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# Table of Contents

# Care, Inequalities, and Health Justice: Interdisciplinary Perspectives on Global Health

by Alessandro Boccanelli, Mario Marasco, Laura Elena Pacifici Noja*

In an era deeply marked by overlapping health crises, persistent conflicts, and systemic inequalities, the field of global health is increasingly emerging as a contested space. It is a domain characterized by a constant tension between standardized, technical interventions – often designed in the Global North – and the situated, messy, and deeply human practices of care enacted in local contexts. This thematic issue of the «UniCamillus Global Health Journal» does not merely document this tension; it aims to inhabit it. By weaving together anthropological, historical, pedagogical, and philosophical perspectives with advocacy practices and social inclusion strategies, the contributions collected here offer a multifaceted reflection on how health is negotiated, organized, and transmitted across diverse territories, revealing itself as an inherently historical and situated product.

The articles in this issue, heterogeneous in method and scale, converge on a fundamental premise: health cannot be reduced to a biological fact or a bureaucratic metric. It is, fundamentally, a relational project. The authors challenge us to look beyond the structural fragilities of contemporary healthcare systems and to examine the "molecular" dynamics of care – the specific gestures, the educational encounters, the historical legacies, and the political struggles that shape the wellbeing of communities.

The issue opens with a strong focus on the pedagogical challenges of medical training, exploring how well future health professionals are equipped to understand the complexity of the human subject. Virginia De Silva proposes a reflective itinerary that bridges the gap between the ethnographic field and the university classroom. Drawing on her experience teaching medical anthropology to nursing students, De Silva illustrates the difficulty students face in grasping concepts that seem abstract or distant from their biomedical training. She argues for the use of "ethnographic vignettes" – such as the startling gesture for "yes" in Tigray or the figure of a traditional healer who learns from *National Geographic* – to trigger a productive culture shock. This pedagogical approach serves to deconstruct the assumed universality of biomedical categories, helping students recognize that the body itself is a culturally and historically constructed entity.

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In a complementary dialogue, the article by Alessandro Boccanelli and Laura Elena Pacifici Noja examines the structural integration of humanities into medical education through the lens of a seven-year experience at UniCamillus University. The authors argue that medicine, having a practical purpose focused on the human being, cannot be a "pure science" and thus requires a robust philosophical foundation. Their paper details an integrated curriculum where Moral Philosophy is not an add-on but a core component, designed to foster moral reasoning and narrative competence in future doctors. By engaging with topics ranging from the epistemology of care to the ethics of artificial intelligence, they demonstrate that interdisciplinary education is essential for navigating the "forest" of medicine, where patients must be encountered as unique narratives rather than interchangeable diagnoses.

Moving from education to history, Christina Savino offers a compelling re-reading of Camillo de Lellis in the context of Counter-Reformation Rome. Savino situates the saint's work not merely within hagiography but within the gritty reality of a city plagued by malaria, floods, and social stratification. The paper highlights Camillo's revolutionary intuition of "global healthcare" that attends to the whole person – body and soul – anticipating modern holistic models. Crucially, Savino traces the historical trajectory of this ideal beyond its inception. While grounded in the material response to the urban pathologies of early modern Rome – from the reorganization of hospital shifts to the physical cleansing of patients – the paper explores how this model of comprehensive nursing care expanded across centuries and continents, evolving into a foundational paradigm for modern global healthcare.

The intersection of health policies and community dynamics is explored in depth by Corinna Santullo, who presents an ethnographic analysis of immunization practices in Tigray, Ethiopia, between 2015 and 2019. Santullo deconstructs the notion of "vaccine hesitancy"' by revealing the sophisticated mechanisms of persuasion and control embedded in the Ethiopian health extension system. Her analysis of the Women Development Army, operating through a capillary "one-to-five" network, shows how compliance is often manufactured through social pressure, the mobilization of shame (*yiluññta*), and the framing of the unvaccinated body as a threat to collective modernity. This contribution, based on fieldwork conducted just prior to the recent conflict in Tigray (2020-2022), serves as a vital document of the biopolitical infrastructure that underpins global health initiatives in the region.

Shifting the focus to disability rights and civil society initiatives, Hewan Mulugeta Asfeha and Roel van der Veen discuss the outcomes of the *Down Syndrome and Other Intellectual Disabilities Awareness Event* held in Addis Ababa in November 2024. The authors expose the pervasive stigma and misconceptions surrounding Down syndrome in Africa, often attributed to supernatural causes. However, rather than presenting a narrative of victimization, the article highlights the power of self-advocacy. By detailing the strategic outcomes of the event – including the *With Us Not For Us* initiative – they outline a concrete roadmap for shifting from a charity-based model to one grounded in rights, inclusion, and the active participa-

tion of people with disabilities in the policies that affect them.

The issue concludes with Marco Menon, who traces the genealogy of urban bioethics, distinguishing between its North American origins – focused on density, diversity, and disparity – and its radical reinterpretations in the Global South. Offering a distinct theoretical lens, he explores how Latin American scholars have politicized the field, viewing urban bioethics as a tool for resistance against biopolitical control, while also engaging with the European legacy of Fritz Jahr to include environmental concerns. Menon's contribution invites us to expand bioethics beyond the clinical encounter to address the very design of our living spaces, suggesting that the city itself is a fundamental determinant of moral and physical well-being.

Together, these six contributions offer more than a collection of case studies. They provide a methodological blueprint for a more just global health. They remind us that whether we are discussing the training of a nurse in Italy, the vaccination of a child in Tigray, or the planning of a "healthy city", we are always dealing with questions of power, history, and human dignity. It is our hope that this issue will serve as a tool for scholars and practitioners alike to navigate these complexities with critical rigor and ethical commitment.

# From the Field of Research to a Field of Knowledge: Preliminary Reflections on a Lesson in Medical Anthropology

by Virginia De Silva*

**Abstract**
This article reflects on the pedagogical use of ethnographic material gathered in Ethiopia to teach key concepts in medical anthropology to nursing students. Drawing on field experiences with diverse healing figures, local nosologies, and culturally grounded interpretations of illness, the paper shows how biomedical training often assumes universal meanings for the dimensions of disease, aetiology, and therapeutic authority. By presenting ethnographic situations in which biomedical and traditional explanatory models diverge, the article highlights how conflicts arise from different interpretations of symptoms, accountability, and causality. Building on discussions of medical pluralism and the notion of *medicoscapes*, it argues that biomedicine represents one cultural paradigm among many. Recognizing this plurality helps future nurses develop cultural mediation skills essential for clinical practice in multicultural settings, fostering more effective communication and therapeutic alliances between professionals and patients.

**Keywords**
Medical Anthropology, Didactic Use of Ethnography, Medical Pluralism, Cultural Mediation in Nursing.

## 1. Introduction

This paper was conceived after more than three years of teaching cultural anthropology within a bachelor's degree program in Nursing at an Italian university. Given the profile of the students – future nurses – I chose to frame the course through the lens of medical anthropology.

I soon noticed how difficult it was for them to grasp concepts that seemed far removed from both their everyday experience and the rest of their academic training. The need to find meaningful answers to their questions – and, at the same time, to my own – led me to revisit an ethnography that, though distant in time and space, still speaks to us today.

Indeed, the materials gathered during our fieldwork never cease to tell us something new, if interrogated with a fresh gaze. Once accepted, they never become obsolete but rather capable of inspiring new paths of inquiry and reflection.

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Does it make sense, in 2025, to return to materials collected in 2010? For a long time, I was uncertain. Yet those "materials" – not only the recorded interviews, diaries, and fieldnotes, but also the embodied experience of research – remain valuable for rethinking key issues. These materials originate from my long-term fieldwork in Wukro, a mid-sized town in the Tigray region of northern Ethiopia, which for years represented a privileged ethnographic site for the study of local healing practices, community health initiatives, and the intersections between biomedicine and traditional medicine. Perhaps this return also stems from the need to remember, to stay connected to a field since I have not physically returned to my field site since 2018, except through memory and a renewed epistemic intention. I have often shared stories from my earlier research experiences with students and observed that weaving together anecdotes and "ethnographic vignettes", real people and events, with theoretical concepts helps them better understand what might otherwise seem abstract, lifeless notions.

The aim of this article, therefore, is to retrace that ethnographic experience in order to reveal its didactic potential.

Each paragraph focuses on an ethnographic episode used in class to illustrate key concepts in the medical anthropology course.

## 2. A Startlement for "Yes": Culture Shock as a Tool for Critical Deconstruction and Reconstruction

Standing before a group of first-year students, their faces marked by curiosity and doubt, one can almost read the question in their eyes: *What could an anthropologist possibly do for us and for our training?* Many of them are still unsure what an anthropologist actually does. Engaging such an audience requires effort. It calls for building a connection, a shared space of understanding and trust – a sort of pact, much like the one sought with informants in the field. Above all, however, it requires capturing their attention and showing them that we do indeed have something valuable to offer: a small treasure to hand over.

It is often difficult to explain that, beyond abstract concepts, what we are trying to transmit is a modest "toolbox" containing a set of intellectual instruments they can use to dismantle the shelves of assumptions and "natural" norms to which we are all accustomed. It is equally challenging to clarify that the aim of the course is not to provide a list of concepts or evaluative criteria, but rather to equip them with the critical tools to question those very concepts and criteria.

Irony is always a good way to build relationships. In my early classes, I often introduced key anthropological notions such as the body, *techniques of the body* [1], and *habitus* [2], through an episode that occurred during fieldwork.

During a conversation, my interlocutor suddenly looked startled. In our context, such a bodily reaction would be read as surprise or amazement. Yet, I had said nothing that could have provoked astonishment. Without revealing the outcome of that exchange to my students, I asked them to pose questions to which they were sure I would answer "yes" – for example, whether I was their anthropology professor, whether it was daytime, or whether we were in the classroom. Then, to their bewilderment, I "answered" by looking startled, just as my interlocutor had done. In Tigray, this bodily

and vocal expression signifies assent.

The "banality" of such an episode was exactly what I wanted to use to awaken their sense of culture shock toward a reality so different from their own, while simultaneously prompting estrangement [3] from their everyday life. Realizing that even nodding does not mean the same thing everywhere allows students to recognize that what they perceive as "natural" behavior is, in fact, culturally contingent. The way we use our bodies to inhabit the world – and the very conception of the body itself – is socially, politically, and historically constructed.

This reflection is essential to understanding some of the key concepts of medical anthropology, such as the body as the "existential ground of culture and self" and *embodiment* [4], and Mauss's idea of *techniques of the body* as socially acquired ways of using the body [1].

In this way, young nursing students come to understand that the body is not – at least not only – the sum of organs and tissues represented by the anatomical mannequin that stands beside the lecturer's desk. Rather, it is the primary vessel of human ambivalence, where the biological and the social are inseparably intertwined [5].

This awareness also becomes useful for explaining the three dimensions of illness in anthropological thought. If the body is not merely an assemblage of organs, illness cannot simply be defined as biological damage or malfunction, as in the biomedical model. Illness becomes something that "human beings do":

> Illness is something that human beings *do* [...] Illness can be read as a genuinely cultural practice, in which the body expresses itself through the historical repertoires of its cultural construction, positioning the subject in dissonant terms with respect to their social world. [6]

Illness, as a fundamental human event, is simultaneously the most individual and the most social of phenomena; biological disorder becomes a symptom of social disorder:

> At the same time everything about illness is social, not just because a certain number of institutions take it in charge at the different phases of its evolution, but because the patterns of thought which allow one to recognize it, to identify and treat it are eminently social: to think about one's illness is already to make reference to others. [7]

If both the body and illness are cultural products, then the act of healing must also be understood in all its complexity – as a "shared space for the co-construction of meaning between healthcare workers and patients" [8].

## 3. An Aleka and the *National Geographic*: Medical Pluralism

The model of biomedical training in a nursing degree implicitly assumes that nosologies, aetiologies, and, more generally, the meanings of "disease" must be interpreted exclusively through biomedical paradigms – paradigms that are often presented as universal, unique, non-ideological, apolitical, amoral, and transparent [9]. At the same time, it presupposes that only those who have followed a specific professional path – the biomedical one – are endowed with the legitimate authority to act upon bodies. In many contexts outside the Euro-American world, how-

ever, the power to heal is distributed among a plurality of social actors [10].

For this reason, the concept of medical pluralism becomes a fundamental theoretical tool that students must acquire in order to understand that the realities of illness and healing are decidedly more complex and varied. In Ethiopia, my field of research, multiple figures are recognized by the community as possessing healing knowledge and authority – *aleka*, *mergheta*, *debterà*, *mama*, as well as biomedical professionals.

Within the Tewahedo Orthodox Church, *aleka*, *mergheta*, and *debterà* represent different levels of religious and therapeutic expertise. Many traditional healers in Ethiopia acquire their knowledge during church schooling, often informally and in parallel with religious education. The highest rank is that of the *debterà*, a figure both respected and feared, believed capable of manipulating spirits and acting for both good and harm [11]. These healers combine herbal knowledge and spiritual techniques, illustrating how therapeutic competence in Ethiopia rarely fits neatly into a division between "secular" and "spiritual" healing – an overly simplistic distinction, as noted by Wondwosen [12]. Alongside these church-trained practitioners are the *mama*, elderly women renowned locally for their expertise in home-based remedies. Their treatments typically address a limited set of illnesses and rely on herbal preparations; unlike traditional religious healers, their knowledge is not acquired through formal study or apprenticeship but is transmitted within families, usually from mother to daughter.

Through the description and accounts of some healers I have met, I intend to show that not only does biomedicine not exist alone, but also that in contexts of medical pluralism, it is entirely coherent not to think of traditional medicine and biomedicine as separate and dichotomous compartments.

This logic is particularly evident in the case of Ato K., described below. His distinctive feature is that he is a healer who moves dynamically between different horizons and paradigms of care, without any contradiction, as the health-seeking behavior of patients has already demonstrated in many cases.

Ato K. – the youngest of the healers I met during my fieldwork – immediately struck me both with his attitude and his age. He spoke *Amharic*, having been born and raised in Bahr-Dar. It seemed that his vocation in life was "to fix things": he ran a small shop repairing computers and stereos, yet as we spoke, I discovered that this inclination toward repair extended also to bodies. "I know how to heal people", he told me.

He had studied as an *aleka* (see above) for four years within the Orthodox Church education system, where he began to take an interest in medicine. He explained that he used to write down remedies and discuss them with fellow students – an example, he said, of how one could access certain forms of knowledge not necessarily transmitted through kinship lines (Interview with Ato K., January 4, 2011).

His fascination with healing evolved into what he himself defined as a genuine scientific inquiry. He continued his apprenticeship not only under traditional practitioners but also through exchanges with biomedical professionals, expanding his knowledge of both theories and practices in every

possible way – including by watching television channels such as *National Geographic*.

He often mentioned *National Geographic* as a source of learning, especially when episodes focused on diseases or medicine. For instance, he had deepened his understanding of *herpes zoster*, using the biomedical term rather than the local designation *Almazbalechera*, which refers to a similar ailment. His familiarity with biomedical language and reasoning was evident in the way he discussed pharmaceuticals and treatment methods, as well as in his linguistic choice to employ biomedical nosologies while still explaining their traditional equivalents. Thus, he spoke of *asthma*, *gastritis*, *impotence*, or *tumor* to refer to *kintaroot* – a term that does not have a direct biomedical equivalent. In some cases, *kintaroot* is associated with the biomedical category of *haemorrhoids*. However, in traditional medicine *kintaroot* can appear in different parts of the body – for example not only in the anus, but also in the legs or the hands. It should therefore be understood within its own local nosological frame. He also spoke of "blood circulation blockage" to describe the illness of a young man whose mouth was drawn to one side, a condition locally regarded as the result of an attack by an evil spirit called *ganien*.

So fluent was he in both cultural worlds that he navigated between them with great dexterity. When talking about HIV, for example, he said he preferred to use its traditional equivalent, *Amenmin* – an Amharic term meaning "the disease that makes you very thin" – because he was "able to treat it": its cure was described in ancient texts, but it was forbidden to claim publicly that one could cure HIV.

He thus dealt with *pathologies*, even when the illnesses in question, according to local cosmologies, were thought to originate from supernatural attacks. Yet his approach to healing focused deliberately on biological aspects. Whether a disease was called *ganien* or "circulatory blockage" made little difference to him – they were simply two ways of naming the same symptomatic manifestation.

For other healers, as for patients, negotiating whether a given set of symptoms belongs to a spiritual or a natural illness is a crucial step that shapes therapeutic choices and strategies. Ato K., however, followed a more biomedical logic – transforming symptoms into unambiguous signs and privileging biological manifestations over their cultural meanings in order to provide therapeutic responses.

Throughout our repeated encounters, he often stressed his distance from the religious and esoteric dimensions of traditional practices, and from conceptions linking illness to supernatural agents such as *evil eye*, *ganien*, or *Ide Seb*, which he dismissed as "traditional stuff":

> Those things, like fumigating with myrrh or incense sticks, or wearing the *Gelebia* [a garment typical of Muslims] – that's not for me. (Interview with Ato K., January 4, 2011)

His therapeutic style also reflected this orientation. He preferred an approach closer to that of biomedical professionals than to traditional healers. He said he prepared his own herbal medicines but had no hesitation in writing down the names and quantities of the herbs so that patients could obtain them themselves. He "prescribed" remedies on paper – "writing medicines like modern doctors do" (Interview

with Ato K., January 4, 2011). For this reason, he believed other healers looked down on him, as they would never reveal their recipes to the community, in order to preserve their authority. In his view, since herbal manuals could even be found in the local markets and were therefore accessible to everyone, it made no sense to keep medicines secret.

His healing practices relied on the use of herbal remedies and faith in God. Although he disapproved of healers who, in his words, dealt with the "dark side" of religion – many of whom he considered satanic – he continually invoked the religious horizon and the divine as the ultimate source of healing and well-being.

Another ethnographic episode useful for introducing students to the topic of *medical pluralism* involved a different healer I met on a market day. When arranging our next interview, he showed me an appointment slip: he would be unable to meet the following week because he was scheduled for cataract surgery at the hospital. After spending hours discussing the importance and efficacy of traditional medicine, which he had practiced for years, his decision to undergo a biomedical procedure left me perplexed. Yet, within his interpretive framework, the interchangeability and coexistence of different therapeutic traditions did not signify contradiction or confusion but rather a rational and resourceful use of the options available.

As Fassin [13] noted,

> illness trajectories in search of diagnosis and treatment result from multiple logics – structural causes (systems of representation of illness, the individual's social status) and situational causes (economic changes, advice from a neighbor) – which render all attempts at strict formalization futile.

At this point, it is useful to recall the notion of *medicoscapes*, which offers a more process-oriented way of understanding medical pluralism. Rather than treating cultures, places, and bodies of knowledge as neatly bounded units – as some static interpretations of medical pluralism risk doing [14] – the concept of *medicoscapes* highlights the dynamic processes through which differences in medical systems are generated and sustained. In this sense, medicoscapes address a key limitation of classic medical pluralism, which tends to be descriptive rather than theoretically grounded [15].

Plural medicoscapes, therefore, are far more common than one might assume, and there is nothing irrational or contradictory about their coexistence. For young nursing students, understanding this means recognizing that biomedicine is merely one cultural paradigm among others – indeed, it is our own form of *traditional medicine*, the one we have been taught and trained to practice.

## 4. Explanatory Models

Kleinman [16] analyzed *explanatory models*, that is, the sets of notions used by those involved in the healing process to understand the cause and meaning of an illness and to develop knowledge useful for potential therapeutic actions. In the medical encounter, the interpretations and meanings attributed to a health condition by the healthcare provider – shaped by professional training – and by the patient – shaped by lived experience – often collide.

The biomedical claim to universality, both in the efficacy of treatments and in the classification of pathologies,

is challenged by the evident arbitrariness of the *sign* in a context of medical pluralism such as the one I studied. Signs appear to convey self-evident truths; in reality, through the performative process of signification – generated in the interaction between one who signifies and one who interprets, and through the constant alternation of these roles [17] – signs reveal their contingent and cultural nature. As de Saussure demonstrated, the sign is the relationship between two entities: one present (the *signifier*) and one absent (the *signified*), to which the former refers. This relationship, however, is neither natural nor necessary – it is arbitrary.

The different theoretical frameworks coexisting within plural medical contexts such as my fieldwork research in Wukro offer multiple paradigms for interpreting not only illness but also, more broadly, "reality" itself. These frameworks become medical, moral, and interpretive models all at once. In their interplay and overlapping, they reveal what Aragona [18] calls the "myth of facts", that is, the illusory objectivity of evidence. Illness thus emerges in its true nature – as a social construct deeply tied to the way societies are organized and to their underlying theoretical models.

> In biomedical terminology, the *sign* maintains a close connection with what semiotics defines as *indexes* or *natural signals*. Just as one infers the presence of fire from smoke, disease is inferred from medical signs such as fever. Neither fever nor smoke are meaningful creations based on semiotic or cultural conventions; rather, they are natural manifestations. In this sense, the sign has the peculiarity of being itself a fragment of natural reality which, like the tip of an iceberg, reveals its own presence and enters the field of semiosis only insofar as there is an interpreter – someone who, upon observing fever, infers a specific disease. [19]

But what happens in a context where signs point to different meanings? In Wukro, where I conducted fieldwork, the arbitrariness of the sign constantly manifests itself – not only in the distinction between *sign* and *symptom* (the latter being the patient's expression), but also in the diverse interpretations and corresponding meanings that biomedicine and traditional medicine elaborate. Shortness of breath, chest tightness, and high fever are considered unmistakable signs of a *ganien* attack in traditional medicine. For a "biomedical" gaze, however, the same complex of symptoms would unmistakably point to *pneumonia*.

In the conflict between biomedical and traditional paradigms, which occurs in cases of "arbitrariness of the sign", i.e. when the patient or the patient's family interprets a complex set of symptoms differently from the biomedical professional, the request for healing and the therapeutic response become irreconcilable. This can lead to non-compliance and failure of the therapeutic alliance, with negative consequences for the patient's health.

Almost certainly, none of the students to whom I have recounted this ethnographic truth will encounter a patient whose interpretation of illness stems from traditional Ethiopian medicine or who attributes its cause to supernatural agents, but it is very likely that they will encounter personal interpretations of illness that differ from the biomedical one. Future nurses may find

themselves in multicultural contexts, and it is important that they learn to listen to patients' accounts of illness and learn to be *cultural mediators* in healthcare settings, attempting to resolve conflicts and promoting understanding between doctors and patients.

For students, being confronted with such situations helps them understand how to act in multicultural clinical settings – how to engage with patients from different cultural backgrounds, to distance themselves from familiar concepts, and to approach those that seem distant.

## 5. Bringing It All Back Home: Concluding Notes

The social function of anthropology is to identify problematic situations, disseminate results, and take a stand [20]. Within a university course in medical anthropology, the outcomes of ethnographic research can thus serve to enhance the *emic* perspective, acknowledge the legitimacy of traditional healing figures, and foster greater compliance and dialogue between healthcare workers and patients in the contexts under study.

Moreover, such experiences can be productively reinterpreted *at home*, within the framework of what Seppilli [20, p. 12] called the "cultural calibration of healthcare services" – one of the "most complex and urgent critical issues" that Western health systems must face today. Understanding the cultural dimensions of health, illness, and care becomes a vital tool for future practitioners, enabling them to work more effectively across diverse healthcare settings. It also reveals that anthropology's vocation to *listen to voices*, to grasp other people's needs, and to dismantle one's own certainties is not merely a theoretical posture but an operational practice – a way to create shared spaces of encounter, negotiation, and cooperation in the everyday relationship between healthcare provider and patient.

Beyond the classroom, this pedagogical use of ethnography points to a broader epistemic responsibility: to cultivate reflexivity and critical empathy among health professionals, encouraging them to see each clinical encounter as a site of cultural translation. In this sense, teaching medical anthropology through lived field experiences – such as those conducted in Wukro – can become an exercise in reorienting care toward mutual understanding, where scientific knowledge and cultural knowledge are not opposed but mutually generative. Such an approach ultimately reminds us that anthropology's most enduring lesson lies in its capacity to turn distance into connection, and difference into dialogue.

## 6. Acknowledgements

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