Migration, Mobilities and Global Health

Developing partnerships for new research

Workshop Report

Friday 25th May, 2012

School of Global Studies, Arts C

University of Sussex

Contents

Workshop Programme

MIGRATION, MOBILITIES AND GLOBAL HEALTH

9.30am-5.30pm, FRIDAY 25TH MAY

Global Studies Resource Centre, School of Global Studies, Arts C

University of Sussex

9.30: Arrival and coffee

9.45: Welcome and introduction

10.00: Daniela DeBono: We are dying in detention": The adverse effects of detention on the well being of irregular migrants' in Malta

10.15: Kirat Randhawa : Recent migrants using UK healthcare and their experiences of discrimination.

10.30: Nikki Khan: A 'Moving Heart': Everyday suffering and a dilemma of 'immobility' in Afghan migration

10.45: Discussant: Elizabeth Challinor (CRIA, Portugal)

11.15- 11.30: Coffee

11.30: Sajida Ally: Emotion, Agency and Sexuality in Sri Lankan Migrant Narratives

11.45: Anastasia Christou: "Ageing in the ancestral homeland: ethno-biographical reflections on emotional well-being during return migration in later life"

12.00: Discussant: Hayley MacGregor (IDS, Sussex)

12.45-1.45: Lunch

1.45: Gillian Bendelow: Towards a Transnational Caring Response to Suffering

2.00: Priya Deshingkar, Matteo Sandi: Poverty Impacts of Migrants' Out of Pocket

Expenditure on Health

2.15: Stefan Elbe: 'Migration, Mobilities and Global Health: The Global Governance of Circulation'.

2.30: Discussant: Mike Collyer (SCMR, Sussex)

3.00-3.15: Tea

3.15: Elizabeth Challinor: Cape Verdean Migrant Subjectivities, Maternal Health and Body Politics in the Portuguese Health Care System.

3.30 : Rachel Olson: Midwifery, maternal health and shifting locations of birth among first nations people in Canada

3.45: Maya Unnithan: Understanding Health Inequalities through Migrant Mothers' Accounts of Birth and Loss

4.00: Discussant: Laura Griffiths (DPHPC, Oxford)

4.30-5.30: **Plenary discussion,** Chair: Gillian Bendelow (Sociology, Sussex)

Introduction

The workshop was organised as part of a wider research initiative undertaken in July 2011 led by Maya Unnithan (Anthropology), bringing together a group of staff and graduate students to develop a working group centred on Migration, Mobilities and Global Health issues at Sussex. She was further supported by Gillian Bendelow (Sociology), Melanie Newport (Medical School) and Stefan Elbe (International Relations), in procuring funding from the University Seed Corn Fund and the Centre for Global Health Policy.

The working group, having emerged just under one year ago, re-gathered for a workshop on Friday 25th May to report research and create the opportunities to share and discuss ideas. The main aim of the amalgamation of such work and ideas was to potentially enhance and develop research partnerships between colleagues in Europe and Asia that could also lead to further funding opportunities.

Sussex is internationally recognised for its interdisciplinary research in migration studies. Also, within the University, in the past two years, Global Health has emerged as an important and vibrant area of collaboration across the social and medical sciences. There is a small but growing body of established and doctoral researchers whose work brings together the areas of health and migration. The aim of this project is to connect these researchers in a common forum, to share and develop ideas for research and teaching and to establish international links and collaboration. Work on the interface between migration and health is both conceptually challenging and pioneering - within migration studies, the health of migrant and mobile populations is as yet a neglected area of research, and equally, within Global Health, the focus on migrant populations is as yet nascent.

Topics of particular research interest within the Migration, Mobilities and Global Health project include the health and human rights of migrants in the context of their economic well-being, transnational caring, mental health of migrants, cultures of migrating health workers, sexuality, reproductive health of migrant labourers, health scares and global governance of migration and understandings of place in migrant therapeutics.

A major part of the proposed project is geared toward developing research connections in order to attract funding. In terms of research collaboration the aim is to develop this especially with European colleagues (in Portugal and France, for example) but also further afield, in India, China, Australia and South Africa.

The May workshop was organised to identify four aspects of the research; 1. It highlighted the key themes and theoretical underpinnings, 2. It also drew attention to the factors that made the research particularly groundbreaking and significant. 3. The workshop gave the opportunity to consider what still needs to be addressed and how can research be furthered, 4. Applying this research furthermore, its applicability to local and global policy was explored.

The day was structured by four sessions, each one being concluded with a discussion, initiated and chaired by an appointed discussant. The last hour of the day was dedicated to a plenary where key themes were identified and participants were given the opportunity to share what they believed the day offered in terms of research and policy potential.

"We are dying in detention": The adverse effects of detention on the well being irregular migrants in Malta

Daniela DeBono

The work presented by Daniela DeBono builds on from her previous PhD work where she looked at irregular migration in Malta from a human rights point of view. In carrying out part of this research in detention centres, it became evident, that whilst the right to freedom was a significant concern for detainees, so was health a key priority. Traditionally, reports by human rights bodies such as the Council of Europe Human Rights Commissioner, adopt a reporting approach, which takes one right at a time, with the result that, the right to freedom and the right to health are considered separately. Conceptually this contradicts the basic premise that all human rights are interconnected and interdependent. However, this kind of reporting could, inadvertently, also have implications on policy, which are less than desirable. Daniela is attempting to identify the risks of separating these rights in human rights reports and therefore emphasise the relevance of their interconnectivity.

Placing the concern for both the right to freedom and health into context, Daniela has focussed this research in Maltese Detention Centres. The concern for health is particularly evident amongst migrants within these centres which are primarily set up to improve state security. The vast majority of irregular immigrants in Malta arrive by sea and are generally rescued by the Armed Forces of Malta. All irregular immigrants, irrespective of whether they apply for asylum or not, are detained. The length of detention, which can take up to 18 months, is compounded by the 'appalling' conditions within the centres. The health and well being of migrants during their stay in detention is necessarily a concern.

Primary and secondary research shows that the centres themselves are creating health issues and this was articulated by detainees. Amongst the health and well-being issues raised by the migrants are the risk of infectious disease, poor communication with doctors, lack of sleep and mental health problems. Health is a concern for detainees and for the detainees is intrinsically linked with their right to freedom, since freedom could only be valued and utilised if in good health. Primarily, good health

once free in the community was rightly seen as improving one's capability to work, send remittances, and live their lives.

Daniela's work critiqued the prevailing human rights approach to health in human rights reports on immigration in Malta which tends to be predominantly limited and negative, focusing, for example, solely on the availability of health services. This is not in line with the 1946 WHO definition of health which is more positive and broad, and advocates an approach which considers health beyond its acute nature, but draws attention to the more long-term nature of health and well-being. Considering this, she praised approaches from health-focused human rights organisations such as Medecins Sans Frontieres and Medecins du Monde, which were able to utilise this definition in their reports. Daniela speculated that the methodology of observation and reporting might impact on the conceptualisation of health in human rights reports, since these are organisations which have lengthy experiences working within the Maltese detention centres, unlike other organisations which tend to rely on secondary sources, a few visits and interviews with stakeholders.

Whilst Daniela addressed the need to consider the rigor of research that is able to explore beyond the acute to the broader in-depth experiences of health, she also recognised the dangers of having different approaches to health within the context of other human rights organisations and perspectives. Such dangers included conflicts in human rights voices and the development of hierarchy between different rights, which may ultimately undermine the effectiveness of such reports on health policies. In order to address these specific issues, Daniela suggests a need for education on human rights, particularly within the field of irregular migration and also addressing the definition of health in traditional human rights literature. This definition needs to go beyond merely the right to life and focus rather on the right to life and development as articulated in the 1989 UNCRC, hinting towards a definition that incorporates quality of life.

Daniela DeBono recently completed a D.Phil at the Sussex Centre for Migration Research, University of Sussex, funded by the Commonwealth Scholarship Commission in the UK. My research project was entitled 'In Search of the Building Blocks of a Human Rights Culture: Lessons Learnt from the Treatment of Irregular Immigrants in Malta'. The project used an interdisciplinary approach to identify the cultural and socio-political aspects of Maltese culture, which hinder the adoption of human rights within the irregular migration field.

Recent Migrants' Experiences of Discrimination when using healthcare in the UK

Kirat Randhawa

Kirat Randhawa's PhD research is funded by ESRC and Brighton & Hove Council and NHS. This analysis is an exploration of the concepts of stigma and discrimination utilising the narratives of a group of recent migrants that used the UK health system between 2009 and 2011. Grounding her work in constructivist epistemology that accepts reality as being partially socially constructed, the investigation studied individual lived experiences in the form of illness narratives. Inductive analyses of narratives were carried out, illustrating the presence of stigmatisation and discrimination. This was found to exist in structural conditions, which in turn could explain the experiences recounted.

Kirat's work involved conducting 47 semi-structured interviews to elicit narrative accounts. Participants fitted within the UK government's category of low income households and had been resident in the UK for up to seven years at the time of interview. They were recruited from a number of locations, including community projects, places of worships, educational institutions, a workplace and a clinic. In these interviews participants (or their dependents) who had been recently ill were asked to reflect on their experiences of using primary and secondary health services in the recent past. The analysis did not look for or conclude that there were binaries of positive or negative experiences, but this paper focuses on the dissatisfaction articulated by many of the participants. Analysis involved applying a framework of stigmatisation and discrimination.

Goffman's conceptualisation of stigma involved the categorization of people by applying false and negative attributes. Link & Phelan's concept of stigmatisation built on to Goffman's work, distinguishing between types of discrimination, and identifying five components of stigmatisation. The first two components were about the grouping and labelling of characteristics. The third was seen to be present when labelling progressed, possessing negative connotations and in so doing creating negative stereotypes. The fourth and fifth components were identified as discrimination and related to power structures that were needed for stigmatisation to occur.

Link & Phelan's framework was used to analyse the narratives in this study: Component 1 referred to the labelling of individuals as migrants which participants were asked about at the beginning of the meeting. Many participants perceived the term migrant as negative with undesirable connotations. Some healthcare staff saw negative stereotypes in participants, resonating in the descriptions of the participants' treatment in primary and secondary care. The third component, loss of status was felt and shown when participants talked about how negative experiences made them question their entitlement to healthcare. Discrimination, the fourth component, was seen in the explanations from a number of participants in which they used race, ethnicity, and immigration status to explain their experiences. Other explanations for discriminatory behaviour in their experiences referred to language, communication and lack of knowledge of staff.

Discrimination that occurred indirectly was considered through the analysis of the Overseas Visitors Charging Regulations. This policy has created a binary of 'ordinary resident' and 'overseas visitor' and a set of guidelines obliging NHS staff to identify patients in hospitals that could be charged for secondary care. A connection was made with participant experiences and this policy. Indirect discrimination that occurs though policies such as this also reflects the power structures that exist in healthcare. In this case, disciplinary power is used through the checking of immigration status of some patients in order to grant entitlement to free healthcare. The ethical implications of giving treatment only after entitlement is known or a willingness to pay is assured (in a system that is otherwise free to residents) have been largely ignored or are not considered valid reasons for changing the policy by policymakers and politicians.

This research involved participants who were less likely to participate in common healthcare research. Through narratives and using inductive methods of analysis, this study has brought to light the susceptibility of people who are categorised as recent low income migrants to discrimination. To further develop this research other methods could be used such as ethnography during the receipt of healthcare or by large scale surveys focussing on particular themes or systems of the NHS. Further work on the Overseas Visitors Charging Policy would also provide more evidence of the way indirect discrimination can operate through policy.

Kirat Randhawa has worked in a variety of community health practitioner jobs on issues related to mental, physical health and social welfare with vulnerable or marginalised people. She was the successful applicant for the ESRC case studentship award to study migrants and health in the UK and completed the MSc in social research methods in 2009

'A Moving Heart': Everyday suffering and a dilemma of 'immobility' in Afghan migration

Niki Khan

Niki Khan has carried exploratory multi-sited ethnographic research in Brighton and Peshawar. This research has been in partnership with the Community-University Partnership Programme at Brighton University focusing on the experience of Afghan migration to Brighton. Niki argues that this work is theoretically important as it challenges the dominant conceptualisations of Afghan migration in context of asylum claims and performing political and economic roles in reconstruction as diaspora. Niki is trying to present the experience of migration of a little researched Afghan Pashtun community, outside of these frameworks and rather, considers their 'everyday suffering' ('Khapa'-Pashto; 'feeling down') which has impacted their transnational identity and feelings of immobility alluding to a more a more chronic experience of ongoing crisis.

The theoretical underpinnings of Niki's work lie in the understandings of migration, subjectivity and techniques of labour exchange through anthropological theories of affect, and emotive imagery. Theories used included, the political economy of labour, Harvey's spaces of home, and concepts of hope, as defined as a tactic to bypass suffering of the present.

The case study Niki uses to illustrate her research was primarily with 'Zmarai' a Brighton taxi driver, who immigrated to the UK in 1998 as a result of war and open door asylum policy of the 1990s. Initially, Zmarai initially worked in a take-away restaurant, which he later owned with his brothers. This business was then sold prior to becoming a taxi driver. Through his work he and his brothers were able to send home remittances to his family residing in Peshawar as permanent refugees. Remittances were instrumental in safeguarding the reputation for the family in the UK and those on the receiving end, justifying the cost of their migration. This particular type of migration established a transnational family based on exchange, yet also giving a measure of distal autonomy to the remitting subjects.

For five years, however, Zmarai has been unable to work as a result of hopelessness and depression, referred to as *khapa,* which in turn has impacted his transnational family, having not visited them in a few years and failing to send remittances. There were multiple reasons why these feelings of *khapa* may have emerged, and symptoms could arguably be indicative of Chronic Depression and PTSD. Niki further evaluated his dreams of escape and freedom from reality as a means to create positive space for mitigating and critiquing the strain of his daily suffering. Referring to his life, which has been conceived as a result of movement, his current immobility may signify the hope of being able to change and adapt life differently from the transnational context.

The questions posed as a result of Zmarai's situation, refer to his immobility and its role in recalibrating 'oppressive realities of spaces of hope or autonomy'. It also asks one to consider how migrant mobility subjectivity may challenge the conceptualisation of political and medical spaces of power.

This research realises the importance of recognising individual experience. By looking at individual lives and crises, one can become more aware of the surrounding structural matrices of power and politics.

Relating this work to the broader community context one can begin to look at how methods of community engagement by the council may work to subjectivate migrants within technologies of citizenship in an over-determined political context. This has arguably been emphasised through the Afghan migrant community to reject English models of integration and bring the community together through their own means and initiatives.

The main thrust of Niki's work has considered the coping and survival strategies for one Afghan migrant living in Brighton. This work has highlighted that the conventional category of personhood can be problematic. It questions, to what extent, in an over-determined political context, Zmarai's illness is a refusal or resistance to be subjectivated in discourse. Whilst critiquing the models of personhood, Niki also recognises challenges in using any model to understand experience, but that in rejecting models, there is difficulty in linking such experience to policy, thus calling for new means to communicate such issues effectively.

Nikki Khan is a lecturer in Psychology at the University of Brighton. Her current research explores Afghan migration, diaspora and transnationalism, affect and subjectivity- following Brighton Afghans to their 'home' communities in Pakistan (Peshawar) and Afghanistan. In 2011 she received a sabbatical award to develop links between the University of Brighton's Community-University Partnership Programme (CUPP) and local community organisations (Brighton and Hove council; Links Project; MIND) around issues of refugee/migrant mental health.

Discussion

Discussant: Elizabeth Challinor

In conclusion, to the first three sessions, Elizabeth Challinor rounded up the presentations, which were then further discussed amongst the participants.

In summary of Daniela DeBono's presentation on irregular migrants in Malta, it was recognised that some institutions trying to help detainees within a human rights perspective were under-politicized with a narrow focus on medical care whilst others were over politicized by ignoring health. Daniela tells us that the detention centres are not constructed to address health concerns, or to improve the quality of life of migrants: their main concern is state security. It emphasised that in the current situation, reports on migration detention centres appear to focus largely on the lack of freedom over health, in its broader conceptualisation, which would include well being.

The marginalisation of migrant health and stigma felt by migrants was addressed by Kirat Randhawa in the environment of the British health system. The overseas visitor charging policy in the UK analysed by Kirat reveals that not all suffering is recognized as "morally legitimate". Non-emergency health care has to be paid for unless one is an asylum seeker or refugee which related to Niki Khan's work on the narrow focus on trauma and war in the Afghan case in which the issues of stigma were further built upon, whereby we saw how Afghan refugees in Brighton, felt more comfortable organising themselves, rather than responding to services explicitly directed to refugees. Niki's work further builds upon the Afghan migrant identity, and argues for a necessity to extend the narrow, over-politicised, perception, that defines this group by experiences of war. In all three cases we hear of stigmatisation, categorisation, labelling, over determinations and a refusal to play identity politics.

This then led Elizabeth Challinor to quote Ticktin's study (2011) on "new humanitarianism" and the "imagined universal suffering body" (IUSB) which gives an excellent framework from which to discuss all three papers. Ticktin argues that the biological body is the lowest common denominator to qualify for universal personhood. It is imagined outside time and place, outside history and politics. There is an assumption that we can recognize suffering whenever we see it because it is located in our bodies, particularly bodies in pain. The IUSB is glimpsed in moments of crisis (the focus on trauma, war and emergency health care needs) so that interventions take place in the name of a moral imperative with the rhetoric of emergency. We see the "bare" life of a pure and simple sufferer in a moment of need and no one is seen to be directly responsible for the suffering. But the suffering body

must be seen as "morally legitimate" in order to be recognised as universal and worthy of being saved. Questions we need to ask are when and for whom does the body become the primary source of access to universal personhood and hence to care? Who decides? The asylum seeker does not qualify for free health care if his claim is turned down. What political choices may be uncovered behind use of the rhetoric of the morally legitimate universal suffering body? Some of them are voiced by the migrants interviewed in Kirat's study who are aware that they are seen as a drain on national health care resources. Only an emergency can be seen as morally legitimate. And what about the lack of separation of male and female detainees in Malta and the abuse experienced by female immigrants? Does the imagined universal suffering body have a gender? The failure to link lack of freedom with health issues means that the legitimacy of the detention centres themselves goes unquestioned: reproducing the hierarchy between civil and political rights on the one hand, and economic, social and cultural on the other. The cases highlight the need for a wider context of analysis beyond the obvious, the immediate and the urgent. To focus on war and trauma is to ignore the political economy of labour, to focus on the right to health and not on the right to life is to ignore the increasing tension between regimes of capital and of people. To quote Tictin again "capital circulates freely, people can't". These cases suggest that we can't talk about mobility without talking about immobility.

The case studies also highlight a need for a more integrated approach, which has the capacity to be conscious both of the inner perspectives, less visible, as well as that, which is more physical and obvious to the eye. Elizabeth, recognised the importance of the inner perspective within the research presented. For Daniela, the inner perspective could be harnessed through the long and in depth field work, as was evident in Niki's work, and through Kirat's research the voice of recent migrants was primary.

The association of individuals with particular categories was argued to be influential in relations with others and experiences of health. There is a need to consider complexity of individuals and different groups that cannot be so neatly defined. One needs to consider the social, political and biological body when addressing health, in recognition of complexity and wider relations. This needs to be in a form of digestible complexity, which enables complex issues to be more accessible, and in turn inform doctors and nurses with the information to enhance understanding and avoid discrimination they may have not been aware of making.

To conclude, these three presentations draw our attention to the danger of using the terms migration, mobility and global health as self-explanatory categories. We need to distinguish between their use in political discourses and in academic analysis. What are the consequences of overly determined explanations and labels? The presentations highlight the importance of striving for an insider perspective that does not bring migrants down to the lowest common denominator of the apolitical suffering body and that resists the temptation for labelling and explanatory closure by highlighting relationships and complexity.

Elizabeth then opened the discussion to the floor to further develop the concepts and understandings. It was suggested that this complexity could be translated to policy makers through use the in depth case studies to represent experience and be utilised as triggers to engage with particular issues. It was also recognised that these complexities, developed through constellations of power within the state, are created definitions of who is humanised versus those who are sub-humanised. Such definitions are then put into action by individuals from the bottom up, yet equally guided at the state level, hence a complex social justice agenda. Actors that may represent these hegemonic agendas on the everyday level may include doctors and nurses. This then extended to discussions on the powers of biomedicine, and how it is operationalised under the state agendas and actors who as individuals are also guided by their values.

Considering the recognition of the complexities of the migrant identity and the existing structural powers, the discussions were concluded by highlighting the importance of finding the appropriate means to translate findings to the appropriate language for policy makers and practitioners to effect change.

Sajida Ally

Emotion, Agency and Sexuality in Sri Lankan Migrant Narratives

Sajida Ally presented her paper on emotion, agency and sexuality among Sri Lankan migrant women, focusing on narrative and ethnographic analysis of their experiences in health. This paper is based on her DPhil research that was conducted in a predominantly Tamil-speaking area of Northwestern Sri Lanka—Kalpitiya. Within South Asia, Sri Lanka sends the largest number of female economic migrants to work abroad largely in domestic labour, a sector that generates the second largest source of GDP in the country through remittances. Kuwait, which receives the second-largest number of Sri Lankan migrants, served as her secondary field site.

Her paper focuses on what she describes as a sexualised discourse on women's migration for domestic work, as the actions of mobile Sri Lankan women challenge normative views of sexual morality, as argued by Lynch (1999). Her analysis responds partly to binary images generated by the media, advocacies of human rights organisations, and gendered and feminist analyses of migrant domestic workers. While the economic necessity of women's transnational migration is widely upheld, its social and moral consequences remain issues of contention, particularly in terms of its transformative impact upon sexuality. Using Cantu (2009), Sajida describes sexuality as a dimension of political power that needs to be considered in analyses of migration.

Sajida's ethnographic analysis was presented through one of her in-depth interviewees, 'Amina', a mother of three sons who had migrated to Kuwait after her first husband had died in the ethno-political conflict in Northern Sri Lanka. Amina's narrative conveys a clear conflation of her emotional, financial and cultural motivations to migrate, and how these transformed in the course of migration. She gradually transforms from being in a state of bereavement, to one where she develops feelings of attraction for a new man, whom she courts while working in her employer's home and eventually marries. Amina discusses how her second marriage 're-humanised' her following her

'dehumanising' experience of widowhood. Also from her narrative, it became evident, that Amina did not relate to her health (her chronic migraines and back pain) solely in terms of her biological body, but in relation to her emotional pain, her sense of 'hope' in what her future holds and her 'faith'. Her pain is presented in negotiation with Amina's moral image as a 'good woman', a successful wife, mother and breadwinner.

Sajida discusses how health, sexuality and morality arise in her case study narratives in relation to notions of agency. Using theory developed by Mahmood (2001), Butler (1997) and Unnithan-Kumar, she asserts that even under subordinated conditions, women can find particular ways to exercise their agency. For example, in these women's choice to migrate, they often secure hope, aspiration and inspiration, and these expressions may be considered as forms of agency. Various women migrating expressed agency differently, ranging from redefinitions of personhood through their spousal relations, to transformations in self through divorce, re-marriage or setting up their personal business. Sajida argues that despite the varied effects of migration upon women's sense of self, women were nonetheless able to act as moral agents engaged in processes of making a more embodied self as they hoped for change in their lives.

The research presented by Sajida highlighted the importance of understanding health through representations of daily experiences and sexuality as an axis of power that organises women's processes of self re-making. She suggests that her 'embodied' and emotion-focused approach to transnational migration provides a more complex and nuanced view of both agency and migration that breaks down binary categories of migrant women being 'victims' or 'agents'. Recognising the difficulty in quantifying data on emotion and presenting it in a language understandable to policy makers, she suggests that in-depth ethnographic approaches could be situated alongside quantitative data to create more effective ways to communicate to different audiences.

Sajida Ally is a fourth-year DPhil student in Anthropology and Migration Studies at the University of Sussex. Sajida's doctoral research focuses on the psychosocial health of transnational, temporary domestic workers and how it is influenced by socio-cultural, economic and political conditions. Towards the development of the Sussex Mobilities and Health Group, she will bring her experience as an ethnographer of migrants' psychosocial health and socio-cultural change, as well as the skills she has gained through her work experience in migration policy advocacy and organizational/network development.

Ageing in the ancestral homeland: ethno-biographical reflections on emotional well-being during return migration later in life

Anastasia Christou

Anastasia Christou carried out life history research with first and second generation Greek Danish migrants. The research covered a number of themes including, gender, ethnicity, and racialisations in spaces of everyday life in Denmark. This data collected was further situated within the field of cultural geography and the emotional/embodied turn in qualitative research reflecting on feelings of belonging and displacement within cultural geographies of transnational mobility. This research was carried out at a significant time for migrants in Denmark, in the midst of a significant rise in xenophobia and racism following the election of a conservative government on the basis of an anti-immigration political campaign. The content of this work largely considered the embodiment and emotional representations of translocal and transnational lives and how this was reflected through everyday experience.

Anastasia's work is particularly ground-breaking, being the first ethnography on the mobility of Greek Danish migrants in Denmark. Through its depth, the research developed a matrix of different types of migration, including labour migration in the 50s and 60s, political refugees and migration for personal reasons such as, education, love or marriage. A typology of migration was further considered in the context of other aspects of one's identity, including gender, class, age and 'race'.

It was also presented that research was ground-breaking in other aspects, namely in its attention and value given to ageing oral histories. Giving further understandings to the development and fluidity of lived identities and how they are reconfigured over the life course, particularly as they return to Greece in later life.

In order to further develop this research, suggestions were made to consider migration in a context of contemporary crises within Greece, Denmark and Europe. Furthermore, to enhance research, suggestions were also made towards extending it to multi-sited research.

In applying this research to policy, it was felt that this particular study could enable, greater understanding of the mobility of care, and awareness of the social capital of aged migrants on return to home countries. This could therefore have implications on medical care, pensions and taxation for those migrants of retirement age.

Anastasia Christou is a lecturer in Cultural Geography, researching within critical perspectives and an interdisciplinary approach to social and cultural theory. In relation to the 'health mobilities' group she aims to further develop qualitative/ethnographic/narrative research on the emotional (health/well being) and embodied aspects of migrant/transnational lives/ageing/caring as well as trauma and non/belonging in diasporic spaces.

Discussion

Discussant: Hayley MacGregor

Our second discussant, Hayley MacGregor an IDS research fellow, further reflected on both the research presented by Sajida Ally and Anastasia Christou.

Remarking on Sajida's work on Sri Lankan Women Migrant workers, the transformative nature of migration was recognised. It was felt that in using the agency to migrate, women developed tarnished representations and consequentially entered a sexualised discourse. This work therefore highlighted, the necessity to break down the dichotomy of women existing either as victims or as agents, and rather consider their potential to exist as both. In considering these identities, it draws into question how can one strategically engage with how it is shaped.

It was found that even in actively shaping ones identities and daily activities, there were constraints and that, in migrating, one was creating space for hope and change whereby identities could be reshaped and developed. It was found however, that in migrating and redeveloping identities, it put one in a position that challenged their identities and their integration in either the host or source location.

The theme of double meanings and experiences were also presented in this research, whereby individual words could have dual meanings, referring to both emotional and physical pain, and so highlighting somatisation and a sense that the language and culture unifies the language of emotion and ones bodily experience. These were reflected in how the women described themselves and their health and particularly sexuality in context of their complex identity as both victim and agent. In context of policy, it was suggested that this research highlighted issues of transnational care economy and that there is a need to reconsider the dominance of medicalized language**.**

In reference to Anastasia's work, again, it relates to transnational care and reshaping of identities, however this is with emphasis on the life course, ageing and nostalgia. The research considers how identities change as they move from home countries of Greece to Denmark, then returning to Greece. It consequentially raised questions, over whether, when this movement is made on return, did people still feel as though they belonged? These identities are made in context of hostile political spaces, and draws into question, whether, ones identity becomes crystallised in these situations, and in turn contribute to the mythologizing of place.

The policy issues that emerged from this research, referred to how migration status impacted access to health care, particular in context of older generations who have hybrid identities, developed over different spaces and time.

In further discussion open to the group, the main issues emerging resolved about wider structural limitations in context of global crises and state responsibilities to the individual and their health, In turn this extends to individuals being aware of their rights and rules and regulations in place as well as responsibilities of communities. Language was also explored, particular through the limitations of medicalized terms and the needs to explore meanings of language further which in turn may enable one to see beyond strictly defined binaries and labelling, which in themselves may be restrictive of ones understanding of key issues.

Hayley MacGregor, originally trained as a medical doctor in South Africa, pursued further studies in Social Anthropology, completing a PhD at the University of Cambridge in 2003. This doctoral research pursued an interest in medical anthropology, in particular mental illness and mental health service provisioning in post conflict and low income settings. A subsequent period at the Human Sciences Research Council of South Africa broadened her work to address changes in social security provisioning in the event of illness, and the politics of 'disability'. Current research interests include the dynamics of poverty and illness/disability, human rights discourses and citizen mobilisation in the context of health provisioning, and the ethnography of biomedical research and health technologies

Towards a Transnational 'Caring' Response to Suffering

Gillian Bendelow

Gillian Bendelow is a medical sociologist, who has worked for many years in the field of chronic illness and pain, developing a sociological understanding to suffering and humanitarianism. Using theory driven research, Gillian's work aims to highlight the limitations of biomedicine in this arena of healthcare practice and to develop integrated approaches which may range though, philosophy to neuroscience. As a working concept 'care' is undertheorised and we need to understand how caring is intertwined with emotion and embodiment, using sociolological insights from health and illness, the body, emotion, suffering and extending to feminist and postcolonial social theory and global health.

Key to this process is the dissolution of the unhelpful divisions between mental and physical health which in turn creates polarised divides between mind and body. A more sophisticated understanding of emotion as the link between mind and body along the continuum between the biological and social allows us to understand that whereas emotions have biological substrates related to instinct and survival, they are nevertheless socially shaped by social hierarchies and relationships. Thus the nature of this 'emotion work' that we perform on ourselves or others is highlighted through integrated or interactive accounts of emotion, as championed by Hochschild (1983, 2003), and has implications for understanding our responses to pain and suffering in ourselves and others.

This approach challenges the tendency for biomedicine to be dominated by Cartesian dualism, that does not allow one to focus on the phenomenological and chronic experience of suffering, but highlights pain in terms of acute physical or *nociceptive* experience. Referring on to the socio-cultural metaphorical aspects of pain, the research highlights the importance of the concept 'total' pain (Saunders 1974) A practical means to address this limitation is through Value Based Medicine, which is able to utilise phenomenological narrative accounts in healthcare, practice and treatment in order to complement Evidence Based Medicine and thus develop more holistic person-based approaches in healthcare.

Inevitably, this leads to a moral discussion of how compassion emerges. In what situations should one intervene with suffering? How do we develop concepts of deserving and non-deserving? In analysing compassion it is also relevant to understand the people who do the 'caring', for instance at the phenomenon of so-called 'compassion fatigue' whereby suffering can be ignored, or even seemingly incomprehensively deliberately perpetrated.

Models of Emotion (Bendelow 2009)

BIOLOGICAL ←→ SOCIAL

Organismic	Interactionist	Social constructionist
Biological correlates, ie causes of emotion 'wired in' via brain for instinct / survival	Social correlates, ie causes of emotion found in relationships but **have embodied expression**	Emotion not a 'thing' but is invented and expressed in differing social contexts
BIOLOGICAL (primary)	SOCIAL (primary)	SOCIAL (primary)
SOCIAL (secondary)	BIOLOGICAL (secondary)	BIOLOGICAL (irrelevant)
Emotions are universal across cultures	**Emotions have biological substrates but are socially shaped therefore subject to hierarchical manipulation**	Emotions are culturally and contextually relative

Gillian Bendelow is a Professor of Medical Sociology in the School of Law Politics and Sociology. Before entering higher education as a mature student, she worked in London's East End as a community psychiatric nurse. Gillian has made significant research contributions to the fields of chronic pain and 'contested' illness conditions; mental health and emotional wellbeing; health promotion and lay concepts of health and illness. She is author of Pain and Gender (Pearson Education 2000), Health Emotion and the Body (Polity 2009) and co-author of The Lived Body (Routledge 1998) as well as many edited books and journal articles.

Poverty Impacts of Migrants' Out of Pocket Expenditure on Health

Priya Deshinkar and Matteo Sandi

This presentation offered a combination of social and economic analysis when considering the relationship between migration and out of pocket expenditure on health. The focus of the research was on internal migration (within national boundaries) in India based on data from the nationally representative National Sample Survey of 2007-8, which is detailed below

It was recognised that the relationship between health and migration is complex with both negative and positive outcomes possible. The data shows that migration does improve expenditure on health for some categories of household. However, the overall impact of migration on health is determined by the many risks that they are exposed to during the migration journey and at destination due to hazardous working and living conditions. Commonly, migrants from rural backgrounds with low literacy skills were employed in the unregulated informal sector, thus exposing them to hazardous working conditions. Furthermore, many lived in slums which in themselves have multiple health risks, ranging from issues of sanitation to overcrowding. It has also been recognised that for many lone migrants, being away from ones family and thus family regulations may increase ones susceptibility to risky behaviour.

Compounding these negative factors is the use of unregulated private health providers, which are often more convenient and accessible for the urban poor. Therefore, an increase in disposable income, which could be used to spend on health care, doesn't necessarily correlate with better health. It was suggested by Priya Deshingkar that further research is required on how out of pocket expenditure on health impacts on migrants and their families.

Matteo Sandi elaborated on the analysis of quantitative data. This data was collected between 2007 and 2008, in a nationally representative survey, posing questions about household members and expenditure. There were two aspects to observing the expenditure behaviour. These aspects were observing difference as according to social groups and through comparisons of migrant and

non-migrant households. The findings showed that, in urban areas, the positive difference between the marginal shares of expenditure on health of households with migrants and those of households without migrants were higher than they were in rural areas.   The results show that as a consequence of the migration experience of one or more members, Indian households tend to accumulate more human capital than households without migrants do, as they devote higher shares of marginal expenditure to the health conditions of their members. The reason for this could simply be the exchange of information with the migrant, who encourages origin family members to invest in human capital; or, the joint combination of information from the migrant and the hard living and working conditions of the migrant away from home. These two elements, taken together, may play a significant role in making origin households more concerned with health issues than they would be otherwise.

Questions were raised as to whether this was an indicator of an unmet need for health care in rural areas, but equally highlighted risky spending on private health services in the urban areas.

In response to the research it was suggested that it may be necessary to improve regulation, particularly in urban areas to improve the quality of health services, and better education of migrants may inform groups on health risks and access to health care and equally create the potential to enable access to less hazardous jobs, and better incomes.

Priya Deshingkar is Research Director of the Migrating out of Poverty Research Consortium and Senior Research Fellow in the School of Global Studies, University of Sussex. Priya is interested in two dimensions of migration and health a) the impact of migration on health. b) out of pocket expenditure on health among poor migrant households and the implications of this for poverty reduction. She hopes to develop both themes of work further through the health and mobilities group.

Matteo Sandi graduated in Economics in Milan in 2009 and completed a postgraduate programme in Development Economics at the University of Sussex in 2010. He started exploring the important issues related to social and geographic mobility and their links to economics in his MSc dissertation; since February 2011, he has been working for the Sussex Centre for Migration Research, exploring the impact of migration on poverty and Investment behaviour in Africa and India. Currently enrolled in a DPhil Economics programme at the University of Sussex his research focuses on the mobility that took place in Indonesia in response to the East-Asian crisis in the late 1990s.

Migration, Mobilities and Global Health: The Global Governance of Circulation

Stefan Elbe

Stefan Elbe joined the Department of International Relations at the University of Sussex in 2004 where he has served as Head of the International Relations Department, and as Director of Research in the School of Global Studies. In terms of the Migration, Mobilities and Global Health Group, Stefan could contribute in a number of areas. He can provide insights and understanding about the role of international organizations and the international systems in the area of global health, and how this might be relevant within the context of migration. He also has a background in theories of governmentality, biopolitics, circulation, risk, and other theories that may be relevant to the conceptualization of any future projects that the group may wish to undertake.

Stefan Elbe, coming from a background in International Relations and Global Health background, has drawn links between his work within this field and that in migration and mobilities.

The dominant research that Stefan has carried out in the relevant field has been on HIV/AIDS and security, particularly considering the politics of securitizing the disease, which developed further to explore areas such as pandemic preparedness, bio –terrorism and lifestyle diseases. In the context of these interests, combined with those of mobility, it one particularly relevant - but also politically sensitive - area of concern is the spread of HIV through the mobility of people. In the context of security, mobile populations may refer to the military population or mass movement of people in conflict zones.

From the perspective of migration, an interesting aspect of Stefan's work has been to consider the migration of disease, rather than just that of people. This raises further questions about the migration of disease external to anthropogenic means of movement, and therefore highlights the need to explore the risks and spread of disease through other, multiple channels.

The theoretical approach that Stefan has taken in his work refers both to security studies and wider concepts of movement. Combining these two generates novel insights in the disciplinary context of International Relations, which is classically fixed and bordered. Rather, this approach to security analyses how movement and flows are secured. This may be placing attention on a number of different flows, ranging from biological and professional human bodies, to diseases and medicine.

In conclusion, Stefan Elbe's work emphasised the interdisciplinarity of the Global Governance of Circulation. The international governance architecture needs to be explored in relation to the complex interactions of migrations, motilities and global health, and who holds the power in managing appropriate policy responses. This way one can begin to highlight the level of accountability, justice and equality in health.

Discussion

Discussant: Mike Collyer

In responding to the session, Mike Collyer made a response to the research presentation, which then initiated a further response. The three presentations of the session covered numerous themes, ranging from the narratives of pain and suffering to the migration of non-anthropocentric aspects of health such as viruses.

In reflection of the multiple approaches to the workshop's theme, there was a realisation that the relevance of the link between migration and health may incorporate numerous factors. In Priya Deshingkar and Matteo Sandi's work, it was evident that because of migration, individuals faced particular risks. Commenting on this Mike, referred to the particular risks faced through the routes of migration, namely those done clandestinely. Linking this to Gillian Bendelow's work on compassion, Mike asked whether those who take a particularly risky route of migration are less entitled to compassion. Furthermore does this compassion lie nationally or internationally. Incidents that may lead to injury through migration may not just include risky passage but also due to interaction with racist peace keeping forces or border control. In general it was recognised that migration it self was potentially risky. Referring to Gillian's work, there may be a variety of cultural understandings of pain and suffering as according to different groups and contexts, which in turn may impact the response and compassion. There were also references made to the link between migration and health with reference to military, politics and the migration of health care workers, thus emphasising the existence of a variety of links from a range of perspectives.

Mike also explored how one may link theory to policy. Throughout the presentation, numerous theories were referred to, including, feminist theory, practices of embodiment, bio politics and the spacialisation of state authority at the level of the individual. In considering this range of lenses, the concern was on how one could frame the research to be relevant and understandable so that it may drive and influence policy.

Opening the discussion to the floor, Priya highlighted that her research had a theoretical framework referring to underlying notions of entitlement and capabilities, which, furthermore, were related to governance of health care provision. Questions were also raised regarding the healthy migrant effect and whether there was a time lag before the positive impacts of migration were felt after initial migration. The response suggested that this would be a potential field to explore in the future. It was also suggested that it might be interesting to see how out of pocket expenditure on health may impact poverty.

It was then highlighted that even when access to public health services of a good standard, one may not necessarily reduce spending on private health, thus recognising it complex nature.

The concepts of compassion were also built on, referring to human rights and how it has been described as the language of compassion. In response to compassion, Gillian spoke about concepts of the Other. The ideas was that compassion could be influenced by the othering of certain groups, evident particularly through post-colonial notions that those 'closer to nature' would be more resilient to pain. Globalisation and interconnectivity of the world was also referred to with regards to generating global compassion. There was recognition of the media package of suffering and how this impacted compassion. It was also highlighted that from this there may also be risks of compassion fatigue, now that it is much more feasible to have access to suffering beyond international boundaries.

The governance of health was also discussed, commenting o the power of international bodies such as the WHO, who in the past have applied successful frameworks to respond to certain health issues, such as SARS.

Mike Collyer is Senior Lecturer in Geography. He convenes the MA in Migration Studies and the DPhil Programme in Migration Studies and is currently School Research Ethics Officer in the School of Global Studies. He recently completed a three-year Marie Curie Outgoing International Fellowship, based at the University of Colombo, Sri Lanka. He was previously a Nuffield Foundation New Career Development Fellow at Abdelmalek Essaadi University in Tétouan, Morocco. He completed his PhD, on the dynamics of the Euro-Algerian migration system, in 2002.

Cape Verdean Migrant Subjectivities, Maternal Health and Body Politics in the Portuguese Health Care System

Elizabeth Challinor

This ethnographic research was based in Portugal amongst young women student migrants from Cape Verde, who had fallen pregnant, a number of which unplanned, and explored their relation with reproductive healthcare and the surrounding gender relations. The fieldwork of this research has been carried out since 2008 and involved accompanying women to social workers, immigration officers and carrying out in-depth interviews. The aim was to produce a unified framework of analysis through an ethnography of reasoning grounded in the women's embodied responses to family relations and state practices and policies.

The theoretical background of this research considered the social and biological body, Foucault's concepts of governmentality, and the existence of different knowledge systems. There was reference also made to stratified reproduction as a theoretical framework, which considered how some individuals were comparatively more empowered in their reproduction. This research considered notions of normality and pathology, focusing in particular on the notion that Cape Verdean students did not have the 'right' to become mothers, and how this contrasted with the mobilisation of new social identities and subjectivities experienced by the students as a result of their pregnancies.

A key part of this research was an attempt to conduct an ethnography of reasoning by taking recourse to Archer's (2000) notion of the "inner conversation", which is made up of the thought processes that perhaps are not discussed out loud but have significant impact upon women's choices and decisions. Through carrying out in-depth interviews, one is able to engage with the inner conversation and thought processes and thus understand the variety of pros and cons attached to these individual's commentaries on their lives. Elizabeth also highlighted the importance of focusing on the links between individual, social and politicized bodies.

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Elizabeth Challinor is senior associate researcher at the Centre for Research in Social Anthropology (CRIA/UM) in Portugal. She has carried out research on Cape Verdean women's experiences of maternity and motherhood in Portugal since 2008. Elizabeth's contribution to the health mobilities group will be to bring a phenomenological perspective to migrant women's experiences of health services - sexual health, maternity, and paediatrics - in a European country (Portugal), as well as practical experience in intercultural competency training for health professionals and cultural mediators

Midwifery, maternal health and shifting locations of birth among first nations people in Canada

Rachel Olson

Rachel Olson's research explored on going relations between state, mobility and the peri-natal period. More specifically this looked at the impact of maternal evacuation in first nation mothers, specifically located in Manitoba. Maternal evacuation refers to the laws that require pregnant women in rural remote areas to be sent unaccompanied to hospitals in the city at 36 or 37 weeks. The only occasion when a woman can have an escort is if they are under 16 or have some form of disability. The research explored this experience from numerous angles and sites, ranging from the hospital, Manitoba and the boarding homes where the pregnant women stayed prior to having their babies.

It had been recognised that this movement caused stress and was resisted by many of the women. This resistance, manifested through different emergency strategies by the women such as running away from the boarding homes, only to return to nurse-post when it was too late to be evacuated to the cities. In consideration of this resistance, research had attempted to assist in implementing an aboriginal midwife to work in the indigenous community to prevent the significant upheaval during pregnancy. Currently aboriginal midwives work in 6 communities whilst the remaining 500 aboriginal communities have to be evacuated for the birth process.

Politics of the land determine the distance that the pregnant women are evacuated to, as according law, Indian reserve land is considered Crown Land and therefore the federal government are responsible for the people and land within it. Therefore as the Indian community in these locations are federally controlled rather than provincially controlled, there is a need to relocate to more centralised areas, and hence the movement of pregnant women out of reserve areas, for the process of giving birth. Provincial midwives that live on federal land and therefore challenged by the state's relocation laws. Different notions of the body, impact the attitudes different groups have to the evacuation period. For the federal state, evacuation of the women is a form of risk management, whereby they believe that they are moving bodies from unsafe, low technological areas to safer areas with access to medical technologies. It has been noted that here exists

a strong focus on the biological model of care, with less attention given to ones cultural emotional body, which is forced to leave other children, spouses and families behind. For the aboriginal women's, this movement creates a significant upheaval, discordant with their culture and mental health around childbirth.

Rachel Olson's research has highlighted the necessity to give aboriginal midwives a more dominant voice that can be heard at different government levels. Through the use of the aboriginal midwives, communities can be empowered, and respected in the birth process and allow for the continuity of their culture.

Rachel Olson is a citizen of the Tr'ondek Hwech'in First Nation from the Yukon territory, Canada. She has been conducting research in First Nation communities since 1998, working on various projects from oral history, traditional land use, natural resource management, to First Nations health issues. She is a Director of the Firelight Group Research Cooperative, and is currently in her final year of the DPhil programme in Social Anthropology looking at the issue of maternal health and childbirth in Manitoba First Nations communities.

Understanding Health Inequalities through Migrant Mothers' Accounts of Birth and Loss

Maya Unnithan

Focusing on migrant women's reproductive experiences in their move from rural to urban slums in India between 2002 and 2005, Maya Unnithan's work has explored how decision-making regarding child health and reproductive health takes place. Migrant health-related decision making as well as their health seeking behaviour are influenced by numerous factors, ranging from the perception of space as therapeutically constituted, to notions of legitimacy that underpinned migrant engagement with health services. Maya's work highlighted that the challenges migrants' faced in terms of access to healthcare went beyond merely physical and infrastructural provision. It was important to understand specifically migrant perceptions as they underlie agency and explain choice.

Drawing on case studies which considered the movement from rural to urban locations, Maya found that there were mixed responses with regard to the health benefits of moving to the slums of the city. For some, these slums, offered better prospects for employment and consequentially an income, to feed the family. For others the slum represented a place of squalor and health dangers. The perspective of place as connected with the ability to mother were of high importance, whereby, those women unable to provide for their children or had experienced child loss, felt a sense of personal failure and a loss of personhood.

Maya went deeper into the rural-urban binaries of migrant perceptions of the slum as being dirty and unsafe to give birth in, in comparison to rural locations. For several women travelling back to their villages to give birth meant they could avoid discrimination from medical professionals and avoid state surveillance (of their bodies as conforming to family planning policies). Discrimination against poor women, including migrant women existed in the public health setting, whereby these women would often be sterilised at the time of giving birth. On the other hand, the benefits of giving birth in the urban areas were to be found in the expanded choice of private and faith healers, enabling women to exercise a form of agency over ones own body. The appeal of faith healers were manifold,

including the consolation received by women who experienced child loss. The use of faith healers was also seen as a means to support but also challenge male control over reproduction as well as the power and discrimination of the state.

The research highlighted migration as a gendered and embodied process, which for women commenced at marriage. Intimately connected with poverty, migrant movement reflected 'structural violence' (Farmer 1998, 2004) with emphasis on the more systemic inequalities and their production. It also drew on the theories of reproductive stratification (Collen, Ginsburg and Rapp, 1995, Browner and Sargent 2011) wherein 'some people's reproduction is valued and others' not'.

This research could be pivotal in helping policy makers aware of women migrants' needs and looking at what lies beneath the statistics on maternal and child morbidity and mortality. Taking the research on migrant health seeking behaviour forward to policy, it could be used to inform meaningful and effective health programmes and frame understandings of migrant-centred rights in the domain of health policy.

The data could also be utilised to reflect on newly instituted safe motherhood programmes and on the practice of medical professionals working with this population. It would be necessary to incorporate men's reproductive health into such future studies and also acknowledge the role of state-civil society collaborations in the area of migrant health.

Maya Unnithan is a Reader in Anthropology, and a medical anthropologist with a specific interest in human reproduction, childbirth and maternal health. She has carried out field research in NW India on health issues since 1998 and worked on the role of emotion, notions of reproductive entitlement, social aspects of technology and meanings of place in migrant sexual and reproductive health. Her current research, funded by the Economic and Social Sciences Research Council (ESRC, UK), focuses on State and NGO engagement with global human rights discourse in the fields of sexual, maternal and reproductive health in India.

Discussion

Discussant: Laura Griffiths

Laura Griffith is a Senior Qualitative Researcher in the Health Experiences Research Group in the Department of Primary Health Care at Oxford University. Laura's research interests include qualitative research into personal experiences of health and illness, especially in the field of mental health and the provision of health services to address social inequalities. Laura did her DPhil concerning the emotional experiences of Bangladeshi mothers in the East End of London.

The common theme between the three research presentations was around choice. Choice had been looked at through a number of angles, with particular attention given to how it is conceptualised and constructed. Within Elizabeth Challinor's work we saw an ethnography of reasoning which encompassed choice of contraception in context of cultural values of extended mothering, and being a young Cape Verdean mother in Portugal. For Rachel Olson, choice was explored through the notion that one was disempowered in their choices regarding childbirth. Maya Unnithan's work drew similarities to both of these aspects of choice, focusing on how entitlements to health are conceptualised, and which choices have positive outcomes.

With each piece situated within specific locations and contexts, understanding could be further enhanced through understanding of Paul Farmer's work and structural violence. Through approaching work through this theory, one can enrich research through exemplifying the intersections of inequalities. In extension of this theory, suggestion were made to adopt a lens that was conscious of the geopolitical notions of birthing, whereby certain people are pathologized and others are not. For example, post colonial management of birth in Canada's reserve could be referred to, noting the evacuation of aboriginal mothers to be from unsafe reserve to the safety of the city hospital. Maya's work also extends on the notion of safe and unsafe locations. There is a need to combat inequalities, but in doing so there needs to be further understanding on ones conceptualisations of experience in relation to axis of power, and concepts of change. In doing so, one also needs to extend the experience of reproductive health from exclusively being a woman's issue to one that is also conscious of the influence and participation of men.

In further discussion with the group, place was highlighted as a having a big influence on migrant experience and that movement had circulation thus extending from the binaries of leaving and coming to an area. Language and cultural barriers were also significant. It was emphasised that translation for migrants would need to exist in terms of both language and culture. In doing so, effective engagement with migrants can occur, which may enhance understandings of coping strategies. Coping strategies that were prevalent in the studies were an avoidance of state health services, thus emphasising an overwhelming sense of stigma and discrimination within the system, which needs to be addressed.

Plenary and Key Messages

Chair: Gillian Bendelow

The concluding plenary reflected on the key messages and themes of the workshop, allowing every participant to share their thoughts on the proceedings of the day and with regards to future research for the Migrations, Mobilities and Global Health network.

The key themes are summarised thus:

-**Issues of access to healthcare and the need for research to focus on making health services more inclusive to the marginalised.**

Discussion encompassed a range of themes across human rights and health inequalities. It commented on the theme of migrants' rights to health and the inequalities that are faced by different categories of migrants relating to their varied social, political and economic conditions and depending on the countries in which they are located. Sajida Ally highlighted how even documented migrants experience barriers to accessing health care, with these barriers being far more pronounced in host-countries where migrants' 'right to health' was barely recognised (e.g. the Gulf states). Within the global migrant population, there is a multitude of differences regarding notions of 'deservingness' for health and social care. While some groups may be perceived as having a legitimate need for health care, others could be perceived as a security risk for the rest of the population. Laura Griffiths raised the importance of culture and values in concepts of health and illness, for example in the definition of able- bodiedness and the ability to work, which may not fit with traditional biomedical categories. Discussion developed further as follows:

-**Sensitivity to vulnerabilities and fragilities of migrants as research subjects whilst avoiding stereotypes and consequential stigma.**

Many examples from the presentations and discussions, such as Yasmin Alakhansa's work with UNICEF in Iran with Afghan migrant children, involve sophisticated understanding of suffering and compassion. Hayley Macgregor raised the politics of framing ethnographic research and the need for sensitivity when deciding what aspects of these narratives should be used, and on what scale i.e. locally or nationally? For pressure groups, politicians, and journalists? There was much discussion of the value of qualitative, as well as quantitative research methods in context of their ability to reflect complex experiences, which led to the next important issue, namely:

-The need for qualitative research (e.g. ethnographic studies, illness narratives) to have more impact in policy making.

Laura Griffiths highlighted the importance of building in policy impact into all research design research and Saskia Gent, asked if research is for changing policy, then at what stage do we want policy makers involved? Different actors have different roles at the different stages of policymaking, and there is a need for appropriate policy language to be used, suggestions were made for qualitative research to act as case studies that policy or regulating bodies should respond to. In depth qualitative data may be instrumental in deciding which domains of care are important through the questions and routes of investigation they take. Methods of communication in policy may need to change to include qualitative data, and quantitative and qualitative data need to work in partnership so that the detailed data collected in qualitative research may be translated appropriately to the more dominant policy speak of quantitative data.

Kirat Randhawa added attention to the need of different actors in policymaking, and furthermore the different stages of its development. There was a realisation of the importance to recognise that research may not necessarily immediately impact policy makers. Research may develop and find synergy with other research and actors over time, building up arguments that may lead to policy change. Building on from this further discussion was formed as follows:

- When and how is the category of 'migrant' invoked?

Elizabeth Challinor drew attention to the distinction between normative and analytical categories and Maya Unnithan felt that the vexed question of the definition and conceptualisation of migrants was the final and highly significant theme of the day. Often characterised as a homogenous group, and only recognised in relation to security, how are distinctions made within health policy and healthcare? Using Cyprus as an example, research has revealed how Greek Cypriot refugees were prioritised and others not, and therefore there were a differentiation between these migrants over access to human rights and health.

Finally, the future of the working group was discussed with optimism, given its strengths in interdisciplinary, mixed methods and pragmatic collaborations and connections. Paul Statham reflected on the vibrancy of the group, seeing its potential to grow and develop alongside the Centre for Migration Studies.

Soundbites on policy and research potential from the presentations:

Policy:

'The use of rights to address migrant subjectivity- that leads to a sense of not being entitled.'

'How can policy matters gain a better understanding of migrants own interpretations of health, ill health and how can this result in a chosen match between official perception and their own.'

'Why are there no health services in Migration Detention Centres?

Increase response time to medical needs of migrants.

Mental health of migrants'

'How can we conceptualise 'well-being' whereas access to healthcare can be measured and outcomes assessed, how can well-being be reported?'

'Health as a human right

Deserving and non-deserving, impact on access for migrants'

Research:

'What can discussions amongst medical sociologists and anthropologist contribute to the cultural turn in human rights theory?'

'Develop methods to build policy relevant evidence on subjectivities related to health'

'Identify methodological approaches that are more legible for policy makers.'

'Need multi-method approach to inform policy practice through case studies/ narratives/ ethnographies.

'Framing human rights/right to health'

'Role of stigma in migrant health'

'How immigrant policy is experienced? Something that is bureaucratic can have another life when they are opertionalised.'

Thematic and Theoretical Underpinnings of Research at Sussex

- Critique of the dominant human rights approach to health.

- The experience of discrimination through health systems through the lens of constructivist theory and through frameworks of discrimination (UK).

- The understandings of migration, subjectivity and techniques of labour exchange through anthropological theories of affect, and emotive imagery.

- The transformative impact on normative views on sexuality of migrant women (Sri Lanka).

- Gender, ethnicity and racialisation of migrant populations (Denmark, Greece)

-Sociological aspects of suffering and humanitarianism.

-Consideration of the relationship between migration and out of pocket expenditure on health.

- Emphasis on the interdisciplinarity of the Global Governance of Circulation.

- Consideration of the social and biological body, Foucault's concepts of governmentality, and the existence of different knowledge systems, in context of maternal health (Cape Verdean migrants in Portugal).

- The relationship between state, mobility and the peri-natal period.

- Migrant perceptions of the efficacy and legitimacy of care.

Significance of the Research

- Highlights the importance of the broader conceptualisation of health as closer to the health concerns of migrant detainees.

- Taking narrative accounts from participants less likely to participate in common surveys.

- Challenges the dominant conceptualisations of migration in context of asylum claims and performing political and economic roles in reconstruction as diaspora (Afghan migrants to the UK)**.**

- Highlights sexuality as a key perspective to the axis of power with regard to emotion and health in the context of migration.

- The first ethnography on the mobility of Greek Danish migrants in Denmark.

- Aims to influence controversial medical practice through theorising care.

-Highlights that a disposable income does not necessarily correlate with better health.

- Consideration of the migration of disease beyond an anthropocentric lens.

- Raising awareness to the inner conversation and thought processes that may impact choices made with regard to health.

- Emphasis on reproductive stratification in choosing the location to give birth.

Areas for further Research

- To further develop research a wider range of qualitative methodology could be used such as ethnographies.

- Develop a means to translate experience and personhood to policy.

- Develop mixed methodology to present data on emotion effectively to policy makers.

- Consider migration in context of contemporary crises (e.g Greece, Denmark and Europe).

- Greater examination needed into how increased income and health expenditure can result in negative health outcomes for migrants.

-Further explore and critique the international governance architecture in context of migrations mobilities and global health.

- Raise attention to men's reproductive health issues.

How the research speaks to local and global policies

- Calls for international bodies to re-address the definition of health in human rights frameworks.

- Highlights the discrimination found in significant power structures that exist in healthcare such as the health tourist policy.

- Enable greater understanding of the mobility of care and the awareness of the social capital of aged migrants on return to home countries, having implications on medical care and pensions.

-Healthcare could be enhanced through working Value Based Medicine alongside Evidence Based Medicine.

-Suggests improvements need to made in regulating the quality of health services (India)

- Improvements needed on health system literacy, not just health literacy.

- Greater cultural competency, without reinforcing stereotypes.

- Highlighted the need to give traditional midwives a more dominant voice in the policies surrounding pregnancy (Canadian Aborigines).

- For Indian policy to further understand health, one needs to consider the impact of structural violence on choices, perceptions of health in relation to ones poverty, agency and inequality.

Contact Details

Participants	Organisation/School	Email Address
Yasmin Alakhansa	IDS, Sussex	y.alkhansa@ids.ac.uk
Sajida Ally	Global Studies, Sussex	S.Ally@sussex.ac.uk
Prof. Gillian Bendelow	School of Law Politics and Sociology, Sussex	G.Bendelow@sussex.ac.uk
Dr. Elizabeth Challinor	CRIA, Portugal	e.p.challinor@gmail.com
Dr. Anastasia Christou	SCMR, Sussex	A.Christou@sussex.ac.uk
Dr. Mike Collyer	SCMR, Sussex	M.Collyer@sussex.ac.uk
Dr. Daniela DeBono	Migration Studies, Sussex	danieladebono@gmail.com
Dr. Priya Deshingkar	Migrating Out of Poverty, SCMR	P.Deshingkar@sussex.ac.uk
Prof. Stefan Elbe	Sussex Centre for Global Health	S.Elbe@sussex.ac.uk
Saskia Gent	Global Studies, Sussex	S.Gent@sussex.ac.uk
Dr. Laura Griffiths	DPHPC, Oxford	Laura.Griffith@phc.ox.ac.uk
Dr. Pamela Kea	Anthropology, Sussex	P.Kea@sussex.ac.uk
Dr. Nikki Khan	Psychology, Brighton	Nichola.Khan@gmail.com
Chris Long	Sussex	C.Long@sussex.ac.uk
Dr. Hayley MacGregor	IDS, Sussex	H.Macgregor@ids.ac.uk
Rachel Olson	Anthropology, Sussex	R.Olson@sussex.ac.uk
Danielle Oxenham	BSMS	BSMS3025@sussex.ac.uk
Rebecca Pietrelli	Sussex	Rebbecca.pietrelli@gmail.com
Dr. Kaveri Qureshi	ISCA, Oxford	Kaveri.qureshi@anthro.ox.ac.uk
Kirat Randhawa	PhD Student Sussex	
Prof. Ben Rogaly	Sussex	B.Rogaly@sussex.ac.uk
Dr Fiona Samuels	ODI, London	1.Samuels@odi.org.uk
Matteo Sandi	Migrating Out of Poverty/SCMR	M.Sandi@sussex.ac.uk
Dr. Maya Unnithan	Anthropology, Sussex	M.Unnithan@sussex.ac.uk