutic mobilities in Laos.

The ambivalent impacts on local society: a new economic market, sustainability of traditional knowledge, pressure on natural resources

Transnational health care constitutes an important resource for Hmong living outside Laos. Healers in Laos, together with herbal remedies sellers and pickers, provide migrants significant health-seeking alternatives. As mentioned by Hannam et al. (2006), “*multiple and intersecting mobilities seem to produce a more ‘networked’ patterning of economic and social*

life, even for those who have not moved". Indeed, therapeutic mobilities are an important resource for local healers and sellers in Laos since circulations allow to expand the sales opportunities of the medicinal plants and thus to increase the revenues derived from them.

Several interlocutors interviewed in Nong Hed district and in the 'km52' village establish the emergence of a transnational medicinal plants market between 2000 and 2004. Before that, other forms of transnational trade patterns, formal or informal, were already prevailing within the Hmong diaspora; for example, many traditional Hmong clothes and embroidery made in Laos supply stalls in Hmong markets in the U.S. Hmong clothing is also a famous Thai tourist product, and the materials used for making these products are mainly imported from Hmong villages in China via Laos involving a lot of different groups in this trade (Yun 2010). Hmong also played a major role in the informal trade of opium at a regional level in South-East Asia during the 20th century (McCoy 2003). In 2003, more than 90% of the illicit cultivation of opium poppy took place in three countries: Afghanistan, Myanmar and Laos (UNODC 2004). In the early 1990s, the sale of opium represented 90% of the average annual monetary income and 50% of the total income of the households' involved (Ducourtieux et al. 2008). However in 1998, an agreement was signed between the Laotian government and the United Nations Office on Drugs and Crime (UNODC) to totally eliminate the production, the consumption and sale of opium in Laos before 2006. After the ban, family incomes fell sharply and the poverty among ethnic minority groups, mostly the Hmong, increased. In this context, farmers tried to start new cash crops, stock-raising or businesses to compensate for losses suffered after the poppy cultivation ban. This is also when some women in Nong Hed district and 'km 52' village started to gather and sell medicinal plants giving rise to formal production networks and trade networks in the early 2000s. .

Activities diversification and income increase

The plants growth by Hmong women were mainly intended for family or medicine doctors. Because of revenue decline and in order to switch their activities, women from Nong Hed district started out going back and forth and sharing their time between gathering and direct selling in Phonsavanh, km52 village, Vientiane and Northern provinces. ‘I started selling here about 10 years ago. Before that, I used to grow poppy and to sell opium paste but as it became illegal, I started selling medicinal plants’ (saleswoman in km52 village, 2011).

The physical and climatic characteristics of the Nong Hed district are the reason why it became a major place for plant gathering. Its mountainous terrain offers a so-far unspoiled rich and diversified forest cover compared to other overexploited forest areas in Laos (used for the sale of precious wood and new crops: rubber, corn, etc.).

After a few years, some of the women who started this national and transnational business bought a small shop to settle a permanent business in km52 village. Other women continue to collect plants in Nong Hed once a month but most of them buy the herbs from intermediaries (all women) based in Nong Hed or ask extended family members to collect for them. The sale of medicinal plants has some advantages described by several vendors. This trade does not require a start-up capital: ‘if you start another business, you need cash to purchase equipment and devices for sale while there, it is easy, the plants are in the forest and are available for free’ (saleswoman in the km52 village). Another vendor also emphasized that as ‘I do not speak very good Lao, that's a bit hard for me to sell clothes to Laotians. Here, I sell traditional medicine only to Hmong people’ (saleswoman in Phonsavanh). Finally some sellers decided to sell herbs rather than anything else because they thought there was less competition.

There is one main route used for transporting the medicinal herbs from Laos to overseas destinations: it starts from Nong Hed, passes through Phonsavanh, ‘kilometer 52’

and Vientiane (see map 1). The central node of this transnational business is the km52 village. In recent years, the village and its surroundings experienced a strong population increase, with Hmong people coming from Xieng Khouang and Saysomboun provinces. Moreover, this area is a flat open country in sharp contrast to the mountainous areas where the Hmong traditionally live. Consequently, the plants available there are not the same as those used for traditional remedies available in upland areas. The demand for the plants from the forest has increased and a medicinal plant market has emerged, mostly run by saleswomen from Nong Hed district. 'I decided to come to km52 because there are not many customers in Xieng Khouang province. In addition, in Vientiane, housing is more expensive than here' (saleswoman in the km52 village).

The increase in sales of plants in the markets of Phonsavanh, km52 and Vientiane progressively made new stakeholders aware of the benefits of this sector and vendors required new recruits to increase their supplies of plants. The vendors from km52 gradually involved their daughters, sisters, cousins, nieces in the business by asking them to send plants regularly by bus (the bags of plants are placed in the bunkers and the journey takes about 10-12 hours), once a month during the rainy season and 2 or 3 times per month during the dry season on average. The volumes of plants collected and delivered range from 10kg up to 80kg each time. The pickers involved decided in turn to sell on Tam Say (Nong Hed District Center) market every Saturday morning in order to gain new customers and increase plant purchases. Due to a snowball effect, women living in remote villages (2-3 hours walk from Tam Say) are also involved in this business as plant gatherers.

The incomes of women involved in the medicinal plants trade depend on the role they play in the sector: pickers, intermediaries, sellers, healers. It also depends on how closely and directly they are connected to the transnational market. The pickers from Nong Hed district are the first link in the supply chain and earn a moderate income: from US\$100/year for the

least regular pickers to US\$400/year for the pickers who have contacts with numerous customers and collect plants regularly. Among gatherers encountered in Tam Say market, one stated: 'it's a good business because customers sometimes order 100 or 200 kg of plants. That's a lot of money.' According to the women interviewed, these additional incomes mostly allow them to send children to school and to buy food.

The pickers with relatives established in the U.S. enjoy higher incomes as they have the opportunity to send plants without hiring the services of intermediaries. A woman whose sister left Laos to settle in the U.S. the year before, already received 5 orders of medicinal plants (between 5 and 8 kg). Her sister calls her and describes the type and the amount of plants she needs. After picking, she sends the raw herbs and once they reach the U.S., they are cut into pieces and packaged. Her sister often makes mixtures of several plants to treat high blood pressure, gastric problems (stomach burn) and overweight. 'My sister seems to earn a good living there. When I send her some plants, she often sends me back 200-300 US\$.' The opportunity of direct transactions with the United States is highly pursued: a woman from km52 wanted to send some plants to her relatives living in the U.S. so that they could sell on-site. 'But my cousins are very busy, they do not have time to do that. So I've never sent anything at the moment' (saleswoman in km52). Two women from Nong Hed district who started this business at an early stage are now the main negotiators between pickers and resellers in the markets in Laos and abroad. The income they derive from this full-time activity approximates US\$ 300-400/month which brings them a very comfortable income supplement in addition to the cultivation of rice.

The herb vendors in the markets have the highest incomes but these vary with the seasons. A woman from km52 stated she earned between US\$40 and US\$120/day. Her Hmong customers come from the surrounding villages and even from Thailand, France and the U.S.

According to all sellers, the best time to sell medicinal herbs starts at the end of the rainy season in November and especially around the Hmong New Year in December. ‘This is the dry season, people have more time to come to market. At that time of the year the weather is often unstable and cold, so there are more diseases.’ The Hmong New Year is also the time when many Hmong living abroad return to Laos to participate in celebrations; as referred above, some visitors then use this opportunity to take back with them plants purchased locally. Part of the incomes derived from this transnational trade of plants results at last from vendors selling herbs while visiting their relatives abroad.

The growing demand for herbal medicine from the U.S. has several impacts on the economy in Laos. In Nong Hed district the economy has been boosted and demand for plants has changed women’s activities. This brief depiction of the channels used by farmers, go-betweens, resellers in Laos and the U.S., and consumers shows how the Hmong herbal medicine trade is flourishing within a larger network that spreads throughout Laos and outside its borders.

Reassertion of traditional knowledge and shaking up perceptions of medical systems

The growing demand for medicinal plants from the American Hmong also reasserts the value of traditional remedies within the Hmong community in the Lao PDR: indeed, the fact that American Hmong still use herbal medicine from their place of origin when they live in the most developed country in the world, contributes to enforcing the image of a powerful traditional healing system and changing perceptions about these products. As it develops economically, the Lao PDR experiences a growing availability of biomedical drugs which are increasingly used by the Laotian population. As a consequence, we observed that traditional knowledge about herbal medicine is generally decreasing among other ethnic groups in Laos, the Lao, Lü, and Khmu communities. As opposed to this, the therapeutic mobilities associated with the medicinal plant trade within the Hmong diaspora seem to contribute to the

preservation of traditional knowledge and affect directly the intergenerational transmission of knowledge: indeed, during the plant gathering season, women share their knowledge and also teach their children who often come to help. These trips to the forest are therefore unique opportunities for knowledge transfer from adults to the young generation. These gatherings in the forest become more numerous as the demand for shipments abroad increased, and thus they represent a real chance to transmit comprehensive medicinal plant knowledge over time. Among the women interviewed in Nong Hed, one explained she started to learn how to use medicinal plants at the same time as she started her business. ‘A villager came to see me to gather plants for her.’ She claims not to have known many plants (10 to 15) but she gradually gained experience as she gathered together with her two cousins in the forest. This example illustrates how therapeutic mobilities motivate women to deepen their knowledge of local medicinal plants and to expand their practices beyond, but also for the benefit, of their family unit. ‘Now I can treat my children in case of problems. Before, I bought modern medicines only.’

This case shows well how knowledge and skills of traditional medicine are acquired through apprenticeship within the Hmong community. We can refer to Lave and Wenger's research (1991) who studied how apprenticeships help people learn, and more precisely to their concept of “community of practice” or situated learning, to describe learning through practice and participation. In the example described above, the woman appears as the newcomer who first joined the established group of pickers in the village, and initially spent some time observing and helping them through simple tasks: collect, sort, clean the plants. Gradually as she learned to recognize plants and their therapeutic uses, she fully participates in picking for the international market. In our case study, the members of the community of practice are both the users and the practitioners of traditional healing practices, and they appear to share a common set of values and cultural beliefs across time and space.

Through this example, we also become aware how therapeutic mobilities change the perceptions of healthcare and challenge the hierarchy between the medical systems, biomedicine and traditional medicine. In this case, traditional medicine is no longer seen as backward. This contrasts we have often observed in other Laotian communities that are more oriented towards biomedicine drugs that are perceived to be effective and fairly easy to access. In our study sites, Western medicine, which is often regarded as a sign of modern life, is no longer perceived as superior. The emerging trade in medicinal plants and the mobility with which they are embedded is shaking up the hierarchy perceived between medical systems.

Environmental pressure

Despite the economic benefits of herbal remedies' circulation from Laos to the U.S., it should be emphasized that the growth of plant picking for commercial purposes has some negative consequences for the environment and local biodiversity. The Lao Government signed the Convention on Biological Diversity (Rio Convention) in 1996- but the country still faces numerous challenges in terms of sustainable management of biological diversity and responsible usage of natural resources. To our knowledge, there is no regulation in Laos concerning wild plant collection periods or permitted harvesting quantities. According to the pickers in Nong Hed district in 2011, harvest increases and the rise of grazing areas in forest areas means that some species are becoming scarce and increasingly difficult to locate. For this reason, some healers and sellers have decided to expand the number of plants grown in gardens around their homes or on dedicated space. However, some plants cannot be grown in such settings, and therefore become rare in the wild. Pickers said they sometimes had to travel very long distances to find specific remedies, especially some mosses and lichens that grow on trees and are very difficult to grow in a garden. Therefore, in order to preserve the biodiversity and availability of these medicinal resources on which ultimately depends the

sustainability of medicinal knowledge, it seems important that the Lao government sets up some regulations around medicinal plants. There is also an urgent need to inventory the species marketed and evaluate the importance of the samples. These measures of protection are crucial, especially in a context where traders and inhabitants of the neighbouring countries are also increasingly interested in purchasing local plants in Nong Hed district. These external pressures on wild plants in Northern Laos (through cross-border demand and transnational trade) correlate with the fact that, within the Greater Mekong Subregion, Laos is mostly considered as a valuable source of natural resources by Thailand, Vietnam and China. In order to satisfy their significant domestic demand, logging trade, mining and hydropower land concessions (Miles Kenney-Lazar 2017) expand across the country, boosting natural resource-based exports from the Lao economy.

Conclusion

The transnational health practices of the Hmong diaspora consist of a variety of multidirectional flows, including medicine, diagnosis and advice, healers and patients. These multifaceted therapeutic mobilities illustrate Appadurai's (2001) significant argument that contemporary life is shaped by flows and objects in motion. This case study provides valuable insight into this debate and stokes the idea that processes of globalisation facilitate multiple forms of transnational interactions and not only unidirectional flows of a so-called hegemonic biomedical knowledge from the 'developed' to the 'developing' world, as highlighted in many approaches (Thomas 2010).

Therapeutic mobilities not only involve border-crossing, they also strengthen existing bonds and world views within the Hmong diaspora. Similarly, herbal treatments not only achieve a therapeutic function, they also represent a range of meanings and values for patients. As tangible substances, medicines and remedies 'can be used to facilitate, mark, reinforce social relationships' (Van der Geest et al. 1996). Through this example, we have

evidence that the notion of medical pluralism is enriched within transnational healthcare: the Hmong case study shows that traditional medicine and herbal remedies are not only alternative care practices to biomedicine, but that the place of origin for these products constitutes a ‘therapeutic landscape’ as well, bringing an extra dimension to the notion of medical pluralism.

Herbal medicine has been used for centuries by Hmong people and other ethnic groups living in Laos and has played a crucial role in maintaining local populations in good health in the past. However, during numerous fieldtrips in rural Laos, the therapeutic mobilities described above appear to be specific to the ethnic Hmong community, even though other Laotian ethnic groups live abroad (e.g. the Lao ethnic group). This highlights the fact that even though health-related knowledge is recognized in the country of origin, it does not always travel with migrants and, therefore migration does not automatically involve medical knowledge circulation. This raises a number of questions about the specificity of the Hmong community and the strength of a transnational identity that incorporate these therapeutic products. In this case study, therapeutic mobilities result from a unique assemblage of specific historical and political backgrounds, economic context and, cultural and health determinants among the Hmong. The escape of a large number of Hmong families after the arrival of the Lao People’s Democratic Republic in 1975 contributed to the formation of the Hmong diaspora transnationally. However, this forced migration left many psychological scars and a general feeling of mistrust of U.S. and Laos authority among the Hmong community. In health terms this mistrust results in a very ambivalent feeling towards biomedicine, between admiration and rejection, both in the U.S. and in Laos. Conversely, despite the distance from collection areas, traditional herbal treatments are trusted and actively sought after by Hmong diaspora who cause their circulation and apply their translocal identity to care. Moreover, the mandatory cessation of opium cultivation in the early 2000s in

Laos created suitable economic conditions for the emergence of new forms of business which includes the transnational trade of medicinal plants. The development of therapeutic mobilities within the Hmong community finally appears as multiple forms of resistance and adaptation to the conflictual relations of the past, forced migration and recent economic changes. Hmong medicinal plants appear strongly inscribed in transnational networks even more than in local and national networks. The forests, where the plants are picked, the local markets, where they are sold and the post offices, where they are sent constitute the main nodes of this translocal economy.

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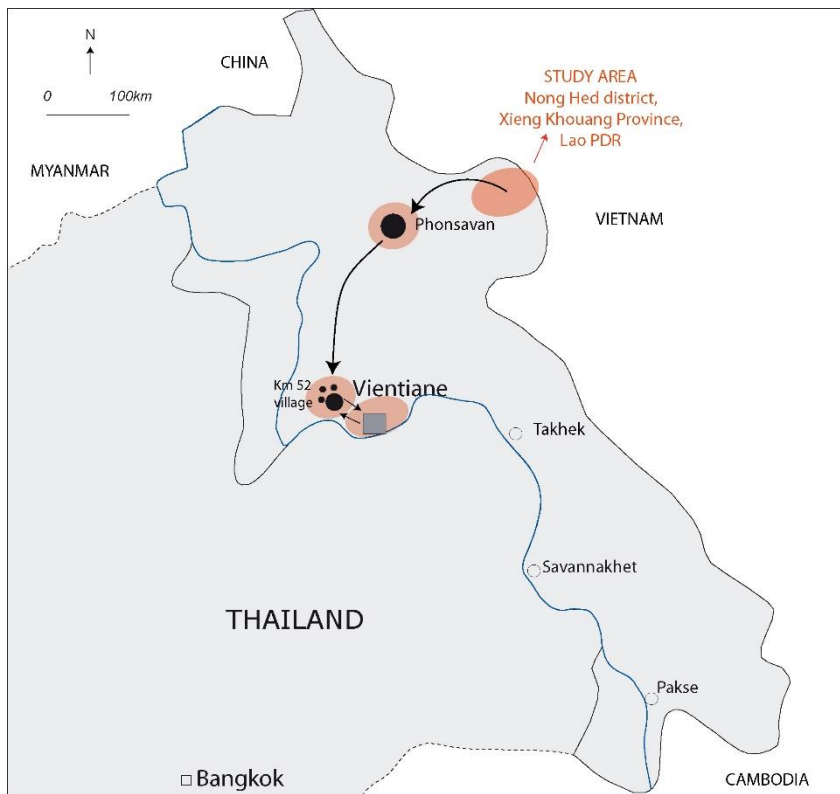
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Map 1: the main trade route of medicinal plants from the district of Nong Hed, Laos



ⁱ Lao Post Office data was gathered by the author in multiple post offices in Laos, as elaborated also in the Method section of the paper.