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Managing pathogenic circulation: Human security and the migrant health assemblage in Thailand

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Abstract

This article traces the emergence of human security as a situated political strategy for managing the circulation of pathogens relating to Burmese migrant communities in Thailand. Specifically, it focuses on the intricate and productive interplay of a range of human and non-human elements that helped to bring forth and shape the vernacular micropolitics of human security. The article documents the techno-(bio)political mechanisms of the human security intervention in two of Thailand's provinces. By enframing, ordering and depoliticizing the complex health world of Burmese migrants in terms of simple dichotomies in which 'unruly' nature (pathogens, diseases, bodies) is contrasted with human techno-scientific ingenuity (scientific evidence, technological innovations, managerial effectiveness), these mechanisms render the circulation of pathogens amenable to biopolitical governance. It is here argued that in the struggle to manage pathogenic circulation, human security transforms the issue of migrant health into a technical matter concerned with the (self-)management of bodies and the governmentalization of the Thai state to the exclusion of important but difficult questions concerning a violent politics of exclusion.

Keywords

human security, migrant health, governmentality, assemblage, materiality

Introduction

Human security is often presented, if controversially, as a response to 'globalization' (see, for example, Chen et al., 2003; Commission on Human Security, 2003; Duffield, 2007; Hampson, 2001; Tadjbakhsh and Chenoy, 2007; Tehranian, 1999; UNDP, 1994).[1] Globalization, as Bennett (2005: 445) suggests, refers to a state of affairs in which Earth (or the globe, the world) is taken as the whole within which various parts, human and non-human, now *circulate*. The circulating parts include goods, services, finance, people, labour, images and information, along with – which in the literature on human security are arguably referred to as the 'downside risks' of globalization or

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(global) human insecurities – carbon dioxide emissions, refugees, viruses, trafficked persons, ozone and transnational terrorism (Commission on Human Security, 2003: 2–6; Fukada-Parr, 2003). These parts present in different and dispersed modes and cultures of circulation (Lee and LiPuma, 2002). Accordingly, in response to this state of complex circulation, the Commission on Human Security (2003: 2) notes that 'we share a planet, a biosphere, a technological arsenal, a social fabric' – that is, the whole, in which 'today's global flows spotlight the many interlinkages in the security of all people'. Within such a perspective, the relationality obtaining between the parts of this 'complex, gigantic whole' is characterized by an obtuse interdependency of security, in which the 'downside risks' of circulation are perceived as threatening the security of 'humanity' (see Dalby, 2000; Gasper, 2005; Annan, 2005).

From a Foucauldian point of view, human security emerges as a struggle for, among other things, governmental management of circulation, in which 'unruly' mobility (e.g. refugees) is to be prevented, contingencies pre-empted and good circulation (e.g. trade) encouraged (Foucault, 2007; Voelkner, 2010).[2] Notwithstanding the compelling critiques of human security as a site of biopolitics and governmentality advanced, if controversially, by scholars drawing also on Foucault (see, for example, De Larrinaga and Doucet, 2008; Dillon and Reid, 2000; Duffield and Waddell, 2006; Elbe, 2009; Grayson, 2008; Roberts, 2008; Truong, 2006), little has been said about how human security, or the struggle to manage circulation through human security, takes concrete form. Since human security interventions have taken or are taking place in multiple, dispersed and different vernacular sites (see, for example, UN Trust Fund for Human Security, 2011), rather than interpreting human security in terms of large-scale national and international policies, this article begins to trace the micropolitics of human security in one site (see Appadurai, 1996; Bubandt, 2005). Specifically, it begins to draw out the force relations flowing at 'the molecular level' (Rose, 1999: 5) in human security's struggle to manage the double circulation problematic embodied by Burmese migrants in Thailand, whose travelling bodies are both desired for the labour they yield and repulsed and criminalized for the diseases and illegalities they are said to carry.

In this context, although such things as small arms, carbon dioxide emissions, viruses, computers and airplanes are emphasized in the human security discourse, they tend to appear only as raw, brute or inert objects whose existence and circulation either benefits or risks (global) human security. Rather than taking them as the passive background setting of human security's struggle, this article sees them as giving the struggle concrete form. Indeed, human security comprises ad hoc complexes or assemblages of 'men and things' in which material objects, just like human beings, play a *constitutive role* (Foucault, 2007: 96; Deleuze and Guattari, 2004). For example, the interrelation between pathogens and the bodies of Burmese migrants 'with their materiality and their forces' helped to bring forth and shape (the vernacular micropolitics of) human security in Thailand (Foucault, 1979: 26). Though Foucault (1971, 1998, 2007) implied the composite role of all elements – human and non-human – in giving rise to power effects such as governmentalities, others have more decidedly, if controversially, expressed the way in which the interrelation between differential elements produces dynamic and mobile forces that help to constitute specific sciences, politics and subjectivities (see, for example, Barad, 2007; Bennett, 2010; Coward, 2009; De Landa, 1991; Deleuze and Guattari, 2004; Hinchliffe, 2007; Latour, 2004; Mitchell, 2002).

Given the constitutive role of non-human elements, the human element is never entirely in control of the world, since the interrelation between *actants* – a term coined by Latour (1987, 1993) to refer to human and non-human elements with agential capacity – produces differential effects that enter 'into resonance or contradiction' with each other, perpetually calling for a 're-adjustment ... of the heterogeneous elements', giving rise to new – and, for the human element, potentially unintended and undesirable – effects (Foucault, 1980: 195–6). That (human security) politics,

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nonetheless, appears as the effect of singular human intention is, as Coward (2006: 421) has argued, the legacy of Enlightenment thinking, which regards the human, 'by virtue of being the sole element endowed with reason', as taking precedence over, and as master of, all other elements. This anthropocentricism remains salient in modern thinking, producing a world in which productive forms of activity remain the preserve of humans and not of human–non-human alliances (Bennett, 2005: 455). This article shows how such thinking is carried forward into human security mechanisms, overshadowing not only the constitutive role of human–non-human alliances in giving concrete form to human security strategies and effects but also, importantly, the inherently contingent and precarious nature of these effects. In the example of the Burmese migrants in Thailand analysed here, the human security struggle to manage pathogenic circulation had the effect of generating a shift in the relations, subjectivities and institutions of the Burmese communities and the Thai state. These important power effects, the article concludes, were both produced by and contingent on the interrelation between the human and non-human elements that helped set up the migrant health assemblage in Thailand.

Migrant health as emerging assemblage in Thailand

Thailand shares with Burma[3] a long border stretching 2401 kilometres and has become a reluctant host to increasing numbers of displaced people fleeing from Burma into Thailand (Hynd, 2002; Lang, 2002). In their travel, these individuals and groups are accompanied by, among other things, mosquitoes and other carriers of parasites that feed on their undernourished and abused bodies (Beyrer and Lee, 2008), as well as 'flimsy' boats and the 'free' flows of the Salween River. The number of Burmese people migrating to Thailand rose sharply following 'a crackdown on urban, pro-democracy supporters' and various Burmese government offensives against 'sundry ethnic minorities along the Thai border' in the 1980s and 1990s (Hynd, 2002). As of September 2009, Thailand's Burmese migrant community is estimated at two to three million (Fry, 2009a). Around 140,000 (Srithamrongsawar et al., 2009) are living legally in the few available 'temporary shelter areas' in the Thai borderlands.[4] Most migrants, however, live and work illegally in Thai villages and cities in and beyond Thailand's border areas. Their living and working situations render them hugely vulnerable, mostly voiceless and anonymous, often highly exploited as seasonal labour and sex workers (Rajaram and Grundy-Warr, 2004: 55). Indeed, their aberrant existence in Thailand is perceived as an increasing threat to the Thai social fabric (Fry, 2009a). Unregistered Burmese thus find themselves 'in a status of non-belonging, non-citizenship' (Rajaram and Grundy-Warr, 2004: 54).

Burmese migrants in Thailand are often forced to live in unsanitary and overcrowded conditions in which pathogens flourish:

> Many lack access to latrines, safe water for washing and drinking, and means of disposing of solid waste. Some ... are located above cesspools into which are deposited garbage and human fecies [*sic*], where pathogens proliferate, and where disease-carrying mosquitoes breed. (WHO, 2004)

Since they have limited or no access to appropriate healthcare, including preventive care and vaccinations, they are considered more likely to contract communicable diseases (Jitthai, 2009: 14). Indeed, experiences of Thai government crackdowns on 'illegals', the poverty-ridden conditions of life experienced in Thailand, and violent exploitation in Thai work situations are just some of the stress factors that render Burmese migrant bodies particularly vulnerable to various health conditions. Migrants typically treat themselves as long as possible (Archavanitkul et al., 2000: xii).

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Migrants in Thailand suffer from higher levels of case fatality and morbidity than their Thai counterparts, as health statisticians have deduced from the limited accepted data and research available (WHO, 2004). Often, migrant bodies surrender to and die from treatable health problems. In Ranong, the 'top five reportable infectious diseases' captured in 2003 were malaria, diarrhoea, pneumonia, tuberculosis and food poisoning. A high level of prevalence of the human immunodeficiency virus (HIV) – passed, among other channels, through the body fluids of migrant sex workers and seafarers – was also recorded (WHO, 2004).

In the mid-1990s, levels of HIV infection among migrants within and from Burma were found to be the highest recorded in the region (Porter, 1995). Since migrants are mostly integrated into the local communities where they reside and work, pressure mounted to address migrant health needs, particularly those relating to communicable illnesses. There was fear that lethal pathogens taking advantage of weakened migrant bodies would pass through to, and circulate among, Thai communities. Since this time, the health of migrants has increasingly been recognized as a public health problem in Thailand (Archavanitkul et al., 2000: 3), first giving rise to haphazard and mostly uncoordinated attempts by local and central public health offices, sometimes in collaboration with nongovernmental organizations (NGOs) and international governmental organizations (IGOs), to control migrant health. From the intricate interplay between Burmese migrant bodies, pathogens and impromptu government initiatives, there has gradually emerged a distinct assemblage oriented towards the control of migrant health in Thailand. The emergence of Thailand's migrant health assemblage has not been 'a process in which rule extends itself unproblematically across a territory, but a matter of fragile relays, contested locales and fissiparous affiliations' (Rose, 1999: 51). Indeed, much hard work is required to 'draw heterogeneous elements together, forge connections between them and sustain these connections in the face of tension' (Li, 2007: 264). Tension arises, for example, from factors such as the mutability of pathogens and shifts in migration trends.

In this respect, to this day, the Thai government is criticized for not having adequately addressed public health issues concerning the burgeoning migrant population in Thailand (Fry, 2009b). Authorities have primarily been concerned with promoting migrant labour circulation. For example, in order to meet the growing labour demands of the flourishing private sector, the Thai government extended rules governing the permissibility of illegal migrant employment from 9 to 43 provinces (Archavanitkul et al., 2000: 49; Hyndman, 2001). While encouraging labour circulation, this was also seen, in the absence of sustained public health initiatives, as increasing the risk of 'migrant disease' circulation, further straining ill-equipped public health facilities. In fact, the Thai government has attempted to manage the migrant population through a series of registrations. Yet, few migrants have been in a position to respond to the calls that migrant workers register themselves both to legalize their status and to secure limited access to public services, including healthcare. In 2007, out of an estimated total of 1.8 million migrants, only 532,305 migrants from Burma, Lao PDR and Cambodia registered. This is because the registration process is selective, expensive, complex and dangerous. Few have passports or other forms of identification, sufficient funds or adequate knowledge of the Thai language to register. Moreover, the fear of deportation is very real (Srithamrongsawar et al., 2009).

Nonetheless, provincial health offices, especially in border provinces, are treating a growing number of Burmese migrants in Thailand, of whom the majority are not registered and thus not accounted for *technically*. This has led to shortages of medication and equipment in health offices burdened by insufficient welfare budgets. The situation was compounded further by the protracted consequences of the 1997 Asian financial crisis, whereby public health budgets, including funds for medication, equipment and welfare services, were drastically cut (Archavanitkul et al., 2000: 48). In response to these financial challenges, in 1998 the Thai government made the purchase of

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an annual health insurance card by migrant workers mandatory. This *governmental thing*, through which an attempt has been made to manage the health of migrants, has proven largely ineffective. Many employers have been found retaining health insurance cards in order to prevent migrants from 'running away or changing jobs' (Archavanitkul et al., 2000: 48). Meanwhile, several provincial health offices have initiated programmes targeting migrants that involve the promotion of disease prevention and environmental sanitation, as well as a reporting system for tracking the spread of diseases within communities. Some provinces have collaborated with NGOs, setting up clinics exclusively for migrants. These minuscule and haphazard attempts to control migrant health, however, have had little effect in dealing with the problem of migrant health in Thailand. Meanwhile, pathogens continue to develop in crowded and unhygienic spaces, feeding on weakened Burmese migrant bodies.

Interestingly, Thailand's Ministry of Public Health began forging new alignments between Burmese migrants and government offices in the sense that it sought to link the health objectives of migrants themselves with those of government offices. It did so by promoting self-care guidelines for migrant workers 'so that they can take care of themselves', reducing dependency on public health services (Archavanitkul et al., 2000). A similar strategy formed the core of the human security intervention discussed in more detail below. In 2004, indicating a shift, the ministry launched the 'Healthy Thailand' policy, within which it was acknowledged that it was 'impossible for the country to achieve the Healthy Thailand goal when the health needs of some 2.5 million migrants remain unmet' (Jitthai, 2009: 17). Recently, the Ministry of Public Health has developed several key governmental strategies aimed at addressing the problem of migrant health, including the forging of new alignments with the governments of neighbouring countries such as Burma. The governmental strategies involved also developing governmental things such as information systems and migrant health service systems. Essentially, these strategies and governmental things render the problem of migrant health a *technical problem*, that is, a problem of effective public health management.

Since at least the end of the 1990s, the Thai government has drawn heavily on the technical support and expertise of national and international migration and health experts in its efforts to deal with the issue of migrant health. The intimacy of this relationship is demonstrated by the Ministry of Public Health's extending an invitation to the World Health Organization (WHO) to set up an office within the ministry compound, which resulted in the WHO being physically integrated into the political architecture of a Thai government ministry. Similarly, the process of establishing dedicated migrant health units within provincial health offices, a process beset with political difficulties, is partly due to advocacy by field offices of the International Organization for Migration (IOM). These units, in which the politics of the migrant health assemblage takes concrete physical form, embody the shift in governing the health of migrants that has been assembled over the last two decades. International and nongovernmental organizations are in many ways formative of the fields in which they intervene. The alignments that are being forged between these organizations and Thai (non)governmental organizations are dealt with at several levels, including the authorization of mainly scientifically verifiable knowledge. Indeed, the 'reality' of migrant health is stabilized through the perpetual production of scientific knowledge by experts, including statistics, analyses and the guidelines on which interventions are subsequently based.

Several major programmes to tackle the problem of migrant health have emerged in Thailand over the last decade. Most notable are the IOM-led Migrant Health Program and the WHO-led Border Health Program. Indeed, strategies are converging: much like the Ministry of Public Health strategies outlined above, the WHO programme is oriented towards improving coordination among key players, data collection, technical training (e.g. emergency preparedness and response) and

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information sharing (e.g. the border health report, which contains health statistics, along with information on provinces and organizations). The activities these organizations carry out in migrant communities, as well as with Thai state authorities, are bound up with knowledges, practices and other things associated with what Mitchell (2002) has termed a *techno-politics logic*. Herein are included practices of categorization, measurement, monitoring and evaluation, lessons learned and logical framing, as well as the production of the governmental things through which the complex health world of Burmese migrants was enframed and ordered, turning the issue of migrant health into a simple, dualistic world of 'unruly' nature (pathogens, diseases) versus science, the human versus the (biopolitical) machine, bodies versus hygiene (Mitchell, 2002: 210). The relations that are forged in these activities interconnect in important ways, forming a web in which the individual migrant is linked to local and central public authorities, the public authorities of neighbouring countries, and (transnational) nongovernmental and intergovernmental organizations.

When the IOM and the WHO applied to the global Human Security Fund[5] in 2004 for funding to run a co-managed migrant health project in two Thai provinces, migrant health was reframed in terms of the problem of human security, and the baggage of actants with which human security is inevitably loaded was plugged into the migrant health assemblage (see, for example, Grayson, 2008). Speaking migrant health in Thailand through human security has had at least two effects. First, it is arguably providing human actants with a distinct grammar with which to think and articulate the complexities of contemporary migrant politics in Thailand. Indeed, human security's governing logic for promoting the life of unruly transnational populations in Thailand, such as Burmese migrants, now speaks directly to the security of the 'Thai geo-body'. In this perspective, improving the health conditions of migrant populations is understood to 'benefit and assist with maintaining the *health security*' of the Thai people (Srithamrongsawar et al., 2009: 11; emphasis added), prompting one IOM expert to claim recently that the problem of migrant health is a matter of 'national health security' (Jitthai, 2009: 14). Second, and more important, Thai public health officials have begun rearticulating Thailand as a transnational state. It is a 'transit state' through which run flows of people and goods from neighbouring and distant countries.[6] Since the flow of Burmese migrants into Thailand is considered difficult to stem, partly owing to the desirability of the labour they constitute, their health insecurity – and by extension that of the Thai population, according to public health officials in Ranong – is best managed by including migrant health into public health considerations.[7]

The intricate and complex interplay between Burmese conflict-time traffic to Thailand, the 'free' flows of the Salween River, travelling pathogens, mosquitoes, crowded and unhygienic spaces, weakened and neglected refugee bodies, human intentions and desires, Thai refugee and migrant policy, 'states of non-belonging', fear and anxiety, failed governmental initiatives, sex work and body fluids, the problem of circulation, foreign aid capital, transnational agencies, inadequate health funds and the rise of global human security helped to bring forth and shape the migrant health assemblage in Thailand. The different properties of these various elements, involving 'very different forces, agents, elements, spatial scales, and temporalities', interlinked with and shaped each other, forming biological, ethical, discursive, techno-scientific, knowledge, transnational and political alliances that comprise the migrant health assemblage (Mitchell, 2002: 27). In spite of the constitutive role of human–non-human associations in setting up and shaping the assemblage, the IOM and WHO represented the assemblage only in terms of the actions and intentions of human actors whose techno-scientific ingenuity could tame pathogenic circulation. That the assemblage's representation is itself a 'technical body', one that 'must emerge from a process of manufacture whose ingredients are both human and nonhuman, both intentional and not, and in which the intentional or the human is always somewhat overrun by the unintended' – such as

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tensions and contradictions between policies, pathogen mutations and initiatives such as the health insurance cards – is not taken into account (Mitchell, 2002: 42–3).

Framing logically and the foreclosure of the political

Human security was plugged into the migrant health assemblage cleansed of politics; all but *techno-(bio)political strategies* were put forward to deal with the problem of migrant health in Thailand. In their proposal to the Human Security Fund, IOM and WHO experts argued that migrants were 'at high Human Security risk' and their health was 'a particular Human Security concern'. Migrant health *in*security was due 'in large part' to the inability of migrants 'to access basic preventative and curative health services'. Three primary factors disabling migrants from accessing healthcare services were identified: security concerns (fear of arrest and deportation), socio-linguistic factors (the language barrier, citizen–denizen tensions and differences in health cultures) and economic factors (opportunity, travel and health costs) (WHO, 2004). While the problem of access essentially is symptomatic of a violent politics of exclusion, the solution to the problem was seen as lying mainly with migrants themselves: they were to learn to care for themselves. This involved the making of self-governing migrant health subjects. It involved also the making of a migrant health information system (MHIS) developed by WHO officials and maintained by public health authorities to regulate the internal dynamics of this largely illegal population in Thailand.

By foreclosing the political to the exclusion of important but difficult and highly political questions related to such issues as legality, refugee status, labour exploitation, racism and citizenship, the human security intervention rendered migrant health in Thailand as a technical problem to which a technical solution applies. The exclusion of sensitive political matter from their proposed intervention was necessary if the intergovernmental WHO and IOM were to successfully negotiate their entry into the field of migrant health in Thailand. Such a move not only enabled these organizations to work alongside and with the Ministry of Public Health in this situated matter of global circulation. Importantly, it also allowed the Ministry of Public Health, a government department, to work with the group of Burmese otherwise handled as legally aberrant in Thailand – read: not generally qualified to receive public services. The technicalization of migrant health, in which disparate datasets and expert knowledges, strategies and practices are assembled, saw the objectives of the Ministry of Public Health and the intergovernmental organizations converge. This transnationalization of this particular Thai ministry was seen as necessary for taming the (global) circulation of pathogens said to originate in Thai migrant communities.

The process of rendering migrant health a technical problem involved framing the human security intervention 'logically'. The conception of the project was organized around a logical framework, otherwise referred to as a logframe, now a standard requirement in applications to the Human Security Fund and widely used in the aid community (Bakewell and Garbutt, 2005: 1). This governmental thing is a project management tool that is considered 'useful in the design and planning, implementation, monitoring and evaluation of a project'. Most importantly, according to the Human Security Fund, it must have good – read: measurable – indicators. These are to provide data that allow for 'making more informed and better decisions throughout the process of a project'. Moreover, a logframe must be politically correct: 'It is important to check that gender and other equity differences have been adequately addressed' (UN Trust Fund for Human Security, 2008: 9). In fact, the logframe is charged with political meaning. It sets the parameters of a project in no uncertain terms: objectives, targets and outputs. Accordingly, this thing called the logframe obliges users – whether the project managers who design the project or field workers acting on their designs – to think a problem field in distinctly techno-scientific terms.

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The *target sites* for the project were defined as high-priority areas in two provinces in Thailand, namely Ranong and Samutsakorn. It was argued that these Thai coastal provinces hosted large numbers of mostly Burmese migrant workers. An IOM map (IOM, 2009) shows all target sites under the IOM Migrant Health Program, including the sites of the human security component, namely, Ranong and Samutsakorn.

Ranong is bordered to the west by Burma and the Indian Ocean. The town of Ranong is located opposite Kawthaung, Burma's southernmost town, from where most Burmese migrants in Ranong have entered Thailand. Many of those fleeing Burma since the pro-democracy protests in 1988 have remained in Ranong. They live in communities throughout the province (Archavanitkul et al., 2000: 14). The main industries in Ranong are fishing, rubber and cashew-nut farming. Samutsakorn province is located just 50 kilometres south of Bangkok, facing the Gulf of Thailand. It is recognized as the largest seafood producer in Thailand, employing a large number of registered and unregistered migrants in local fishing and fishing-related businesses. Most migrants live within the urban area. Overall, approximately 9500 migrants in each province were to be targeted directly through 'direct outreach, referral mobile medical clinics, and other healthcare services'. Approximately 20,000 additional migrants were to be targeted indirectly through health-awareness campaigns. The target beneficiaries or *target populations*, understood as statistical cohorts, were considered to be 'primarily employed in the sectors of seafood processing and fisheries, with others working as general labourers, sex workers, and agricultural labourers'. These migrant women and men and their dependants were to be targeted regardless of their legal status in Thailand.

The main objective was loosely laid out in the proposal of the human security project: 'To contribute to the improved Human Security of migrants in Ranong, Samutsakorn, and other provinces of Thailand, through enhancing their overall health standing'. For effective project management purposes, given also the short but standard project life of three years, the ambitious human security objective of improving migrant health underwent significant technicalization. It was broken down into smaller and more manageable bits: activity clusters of sub-activities with sub-objectives, methodologies, outputs and timeframes involving extensive planning, data and information gathering, coordinating, supervising, training, campaigning, programming and documenting (WHO, 2004). Buried under a string of technicalities, the *politics of migrant health* (be this donor politics, inter- and intra-organizational politics, immigration politics or gender politics) was mostly written out of the human security project.

Logframes are the epitome of project management logic, by which the demand to manage effectively establishes an exclusive claim to politics. As an inscription device (Latour, 1999), a logframe is the site where problematizations such as migrant health and biopolitical subjectivities are *written and con-textualized* in terms of the dichotomous logic of nature versus science and technology and body versus hygiene. The logframe establishes an exclusive claim on a specific class of subjects – for example, migrants (mostly Burmese and illegal in Ranong and Samutsakorn) – on whom it writes forms of subjectivation in the pursuit of effective management – for example, in relation to pathogenic circulation. To technical experts of the WHO and the IOM, then, the migrant body presented a technical problem requiring effective public health management. This not only meant developing mechanisms such as training migrants to care for themselves – for example, through improved hygiene – so that migrant health could be governed from afar. It meant also being able to *account* for all migrants (whatever their legal status), in terms of costs for (provincial, central) health budgets and monitoring disease trends in order to intervene in the regularities of migrant populations. Through the governmental thing that is the logframe, human security presented in the space of a few paragraphs the migrant health assemblage with a discrete problem, a target population, evidence, strategies, methods, tools, funds – and a solution.

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MCHWs and cartographies of self

Under the human security project, a network of dedicated migrant community health workers (MCHWs) and migrant community health volunteers (MCHVs) was established in the target provinces of Ranong and Samutsakorn under the steering of public health offices and IOM field personnel. The role of these MCHWs in bringing migrant health under the primary control of the Thai government is substantial. First, they provide basic health services to targeted migrants. Second, they campaign for health awareness and behavioural change in targeted migrant communities. Third, they monitor disease trends in these migrant communities, standing in as pseudo-disease surveillance officers. Finally, they conduct migrant community mapping, providing 'informative evidence such as the location and distance between migrant communities and public health facilities' (Jitthai, 2009: 35). The data recorded through social mapping exercises carried out by MCHWs is essential for feeding the computerized migrant health management system designed and programmed by the WHO in this project, as discussed below.

At least two-thirds of the MCHWs are Burmese. Importantly, these women and men are respected members of the migrant communities targeted for intervention under the human security project. They are informal practitioners, such as traditional birth attendants, hospital translators and health volunteers, recruited through existing networks by public health offices and IOM field offices. They speak Burmese and/or relevant languages/dialects,[8] and they understand the cultural nuances of Burmese ways of life. Given the exclusionary political climate in which Burmese migrants navigate their lives in Thailand, MCHWs have proven to be a valued resource for all parties involved. For targeted migrants, MCHWs are trusted healthcare providers. For public (health) authorities, MCHWs *know* and are able to penetrate targeted migrant communities in ways that public (health) authorities cannot. Indeed, MCHWs are employed by public health authorities, with donor funding from the Human Security Fund. Their (re)training takes mainly two forms and is considered 'an investment in the technical capacity' of targeted people. First, MCHWs are trained in basic health knowledge. Second, they are trained in scientific methodology such as survey data-gathering for baseline surveys that are later used for the assessment of project impact. This is considered 'a learning process in itself worthy of notice' (WHO, 2004).

While usually operating out of public health centres or hospitals, 'trained MCHWs', clad in blue uniforms typical of Thai healthcare professionals, also administer community health posts and health corners in migrant communities, providing 'frontline service in target populations' (Jitthai, 2009: 18). For example, some business owners and employers of migrants in Ranong and Samutsakorn have provided space in their workplaces for the setting up of migrant health posts. Indeed, some MCHWs and MCHVs have offered a space within their own residences to be used as a health corner (Jitthai, 2009: 39). MCHWs also conduct home visits, following up patients to ensure treatment adherence. They perform medical translation during diagnosis and treatment, as well as explaining medication details in the appropriate native languages. Together with health volunteers or MCHVs, MCHWs are establishing deep within migrant communities an elaborate web of control points, linking these to public (health) authorities that seek to manage migrant health. They are the '*key catalysts* for improving the reach' to migrant communities, which they are able to do 'more efficiently than public health personnel' (Jitthai, 2009: 61; emphasis added).

MCHWs' control points within migrant communities are considered crucial for monitoring communicable disease trends within those communities. Indeed, MCHWs are being integrated into district- and provincial-level surveillance and rapid response teams (SRRTs). They have been drawn in by local health authorities to assist in outbreak assistance and control, supporting 'government SRRT with translation services during the case tracing interviews' and 'investigation

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measures such as rectal swab samples in suspected Cholera cases'. The state surveillance apparatus they helped set up is dispersed throughout targeted migrant communities. This apparatus functions as a disease-trend monitoring system. Indeed, MCHWs are credited for the timely halt of the 2007 cholera outbreak in Samutsakorn (Jitthai, 2009: 58). It is in this context that the head of the migrant health unit at the provincial health office in Ranong referred to MCHWs as small epidemiologists or outbreak investigators.[9] This strategy to draw in migrants themselves in the taming of pathogenic circulation is being adopted by other organizations specializing in other aspects of migrant life. For example, in the case of avian flu, in the spirit of the governmental technology of the MCHW introduced by the IOM and the WHO, the International Labour Organization recently pushed for Burmese migrant workers to 'take on a greater role in detecting and stopping the spread of the deadly H5N1 virus' (Macan-Markar, 2009).

Following the cholera event in Samutsakorn, when the *vibrio cholera* bacteria travelled through contaminated drinking water and food into migrant bodies, MCHWs 'intensified health education efforts on Cholera, Diarrhea and sanitizing strategies' in the province (Jitthai, 2009: 58). Indeed, they train in, and campaign on a large scale, on a number of health-related issues in targeted migrant communities. For example, the 'Information, Education, Communication' material produced in Ranong included a bilingual version (Thai and the local Burmese dialect) of the Ministry of Public Health's *Maternal and Child Health Handbook*, which was distributed to migrant mothers to enable them to record the growth and vaccination schedules of their children. At health centres in Ranong and Samutsakorn, bilingual posters remind Burmese migrants to wash their hands. MCHWs in Ranong also developed and delivered a bilingual puppet-show to raise awareness about specific health issues. Using dramatization 'to convey health messages and learning via entertainment' is considered 'an effective and popular strategy to internalize and disseminate' knowledge of health among migrant communities, according to the IOM (Jitthai, 2009: 51).

Addressing the problem of migrant health in Thailand 'effectively', however, is considered a two-pronged matter. Apart from the elaborate range of (self-)governing techniques involving MCHWs outlined above – including directing migrants' health behaviour towards modes of *self-governing* and erecting migrant-operated governmental apparatuses of disease surveillance loosely bound and strategically dispersed in targeted communities – the human security intervention involved also developing public administrative information and service systems. In order for public health authorities to be able to act on migrant health in more than haphazard ways, it needed to be brought into the domain of government responsibility more determinedly. As will become clearer below, transferring migrant health into the domain of government responsibility is a matter of finance, legality, politics and technology. Foremost, provincial health offices generally lack the funds to provide healthcare to 'non-registered irregular' migrants that they are in the process of moving into their sphere of responsibility. They require a headcount to present to central authorities in order to secure the allocation of government funds befitting the number of people for whom they have assumed responsibility. The human security project introduced a system by which authorities were able to account for – that is, cost for – unregistered, essentially illegal, migrants in (provincial and central) health budgets. In this way, sources of finance and decisionmaking centres were moved, and forms of control modified.

The public health management system introduced by the WHO, however, presupposes the availability of intimate details around migrants' health. The kind of knowledge sought includes details of migrants' movements, health and residence; the numbers of migrants and their relations to one another; their living conditions; the types of disease circulating; migrants' medical histories, immunization and treatments received; and so on. Given the aberrant status and therefore usually covert existence of migrants in Thailand, these details are notoriously difficult to come by. Indeed,

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'the scarcity of valid data to measure the health status of the migrant population in Thailand [poses] serious challenges in the effective planning of health programs (and policy-making) for migrants' (WHO, 2004). Here, again, MCHWs prove valuable semi-public health officials. During their visits and consultations in migrant communities, MCHWs record information related to migrants and their health situations in family health folders. Armed with these governmental things, MCHWs cut an authoritative figure as they enter the dark alleyways of Burmese migrant housing. In effect, MCHWs discipline migrants to confess their health predicaments and histories, as well as those of their co-migrants.

The visually impressive inscription device that is The Folder also disciplines the MCHW to take stock of health subjects. It bids trained MCHWs to map and characterize the health of co-migrants according to variables predetermined by the public health systems standards of the Thai Ministry of Public Health and the WHO. Indeed, these Folders were modelled on existing health folders for Thais.[10] MCHWs are trained by IOM field personnel in community or social mapping, a technique whereby they draw out the location of a migrant who lacks an official address, as illustrated in Figure 1. Social mapping is a visualization tool, used to present information on neighbourhood layout, infrastructure, demography, ethno-linguistic groups, health patterns, wealth and other social issues. MCHWs map networks of co-residents, co-environments (access to safe water, cleanliness, and so on) and health provider contact points. It is within these networks that the health of migrants in Thailand is to be found.

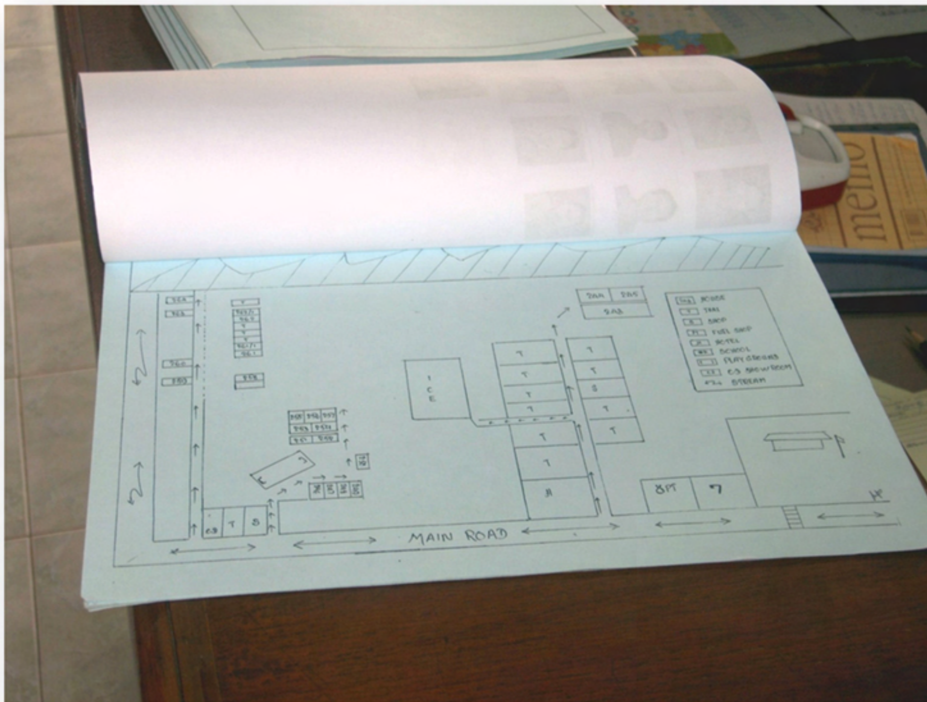

Figure 1. Map of location of one Burmese migrant in Ranong (September 2008)
Photo © Voelkner September 2008

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Figure 2. Filing cabinet for Thai (blue, top three shelves) and migrant family (green, bottom two shelves) health folders at a public health centre in Ranong (September 2008)
Photo ©Voelkner September 2008

Like Thai folders, migrants' folders are filed in relevant public health centres, separated by colour from Thai family health folders (as shown in Figure 2), and are retrieved whenever the migrant visits the health centre or is visited by a MCHW. The separation between Thai (normal) and migrant (abnormal) folders filed away in large, open cabinets is clearly within view when one enters the health centres. Although the agency of migrants – both MCHWs and the populations under their care – Thai health officers, and IOM and WHO officers in Thailand, Geneva and elsewhere is distributed in the tools (e.g. the Folder), colours (e.g. blue or green folders) and spaces (e.g. the location of the filing cabinet), in fact, as Bennett (2005: 463) has suggested, human agency can only emerge by way of a distribution into these materialities.

The willingness to employ registered Burmese migrants as semi-legal subjects in the form of MCHWs, albeit with external funding, constitutes a significant development in Thailand. Currently, there is no government policy that allows migrants from neighbouring countries to work as health workers. Migrants are only permitted to be 'employed in unskilled or low-skilled work whereas health work is considered skilled work' (Jitthai, 2009: 72). Moreover, there is no official Ministry of Public Health national training curriculum and accreditation for MCHWs. The IOM noted after project completion that MCHWs' (re)training has not been standardized at the level of the Ministry of Public Health. Nor has there been government budget allocation to continue the employment of

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MCHWs (Jitthai, 2009: 72). Nonetheless, local health authorities are willing to secure a degree of financial support in future by circumscribing existing and planned funds in order to sustain MCHWs beyond WHO/IOM contributions.[11]

MCHWs indeed play a 'catalytic role' in 'bridging the gaps between migrant populations and available public health services' (Jitthai, 2009: 29). They make governing migrant health possible from afar, while ensuring nonetheless an extension of the state whereby 'the state' is by proxy ever-present in evasive migrant communities. They map the unmapped social – that is, the migrant populations targeted – with a view to bringing to the fore and enabling intervention on the internal regularities of this population. MCHWs and the governmental things they employ, such as the Folder, are the supposed missing link between Burmese migrant communities, local and provincial offshoots of the Ministry of Public Health, and global governmental organizations. As attracter and container of knowledge, however, the Folder is but one step in the chain linking together the various human and non-human elements, including individual migrants, Thai state authorities, intergovernmental agencies and a rationality of governing that is global in perspective.

MHIS and the digitization of migrant health

In Ranong, the elaborate information recorded by MHCWs in Folders is logged by health personnel at local public health centres in an experimental computing system. This system collects and collates the information for 'effective planning of health problems (and policy-making) for migrants' (WHO, 2004). While the Ministry of Public Health had previously begun to develop such a migrant health information system (MHIS), with human security funds it was possible to complete the development of a standardized system replicable in all provinces. The MHIS is to run parallel to the Thai Health Information System (HIS), and is intended eventually to be fused with the latter. Developing the MHIS is a 'really difficult issue', according to one WHO officer – 'not only [a] technical issue but in terms of capacity, coordination, and politically'.[12] Indeed, in Samutsakorn, the promotion of the MHIS is rife with tension and practical difficulties that are blamed on the absence of a political will and, interestingly, the built environment: Samutsakorn's dense urban space had given rise to a central hospital that was managed through a central administrative system that was allegedly incapable of running the MHIS.[13]

In Ranong, the information collected from migrant communities is brought back to local health centres, where it is uploaded to the new administrative software developed by the WHO. Health providers working at the health centres are trained by WHO personnel to input all the details of the Folders into the new database, as illustrated in Figure 3. The indicators by which the software computes migrant health include population (proportion of population by age and sex and district, crude birth rate), mortality, morbidity (acute and chronic diseases), nutrition and child health, insurance, service utilization, family planning (vaccination, contraception) and special disease surveillance (HIV). The computer that maintains the MHIS database and the Folder filing cabinet give the migrant health assemblage an almost physical presence in the room. The Burmese readily provide all of the required information because, first, the person asking is from their own community; second, they have indeed apparently benefited from better healthcare and services; and, third, they have experienced a change in attitude in terms of self-care and responsibility towards oneself and one's community – for example, in relation to monitoring disease trends within the community.[14]

So far, it is their illegal or unrecognized political status that largely prevents migrants from entering the imaginary of public health administration in Thailand. Migrants do not officially figure in public (health) records and systems, even when out of necessity they must access

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Figure 3. Training in MHIS data input at a public health centre in Ranong (September 2008)
Photo © Voelkner September 2008

health services. The system developed by the WHO, however, is designed to bring migrants, *regardless of their legal status*, into the domain of public health responsibility, rendering them governable through state authorities. As one Thai WHO official conceded, 'if we want to achieve the health security, we need a good health system'.[15] Without such a system, as the WHO/IOM-penned proposal to the Human Security Fund reads, 'inefficiencies result and it is not possible to track health trends or compare data between different sites making it difficult to identify priority areas' (WHO, 2004). Essentially, the MHIS is *a techno-(bio)political machine* served by state health authorities to facilitate computation, statistical inference and decisionmaking regarding the regulation of the internal health dynamics of migrant populations in Thailand. Foucault termed such a form of governing *biopolitics*, which refers to 'the strategic uses of knowledges which invest bodies and populations with *properties* making them amenable to various technologies of control' (Ong, 1995: 1243; emphasis added). Indeed, the unruly bodies of migrants are 'recuperated through the language of numbers that allows these very bodies to be brought back, now counted and accounted, for the humdrum projects of ... sanitation, education, welfare, and loyalty' (Appadurai, 1996: 133).

Indeed, 'when we talk about migrants in the health system, we have to divide them into categories'.[16] The properties invested in or the (sub)categories into which migrant and other aberrant populations are divided concern their (il)legal status in Thailand: (1) hill tribes (ethnic minorities) with identification cards beginning with '6', '7' or '8' – the 'ambivalent categories' (Toyota, 2007);

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(2) registered migrants with ID cards beginning with '0'; (2a) with work permit; (2b) without work permit; (3) migrants without IDs; (3a) refugees; (3b) other; (4) nationally verified registered migrants from Laos and Cambodia; (5) other (not mentioned above). Though this may appear to contradict efforts to steer clear of sensitive issues such as legality, it shows that, in fact, distinctions of legality/illegality are reinstated in the techno-(bio)political management of migrant health. Through the use of these migrant categories, the MHIS is said to be 'capable of identifying, quantifying, and monitoring the health situation of migrants'. It is by quantifying the health of migrants and comparing the resultant statistics to those for the 'normal' Thai population, their values and degree of 'natural fluctuation', that it becomes possible to infer whether or not the health of migrant populations is outlying or *abnormal*, therefore necessitating intervention to minimize statistical divergence. For example, in the Human Security Fund proposal, 'irregular' migrants are represented, in comparison to the local (and 'normal') population, as suffering from higher levels of morbidity and higher levels of case fatality, and as displaying lower rates of compliance with treatment for a range of health conditions, legitimating intervention in their health (WHO, 2004).

The governmental logic unfolding in the MHIS and MCHWs is at least twofold. On the one hand, migrants themselves in the form of MCHWs are recruited as semi-legal governmental subjects to make the health of their communities governable for public health authorities and intergovernmental agencies. MCHWs do this not only by providing basic everyday health services and consolation. As campaigners, they promote voluntary behaviour change in terms of self-healthcare at the level of the individual as well as at the level of the population – for example, the 20,000 additional migrants targeted through large-scale campaigns. As disease controllers, they are deciding points of intervention into the regularities of migrant populations. As cartographers, MCHWs are making these communities legible to health interventions by drawing out maps of migrants and their health specificities that are convertible into indicators legible to biopolitical machines such as the MHIS. The MHIS is a machine maintained by public health authorities that is able to compute migrant health regularities, which are now comparable with Thai health regularities. Intervention in the health of migrants takes the form of *normalizing techniques* unfolding in the activities of MCHWs. Regardless of their official political status in Thailand, as a result of the governmental strategies deployed through human security that are the MCHW and the MHIS, Burmese migrants previously excluded from matters of public health administration now gradually come to be included in significant ways in Thai public health policy and administration.

Conclusion

Human security emerges as a situated political strategy for managing pathogenic circulation in Thailand through the intricate and productive interplay of a range of human and non-human elements that form a multiplicity of alliances with each other. However, in spite of the constitutive power of both humans and non-humans in producing the assemblage, it is represented by the IOM and the WHO only in terms of the human intentions, activities and techno-scientific ingenuity that are to bring pathogenic circulation under control. Indeed, the *techno-(bio)political mechanisms* enframe, depoliticize, order, authorize knowledge in and align the complex health world of Burmese migrants in terms of simple dichotomies of 'unruly' nature (pathogens, diseases, bodies) versus human technologies (scientific evidence, technological innovations, managerial effectiveness), rendering migrant health manageable. Tensions, contradictions and practical difficulties in techno-(bio)political encounters arising from the productive interplay inherent in the assemblage are explained away in terms of the mystique of the unruly 'nature'. Nonetheless, they attest to the productive power of human–non-human alliances in the manufacture of political decisions and

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subjectivities. Moreover, they remind us of the contingent and therefore precarious nature of human intentions and strategies encapsulated in initiatives like human security.

Human security's struggle is given concrete form through, among other things, the Burmese migrant bodies and migrant behaviour, the pathogens, and the governmental things that are the logframe and the Folder, the filing cabinet, the information systems software and the personal computer stationed at the public health centres, and so on, which make possible the unfolding of the governmental logic of human security. Some of these objects are developed elsewhere and dropped by the circuits of global human security governance. Some are readjusted from existing repertoires and habits: they are accretions, bricolages (Li, 2007: 265). They allow the health of Burmese migrants in Thailand to be rendered governable by mapping this unmapped population and digitizing and informationalizing its members' lives (see, for example, Dillon and Lobo-Guerrero, 2009), through which process intervention into the regularities of their health/life dynamics becomes possible. As actants, these things are not so much social constructions as elements with constitutive power, bearing in equally important ways upon the lives of Burmese migrants and MCHWs, Thai public health officials, and WHO and IOM officials, as well as the 'gigantic, complex whole' that is the migrant health assemblage. They make demands on us (discipline, visualize, translate, delimit, obstruct), but these demands only come alive by way of a distribution into the material objects that help to shape the assemblage.

In the struggle to manage pathogenic circulation, human security has transformed the issue of migrant health into a technical matter concerned with the (self-)management of bodies and the governmentalization and transnationalization of the Thai state to the exclusion of important but difficult questions concerning a violent politics of exclusion. The biopolitical subjectivity produced out of human security to manage pathogenic circulation embodied in the MCHWs and MCHVs is concentrated mainly in Ranong and Samutsakorn provinces, where the human security intervention took place. Accordingly, the migrant health assemblage is 'a web of uneven topography' in which governmental power is unevenly distributed. While the assemblage as a whole and its elements such as human security are doing things, power is not equally strong everywhere (Bennett, 2005: 448). Of the various points at which the trajectories of elements cross each other, those relating to human security in Ranong province, for example, are more heavily trafficked than others. Here, migrants are more determinedly rendered governable and brought under governmental control. The immersion of the Thai state into the transnational assemblage made it possible to imagine managing the health of displaced persons from Burma in spite of their illegal status and evasiveness in Thailand. Not only could the state materialize deep in migrant communities through the work of the MCHWs and their tools, it could also, through the work of the MHIS, calculate the (ir)regularities of migrant health in order to decide points of intervention. These developments fundamentally challenge, disrupt even, the *excess* and *bare life* conditions – as some Agamben scholars have interpreted migrant life in Thailand (Rajaram and Grundy-Warr, 2004; Tangseefa, 2006) – under which the majority of migrants must navigate their lives. If, as these scholars hold, the discourse of migrants in Thailand functions as the boundary-producing discourse instrumental to the task of statecraft, then the inclusion of the health of migrants into public health policymaking can be understood as a mutation in Thai statecraft. Ong's (2006: 499) argument that we are moving beyond the citizenship-versus-statelessness model in 'an ever-shifting landscape shaped by the flows of markets, technologies, and populations' is instructive here.

These small mutations in statecraft are fundamental to human security's struggle for governmental management of global circulation. Migrant health in Thailand presents a situated example of circulation to be managed. On the one hand, the migrant body is desired for her labour, the

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circulation of which is to be encouraged. On the other hand, her body is a 'menace' insofar as it is constituted as a carrier of disease and illegalities, the circulation of which is to be contained or eliminated. The human security way of resolving this dilemma is to bring Burmese migrants not under sovereign but under governmental control. What is at stake in these governmental strategies is not the extension of sovereign power over territory, expressed in draconian border regulation practices, but a governmental concern for circulation. This concern, bound up as it is with and formative of the migrant health assemblage, is contributing to the extension and transnationalization of the already governmental Thai state. In a small measure, though only concentrated in the Ranong site, human security's political ambition of assembling a 'global alliance' and reassembling the link between 'individuals [legal or illegal] and the state – and the state with a global world' had been achieved (Commission on Human Security, 2003: 4).

In this picture, however, the Thai state is not a 'governance state', where 'the international community exerts a good deal of control and oversight over the core economic, environmental and welfare functions of the state, that is, its core biopolitical functions' (Duffield, 2007: 82). On the contrary, its absorption into the transnational migrant health assemblage need not be understood as an act of relinquishing to the international community control and oversight over its core biopolitical functions but as a move that strengthens the capacity of Thai authorities to extend control over ungoverned populations within Thai territory. Indeed, these mutations in statecraft can be read as indicative of the inherent flexibility of statecraft in global politics (Ong, 1999: 214).

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Notes

1. I draw mainly on the literature relating to the broad conception of human security promoted within the United Nations system and transnational organizations associated with the United Nations.
2. For Foucauldian debates on circulation within the field of international relations more generally, see, for example, Dillon and Lobo-Guerrero (2009), Lobo-Guerrero (2008) and the contributions in De Larrinaga and Doucet's (2010) edited volume, particularly that by Aradau and Blanke (2010).
3. I refer to Burma throughout the present article. The change from Burma to Myanmar was a political feat by the Myanmar military government that is not accepted by the country's opposition. Use of the term Burma is politically charged.
4. The UNHCR considers these shelters refugee camps. Thailand is not a signatory to the 1951 Convention Relating to the Status of Refugees or to its 1967 Protocol. Given this, these people are seen largely as economic migrants, 'despite their frequently mixed reasons for entering Thailand', and are classed as 'illegal migrant workers'; see Hynd (2002: 17).
5. The United Nations Trust Fund for Human Security, also known as the Human Security Fund (HSF), is managed by the Human Security Unit based in the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA).
6. Interview with an officer of the Thai Ministry of Social Development and Human Security, Bangkok, September 2008.

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7. Interview with the chief medical officer and head of the Migrant Health Unit, Ranong Provincial Public Health Office, September 2008.
8. There are more than ten languages/dialects among Burmese migrant communities in Thailand.
9. Interview with the head of the Migrant Health Unit, Public Health Office Ranong, September 2008.
10. Although only part of this information is collected for the Thai population, prompting the argument that the migrant folder is more 'advanced' than the existing system for local Thais.
11. Interview with heads of Ranong and Samutsakorn migrant health units (September 2008).
12. Interview with WHO officer, September 2008.
13. Interview with an IOM field officer in Samutsakorn, September 2008.
14. According to interviews with Burmese health workers as well as members of NGOs, September 2008.
15. Interview with WHO officer, September 2008.
16. Interview with WHO officer, September 2008.

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