MIGRATION AND HEALTH GOVERNANCE. FROM INTERNATIONAL LAW TO NATIONAL BURDENS

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Abstract: *The migration we are witnessing has a big impact over the world and especially over the European states. Weather the causes of the migration is political – military or socio-economical, the impact is owed to the scale of the phenomena. But the migration does not generate only problems of international law regarding the statue of refugees or migrants, national law concerning the same area, social aspects and economic difficulties in ensuring their wellbeing or security issues. It also generates health concerns. The nowadays migrants come from different parts of the world, Middle East and South Asia, Saharan and Sub-Saharan countries. The regional burden of disease is different in these parts of the world than the European area. The study analyses aspects related to health issues in the WHO European Region in bases of regional and global governance aspects related to health. The purpose is to identify common policies that have to be promoted or developed in order to ensure a high level of protection in the context of human dynamics in the world.*

Keywords: health governance, migration, international law, regional burden of disease, health diplomacy

Introduction

Migration is not a new phenomenon, it always existed and presented itself as a natural movement, in which a group of people moves from a geographic area to another due to certain factors such as socio-economic, geographic or military conflict.

In the present days Europe is stormed by emigrants coming from Africa, Middle-East or South Asia. In 2015 an estimated number of 845.893 migrants arrived in Europe by the end of November[1]. The geometric of the motives behind the migration differs based on the origin state. For the African states the migration is mostly generated by socio-economic aspects, related mainly to a high poverty rate. In this context they try to

[1] International Organization for Migration, Mediterranean Update, 20 November 2015. https://www.iom.int/infographics/missing-migrants-project-mediterranean-update-20-november-2015

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flee severe poverty, lack of medical care and facilities and, in certain cases, lack of food or drinking water. Migrants from the Middle East and South Asia have however a different motivation: they are fleeing war, the insecurity of their home lands and the brutality of extremist movements like Islamic state, Talibans or others.

If we look at the global burden of disease these regions have particularities, mostly related to communicable diseases. This problem is not new. If we look back in history migration always generated a spread of regional diseases to other regions or continents. So we have classic examples like syphilis, the plague or other infectious diseases[2] that spread due to merchandise or people traveling from one area to another. This generated a practice called quarantine among states in an effort to diminish the imported cases of communicable disease[3]. In this context the first international conferences was held in order to convey on a general practice regarding these diseases. So the International Sanitary Conferences were established aimed at generating synergic negotiations between states. The first one was in 1851 and even tough it had an ambitious project concerning standard in dealing with the plague, black fever and cholera[4] little was achieved in practice. This is due to the fact that the international environment does not always favour successful negotiation and it was not until 1892, almost 50 years later, that the first convention on cholera was adopted[5]. Since than a considerable number of international organisations were founded. The first that must be considered is PAHO, in 1902, which generated regional governance in the American continent[6]. Another important organization was Office International d'Hygiène Publique founded in 1907[7] which not only

[2]Gian Franco Gensinia, Magdi H. Yacouba, Andrea A. Conti, „The concept of quarantine in history: from plague to SARS", *Journal of Infection,* Volume 49, Issue 4, November 2004, pp 257–261, Obijiofor Aginam, *Global Health Governance: International Law and Public Health in a Divided World*, University of Toronto Press, 2005, p. 58

[3]Gian Franco Gensinia, Magdi H. Yacouba, Andrea A. Conti, „The concept of quarantine in history: from plague to SARS", *Journal of Infection,* Volume 49, Issue 4, November 2004, pp 257–261.

[4] David P. Fidler, The globalization of public health: the first 100 years of international health diplomacy, Bulletin of the World Health Organization, 2001, no. 79

[5]Jeremy Youde, *Global Health Governance*, Ed. Polity Press, Anglia, 2012,. p. 15-16

[6]Jeremy Youde, *Global Health Governance*, Ed. Polity Press, Anglia, 2012, p. 18

[7] OMS, *Archives of the Office International d'Hygiène Publique (OIHP)*, http://www.who.int/archives/fonds_collections/bytitle/fonds_1/en/

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monitored the status of communicable diseases in Europe but also the Middle East especially during Hajj time[8]. Finally the Health Organization of the League of Nations represents the predecessor of WHO, and the organization that tried to ensure global health governance in an international environment prone to war.

WHO is the main international actor when it comes to global health governance. This organization inherited the obligations regarding international alerts for communicable diseases. Every time an outbreak occurs in one part of the world this organization should notify its members concerning the particular aspects that my lead to an epidemic or worst pandemic.

Migration and regional health problems

According to the International Organization for migration the migrants originate from Africa, mainly Eritrea, Nigeria, Somalia, Sudan, and Middle East and South Asia, namely Syria, Irak, Afghanistan, Pakistan[9].

The burden of disease regarding communicable diseases presents itself in the following manner.

Cholera, malaria poliomyelitis and tuberculosis cases

State	Cholera	Malaria	Poliomyelitis	Tuberculosis
Afghanistan	3957	39263	17	30507
Eritrea	0	21317	0	2860
Irak	1	0	0	8554
Nigeria	6600	0	56	94825
Pakistan	169	281755	138	288910
Somalia	6864	10470	191	12994
Sudan	0	592383	0	19056
Syria	0	0	23	2735
Romania	0	0	0	15523

Table 1 Cholera, malaria,poliomyelitis and tuberculosis cases in migrant's states of origin, compared to Romania. 2013. Source: WHO[10]

[8]Jeremy Youde, *Global Health Governance*, Ed. Polity Press, Anglia, 2012, p. 19

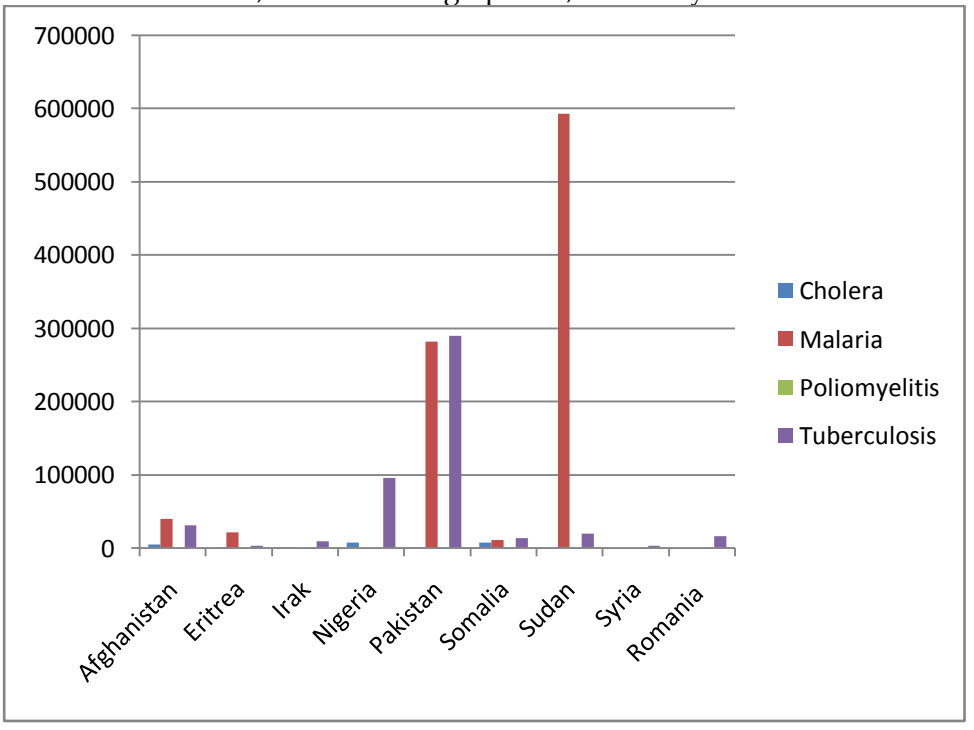
[9]International Organization for Migration, Mediterranean Update, 20 November 2015. https://www.iom.int/infographics/missing-migrants-project-mediterranean-update-20-november-2015

[10] Global Health Observatory Data Repository http://apps.who.int/gho/data/node.main.WHS3_40?lang=en

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It is obvious that these countries have significant different problems regarding communicable diseases than in Romania, a EU member. It is a significant different situation due to regional aspects but also the socio-economic context. In Romania there is no Malaria, Cholera or Poliomyelitis, but it has one of the highest rates of tuberculosis in the EU region. The situation is different if we apart African states from other states. So the highest number in Malaria cases can be encountered in Sudan. The most cases of poliomyelitis are present in Somalia and in the case of cholera Nigeria and Somalia are in the top of the list. If we add to the list the incidence of AIDS/HIV, which is high in Africa[11]we can get a clear picture of the health problems that the movement of persons from these countries to Europe can generate.

Some are problems that can be contained easily others more difficult and can pose long term problems for the health systems because of the need to ensure treatment, sometimes high priced, to the asylum seekers.



[11] WHO, Health by topic, AIDS/HIV http://www.who.int/topics/hiv_aids/en/

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Discussions

Certainly there is a high risk of carrying a virus from one part of the world to another. And more so taking into account the current speed at which the world is racing, with the new means of communication and travel. This is why the WHO pointed out that: *"a national health problem represents an international challenge"*[12].ObijioforAginam emphasizes that *"health has clearly become globalized"*[13] and thus preventing viruses to spread from one part of the world to another is impossible. The only solution is that international measures must be adopted in order to cope with such problems. In the Ebola outbreak an important aspect was limiting the international travel and imposing public health measures in order to avoid transiting the virus in other countries[14].

In the case of migrant the problem is the same. They are traveling from one part of the world to another and certainly they are carrying regional diseases. The spread from one continent to another is plausible and quite possible.

The international law gives extensive rights only to one type of migrants: the asylum seekers. They are protected by the 1951 Refugee convention and the United Nations High Commissioner on Refugees. The Convention states in the article 10 the obligation of the receiving state to offer, without delay, medical care to the refugee[15]. The Dublin regulation also stipulates, for the EU, some general rules regarding the transfer of a displaced person and their medical file[16]. After this we have the national

[12] Obijiofor Aginam, *Global Health Governance: International Law and Public Health in a Divided World*, University of Toronto Press, 2005, p. 58

[13] *Ibidem*

[14] CDC, Ebola Outbreak: Airport, Border, & Port of Entry Resources for Use by International Partnershttp://wwwnc.cdc.gov/travel/page/ebola-outbreak-communication-resources

[15] Paola Pace, Migration and the Right to Health: A Review of International Law, International Organization for Migration, p. 212, http://publications.iom.int/system/files/pdf/iml_19.pdf

[16] REGULATION (EU) No 604/2013 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast)

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layer of laws. In the case of other migrants they are protected by humanitarian law[17].

The rule tries to protect the refugee and their wellbeing, by imposing access to medical treatment. This generate costs for the destination state, in some cases the cost is small in other the cost is significant. Here the cost points to communicable and non-communicable diseases.

Conclusions

In international relations one of the main values that a state must guarantee to its citizens is their security and wellbeing[18]. This may explain the general European debate regarding the refugee quota. Accepting refugees may generate public health problems, that the state have to handle and also added costs for the health system. In this context the state must decide if complying with international regulations is more important than its own interest.

But even if the state adopts an extreme protection in the migrant cases, there is still the problem of international travel of persons and goodsthat could generate international, regional or nations problems with communicable diseases. The solution can come only trough health global governance, because reducing the malaria incidence will lower the risk to other countries. The same is in the case of poliomyelitis where international governmental organizations such as WHO, UNICEF, UN or non-governmental organizations such as Medics without Borders or Bill and Melinda Gates Foundation are trying to eradicate the disease by providing free vaccination in low income countries. This is the only viable solution in a global world in which the boundaries seem to matter less and less for the international citizen.

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[18] Robert Jackson, Georg Sorensen, *Introduction to International Relations. Theories and* approaches, Ed. Oxford University Press, Anglia, 2007, p.3

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