

Asian Anthropology

ISSN: 1683-478X (Print) 2168-4227 (Online) Journal homepage: www.tandfonline.com/journals/raan20

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To cite this article: Shao-Yun Chang (2024) Governing migrants' health: how activists in Taiwan construct Southeast Asian migrants' access to (health)care, Asian Anthropology, 23:3, 178-194, DOI: 10.1080/1683478X.2024.2364555

To link to this article: https://doi.org/10.1080/1683478X.2024.2364555

Published online: 30 Jun 2024.

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ASIAN ANTHROPOLOGY
2024, VOL. 23, NO. 3, 178–194
https://doi.org/10.1080/1683478X.2024.2364555

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Governing migrants' health: how activists in Taiwan construct Southeast Asian migrants' access to (health)care

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ABSTRACT

Access to healthcare among Southeast Asian migrants in Taiwan is a pressing concern. Once migrants fall ill, they are at risk of losing jobs and even jeopardizing their legal status to work and stay. While existing studies have shed light on migrants' experiences of alienation in healthcare, there has been limited attention given to the role of migrant activists in negotiating and mobilizing concepts of health. In this article, I examine how activists mediate migrants' access to health resources. As migrant organizations step in to care for migrants, they render migrants' bodies legible and admissible by guiding them through the healthcare system. I suggest that activists wield the power to govern by shaping the ideals of a healthy and morally responsible migrant. Their authority to care also hinges upon crafting narratives of collective wellness that foreground the interdependent relationship between citizens and migrants, elevating migrants' health into vital projects of governance. Through a critical analysis of discourse and praxis around migrant care, my intention is not only to challenge the narrow focus on migrants' physical wellbeing but also to cast light on the affects of mediating care and how it shapes meanings and values attributed to migrants' lives.

ARTICLE HISTORY
Received 12 February 2024
Accepted 2 June 2024

KEYWORDS
Migrants' health; health inequality; migrant advocacy; healthcare; legibility

Introduction

As I massaged Wati's hands in aromatherapy class, she explained that she had developed wrist pain soon after starting work as a caregiver in Taiwan. She took care of an 80-year-old grandma by herself and had an endless list of chores to do around the house. By nighttime, she could feel pins and needles in her wrists but had to keep working the next day. I recalled another Indonesian worker also suffering from wrist pain but would not consider surgery as it required time-off from work. "*Lao-ban* (the employer) would not like it," she said. I contemplated what a thoughtful response would be. Clearly, Wati was aware of the severity of her pain but the nearest clinic was almost an hour away. Having dealt with repeated wrist injuries myself, I could easily imagine the doctor asking her to rest and refrain from any heavy chores. That just seemed unhelpful for workers like Wati. For migrant workers, having access to

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healthcare does not guarantee healthfulness. Yet, as I worked alongside migrant activists, the initial response to migrants in pain was always, "Have you seen a doctor?" As migrants I met talked about coping with pain through acupuncture and even seeking religious support, activists tended to frame these attempts as makeshift solutions. Visiting a doctor in a clinical setting had become the only rational way to deal with illness.

Migrants' access to health has long been a focus in discussions on transnational migration (see Amrith and Amrith 2016; Sahraoui 2022; Troccoli et al. 2022, for example). As migrants move, they also pass through several medical systems and some even fall out of care. Based on the features of each migrant population, some are at a much higher risk of illness and lack access to care. Many migrant workers often work in dangerous conditions with little financial and employment securities (Sargent and Larchanché 2011; Sunam 2023). Although migrants face more challenges beyond illness and healthcare, health is a prism for addressing competing anxieties in receiving nations experiencing waves of transnational migration. As health is increasingly considered a basic human necessity and even a universal right, access to healthcare is seen as a pathway to mitigate inequality and the effects of social marginalization (United Nations 2019) that migrants so often experience. But the universal framework of health is a double-edged sword. While this frame addresses migrants' wellbeing independent of their social and legal statuses, this emphasis on health also runs into the risk of imposing a set of medicalized criteria determining how migrants should relate to and care for their bodies.

For migrants, health is far from an individual endeavor. As migrants come into contact with health systems, other actors are drawn into the encounter. In this article, I examine how migrants and activists at migrant organizations come together to conceptualize and shape discourses of migrant health. For many migrants, getting care is challenging whether they qualify for healthcare resources or not (Low, Tong, and Binns 2015). Not only are they unfamiliar with the local language and thus unable to express symptoms and pain (Kuan, Chen, and Lee 2020), but medical costs also deter them from seeking care (Chavez 1986). In addition, medical practitioners work within their own "culture of biomedicine" and may pathologize certain features among migrant populations (Borovoy and Hine 2008; Kleinman and Benson 2006). To mitigate these challenges, both migrants and practitioners are dependent upon mediators to facilitate exchange, some of these include interpreters, cultural mediators, and volunteers (Giordano 2008; Willen 2011). While mediators make migrants' stories and pain legible, they may also reify or construct hierarchies by determining migrants' deservingness of care and medical attention (Santilli 2020).

Rather than taking health at face value, I am interested in understanding how different actors mobilize notions of health. The health and wellbeing of migrants, I argue, have almost become synonymous with access to healthcare. In such light, how does access to healthcare operate as a governing ideology for disciplining migrant bodies? How do migrant activists, acting as the intermediary between migrants and the healthcare system, impose their own understandings of wellbeing on migrants' deservingness and social citizenship? Additionally, when activists' craft narratives of health inequality based on their encounters, to whom are these claims addressed? This article

takes up migrants' health as an ethnographic object and examines what Willen (2011, 306) calls "idioms of social justice mobilization." By showing diverse encounters between migrants, medical institutions, and migrant organizations in Taiwan, I demonstrate how narratives of wellbeing take shape through the liminal space of competing governing strategies for migrant bodies. I further show that, through examining mediated processes it is possible to make sense of elusive public opinions that drive meanings and values attached to migrants' lives.

Situating migrants and healthcare in Taiwan

Taiwan is an especially interesting case for understanding migrants' access to healthcare. Debates around migrants using healthcare show the limits of rights-based advocacy even when migrants are formally incorporated into the healthcare system. I demonstrate that having rights to healthcare does not guarantee access to health. Additionally, healthcare can serve as a morally rigid framework stipulating how migrants relate to their own bodies for the sake of the public good. From a policymaking perspective, the case in Taiwan also brings medical access into sharp focus. Is having multilingual translation resources enough for dealing with migrant patients? As I demonstrate in this article, language resources, despite their importance, are a band-aid-like "technical solution" (Ong 2006) to deeply political and moral questions of health. These discussions shed light on how policymaking on im/migration may better resolve disjunctions between maintaining ideals of healthfulness and providing resources for migrant populations.

In Taiwan, the National Health Insurance (NHI) is a compulsory program for all citizens and international residents. However, NHI coverage is only extended toward legal residents, leaving out large numbers of absconding migrant workers who break contracts to seek employment elsewhere. This is an important distinction that I will return to later in this article. For citizens and legal residents, insurance coverage is maintained through their employers or family members. In most cases, the insured pays 30% of the insurance premium while the rest is covered by their employer and the state. The NHI prides itself in providing comprehensive coverage, including inpatient care, outpatient care, dental visits, traditional Chinese medicine, and other costly treatments. For most visits, patients pay around 100–200NTD upfront (about 4–7USD) while the rest is mostly covered by the NHI.

NHI's affordability and extensive coverage, however, have sparked debates on its financial sustainability, and migrant healthcare is seen as part of that problem. Since its inception in 1995, the NHI has barely raised its premium while overall medical expenses increased exponentially in the past two decades. To address the mismatch, policymakers have suggested further adjusting premiums and NHI's payment structure, a reform met with angry pushback from the public. While NHI's financial instability has been a constant debate among the health system, NHI's potential collapse has prompted anxieties on who deserves care, placing the blame on migrants for their lack of long-term residency in Taiwan and short-term contributions to NHI. When I inquired into migrants' access to NHI, a migrant activist showed me screenshots of an online chat group consisting of brokers. These brokers, primarily Taiwanese citizens

employed by state-regulated brokering agencies, assist Taiwanese employers in hiring foreign labor and oversee the management of migrant workers, including housing accommodation and getting medical care—a point I will revisit later in this paper. In the chat group, where brokers could post anonymously, there was significant disapproval of migrant workers utilizing the NHI. They argued that workers had only resided in Taiwan for a short period while citizens had long-term financial contributions to the NHI. Giving migrants the same form of care was deemed unfair and even hurt the NHI.

These comments are reminiscent of anti-immigration discourses in migrant-receiving countries that cast migrants as threats who take medical resources away from citizens (Chavez 2013). Paradoxically, it is their lack of formal citizenship that makes migrants' health so fragile (Marshall 1992). Without established civil belonging, migrants' medical welfare is easily manipulated to serve the interest of citizen subjects in public discourse. This fragility between social and civil citizenship raises tough questions for ongoing advocacy for migrants' health. When incorporating migrants into the healthcare system fails to mitigate the effects of social marginalization, what kinds of conversation are happening that continue to uphold these old hierarchies that reify distinctions between citizens and foreign Others? In addition, who is participating in these dialogues? As I demonstrate throughout this article, migrants are largely left out of these conversations while migrant activists take over as interlocutors to interact with medical institutions. While migrants are physically present, they remain unintelligible and rendered as passive receivers of aid (Shindo 2019).

I focus on Southeast Asian migrants in Taiwan and their encounters with medical systems and migrant organizations as they attempt to seek care. While I use the term "migrant," I am predominantly concerned with the experience of migrant workers (*yígōng*). Migrant workers have emigrated from Southeast Asian nations into Taiwan since the late 1980s, filling job vacancies in factories, agriculture, fishing, and the care industry. Up until 2022, workers could only legally work in Taiwan for a maximum of 12 years and were ineligible for permanent residency. As a result of such limitations, workers are externally transient subjects who spend most of their time working as caregivers, factory workers, or fishermen at sea. While workers are given simple Chinese lessons during training, most workers rely on brokers to communicate with employers and deal with errands in everyday life, such as filing paperwork or getting a health checkup.

By using the term migrant, I also hope to account for how distinctions between workers and other migrants are blurred. Workers often cross paths with Southeast Asian wives who have married into Taiwanese families. Some workers even become wives after working in Taiwan for a few years. In everyday interactions, migrants' nation of origin matter far more than their immigration category since migrants from the same country share linguistic knowledge. The distinction between migrant workers and other migrants matters even less to Taiwanese since most do not speak Southeast Asian languages. As I began to investigate migrants' encounters with medical practitioners, I realized how wives and workers were subject to similar marginalization in the health system. One of the most cited challenges is their shared struggle to communicate their own experiences and feelings in medical examinations (Huang and Chi 2017; Lee 2006). In times of illness, workers also turn to wives for assistance in everyday life, whether to acquire medication or seek help with communication. I, therefore,

use the term migrants to denote their collective struggles. By way of using migrants as a unit of analysis, I shed light on interpersonal connections that are not only increasingly influential across migrant advocacy but also fundamental to the making of a Southeast Asian migrant collective as a target for governance.

Research methods

I collected data for the project over non-consecutive 18 months of fieldwork in Taiwan from September 2021 to March 2023. I worked closely with Yuèzàijiā (YZJ), a migrant organization based in Mínxióng Township, Jīayì County and participated in their day-to-day activities. Some of these activities included assisting migrant workers with legal issues, organizing multicultural events, responding to press inquiries, and seeking funding support. I placed my primary emphasis on collaboration as an observing participant (Costa Vargas 2008) and actively assisted YZJ with several curated exhibitions during fieldwork. Following extensive discussions with Nguyễn Kimhồng and Tsung-Lung Tsai, the founders of YZJ, I received consent to utilize their real names. Being documentary filmmakers themselves, they were aware of the ethics of representation and were open to acknowledgment for their efforts in supporting migrants. Pseudonyms have been used for all other activists and migrant organizations mentioned.

Through colleagues at YZJ, I built ties with migrant organizations located across several regions. I employ the term migrant organization broadly to encompass advocacy groups, non-profit organizations, service-oriented groups, and self-help organizations serving diverse Southeast Asian migrant communities in Taiwan. These organizations comprise both Taiwanese citizens and Southeast Asian migrants among their members, staff, and volunteers, whom I refer to as migrant activists in this paper. With snowball sampling, I conducted semi-structured and informal interviews across 10 migrant organizations. Among these organizations, five of them were in metropolitan areas and the other five were based in more rural settings. My interviewees comprised both Taiwanese activists and Southeast Asian migrants, with interviews predominantly conducted in Mandarin Chinese and a few in English. Despite years of enrollment in language lessons, my command of Southeast Asian languages remained limited as a Taiwanese individual. To facilitate communication with migrants, I engaged Vietnamese and Bahasa Indonesian speakers, many of whom were activists themselves, to assist with translation. I was interested in discerning their experiences in migrant advocacy and how they understood themselves in relation to policymakers and other stakeholders. Data for this article consists of fieldnotes from participation and observation, as well as semi-structured and informal interviews. Fieldnotes and transcribed interviews were imported into NVivo for detailed qualitative analysis.

Migrants' health as a confluence of power

Though much scholarship has focused on migrants' health rights and equity, assumptions and associations relating to migrants' health remain understudied. Public health scholars have argued that improving migrants' access to health resources not only lowers risks for migrants working in dangerous conditions, but also contributes to the

public good as citizens and migrants dwell together (Illingworth and Parmet 2015). Through underscoring the public good, receiving nations are called upon to take responsibility toward the *protection* of migrants' health (Low, Tong, and Binns 2015, 585, emphasis mine). But this claim foregrounds migrants' health only insofar as it acquires meaning when set against the backdrop of the nation and citizen subjects. This approach suggests that migrants' health is not an issue of health *per se*, but a contested site of political governance that is of great interest to maintaining the well-being of the national body.

Juxtaposing foreign bodies against the nation is where boundaries are reified, sometimes undermined, and even reimagined. Boundaries take shape through institutional languages that can reinforce long-standing social categories such as race, ethnicity, and citizenship. In Cheng's (2022) study of health assessment measures for migrant workers in Taiwan, she highlights how regulations reinforce a hierarchy of sanitization as workers from Southeast Asian nations undergo compulsory health checkups. Compared to foreign nationals, the bodies of migrant workers are perceived as more prone to carrying infectious diseases, thus posing a greater risk to public health. Similarly, through their work on public health campaigns in the US, Horton and Barker (2009) explain how public health discourses, especially hygiene, have been central to exclusionary immigration policies and continue to justify racialized health practices on scientific grounds. In addition, migrants' lack of compliance with the ideals of healthiness are under scrutiny, such that poor health signals "unfitness for citizenship of such newly arrived 'foreigners'" (Horton and Barker 2009, 790). To assess and evaluate migrants' healthiness, health professionals are vested with authority to act as experts through which they reify social hierarchies that subjugate migrants.

Institutions and health professionals, however, are not merely actors upholding social rule but are actively participating in rulemaking. As a result of uneven resource distribution, migrant populations struggle with access to care (Sargent and Larchanché 2011). With the decline of welfare programs, NGOs, activists, and international organizations are increasingly taking on governance roles for marginalized populations neglected by the state (Ticktin 2012). Within European national healthcare systems, the responsibility for migrant care is shifted to local humanitarian associations, where NGOs and activists influence migrants' medical and legal status by determining their eligibility for treatment, often based on existing state regulations such as healthcare frameworks and immigration policies (Santilli 2020). Activists thus play prominent roles in shaping local principles of justice and even legitimize discourse on entitlement to care (Castañeda 2023). The ability to arbitrate migrants' vulnerability also highlights the structuring power of state governing strategies. While principles of healthcare and health practices are initially imposed to facilitate care towards migrant bodies, they "end up becoming categories that organize people's daily experience" as actors are deeply embedded in these state-created institutions (Scott 1998, 83).

Interactions between health professionals and migrants are never straightforward or direct. When translation and intelligibility continue to pose challenges for both sides, migrants' health draws in a confluence of professionals and mediators to facilitate communication across several institutional fields. Through acts of translating, mediators such as volunteers and NGO staff members partake in claim-making on behalf of

migrants who are physically present yet lack linguistic proficiency in the language used by most citizens (Shindo 2019, 46). In medical settings, migrants' physical realities further run up against the language of biomedicine. To obtain a diagnosis, migrants rely on interpreters and mediators to create space to articulate their experiences. The process of translation, however, is not a one-way street that only channels migrant voices into information commensurable enough for institutional languages. As much as translation transforms migrants' experiences, it also alters the language translated into and sheds new light upon ways to constitute both migrant subjectivities and citizenship (Giordano 2008, 597).

By way of translation, the foreignness in migrants' bodies becomes legible and almost only through mediation does migrants' health become admissible. It is thus crucial to pay attention to how these acts of mediating are capable of ascribing "meanings and values of life" (Fassin 2009, 52), or the power of life in discussions on biolegitimacy. Further building on the idea of biolegitimacy, Willen pushes for a critical examination of "idioms of social justice mobilization" (2011, 307) to not only unpack the meta-values of health but also understand how actors invoke health along with moral and ethical arguments that bear upon migrants' deservingness of health. Furthermore, these processes that seek to define and shape meanings of migrants "emerge in the public sphere, where social institutions, the media, public opinion, and civil society all play leading roles" (Willen 2011, 324).

By examining the roles of mediators, I ask whose accounts of migrants' health are deemed credible for the wellbeing of migrants to hold significance. How are these notions of health established? And how do they come to determine and shape values of health for both citizens and migrant subjects? While migrants depend on various types of mediators to access healthcare, including translators, care workers, activists, and even their own brokers, I specifically focus on the roles that migrant activists play in providing care and support to migrants. Activists serve a dual role: not only do they assist migrants in accessing care, but they also act as bridges between migrant communities and Taiwanese society, drawing attention to migrants' foreignness and lack of care among policymakers and Mandarin-speaking audiences. As I demonstrate throughout this article, this dual role particularly empowers activists to govern and assign values to migrants' lives. What I hope to achieve through these inquiries is to break free from the fixation on migrant' bodies with a clinical gaze that "sees through the patient" to focus on disease (Holmes 2013) and render migrants as silent subjects. As much as migrants' health is about migrants, it is also about how migrants' pain is "lifted into the visible world" and whether migrants' "sufferings will become knowable to a second person" (Scarry 1985, 13). It is through mediators who do this lifting that migrants' health gains traction, profoundly influencing public perception of migrants' lives.

Migrant activists stepping in to care

Migrant organizations streamline migrants through the healthcare system. However, almost none of them are established on a medical humanitarian basis nor place specific focus in health.[1] YZJ, like most other migrant organizations, focuses on cultural

representation, improving working rights, and advocacy for social justice. Kimhồng, who founded YZJ in 2017, saw her work as a passion to promote culture. However, during my time working with YZJ, both Kimhồng and her husband, Tsai, were frequently chauffeuring migrants to see doctors besides from planning cultural events. Kimhồng had emigrated from southern Vietnam to Taiwan in early 2000s. Her first marriage was extremely turbulent and she only began to build close ties with other Vietnamese migrants after divorce. She later met Tsai, a budding Taiwanese filmmaker at the time, and together they made several well-received documentaries on Vietnamese wives and workers in Taiwan. YZJ was the culmination of their interests and resources that spoke to growing public interest in Southeast Asian cultures in recent decades.

Kimhồng had a network of Vietnamese migrants who would often contact her for help. At first, they were mostly Vietnamese wives living in the neighborhood. They later grew acquainted with Vietnamese workers working in nearby factories. On weekends and holidays, a group of familiar faces would show up at YZJ for home-cooked meals and beer. They often brought in younger migrants who had just arrived in Taiwan and introduced friends to Kimhồng who were experiencing challenges at work. One of them was Trung. When I first met Trung in the summer of 2022, he had a limp and relied on Kimhồng to take him to doctors. Trung appeared at YZJ infrequently and had not showed up for weekend dinners or birthday parties that year. He was there because of foot pain. Over a month, Kimhồng took Trung to see doctors but none of the prescriptions worked. When Kimhồng was tied up with her other commitments, she would ask Tsai to take Trung to the doctor. One evening, before ushering Trung into his car, Tsai had Kimhồng double-check with Trung in Vietnamese, to make sure if he had pain in his bones or his muscles. Trung replied quietly in Vietnamese while Kimhồng explained the symptoms in Mandarin to Tsai. They quickly left for the clinic in town before it filled up with patients. Tsai went in with Trung and made sure the doctor understood Trung's pain.

In the health setting, migrants are unable to fully communicate with medical practitioners. One of the most prominent challenges remains the language barrier. Migrants find difficulty in expressing pain and symptoms in Mandarin Chinese while doctors and nurses are only capable of communicating in Mandarin and sometimes English. Workers like Trung, compared to other migrants, can in principle request help from their brokers as part of their contract. Each month, brokering agencies charge workers a service fee between 1500 and 1800NTD (about 50–60USD) as permitted by the Ministry of Labor, covering basic services such as translation or getting medical care. However, brokers are often reported to be unreliable or request exorbitant fees on top of monthly charges. In an exchange with Peter, a social worker affiliated with a Catholic non-profit in northern Taiwan, he recalled an Indonesian fisherman who experienced a hernia. The fisherman contacted his broker as the pain grew intense. The broker quoted 6000NTD (about 200USD) just to transport him from the fishing harbor to the nearest hospital. Unwilling to pay extra, the fisherman sought alternative care by asking his Indonesian friends to massage his organs back into place. Peter was shocked and later took the fisherman to hospital. He stressed that it was through his intervention that the fisherman was nursed back to health.

When activists come across migrants experiencing ailments, shuttling them through the healthcare system is presented as the common-sense solution. Why should migrants seek other forms of treatment when they have access to affordable healthcare? The availability of healthcare through NHI, with quick appointments and low costs, has profoundly rationalized the relationship between illness and the health system. Going to a doctor is almost the only response to any discomfort. When I was struggling with loss of smell after COVID-19, Tsai half-jokingly said it was because I had not scheduled a virtual appointment and gotten a prescription like most Taiwanese did. In such cases, the accessibility of care through universal healthcare, on the one hand, has shaped perceptions of illness as problems to be resolved through health professionals and medical institutions. On the other hand, healthcare has become synonymous with care, eclipsing other forms of treatment that take place outside of the healthcare system with the tendency to render them ineffective.

Measuring wellbeing through access to the healthcare system often fails when working with marginalized populations. Migrants are especially at a disadvantage as use of healthcare already requires knowledge of services available from medical institutions (Chavez 1986). Besides from medical literacy, migrant workers in particular face additional challenges such as arranging transportation to clinics or following through with medical treatments given their long work hours. Having observed these challenges firsthand, activists were aware that migrants sought their own forms of care. Some of these means include taking medicine from home or purchasing semilegal over-the-counter drugs from Southeast Asian supermarkets. However, sharing Peter's shock with a massage treatment for hernia, activists often portrayed these acts of care to be a makeshift option and eventually migrants will require healthcare. As a staff member from a migrant group working with Indonesians explained, while they would inform migrants about over-the-counter medication for illness, they generally advised migrants to visit the doctor. "What if it blows up and becomes a serious illness? It can be dangerous," she said anxiously. In such light, activists center the healthcare system and push other forms of care to the margins. This approach tends to subjugate migrants' own agencies and techniques in managing their bodily wellness.

The "lack" of health

Equating care to healthcare is well cemented by the political aspiration in the previous century to ensure a nation's health. Instruments developed by pharmaceutical and insurance industries further became one of many drivers to ensure health (Rose 2001). What makes evaluating migrants' health in light of healthcare concerning is that migrants are always in a position of lacking—lacking health and lacking care—since they were never included in ideas of a healthy population in the first place. The idea of lack, as Nader (2005) theorizes, has been extremely persuasive in legitimizing rational order to justify ruling over those who fail to mobilize resources efficiently and rightly, perpetuating a framework for intervention and plunder especially in international development. In such a case, migrants' health is thus concerning not just because of its visceral impacts on foreign bodies but also because only very few tools are available to position migrants' health renders migrants as subjects in need of care

and a high-risk group. While risk thinking in this context comes as a desire to intervene and control a potential future, the uncertainty of migrants' health, however, is not so much based on somatic or genetic defects (Rose 2001). Instead, the risk originates from the unknowability of migrants' bodies and migrants' muteness in medical examination rooms.

The lack, meanwhile, provides space for migrant NGOs to assert claims for migrants' wellbeing. For one, it enables migrant groups to step in and undermine the authority of the brokering system. Echoing Peter's complaint, almost all activists I met were outspoken about their frustration with brokers, citing their unreliability in assisting migrants in need. The brokering system, more than immigration control and policies, has drawn tremendous criticism in the past few years for exploiting migrants (Lee 2019). However, both employers and migrants continue to rely on brokers for job matching, facilitating everyday communication, and filing paperwork. An employer explained that it was just easier for him to work with a broker, just to make sure he was following the rules. Brokering foreign labor thus constitutes a social field in the sense of Bourdieu in which brokering rests upon a set of structured and patterned practices that confer legitimacy (Bourdieu 1987, 805). To occupy a counter position against brokers is thus to compete against their authority. While activists speak for migrants, brokers represent the interests of brokers, positioning migrants' and Taiwanese employers' wellbeing as mutually exclusive. The relationship between migrant NGOs and brokers is extremely strained as they navigate the murky waters of migration politics.

Migrants' health advocacy emerges as one of the very few avenues through which activists can achieve broader recognition without debating migrants' deservingness of care. Representing migrants' access to healthcare has become crucial for storytelling advocacy work. Activists frequently document experiences of taking migrants to doctors themselves on social media, such as the one told by Peter, in order to express their total bewilderment at navigating the medical system with migrants. Throughout my fieldwork at YZJ, my colleagues and I were also regularly approached by medical institutions and healthcare professionals seeking insights into migrants' health experiences. The direct and long-term relationships between migrants and activists position the latter as credible storytellers who render migrants' pain tangible and undeniable to a Mandarin-speaking public. Activists' depictions of care thus convert the migrants' embodied pain into a discourse that focuses on the inaccessibility of healthcare and the perils of living in a state of lack. Through making migrants' pain visible, these stories thus take on an affective dimension in shaping moral understandings of migrants' wellbeing.

Care as everyday governance

In making their subjugated experiences visible, activists also make migrants' bodies legible and manageable. By taming migrants' bodies through medical examinations and checkups, activists highlight healthcare as the promise of a good life. The good is not only rooted in the migrant's physical wellbeing, but more importantly, in the interrelationality of citizens and migrants.

Yohanes is the founder of Indonesian Migrants Caring Society (IMCS), a migrant organization with a primary focus on Indonesian migrants. To pursue a medical career, Yohanes left Indonesia at a young age and later became a gynecologist in Taiwan. Since Yohanes had been working in medical settings, IMCS had always emphasized health resources in addition to promoting Indonesian cultural events. When I asked Yohanes about what they did for migrants' health, he proudly pointed out their efforts in offering wellness checkups at the ASEAN plaza in Taichung, a popular weekend gathering place for Vietnamese, Thai, and Indonesian migrants in central Taiwan. They did screenings for breast cancer, HPV, oral cancer, and colon cancer, all free of charge. Although migrants already undergo annual health checkups (Cheng 2022) and are eligible for medical screenings at medical institutions, Yohanes prided himself in promoting care. I asked if migrants were willing to undergo screenings, to which Yohanes replied, "Of course! Even if they have to pay out of pocket. I tell them how much examinations such as a pap smear test cost in Indonesia, at least 250 thousand rupiah. That's more than 500NTD. Here it's only 320NTD and I can do it for free at my clinic too."

Through their Christian church network, Yohanes met Alice, who was interested in supporting the Muslim community in Taiwan. Alice later took over the reins of IMCS and became responsible for organizing cultural events, seeking financial support, and connecting with migrants. She saw their work as *guānhuái*, meaning to care and to be concerned about. I found her usage of *guānhuái* to be peculiar. Although the term is part of IMCS's name, Alice framed almost all their efforts as a labor of care as she explained, "Migrants left their families to come here. We should care about them." Alice's idea of care was anchored within interpersonal interactions that provided a sense of intimacy for migrants in the absence of family ties. Care was a constant project in the making.

When I asked Alice about IMCS's wellness workshop, she offered her take on migrants' *wèishēng*, or hygiene. Although *wèishēng* is closely associated with the idea of *jiànkāng*, also meaning health, the former carries a connotation of cleanliness with a strong emphasis on the present. Acts that lack *wèishēng* can do immediate harm to one's body, such as not washing hands prior to eating; while neglecting *jiànkāng* is often thought of as over-drinking, poor diet, and other habits that cause long-term harm. The distinction of temporality is important here. Alice framed IMCS's rationale for offering wellness classes in light of Indonesian migrants' lack of profound understanding of *wèishēng*:

> I think this has a lot to do with level of education. I'm not trying to criticize them. In the case of Indonesia, there are just too many people and most do not have a good level of education. A high school diploma would be ideal but most only graduated with diplomas from elementary or middle schools. Indonesian families do not have good relationships either. Mothers don't support their daughters through school and have them find jobs instead. Where do they find jobs? Indonesians think Taiwan is a good place. Some come to Taiwan when they are fifteen or sixteen years old. Some families tell them to get married and have kids before they leave. I don't think they have a good idea of *wèishēng*. They don't have good teeth. They like deep-fried and spicy foods. They have problems with their stomach, liver, and kidneys. We offered lessons, teaching them how to brush their teeth and get their teeth cleaned. They had no idea. Nowadays most Taiwanese care about oral health. It wasn't the same when I was growing up. Who cared about getting

> their teeth cleaned every six months? Unless it was a toothache. Most Taiwanese are good with oral care now but migrants are not. They only take action when they are really in pain or uncomfortable.

Alice's contextualization of *wèishēng* prompts a closer examination of evaluating health in migrant Others. If health is to have soundness in the body, how does one begin to measure healthiness? Is it even possible to use measurements based on the health system to gauge migrants' health? As modern nation-states became more invested in the wellbeing of a population that ensured national strength, health was one of the projects of social engineering. For migrants who fail to adhere to the same health ideals, medical professionals tend to label them as lacking self-management and even question migrants' cultural practices (Borovoy and Hine 2008). Some diseases, more than others, come with strong connotations. Oral hygiene has been one of them as diseases such as cavities have become mostly preventable through modern scientific measures. Oral diseases among migrant population are manifestations of the "stain of backwardness" through which public health campaigns reiterate racialized discourse (Horton and Barker 2009), agitating anxieties of racial contamination deeply entrenched in colonial histories (see Stoler 1989, for example).

Since universal health coverage provides access to health resources regardless of citizenship, migrants are held up to the same standards of health ideals available for citizens. As NHI covers two dental cleanings per year, getting one's teeth cleaned every six months builds into a homogenous measure, one that makes health legible and easily administered (Scott 1998). Although activists are not the ones to provide medical care, they are deeply embedded in medical institutions created by the state through their own participation as medical subjects. By extending institutionalized categories towards migrants' health, activists work to make foreign bodies and health practices perceptible even if in a negative light. It is important to note that the yardstick of healthfulness is not so much about acculturating migrant bodies into the receiving society but a measurement to gauge their commitment and fitness to work. As Alice stressed, "Without these migrant workers, our economy will tank. If they [migrant caregivers] aren't here to take care of *a-gong a-ma* (grandparents), who's going to take care of them?" By emphasizing labor contribution, migrants' bodies are always *oriented towards* the wellbeing of citizens and the national economy. The latter serves as a "form of extension," determining what bodies "can 'have' and 'do'" (Ahmed 2006, 115). Healthcare is presented as a means through which migrants can tend to the nation as dutiful subjects.

Making migrant bodies legible

The promise of healthcare also works to convince migrants to stay legible. Among activists, healthcare is often used as the last line of defense to convince migrant workers to stay on their contracts. In other words, healthcare is not just the means to stay healthy to work, but also the reason to stay legally employed in the first place. Workers break contracts for a myriad of reasons. Some seek to leave demanding working conditions but fail to obtain permission from their employers. Others pursue better-paying jobs to pay off debt faster or send remittances back home. Those who go

underground are termed *táopǎo wàiláo* (runaway foreign workers), *fēifǎ yígōng* (illegal migrant worker), or *shīlián yígōng* (untraceable migrant workers) and can be deported immediately by the National Immigration Agency. While activists are sympathetic to migrants' undesirable working conditions and financial troubles, most strongly discourage migrants from running away and cite healthcare as one of their main arguments.

Working as missionaries in Taiwan, Pastor Nguyen and his wife Amy recalled how they dissuaded Kiệt, a Vietnamese migrant worker, from going underground. Kiệt was employed at a pig farm and left angrily after feeling misunderstood at work. Instead of reporting to the authorities, the farm owner called Nguyen for help to convince Kiệt to return. Amy explained, "When he left, somebody took him in immediately and offered a job [that paid] two or three times more than the money that he was getting there. We kept telling him: Number one [you are] a Christian and that is not the right thing to do. Number two, you don't know. Some people [are] safe for many years. They don't have accidents, anything. But other people like the ones we have helped, [accidents happen] just like that and they have no type of health from any sources. They are on their own and that is a burden for anyone, even their family back in Vietnam."

Through Amy's explanation, healthcare functions as a strategy to make migrant bodies visible and legible by emphasizing contingencies in the lack of care. The argument for legibility guarantees promises to overcome hardship while illegibility is subject to admonishment on both moral and legal grounds. During the COVID-19 pandemic, absconding workers were even seen as a threat to public security as they were "out of reach" of formal healthcare (Cheng 2022, 304).

When viewed in such a light, healthcare governs how migrants may act and nurse their bodies in relation to the wellbeing of citizens. It is important to note that the governing power is not explicit, but a dispersed form of governance embodied by activists as they instruct migrants to act by health practices and stay within the reach of medical institutions. Activists like Peter and Alice reframe these encounters to emphasize the urgency of caring for migrants as the foundation of advocacy, thereby profoundly shaping how migrants' ailing bodies, seen as symbols of reduced productivity and even potential threats to public safety, become eligible for recognition and sympathy from Taiwanese society. From the standpoint of advocacy, orienting migrants' health to citizens is a compelling strategy as it finally draws attention from citizens without subjugating most migrants. When coming across community organizers who were hesitant to direct resources toward migrants, I found myself making similar arguments too. Despite its potency, this line of reasoning locks migrants down to the wellbeing of the nation–state such that their health ceases to matter outside of this relationship. Healthcare for the collective wellbeing of both citizens and migrants thus becomes a disconcerting assertion as it only tolerates migrants who live up to the ideal while chastising those who live on the margins of health and morality.

Conclusion

In this article, I have taken a critical approach toward investigating the discourse and praxis around migrants' health. The point is not to reject migrants' health as a

plausible form of advocacy nor to discourage scholars and activists in bringing health resources into marginalized communities. If anything, I demonstrate why migrants' health deserves more attention than simply viewing the issue as a public health initiative and concern. Rather than focusing on migrants' bodies *per se*, I foreground how mediated processes, facilitated by migrant organizations, have a heavy hand in shaping understandings of migrants' health and their wellness. I place my emphasis on narratives and encounters not as a distraction from migrants' own experiences in getting care. Instead, I hope to push back against the gaze on migrants' bodies that I have encountered repeatedly in both conducting fieldwork and presenting work on migrants' health. What requires closer examination is not migrants' bodies, but the fixation on managing migrants' bodies and making their pain visible.

I have shown how governance over migrants' health takes place through interactions between migrant organizations, healthcare systems, and occasionally migrants themselves. These are horizontal connections that decenter the state as the sole actor. As migrant organizations step in to care for migrants, their experiences in facilitating migrants' access to medical resources are crucial for asserting authority to speak *about* care and to speak *for* migrants. Narratives of care take shape through maintaining an ideal for interrelated wellness, or more explicitly, attending to the wellbeing of both citizens and migrant subjects. The approach, on the one hand, appeals to citizens by highlighting migrants' healthfulness as a valuable investment for both citizens and the nation-state. On the other hand, as citizens' wellbeing becomes interdependent with migrants' health, the legibility and visibility of migrants' bodies grow into pivotal projects for governance and draw in various political actors to mobilize ideas of health.

It is worth taking a moment to contemplate assumptions of this idea of interrelatedness that drive governing strategies against the backdrop of contemporary migration politics. This political frame is a prevalent multicultural emphasis in receiving countries that seeks to increase the active role of migrant Others and has driven huge sums of money into migrant organizations and civil societies. In Taiwan, while migrant organizations and health professionals emphasize their appreciation of cultural diversity, their judgments on migrants' health manifest without disguise. In the name of health, it is easy to attach labels to migrants laden with values – good, bad, productive, sick, lack of contribution, and so on. The argument for good health, presuming a physical sameness between citizens and migrants, enables intervention into migrant communities that would be impossible through judgment of lifestyles or social practices. The medicalization of migrants, as well as marginalization based on lack of health, thus emerge as important new techniques in the contemporary to not only control migrant bodies, but also profoundly shape public perception of migrants based on their ableness to contribute.

Moral judgments of migrants and their pertinence to national wellbeing are thus as important, if not more so than governing practices in shaping how migrants can and should dwell in everyday life. While collective moral judgments profoundly shape modern-day biopolitics (Fassin 2009; Willen 2011), capturing the opinion of the mass can be more difficult than expected. The mass lacks specific faces and names yet exists as a feeling saturating everyday interactions between citizens and migrants. Rather than trying to grasp a faceless mass, I hope that, through contextualizing the

micropolitics of governing migrants' health, I have demonstrated the affective dimensions in caring for migrants' bodies and how they mark new connections between citizens and migrant subjects.

Note

1. The only exception is Rumahku, a group founded by medical students at the National Defense Medical Center in Taipei. While Rumahku focuses on medical wellbeing, such as assisting migrants with medical referrals and improving working conditions of care facilities, they have also been vocal on migrant workers' job security and human rights. It is thus difficult to single out migrant organizations that only take on a medical approach.

Acknowledgements

I thank my interlocutors, especially Hang-Tang Chen, for their support during fieldwork. This article benefited from valuable feedback from colleagues at the annual meeting of the Taiwan Society for Anthropology and Ethnology (TSAE) in Kaohsiung, Taiwan, in 2022. I am grateful to Allison Truitt for her comments and productive discussions. I also appreciate the feedback from two anonymous reviewers.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work received funding from the Ministry of Culture, Taiwan and the Tulane Connolly Alexander Institute for Data Science.

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