THE IMPACTS OF CROSS-BORDER MIGRATION ON HEALTH SECURITY IN INDIA

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ABSTRACT

The study assessed the impacts of cross-border migration on health security in India in Nigeria. One specific research objective was formulated to guide the study. The research design was an Expost-Facto research design. The population of the study comprised of all the custom officers and the residents in India. 376 respondents were randomly selected for the study, using simple random sampling technique. The instrument known as "Cross Border Migration and Health Security Questionnaire (CBMHSQ)" was used to collect data from the respondents. The test produced high average reliability coefficient of 0.79 which helped justify the use of the instrument. The findings from the data collection and analysis showed significant impact of cross-border migration on health security in India. Among others, it was recommended that migrants should have complete official authorizations to travel, enter, or reside in a host country as lack of such legal documents may cause rejection in the host country.

KEYWORD: Cross-border, migration, health security and India

INTRODUCTION

Cross-border migration and health are increasingly recognized as a global public health priority. Incorporating mixed flows of economic, forced, and irregular migration, migration has increased in extent and complexity. Globally, it is estimated that there are 244 million international migrants and significantly more internal migrants–people moving within their country of birth (*International Organization for Migration (IOM*), 2017). Whilst the majority of international migrants move between countries of the 'global south', these movements between low and middle-income countries remain a "blind spot" for policymakers, researchers and the media, with disproportionate political and policy attention focused on irregular migration to high-income countries. According to Castaneda, Holmes and Madrigal (2015), cross- border migration is increasingly recognized as a determinant of health. However, the bidirectional relationship between migration and health remains poorly understood, and action on migration and health remains limited, negatively impacting not only those who migrate but also the sending, receiving and 'left-behind' communities (United Nations Department of Economic and Social Affairs Population Division, 2009).

The United Nations Development Programme (UNDP) (2009) reports that the growth of migration and population mobility, international trade and communication technologies are shaping global health. The relationships between these globalizing processes and health are introducing health into foreign policy discussions. Migration and mobility feature prominently in this dialogue by addressing the disease risks associated with increasing international population flows. Davies, Basten nd Frattini (2016) assert that population mobility encompasses the processes common to evolving patterns of human mobility, whereas migration reflects the legal and administrative aspects of the movement of individuals and groups. Relationships between migration, population mobility and health have long been acknowledged; however, they have received renewed attention due to the emerging and re-emerging infectious disease paradigm that

has developed since the 1990s (World Health Organization, 2010). This attention has been accompanied by requests at the national government and international nongovernmental agency levels for foreign policy initiatives to address aspects of health in the context of migration and population mobility (Castles, 2000; Pace and Gushulak, 2010).

Following a trajectory that parallels other aspects of modern globalization, the movement and flow of individuals, communities and populations exerts ever greater influence on the international stage. Abubakar, Devakumar and Madise (2016) stated that cross-border migration influences many health determinants and outcomes across the globe. These influences extend across the entire global health spectrum. They can be observed at both the individual and population health level and affect the health sector at all levels, from the provision of clinical services to public health planning and health policy development. In this regard, cross border migration is increasingly being recognized and appreciated as a fundamental component of global health (Gushula, Weekers and MacPherson, 2009).

Conflict, geo-political and economic situations have created and supported the largest number of refugees, displaced populations and forced migrants since the end of the Second World War. Large numbers of those individuals who have flowed towards areas of safe haven and/or better conditions are often at great risk, producing a crisis situation in parts of the Middle East and Nigeria. Cross-border migration is among the strong factors that are driving globalization in recent decades. The patterns of this movement over the years have been changing the size, structure and efficiency of labour markets, culture, political situations and people in many countries across the globe.

Underlying health threats associated with international population movements have driven the development of national and international border control health policies. These policies reflect the volumes and diversities of populations moving between countries and regions with wide disparities in disease risk and prevalence. Fear of imported diseases and their local consequences has historically been tempered by outward demands for trade, economy, exploration, exploitation and conquest. Even before the concepts of germ theory and transmissible diseases were properly understood, foreign-born migrants, returning traders, explorers, and military forces were perceived as potential public health threats. There is also the possibility of transmission of diseases through contact between migrants and the resident population. Hence, this study seeks to assess the impact of cross-border migration on health security in India.

The Concept of Cross-Border Migration

According to Betts (2010), cross-border migrants are individuals who leave their legal place of origin and who cross international boundaries. Cross-border migration is commonly represented as a slow and unidirectional process resulting in permanent resettlement. However, modern population dynamics alter those concepts. Emigration and immigration continue to represent components of those populations that change their place of residence for work or study (Fortier, 2010; Pessar, 2005). Often times, it is noticed that larger groups of migrants who are not immigrants in the legal or regulatory sense move regionally and internationally for varying periods of time (Portes and Borocz, 2001).

Wickramage and Mosca (2014) assert that migrants may enter the host country by regular or unofficial means. Regular migrants may arrive for permanent or temporary residency; their international movements are regulated through mechanisms such as identity cards and travel documents (passports, visas and permits). These migrants are granted the rights to cross borders and remain for defined periods of time in a host country. These regulatory processes govern immigrants, refugees, participants in sanctioned humanitarian movements, migrant workers, travellers requiring visas or permits, international students, tourists and those travelling for

business purposes (Hu, Cook and Salazar, 2008). Irregular migrants, lack one or more of the following official authorizations to travel, enter, or reside in a host country. Irregular migrants are also referred to as illegal immigrants, asylum seekers and refugee claimants in various national jurisdictions, and may include individuals who have been smuggled or trafficked into the country. Irregular migrants also include migrants who were initially admitted legally to a host country, but who overstay their allowed residency period. Nomads and internally displaced people share many characteristics with other mobile populations, but do not cross international borders. Nevertheless, they too may have health needs with implications for foreign policy. Together, these new patterns of population mobility influence and challenge existing international foreign policies relating to trade, economics and security (Wickramage and Mosca, 2014).

According to Lougarre (2016), the health of migrants and non-migrants alike is influenced by determinants including genetics and biological factors, socioeconomic status, environmental exposure, and behaviour. Migrants may also display health characteristics that result from risks present in their country of origin or arising from the migration process itself. Health-care services at transit and destination locations can also be influenced by migration. Such services may experience high demand due to numbers of migrants, or due to migrants having different diseases or disease presentation in comparison to the host population. For diseases of public health significance, migrants may represent vectors for introduced and transmitted diseases in the host country.

Concept of Health Security

WHO Constitution (2006) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It further states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, that the achievement of any State in the promotion and protection of health is of value to all and that the health of all peoples is fundamental to the attainment of peace and security. WHO, established in 1948, is a specialized agency of the UN system that acts as a coordinating authority on international public health. It defined “global public health security” as “the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries”.

The health chapter of the Commission’s report on Human security (2003) examines the links between health and human security, identifying four criteria that influence the strength of these links. These criteria are:

a) the scale of the disease burden
b) the urgency for action;
c) the scale of the impact on society; and
d) the interdependencies or externalities with potential to cause ripple effects. By applying these criteria, the report concludes that the following three health challenges stand out as closely linked to human security: global communicable diseases; poverty-related threats; and violence and crisis (Forster-Cox, Mangadu, Jacquez and Fullerton, 2010).

According to Human security report (2003), globalization forces and increased interdependence have contributed to the changing role of health on the international agenda. Many recent developments and events have influenced the current debate on health security. WHO (2016) stated that health and human security are central to human survival in the 21st century. This new awareness and responsiveness needs to be appropriately harnessed to improve health security globally, nationally and in communities in the future.

An apparently widely accepted assumption is that the deteriorating health of a population can lead to socioeconomic instability and therefore to more generalized insecurity, whereas healthier people tend to form more stable and secure societies (Fidler and Gostin, 2006; Newbold, 2005). It remains unclear, however, to what extent poor health actually contributes to internal instability and whether improving health and health care can stabilize states, particularly in a post-conflict environment. Although the existing links and common ground between health, security and foreign policy are broadly recognized, McInnes and Lee (2006) assert that "there is a lack of clarity over two questions crucial to the framing of the future agenda: whose health and whose security is at risk; and what issues should be part of the global health security agenda (and which are not)".

The concept of Cross-border Migration and Health Security in India

According to Gushulak (2000), cross border migration in international commercial activity has long been associated with the spread of infectious disease. The principles of quarantine emerged from the busiest shipping ports of 14th-century, where initial border control measures centred on inspection and exclusion of goods, vessels and people with the aim of protecting inhabitants from imported plagues (Rowland and Nosten, 2001). As international health threats emerge, some countries are again augmenting their quarantine functions, reaffirming the port authorities' principles and practices of centuries ago. The operational challenges of addressing global public health threats at borders belies the reality of mass movements bridging international regions with marked health disparities over ever-shorter time periods (Steel, Silove, Brooks, ShakehMomartin, and Alzuhairi, 2006). Even if effective medical screening at international borders were possible today, the shortest-incubating virulent disease of public health concern can be carried over a border before being clinically expressed (Willen, Knipper, Abadía, 2016).

Border health practices can disrupt the trans-border flow of people and goods (Piper, 2003). The need to maximize health protection while minimizing interference with international trade became the guiding principles of the International Health Regulations (IHR) (2005) that originated from these first maritime sanitation regulations. The 2005 revision of the IHR retains the principles of quarantine, but also recommends early international notification and national infrastructure support to control outbreaks that could affect global public health.

According to Vearey (2016), Kim, Torbay and Lawry (2007), the impact of migration on health can be positive or negative. On the positive side:

•Returning migrants may spread health-related knowledge and good practices through the high-quality training they received overseas.

• They may also introduce new practices, procedures and medical training.

•They also establish health facilities, such as clinics and hospitals, with the proceeds of their sojourn overseas. Indeed, many Nigerian medical doctors who departed from Nigeria in the 1970s and 1980s set up private practice in their own facilities upon their return to the country (Awases, Gbary, Nyoni and Chatora, 2004).

On the negative side:

• Brain drain of medical personnel (doctors, nurses and pharmacists) may undermine health-care provision and worsen infant and child mortality as well as maternal mortality. For instance, 2,701 doctors trained in Nigeria left the country to work in other countries in 2009–2012. Currently, all the medical schools graduate between 3,500 and 4,000 new doctors annually.

•There is also the possibility of transmission of diseases through contact between migrants and the resident population. For instance, the return to Nigeria of girls who were involved in prostitution in Europe might lead to transmission of sexually transmitted diseases, including HIV/AIDS (Gushulak and MacPherson, 2000; Todrys and Amon, 2009).

•The outbreak of Ebola virus disease in West Africa has heightened the concern over the spread of the deadly disease through migrants or returning citizens from these countries (World Health Assembly, 2008).

Securitization Theory by Weaver (2004)

According to Weaver (2004), security is a social and inter-subjective construction. Buzan (1998) asserts that to prevent 'everything' from becoming a security issue, a successful securitization consists of three steps. These are: (1) identification of existential threats; (2) emergency action; and (3) effects on inter-unit relations by breaking free of rules (Buzan, 1998). To present an issue as an existential threat is to say that: 'If we do not tackle this problem, everything else will be irrelevant (because we will not be here or will not be free to deal with it in our own way)' (Buzan, 1998). This first step towards a successful securitization is called a securitizing move. A securitizing move is in theory an option open to any unit because only once an actor has convinced an audience (inter-unit relations) of its legitimate need to go beyond otherwise binding rules and regulations (emergency mode) can we identify a case of securitization. In practice, securitization is thus far from being open to all units and their respective subjective threats. Rather, it is largely based on power and capability and therewith the means to socially and politically construct a threat. In this way the study of security remains wide, but with restrictions pertaining to 'who' can securitize it is neither unmanageable nor incoherent. This being said it should be noted that Weaver (1998) is extremely critical of framing issues in terms of security. For him: 'security should be seen as a negative, as a failure to deal with issues of normal politics' (Buzan, 1998). Because of this, he favours a strategy of desecuritization whereby securitization is reversed and issues are moved out of 'the threat-defence sequence and into the ordinary public sphere' where they can be dealt with in accordance with the rules of the (democratic) political system. Although this is clearly a normative statement on the part of Weaver, it is important to notice that it has no bearing on what securitization theory can do. While for normative theorists being political lies at the very heart of their approach to security, in Weaver's securitization theory being political (intended or unintended) is only of secondary importance. This is because being political can never replace the political act that is securitization/desecuritisation (Weaver, 2000). Securitization/desecuritization is a political choice by a securitizing actor, which the analyst seeks to uncover by means of using securitization theory.

The application of this theory to the study implies that there is a need to assess cross border migrants and properly check them for diseases before entry into a community. In other words, the physical security of people as well as the socio-economic wellbeing of the people should be prioritized by the state. The scope of global security should be expanded to include threats in seven areas such as health security which requires appropriate measures to checkmate cross-border migrants. Hence, this study draws on the analytical strength of this approach which is based on its ability to situate a community at the heart of health security.

RESEARCH METHOD

The researcher used an Expost-Facto design was used in conducting this study. In this type of design the researcher only has the liberty to obtain the effect already existing in the natural course of events. The research area for this study was India

The population of this study comprised all custom officers and the residents in India while a simple sampling technique was used to draw the 376 respondents. The main instrument to be used in this study is questionnaire titled "CROSS BORDER MIGRATION AND HEALTH SECURITY QUESTIONNAIRE (CBMHSQ)". The questionnaire was made up of two sections, sections A and part B. Part A was used to collect information on personal data of the respondents while section B of the questionnaire was made up of three variables. The obtained data was

coded statistically before the statistical analysis of the data. However, Likert scale method was used, that is strongly agree, (4) agree (3), disagree (2) and strongly disagree (1) for the positive responses but for the negative responses the reverse will be the case. It was necessary that the instrument had to be validated by the one expert in test and measurement and evaluation. This instrument was tested to determine its reliability. In the trial test, a total of 30 respondents who did not form part of the main study were randomly selected from the state government, and the instrument administered on them. The reliability coefficient obtained was 0.79 and this was high enough to justify the use of the instrument. An introduction letter written was to introduce the researcher to the respondents for understanding and assistance. The questionnaire were issued and retrieved 3 days latter from each respondent. The exercise took about one week.

Model Specification:

Research question (using percentage analysis)

$$\% = \frac{CF}{TF} \times \frac{100}{1}$$

Where CF is the Cell Frequency
TF is the total frequency
100 is a constant value

Hypotheses one: (using Simple Regression Analysis)

The null hypothesis states that there is no significant impact of cross-border migration on health security in India.

$Y = f(X)$ - - - - (1)

The variables will be treated independently and jointly,

Where Y = health security
X = cross-border migration

Therefore $Y = a + bX + e$ - - (2)

Where a and bare coefficients and e is error term.

Method of Data Analysis

The researcher subjected the data generated for this study to appropriate statistical techniques such as regression analysis. The test for significance was done at 0.05 alpha levels.

RESULTS AND DISCUSSIONS

Answering the Research Questions

Research Question One

The research question sought to find out the impact of cross-border migration on health security in India. In order to answer the research question, descriptive analysis was performed on the data collected as shown in table 1

Table 1
Descriptive analysis of the impact of cross-border migration on health security in India

Variable	N	Arithmetic mean	Expected mean	R	Remarks
Cross-border migration	5	12.56	12.50	0.90	*Strong to perfect relationship
Health Security in India		13.09	12.50		

Source: Field Survey

Table 1 presents the result of the descriptive statistics of the impact of cross-border migration on health security in India. The two variables were observed to have strong to perfect relationship at 90%. The arithmetic mean for cross-border migration 12.56 was observed to be slightly greater than the expected mean score of 12.50. In addition to that, the arithmetic mean as regards Health Security in India 13.09 was observed to be higher than the expected mean score of 12.50. The result therefore means that there is significant impact of cross-border migration on health security in India.

Testing the Hypotheses
Hypotheses One
The null hypothesis states that there is no significant impact of cross-border migration on health security in India. In order to test the hypothesis regression analysis was performed on the data, (see table 2).

TABLE 2
Regression Analysis of the impact of cross-border migration on health security in India

Model	R	R-Square	Adjusted R Square	Std. error of the Estimate	R Square Change
	.902[a]	.814	.813	.68345	.814

***Significant at 0.05 level; df= 374; N= 376; critical R-value = 0.113**

The table shows that the calculated R-value 0.902 was greater than the critical R-value of 0.113 at 0.5 alpha level with 374 degree of freedom. The R-Square value of 0.814 predicts 81% of the impact of cross-border migration on health security in India. It was also deemed necessary to find out the extent of the variance of each case of independent variable (impact of cross-border migration on health security in India) as responded by each respondent (see table 3).

TABLE 3
Analysis of variance of the impact of cross-border migration on health security in India

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	762.23	1	762.23	1631.80*	.000[b]
Residual	174.70	374	.47		
Total	936.93	375			

The above table presents the calculated F-value as (1631.80) and the P-value as (.000). Being that the P-value (000) is below the probability level of 0.05, the result therefore means that there is significant impact of cross-border migration on health security in India

Discussion of the Findings

The result of the data analysis in table 1 and 2 was significant due to the fact that the calculated R-value (0.902) at 0.05 was greater than the critical R-value of level with 374 degree of freedom. The result implies that there is significant impact of cross-border migration on health security in India. The result therefore is in agreement with the findings of many experts on this issue. The significance of the result caused the null hypotheses to be rejected while the alternative one was accepted.

Conclusion

In conclusion, this study examined the impact of cross-border migration on health security in India. The conceptual framework were reviewed as such; concept of cross-border migration, concept of health security and the concept of cross-border migration and health security in India. Securitization theory was applied in the study and based on the result of the findings, it was concluded that there is significant impact of cross-border migration on health security in India. The following are hereby recommended:

1. Migrants should have complete official authorizations to travel, enter, or reside in a host country as lack of such legal documents may cause rejection in the host country.
2. Returning migrants may spread health challenges and diseases to the host community and so they should be properly quarantined and examined before they are allowed entry into a country.

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