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SECURING BORDERS: THE DANGER OF BLURRING GLOBAL MIGRATION GOVERNANCE AND HEALTH SECURITY AGENDAS IN SOUTHERN AFRICA

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African perspectives. Global insights.

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Cover image: Refugees from the DRC prepare to depart the UNHCR landing site for refugee arrivals on a bus for the Kagoma reception centre on 4 April 2018 in Sebagoro, Uganda. The perilous journey across Lake Albert from DRC to Uganda can take up to two days and has seen a number of Congolese die during the crossing. According to the UNHCR almost 70 000 people have arrived in Uganda from the DRC since the beginning of 2018 as they escape violence in the Ituri province. The majority of refugees are arriving by boat across Lake Albert, which lies between the two countries. With refugee settlements in Uganda almost at maximum capacity there are plans for new settlements to be built to deal with the continuing influx of people. A cholera outbreak in the settlements has left at least 42 dead and many hundreds severely affected. The World Food Programme anticipates providing food and nutrition for up to 1.6 million refugees.
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ABSTRACT

This paper explores the potential risks associated with the blurring of global migration governance and health security agendas in Southern Africa, a region associated with high levels of population mobility as well as communicable and, increasingly, non-communicable diseases. The current development of the Global Compact on Safe, Orderly and Regular Migration and the Global Compact on Refugees – agreements that aim to guide global practice – has a securitisation agenda at its core. This framing responds to the global moral panics associated with the movement of people across national borders. These increasingly nationalistic and racist panics are dangerous for multiple reasons, and the securitisation agendas of the global compacts risk negatively affecting health in Southern Africa in two ways. Firstly, increased securitisation may undermine much-needed efforts to develop migration-aware and mobility-competent cross-border, regional health system responses. Concerns include the ways in which an increasingly securitised migration management system will likely result in a growing population of irregular migrants who, owing to fear of arrest, detention and deportation, will avoid (and evade) public healthcare services, with negative consequences for all. Secondly, the development of (im)migration interventions centred around a securitisation approach may provide opportunities for co-opting components of the global health security movement – itself a problematic and contested terrain – by using health status (or perceived health risk) as an additional securitisation measure through which to further restrict movement across national borders and/or to justify deportation of non-nationals. This could be achieved through compulsory health screening, risk assessments and health-related restrictions on movement across borders. Collectively, these processes risk producing challenges that will further stall progress towards global health goals by undermining attempts to develop coordinated, cross-border, migration-aware and mobility-competent health programmes. In addition, they risk deterring irregular cross-border migrants from accessing prevention and treatment programmes for both communicable and non-communicable diseases. If these concerns are not addressed proactively, the consequences could be devastating for both Southern Africa and the global community.

ABOUT THE AUTHOR

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ABBREVIATIONS AND ACRONYMS

IOM	International Organization for Migration
SADC	Southern African Development Community
TB	tuberculosis
UK	United Kingdom
UN	United Nations
WHO	World Health Organization

INTRODUCTION

Globally, migration is increasingly recognised as a key determinant of health, but not in the ways often assumed. Contrary to popular assumptions, many who move are positively selected and experience a better health status than either the populations they leave or those to which they move.[1] However, these health benefits can diminish rapidly if recently arrived migrants or mobile populations struggle to access positive health determinants – such as quality healthcare, housing, food, water and sanitation – which can lead to migrant populations' experiencing poorer health than the host community.[2] These negative health experiences impact not only those who move but also the wider population.[3] Interventions to improve and maintain health must therefore engage with migration and mobility, as 'there is no public health without migrant health'.[4]

With approximately 240 million international migrants, and three times as many people moving within their country of birth (internal migrants), population mobility is a global norm.[5] However, health responses – including the prevention and treatment of communicable (infectious) and non-communicable diseases – do not adequately engage with migration and mobility.[6] As a result, some public health interventions struggle, as their design is based on the assumption that populations are static, ie, that populations can be continuously accessed at one geographical location and that healthcare users will access care and treatment at a single healthcare facility over time. Evidence indicates otherwise: healthcare users in Southern Africa are mobile and are moving for reasons other than seeking healthcare.[7] The need to engage with diverse population movements to improve global health programming is increasingly recognised, including by international

1 Abraído-Lanza AF *et al.*, 'The Latino mortality paradox: A test of the "salmon bias" and healthy migrant hypotheses', *American Journal of Public Health*, 89, 10, 1999, pp. 1543–8; Chen J, 'Internal migration and health: Re-examining the healthy migrant phenomenon in China', *Social Science & Medicine*, 72, 8, 2011, pp. 1294–301.

2 Castañeda H *et al.*, 'Immigration as a social determinant of health', *Annual Review of Public Health*, 36, 1, 2015, pp. 375–92; Davies A, Basten A & C Frattini, 'Migration: A social determinant of migrants' health', *Migration and Health in the European Union*, 16, 1, 2010, pp. 10–2; IOM (International Organization for Migration), 'Health of Migrants: Resetting the Agenda: Report of the 2nd Global Consultation, Colombo, Sri Lanka, 21–23 February 2017'. Geneva: IOM, 2017a; Malmusi D, Borrell C & J Benach, 'Migration-related health inequalities: Showing the complex interactions between gender, social class and place of origin', *Social Science & Medicine*, 71, 9, 2010, pp. 1610–9.

3 IOM, 2017a, *op. cit.*

4 *The Lancet Public Health*, 'No public health without migrant health', 2018.

5 UN, 'World Population Prospects: The 2017 Revision, Key Findings and Advance Tables', Working Paper, ESA/P/WP/248. New York: UNDESA (UN Department of Economic and Social Affairs), Population Division, 2017.

6 Hanefeld J *et al.*, 'A global research agenda on migration, mobility, and health', *The Lancet*, 389, 10087, 2017, pp. 2358–9; *The Lancet Public Health*, *op. cit.*; IOM, 2017a, *op. cit.*

7 For example, see Vearey J, 'Mobility, migration and generalised HIV epidemics: A focus on sub-Saharan Africa', in Thomas F (ed.), *Handbook on Migration and Health*. Cheltenham: Edward Elgar Publishing, 2016.

Global health actors are increasingly recognising migration and population mobility as a key public health concern, and calling for the development of evidence-informed responses to support progress on the Sustainable Development Goals, universal health coverage and other key global health targets

organisations such as the World Health Organization (WHO) and the International Organization for Migration (IOM).[8] Linked to this, various global health policy processes that engage with migration have been developed over recent years.[9] However, the current political climate – associated with increasingly anti-foreigner and xenophobic sentiments – is driving uninformed, non-evidence-based and potentially dangerous international (im)migration policy discussions and processes that may pose a threat to global health.[10]

The good news is that global health actors are increasingly recognising migration and population mobility as a key public health concern, and calling for the development of evidence-informed responses to support progress on the Sustainable Development Goals, universal health coverage and other key global health targets.[11] However, the potential consequences associated with working to improve responses to migration and health in the contemporary nationalistic immigration policy terrain deserve more attention. This paper draws on the work of Feldbaum *et al.*, who show how '[t]he increasing relevance of global health to foreign policy holds both opportunities and dangers for global efforts

8 ILO (International Labour Organization), 'Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action'. Geneva: ILO, 2017; IOM, 'The Health of Migrants: A Core Cross-Cutting Issue'. Geneva: IOM, 2017b; IOM, 2017a, *op. cit.*; WHO (World Health Organization), 'Health of Migrants: The Way Forward: Report of a Global Consultation, Madrid, Spain, 3–5 March 2010'. Geneva: WHO, 2010; WHO, 'Technical Briefing on Migration and Health. WHA 2016'. Geneva: WHO, 2016a; WHO, 'Promoting the Health of Refugees and Migrants. Draft Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants. Report by the Secretariat, 70th World Health Assembly, Provisional Agenda Item 13.7'. Geneva: WHO, 2017a.

9 See Vearey J, 'Moving forward: Why responding to migration, mobility and HIV in South(ern) Africa is a public health priority', *Journal of the International AIDS Society*, 2018, for an overview.

10 *Ibid.*; *The Lancet Public Health*, *op. cit.*

11 Castañeda H *et al.*, *op. cit.*; Griswold KS *et al.*, 'Strengthening effective preventive services for refugee populations: Toward communities of solution', Public Health Reviews, 39, 1, 2018; Hanefeld J *et al.*, *op. cit.*; *The Lancet Public Health*, *op. cit.*; IOM, 2017a, *op. cit.*; Knipper M, 'Migration, public health and human rights', *International Journal of Public Health*, 61, 9, 2016, pp. 993–4; Krasnik A *et al.*, 'Advancing a unified, global effort to address health disadvantages associated with migration, ethnicity and race', *European Journal of Public Health*, 28, suppl_1, 2018; Pocock NS *et al.*, 'Reflections on migrant and refugee health in Malaysia and the ASEAN region', *BMC Proceedings*, 12, 4, 2018, p. 4; Pottie K *et al.*, 'Building responsive health systems to help communities affected by migration: An international Delphi Consensus', *International Journal of Environmental Research and Public Health*, 14, 2, 2017, p. 144; Thiel de Bocanegra H *et al.*, 'Addressing refugee health through evidence-based policies: A case study', *Annals of Epidemiology*, 2017; Vearey J, 2018, *op. cit.*; Wickramage K, Mosca D & D Peiris (eds), Migration health research to advance evidence based policy and practice', in *Sri Lanka*, volume 1. Manila: Institute of Medicine, 2017; Wickramage K *et al.*, 'Migration and health: A global public health research priority', *BMC Public Health,* 18, 1, 2018; Wild V & A Dawson, 'Migration: A core public health ethics issue', *Public Health*, 158, 2018, pp. 66–70.

to improve health'.[12] It suggests some of the dangers could arise from the increasingly blurred governance agendas of national security and of global health security.

When considering (im)migration, global policy attention has been on border management and securitisation agendas driven by increasingly nationalistic arguments associated with the sovereignty of nation states and the post-9/11 era of anti-terrorism. The development of interventions to further restrict international migration and protect the sovereignty of nation states is higher up the international political agenda than global health. There is, however, one exception: the global health security agenda – which ultimately aims to protect global health[13] – straddles discussions on both global health and the securitisation agenda associated with state sovereignty. The current global health security agenda is informed by concerns associated with bioterrorism (the use of infectious agents and other biological material to harm) and infectious disease control, with a focus on pandemic preparedness.[14] It has been suggested that[15]

> part of global health governance involves the utilisation and framing of fear and susceptibility to risk as an instrument to help shape global health policy and to elicit political and technical mobilisation and cooperation from a vast array of stakeholders.

These global health security concerns can present opportunities and possible justifications for nation states to further restrict population movements across international borders and/or deport migrants. As will be argued in this paper, such practices could have negative, and possibly dangerous, health consequences for all.

In order to develop and implement effective responses to international global health targets, a better understanding of the ways in which foreign policy discussions may affect public health programming is required.[16] Evidence should be used to inform rational, global public health programming that actively engages with the determinants of poor health and is dependent on bilateral, regional and global agreements.[17] However, health – like immigration – is a contentious and politically sensitive issue. Any attempt to bring global health security and global immigration agendas together must be attuned to the potential

12 Feldbaum H, Lee K & J Michaud, 'Global health and foreign policy', *Epidemiologic Reviews*, 32, 1, 2010, pp. 82–92.

13 WHO, *Global Public Health Security in the 21st Century: Global Public Health Security*. Geneva: WHO, 2007.

14 Aldis W, 'Health security as a public health concept: A critical analysis', *Health Policy and Planning*, 23, 6, 2008, pp. 369–75; Elbe S, 'Pandemics on the radar screen: Health security, infectious disease and the medicalisation of insecurity', *Political Studies*, 59, 4, 2011, pp. 848–66.

15 Brown GW & S Harman, 'Preface: Risk, perceptions of risk and global health governance', *Political Studies*, 59, 4, 2011, p. 773.

16 Feldbaum H, Lee K & J Michaud, *op. cit.*; Feldbaum H *et al.*, 'Global health and national security: The need for critical engagement', *Medicine, Conflict and Survival*, 22, 3, 2006, pp. 192–8.

17 IOM, 'Advancing the Unfinished Agenda of Migrant Health for the Benefit of All'. Geneva: IOM, 2015a; IOM, 2017b, *op. cit.*

for inadvertently providing states with opportunities to use the global health security agenda to justify further restrictions on the movement of people across national borders.

'The global health community should carefully scrutinise areas where global health and national security interests overlap.'[18]

These concerns are particularly relevant in SADC, a region associated with diverse population movements and a high communicable – and increasing non-communicable – disease burden.[19] Southern Africa is home to the largest population of people living with HIV and tuberculosis (TB). While many positive developments have taken place, the incidence of new HIV and TB infections remains high and the region has a growing multi- and extensively drug-resistant TB epidemic. Both HIV and TB require strong prevention and treatment programming, but current health programming in SADC – at both the regional and member-state level – fails to effectively engage with migration and mobility. It has been argued elsewhere that this is a key contributing factor to the challenges associated with HIV prevention and treatment, and the increasing burden of multi- and extensively drug-resistant TB.[20]

Both HIV and TB require strong intervention and treatment programming, but current health programming in SADC fails to effectively engage with migration and mobility'

This paper intends to explore the possible implications for migration and health in Southern Africa in the context of current global panics about immigration, and the resultant global compacts. Concerns are raised about how these politics may prevent – or negatively impact – any future attempts to develop migration-aware[21] and mobility-competent[22] regional responses to health in SADC – particularly those associated with HIV and TB.

PANICS AND POLICIES IN MIGRATION AND HEALTH

Increasingly xenophobic and nationalist moral panics associated with state sovereignty are driving global politics and policymaking on international migration, with potentially disastrous consequences for population health.[23] Parallels between the moral panics driving the policy processes associated with migration and global health security are clear: both revolve around racist and xenophobic sentiments and a growing fear of the Other, positioning those who move – especially from global South into global North contexts

18 Feldbaum H *et al.*, *op. cit.*, p. 1.

19 Vearey J, 'Healthy migration: A public health and development imperative for South(ern) Africa', *South African Medical Journal*, 104, 10, 2014, p. 663; Walls HL *et al.*, 'Understanding healthcare and population mobility in Southern Africa: The case of South Africa', *South African Medical Journal*, 106, 1, 2015, p. 14.

20 Vearey J, 2016, *op. cit.*; Vearey J, 2018, *op. cit.*

21 Vearey J, 2016, *op. cit.*

22 WHO, 2010, *op. cit.*

23 Aldis W, *op. cit.*; Elbe S, *op. cit.*; Feldbaum H, Lee K & J Michaud, *op. cit.*; Ferri BA, 'Metaphors of contagion and the autoimmune body', *Feminist Formations*, 30, 1, 2018, pp. 1–20; King NB, 'Security, disease, commerce: Ideologies of postcolonial global health', Social Studies of Science, 32, 5–6, 2002, pp. 763–789; Rushton S, 'Global health security: Security for whom? Security from what?', *Political Studies*, 59, 4, 2011, pp. 779–96.

(in particular from Africa into Europe) – as a threat to host populations. These discourses are not new, and anxieties associated with migration and health are pervasive:[24]

> While colonial anxiety revolved around fears of contamination as certain (white, European, male) bodies moved into vulnerable places and faced novel contaminating environments and (non-white, non-European, female) peoples, postcolonial anxiety revolves around the contamination of space itself by mobile bodies and motile environments.

Until now, the global health security agenda has been influenced by two key concerns: the need to develop and implement effective communicable disease control, with HIV and emerging infections at the centre; and the need to develop effective bioterrorism responses in the post-9/11 era.[25] Migrant and mobile populations have been mostly absent from global health security programmes and preparedness plans.[26] While good population health is dependent on outbreak control and pandemic preparedness, the global health security agenda finds itself moving beyond disease control and into the realm of foreign policy. It is increasingly influenced by moral panics and fear of the Other, an agenda that can be (mis)used and (mis)applied to justify the increased securitisation of borders and restriction of international migration.[27] This has been witnessed in different contexts, including in the UK and Australia, where health status is increasingly being used to identify, detain and deport undocumented migrants, and – particularly in the Australian context – to deny asylum seekers entry to the country.[28] Concerns have been raised elsewhere about the problematics associated with securitising health through the 'uncritical insertion of military and foreign policy (political) interests into the arena of global public health',[29] and a growing body of literature outlines how an increasingly securitised world has negative health implications for those who move.[30]

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24 King NB, *op. cit.*, p. 773.

25 Feldbaum H, Lee K & J Michaud, *op. cit.*; Heymann D, 'The evolving infectious disease threat: Implications for national and global security', *Journal of Human Development*, 4, 2, 2003, pp. 191–207; Ingram A, 'The new geopolitics of disease: Between global health and global security', *Geopolitics*, 10, 3, 2005, pp. 522–45; Ingram A, Nuffield Health & Social Services Fund & UK Global Health Programme, *Health, Foreign Policy & Security: Towards a Conceptual Framework for Research and Policy*. London: Nuffield Trust, 2004; Rushton S, *op. cit.*

26 IOM, 2015a, *op. cit.*

27 Elbe S, *op. cit.*; Feldbaum H, Lee K & J Michaud, *op. cit.*; Ferri BA, *op. cit.*; Fidler DP, 'Caught between paradise and power: Public health, pathogenic threats, and the axis of illness', *McGeorge L. Rev.*, 35, 2004, p. 45.

28 Ashcroft RE, 'Standing up for the medical rights of asylum seekers', *Journal of Medical Ethics*, 31, 3, 2005, pp. 125–6; Feldbaum H, Lee K & J Michaud, *op. cit.*; Wild V & A Dawson, *op. cit.*; Wild V, Zion D & R Ashcroft, 'Health of migrants: Approaches from a public health ethics perspective', *Public Health Ethics*, 8, 2, 2015, pp. 107–9.

29 Aldis W, *op. cit.*, p. 372.

30 Briskman L, Zion D & B Loff, 'Care or collusion in asylum seeker detention', *Ethics and Social Welfare*, 6, 1, 2012, pp. 37–55; Larchanché S, 'Intangible obstacles: Health implications of stigmatization, structural violence, and fear among undocumented immigrants in France', *Social Science & Medicine*, 74, 6, 2012, pp. 858–63; Martinez O *et al.*, 'Evaluating the impact of immigration policies on health status among undocumented

Current immigration policy discussions focus on the development of two global compacts – the Global Compact on Safe, Orderly and Regular Migration and the Global Compact on Refugees.[31] Coordinated by the UN, these compacts are designed to provide a set of agreed-upon principles to guide international responses.[32] Due to be finalised by the end of 2018, concerns have been raised globally about their content, particularly in relation to the securitisation of immigration.[33] From a public health perspective, there are concerns about the limited references to the health and wellbeing of migrants and mobile populations, with the focus being on immigration management and increased securitisation to restrict the movement of people across national borders.[34] By foregrounding immigration as a national security threat, the compacts run the risk of legitimising global health security panics that stigmatise migrants, and/or adopting global health security interventions to bolster national security. As with other aspects of national security, it is the high-income countries (such as in Europe and North America) that unjustly direct these concerns towards people moving from low-income contexts (such as Africa):[35]

> [T]reating global health issues as national security threats may focus attention disproportionately on countries or diseases which pose security threats to wealthy nations, rather than on the greatest threats to global health. The global health community should carefully scrutinise areas where global health and national security interests overlap.

Ultimately, if this goes unchecked, such action will undermine much-needed (and currently limited) approaches to cross-border and global communicable disease management. For example, the global immigration security agenda could be extended to include health

immigrants: A systematic review', *Journal of Immigrant and Minority Health* / Center for Minority Public Health, 17, 3, 2015, pp. 947–70.

31 UN, 'Global Compact on Refugees, Zero Draft'. New York: UN, 2018a; UN, 'Global Compact for Safe, Regular and Orderly Migration. Zero Draft'. New York: UN, 2018b.

32 Guild E & S Grant, 'Migration Governance in the UN: What is the Global Compact and What Does It Mean?', Queen Mary University of London, School of Law Legal Studies Research Paper, 252/2017, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2895636, accessed 1 August 2018; Nanopoulos E, Guild E & K Weatherhead, 'Securitisation of Borders and the UN's Global Compact on Safe, Orderly and Regular Migration', Queen Mary University of London, School of Law Legal Studies Research Paper, 270/2018, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3099996, accessed 1 August 2018; Parshotam A, 'The UN Global Compacts on Migration and Refugees: A New Solution to Migration Management, or More of the Same?', Africa Portal, 30 November 2017, https://www.africaportal.org/publications/un-global-compacts-migration-and-refugees-new-solution-migration-management-or-more-same/, accessed 17 April 2018.

33 Landau LB, 'UN "Global Compact" may prove regressive for Africa's migrants', *Refugees Deeply*, 14 September 2016, https://www.newsdeeply.com/refugees/community/2016/09/14/u-n-global-compact-may-prove-regressive-for-africas-migrants, accessed 11 November 2017; Landau LB, 'Southern urbanism, legalization, and the limits of migration law', *AJIL Unbound*, 111, 2017, pp. 165–71; Nanopoulos E, Guild E & K Weatherhead, *op. cit.*

34 Nanopoulos E, Guild E & K Weatherhead, *op. cit.*; Women in Migration Network, 'The Global Compact on Migration: General Concerns', 2017, http://womeninmigration.org/wp-content/uploads/2017/06/Berlin-2017_1-General-Concern.pdf, accessed 1 August 2018.

35 Feldbaum H *et al.*, *op. cit.*, p. 1.

security, with potentially disastrous consequences. Experiences in Australia and the UK highlight the challenges associated with mandatory health screening and restrictions (or an outright ban) on travel for people living with certain diseases.[36] Alongside increasingly restrictive immigration policies, such health programming would likely lead to an increase in irregular border crossings and create a growing population of undocumented migrants who might not access public healthcare interventions – including HIV testing and treatment, and outbreak control interventions – for fear of arrest, detention and deportation.

Often influenced by a securitisation agenda that responds to the moral panics associated with HIV, emerging infectious diseases and bioterrorism, concerns have been raised about the ways the global health security movement has been used to justify increasingly restrictive immigration policies and practices. For example, this could see a return to stigmatising people who face unnecessary and restrictive immigration practices, undoing of years of global public health advocacy work to reduce and, where possible, remove such travel restrictions for people living with HIV. From a public health perspective, global health security should address the prevention and treatment of chronic diseases, including communicable diseases such as HIV, TB and malaria and non-communicable diseases such as diabetes and heart disease; the management and elimination of neglected diseases such as Chagas' disease and trachoma; and pandemic preparedness for infectious diseases, including emerging infections.[37]

MIGRATION AND HEALTH IN SADC

The SADC region is associated with a high communicable disease burden, and historical and contemporary population movements. While the relationship between migration and health is increasingly recognised, SADC has – to date – failed to effectively design and implement migration-aware and mobility-competent public healthcare systems.[38] Recent years have seen some attempts by international organisations and local non-governmental organisations, often in partnership with local government, to develop responses to health and migration. These initiatives have mostly focussed on HIV and have included engagement at border posts with people crossing borders, migrant farm workers, long-distance truck drivers, and people moving between South Africa and Zimbabwe.[39]

While the relationship between migration and health is increasingly recognised, SADC has – to date – failed to effectively design and implement migration-aware and mobility-competent public healthcare systems

36 Ashcroft RE, *op. cit.*; Briskman L, Zion D & B Loff, *op. cit.*; Feldbaum H *et al.*, *op. cit.*

37 Feldbaum H *et al.*, *op. cit.*; Rushton S, *op. cit.*; WHO, 2007, *op. cit.*

38 Hanefeld J *et al.*, *op. cit.*; Vearey J, 2014, *op. cit.*; Vearey J, Modisenyane M & J Hunter-Adams, 'Towards a migration-aware health system in South Africa: A strategic opportunity to address health inequity', *South African Health Review*, 2017; Walls HL *et al.*, *op. cit.*

39 De Gruchy T, 'Between Securitisation and Well-being: Framing Responses to Migration and Health in Limpopo', Global Health Action (forthcoming); MSF (Médicins sans Frontières), 'Providing Antiretroviral Therapy for Mobile Populations: Lessons Learned from a Cross Border ARV Programme in Musina, South Africa'. Brussels: MSF, 2012; SADC, 'SADC HIV and AIDS Cross Border Initiative – A Global Fund Project'. Gaborone: SADC, 2012; SADC Directorate for Social and Human Development and Special Programs, 'SADC Declaration on Tuberculosis in the Mining Sector'. Gaborone: SADC, 2012; Vearey J & J Anderson,

Attempts to develop a coordinated regional response to migration and communicable diseases have thus far been unsuccessful, with the Framework on Communicable Diseases and Population Mobility of 2009 still in draft form.[40] As outlined in Box 1, there are four key interlinked and complex concerns when considering migration and health in Southern Africa.

BOX 1 MIGRATION AND HEALTH IN SOUTHERN AFRICA: FOUR KEY CONCERNS [a]

1. **Southern Africa is associated with mixed migration flows:** Internal > cross-border; livelihood seeking > forced migration; urban refugees; marginalised and hidden migrant groups; spaces of vulnerability; negative assumptions persist
2. **Current public health responses do not engage with migration and mobility:** Implications for communicable disease control (TB, HIV, malaria); chronic treatment continuity; challenges in accessing the public system for non-nationals.
3. **Public health and social welfare systems are overburdened and struggling:** Challenges are raised in a context of high inequality where nationals are also struggling to access their basic rights.
4. **Structural violence: increasing anti-foreigner sentiments and xenophobic attitudes:** Migration management is associated with increased securitisation; a lack of regional responses; restrictive immigration legislation; limited understanding of migration dynamics; violence; fear; securitisation of health.

Source: Vearey J, 'Healthy migration: A public health and development imperative for South(ern) Africa', *South African Medical Journal*, 104, 10, 2014; Vearey J, 'Mobility, migration and generalised HIV epidemics: A focus on sub-Saharan Africa', in Thomas F (ed.), Handbook on Migration and Health. Cheltenham: Edward Elgar Publishing, 2016; Vearey J, 'Moving forward: Why responding to migration, mobility and HIV in South(ern) Africa is a public health priority', *Journal of the International AIDS Society*, 2018

As outlined in Box 1, both immigration and health are contentious political issues globally, with the movement of people often used as a scapegoat for the failings of public healthcare systems.[41]

'Emerging Best Practices: Unpacking the Evolving Response to Migration in Musina, 2007–2012, A Focus on the South African Government and the International Organization for Migration (IOM)', IOM (unpublished), 2013.

40 SADC Directorate for Social and Human Development and Special Programs, 'SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region: Final Draft April 2009', 2009, http://www.arasa.info/files/6613/7574/3254/SADC_Policy_Framework_FINAL.pdf, accessed 15 May 2018.

41 Grove NJ & AB Zwi, 'Our health and theirs: Forced migration, othering, and public health', *Social Science & Medicine*, 62, 8, 2006, pp. 1931–42; Quesada J, 'Special issue part II: Illegalization and embodied vulnerability in health', *Social Science & Medicine*, 74, 6, 2012,

This is no different in the SADC region, where responses to migration are often pushed by international donors,[42] and where anti-foreigner and xenophobic tendencies often inform the politics of migration policymaking, including in relation to health.[43]

Population health for all

> '[E]ffective public health cannot and should not be confined within the borders and to the citizens of any host country.'[44]

Developing effective responses to migration and health in SADC is a key population health concern. Without engaging with the movement of people, attempts at addressing HIV, TB and malaria – along with increasing chronic non-communicable diseases – will fail. Currently, people moving within countries (internal migration) and across international borders (cross-border migration) face challenges when attempting to access public healthcare services. These challenges include discrimination by healthcare providers, language difficulties and accessing care, owing to a lack of documentation. The resultant interruption of care – whether for HIV, antenatal support, or diabetes management – has far-reaching consequences. It is not only the health of people who move that will be affected; rather, by failing to develop mobility-competent healthcare planning, negative effects will also be felt at the population level, including through a strain on public healthcare services. Communicable diseases affect everyone, regardless of nationality or location, while disrupting testing and treatment opportunities for chronic non-communicable diseases will likely result in a higher burden on public healthcare systems as individuals will only present for care once very ill, increasing treatment costs. Consequently, both bilateral and regional public health interventions are necessary.

However, as has been documented, 'nativist anxieties determining public health policy' often inform global health security policymaking and practice.[45] This is not new; while communicable disease control is a real concern that requires appropriate global cooperation, health has – historically – been used to justify restricting the movement of non-nationals, by applying '… "a medical rationale to isolate and stigmatize social groups reviled for other reasons", particularly immigrants and racial and ethnic minorities that personified frightening social change'.[46]

pp. 894–6; Sargent C, 'Special issue part I: "Deservingness" and the politics of health care', *Social Science & Medicine*, 74, 6, 2012, pp. 855–7.

42 Kabwe-Segatti AW, 'Regional integration policy and migration reform in SADC countries: An institutional overview of power relations', *African Yearbook of International Law Online/ Annuaire Africain de droit international Online*, 16, 1, 2010, pp. 53–77.

43 Vearey J, 2014, *op. cit.*

44 Wild V & A Dawson, *op. cit.*, p. 69.

45 King NB, *op. cit.*, p. 766.

46 Markel H, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892*. Baltimore: Johns Hopkins University Press, 1997, p. 4, quoted in *ibid.*

Key migration and health policies

Table 1 presents an overview of key migration and health processes at the global and regional (SADC) levels. Recent years have seen an increasing engagement with migration and health as a policy concern with two global consultations on migration and health[47] being undertaken, and the World Health Assembly responding through the development of resolutions calling for improved responses to migration and health.[48] The WHO Draft Global Action Plan on the Health of Refugees and Migrants is due to be launched in 2019, with various activities planned to support its development.[49] However, it remains to be seen how the concurrent global compact and securitisation agendas will affect this.[50]

TABLE 1 OVERVIEW OF KEY GLOBAL AND REGIONAL MIGRATION AND HEALTH POLICY PROCESSES

Year	Process
2003	WHO *International Migration, Health and Human Rights*[a]
	IOM Position Paper on Psychosocial and Mental Well-Being of Migrants[b]
2004	Migrant Health for the Benefit of All MC/INF/275[c]
2006	AU Executive Council, African Common Position on Migration and Development, 2006[d]
	AU Executive Council, The Migration Policy Framework for Africa, 2006[e]
2009	SADC Draft 2009 Declaration on Population Mobility and Communicable Diseases, and associated financing model[f]
2008	World Health Assembly Resolution 61.17 on the Health of Migrants[g]
2010	2010 1st Global Consultation: The Health of Migrants: The Way Forward, Madrid, Spain, 3–5 March 2010[h]
	SADC HIV Cross Border Initiative[i]
2012	SADC Declaration on TB in the Mining Sector[j]
2015	IOM 106th Council Session, Geneva, Switzerland, 26 November 2015 • Advancing the Unfinished Agenda of Migrant Health for the Benefit of All C/106/INF/15[k] • High-level Panel Discussion on Migration, Human Mobility and Global Health: A Matter for Diplomacy and Intersectional Partnership[l]

47 IOM, 2017a, *op. cit.*; WHO, 2010, *op. cit.*

48 World Health Assembly, 'World Health Assembly Resolution 61.17: Health of Migrants'. Geneva: World Health Assembly, 2008; World Health Assembly, 'WHA Resolution 70.15 Promoting the Health of Refugees and Migrants'. Geneva: World Health Assembly, 2017.

49 WHO, 2017a, *op. cit.*

50 IOM, 2017a, *op. cit.*, p. 23; Vearey J. *et al.*, 2017, *op. cit.*; Vearey J, 2018, *op. cit.*

Year	Process
2016	UN General Assembly High-level Meeting on Addressing Large Movements of Refugees and Migrants, 9 May 2016 • Report of the Secretary-General: In Safety and Dignity: Addressing Large Movements of Refugees and Migrants[m]
	69th World Health Assembly, 27 May 2016 • WHO Technical Briefing on Migration and Health • Promoting the Health of Migrants: Report from the WHO Secretariat
	UN General Assembly High-level Meeting to Address Large Movements of Refugees and Migrants, 22 September 2016 • Side Event Report: Health in the Context of Migration and Forced Displacement[n]
	New York Declaration for Refugees and Migrants, 3 October 2016 Resolution adopted by the General Assembly on 19 September 2016[o]
	Leaving No One Behind: The Imperative of Inclusive Development, Report on the World Social Situation 2016[p]
2017	140th Session of the WHO Executive Board, January 2017 • WHO Secretariat Report on 'Promoting the Health of Migrants' • Decision EB140(9): Promoting the Health of Refugees and Migrants[q]
	Second Global Consultation: Health of Migrants: Resetting the Agenda, February 2017[r]
	WHO Input to the 70th World Health Assembly: Draft Framework of Priorities and Guiding Principles A70/24, 17 May 2017[s]
	70th World Health Assembly, 30 May 2017 • Resolution 70.15: Promoting the Health of Refugees and Migrants[t]
	Global Compact Process • IOM Thematic Paper: The Health Of Migrants: A Core Cross-Cutting Theme[u]
	IOM Migration Health Division – Thematic Paper Series • Migration Health in the Sustainable Development Goals: 'Leave No One Behind' in an Increasingly Mobile Society[v]
2018	142nd WHO Executive Board Meeting 71st World Health Assembly 109th IOM Council • Global Compact on Refugees[w] • Global Compact on Safe, Regular and Orderly Migration[x]

Year	Process
2019	144th WHO Executive Board session 72nd World Health Assembly • WHO Draft Global Action Plan on the Health of Refugees and Migrants (to be submitted for consideration)
2030	UN 2030 Agenda for Sustainable Development, 'Transforming our World: The 2030 Agenda for Sustainable Development. A/RES/70/1'

a WHO, *Migration, Health and Human Rights*. Geneva: WHO, 2003.

b IOM, 'Position Paper on the Psychosocial and Mental Well-Being of Migrants'. Geneva: IOM, 2003.

c IOM, 2015a, *op. cit.*

d AU, 'African Common Position on Migration and Development'. Addis Ababa: AU, 2006.

e AU, 'The Migration Policy Framework for Africa'. Addis Ababa: AU, 2006.

f Oxford Policy Management, 'Developing Financing Mechanisms to Support the Implementation of the Draft "Policy Framework for Population Mobility and Communicable Diseases in the SADC Region". Draft Proposals for Financing Mechanisms and Involvement of the Private Sector' (unpublished), 2015; SADC Directorate for Social and Human Development and Special Programs, 2009, *op. cit.*

g World Health Assembly, 2008, *op. cit.*

h WHO, 2010, *op. cit.*

i SADC, 2012, *op. cit.*

j SADC Directorate for Social and Human Development and Special Programs, 2012, *op. cit.*

k IOM, 2015a, *op. cit.*

l IOM, 'High-level Panel Discussion on Migration, Human Mobility and Global Health: A Matter for Diplomacy and Intersectional Partnership'. Geneva: IOM, 2015b.

m UN, 'In Safety and Dignity: Addressing Large Movements of Refugees and Migrants. Report of the Secretary General, High-level Meeting on Addressing Large Movements of Refugees and Migrants, 70th Session of the UN General Assembly, Agenda Item 15,116'. New York: UN, 2016a.

n WHO, 'Health In the Context of Migration and Forced Displacement. Side Event Report, UN General Assembly High-level Meeting to Address Large Movements of Refugees and Migrants'. Geneva: WHO, 2017b.

o UN, 'New York Declaration for Refugees and Migrants'. New York: UN, 2016b.

p UN, 'Leaving No One Behind: The Imperative of Inclusive Development. Report on the World Social Situation 2016'. New York: UN, 2016c.

q WHO, 'Promoting the Health of Migrants. Report by the Secretariat'. Geneva: WHO, 2016b.

r IOM, 2017a, *op. cit.*

s WHO, 'Promoting the Health of Refugees and Migrants, 140th Session of the WHO Executive Board, Agenda Item 8.7'. Geneva: WHO, 2017c.

t World Health Assembly, 2017, *op. cit.*, p. 15.

u IOM, 2017b, *op. cit.*

v IOM, 'Migration Health in the Sustainable Development Goals: "Leave No One Behind" in an Increasingly Mobile Society'. Geneva: IOM, 2017c.

w UN, 2018a, *op. cit.*

x UN, 2018b, *op. cit.*

SECURING HEALTH

'Unhealthy (non-Western) places or populations posed a threat to healthy (Western) individuals when the borders between them were transgressed, either by colonials in foreign lands, or by immigrants contaminating home countries. It relied on strategies of avoidance, segregation and establishment of sanitary cordons in order to preserve territorial boundaries, isolating populations from one another either through control of borders (to guard against immigrant carriers) or control of populations in colonized territories (to guard against the contamination of colonial interlopers).'[51]

Public health practice was historically premised on ideas relating to containment and coloniality as a way to single out the 'diseased bodies' of 'natives' or immigrants who pose a threat to the 'healthy bodies' of the coloniser. Contemporary public health practice has disease control as one of its central tenets, but has moved to a 'new public health' that is cognisant of the danger of this stigmatising language and practice and is driven by a health justice agenda centred on human rights.[52] However, communicable disease and outbreak control does require a consideration of how best to contain infection, which is warranted, in certain instances, to include the restricting of some movements within and across international borders.[53] Increasingly, however, global health security interventions are influenced (co-opted) by foreign policy concerns, including securitisation.[54] This co-opting of health concerns to justify securitisation of borders and sovereignty began to emerge at the end of the Cold War, when a renewed approach to what is now framed as global health security was initiated.[55] In an attempt to guide global health security actions, the WHO developed the International Health Regulations, which aim 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade'.[56] However, concerns have been raised relating to the dangers of blurring global public health with the global health security agenda.[57] Currently, '[t]here is no consensus on the role and limitations of foreign policy in public health and health security'.[58] What is clear, however, is that securitisation approaches can 'lead directly to practices which place at risk the lives of real people and transform what should be a simple activity of checking passports into a cat and mouse securitised game with degrading, humiliating, and often deadly outcomes'.[59]

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51 Anderson WA, 'Excremental colonialism: Public health and the poetics of pollution', *Critical Inquiry*, 21, Spring 1995, pp. 640–69; Ileto RC, 'Cholera and the origins of the American sanitary order in the Philippines', in Arnold D (ed.), *Imperial Medicine and Indigenous Societies*. Manchester: Manchester University Press, 1988, pp. 125–48; King NB, *op. cit*., p. 772.

52 Tulchinsky T & E Varavikova, *The New Public Health*. Amsterdam: Elsevier, 2014.

53 WHO, 2007, *op. cit*.

54 King NB, *op. cit*, p. 763.

55 Ingram A, *op. cit*.

56 WHO, *International Health Regulations* (2005), Third Edition. Geneva: WHO, 2016, p. 1.

57 Aldis W, *op. cit*.; Feldbaum H *et al*., *op. cit*.; Ferri BA, *op. cit*.; Nanopoulos E, Guild E & K Weatherhead, *op. cit*.; Rushton S, *op. cit*.

58 Aldis W, *op. cit*., p. 372.

59 Nanopoulos E, Guild E & K Weatherhead, *op. cit*., p. 3.

The processes associated with the development and finalisation of the two global compacts have the potential to negatively impact the development of responses to migration and health in the SADC region. Moral panics – which are increasingly racialised and nationalist[60] – are all too familiar in global (im)migration discourses, and there is an urgent need to determine the position of the global health security agenda in relation to other global health imperatives/processes[61] and to ensure that global health is not redefined as a national security issue. Fears of the dangerous implications of blurring the global immigration governance and global health security agendas include concerns about strengthening stigmatising and unnecessary health-related travel restrictions.[62] HIV presents an important case study: the disease was framed as a national security threat and travel restrictions were implemented. Hard-won battles mean that few countries still have restrictions still in place. However, there are concerns that this blurring of agendas could see a return to the kinds of HIV travel restrictions applied in the 1980s and 1990s.[63]

BOX 2 HIV TRAVEL RESTRICTIONS

The impacts of HIV travel restrictions include:

- increased risk of interrupted adherence to anti-retroviral medication;
- increased risk of deportation and detainment, which has implications with regard to reduced access to treatment;
- risk of psychological stress in travel/immigration process;
- stigma and discrimination;
- lost opportunities for treatment and prevention when persons at risk of infection or already infected with the virus avoid formal systems; and
- fewer progressive developments such as the design of culturally and linguistically appropriate clinical and public health services.

Source: Chang F *et al.*, 'HIV-related travel restrictions: Trends and country characteristics', *Global Health Action*, 6, 2013

SECURING MIGRATION

'Just as open borders are not synonymous with disorderly migration, securitised borders are not synonymous with orderly migration. Walls and hard border controls on movement of people lead to friction between neighboring States. The harder the borders for the

60 Ferri BA, *op. cit*.
61 Rushton S, *op. cit*.
62 Feldbaum H, Lee K & J Michaud, *op. cit*..
63 Chang F *et al.*, 'HIV-related travel restrictions: Trends and country characteristics', *Global Health Action*, 6, 2013.

movement of persons, moreover, the greater the risk of injury and death at those places where people may try to pass notwithstanding the heavy controls.'[64]

Public health has, historically, involved the management of disease outbreaks, and many public health interventions were designed to prevent and/or restrict the movement of people to stop the spread of disease.[65] While such practices are necessary for communicable disease control, current moral panics relating to population movements could be used to support and reinforce global health security agendas, resulting in the use of health as an additional mode for securing national borders.[66] Much of the discourse associated with the global compacts on immigration and the securitisation of migration could be mistaken for those on current global health security concerns, or historical responses to communicable disease outbreaks. The prevailing fear and threat of the diseased, foreign body as an unknown outsider whose movements should be restricted in order to exercise sovereignty and 'protect' a native population are applied across both global health security and national security agendas. These public anxieties about 'the contamination of space itself by mobile bodies'[67] have, over time, led to multiple actions to prevent or restrict population movements, with international security and sovereignty debates being inappropriately influenced.[68]

As one study points out,[69]

> the relationship between global public health, and foreign and security policy has prioritised the concerns of the latter over the former – how selected health issues may create risks for (inter)national security or economic growth. Moreover the interests of the West are prominent on this agenda, focusing (largely though not exclusively) on how health risks in the developing world might impact upon the West. It is less concerned with the promotion of global public health.

Literature has shown how current global health moral panics that frame the (poor) health of people living in lower-income contexts as threatening the (good) health of those residing in higher-income contexts through migration have led to restrictions on population movement across borders.[70] This global health security agenda has, at times, been co-opted by nation states to strengthen/justify national securitisation agendas, raising concerns about how the global compact processes could provide (further) opportunities for the (mis)application of the important global health security agenda to support and justify an increasingly securitised world.[71] How to respond to this is of concern,

Current global health moral panics that frame the (poor) health of people living in lower-income contexts as threatening the (good) health of those residing in higher-income contexts through migration have led to restrictions on population movement across borders

64 Nanopoulos E, Guild E & K Weatherhead, *op. cit.*, p. 7.
65 Rosen G, *A History of Public Health*. Baltimore: JHU Press, 2015; Tulchinsky T & E Varavikova, *op. cit.*
66 Feldbaum H, Lee K & J Michaud, *op. cit.*; Ingram A, *op. cit.*
67 King NB, *op. cit.*, p. 773.
68 Elbe S, *op. cit.*
69 McInnes C & K Lee, 'Health, security and foreign policy', *Review of International Studies*, 32, 1, 2006, pp. 5–23.
70 Ashcroft RE, *op. cit.*
71 Feldbaum H, Lee K & J Michaud, *op. cit.*

particularly in the SADC region, where population mobility and communicable diseases are prevalent, the non-communicable disease burden is increasing, and maternal health indicators are poor. Effective migration-aware[72] and mobility-competent[73] responses are urgently required.

CONCLUSION

'There is no consensus on the role and limitations of foreign policy in public health and health security, and the subject has been described as "divided politically and fragmented analytically".'[74]

The increasingly nationalistic and racist moral panics associated with migration are dangerous, and the resultant securitisation agendas embedded in the global compacts risk negatively affecting health in Southern Africa

The increasingly nationalistic and racist moral panics associated with migration are dangerous, and the resultant securitisation agendas embedded in the global compacts risk negatively affecting health in Southern Africa in two ways. Firstly, increasing securitisation may undermine efforts to develop migration-aware and mobility-competent health system responses. This includes the ways in which an increasingly securitised migration management system will create a growing population of irregular migrants who, owing to fears of arrest, detention and deportation, might avoid public healthcare services. Secondly, the development of securitisation interventions may involve the co-option of the global health security movement, which is itself a problematic and contested terrain, in order to use health status as an additional securitisation measure through increased health screening, risk assessments and resultant health-related restrictions on movement across borders. Collectively, these processes risk producing additional challenges in the already limited progress towards global health goals by undermining attempts to develop coordinated, cross-border health programmes, and by deterring irregular cross-border migrants from accessing prevention and treatment programmes for communicable and non-communicable diseases. The consequences of this would be devastating for both Southern Africa and the global community.

In order to develop appropriate responses to migration and health in SADC, evidence should be used to inform rational, public health programming that actively engages with the determinants of poor health; involves bilateral, regional and global agreements; and is based on a human rights approach to health. Member states should critically review the final compacts and explore collective efforts to ensure that these have a contextual relevance to Southern Africa. This will include revisiting current public health programming and assessing whether existing responses are migration aware and mobility competent. Bilateral agreements between member states that are organised via ministries of health that prioritise health over restricting the movement of people are needed. These ministries should engage with their counterparts involved in the management of borders and immigration (for example, in ministries of home or foreign affairs) and ensure that

72 Vearey J, 2016, *op. cit*.

73 IOM, 2017a, *op. cit*.

74 Feldbaum H, Lee K & A Ingram, 'Public health and security', in *Health, Foreign Policy and Security: Towards a Conceptual Framework for Research And Policy*. London: The Nuffield Trust, 2004, as quoted in Aldis W, *op. cit*.

health interventions are not threatened by securitisation agendas and practices. Health is a public good, and efforts to improve health for all will support the social and economic development agendas of Southern Africa. Healthy migration has been proven to be a key contributor to development: investing in evidence-informed migration and health programming will improve health for all. It is clear that 'the increasing relevance of global health to foreign policy holds both opportunities and dangers for global efforts to improve health'.[75] It is critical that the differences between these agendas are understood and remain clearly delineated as the global compacts are finalised.

Healthy migration has been proven to be a key contributor to development: investing in evidence-informed migration and health programming will improve health for all

75 Feldbaum H, Lee K & J Michaud, *op. cit*.

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