Crisis, Migration, and Public Health
CGIS-S 030, 1730 Cambridge Street, Harvard University
Wednesday 5 May 2010

Speakers and Participants (note: this is not an exhaustive list of all attendees)

Megha Amrith (MA)
Sunil Amrith (SA)
Lincoln Chen (LC)
Luca Einaudi (LE)
Tim Harper (TH)
Peggy Levitt (PL)
Pedro Ramos Pinto (PRP)
Emma Rothschild (ER)
Urvesh Shelat (US)
Kavita Sivaramakrishnan (KS)
Marlena Smith (MS)
Rachel St John (RSJ)
Melissa Teixeira (MT)
Kirsty Walker (KW)
Mary Wilson (MW)

Introduction

ER opened the meeting by discussing the mood and the expectations of 2008 that prompted the foundation of this seminar series. She pointed out how some of the effects that were expected in the early months of the recession, such as cutbacks to vaccination programs, appear not to have taken place. In that respect, she explained, during the first year and a half of the Great Recession in developed countries, institutions of the welfare state in relation to health have done what their founders hoped they would do.

Next, ER directed the group's attention to the experience of the crisis in the "Global South." She referred to PRP's and MT's discussion of Mozambique in the earlier Crisis and Health Seminar. Given that country's large population of migrant workers, one would expect to see rapid effects of the crisis, based on the experience of the 1930s. MT's analysis of online media, however, suggests that the adverse consequences for health have not been seen. One of the explanations for that seems to be Brazilian programs in Mozambique that were active and were not cut back because of the crisis. In this respect, south-south cooperation has a positive effect in Mozambique.

ER discussed global philanthropic organizations as a distinct yet critical group of actors in the history of crisis and health. The invention of "global health" in the 1930s and subsequently of "global public health" in the 1970s marked important shifts in the role of national and international discourse on health. That invention of a new global concept was followed in the late 1980s and 1990s by a substantial privatization of global public health, as government retrenchment and shifts in aid conditionality led to fewer publicly available resources. Much of this philanthropic expenditure was mandated for specific, targeted immunization initiatives. ER questioned the resilience of those private flows to Africa. Did cuts in endowments result in cuts in the enterprise of public health in Africa? While it is currently difficult to tell, since many budgets had already been set in 2009 before the most dramatic effects of the crisis were known, ER noted that this issue deserves continued attention.

ER commented on the distance between debates among historians, economists, and social scientists, and debates among medical practitioners and public policy experts. The

workshop was an attempt to engage scholars of many backgrounds to have a relatively sustained conversation that can address the economic, social, political, and medical lives of people.

Migration and Health: An Overview

SA focused his discussion on migration as part of the written and visual historical record of periods of crisis. Migration, he suggested, was central to the ways people thought about and remembered the middle of the 20th century: immigration, forced migration, accidental migration, repatriation, etc. The war swelled the flow of displaced and migrated refugees, and uncontrolled or unwilling migration features prominently in pictures from the middle of the century. A sense of human movement is essential to these images, and, SA explained, a similar visual motif about movement is essential to current depictions of climate change. Migration has become a sort of index for crisis, and thus provides an illuminating factor to consider alongside economic tumult.

SA then focused on the relationship between crisis and migration in Asia. Around 1870 flows of migration in Asia underwent a step change in magnitude and truly began an age of migration that was quantitatively on a par with the transatlantic migration of the same period. Despite the similarity in size, European writers differentiated migration in Asia at the time from its Atlantic counterpart, and they thought about this movement firmly within the framework of crisis. It was crisis, more than any other factor, that marked these Asian movements. One British author commented that any comparison between Asian migration and free willing migration of people in London was fallacious. Furthermore, in this European understanding crisis was not just an event, but an ongoing, continuing state.

At around this time, Indian and Chinese leaders began to speak of migration in terms of crisis. They began to conceive of migration as manifestations of a people without leadership or self-respect, and, in turn, these governments tried to clamp down on overseas migration. They established systems of emigration checks to go to certain countries; however, such checks were notably deemed unnecessary for migration to the West. Yet crisis also had a braking effect; observers in the 1930s noted that because of trade congestion international migration in Asia was arrested and even reversed its course.

Given this perceived connection between migration, crisis, and risk, SA asked whether the rhythms of migration paralleled the rhythms of crisis. Recent evidence suggests straightforward connections between peaks and troughs of migration and economic crisis. In the current crisis, one estimate suggests 1 million contract workers in Malaysia were repatriated after expiry of their permits, and in China, an estimated 20 million people moved back to rural areas from urban areas in 2008-2009. Although migration increased during times of crisis, SA warned against an unnecessary emphasis on only these swells of human movement.

Migrants did not react blindly to the crisis, and there were often networks of information, of credit, of connections, and of mutual support that pre-dated and outlasted periods of crisis. Their experience demonstrates that deep traditions of migration are adaptable to changing situations. SA argued that if we put the agency of migrants at the heart of our history, crisis becomes only one set of circumstances among other changes in legal, financial, and social events that shape migration. SA opened discussion to the health implications of this approach as, he explained, health is inextricable from these views of crisis. Controlling the spread of infectious disease has been at the root of attempts to control migration in Asia, and for migrants looking after their own health and health of their families was fundamental to their survival.

TH offered two points that make the situation in Asia notably different from that found elsewhere. First, he said Asian history is built on the circulation of cultures and the circulation of healers from the earliest times, and this creates a striking pluralism of medical practices. Such pluralism continued in the modern period alongside other different modernization projects. Second, while many histories focus primarily on state provision, the reality demonstrates many

agents at work including the state, missionary organizations, local philanthropies, and international agencies.

This network of institutions is affected by the wide variety of forms that crisis takes, and, TH explained, researchers should be mindful of how many Asian crises come at moments of key political transitions. The first crisis he described was the crisis of colonialism itself; a protracted affair that involved violence to existing therapeutic systems. One prominent example of this tension between the medical systems of the colonizers and the colonized is the Spanish dismantling of many traditional Filipino healing institutions. The second crisis is the epidemiological expansion of colonialism itself which was a burden borne by colonial natives. The colonial state was slow to catch up on the scale of this crisis, and so, too, has historical writing on the colonial state.

Some of the writing on the colonial period has been dominated by two concerns. A lot of the writing on tropical health has focused on the health of Europeans and the European body in the colony. This focus has helped to define fundamental boundaries of colonial rule (consider, for example, the magic mountains of colonial hill stations). A second kind of historical approach studies health through the role of capital and systems of control and discipline of subjects. Medicine in this context--and, on a related note, famine relief--is a part of the process of legitimating the colonial state and is less concerned with health per se. Health practitioners had to adopt these legitimating arguments themselves. For example, by 1919, 2 million working days a year were lost to malaria in Malaya. Health of the labor force created a purpose and mission for the colonial state. Similar concerns governed international relations and regulations for the colonies. A major concern for South and Southeast Asia was the issue of pilgrimage. Controlling the Hajj created an elaborate web of health workers and local agents.

These interventions gathered momentum and were propelled by a new series of crises in which new themes came into play. By the end of the 19th century, the technocratic aspect was very important. In the Dutch East Indies, a new alliance formed as commercial interest sought a better-equipped labor force. The necessity of a laboratory for the empire was recognized. Ethical policy in Indonesia created a positively competitive environment for colonial provision of health and international debates about public health. The first instances of cooperation among colonial powers had a very important health dimension through the sharing of data and best practices. Also, the expansion of western medical education happened suddenly at this time and caused the internationalization and professionalization of healing. On this point, PL inquired about the enrollment at colonial medical schools, and TH explained that the student cohorts came from diverse groups, with early classes drawn from the more cosmopolitan, elite government schools.

TH stressed the complicated relationship between Asian agency and war for those studying this topic. The debates on the control of labor and of indenture developed into moral crusades that were transnational in scope. Debates were provoked by crisis and displacement of people, and war was central to this ongoing displacement. The Dutch fought continuing wars in the Ache region, which were very important to medical provision since it prioritized the need to protect troops from all kinds of infection. WWI had a colossal effect in Asia with the unprecedented movement it generated. Massive cholera and smallpox epidemics caused close to 120,000 preventable deaths. In meeting these health crises, military actors often took the lead. WWII involved a further complexity of agency. The collapse of western rule especially in large parts of Southeast Asia promoted Asians to new prominence in health systems where previously top posts had been held by Westerners. There was a massive expansion of nursing services, and in this period medical leaders became important as general social and political leaders.

This led into the crises of the end of empire. Politics and certain types of state building surely shaped health concerns. TH asked the group to consider how colonial practices were thus taken forward in post-colonial systems. The end of the colonial period was the beginning of a different set of tensions through the Cold War. Across Asia many things were shaped by the Cold War context and emergency powers, which led to massive planned movements of the

population and counter insurgency programs. In Indonesia some of the health programs of the new order are still shaped by similar considerations as the state building of 1966.

One participant asked about forced migrations that are still happening in Southeast Asia. SA clarified by discussing the sheer diversity of forms of forced migration. Force could be explicit, as in the case of indentured labor, or more circumstantial through forms of debt pressure. SA stressed the importance of local intermediaries such as recruiting agents and traffickers, and since the 19th century, these local networks have frustrated attempts to stop forced migration. Another participant asked about the impact of changing technology and industry on the public health of migration. TH explained that unlike modern migration to polluted, crowded cities, a lot of the early migration led to isolated geographic areas such as rubber plantations. Nowadays, however, migration control and economic pressures have meant that more people are directed to cities that are stretched to their capacity to absorb more and more people.

MW inquired about patterns of reverse migration. SA pointed out that most migration was circular. Until the 1930s, most migration did not move to stay but were rather sojourners. For example, many Indian migrants would go to South East Asia and then come back to India. This circulation was partly because of relative economic opportunities or growing seasons. In the 1930s these patterns changed for a variety of reasons, including the Great Depression and more restrictive immigration laws.

An audience member pointed out that the archive with perhaps the most broad and constant source of information on migration and health is the International Labor Organization (ILO). The ILO, she argued, seems to have had health and migration at the center of its mission possibly more than any other continuously existing international institution-- given that it had a life through the period of the League of Nations and continuing into the era of the United Nations. TH agreed about the ILO and suggested that religious missions are another valuable source of information on sanitary issues.

Another participant pointed out how health professionals in the modern day form a critical component of efforts to combat forced migration. SA saw some kind of historical parallel in the period TH had spoken about. Indentured labor went to the jungle with no legal rights, and the only people that could care for their health and well-being were colonial doctors. Sometimes doctors were not initially critical of the colonial state and its treatment of these laborers but became so. Many of the effects of forced migration were dealt with first and foremost on a health practitioner level, and practitioners helped to stop forced migration not as activists but as experts.

Migration of Health Professionals

MA discussed the circumstances of Filipino health workers in Singapore and how they have been affected by the recent economic crises. Despite the economic downturn, the expansion in health services continues at a fast pace. Filipino nurses go to Singapore, MA said, because of attractive compensation and because they can build up credentials to take them on to further work in Europe or North America. She found constant discussion of the necessary examinations, visas, and policies. Stories, rumors, and informal networks of information via the internet have become key sources of information about such new job opportunities. In the experience of her contacts, MA explained that gossip and rumor caused just as much anxiety as the actual events of the crisis itself. Opportunities were still opening up, but people listened to what friends said about hiring freezes and cutbacks.

MA described the constant sense of movement in the lives of these nurses as migrant workers. The uncertainty generated by the economic crises was not unique. Migrant lives are already marked by uncertainty even before the crisis. Nurses are always thinking about moving and felt a constant sense of insecurity. Transit cities such as Singapore, which is seen as a

stepping stone to Europe or America, may come to be places where migrants stay longer than they expect. Direct attempts to move abroad were not always successful. MA related the story of one woman who worked in Singapore in a Buddhist nursing home and as a phlebotomist taking blood. She wanted to go to UK where her three sisters were. Because of UK regulations she could not go as a worker, but she could go as a student and work 20 hours per week. MA described what types of adjustment have been necessary because of the current economic crisis. Reductions in new hires have placed more responsibilities on those employed. In order to stay in touch with people back home, nurses have become adept at using online tools such as Skype, Facebook, and Friendster.

Such appealing job prospects for nurses abroad have had complex effects in the Philippines. Even with migration, the country faces a surfeit of nurses, and many health workers have to volunteer or go into other industries for a considerable period before working in their chosen field. This frustrating domestic situation and the appeal of working internationally have led to the loss of the most skilled nurses in the Philippines. The actual journeys of these migrant nurses exist alongside several other imagined journeys to elsewhere in the world. This resilience, MA explained, supported extensive planning and lives of waiting for the right moment. MA concluded that for these migrant nurses, the economic crisis compounded existing uncertainties rather than marking a new period of drastic change.

KS responded to MA's discussion in two parts, first by looking at the work of the Asia Pacific Alliance research on the human resources of health and second by looking at the issues of an aging population. In 2008, KS was involved in coordinating a 15 country review of human resources of health professionals. The review produced case studies by country on the challenges of having adequate numbers of committed health professionals. She pointed out some of the conceptual challenges in the study of human resources in health care. First, most reports and case studies overlooked the potential plural interpretations of health and migration. Reports from Burma implied there was one definition and experience of migration, namely that of moving patient populations, even though the experience in India of brain drain poses markedly different issues. Second, physical and conceptual borders themselves posed challenges of interpretation. National borders are not all viewed in the same manner and certainly do not necessarily represent a schism or break in practices or context. Migration across communities was also not necessarily marked by sudden disjoint. KS argued that it is necessary to have regional studies. Regional experience of primary healthcare programs and migration challenges associated with rural health workers could yield usable lessons. Most of these reports on human resources in health mentioned that policy pathways 'need systematic coordination.' But planning documents are rapidly produced management tools, and the issue of power relations and political interaction both internationally and nationally remain neglected.

KS then turned to the crisis of demographic aging. The pace of population aging in developing countries is much faster than in developed countries. India is expected to undergo a demographic transition by 2025. Recent legislation mandates parental maintenance by children who migrate from urban areas to foreign countries and from rural to urban areas. The state, in effect, legislates filial responsibility. In a sense, KS explained, we are looking at the internationalization of migration and issues of providing informal care. Given that international migration is largely class based and mainly occurs in urban areas, this legislation is relevant to only a narrow band of society. On the other end of the spectrum are families who cannot handle the balance of care and whose destitution means that the state must intervene. Another question that such legislation raises is whether there is an alternative model of welfare that we can look to in developing versus developed countries. These issues of care for the elderly underscores interconnectedness of health and migration, and it makes us rethink issues of dependence for older persons. Aging, KS said, is going to shape the way we look at human resources and health, yet there is a sense that these questions of aging and migration fall between the mandates of all major organizations (WHO, ILO, etc.) and so it is hard to define how to address these issues.

LC focused on the multiple levels of health worker migration. In addition to health workers moving, you have people as potential patients moving. Vectors of disease move with people, and environmental threats move across borders. Responses to these threats raise further issues about migration. Responses necessitate transnational cooperation with intergovernmental organizations and NGOs collectively addressing problems by distributing resources. More powerful still is the sharing of knowledge, which is essential to control disease.

There is also the fraught connection between international imbalances and domestic maldistribution. Even though the Philippines produces huge cohorts of nurses, there is a dearth of nurses in rural areas, and many are not absorbed in the domestic market to serve in less popular locations. This raises questions about the intervention of public bodies. The WHO might debate a code of conduct on controlling human movement of healthcare workers in situations where depleted countries are asking for reparations for their displaced investments.

LC then turned to the demographic transition in East Asia. The Japanese claim to be the world's oldest society, and the demographic balance may have reached a point of crisis in that country. Although the immigration of young workers into the country is generally not well tolerated, the Japanese have had to look to import nurses to meet the needs of their aging population. In these instances of importation of healthcare labor, the social and cultural politics in the country of origin become difficult to navigate. In Cambodia, for example, a nursing school set up by Koreans to train and recruit nurses came under fire when it was revealed that the Cambodian students received Korean language training alongside their nursing studies. The reality of training for export made the school unpopular among the local population.

TH pointed out that when considering aging populations, the definition of health worker becomes blurry where domestic and personal support staff are necessary. One participant brought up the question of how gender factors into this. MA explained that in the Philippines nursing is seen as a prestigious profession, and men did not feel bad about being nurses in uniform. However, when these male nurses went to Singapore and their duties extended beyond professional medical care to bedside care (such as washing dishes and cleaning patients), concerns about masculinity did arise. Someone then asked about the role of compensation or reparations back to the countries of training. MA explained that there were a few agreements or memorandums of understanding but those were between certain small communities and almost nothing existing on a national level.

The Health of Migrants

KW expanded on some of the earlier themes from the day by discussing personal stories of health from colonial Malaya, where waves of migration in Southeast Asia shaped conceptions of health and the systems that evolved to cope with them. From the late 19th century to the 1930s, Malaya drew migrants from all over Asia. In addition to innumerable itinerant merchants, peddlers and pilgrims made for a restless population throughout the territory, and public health in this region was very much built up around the constantly circulating migrants. Imperial medicine was a means of control in institutionalizing colonial conceptions of race; it was a cultural system as much as a biomedical one. KW pointed out that while histories of health have focused on the ideologies of colonial medicine, there is a considerable lacuna in our understanding of the individuals they aim to describe. Specifically, scholarship has overlooked systems of how migrants gave health meaning embedded in narratives of migration as well as assessments of the agency of migrants in defining health in alternative informal worlds of medicine. KW aimed to address this gap.

Ideas of health and the threat of illness feature prominently in narratives of migration. For many, the passage to Malaya was marked by illness, as highlighted by the health officer of Malaya who in 1919 called ships from India "incubators of cholera." Most migrants had their first experience of being regulated by a public health system when they were inspected,

disinfected, vaccinated, or even quarantined upon arrival. Expectations, rules, and responses evolved over time. Passengers were assumed to be "full of filth" like cargo, and some migrants viewed evasion of regulations with pride. Indeed for some, evasion of regulation was an intelligent choice; quarantine stations were unhealthy places where overcrowding became a frequent problem and cause for illness in its own right.

KW explained that many itineraries of migration were shaped by health in very literal ways. Health became a stimulus to migration through the search for a cure or a return home to recover from illness. The archive of memory within migrant families is shaped by health, illness, and death. Social class also had a significant impact on this experience. Quarantine entailed a flattening of social hierarchy where all migrants were considered as a similar risk.

The relationship between different medical systems practiced by various migrant groups changed over time. Chinese prostitutes were reluctant to see western doctors. During an outbreak of typhoid in 1912, more than half of the rickshaw pullers affected did not see a doctor, and instead they chose to self-medicate with opium. The widespread belief was that hospitals were places people went to die, a last resort. Alternative medical systems were abundant; western colonial medicine was only one part of a diverse landscape of healing specialists. In Singapore, the early Chinese druggist shops dated form the 1830s. A growing demand for Chinese medicine in the early 20th century was supplemented by these pharmacists and medicine shops. Alongside these, many Indian migrants sought treatments from Ayurvedic therapies, and people of all backgrounds turned to the Malay bomoh healers. An extensive network of medicine and healers arose. Immigrants would often use local medicine or whatever appeared most convenient or effective. They freely moved between medical systems, and over time these medical systems overlapped and worked across ethnic lines. KS inquired about the language of practice, and KW explained that her impression was that there seemed to be multiple languages through which these healing interactions took place. KW went on to describe how the colonial state dismissed these practices as superstition; however, efforts to replace alternative healing systems met with limited success. As immigration policies were altered to increase the number of women, migrant families increasingly relied on homemade remedies provided by the mother. Evidence suggests that second generation migrants continued to use their parents' own remedies.

This plurality of systems was clearly seen during the 1918 influenza, where rumor and hearsay had much influence during the times of crisis. In moments of crisis, state health officials were forced to acknowledge the importance of local health workers even if their systems of healing were different from those sanctioned by the state. In practice, Malaya's medical systems were innately flexible. Migrants often sought explanations of illness and disease rooted in larger religious cosmologies. By focusing on diversity of medical knowledge and practice, KW argued, scholars can move to understand practices of health in migrants' personal and social worlds. US inquired about the continuity of care for itinerant migrants such as Indian laborers who, while in Malaya, found Chinese medicine appealing before returning to India. He asked if there is evidence of these medical practices being taken back and established in the country of origin. SA explained that there was evidence in the Indian context of Chinese pharmacies being established in India to serve such circulating communities.

PL offered additional perspective by describing the triangular relationship between migration, health, and crisis. She referred to thinking about how ideas and cultural objects move alongside people and to the intersection between the movement of bodies and the ideas associated with them. She described an issue of "methodological nationalism" that she saw as holding back fruitful investigation into this topic. People stay connected to their homelands at the same time that they move, yet this distant connection, in her view, does not receive enough attention when scholars assume the nation state is the logical container of experience. PL argued for a transnational optic for studying migration and all kinds of social phenomena, though she also recognized that there may be a constantly shifting appropriate spatial unit of analysis that does not unfairly privilege the global or local. By taking an approach that tries to hold all layers in

conversation, social units that are assumed to be bounded and bordered become transnational. When using the national social field as the frame of reference, narratives become as much about non-migrants as about migrants. Those left behind and those moving may be separated by physical distance, they occupy the same social and emotional space, and both are influenced by the same people, ideas, money, and objects.

Simultaneously, movement is not a requisite for that kind of experience as non-migrants in the country of origin can be influenced by ideas and practices from afar. From some of her own research, PL argued for not just studying Dominicans that settled in one neighborhood in Boston but how that group is itself embedded in other regional, national, and global dynamics. Remittances sent back by migrants are not only monetary; social remittances such as ideas, know how, practices, and skills transfer between all groups. To achieve a sufficiently detailed understanding, PL explained that researchers would need to look at how health is defined all over the transnational social field. In some countries of origin, the influx of western medical knowledge, practices, and healing devices have greatly advanced medical treatment while also raising the cost of living to unattainable levels for those who lack transnational connections. This then creates points of disjuncture and division for communities of origin for migrants as they grapple with questions such as "Who is making the decision?" when those who have migrated away try to impose ideas of what is best upon this original community. Frequently, the migrants end up with decision-making power by virtue of the money they can command.

RSJ reflected on some of these themes in the modern context. In current immigration legislation in the USA, one finds explicit attempts to control access of certain migrant groups to healthcare, and in much of the recent healthcare reform debate, the availability of care to migrants was among the most contentious points of argument. This situation is, by no means, an unchanging status quo, and over time, the boundaries between physical, political, and moral health in state immigration restrictions blur together. During the late 19th and early 20th century, the US and Mexican states paid little attention to concerns about health and restrictions of migration. Immigration restrictions, RSJ explained, came at the same moment that the US state expanded in other ways, especially social welfare services. Thinking about migrants in the state's approach to public health began with thinking about migrants as laborers. People who were too old or too sick were not desirable as laborers, and so the first migration restrictions were about weeding out the unfit. Later on the first legislation to enforce quarantine were laws restricting the entrance of anarchists and prostitutes under the theme of contagion. The state was concerned that anarchists would contaminate the American public in the same way that someone suffering from smallpox or yellow fever might do as well.

On the border, the tightening and enforcement of immigration restrictions such as quarantine and health checks happened coincident with the occasion of the Mexican revolution. These changes were justified as public health crises, but looking at them in context reveals other potential political motivations. What we can take away, RSJ explained, is first that this is a clear instance in which migrants are defined as a threat to the public rather than a part of the public itself. They are seen as outside the public and thus outside the purview of the federal government and the state/local government's responsibility. Migrants went from potential citizens to being seen as threats to and parasites on the body politic.

LE turned to the relationship between migration and health in the European context. He explained that in Italy, crises are important in shaping policies, and indeed, Italian immigration policies have been described as only driven by crisis. The shift in Italy from being an emigration country to immigration country took place rather late and without acknowledgement for some years. While there was some influx of immigrants in the 1960s and 1970s, it was only in the 1980s and 1990s that strong immigration policies started appearing. The main mechanism used to support migration was adoption and then implementation of principles of the ILO concerning the social and work rights of migrants. The relatively late immigration debate in Italy had certain positive implications for migrants. Italy established a universal, free healthcare system in the late

1970s, and after the 1986 migration laws, all migrants who were legally present had a right to free healthcare. In practice, this did not work out smoothly because migrants often did not know or did not have the right papers, but in principle the services were available to them. More recently, LE explained, illegal migrants were given a card that could get them access to basic essential healthcare, though there has also been a push to force non-medical employees of hospitals to report illegal migrants to the police.

MT suggested that another valuable vein of research might be in the role of the government of origin in the health of its own emigrants. MT cited the establishment of hospitals at ports so that the Portuguese government could guarantee that the emigrant was a good laborer and offer doctor's certification that the individual could work abroad. MW added that there was a considerable asymmetry in the modern day where the focus at the border is on preventing things from coming in but allowing anyone/everyone to move out.

MS explained the difficulty of assessing the specific health problems that afflict specifically migrants. Research studies suggest that there are health problems unique to these groups. However, in her experience in the European context, there is resistance to asking questions of ethnic origin, and finding methods of identifying migrant groups to get representative and accurate information proved difficult. PL suggested using proxies of religion or language, and LE suggested asking about citizenship which can be a less loaded question.

LC described the constellation of relationships that determine migration and health policies between them. One country may offer to buy a large shipment of otherwise unnecessary drugs from a trading partner in a show of good faith to provide health for its people with the true motive of maintaining regular trade between the countries.

Conclusion

ER offered some closing thoughts by returning to the earlier conversation on creating a transnational social space. PL had previously highlighted the importance of history and how historians can look at the world in a way that contemporary social scientists cannot, and ER responded by describing how many ideas from contemporary social theory are suggestive for historians.

She then turned to three issues that arose from the day's conversations. One issue that came across clearly in the conference was the extent to which a transnational history of public health is a transnational history of the state. There are many respects in which the construction of the state is not a national process but is a process involving borders and people who cross borders. A second theme was the sort of challenge TH discussed with the established division of tropical or colonial medicine and the bodies of Asian people. There were, in the experience of many Asian people, a multiplicity of ways of being healthy and being ill that a narrow definition of medicine overlooks.

Finally, she closed by discussing the striking difference between the historiography of Asia and the historiography of North America. There has been some discussion of the epidemiological consequences of the first encounter with very high mortality rates among indigenous people in Malaya and the same first transatlantic encounter. But while the trans-Atlantic encounter is documented, Southeast Asia is not as well understood. Similarly, there is abundant historical literature in both contemporary histories and works going back to the 18th century on the Middle Passage and the conditions of transit on slave ships, but there is very little on that in Asia. These journeys which involved tens of millions of people is something that is barely explored in much of the historiography, and ER noted the lack of a contemporary understanding of the history of those journeys, including the medical history. Picking up on upcoming work by TH and SA, ER urged further research on these sites of Asian interaction where questions of health were central.