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COMMENTARY

Thinking beyond borders: reconceptualising migration to better meet the needs of people in transit

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Introduction

The International Organisation for Migration (IOM) estimates that more than 909,000 people crossed into Europe by sea in 2015 (IOM 2015). Driven by violence and conflict, political instability, and economic insecurity, hundreds of thousands of migrants and exiles now seek supposed safety in Europe's southern states and neighbouring countries.

The international response to the mass movement of people within and beyond the Middle East and North Africa has further exposed an established friction between state priorities, international refugee law, humanitarian action, and the policies and praxis that define contemporary global public health. Discourse pertaining to migration has been shaped by a fixation on a particularly narrow interpretation of the refugee, and his or her needs, which in turn has been shaped by a political agenda that seeks to securitise the movement of people, and in turn frame migration as a threat to health, economic stability, and national sociocultural identity (Grove and Zwi 2006). For this reason, member states of the European Union have chosen to externalise their humanitarian contributions, while suppressing the moral imperative to redress inequity and to provide assistance to people in need at a local and regional level, fearing that such assistance could interfere with the implementation of domestic immigration policies and effective border control. As Muller observes, the demonisation of the

> refugee as a sick body, terrorist, threat to identity, etc., plays out in the governmentality of the state vis-à-vis complex border controls that differentiate on the basis of race, class, economic need, "well-founded fears," health, and a host of other (arguably arbitrary) categories between the legitimate and the illegitimate, the banal asylum seeker, and the terrorist, the disease carrier, the job thief (Muller 2004).

Muller goes on to claim that, 'as a threat in terms of disease and terrorism … the refugee becomes an object of scientific regulation and discipline. As the "political subjectivity" of the refugee is of little interest to the state, 'the refugee is little more than a biological being that requires management and discipline' (Muller 2004). As such, Muller's observations concerning the biopolitics of the refugee caution against a reductive and superficial engagement with the relationship between migration and health. Historically, health actors have chosen to explore this association by focusing principally on the transmission of communicable diseases (MacPherson et al. 2007). This trend was further fuelled by the rise of global health security as a unique field of study in the 1990s, during which time globalisation and population mobility were portrayed as a threat to the effective containment of infectious diseases. As such, a substantial body of literature now details the health status—particularly the communicable disease carrier profiles—of asylum seekers and refugees resident in high-income countries, and of their health needs following resettlement (Burnett and Peel 2001; Monge-Maillo et al. 2015). In comparison, a relative dearth of literature engages with the needs of populations

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in transit, and even less with the policies and practices that have shaped cross-border migration. At its best this trend can be attributed to inquisitive local public health and academic opportunism; at its worst, it is reflective of a system of knowledge production that is driven by the contemporary political conceptualisation of refugees as conveyors of disease, and as such, as a collective threat to the health of the recipient population.

Some notable exceptions to this trend have emerged in recent years. In 2011, the World Health Organisation (WHO) launched the Public Health Aspects of Migration in Europe (PHAME) project; acknowledging that, while 'universal health is recognized as a fundamental human right, it is often subject to heterogeneous regulations that change throughout Europe and over time, impacting negatively on migrants', the PHAME project purports to employ an intersectoral approach to reduce health inequalities and enhance governance for health (WHO 2014). Conceptual work published in the same year by Zimmerman and colleagues placed equal emphasis on the pre-departure, travel, destination, interception, and return phases of migration. This seminal paper presents a '21st century' framework that recognises the complex interplay between migration and health at each distinct stage of the migratory process (Zimmerman et al. 2011). Speaking more recently at a high-level meeting on refugee and migrant health in Rome, Dr Zsuzsanna Jakab, the WHO's Regional Director for Europe, identified 'psychosocial disorders, reproductive health complications, [the] risk of [an] increase in infant mortality, drug abuse, nutrition disorders, alcoholism and exposure to injuries and violence, and … communicable diseases' as a major threat to the health of people in transit. She further identified that the 'limited access to an appropriate care during the transit and early arrival phases of migration increases the eventual burden of untreated noncommunicable conditions' (Jakab 2015).

Together these developments are suggestive of a growing appreciation of the complex needs of people in transit. Equipped with a more nuanced interpretation of the interplay between migration and health, the public health community is well placed to contest ill-conceived securitisation narratives, which continue to reduce people with unique fears, aspirations, and motivations, to supposedly sick bodies. At its most fundamental, the study and practice of public health seeks to improve population health outcomes; the skewed domestic and foreign policy interests of many of the European Union's member states remain an affront to this ambition. A failure to adequately challenge these skewed interests will only lend tacit endorsement to a pathologised conception of the 'other' (Grove and Zwi 2006).

In 2002 Helton observed that, 'refugees matter fundamentally because of the way that they challenge policy makers to address the new chaos of the 21st century' (Helton 2002). To counter the conservative ambitions of many of the European Union's member states, the public health community must urgently take heed of this challenge, interrogating the ways in which barbed wire fences and other border measures are a threat to health and humanity. In turn, we must demand a more nuanced interpretation of 'refugee'; the current 1951 definition serves to overlook the multitude of reasons people choose to seek 'refuge', leaving high-income countries free from the legal obligation to receive vulnerable people. Without a necessarily radical reimagination of migration, the undocumented movement of people across Europe's external borders is likely to remain a story of marginalisation and neglect.

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Compliance with ethical standards

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