**The United Kingdom’s Somali populations as medical nomads**

**Abstract**

Much medical travel scholarship has been driven by a commercial focus whereby private providers pursue a high-value and complex patient market, primarily emanating from the Middle East, North America and Western Europe. This emphasis has led to a framing around ‘medical tourism’, prompting countervailing critiques of the term and the introduction of alternatives including ‘medical pilgrimage’ and ‘medical exile’. Reappraising the dynamics of mobility has led to explanations of medical travel increasingly located in fields of diaspora and transnationalism. The article identifies how diasporas and transnational communities resist straightforward categorization regarding the routes and processes through which they utilise healthcare. In this vein the article introduces the concept of ‘medical nomadism’ and grounds it in the experiences of Somali patients’ travel from the United Kingdom for healthcare overseas. It argues medical nomadism is a distinct medical travel behaviour, pointing to similar behaviours of Cape Verdeans living in Netherlands, and the concept’s utility in interrogating broader health-seeking mobility.

**Keywords**

**Medical tourism, pilgrim, exile, medical nomad, transnationalism, Somali**

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**Introduction**

Medical travel embraces a range of healthcare services, geographical settings, health systems and patient circumstances. As a subset of patient mobility, it entails travel beyond national jurisdiction for healthcare treatment, with a primary aim of obtaining that treatment. Within this broad definition, there exists a huge amount of diversity because of differing motivations, destinations, treatment types, funding mechanisms and types of provision. Much of the earlier governmental and commercial attention sought to normalise such travel, frequently invoking unsubstantiated numbers of travellers and projections of an upward slope of industry growth and development (Keckley and Underwood 2008). Combined with a growing criticality about who is producing numbers has been a rethinking around medical travel and growing empirical acknowledgement of the diversity of medical travellers with diaspora, transnationalism, regionalism, and South-South exchanges as emerging themes (Bochaton 2015; Chanda 2015; Crush and Chikanda 2015; Suzana et al. 2015; Connell 2016; Ormond and Sulianti 2017; Whittaker et al. 2017).

The article aims to introduce and develop a concept of medical nomadism – a form of deterritorialised healthcare seeking that is distinctive from existing concepts within the field. The paper structure is threefold. First, it re-examines how concepts of medical tourist, medical pilgrim and medical exile have attempted to frame the context and practices of medical travel. Following this assessment, medical nomad is explained and set within a wider diaspora and transnationalism literature. Second, the United Kingdom’s (UK) Somali populations’ health-seeking behaviour is examined and set within this concept of medical nomadism. The third section both extends and evaluates medical nomadism, setting it alongside existing concepts. Nomadism is a distinctive contribution to the wider medical travel field, and both its strengths and limitations are highlighted. The article concludes that framings of tourist, pilgrim, exile and nomad each bring something unique to our understanding of medical travel and its drivers, behaviours, and motivations.

**Tourists, pilgrims, exiles and nomads**

As Ormond and Lunt (2018) outline, medical travel scholarship has engaged in a vigorous debate around terminology that best captures travel of individuals overseas for treatment. A range of nomenclature capturing patient mobility and travel for healthcare exists within the social science literature and there does not seem any prospect of agreement soon (Connell 2015). In reviewing this plethora of terms, there are four distinct traveller conceptualisations: *tourist*, *pilgrim*, *exile* and *nomad*, and each is useful for identifying particular elements of patient motivation, treatment type, domestic context, and the connections travellers have to their destination.

***Tourist***: The use of medical tourism to describe travel out of jurisdiction has been widespread in both marketing and, subsequently, health and social science, literature. The term has generated controversy concerning both accuracy and implications for understanding the experiences of those who travel. That patients must travel and stay somewhere, has seen medical travel linked to the tourism industry (Connell 2011), whilst travelling for medical treatment (by patients and those accompanying them), involves mainstream tourist activities (accommodation, flights, restaurants, shopping, sightseeing). Some authors (Lunt et al. 2011; Toyota et al. 2013) suggest the strength of the term medical tourism lies in signalling the commodified nature of activities, and role of business and ancillary interests that promote services. Many writers take issue however with the term’s macro and meso focus on strategy and providers, arguing it is problematic because: ‘the industry-driven term ‘medical tourism’ insinuates leisurely travelling and does not capture the seriousness of most patient mobility’ (Glinos et al. 2010, 1146). Similarly, for Whittaker (2008, 272): ‘medical tourism is a misnomer, as it carries connotations of pleasure not always associated with this travel…’, and, ‘The term promotes a marketplace model that disregards the suffering that patients experience’ (Kangas 2010, 350). In exaggerating vacation, medical or health tourism is also criticised for failing to capture all relevant dimensions of global medicine – patients, destinations, governmental strategies and policies, mobility, and technology (Kangas 2010). Finally, commentators identify how the medical tourism narrative of patients travelling from the north to poorer countries in the south reinforces stereotyped assumptions about race, nation and class (Whittaker 2009, 323). In short, medical tourism stands accused of obscuring more than it reveals, promoting an industry-driven, consumerist narrative of patient mobility that downplays patient subjectivities.

***Pilgrim*:** Priscilla Song’s (2010) exploration of cross-border movements in experimental medicine advances the concept of ‘biotech pilgrimage’ as better reflecting the dynamics of mobility than does ‘medical tourism’. Her account emphasises the interconnection of faith, technology, travel, and healthcare research and treatment, taking issue with assumptions of leisure. She is not alone in pointing to how salvation, optimism and breakthrough are associated with stem cell science. Given stem cell treatments marketed online, to a large extent, lack evidence of efficacy there is a ‘dynamic of hope’ and ‘political economy of hope’ that underpin such travails (Petersen et al. 2014; Petersen and Wilkinson 2015; Prasad 2015), and a subjective ‘quest’ for a particular treatment (Chee et al. 2017). Drawing on her ethnographic research of Yemenis’ treatment abroad, Beth Kangas (2010) reflects that medical journeys often entail both sacrifice and tribulation. Despite referring to Yemenis’ medical journeys as ‘pilgrimages’ to lay audiences, she is reluctant to embrace the term fully given Yemeni’s themselves do not adopt the term, and pilgrimage ‘makes it sound distant and foreign rather than simply one way, a common one for Yemenis, to gain access to sophisticated medical technologies in today’s world’ (Kangas 2010, 352).

Aspects of diasporic tourism (those who travel to their ancestral homelands) overlap with ideas of pilgrimage (Li and McKercher 2016; Huang et al. 2016). Baldassar (2001) writes about annual “return visits” whereby members of migrant communities make periodic but temporary trips to their homeland or places where there are ties. These trips serve a number of functions – visiting friends and relatives, searching for roots, attending celebration and various forms of activity with elevated emotional and spiritual significance (also King and Christou 2010; Corsale and Vuytsyk 2016). Trips may include healthcare utilisation where travel is primarily for tourism and medical treatment is secondary, or a decision is made to purchase services upon arrival (Wongkit and McKercher 2013).

A combination of diaspora tourism, health-seeking, and a literal pilgrimage is reported in some extant literature (see, e.g., Lunt et al. 2014). As part of a wider project, the research team spoke to members of the Gujarati community in Leicester (England) seeking dental treatment in particular during their trips to India. None of the respondents had originated from the specific area of Gujarat to which they travelled and had no direct familial link to their specific destination, as they were more closely tied to East Africa (Lunt et al. 2014). Rather, cultural or, more specifically, religious connections proved to be the major linking factor connecting this community to this region in Gujarat. The centrality of Hinduism and the importance of pilgrimage to this area leads to annual travel, which in turn provides the opportunity for treatment. In Gujarat there are now a number of clinics targeting returning non-resident Indians, who have greater resources than domestic patients do (see also Ormond 2013, 155-6). In short, pilgrimage emphasises attachment, interconnectedness, spirituality and hope that may be associated with medical travel.

***Exile***: Within travel for assisted reproductive technology, ‘exile’ denotes travellers who experience rejection and structural disadvantage in their home health system. The work of Matorras (2005) describes infertile patients who travel to Spain for procedures prohibited at home as ‘exiles’ (also Pennings 2004). For Inhorn and Patrizio (2009), reproductive ‘exile’ as a patient-centred term highlights the difficulties and constraints (social, cultural, financial and legal) facing infertile populations and who are ‘forced’ to travel abroad for treatment (also Inhorn et al. 2012). Inhorn (2015, 7) began to talk about ‘exile’ rather than reproductive tourism because her participants felt the latter ‘was a cavalier and insensitive term, making a mockery of infertile people’s heartbreak and suffering’.

Ideas of exile are prominent in Whittaker’s (2015) examination of ‘outsourced’ patients: those sponsored by governments or insurers and treated in another country. Her study includes Gulf Cooperation Council patients who, because of domestic health system weaknesses and particular treatment needs (e.g. orthopaedics and oncology), are sent overseas, in this case treated in a Thai hospital. She suggests that for some, outsourcing represented a betrayal of the obligations of their states to its citizens. In similar fashion, Milstein and Smith (2006) talk of ‘medical refugees’, describing the plight of ‘seriously ill Americans’ who receive treatment overseas because they cannot afford domestic care (also Ormond 2011).

The term ‘exile’ generates its own controversies. A study that examined National Health Service (NHS) treatment of Gulf patients in London (Lunt et al. 2015) reported that to be sponsored – that is in some way ‘outsourced’ – was not perceived by patients as wholly undesirable; treatment at perceived centres of clinical excellence and recuperating within a global city had advantages and was associated with choice and volition. For other writers, if ‘medical tourism’ carries vacation overtones, the terms ‘medical refugees’ and ‘exiles’ are too political (Kangas 2010). In short, outsourcing, offshoring and medical refugees point to domestic failings in the provision of health services, encompassing a robust socio-political and structural critique. However, such terms do not explain the full range of travel motivations and experiences surrounding medical treatment or find favour with all those writing in the field.

The focus on tourism (consumer decision-making), pilgrimage (spiritual and familial connection, hope), and exile (political and structural critique of domestic provision) capture important dimensions of medical travel activity (for example, availability, affordability, familiarity and perceived quality, see Glinos et al. 2010 and Crooks et al. 2010), reflecting the interplay of agency and structure, and acknowledging diverse motivations that occur across time and space. Granted, there is little touristic intent in much travel; on the other hand, there *is* an industry that encourages pilgrimage or caters to exile. Added to these three conceptualisations is a proposed fourth – that of the nomad – to capture distinctive practices within medical travel activity, and it is to this concept that we now turn.

***Nomadism*:** Nomadism emphasises movement and freedom as against static state power and points to groups that are never fully territorialised (Engebrigtsen 2017, 5). Within contemporary social science, the metaphor of nomadism has become ubiquitous in relation to mobile lifestyles. From a spatially peripheral group, nomadism is viewed figuratively, relating to emerging lifestyle reliance on ICT, youth, and travel (e.g. Richards 2015, 342). There is a case for adopting a more literal usage of the term, and Horst’s (2006) work on Somali “transnational nomads” based in Kenyan refugee camps offers a helpful starting point and her emphasis on diaspora and transnationalism developed further in the section below. Foregrounding personal and social histories that refugees have, she shows how they adapt their ‘nomadic’ heritage in order to cope with camp life. This heritage includes a high degree of mobility and strong social networks that extend beyond the camp and as far as North America and Europe. In the remainder of the paper, nomadism will signal a deterritorialised healthcare experience, acknowledging earlier insights on deterritorialised health-seeking (Beijers and de Freitas 2008). Travel to a range of countries may or may not include homelands. Nomadism may increase choice options and empower individuals. It is however irreducible to movement and freedom because such mobility is shaped by a context where services may be formally available but there are systemic barriers to consumption.

***Diaspora and transnationalism***

Diaspora and transnationalism emphasise how immigrants forge and sustain multi-stranded social relations that tie together their places of origin and settlement (Basch et al. 1994, 7), embracing political activity, economic and information exchanges, travel, as well as intimacies that sustain family and communities across time and space. Both terms relate to cross-border movement, with diaspora typically used to denote groups, and transnationalism to denote enduring ties and processes across countries emphasising mobility and networks. Diaspora shows ‘sedimentation’ over time with different phases of arrival and differences across diasporic communities in their desire to return, especially for later generations (Huang et al. 2016; also Turner and Kleist 2013). The linear emphasis on return is displaced by circular exchange and transnational mobility, involving dense and continuous linkages across borders (Faist 2008).

There are three diasporic waves of migrants from Somalia to the West: movement of Somali seamen to the UK and Somali soldiers during the colonial period; migration of Somalis after Somalia’s independence in 1960; and Somali migration during and after the civil war in 1988 (Kleist 2004, 3). This third wave included refugees and later reunion migration to join relatives (Kleist 2004; Abdile and Pirkkalainen 2011; Fagioli-Ndlovu 2015; Dalmar et al. 2017) and has seen a rapid growth in **numbers born in Somalia but living outside the country – more than doubling** from about 850,000 to 2 million **(1990-2015)** (Connor and Krogstad 2016). Whilst the largest concentration of Somali people outside Somalia is within neighbouring countries and the wider region (almost two-thirds are within Ethiopia, Kenya, Yemen, Djibouti and Libya), its diaspora typically refers to those who live in the West and ‘is associated with access to resources as well as exposure to Western culture, including gender and family relations’ (Kleist 2010, 189).[[1]](#endnote-1) Somalis are increasingly dispersed globally with about 150,000 Somali migrants living in the US, and 110,000 in the UK, 60,000 in Sweden and 30,000 in the Netherlands, and 10,000 in both Italy and Denmark (United Nations Population Division 2015). In the UK, Somali communities are concentrated in various parts of London and other major cities including Bristol and Manchester.

Transnationalism signals the everyday practices of migrants, both novel and mundane, which encompass reciprocity within kinship networks, cultural practices, political projects, and commercial and investment activities. Transnationalism is broader than diaspora, connecting to a range of social formations and focusing on facets of cross-border mobility and networks (e.g. ideas, goods and resources) rather than coalescing around a collective identity.

Under such transnationalism, non-state agents, including migrants, take on explanatory potential and avoid becoming ciphers of macro structures and processes. Fields of diaspora and transnationalism are thus distinct from much of globalisation studies because they eschew universal explanatory ambition and are less likely to generalise (Faist 2010, 33). Within the field of medical travel, ICT developments and low cost travel, a rise of commodified culture, and commercialisation of healthcare are said to create a flattened global marketplace inhabited by rational healthcare consumers (Keckley and Underwood 2008). A globalisation narrative that emerges around medical travel sees it as providing ‘First-World Health Care at Third-World Prices’ (Turner ‎2007). ‘Glocalisation’ accommodates micro and local insights (Robertson 1995), and diaspora and transnationalism focus on agency and processes within global structures. Transnationalism, *a product of* contemporary globalisation, signifies a shift to a lifestyle between national borders whereby individuals maintain connections, build institutions, conduct transactions, and influence local and national events in the countries from which they emigrated. Such movements across borders may be multiple, routine and simultaneous (Glick Schiller et al. 1995, 48; Portes et al. 1999).

Diasporic and transnational travel patterns themselves resist simple categorization. Diasporic groups are increasingly seen as differentiated, generational and shaped by life-course dynamics (Huang et al. 2016; Li and McKercher 2016). Huang et al. (2016) compare first- and second-generation immigrants, identifying the difference between contemporary transnational communities and classic diaspora groups with regard to their diaspora tourism experience. Proficiency in their parents’ language plays a crucial role in shaping second-generation diaspora tourism. Transnational communities may vary in scope, from simply keeping in touch to heavy exchanges of information, goods and people.

**UK Somalis’ nomadic health-seeking: Methods and study**

During a wider study of UK inward and outward medical travel, data was collected from members of the Somali communities in Manchester and Camden, providing insights on the desire to travel overseas to access primary care, which is freely available in the UK. We responded to invitations to meet and discuss these issues as a way to broaden knowledge of patient travel from within the NHS.

Our sample consists of individuals from two urban Somali groups and we report on this data in detail. Access to these groups involved the support of individuals who acted as informal gatekeepers to the communities, organising meetings with respondents, a location in which to meet, providing food and, in some instances, interpreters.[[2]](#endnote-2) Informed consent was a fundamental part of the study approach: however, in line with their accepted cultural practices, Somali participants gave oral consent rather than through a written consent form.

Here it has been necessary to deviate from the accepted method of interviewee identification, in which individual identifiers are attached to verbatim quotes. Given that groups were interviewed within a group setting, sometimes with the facilitation of a cultural gatekeeper, it was not possible to give individuals unique identifier labels. Each discussion forum had two or three researchers present, and this aided the taking of notes and details. The qualitative data analysis involved data reduction (and data cleaning), data organisation and data interpretation, and data were analysed using the ‘framework method’ of thematic analysis (Ritchie and Lewis 2003). This allowed us to explore conceptual definitions, classifications, form and nature (process, system, attitudes, behaviours) and explanations.

Although Somali patients travelled for a range of treatments, routine diagnostics was the predominant reason and Germany the predominant destination. A minority of the groups have travelled to other European destinations, including Italy and the Netherlands. Community members stay with members of the Somali communities in both of those countries. The Netherlands was a prominent destination for Somali refugees during the 1990s and Italy has a colonial connection with Somalia and a long-established community from earlier waves of migration. Members of the community were keen to highlight that it is commonplace within their nomadic culture to travel, including for health purposes.

The overwhelming motivating factor for the Somali groups to travel was their desire to seek a quick and thorough diagnosis. Largely for this reason, in part combined with a sense that the UK healthcare professionals did not take them seriously, members of this community were willing to pay out-of-pocket for services routinely available for no cost on the NHS. Cost was also an influencing factor, as they were able to access diagnostics more cheaply abroad than in the UK private sector with the community contributing to ensure that they are able to travel for diagnostics in serious cases:

Culturally and religiously we’re close-knit so what generally tends to happen is we help each other. So, if people know that somebody is in a really bad way and they need treatment or they need money to be collected to get them something, then that’s what we do. It’s like an obligation as a community to do it. Even people when they have nothing will find a way to help. And that’s kind of how people survive. So, it’s not that people have this disposable income; it’s just they find a way if it’s really serious. If people are so sick that people are worried, then they’ll do something.

Patients often expressed that their general practitioners (GPs) went through a process of vague questioning and prescribing of either paracetamol or antibiotics with the proviso that if their complaint did not improve they should return in a month or so. This led members of the Somali communities to refer to their local GPs as ‘Dr Paracetamol’, demonstrating their dissatisfaction. This has been corroborated by other studies (Feldmann et al. 2007) and is not an experience limited to the Somali population. Research has found this to be the case in America as well, where Somali patients expect to receive immediate results and a diagnosis, in some cases causing tension for patients and physicians (Pavlish et al. 2010). Warfa et al. (2006) found that some Somali patients seek treatment in accident and emergency (A&E) departments to bypass their GP, a finding which was echoed within our focus group discussion.

The Somali community relies heavily on oral information. In Manchester, community leaders were heavily involved in distributing information to the community. Some community members may not be able to access written information, available in different languages, such as leaflets about local NHS services, because of illiteracy. Another key source of information is Somali television channels, available by satellite. German doctors have advertised on Somali television for many years and this has developed as the main route for the Somali communities with which we spoke. This helped develop the connection with German clinics and doctors. German clinics are the only ones to advertise on Somali television in Somali and these adverts are usually at peak viewing times, for example before the early evening news. Once one patient has been to visit a doctor this then rapidly spreads through the community through word of mouth. For example, one Somali explained:

We’re a close-knit oral community, so if someone comes around and says ‘I’m not well’, then they might say, ‘There’s this doctor I’ve been to’. So, lots of advice from word of mouth, but they’ve got Somali channels now and they do adverts on them. So, they’ll have advertisements for hospitals abroad. The doctors out there, I think, have clued on and they advertise. So, people get that if they have satellite TV.

Language barriers exist for members of the Somali community in the UK and these are fundamental to their experience of, and interaction with, the NHS. This can prove problematic on a practical level and lead to misunderstandings. For example, one Somali explained:

Sometimes if you’re not feeling well and you go to the GP and sometimes you don’t know the words. They cannot find a way for an interpreter. So, it can be a bit difficult and so you have to point to it. Sometimes there’s a misunderstanding.

Frustration expressed by Somali women at language and cultural barriers, including brief and rushed appointments, results in further mistrust, which is also the case for Somali women in other countries (Pavlish et al. 2010). This can also affect the services that patients receive: ‘Sometimes if they know your English is not good, they just brush you away’. However, the language barriers between members of the Somali community and their GPs can be seen as one aspect of poor health literacy within the community (Safeer and Keenan, 2005). The majority of patients said that translators were rarely available.[[3]](#endnote-3)This was a key determining factor in their seeking treatment with private Somali doctors in the UK or their choosing to travel abroad. Across the two Somali communities interviewed, accessing a Somali doctor in the UK was their first choice:

The reason they go is because he speaks the same language and you don’t have to look for a translator. You don’t feel like he doesn’t understand you. Sometimes when you go to a GP you feel like they don’t understand you, so you always have doubt. But he 100 per cent understands and we understand him as well.

However, this option was significantly more expensive than travelling abroad and therefore was rarely used. Notably, doctors accessed abroad are not necessarily always of Somali origin. For example, some of the most popular German doctors do not speak Somali but provide interpreters as standard. In contrast, when patients return to a country with familial ties, language does not pose a barrier.

Our findings echo reports from elsewhere: research from both Sweden (Svenberg et al. 2011) and the Netherlands (Gerritsen et al. 2006) demonstrates that members of the Somali communities in these countries travel to Germany for medical treatment, in particular for diagnosis. Tiilikainen and Koehn (2011) found Somali immigrants were pleased with the physical health services in Finland, but dissatisfied with the Finnish mental health services. This resulted from different perceptions of mental illness in Western medicine, whereas for some Somalis mental illness necessitated Islamic healing such as Koranic readings for exorcising spirits. The absence of such services, a lack of understanding of the system, and a lack of trust in the diagnosis given within the Finnish healthcare system influenced Somali immigrants’ view of services and led them to seek mental healthcare in Somalia (Tiilikainen and Koehn 2011). Canales et al. (2006) describe patient travel overseas from the United States for kidney transplantation: eight of the ten patients were from Somalia and travelled abroad to Pakistan for kidney transplantation. Authors suggest the pattern is the result of a common religion between Somalis and Pakistanis coupled with an available market for organ sales in Pakistan.

Medical nomadism therefore also points to particular disenfranchisement within the domestic medical system where services may be available free of charge yet access to and understanding of these services is problematic. Medical nomadism is distinct from the idea ‘doctor shopping’ – seeking multiple treatments providers during a single illness or to obtain prescription medication (Sansone and Sansone 2012). Medical nomadism is underpinned by health system alienation, with groups turning away from delivery systems that are both free and, in theory, have strong patient-GP relations.

**Medical nomadism: Subjectivities, transnationalism and structural inequalities**

Within the preceding analysis of Somali experience, a nomadic, de-territorialised health experience emerged. Nomadism has unique characteristics that set it apart from medical tourism, pilgrimage and exile. Medical tourism emphasises patients as consumers, highlighting the role of advertising, ancillary services, and the broader commercial, professional and industry stakeholders. Pilgrimage foregrounds interconnectedness, spirituality and hope associated with medical travel. Medical exile captures offshoring and the absence of provision in domestic health systems. Finally, nomadism signals a deterritorialised healthcare experience, with travel to a range of countries, shaped by a context of formal availability but systemic barriers to consumption.

Somalis are not an isolated example of nomadic healthcare seeking. Beijers and de Freitas’ (2008) discussion of the health-seeking behaviour of Cape Verdeans living in the Netherlands contains many ideas resonating with the concept of medical nomadism presented here. A community with two centuries of migration experience, Cape Verdeans utilise a global network to experience deterritorialised healthcare. Their findings, juxtaposed with those of the preceding section, strengthen arguments about a distinctive role for medical nomadism within the medical mobility literature. Three points in particular merit require further consideration: subjectivities, the nature of transnationalism and enduring structural inequalities.

***Subjectivities***

As the empirical data suggests, there is subjective acknowledgement from the Somali group itself about the commonness of travel, including for health. Such travel may be funded by financial contributions from within the community and offers a counterbalance to the narrative of high-end consumers in search of value so prevalent in much medical travel scholarship and ‘medical tourism’. Cape Verdeans’ transnational healthcare-seeking shares many characteristics of Somali behaviours, including destination not limited to the home country but extending to places where the diaspora has settled. For Cape Verdeans, perceived quality is the primary consideration and, to quote a respondent, Manuel:

In Cape Verde there are doctors that speak our own language but health has no borders. When a person has a health problem and seeks help there are no borders. If you know there are good doctors in Switzerland you go there. If you are in Portugal and you hear that there are better doctors in Spain, you go to Spain. When you’re searching for health care there are no borders. You go where you have to.

(Beijers and de Freitas 2008, 246)

Highlighting such subjectivities carries an endemic risk of ossifying migrant cultures, and remaining aware of sedimentation that results from waves of settlement and emergence of 1.5- and second-generation identity and practices allow a nuanced analysis. As Beijers and de Freitas (2008) identify with Cape Verdean mental health needs, the second generation has learned how to make use of Dutch healthcare system: “They range between ‘modern’ and ‘knowledgeable’ (second-generation) versus ‘traditional’ and ‘authoritarian’ (first-generation). First-generation immigrants mention that they are hovering between their Cape Verdean origins and the Dutch present time. Second-generation adolescents have learned how to work the healthcare system” (Beijers and de Freitas 2008, 240). Transnationalism acknowledges change over time and diversity within migrant communities regarding the life-course, periods and places of settlement, and differences in resources. In contrast, traditional migratory frames of ‘here’ and ‘there’ have a linearity that emphasises time elapsed since emigration. By incorporating the life course, intergenerational cycles and sedimentation of diaspora within transnationalism, we are able to plot new courses of mobility. This includes, for example, stages in family formation and work experience, and how precise meanings of such points in the life course are influenced by: technology, demographic trends, and social attitudes, as well as being shaped by gender, income and education.

***Transnational links and circuits of mobility***

Within accounts of pilgrimage, socio-cultural dimensions (family visits, festivals and holidays) are seen to matter and they do also for nomadism, albeit in a different fashion. With regard to the Gujarati example outlined earlier, and in instances of diaspora tourism, there is a ‘binary mobility’ bias that assumes an exclusive relationship between place of origin and destination and the ideal of return to homeland (Sinatti and Horst 2015). Medical nomadism weakens and – if no realistic opportunity of return to home country exists – may sever return travel to home destination. Indeed, unlike Cape Verdeans, Somali migrants belong to a fragile state that has been under siege for a very long time. Somali nomadic medical travel appears to be almost exclusively into third countries, reflecting constraints on the availability of good quality care in the homeland. Connell (2013) suggests that diasporic medical tourism takes place because patients seek medical care within healthcare settings that are comfortable in terms of language and other cultural factors. ‘Nomadic medical travel’ – shaped by diaspora and transnationalism – does not assume travellers return to homelands to receive medical care near their family and friends. Hence, whilst studies highlight links between health and place in consumption of health services, these connections are not always straightforward.

Within nomadic activities, the use of transnational links to provide information (e.g. advertising and word-of-mouth) and hosting of visits may transcend boundaries. There are examples of how the Cape Verdean community in Rotterdam have organised bus trips to elsewhere in Europe to see doctors (Beijers and de Freitas 2008, 247-8).

Transnationalism points towards a range of relationships between communities abroad and healthcare delivery in a country of origin (Phillimore et al. 2018). Beijers and de Freitas (2008, 247-9) identify wider health-seeking strategies, including transnational use of medication and consulting complementary healers, and importing of ‘good doctors’ to the Netherlands. For the Cape Verdean community a characteristic of nomadic health-seeking is the back and forth switching of commodities. The community use transnational links to access goods from countries other than their homeland, which are transported to the host country by acquaintances or friends upon return from healthcare seeking travels. Among those goods are medicines which are then consumed by Cape Verdean non-travellers without the requisite prescription. Such processes highlight the resourcefulness of (sometimes reluctant) non-travellers to overcome local constraints, and also reflects nomadic cultural characteristics. However, it also uncovers the risks associated with medical nomadism for those who lack the means necessary to engage in safe consumption of commodities brought about by medical nomadic travel (de Freitas 2005; also Phillimore et al. 2018). The consumption of pharmaceutical products from homelands and self-medication (e.g. Hu and Wang 2014) could be explored more widely, both for Somali and other migrant populations generally.

Indeed, transnational concepts so central to nomadism identify a range of activities related to health-seeking behaviours. For example, remittances directly shape health service consumption: a Vietnamese study identifies how receipt of international and internal remittances increases the number of outpatient healthcare visits by around 14%, with receipt of international remittances being strongly correlated with inpatient healthcare visits (VietNguyen and Nguyen 2015). Financial remittances from the Somali diaspora estimated at up to US$2 billion annually have been used, in part, to purchase health services (Hammond et al. 2011). A household survey in one Somali town found up to one-quarter of households claimed remittances as their sole source of income, used to support living costs and to pay for education and health services (UNDP 2009, citing Lindley 2007).

The Somali diaspora makes direct contributions to development by establishing and supporting local institutions in the home region, district or village (UNDP 2009), or supporting existing institutions to deliver services (e.g. paying salaries for teachers and health workers). In Somaliland, health facilities established by diaspora are often part of a process of return migration where a clinic provides the individual returnee and family an income in Somaliland (Hammond et al. 2011). Establishing a medical facility also enables professionals from the diaspora to continue within their fields of expertise but they often continue to move back and forth between Somaliland and the diaspora. There are geographical differences: for Puntland, few health facilities are reported to have been established by the diaspora and instead diaspora support the provision of basic social services without returning to stay in Puntland (Hammond et al. 2011). Furthermore, the diaspora has supported local civic organizations who assist those with diseases (such as cancers) that require sophisticated medical operations and who have been flown into where a diaspora population are located (e.g. Minneapolis) to receive surgery under the auspices of diaspora ‘philanthropy’ support (UNDP 2009). There is growing attention to the ability of places to draw upon migrant diaspora professional input, experience and business links (Ormond 2013, 2016).

***Structural inequalities***

Unlike medical exiles, medical nomads have access to domestic services and patterns of nomadic behaviour are not simply examples of outsourcing. Black and minority ethnic and migrant communities often encounter difficulties when accessing health care in the UK (Akua-Sakyiwah 2012), and this is often the case in other countries as well (Warfa et al. 2006). Services delivered within the prevailing model of healthcare citizenship may be inappropriate to cultural health systems, and may not be well understood, difficult to negotiate, and language may prove a particular barrier.

Focussing on community use of mental health services, Beijers and de Freitas (2008) highlight limited access to care, as a result of poor information about available services, ‘incompatibilities in relationships with health professionals’, and community skills and resources necessary. They identify the importance of mutual support within the Cape Verdean community in managing ill-health. Their discussion of formal mental health care in the Netherlands – the role of referring GPs or social workers, for instance – again resonates with Somali evidence. They report that need for immediate help may not be met and patients report that they are frequently sent home with nothing more than a prescription for analgesics (Freitas 2006, cited in Beijers and de Freitas 2008, 244). Again, a paracetamol prescription is a metaphor for ineffective treatment, prompting attempts to access more specialised services or emergency services directly (also Feldmann et al. 2007; Madden et al. 2017).

There is a tension within the concept of medical nomadism. On the one hand, travel overseas may increase choice options and empower individuals. On the other, nomadic health mobility is shaped by a context of social, political, economic and cultural disadvantage. Thus, such nomadism is both enabling and risks, ‘contribut[ing] to a persistent distance from one’s local healthcare services, inhibiting the acquisition of the necessary skills needed to navigate the healthcare system’ (Beijers and de Freitas 2008, 249). This tension results from focussing on transnational practices but, ‘not addressing the fundamental causes of health inequalities’ (Villa-Torres et al. 2017, 77). Both Somali and Cape Verdeans exhibit medical nomadism, travelling to third countries or countries with earlier homeland connections. The socio-economic profile of these migrant communities and poor engagement with the domestic system underpins transnational motivations and travel. The emphasis on seeking diagnosis is a recurring theme within these migrant health-seeking behaviours, and less about ‘seeking a second opinion’ and more about alienation within the healthcare system, particularly around mental health (Beijers and de Freitas 2008). Hence, the concept of medical nomadism encourages us to look both outward and inward. Its outward characteristics are those of travel, mobility and transnational process; internally, it focuses on the domestic health system and a reality of systemic disadvantage. In defining medical nomadism they are opposite sides of a core currency: examining one side of the coin, we must also take the other.

**Conclusion**

The healthcare citizenship rights offered by individuals’ country of residence (coverage, eligibility, and cultural dimensions, including discrimination) shape treatments offered to and utilised by migrant groupings. To understand health-seeking behaviours among those in our Somali example we must examine cultural agency, diaspora, transnationalism, and political-cultural structures. To this end, medical nomadism is a distinct concept, and one that may take its place alongside medical tourism, medical pilgrimage and medical exile. The notion of medical nomadism also finds support within examples of deterritorialised health-seeking behaviours described for Cape Verdean communities in the Netherlands (Beijers and de Freitas 2008). The concept incorporates distinctive elements – emphasis on system gatekeepers, de-territorialised experience, transnational linkages, and system disadvantage. The field of medical travel remains fluid and resists closure. As occasional fellow travellers, nomads, tourists, pilgrims and exiles may share some characteristics, routes and destinations. The concepts invoked are proposed less as a way to “label” reality in some authoritative fashion but are better taken more strategically, acknowledged for their usefulness in enabling us to think about aspects of mobility previously overlooked. Some specific instances of health mobility may be informed by concepts taken in tandem. Thus, for example, the Gujarati experience outlined earlier of travel to India for dental treatment draws upon ideas inherent in ‘medical tourism’ and ‘medical pilgrimage’. Similarly, commercial considerations so fundamental to ‘medical tourism’ may also have relevance when considering examples of ‘medical exile’ and ‘medical pilgrimage’. That said, each concept carries foregrounds motivations and nuances that make them singularly distinct and theoretically valuable.

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1. Hammond et al. (2011) notes the Somali diaspora also encompasses ethnic Somalis from Kenya, Ethiopia and Djibouti. [↑](#endnote-ref-1)
2. We also spoke to a group of Gujarati travellers. Across these combined three groups (two Somali, one Gujarati) provided evidence from 31 individuals. [↑](#endnote-ref-2)
3. In one of our group areas, additional funding was provided to employ a Somali nurse at the local surgery who acted as the first point of contact for Somali patients. This was extremely well received and allowed language and cultural differences to be both understood and interpreted in partnership with the GP. [↑](#endnote-ref-3)