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Global health (security), immigration governance and Covid-19 in South(ern) Africa: An evolving research agenda

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ABSTRACT

The Covid-19 pandemic provides a stark reminder of the political tensions associated with the field of immigration and health, highlighting the central role that nationalism, racism and xenophobia play in determining responses to communicable diseases. The blurring of global health, immigration governance, and the global health security agendas has long been recognised. However, an improved understanding of the politics influencing these entanglements, specifically within the context of the Covid-19 response in low- and middle-income country contexts, is urgently needed. This includes – but is not limited to – the immediate concerns surrounding inclusive social, political and medical responses to Covid-19; vaccine nationalism – at both global and national levels; and calls for 'vaccine passports'.

To this end, we draw on the Southern African Development Community (SADC) context – one associated with high levels of diverse population movements and a large burden of communicable diseases – to explore responses to Covid-19. We unpack tensions surrounding the management of migration and the ways in which sovereignty impacts attempts at building regional, coordinated responses to migration and health, and consider how this affects progress towards global health targets. With an initial focus on South Africa, we build on previous work exploring the blurring of global health, immigration governance, and the global health security agendas in SADC, and draw from ongoing research on the governance of migration and health within the region. This includes current and evolving research exploring migration and Covid-19, initiated in March 2020 when the first cases of Covid-19 were identified in Southern Africa.

The aim is for these findings to catalyse a new and evolving researh agenda to inform the development and implementation of appropriate pandemic responses in a region associated with some of the highest levels of inequality globally. To this end, an evolving research agenda should be responsive to current needs. We suggest that, in SADC, priority research should focus on improving our understanding of (1) the political factors influencing the (dis)connections between migration and health governance structures in the context of Covid-19, and how to overcome these in the context of a pandemic; and (2) the motivations for and implications of a 'vaccine passport' system on movement within and beyond the SADC region. This requires a reactive, cross-disciplinary, regional research network. In a context where funding for research is increasingly inaccessible, this requires innovative, informal, collaborative engagement.

Introduction

Whilst concerns around the ways in which health is increasingly co-opted by approaches to national security are not new (Aldis, 2008; Elbe, 2011; Feldbaum et al., 2010, 2006; King, 2002; Wenham, 2019), the Covid-19 pandemic has, in many ways, provided an unwelcome opportunity to witness these concerns unfold in real-time. The pandemic highlights how existing, and growing, tensions relating to the movement of people across national borders – that manifest as xenophobia, racism and nationalism - continue to frame popular imaginations of the spread of communicable diseases (Clissold et al., 2020; Elias et al., 2021; Kwok, 2020; Reny and Barreto, 2020). In many ways, this is unsurprising: immigration and its intersections with health have long been established as divisive issues, both politically and socially (Castañeda et al., 2015; Grove and Zwi, 2006; Hampshire, 2005; King, 2002; Vearey, 2018; White, 2020). Historically, public health practice was premised on ideas relating to containment and "often served as '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 (Markel, 1999, p. 4)" (King, 2002, p. 765).

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While the management of movement is often necessary for communicable disease control at different stages of any given epidemic or pandemic (Rosen, 2015), moral panics relating to the movement of people across borders can, and do, provide nation states with the justification to implement increasingly restrictive approaches to immigration/border control under the guise of a response to a global health threat (Feldbaum et al., 2010; Ingram, 2004). This is often accompanied by racist discourses that frame the (poor) health of people living in low(er) and middle-income country (LMIC) contexts as threatening the (good) health of those residing in high(er)-income country (HIC) contexts through migration, and has led to instances where unnecessary restrictions have been placed to restrict population movement across borders (Ashcroft, 2005; Elbe, 2011; Feldbaum et al., 2010; Ingram, 2004; King, 2002).

Today, whilst awareness of the dangers of this stigmatising language has increased, and public health practice is driven by a health justice agenda centred on human rights (King, 2002), nation states still capitalise on racist, xenophobic 'fear of the other' as

> "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"
> (Brown and Harman, 2011, p. 773).

Since the outbreak of the Covid-19 pandemic, we have witnessed these discourses play out in real time (Elias et al., 2021; Reny and Barreto, 2020). It is clear that "perceptions of contagion play out along the lines of xenophobia and racism" (Hardy, 2020, p. 655), and border closures and travel restrictions - that have had little to no impact on management of the pandemic - have emerged as go to responses for states (Chinazzi et al., 2020; Emeto et al., 2021; Errett et al., 2020; Lee et al., 2020; Spiegel, 2021).

In this paper, we build on existing literature that speaks to the ways in which these discourses are co-opted globally to further the securitisation of both migration and health at the expense of public health globally. We consider the blurring of the intersecting governance approaches to global health, immigration, the (contested and poorly defined) global health security (GHS) agenda, and the politics inherent within and between these frameworks. We expand on previous work exploring the blurring of global health, immigration governance, and the global health security agendas in the Southern African Development Community (SADC) region (Vearey, 2018) and explore the ways in which this blurring has - and has not - manifested in the time of Covid-19. We draw from ongoing research on the governance of migration and health within the region, including current research exploring migration and Covid-19, initiated in March 2020 when the first cases of Covid-19 were identified in Southern Africa. Our evolving research agenda builds on issues identified through the Migration and Coronavirus in Southern Africa (MiCoSA) Coordination Group and aims to inform inclusive, migration-aware programmatic responses to Covid-19 that are necessary for successfully addressing the Covid-19 pandemic in SADC. This initial work highlights that an evolving research agenda should focus on improving our understanding of (1) the political factors influencing the (dis)connections between migration and health governance structures in the context of Covid-19, and how to overcome these in the context of a pandemic; and (2) the motivations for and implications of a 'vaccine passport' system on movement within and beyond the SADC region.

The global governance of migration and health in the time of Covid-19

The importance of understanding and engaging with the field of migration and health is long established but this has not, until recently, been reflected in the global health governance agenda (Vearey et al., 2020). In the last decade, however, there has been a noticeable shift with an increasing number of global initiatives and consultations (see Vearey et al., 2020 for an overview). Inevitably, some of these efforts to constructively and progressively engage with the field of migration and health have been stymied by the Covid-19 pandemic. Nevertheless, the scale of recent pushes around a global health governance agenda are impressive. These include, global consultations on migration and health (IOM, 2017; WHO, 2010); World Health Assembly Resolutions calling for improved responses to migration and health (World Health Assembly, 2017, 2008); a Lancet Commission on Migration and Health (Abubakar et al., 2018); the development of global networks on migration and health (e.g. Gruer et al., 2021; Wickramage et al., 2018b); and, most recently the development of a Global Action Plan on the Health of Refugees and Migrants (WHO, 2019b) which involves various activities, including the development of Global Competency Standards for Health Workers.

The Securisation of Global Migration Governance Agreements

Whilst these global engagements are, of course, welcomed, they come at a time of renewed global preoccupation with migration more broadly. This global attention on all forms of international migration, while often couched in the language of protection and safety, appears to mostly be driven by border management and securitisation agendas based on increasingly nationalistic arguments associated with the sovereignty of nation states and the post-9/11 era of anti-terrorism (for example see Riemsdijk et al., 2021). Thus, recent global cooperation and governance agreements on migration have HIC narratives built into them emphasizing sedentary and local solutions, as well as a focus on root causes of displacement and "return with dignity" over anything that foresees longer cross-border or cross-regional travel (Maple et al., 2020).

Key to these recent global discussions on international migration has been the development of two global compacts – the Global Compact on Safe, Orderly and Regular Migration (GCM) and the Global Compact on Refugees (GCR) (United Nations, 2018a, 2018b). Coordinated by the United Nations (UN), these compacts are designed to provide a set of agreed-upon principles to guide the protection and the safety of migrants who adopt mobility strategies and cross international borders (Maple et al., 2020). Finalised at the end of 2018, concerns were raised globally about their content, particularly in relation to the securitisation of immigration, with the implication being that these Compacts imply that non-regular (or 'non-orderly') migration poses a threat to nation states (Guild and Grant, 2017; Nanopoulos et al., 2018; Parshotam, 2017; Pécoud, 2021).

From a public health perspective, there are concerns about the limited references to the health and wellbeing of migrants and mobile populations within the GCs. Instead, the focus remains on immigration management and increased securitisation to restrict the movement of people across national borders (Landau, 2017; Nanopoulos et al., 2018; Pécoud, 2021). This is especially concerning given the growing body of evidence that demonstrates how immigration policies can negatively affect health of people who move (Bozorgmehr and Jahn, 2019; Juárez et al., 2019; Martinez et al., 2015).

The concern, therefore, is that recent pushes to develop a robust global migration health agenda, based on international human rights, will be (if not already) co-opted by this concurrent broader global security migration agenda. Indeed, as the next section explores, this form of assimilation of health concerns to justify tighter border controls and immobile or sedentary populations would not be a new phenomenon (for example see Wenham, 2019). Nevertheless, with state responses to Covid-19 seen in southern Africa and across the continent using the pandemic as a public health emergency to justify further fortify borders, expelling migrants and generally restrict movement, these concerns become far more pressing.

Securing health

The 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 (GHS) was initiated (Ingram, 2004). We draw from Davies et al.'s description of GHS "as not only identifying the threat posed by pathogens in a globalized world but also as a way of promoting the need for a collective global response" (Davies et al., 2015, p. 56). With the ultimate aim of protecting global health (Feldbaum et al., 2010), GHS straddles discussions on global health and the securitisation agendas associated with state sovereignty through 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 (WHO (Ed.), 2007).

In an attempt to guide global health security actions, the World Health Organization (WHO) developed the International Health Regulations (IHR), 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' (World Health Organization (Ed.), 2016). Whilst '[t]here is no consensus on the role and limitations of foreign policy in public health and health security' (Aldis, 2008, p. 372), it has been shown that global health security interventions are increasingly politicised and influenced (co-opted) by foreign policy concerns, including securitisation (Wenham, 2021; WHO (Ed.), 2007).

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 (Feldbaum et al., 2010, 2006; Ingram, 2004). Migrant and mobile populations have been mostly absent from global health security programmes and preparedness plans (Truman et al., 2009; Wickramage et al., 2018a). 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 (Elbe, 2011; Feldbaum et al., 2010; Ferri, 2018; Fidler, 2004).

Panics and policies in migration and health

As outlined above, the Global Compacts suggest that 'non-orderly' migration is a problem to be solved, and as a threat to states (Pécoud, 2021). Such framing runs 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 HICs (such as in Europe and North America) that unjustly direct these concerns towards people moving from LMICs (such as Africa) (Nanopoulos et al., 2018; Women in Migration Network, 2017). Ultimately, if this goes unchecked, as it largely has during the Covid-19 pandemic, such action will undermine much-needed (and currently limited) approaches to cross-border and global communicable disease management. While this has been witnessed in different contexts in relation to Covid-19, it is not a new phenomenon. In recent years, for example, some countries, including the UK and Australia, have increasingly used health status to identify, detain and deport undocumented migrants, and – particularly in the Australian context – to deny asylum seekers entry to the country (Ashcroft, 2005; Briskman et al., 2012; Feldbaum et al., 2010; Wild and Dawson, 2018). 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' (Aldis, 2008, p. 372) and a growing body of literature outlines how an increasingly securitised world has negative health implications for those who move (Briskman et al., 2012; Larchanché, 2012; Martinez et al., 2015).

The co-opting of public health responses to further securitise human mobility needs to be understood within the context of increasing xenophobia and nationalism. Specifically, the xenophobic and nationalistic moral panics associated with state sovereignty that are driving global politics and policymaking on international migration (Aldis, 2008; Elbe, 2011; Feldbaum et al., 2010; Ferri, 2018; King, 2002; Rushton, 2011).

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 LMIC to HIC contexts (in particular from Africa into Europe) – as a threat to host populations. These discourses and the anxieties associated with migration and health are not new, but are pervasive (King, 2002). Unfortunately, the Covid-19 pandemic appears to have given credence to these discourses and legitimised calls for restricting migration and hoarding medical know-how and supplies. Globally, this has been seen in the response from HIC countries to calls from those in LMICs for a Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) Waiver on Covid-19 related health technologies (WTO, 2020) and the implementation of travel bans on South Africa, in response to the 'South African variant' – despite the number of active cases in South Africa remaining lower than many European countries and the USA. However, to unpack these discourses, it is important to understand how a country like South Africa can simultaneously be a 'victim' of them – facing the largest number of 'travel bans' globally – *and* use them as a way to further its own securitisation agenda to further restrict the movement of people into the country.

Securing borders in the time of Covid-19: the case of SADC

The SADC is a region associated with high levels of population mobility - the Southern African region is home to nearly 20% of the continent's international migrant population, which includes movement from other regions, and just under 300,000 refugees (IOM and African Union Commission, 2020). Communicable diseases, notably tuberculosis (TB), HIV and malaria, remain pressing health issues (Gona et al., 2020; WHO, 2020, 2019a). The failure to adequately engage with migration and mobility regionally, and nationally within the 16 Member States[1] making up SADC, is likely to undermine progress towards global health targets, including the 2030 target of Universal Health Coverage (UHC) (Frade and Vearey, 2019; Mosca et al., 2020; UHC 2030, 2017; Vearey, 2021). Regional coordination in the field of migration and health is lacking and, whilst some policy processes have been initiated (Moonasar et al., 2016; SADC Directorate for Social and Human Development and Special Programs, 2012, 2009; Vearey and Nunez, 2010), there has been little follow-through. Limited programmatic interventions – mostly in South Africa - have involved small-scale, donor-funded projects heavily dependent on support from non-state actors amd have not been scaled up (de Gruchy and Vearey, 2020; MSF, 2012; SADC, 2012; Vearey et al., 2011; Vearey et al., 2017).

To further complicate matters, a coordinated regional approach to the management of migration remains unlikely. Indeed, any real progress on this front has historically been hampered by a lack of political and financial power within SADC; with the regional body remaining entirely beholden to the will of member states, particularly those who hold the most power, including South Africa (IOM and African Union Commission, 2020; Kabwe-Segatti, 2010; Mlambo, 2020; Nshimbi and Fioramonti, 2014). In late 2020, a new migration policy framework for

[1] Angola, Botswana, eSwatini, Democratic Republic of Congo, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia and Zimbabwe.

the SADC Region was drafted 'in order to promote regular, safe and orderly migration in the region',[2] yet it remains unclear how this type of renewed intiative will convince powerful states such as South Africa, Botswana and Namibia, already concerned with inter-regional migration, to open up their borders further.

Against this backdrop, concerns have been raised about the impact of Covid-19 on approaches to address migration and communicable diseases (Brooke et al., 2020; Dorward et al., 2021; Nachega et al., 2021), with obvious implications for the control of Covid-19 in the context of population mobility across the region. These concerns are particularly acute in South Africa, which in addition to hosting the largest number of migrants from elsewhere in SADC and further afield (STATS SA, 2021; UNDESA, 2019), had the 8th highest incidence of TB globally in 2019 (WHO, 2019a), and is the country most affected by HIV globally (UNAIDS, 2020). Despite this, the country – like the region - still lacks adequate migration-aware and mobility-competent healthcare system responses (de Gruchy and Vearey, 2020; Vearey, 2021). As witnessed elsewhere, South Africa's response to the management of immigration is increasingly restrictive, with lower-skilled migrants in particular facing challenges to enter South Africa in regular ways (Carciotto, 2020). Combined with existing challenges in the implementation of immigration governance – including the ways in which the dysfunctional refugee status determination process negatively affects the health and wellbeing of people seeking asylum (Schockaert et al., 2020) - this changing policy terrain will likely increase the risks faced by people crossing into and out of the country, with negative consequences for the health and wellbeing of individuals and the wider population. This, as we will highlight, is particularly concerning in the context of the current Covid-19 pandemic and for future pandemic responses.

South Africa already faces a range of intersecting challenges associated with migration and communicable diseases, including pervasive anti-foreigner sentiments and xenophobia (Misago, 2017) that can lead to non-citizens being unfairly blamed – scapegoated - for the failings of the country's public services (Hiropoulos, 2020; Riemsdijk et al., 2021), including public healthcare systems (Vearey, 2021). Whilst everyone in South Africa who is reliant on the public healthcare system, both citizens and non-citizens alike, face a range of challenges in accessing care (Coovadia et al., 2009; Mayosi et al., 2012; Vearey, 2021), some non-citizens - especially those on short-term visitors visas, asylum seekers and undocumented migrants - may face additional challenges associated with their nationality, the language they speak, and the documents they hold (Chekero and Ross, 2018; Crush and Tawodzera, 2014; Makandwa and Vearey, 2017; Vearey, 2021; Vearey et al., 2016; White et al., 2020b, 2020a).

Responding to Covid-19 in SADC

The pandemic and strategies to mitigate its impact have restricted and complicated livelihood strategies, health seeking behaviour, and mobility both within and between countries in Southern Africa (Mukumbang, 2020; Africa, 2020; Zanker and Moyo, 2020). In March 2020, the first Covid-19 cases were documented in the SADC region amid serious concerns about how rapidly case numbers would rise across SADC and the impact that the pandemic would have given the poor state of many national health systems (Lone and Ahmad, 2020).

To date, some 4 million cases and 106 000 deaths have been officially recorded across the African continent (WHO Regional Office for Africa, 2021) but concerns remain about under reporting, especially as South African data indicates that excess mortality has remained consistently high during the pandemic (Karlinsky and Kobak, 2021). For example, in South Africa, between May 2020 and March 2021, 150,663 excess deaths have been recorded (MRC, 2021) with estimates that "85–95% of the excess natural deaths are attributable to COVID-19. The remaining 5–15% of the excess deaths are considered to be attributable to collateral causes, probably mainly due to overwhelming of the health services during surges in the pandemic" (Moultrie et al., 2021, p. 1).

Regardless, the pandemic has had broader implications for health and wellbeing in the region. The 'covidisation' of healthcare (Pai, 2020) has meant that non-Covid-19 related services, including sexual and reproductive health services, have been deprioritised (Govender et al., 2020). Concerns are rising about the impact of the pandemic on mental health (Semo and Frissa, 2020) and on continuity of care for chronic health conditions, including HIV and TB (Govender et al., 2020; Hofman and Madhi, 2020; Nachega et al., 2021).

The lack of regional harmonisation of Covid-19 test and trace strategies has meant that quarantine policies have been put in place at great expense and with little success (Ndlovu, 2020). In addition, the requirement that those crossing borders present a 'Covid-19 certificate' indicating that they have recently tested negative prior to crossing an international border has meant that many have avoided formal border crossings and concerns have been raised about the production of fake Covid19 certificates (Stoltz, 2021). In addition to broader 'travel bans' and restrictions, which have proven ineffective at curbing Covid-19 in the African context (Emeto et al., 2021), this approach – of securing borders and restricting mobility, at the expense of improving access to healthcare – has complicated livelihood strategies dependent on cross-border mobility, in some instances proving deadly (Mitchley, 2020; Mohamed, 2021) and has led to disruptions in refugee resettlement processes (UNHCR, 2021).

The economic impact of the pandemic and the implementation of lockdowns and travel restrictions have been felt across the region and meant that many have lost livelihoods and income. As such, food insecurity and poverty have risen dramatically across the region for all, not only migrants (Odunitan-Wayas et al., 2021; Strauss et al., 2020). Job losses, rising poverty and hunger, and state responses that have framed cross-border mobility as a threat to the well-being of citizens, have all contributed to rising xenophobic tensions in South Africa; these have been capitalised on by political and community leaders, with xenophobic violence (Manik, 2020) and rhetoric proliferating during the Covid-19 pandemic (Bezuidenhout, 2020).

South Africa has a history of xenophobic violence and has long pushed for increasingly restrictive migration management and the securitisation of national borders (Kabwe-Segatti, 2010; Mlambo, 2020; Nshimbi and Fioramonti, 2014). Within the context of SADC, which has offered little in the way of regional leadership on migration or in relation to the pandemic, in addition to the prominence of responses that are using global health security as a guise to further securitise human mobility globally, South Africa has been able to use the pandemic to stop documented migration into the country and restrict the ways in which non-citizens can make a living (Mukumbang, 2020).

Within this context, attempts to develop migration-aware and mobility-competent health systems and policies at both national and regional levels are unlikely to succeed. Rather, as vaccine programmes will probably be unevenly implemented across the region, we can expect to see Covid-19 and global health security continuing to be used to implement more restrictive migration policies, mirroring the current ways in which HIC countries are using Covid-19 to restrict movement from LMICs.

Moving forward: towards inclusive Covid-19 programming

The entanglement of the global health, immigration governance, and global health security agendas, as precipitated by Covid-19, has made clear that long-held concerns about the blurring of their respective agendas, are well-founded. The Covid-19 pandemic, specifically the securing of borders – both physically and metaphorically - maps onto existing regional, and global, challenges, amplifying existing tensions surrounding immigration and the management of communicable diseases, and the experiences of different migrants globally. Health is a public good, and

[2] https://www.sadc.int/news-events/news/sadc-develops-regional-migration-policy-framework/

efforts to improve health for all will support the social and economic development agendas of Southern Africa, in addition to global calls for UHC. 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.

Although calls are being made for the inclusion of migrant and mobile populations in Covid-19 responses, specifically vaccination programmes (Al-Oraibi et al., 2021; Beyrer et al., 2021; Hoagland and Randrianarisoa, 2021; Orcutt et al., 2020; UNHCR, UN Committee on Migrant Workers, UN Special Rapporteur on the Human Rights of Migrants, African Commission on Human and Peoples' Rights, Inter-American Commission on Human Rights, Council of Europe, 2021), few good practice examples exist of how to strengthen regional harmonisation and operate inclusive health systems during the pandemic (Crawshaw et al., 2021; Greenaway et al., 2020; Knights et al., 2021).

As we enter an era defined by a vaccine apartheid, we must ensure that states themselves do not develop their own vaccine nationalism by denying or delaying access to vaccines for non-citizens (Spiegel, 2021; Vearey, 2021); increasing global interest in a vaccine passport mechanism that will have multiple negative consequences for LMICs in particular (Baral et al., 2021; Gstrein et al., 2021; Phelan, 2020; Schlagenhauf et al., 2021); and, the various, sometimes discrete and other times blatant, manifestations of national security agendas through Covid-19 control programmes. This needs to be better understood by all involved in developing and implementing Covid-19 response measures. Unfortunately, "it appears that social science research is not being read by those in health institutions, and that the public health and global health security communities remain in separate silos" (Davies and Wenham, 2020, p. 1228).

Understanding how the domains of global health and global health security are being shaped by an increasingly conservative global migration agenda is critical. It has long been recognised that "the increasing relevance of global health to foreign policy holds both opportunities and dangers for global efforts to improve health" (Feldbaum et al., 2010, p. 82); in the context of Covid-19, interventions that involve restricting movement across national borders must be carefully interrogated. Misapplying health security approaches to justify nationalistic and xenophobic sentiments will not protect nations, nor their citizens. Rather, the negative effects of failing to develop migration-aware healthcare planning will be felt by all. Communicable diseases affect everyone, regardless of nationality or location, and national, bilateral cross-border and regional public health interventions are necessary.

In order to develop – and, crucially, 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 (Brown and Harman, 2011). Evidence – including analysis of the politics defining the global health agenda (Davies and Wenham, 2020) - 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 (Feldbaum et al., 2010, 2006). 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 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 establishment of a Health Security Agency in the UK may be indicative of an approach whereby states will more explicitly hijack a health security framework to operationalise their national security (i.e. restricting immigration) ambitions.

Conclusions: the need for an evolving research agenda

As we have outlined, the Covid-19 pandemic has served as a stark reminder that both immigration and health are contentious political issues globally; this is no different within the SADC region where the movement of people is often used as a scapegoat for the failings of public healthcare systems. Within SADC, Member States must explore collective efforts to ensure that responses to Covid-19 do not further jeopardise the health of all in Southern Africa. This will require states to revise current public health programming and assess whether existing responses are migration-aware and mobility-competent. Ministries of Health 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 health interventions are not threatened by restrictive immigration agendas and practices.

Border closures and an increasingly restrictive immigration management system risk pushing more people into unsafe and irregular migration routes, rendering people undocumented. As a result, this may increase barriers to access healthcare services – including Covid-19 testing, screening, contact tracing and vaccination - due to documentation status and/or fears of arrest, detention and deportation. Ultimately, unnecessarily restrictive immigration measures will present further challenges to making progress towards global health goals in SADC. This will be the result of 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 as increasing restrictions on movement across borders may undermine efforts to develop migration-aware and mobility-competent health system responses.

The observations and findings above point towards the need for an evolving research agenda to inform the development and implementation of appropriate pandemic responses in the region. To achieve this purpose, a research agenda has to be responsive to current needs through continuous regional consultation. The Migration and Coronavirus in Southern Africa (MiCoSA) Coordination Group presents an existing opportunity through which to undertake such engagements. MiCoSA was established in March 2020 and provides an opportune platform for developing a regional community of practice to inform appropriate responses to Covid-19 that take into account the intersecting fields of global health, immigration governance, and global health security. Based on our findings, we suggest that, in SADC, priority research should focus on improving our understanding of (1) the political factors influencing the (dis)connections between migration and health governance structures in the context of Covid-19, and how to overcome these in the context of a pandemic; and (2) the motivations for and implications of a 'vaccine passport' system on movement within and beyond the SADC region. This requires a reactive, cross-disciplinary, regional research network. In a context where funding for research is increasingly inaccessible, this requires innovative, informal, collaborative engagement.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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