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Migration and health – an issue dominated by human rights or security?
A discourse analysis of the World Health Organization and Swedish media

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Abstract

The health effects of migration receive increased attention in Sweden and internationally, and involves both the effects on the health of migrants and the society. The field encompasses issues such as how migrants' health is affected by the hazardous journey, if the health needs differ from the host population and if migration have any consequences for public health in the recipient country. These issues represent two different perspectives on health – health as a human right and health as security issue. This thesis has investigated which of these perspectives dominate the debate regarding migrants' health in the World Health Organization as well as in Swedish media and what the implications are of the two approaches. The method *Critical Discourse Analysis* has been used to study official documents from WHO and editorials and debate articles in Swedish media regarding health screening of migrants. The theoretical framework is constituted by human rights, securitization theory and global health security. The findings are that human rights dominate within WHO while the security perspective dominates in Swedish media, which frames migrants as carriers of diseases potentially threatening the host population.

Key words: global health security, securitization, migration, health screening, Critical Discourse Analysis
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1 Introduction

More people than ever before has left their homes in search for a better future, in search for a safe haven from war, natural disasters and persecution. In 2015, the numbers of international migrants[1] were estimated to 244 million, which is the highest number in history in absolute terms, but in relative terms the number of migrants have been constant at 3 % for the past decades (IOMa). Of the 244 million international migrants, 65.3 million were forcibly displaced and 21.3 were refugees[2], numbers that the world has not experienced since the Second World War (UNHCR).

This so-called refugee crisis raises demands on the global community in several ways, and one of them is the scope of this thesis - the health of migrants. People on the move experience severe health related challenges that need to be addressed during the journey and in the new place of residence.

The World Health Organization (WHO) is the leading international organization for health and their mission is to ensure the highest attainable level of health for all people worldwide (WHOj). WHO has increasingly addressed the health challenges in relation to migration - the issue has for example been discussed in the governing bodies of the organization, The Executive Board and the World Health Assembly, in the last year (WHO 2017:EB140/1 Rev.1, WHO 2016:A69/1 Rev. 1, EB138/1 Rev.2). This focus on migration has increased in the aftermath of two global public health crises, namely the spread of ebola virus starting in 2014 and zika virus in 2016. The spread of the diseases has once again showed that diseases do not recognize borders - in our interconnected world all countries are potentially vulnerable to the spread of infectious diseases[3] in faraway places. Consequently, the demand on WHO and the global community to

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[1] There is no universally accepted definition of the term *migrant* but in this thesis I will use the definition by the International Organization for Migration: "IOM defines a migrant as any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is" (IOMb).

[2] A *refugee* is a person that meets the criteria in the refugee convention, namely "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (SFS 2005:716:chapter 4 §1, The 1951 Convention Relating to the Status of Refugees and the 1967 Protocol:article 1).

[3] Infectious diseases can spread directly or indirectly from one person to another. Synonyms are *communicable diseases* or *transmitting diseases.* The contrary is non-communicable diseases that cannot spread between persons (WHOf, WHOg).

improve the protection against disease outbreaks[4] has increased, a work that goes under the label *global health security.* I wonder if this increased focus on global health security has also affected the work on migration and health?

In Sweden and in many other countries, asylum seekers[5], refugees, immigrants from family reunification[6], resettlement refugees and undocumented migrants[7] are offered a *health screening* upon arrival. The screening has dual purposes; it is an opportunity for the individual to get help with health needs, and a mean to identify individuals with contagious diseases (SOSFS 2013:25, SFS 2013:407, SFS 2008:344). The screening includes an interview about the mental and physical health status and tests for infectious agents and it is an opportunity to introduce the Swedish health care system. In 2014-2015, 41 percent of all asylum seekers underwent the health screening, and it increased to 77 percent in 2015-2016 (SALAR 2017). The screening is voluntary in Sweden, while mandatory in some countries (The National Board of Health and Welfare). The dual purpose of health screening acknowledge that health is a human right for everyone, established in e.g. *the Universal Declaration of Human Rights* (UNGA 1948, 217 A (III)).

The dual purpose of the screening is crucial, affirmed for example in the *Strategy and action plan for refugee and migrant health in the WHO European Region* – ”[i]nitial screening – not limited to infectious diseases – can be an effective public health instrument, but should be non-discriminatory and non-stigmatizing and carried out to the benefit of the individual and the public; it should also be linked to accessing treatment, care and support.” (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 60). The strategy emphasizes that the screening is primarily for the benefit of the migrant. A Swedish study investigating the experience of health screening by asylum seekers found that they felt the identification of infectious diseases being the focus and not their health needs. The asylum seekers expressed that their health complaints – dominated by psychological problems – were overlooked unless they were about infectious diseases (Lobo Pacheco et al. 2016).

In this thesis, I will investigate which perspectives dominate the debate on the health of migrants by looking at two cases; the debate in the governing bodies of WHO regarding migration in general, and the debate in Swedish newspapers on health screening of migrants specifically. The assumption is that the two perspectives – health as a security issue or health as a human right – will dominate the discussion. Health screening is an appropriate case since its purpose encompasses both perspectives. My hypothesis is that since migration and health

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[4] According to WHO, a *disease outbreak* is “the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season” (WHOh). *Epidemics* is often used as a synonym. A disease outbreak that spread worldwide is called *pandemic* (WHOi).

[5] *Asylum-Seekers* are persons seeking international protection and who has not yet got a decision regarding the application (UNHCR 2006).

[6] *Immigrants from family reunification* means that a person has got residence permit because their family members already have residence permit in the country (SFS 2006:716:chapter 5 §3, Swedish Migration Agency).

[7] *Undocumented migrants* are people residing in a country without the necessary permits (IOM).

– separate from each other – are increasingly put in a security frame, the combination of the two will facilitate securitization of the health of migrants.

The study is conducted using *Critical Discourse Analysis* as developed by Norman Fairclough and the theoretical framework is established by *securitization theory* according to the Copenhagen School, *global health security* and *human rights*. Before addressing the theoretical framework, I will present previous research on migration and health and provide background on the human right to health and the securitization of health issues.

1.1 Aim and research question

The aim of my thesis is to investigate whether there is a conflict between securitization-based and human rights-based approaches to international relations and, if present, how this conflict unfolds. I will address this in the context of a topical issue, namely migration and health. Specifically, I will use the discussions within WHO and discussions on health screening of migrants in Sweden as my cases. The principally interesting is securitization, why apparently soft issues are framed in security terms and how this affects other ways of framing the issue, such as a human rights approach. The purpose is to problematize and illuminate on the current debates regarding migrantion and health and demonstrate the ideas framing the debate. I will look at three concepts – security, global health security and human rights with the first two in focus and human rights more as background.

My research questions are:

1. Is there a conflict between a human rights based and a security based approach to health in relation to migration and if so, how has it played out?
    a. If there is a conflict, how is it visible in the World Health Organization and in Swedish media regarding voluntary health screening for migrants?
    b. Is the health of migrants securitized?
    c. What are the implications of a human rights-based as opposed to a security based approach to the health of migrants?

1.2 Previous research on migration and health

Previous research on migration and health include a variety of issues. Some articles touch upon my topic and discuss the connection between migration and spread of infectious diseases, often in a historical context. Often based on xenophobia, migrants have been blamed for spread of diseases through history

and ships were put in quarantine, people from areas with high prevalence of leprosy, plague or other diseases was restricted from internal migration and immigrants have been forced to undergo a mandatory health screening before entering a country, a practice still used by some countries (McInnes & Lee 2012:149, Totten 2015, Ventura 2016). Health screening and especially the practice of mandatory screening is also discussed by others. The efficiency of such policies is questioned from economic and epidemiological perspectives, stressing that it does not prevent spread of diseases to such an extent that it is economically defensible and they might even be counterproductive, due to the risk that people avoid seeking treatment. In addition, mandatory screening is stressed to neglect human rights and humanitarian ideas, (Coker & van Weezenbeek 2001, Hogan et al. 2005, Horner et al. 2013, Zimmerman et al 2011).

Previous research also address the human rights perspective on the health of migrants, discussing fulfilment of the rights of undocumented migrants to health (Biswas et al. 2012, Ventura 2016).

The message in WHO publications is that migrants in general suffer from extreme versions of the social determinants of health (birth, adolescence and work conditions in combination with structures and forces that affect everyday life (WHOk)). Thus, the health of migrants is not automatically different from the host population, but factors such as interruption in health care, the journey, traumatic experiences in the country of origin, xenophobia and restrictive asylum policies may worsen their health status. Migrants are naturally a heterogeneous group and factors such as country of origin and migration time create a great disparity of health conditions. Also, the health conditions in the country of origin is naturally reflected among migrants – if the vaccination coverage is low, tuberculosis, HIV/AIDS or malaria, for example, is widespread in the country of origin, it is probable that the migrant group suffer from this as well. (WHOl, WHO 2016:EB140/24, WHO 2008:WHA61/12, WHO Regional Office for Europe, WHO Regional Office for Europe 2015).

Information from the Public Health Agency of Sweden (PHAS) follow the same line as WHO's – there are disparities within the migrant group and the situation in the country of origin as well as during the journey expose migrants to health risks. PHAS clearly states that there are limited risks for spread of infectious disease to the host population because of the influx of migrants as such, but migrants might be more exposed to infectious diseases due to overcrowded and/or hazardous accommodations. It is therefore important that asylum seekers undergo health screening and other preventative actions are taken. The clear message is that the risk of widespread outbreaks is low (PHAS 2016).

1.3 The context of the discourse

1.3.1 The human right to health in international and Swedish law

Health is a human right established in several resolutions, declarations and constitutions. The founding document of human rights is the United Nations *Universal Declaration of Human Rights*, adopted by the United Nations General Assembly (UNGA) in 1948, with the following paragraph regarding health:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UNGA 1948 217 A (III): Article 25).[8]

Furthermore, the right to health is established in the constitution of WHO: "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO 1946). The right to health is monitored by four principles; availability, accessibility, acceptability and quality (CESCR 2000, E/C.12/2000/4).

Another document to mention is the *International Convenant on Economic, Social and Cultural Rights,* and its article 12, establishing that "[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UNGA 1966:A/RES/21/2200 article 12).

The human right to health encompasses all humans, and therefore includes migrants, refugees and asylum seekers. The right to health for migrants is especially emphasized in *The International Convention on the Elimination of All Forms of Racial Discrimination*. The convention urge State Parties to eliminate discrimination to "[t]he right to public health, medical care, social security and social services" (UNGA 1965, A/RES/2106(XX), Article 5 (e) (iv)). Discrimination based on national or ethnic origin should be prohibited, which means that non-citizens are included. Also, the Refugee Convention from 1951 states that refugees have right to the same "public relief and assistance" as nationals (The 1951 Convention Relating to the Status of Refugees and the 1967 Protocol: article 23).

Though my thesis focus is broader, there is also a convention on the rights of migrant workers, namely the *International Convention on the Protection of the*

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[8] The Human Rights Council has also appointed a Special Rapporteur on the right to health, with the mandate to visit countries and report to the council on the state of the right (OHCHR [the Office of the United Nations High Commissioner for Human Rights]a).

Rights of All Migrant Workers and Members of Their Families. Articles 28, 43 and 48 state that migrant workers and their families have the right to health services. It is framed in two ways, firstly as it only concern emergency care (UNGA 1990:A/RES/45/158, article 28) and secondly as it should be equal to nationals (UNGA 1990:A/RES/45/158, article 43 and 45), which is a contradiction that I will come back to.

The Committee on Economic, Social and Cultural Rights (CESCR), in its general comment Number 14, affirm that states are obliged to respect the right to health, including providing the same level of health service to asylum seekers and illegal immigrants (CESCR 2000, E/C.12/2000/4, paragraph 14). On the same note, The Committee on the Elimination of Racial Discrimination (CERD), writes in its general recommendation N° 30 on non-citizens:

> Ensure that States parties respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services; (CERD 2004, CERD/C/64/Misc.11/rev.3 paragraph 36)

Even though equal access is affirmed in international law, states generally limit migrants, refugees and asylum seekers right to health to emergency health care only (OHCHR 2008). In Sweden, asylum seekers, refugees, immigrants from family reunification and undocumented migrants are entitled to health care that cannot be postponed, maternal healthcare, care related to abortion as well as family planning. Children under 18 are entitled to the same level of health care as people with residence permit (SOSFS 2013:25, SFS 2013:407, SFS 2008:344).

1.3.2 Development of securitization of health

On the 18th of September 2015, The United Nations Security Council (UNSC) determined that "the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security" (UNSC 2014, S/RES/2177 (2014):1). This was not the first time a health issue was framed as a security issue; rather it is a symbol of an increased focus on the linkages between health and security. These linkages and the work on the issue is called *global health security.*

In the 2007 version of the *World Health Report,* yearly published by WHO, WHO defines global (public) health security as:

> Global public health security widens this definition to include acute public health events that endanger the collective health of populations living across geographical regions and international boundaries. […] Global public health security embraces a wide range of complex and daunting issues, from the international stage to the individual household, including the health consequences of human behavior, weather-related events and infectious diseases, and natural catastrophes and man-made disasters […] (McInnes & Lee 2012:137).

Historically, the link between health and security has mainly been related to armed conflict, e.g. in the Crimean War, cholera and other diseases killed three

times more soldiers than the actual battles (McInnes – Lee, 2012:130). The impact of disease on the military has also been raised in the present time because of the disproportionate HIV infection rate in the military (McInnes – Lee, 2006:8).

The modern concept of global health security started with a report to the United States Institute of Medicine in 1992. The report focused on emerging infectious diseases and named it a national threat and the most important problem for public health in the country. The report proposed a global surveillance system to detect and respond to outbreaks (Weir, 2015:19). Through efficient diplomacy from the US and Canada, the idea gained ground within WHO, starting with a resolution on the issue at the World Health Assembly in 1995 (Weir 2015:20). Following the resolution, WHO has intensified its work on surveillance and response towards emerging diseases and several resolutions have been adopted since (Weir, 2015).

In parallel with this development, the concept of *human security* gained attention, starting with the publication of United Nations Development Programme's (UNDP) 1994 version of the report *Human Development* named *New Dimensions of Human Security* (Aldis, 2008:370). Human security indicate a focus on the security of *people* and not states. The report identified seven areas of threat to human security: economic –, food –, health –, environment –, personal –, community – and political security (UNDP, 1994:24-25). The section on health security addresses both communicable and non-communicable diseases, as well as the disparities in health care services between rich and poor (UNDP 1994:27-28).

Following the connection of health and security during the 90s, health issues have been discussed within the United Nations. HIV/AIDS and Ebola, have been discussed in the Security Council and considered a threat to peace and stability (WHOa). The General Assembly has discussed four health issues: HIV/AIDS in 2001, 2006 and 2011; Non-Communicable Diseases in 2011; Ebola in 2014; and antimicrobial resistance in 2016 (WHOb, General Assembly of the United Nations, WHOc and WHOd).

WHO's primary tool in the work for global health security is the International Health Regulations from 2005 (IHR 2005) that obliges states to develop systems for detection, surveillance and response towards possible public health events. A crucial part of the IHR 2005 is the requirement for states to report events of international concern to WHO (McInnes & Lee 2012:137-139). WHO can then declare the outbreak to be a *Public Health Emergency of International Concern* (PHEIC) (Ventura 2016). A foundational fact in global health security is that the defense against diseases is only as strong as the weakest part, meaning the weakest country. All countries are dependent on each other's abilities to detect and prevent outbreaks and well-developed health systems are therefore necessary in all countries (Heymann et al. 2015).

2 Human rights theory

This section will establish a theoretical framework for the discussion on migrants' right to health. Human rights are to a large extent based in *cosmopolitan* ideas and I will therefore start with an overview of this ethical approach.

2.1 Cosmopolitanism and human rights

There are three basic moral claims of cosmopolitanism, namely individuality, universality and generality. *Individuality* means that human beings are the primary objects of moral concern (contrasted with the realist focus on states). *Universality* or *universalism* means that all humans are equally included, each human has equal value, and all are included in the moral concern. Lastly, *generality* means that the value and the moral concern towards all humans is a matter for everyone. All individuals have obligations towards all other in the world and all share the same moral values (Caney 2005: 4). The cosmopolitan idea thus means that the world constitutes "one single ethical space" (Bergman-Rosamond & Phythian 2011:1) and there are no differences between the moral obligations inside and outside the state.

Human rights are a cosmopolitan project because it acknowledges premises of individuality and universality – it is the individual that holds the rights and all have equal rights. This is for example evident in article 2 of *the Universal Declaration of Human Rights,* stating that all people, regardless of "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (UNGA 1948 217 A (III): Article 2) have the same value and hold the same rights. However, it is uncertain if human rights meet the cosmopolitan criteria of generality since it is not evident if it is indeed a concern for everyone, which I will return to in 2.4.

Criticism towards cosmopolitanism derive from scholars faithful to *communitarianism,* among others. Communitarianism is based on the idea that our moral values is derived from our social identity and community (meaning state, nation, minority group, religious community etc.). Also, moral commitment is restricted to the community and there are no obligations outside it. The communitarian approach claim to respect cultural differences and acknowledge that people have different moral principles dependent on where they come from (Erskine 2007: 127-129).

2.2 What is human rights?

The first article of the *Universal Declaration of Human Rights* (UDHR) reads: "[a]ll human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood" (UNGA 1948 217 A (III): Article 1). The UDHR was adopted by the UN General Assembly in 1948 and is the cornerstone of human rights. The Universal Declaration got force of treaty law in 1966 by the International Human Rights Covenants – the International Covenant on Economy, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). These three documents are sometimes referred to as *the International Bill of Rights* (Donnelly 2013:26). There are however contesting views regarding the *philosophical* origin of human rights.

"Human rights are literally the rights one has simply because one is a human being" (Donnelly 1989:10). This definition of human rights is in line with the *naturalistic theory* that argues for human rights as coming from nature – "(a) right might be 'natural' in the sense that we possess it independently of our social relationships and undertakings, and more generally of any conventionally established rank or status" (Beitz 2009:51). The natural theory shares ideas with cosmopolitanism and has influenced the *Universal Declaration of Human Rights.*

Another approach to the origin of human rights is *cultural relativism*. Cultural relativism stresses that moral values are derived from culture and local traditions, which is similar to the communitarian idea. Human rights are therefore not derived from human nature but local cultures and communities and are consequently not one set of rights that all shares, the content differs between groups (Beitz 2009:73-95, Donnelly 1989:109-124).

In Donnelly's definition of human rights mentioned above, emphasis should be placed on the word *has* – human rights are something one always possess. To have a right gives mandate to *claim* the right, and in order to claim the right there has to be someone with obligations to provide the right. This logic gives us *right-holders* and *obligations-bearers* and it is stressed that no rights exist without obligations (Donnelly 1989:9-12, O'Neill 2005:431).

What is unclear, however, is who holds the obligations? It is not evident from *the Universal Declaration of Human Rights* who is the responsible actor since obligations are assigned to states, nations, countries and people. The covenants are more distinct since obligations are assigned to the signatory states. At the same time, the covenants are narrower in scope by only encompassing special[9] and not general rights, and not assigning states with obligations to respect rights, just to secure or ensure the respect for them (O'Neill 2005: 433-435).

[9] Rights can be divided into two categories, general- and special rights. General rights are rights that all persons have regardless of who they are, for example human rights. Special rights are linked to a specific attribute, for example citizenship or culture (Caney 2005:64).

The logic of right-holders and obligation-bearers is related to criticism against human rights. Common criticism is the issue of cosmopolitanism and generality; the lack of cultural relativism; the accusation of human rights to be Western imperialism and the lack of implementation (Beitz 2009, Donnelly 1989, O'Neill 2005). I will address this in the following section and since I argue that the first three contribute to the fourth I will start with lack of implementation.

2.3 Lack of measures for implementation

Human rights for all are still far from a reality, atrocities are still conducted and those who commit them are often left unpunished. This daunting picture is for example drawn up in Amnesty International's report *The State of the World's Human Rights* from 2016 (Amnesty International 2017). There is a real problem with lack of human rights in the world, but what tools are there to promote implementation?

The state is the main arena for implementation of human rights. If a citizen or another national actor violates human rights they can be tried through the national legal system, but the situation is different when the state itself is the perpetrator. The international human rights system is centered around the UN Human Rights Council, treaty bodies such as the Committee on Economic, Social and Cultural Rights (ICESCR) and the UN High Commissioner for Human Rights (OHCHR) (Donnelly 2013: 161-170). The role of the Human Rights Council is to promote the implementation of human rights by for example bringing up human rights violations to discussion and issue resolutions. Furthermore, the treaty bodies can issue reports on specific human rights and issue *general comments* in order to develop the human rights law by interpreting the obligations in the treaty (Donnelly 2013: 161-170).

The common problem with all the actors in the system is an absence of effective measures against violations of human rights, and the existing ones are often dependent on cooperation by the state in issuing reports or giving consent to external monitoring. The only available sanction is negative publicity through *naming and shaming.* (Donnelly 2013: 161-170). This is a problem that must be solved for human rights to be a reality for all. Onora O'Neill says: "[i]f the claims of the human rights documents have normative force they must be matched by obligations; if they are not matched by obligations, they are at best aspirational." (O'Neill 2005:434).

However, I do not see the lack of efficient instruments as the only barrier to the implementation of human rights but would like to emphasize that the criticisms against the concept itself is part of the problem.

2.4 Human rights, cosmopolitanism and cultural relativism

The challenge with human rights and cosmopolitanism is the contested nature of cosmopolitanism itself. As discussed in 2.1, cosmopolitanism rests on individuality, universality (there are moral values valid to all people) but also on generality, arguing that all people have moral obligations towards all other people. This means that all share the same moral values and the respect of human rights is a concern for all – but I wonder if this really is a shared understanding? I will start with the premise of generality, and not even the *Universal Declaration of Human Rights* portrays acceptance of this premise since it expresses that all share the same moral value (universality) but states only have obligations towards their own citizens or foreign citizens within their borders (Donnelly 2013:32-33).

The Westphalia peace in 1648 laid the foundation for the current world order - all states are sovereign and have the right to decide over their territory and no other actor has the right to interfere in their businesses. This principle is a bit more contested today but the international system still builds on the idea of sovereign states. Sovereignty creates a challenge for the cosmopolitan approach to human rights, since the premise of generality promotes responsibility across borders and in some sense, proclaims external interference (Caney 2005:54-56). Also, Donnelly stress that even though he considers human rights a global concern, he stresses that the national arena is the main place to advocate for human rights. Without a strong national movement, it is difficult to develop a society with respect for human rights – history has shown external interference alone to be unsuccessful (Donnelly 1989, 250-269).

Furthermore, although stated in the *Universal Declaration of Human Rights,* the premise of universality is also contested, for example from a cultural relativistic perspective. Cultural relativism is as mentioned based on the idea that cultures and communities have their own moral values and that others cannot legitimately deliver criticism. Therefore, we cannot talk about a common set of moral principles and neither universal human rights. Instead there must be respect for the particularity of local cultures – which the human rights regime is criticized for neglecting (Donnelly 1989:109-110).

Beitz discuss the respect for cultural particularities in relation to what he names agreement theory – that human rights are based on the values that all can agree on. Simply put, the idea is to find a minimal standard that is acceptable by members of all communities (Beitz 2009:73-77). The agreement theory share ideas with Brian Barry's contractarianism or "justice as impartiality" since this too argues for a set of rights that all can reasonably agree on (Caney 2005:67-68).

Regardless if one agrees with cultural relativism, it is evidently a challenge towards the implementation of the international human rights regime since it does not accept universalism. It is especially problematic if combined with the lack of acceptance of generality. With neither common human rights nor responsibility towards others the whole project of *the Universal Declaration of Human Rights*

will fail. In other words, the problem of implementation of human right might simply be the fact that the cosmopolitan idea is not shared by the international system.

2.5 Human rights and western imperialism

The previous section on cultural relativism and the demand for respect for different cultures is closely related to the topic of this section – the accusation of human rights to be a form of Western imperialism (Beitz 2009: 133-134, 203-209). Human rights are criticized for being based on Western values and imposed on other states. Donnelly accepts that the ideas of human rights originate from a European and Western context but denies that it is about powerful states imposing values on others, because all states have agreed on *the Universal Declaration of Human Rights* (Donnelly 1989:234-235). What I believe he misses in the discussion is the power relation present at the time of adoption of the declaration. It is unclear if all states had the same possibilities to influence the agenda. I believe this is an important component to bear in mind. Similarly, advocating for human rights through foreign policy is accused of being based on national self-interest and not concern of the people of the other state. It is just a tool of international diplomacy to reach other goals (Beitz 2009, 203-209, Donnelly 1989:229-249). This is similar to the criticism against securitization of health issues that I will address in the following section.

A final point on this matter from Donnelly is that the *accusation* of human rights as Western imperialism can be abused as well. It can be an effective way for oppressive governments to legitimate actions that violates human rights (Donnelly 1989:119-121).

The criticism of human rights to be Western imperialism is an evident challenge for implementation. If it is considered a Western project, the motivation to comply with the treaties is probably reduced. Donnelly writes that national advocacy for human rights is necessary for the implementation and if citizens as well as governments do not feel it is *their* project, their human rights, it is difficult to see how an effective national movement can be realized.

We have seen that there are challenges for the successful implementation of human rights that are both associated with the concept itself and to the instruments at hand for effective implementation, which I will come back to in the analysis.

3 Securitization and global health security

This chapter will introduce a relatively new perspective on security called securitization, which will be a part of my theoretical framework. However, if this is a "new" perspective there must be an "old" perspective, and I will begin by giving a historical background on security and International Security Studies in particular.

3.1 Securitization theory

The field of International Security Studies developed after the Second World War mainly in the US and Europe. The basis was a realist approach to international relations – the world consists of sovereign states that are constantly engaged in a struggle of power. Security referred to state security and focused on military capacity and the use of force. States needed protection from external threats (defined in material terms) and security was reached through the balance of power. This is generally labeled a *traditionalist* approach to security (Buzan – Hansen 2009:30, 156, 259). The end of the Cold War opened for a broader view of security and a variety of perspectives has since been introduced, often labeled as *wideners-deepeners* of the security agenda. Some of the new approaches are Post-colonialism, Feminism, Critical Security Studies, Post-structuralism, Human Security and the Copenhagen School with its securitization theory, and the last will be the focus of this thesis. Common features between the new approaches are that they argue for "deepening the referent object beyond the state, widening the concept of security to include other sectors than the military, giving equal emphasis to domestic and trans-border threats, and allowing for a transformation of the Realist, conflictual logic of international security" (Buzan – Hansen 2009:188,187-191).

The Copenhagen School is one of the proponents of a widened approach to security. In the book chapter *Securitization and Desecuritization* (1995) Ole Waever, who first developed the securitization theory, gives his view on how to reconceptualize the concept of security. Waever argues that a reconceptualization is not about creating new forms of security but about how we understand the *creation of security*. The *concept* security is about the survival of the state; the sovereign state is the center of attention. However, what pose a threat against the state should be expanded beyond military threats, as long as it corresponds with the question: "[d]o the challenges determine whether the state is to be or not to

be?" (Waever 1995:53). Also, he stresses that "security problems are developments that threaten the sovereignty or independence of a state in a particular rapid or dramatic fashion, and deprive it of the capacity to manage by itself' (Waever 1995:54). The words *rapid* and *dramatic* are central to securitization theory – issues are described in terms of urgency to evoke action (Waever 1995:55). Security problems are then met by measures to resolve the situation and secure the survival of the state. The idea is therefore not to *redefine* the object of security, but how it is constructed.

Securitization theory rests on the idea that security is socially constructed. There is no *objective* security – what constitutes a threat to security depends on who is being asked. It is also *inter*subjective since security is created relationally (Buzan et al. 1998:29-31). The meaning of this will be developed below.

Furthermore, an issue such as health can be non-politicized, politicized, securitized and desecuritized. If it is non-politicized it is not dealt with at all in the political sphere, i.e. it is not a matter of political debate or action. If it is politicized it is dealt with in the "normal" political sphere i.e. it is subject to political discussion and action. Securitized means that the issue is removed from the political sphere (or bypasses ever being politicized) and dealt with in the security sphere instead. The consequence is that it is not subject to political debate and extraordinary measures can be taken to handle the issue. Desecuritization lastly means that an issue is moved from securitized to politicized (Buzan et al. 1998:23-24).

A key concept in the securitization theory is the *speech act,* which builds on the work on speech act theory conducted by John L. Austin and John R. Searle. The core idea is that certain statements is not just a description of the state of affairs, instead the statements is an 'agent' in the sense that it creates reality. There are three components of the speech act, namely locutionary, illocutionary and perlocutionary acts. Without going into details, the meaning of this is well summarized by Jürgen Habermas; "to say *something* [locutionary], to act *in* saying something [illocutionary], to bring about something *through* acting in saying something [perlocutionary]" (Balzacq 2011:5). The utterance itself is thereby the act. I will come back to this when discussing some of the criticism against the Copenhagen School.

With this background in mind, it is time to look closer at the securitization process, which takes place in two stages. First, a *securitizing actor* (e.g. political leaders, bureaucrats, lobbyists who are trying to securitize an issue) conducts a *speech act* – he or she claims an issue to be an *existential threat* to the survival of a *referent object* (the object that is threatened and need protection – the state according to traditional security studies). This is a *securitizing move*. What constitutes an existential threat and who is the referent object varies between sectors, but it is an issue that need priority and need to be dealt with urgently (Buzan et al. 1998:21-27, 36, Emmers 2007: 111-114).

The second stage is about acceptance of the securitizing move by the *audience*. For securitization to be successful the audience must accept the framing as an existential threat to their survival. If the audience accepts the speech act it permit the securitizing actor to take *extraordinary measures* to handle the

existential threat, which basically mean breaking free of the rules of normal politics. It is not necessary that extraordinary measures are in fact taken but securitization gives the permission to do so (Buzan et al. 1998:21-27, 36, Emmers 2007: 111-114).

So, what makes a securitizing move successful? There are facilitating factors, internal and external, that increase the likelihood of the speech act to succeed. The internal factors relate to the construction of the speech act itself – does it follow the "grammar of security" (Buzan et al. 1998:32-33) and refer to existential threats, point of no return etc.? The external factors relate to both the social capital of the securitizing actor and the nature of the threat. A political leader has a greater chance of convincing the audience of the existential threat from drugs for example, than the average citizen. Also, if the speech act describes the threat in terms of other things normally considered threatening, the chances of success increase further (Buzan et al. 1998: 31-33, see also Balzacq 2011:9).

Related to the facilitating factors is *security complex,* which is "a set of units whose major processes of securitization, desecuritization, or both are so interlinked that their security problems cannot reasonably be analyzed or resolved apart from one another" (Buzan et al. 1998: 201). The point is that a security issue cannot be analyzed in isolation because there are several factors affecting a specific case. Securitization should therefore be subject to cross-sectoral analysis such as studying the connections between economic security and environmental security. The full picture constitutes *aggregate security* (Buzan et al. 1998:167-171). This was important during the Ebola outbreak; the extent of the outbreak in Liberia, Guinea and Sierra Leone was not just due to the disease epidemiology, but also because these countries had suffered from conflict and poverty, which affected their ability to react.

I started this section on securitization by stating that security is socially constructed relationally. I have shown that this is evident both since an audience must accept the speech act, but also because it is constructed in relation to factors outside the issue itself.

3.1.1 Societal security and securitization of migration

The members of the Copenhagen School have also discussed the concept *societal security.* I will not go into depth on this but since it is related to securitization of migrants in general I will address it shortly. The idea is that the security field is reconceptualized into *state-* and *societal* security. The state security concerns the survival of the sovereign state and the societal security concerns the survival of identity (Buzan et al. 1998:119-120, Waever 1995:65-71, Waever et al 1993:25).

The survival of identity means the possibility to remain as a society and to preserve its identity. Societal security can then be defined as "the ability of a society to persist in its essential character under changing conditions and possible or actual threats" (Waever et al. 1993:23). Since migration is accused of being one of the main threats to societal security it is relevant for the scope of this thesis. Migration introduces new cultures in a society and in a European context

migration has loosened the homogenous nations and created a more multi-cultural and heterogeneous society. This could, according to societal security, constitute a threat to the common, stable identity in a society (Buzan et al. 1998:120-121, Dannreuther 2013:189, Waever 1995:65-7, Waever et al 1993:43, 158).

Furthermore, the perceived threat from migration also concerns state security and is then constituted by for example lack of control of movement into the own territory, terrorism, crime and imported conflicts from countries of origin (Waever et al 1993:162). In line with the previous discussion on security complex, the eventual securitization of the health of migrants needs to be considered in light of securitization of migration in general. My hypothesis is that the securitization of migration and migrants in regard of societal security and traditional state security facilitate the securitization in the health sector.

When discussing the securitization of migration, it is important to note that these are *perceived* threats, well expressed by Dannreuteher as "the *empirically unfounded* and *morally objectionable* 'security continuum' between immigration, unemployment, crime and terrorism" (2013:195). It is a risk that nationalistic forces highjack the discourse on migration and frame it as a security threat instead of a humanitarian issue to give people a safe haven (Waever 1995:65-71).

3.1.2 Securitization – good or bad?

Is securitization a desirable situation or not? Paul Roe discusses this and divides the discussion on securitization as a negative concept into *process* and *outcome* arguments, and I will address the process arguments first.

According to the Copenhagen School, an issue is ideally dealt with in the realm of normal politics. Securitization breaks this ideal situation since it opens for dealing with an issue in the security sphere instead of the political, "[r]ather than debate and deliberation, securitization calls for *silence and speed*" (Roe 2012:252). Securitization is thus an undemocratic process and Buzan, Wæver and de Wilde calls for desecuritization. Roe stress, however, that securitization does not necessarily has to be a process dealt with in the darkness, it can be an open political process and security can instead be viewed as a "fast-track" (Roe 2012:256) to legislation and other political measures to deal with the threat (Roe 2012:250-252, 254-257).

The *outcome arguments* regard if securitization is an effective way to solve threats or challenges to a state. Roe means that the effectiveness of securitization differs between issues, some issues such as environmental degradation or health might be better dealt with through desecuritization while other issues would benefit from securitization. Securitization is not a "one size fits all"-concept. For example, the security sector often work with short-term instead of long-term solutions, which is not suitable for some issues (e.g. climate change and health).

Furthermore, Roe stresses that security can create antagonism and a discourse of friends and enemies, of *us and them,* which is not useful to solve global challenges that demands cooperation, such as disease outbreaks. However, Rita Floyd nuance this by stressing that securitization does not *have to* lead to conflict

and antagonism but can lead to cooperation and common solutions. Also, Roe stresses that the extraordinary measures that are said to follow from securitization is exaggerated (Roe 2012:252-253, 258-260).

Another negative aspect with securitization is the risk of abuse. By referring to security reasons the securitizing actor can legitimize extraordinary measures that for example violate human rights and the rule of law, such as quarantine for people suffering from an infectious disease. It also opens for increased control and surveillance of people. This concern has been raised in relation to the War on Terror, among other issues (Emmers 2007:115).

The positive arguments for securitization are not as well defined as the negative. Roe for example rather just stress that the potential for desirable outcomes depend on the context and one should not automatically resist securitization efforts (Roe 2012:260). In a discussion on the securitization of migration, Roland Dannreuther argue that there can be security dimensions of political challenges which should not be denied. Regarding migration specifically, he argues that control of a state's territory is the foundation of survival and that it is therefore natural to control the state border from irregular migrants (Dannreuther 2013:196-197). Buzan, Waever and de Wilde make similar claims and stress that securitization might be inevitable in certain situations such as when a state gets attacked by another state (Buzan et al. 1998:29). They also recognize that even if it is not desirable, securitization can be a tempting process for tactical reasons. Securitization is a way to raise attention for an issue and to put it on the political agenda. Framing an issue in security terms give priority to the issue and will probably lead to increased actions. Therefore, it can be used as a political strategy (Buzan et al. 1998:29, Waever 2011:469). As will be discussed later, this is relevant in relation to the securitization of health issues.

3.1.3 Criticism against securitization theory and the Copenhagen School

Thierry Balzacq presents some criticism towards securitization theory as proposed by the Copenhagen School in the book *Securitization Theory – How Security Problems Emerge and Disolve* (2011). His main criticism is that Copenhagen School is insensitive towards context and reality in their analysis. According to the Copenhagen School, context is constituted by language which means that the speech act of security change the surrounding context. Therefore, the actual context or reality is thus irrelevant for the analysis. Balzacq argues that Copenhagen School therefore has "neglected the importance of 'external or brute threats'" (Balzacq 2011), and that threats are dependent on the discursive constitution of them. Balzacq does not agree and argues instead that it is crucial to understand the context to analyze security problems and a statement of security has to "be related to an external reality" (Balzacq 2011:13) in order to convince the audience.

The Copenhagen School's rejection of context and "reality" can however be contested. As discussed, the facilitating conditions for successful securitization

include both internal and external conditions and the external conditions include the "external, contextual and social" (Buzan et al. 1998:32). Also, the discussion on aggregated security above recognize, in my view, that a securitization process cannot be studied in isolation, which makes context important. However, it is true that context and the real world is of less analytical importance to the Copenhagen School, since the speech act is the focus.

To continue the speech act-track, Balzacq stresses that when the Copenhagen School talks about the speech act as creating securitization, they miss that the action part (perlocutionary act) is just a *related* concept to speech act and not *actually* speech act. It is therefore unclear if the Copenhagen School view security as self-referential, meaning that the statement of security *is* security (illocutionary act) or that security is dependent on response (perlocutionary act) (Balzacq 2011:5). I see how this is a theoretical issue but since the Copenhagen School themselves is clear that securitization is an intersubjective process through the dependency on acceptance from the audience, I do not consider it an issue for the practical usage of the theory.

Balzacq also stresses that the audience is underconceptualized in the Copenhagen School (which is admitted in e.g. Buzan et al. 1998:41). Related to the audience is the criticism that the Copenhagen School does not provide clear answers on when securitization has actually taken place or if an issue really is a threat or not. For example, who constitutes the audience sometimes remains undefined and there is a lack of indicators of when the audience has accepted the securitization move (Balzacq 2011). The Copenhagen School themselves has also admitted this problem (Buzan et al. 1998:206-207).

Securitization is also accused for Eurocentrism – the theory is developed in a European context and much of its work is related to securitization processes in European integration and identity development. Also, securitization, desecuritization and the 'normal' political sphere, is based on the idea of a liberal democratic state. Therefore, the relevance both for democratic non-European countries and non-democratic countries might be limited (Dannreuther 2013:49).

Traditionalists also criticize securitization theory based on traditionalists' view that security only regards military threats and not issues such as environmental security, health security and societal security. Also, even if you accept that security could be expanded beyond the military sector, it is potentially problematic that everything seen as a challenge gets included under the security label (Buzan et al. 1998:195). At the same time, the Copenhagen School has received criticism for not breaking enough with traditionalist security studies, "that it mistakenly ties together security and survival, and that it is state-centric, elite-centric, discourse-dominated, conservative, politically passive, and neither progressive nor radical" (Buzan – Hansen 2009:215).

Buzan and Hansen bring up a last set of criticisms, namely the preference of desecuritization before securitization, as discussed in 3.1.2. A potential risk with desecuritization is that issues are silenced and repressed instead of dealt with in a democratic order. Therefore, securitization should be replaced by p*oliticization* if something, and not simply desecuritization (Buzan – Hansen 2009:217).

3.2 Securitization of health – the concept of global health security

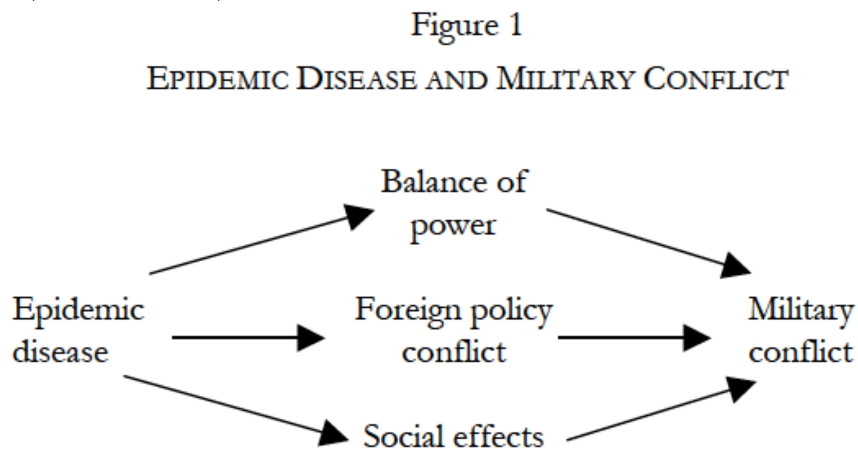
In the background, I provided an overview of the emergence of linkages between security and health, called global health security. I will now explore this concept further and connect this development to securitization theory as proposed by the Copenhagen School. I will start by discussing the connections between health and security, then discuss the consequences of this framing, then relate it to securitization theory and lastly explore if health is in fact securitized.

The health threats that are discussed in the literature on global health security are pandemic diseases such as influenza; bio-terrorism; and the severe burden diseases such as HIV/AIDS put on highly affected countries (Rushton 2011, 2014, McInnes & Lee 2006, 2012:148). For the scope of this thesis, the most relevant threats are those posed by pandemic diseases and the burden of disease. Some scholars discuss the connections from a military point of view (e.g. Susan Peterson); while others take a more human security approach (Aldis 2008) and others focus on the security of the state but from a widener-perspective (e.g. Stefan Elbe).

Susan Peterson discusses the connections between epidemic diseases (in this case HIV/AIDS) and its connection to military conflict and point out three potential areas of conflict, namely 1) balance of power, 2) foreign policy conflict and 3) social effects (see figure below). However, Peterson stresses that it is unlikely that epidemic disease or some other health-related issue would start a violent conflict on its own but it could be a contributing factor to outbreak of violence (Peterson 2002).

Figure 1

EPIDEMIC DISEASE AND MILITARY CONFLICT



(Peterson 2002:64)

Epidemic disease and its effect on the balance of power is connected to the potential mass-death or mass-weakening of the population due to the epidemic. This could weaken a state in relation to another, or a group within a state (Peterson only talk about state conflicts, but as I see it, it could also concern intrastate conflicts) and shift the power-balance. Based in realist international

theory, this could lead to a preventive war to even out the shift in power (Peterson 2002:55-56).

The risk of foreign policy conflict due to epidemic disease regards conflict over state's response to the disease, such as policies regarding the freedom of movement of goods and people (e.g. quarantine and border control), or conflict over intellectual property rights in relation to the production of pharmaceuticals (Peterson 2002:56-57).

Peterson is skeptical that these first two would lead to military conflict and stresses that epidemic disease could also lead to international cooperation and a shift of focus away from the military sector to the health sector. The largest threat to security posed by epidemic disease is instead the social effects: "[b]y causing severe economic, political, and social effects, epidemic disease can produce domestic instability, civil war, or civil-military conflict, or it may lead a state to lash out against another state" (Peterson 2002:57). Potential consequences of HIV/AIDS are that the production in the country is at risk if large proportions of the population are sick and political unrest may spread due to dissatisfaction with the Government's management. The social destabilization can create political instability and in the end intrastate conflict (Peterson 2002:57-64).

Peterson's discussion regarding the social effects are similar to other scholars, who point out HIV/AIDS as a specific security threat due to its high burden on affected countries (e.g. McInnes & Lee 2006, 2012, Rushton 2014). Therefore, I will not discuss this issue further.

As you have seen, Peterson discusses epidemic diseases considering military conflict, but it can also be viewed as a security threat to the state if one takes a widener-deepener approach to security (3.1). An infectious disease such as influenza, ebola or zika could be a threat to the survival of the state if it leads to mass-death or mass-weakening of the population (see for example McInnes & Lee 2012, Rushton 2014). Furthermore, from a human security perspective all threats to the *freedom from want,* which includes health, is a threat to the security of the individual. Infectious diseases fall naturally in this category (Aldis 2008, McInnes & Lee 2012:140-146).

The potential securitization of health calls for action, and the action mentioned in the literature is in line with the International Health Regulations from 2005 (see 1.3.2). It includes protection in the shape of detection of disease, surveillance (or monitoring) of diseases, reporting, early warning systems, control of the outbreak and potential urgent response (Aldis 2008, Rushton 2011:784-785).

3.2.1 Is health being securitized?

This section will explore if the connections between health and security is in fact an example of securitization. Not all scholars discuss health and security from a securitization perspective (e.g. Peterson), while others do (e.g. Elbe, McInnes and Rushton).

Some see the increased attention towards health issues in the United Nations Security Council and the United Nations General Assembly as proof of

securitization, combined with the increased “security talks” in different forums. An example of “security talks” is that health threats are mentioned as one of the eight main threats to Swedish security in the national security strategy (Löfven 2017). Politicians in mainly the United States of America and the United Kingdom of Great Britain and Northern Ireland have conducted similar speech acts for several years (Feldbaum 2006). In relation to the securitization of HIV/AIDS, Stefan Elbe writes in the article *Should HIV/AIDS Be Securitized?:*

> This is precisely what has happened to the issue of HIV/AIDS in recent years, where arguments have shifted from humanitarian and public health ones to officials in international organizations, governments, and non-governmental organizations (securitizing actors) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states, and militaries (referent objects) is now being undermined (existentially threatened), unless drastic measures (emergency measures) are undertaken by national and international actors to better address the global pandemic. HIV/AIDS has become securitized (Elbe 2006:126).

The securitization of health has definitely received widespread attention, but there are those who contest it as an example of securitization. Simon Rushton, for example, conducts a discourse analysis of key documents for the positioning of HIV/AIDS on the global agenda. He stresses that the security frame has not been so influential as one might believe, instead it was the *development* frame that was found the most important (Rushton 2010, see also McInnes and Rushton 2013). Along similar lines, McInnes and Rushton argue for that the speech act to securitize HIV/AIDS in the United Nations Security Council was not actually successful, since the audience (the members of the Council) did not in fact accept it. The resolution was adopted but not all members were convinced of the evidence of the security implications of HIV/AIDS. Instead the adoption of the resolution was maybe due to pressure on the Council to do *something* about the pandemic and securitization was the tool they possessed (McInnes & Rushton 2013:125,127). Thus, “security talk” does not necessarily mean that the speech act of security has convinced its audience and successful securitization is accomplished.

3.2.2 What are the consequences of securitization of health?

Regardless of if it is in fact securitization or not I will in this section discuss the consequences of linking health and security. This will only be a brief overview of the positive and negative consequences since I discussed the outcomes of securitization extensively in 3.1.2, and these are all relevant in the specific case of health.

The most frequently mentioned positive consequence is, as with securitization in general, that it gives attention to the issue and put it on both the national and international political agenda. Hopefully this leads to political and economic resources being invested in solving the problem. The securitization might also

raise the status of the health ministry in the government, which could facilitate appropriate action (Elbe 2006:132, McInnes & Lee 2012:130-133).

The security frame probably brings increased funding as well. International donors and national governments direct focus towards the health issue that has been securitized, and the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria is for example attributed to the framing of HIV/AIDS as a security issue (Feldbaum et al. 2006:192, Rushton 2014:299-300). Securitization could also lead to increased resources on strengthening health systems in general and not only efforts related to the specific disease. Since the health system is mentioned as protection against health threats it makes sense to direct resources to it – with potential benefits beyond the particular disease (McInnes & Kelley 2006:12-15, Rushton 2014:298-299). The need for a strong health system as protection against disease outbreak was evident during the ebola outbreak – the lack of resources and capacity of the health systems in the three most affected countries contributed to the widespread transmission.

On the negative side, securitization of health issues is accused for changing the reason for engaging in global health from a cosmopolitan or humanitarian based approach towards focus on national self-interest. Stefan Elbe, one of the key scholars in the field, worries about the consequences for the future – if the self-interest takes over there is a risk that global health issues are not a valid concern in itself. International cooperation to promote global health apart from the issues that can be connected to state security might consequently face difficulties (Elbe 2006:129).

The national self-interest could lead to skewed attention and funding towards diseases that pose a threat to western states, instead for the diseases that pose the highest burden on societies. Especially manifest is this in relation to noncommunicable diseases, which lead to far more death globally than infectious diseases – but infectious diseases still receive the most attention within global health security. Since infectious diseases can pose a risk to other countries the incentive for Western state to invest in work against them is higher than for noncommuniccable diseases (Aldis 2008:372, Feldbaum et al. 2006:196-197, McInnes & Lee 2006:11, Rushton 2011:793, 2014:291, Ventura 2016). Figures from 2015 presented by WHO show that among the ten major causes of death worldwide, only three are related to communicable diseases and HIV/AIDS is not even included in the top-10 (WHOe). It is a risk that the security label creates security for the few (both countries and groups within a country) instead of the majority (Elbe 2006:130).

Also, Feldbaum et al. stresses that threats to global health are best handled through international cooperation, due to the character of infectious diseases countries are dependent on each other for stopping an outbreak. National interest as driving force might not be the best method to promote cooperation and therefore the security label is problematic (Feldbaum 2006:196, see also McInnes & Lee 2012:28).

Another problem with putting health in a security frame is that it does not solve the underlying problem such as social determinants of health (employment, housing environment etc.). Instead short-term *extraordinary measures* are

employed, such as border control or quarantine for those infected, while long-term solutions such as reducing inequalities and strengthening health systems might not be prioritized (McInnes & Rushton 2013:129). The securitization can also lead to violations of human rights since the measures taken when facing a potential health threat sometimes stand in conflict with human rights (e.g. detention, silencing of people who speak up on the issues, stigmatization and discrimination of patients) (Amon 2014:293-303, Elbe 2006:128, 130). The violations in the name of health security are not only unethical; they also risk being counterproductive. If people who suspect that they might carry an infectious disease see that patients are punished for their disease, the chances that they will seek health care is reduced and the potential to stop the outbreak is therefore diminished (Amon 2014:293-303).

I would like to raise a final point to conclude the discussion on the consequences of securitizing health, namely that the connections between health and security as well as the consequences of such a connection are highly contested. The academic community has not reached consensus on whether there are in fact security implications related to health, neither on if the security frame is positive or negative (see for example Elbe 2006).

4 To study the discourse – methodological framework

I will use discourse analysis to study the debate between a security and a human rights perspective on the health of migrants. Discourse analysis is founded in social constructivism and poststructuralism. The starting point is that meaning and reality is created through language and it is through language we should study society. Our use of language is not a natural reflection of society but participates in its creation (Jørgensen & Phillips 2002:1). Discourse analysis is strongly connected to securitization theory, since it stresses that security is constructed by the way we talk about certain issues – by naming something a threat it can lead to a perception of the issue as one (Buzan et al. 1998). This overlaps with the ontological and epistemological foundation of discourse analysis and is therefore the natural methodological choice.

There are different forms of discourse analysis, and I will use *Critical Discourse Analysis* (CDA) according to Norman Fairclough; it acknowledges that non-discursive factors can constitute the discourse and therefore recognize the importance of the context (Bergström & Boréus 2012:358-378). As the health of migrants is a complex issue with connections to many other fields it is appropriate to analyze it from the multi-dimensional standpoint that CDA offers.

Before addressing the actual method, I will discuss operationalization and material.

4.1 Operationalization and material

To study the presence of a human rights- and security discourse regarding the health of migrants, the theoretical framework needs to be combined with a methodological framework. This is done through operationalization of the theory that is then applied on the material using CDA (Esaiasson et al. 2012:55).

I will base the operationalization on the presence of key words and concepts from the theories in the material. For securitization theory this means studying the following words (and synonyms to them): *urgency, threat, exceptional measures/response, survival, "now or never" and defense*[10]. The complementary theoretical framework provided by global health security gives us the additional key words *surveillance/monitoring, rapid response, detection/early warning,*

[10] In Swedish: brådskande, hot, exceptionella åtgärder/respons, överlevnad, "nu eller aldrig" and försvar

preparedness and preventative work.[11] Human rights are operationalized through the key words *universality, rights, "for all"* and *power over decision* with synonyms such as *"are entitled to"*.[12] The human right to health, specifically, is monitored by the words *universal health coverage, no discrimination or stigmatization* as well as the criteria for evaluating the right to health: *availability, accessibility, acceptability, affordability* and *quality.*

The material for the study is different kinds of documents; official documents from WHO regarding migration and health[13], editorials and opinion articles in Swedish media and finally an interview with a Counselor at the Permanent Mission of Sweden to the United Nations in Geneva, that provide insight in the informal negotiations in WHO. The included official documents from WHO are all the documents (reports, summaries of discussions, resolutions and a decision) on migration and health produced for the governing bodies of WHO; the Executive Board and the World Health Assembly. I will also include two documents (a resolution and a strategy- and action plan) from the governing body of WHO's Regional Office for Europe; the Regional Committee for Europe. These documents are included since the *Strategy and action plan for refugee and migrant health in the WHO European Region,* hereafter referred to as the Strategy, is to date the only one adopted within the WHO-family, and it is more elaborated than the other documents. Also, there is ongoing work within the WHO Headquarter in Geneva to produce a similar plan which makes the document even more relevant (Interview).

In addition, I will study the debate on health screening in Swedish newspapers. I will study editorials and debate articles only and have used the database Retriever, containing all printed press in Sweden, to identify the material. The selection of articles is the result of a search in the database with the following words (originally in Swedish): *health screening* (and the synonym

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[11] In Swedish: övervakning, snabb respons, upptäckt, beredskap and förebyggande arbete
[12] In Swedish: universalitet, "för alla", rättigheter, och makt över beslut
[13] WHO 2008, WHA61/12 *Health of migrants – Report by the Secretariat*
WHO 2008, WHA61.17 *Health of migrants*
WHO 2015, EB138/26 *Promoting the health of migrants*
WHO 2016, A69/27 *Promoting the health of migrants – Report by the Secretariat*
WHO 2016, WHA69/2016/REC/ *Sixty-Ninth World Health Assembly Geneva, 23-28 May 2016, Summary Records of Committees, Reports of Committees, List of Participants*
WHO Regional Office for Europe 2016, EUR/RC66/8 *Strategy and action plan for refugee and migrant health in the WHO European Region*
WHO 2016, EB138/2016/REC/2 *Executive Board 138th Session Geneva, 25-30 January 2016, Summary Records, List of Participants*
WHO Regional Office for Europe 2016, EUR/RC66/R6 *Strategy and action plan for refugee and migrant health in the WHO European Region*
WHO 2016, EB140/24 *Promoting the health of migrants - Report by the Secretariat*
WHO 2017 EB140(9) *Promoting the health of refugees and migrants*
WHO 2017, EB140/PSR/17 *Provisional Summary Record of the Seventeenth Meeting*

health control) and *migrants, asylum seekers* or *refugees*[14]. After removing duplicates, I had 25 articles in total.

The combination of official documents and news articles are used in other studies as well and is for example proposed by the Copenhagen School scholar Lene Hansen in the book *Security as Practice – Discourse analysis and the Bosnian war* (2006).

4.2 Critical discourse analysis

I will use *Critical Discourse Analysis* (CDA) as developed by Norman Fairclough to conduct the analysis. The aim of CDA is to "reveal the role of discursive practice in the maintenance of the social world, including those social relations that involve unequal relations of power" (Jørgensen & Phillips 2002:63). In this section I will only explore the premises of CDA relevant for my study and not provide a full account of Fairclough's work. Focus will be on the so-called three-dimensional model.

The main difference between CDA and other methods for discourse analysis is that Fairclough stresses the dialectical relationship between discourse and social structure, meaning that discourse is both *constitutive* and *constituted* by the social world. The way we talk about an issue is part of the creation of the issue, but the nature of the issue also affects how we talk about it (Fairclough 1992:62-67, Jørgensen & Phillips 2002:61-62). CDA thereby stresses the importance of understanding the surrounding context where the discourse operates and argue that discourse cannot be understood in isolation. Since CDA recognize the importance of discursive as well as non-discursive practice, a phenomenon cannot be studied with discourse analysis alone. Theories related to the specific phenomenon need to be included to understand the social practice that affects the discourse (Jørgensen & Phillips 2002:62-69).

Fairclough has developed a three-dimensional model for the analysis of discourse and the dimensions are the *text, discursive practice* and *social practice* (Jørgensen & Phillips 2002:69). I will address each of them separately in the following sections.

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[14] The exact search was: (hälsoundersökning* OR hälsokontroll*) (asyl* OR migra* OR flykt*) (Placement:opinion OR Placement:debatt OR Placement:ledare)

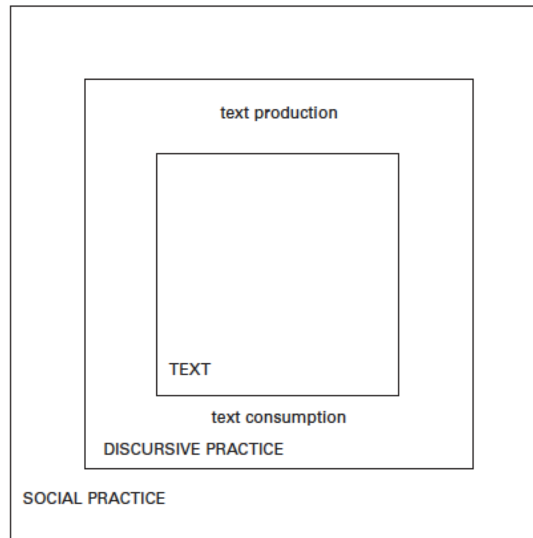

Figure 3.1 *Fairclough's three-dimensional model for critical discourse analysis (1992b: 73)*

(Jorgensen & Phillips 2002: 68).

4.2.1 Fairclough's three-dimensional model: discursive practice

The *discursive practice* looks at the production, consumption, distribution and interpretation of the text, as well as the force of text and coherence. These processes depend largely on the social context and the resources (knowledge, experiences etc.) of the people engaged in the discursive practice. A text can therefore not be understood without these factors and Fairclough suggests a "mental map" of the context of the discourse in order to analyze its influence (Fairclough 1992:72, 78-86).

The force of text relates to the action-oriented part of a text, it is in other words the *speech act* of the text*,* familiar from the theoretical framework on securitization (Fairclough 1992:82-83).

Two key concepts in the analysis are *intertextuality* and *interdiscursivity. Intertextuality* regards how different texts are connected to each other, for example by making references to each other, using the same words and in other ways build on each other (Fairclough 1992:84-86, Jørgensen & Phillips 2002:74). *Interdiscursivity* is a form of intertextuality and regards how different discourses are connected to each other. To investigate this, one studies what discourse types (genres, styles, discourses etc.) are present in a text and where they come from. One example is an increased market oriented discourse within the public sector (Bergström & Boréus 2012:376-377, Fairclough 1992:232).

Questions to pose to the text for the analysis (inspired by Fairclough 1992: 232-238):

1. What other texts are present in the current one, what signs of intertextuality are present?
2. Are there signs of connections to other discourses on migrants (apart from health) in the text?
3. What discourse types are present in the text?
4. What is the "mental map" of the context in which the discursive practice takes place?
5. How is the text produced, distributed and consumed?

4.2.2 Fairclough's three-dimensional model: textual dimension

The *textual dimension* focuses on the linguistic characteristics of a text and includes vocabulary, grammar, cohesion (linkages between parts of the text) and text structure (Fairclough 1992:73-78).

Two important part of grammar is *transitivity* and *modality*. Transitivity regards agency and the connection between what is happening and the subjects and objects in the discourse and if anyone is favored in the text. Modality regards the speaker's commitment to the statement. Truth, permission, intonation and hedges (how an utterance is moderated by words such as well, a bit, potentially) are examples on how to express one's commitment to the statement (Bergström & Boréus 2012:391-399, Jørgensen & Philips 2002:83-84).

Questions to pose to the text for the analysis (inspired by Fairclough 1992: 232-238):

1. How is agency expressed in the text, and is agency prescribed differently to different subjects?
2. What modalities are most common in the text – do they include expressions of commitment like truth, permission, intonation and hedges?
3. What vocabulary is used to talk about migrants, health screening and health of migrants? Is the use of wording different in the material?

4.2.3 Fairclough's three-dimensional model: social practice

The social practice involves the context or setting in which the discourse takes place. Important concepts are hegemony and ideology.

Fairclough is influenced by Gramsci's work on hegemony, and regards it as an expression of power, it is when one discourse has received a position of domination and is seen as the 'truth'. It is a "state of affairs" during which one set of ideas has become "common sense" within an institution, group of people or society. Apart from being a state of dominance, hegemony is also "a process of negotiation out of which emerges a consensus concerning meaning" (Jørgensen &

Phillips 2002:76). Hegemony should thus not be mistaken for a fixed situation – it is a result of a discursive struggle of the meaning of the elements in an order of discourse and can just as well change due to another struggle (Fairclough 1992:91-96, Jørgensen & Phillips 2002:76-77).

Furthermore, Fairclough understand ideologies as "[…] significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of dominations" (Fairclough 1992:87). Ideology is therefore a method to exercise power. The ideologies that underpin the social practice affect the discourse and are therefore an important factor in the analysis (Fairclough 1992:86-91).

In order to analyze the social practice of a discursive event, a map of the *social matrix of discourse* is required, which means the social, hegemonic and ideological relations that form the context of the discursive practice (Fairclough 1992:237-238, Jørgensen & Phillips 2002:86).

Questions to pose to the text for analysis of the social practice (inspired by Fairclough 1992: 232-238):

1. What is the social matrix of discourse for the health of migrants?
    a. What ideologies underpin the discourse?
    b. Is there a hegemonic discourse?
2. What social practices are connected to the hegemonic discourses and ideologies in the material?

5 Analysis of the discourse on migration and health

In this section I will discuss the findings of my analysis of the discourse on migration and health. I have divided the analysis into two parts, one part discusses the operationalization of the theories, and the other study the material in detail from the perspective of Fairclough's three-dimensional model.

The two sets of materials, official documents from WHO and articles in Swedish newspapers regarding health screening, are both dominated by the two anticipated themes; migrants' right to health and securitization. The human right perspective dominates in the WHO documents while securitization dominates in the newspapers. A discourse that migrants drain the health system of its recourses is also present, as well as calls for humanitarianism and solidarity. These themes will however not be addressed since it is out of the scope of the thesis.

Before starting the analysis, I will address the part of the discursive practice in Fairclough's three-dimensional model focusing on how the text is produced, consumed and distributed, since it has implication for the whole analysis.

The WHO documents have different purposes and are produced, consumed and distributed differently. The resolutions and the decision are results of negotiations between the member states and have been subject to political compromises. These documents are binding for the member states and requires action from them and WHO. The reports from the WHO Secretariat are based on evidence in the field and are supposed to guide the work in the governing bodies and demonstrate the work conducted by the organization. Lastly, the summaries from the governing bodies are exact replicates of statements made by the member states in official forums, but does not include negotiations and informal discussions. The statements are often written on beforehand and have undergone political preparation. The summaries therefore appear slightly polished and might not represent the actual discussions or the true standpoints of the countries.

The purpose of the editorials and debate articles is to put forth an argument, evoke discussion and maybe even provoke. Debate articles are also an opportunity for politicians to make political suggestions and show force of action. The articles are argumentative and naturally include proposals for social practice related to the discourse, such as law proposals. There is also a difference between editorials, often signed only with the name of the newspaper, and signed debate articles.

5.1 Discourse of the human right to health in WHO and Swedish media

The dominating theme in all the official documents from WHO is health as a human right for all and they focus on the need to secure this right for migrants, refugees and asylum seekers. The right to health is discussed from two perspectives in the material, it is discussed as a matter of fact but also from an accessibility perspective. Barriers such as language, legal restrains on the extent of health care, and cultural insensitive health care are addressed and the Member States are encouraged to reduce the barriers (WHO 2016:A69/27, WHO 2016:EB140/24).

The *Strategy and action plan for refugee and migrant health in the WHO European Region,* hereafter referred to as the Strategy, include eight guiding principles. The first two clearly express that the work has to be rights-driven (WHO Regional Office for Europe 2016:EUR/RC66/8). The first principle stresses that the work on migrants and health will be informed by the WHO European health policy framework called Health 2020, based on the values enshrined in the Constitution of WHO:

> […]By endorsing Health 2020, Member States in the European Region acknowledged the right to health and have committed themselves to universality, solidarity and equal access as the guiding values for organizing and financing their health systems. (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 15).

The second principle continues on the same track: "[a]dopting a human rights-based approach means that the rights of refugees, asylum seekers and migrants and the right to health are integral to all priorities and actions" (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 16).

Human rights as the dominating discourse is also evident when looking at the eight "Future priorities" in three reports produced by the WHO Secretariat called *Promoting the health of migrants.* The first priority in two of the reports reads: "(i) to support the development and implementation of migrant-sensitive health policies that incorporate a public health approach and *equitable access to health services* (health promotion, disease prevention and clinical care) for migrants and refugees, *regardless of status and without discrimination or stigmatization*;" [emphasis added) (WHO 2016:A69/27, paragraph 11, WHO 2015:EB138/26, paragraph 10).

Additionally, a similar report issued by the WHO Secretariat for the World Health Assembly in 2008 discusses basic principles for a public health approach of the health of migrants, and reads:

> Several basic principles influence the development of a public health approach for migrants. *The main public health goal* is to *avoid disparities in health status* and access to health services between migrants and the host population. The second, closely associated, principle is to *ensure migrants' health rights*. This

> entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population [emphasis added] (WHO 2008:WHA61/12, paragraph 6).

Thus, the main priority is to ensure equal access to health services and that human rights are respected.

The lack of implementation of the human right to health is also discussed, for example in the following quote:

> Despite the fact that the right of everyone to enjoy the highest attainable standard of physical and mental health is established in the WHO Constitution of 1948, and despite the existence of ratified international human rights standards and conventions to protect the rights of migrants and refugees, including their right to health, *migrants and refugees often lack access to health services and financial protection for health*. The health of many migrants and refugees is at risk due to *abuse, violence, exploitation, discrimination, barriers to accessing health and social services, and a lack of continuity of care* [emphasis added] (WHO 2016:EB140/24, paragraph 10).

Related to this, it is interesting to note that the reports from the WHO Secretariat, the summary records, and the Strategy all explicitly state the human right to health, but the documents that demands action by WHO and the Member States (resolutions and decision) do not. They call for promoting policies "within a human rights framework, […]" (WHO Regional Office for Europe 2016:EUR/RC66/R6, paragraph 2(b)) or "to promote equitable access to health promotion, disease prevention and care for migrants, […]" (WHO 2008:WHA61.17, paragraph 1(2)) but do not explicitly mention human rights. Is this an indication of lip service? That the calls for respect of human rights is not followed by action? Along similar lines, the Counsellor in Geneva explained that the intent during the Executive Board in January 2017 was first to adopt a resolution as a follow up of the resolution from the World Health Assembly in 2008 (WHO 2008:WHA61.17). However, the member states were unable to reach a consensus, and a decision was therefore adopted instead. This is not as strong as a resolution, and this one is quite meager. One reason to this, as expressed by the Counsellor, was that several countries were uncomfortable with extensive language on the right to health for migrants and the ensuing demands on member states (Interview).

In the editorials and debate articles on health screening the human right to health is present but it is not the dominating theme, instead protection of the host population (Swedes) from infectious diseases is in focus. Although the writers bring up that health screening is important for the individual (rights perspective) as well as the society (security perspective), and they stress that migrants are entitled to health screening and treatment for health issues, it is clear what is prioritized (see for example Hultgren 2016). The right is not the main focus and is mostly a subordinate clause in the discussion on health screening, as in the following example: "[a]ll asylum seekers *are entitled to* a health screening free of charge, but less than half get examined. *Thus, TB and other disease can go*

undetected with danger to others. The elderly and children run especially high risk of being affected" [my translation, emphasis added] (Vetlanda-Posten 2016).

There are some exceptions from the focus on society, in response to an article stressing that the frequency of health screening need to increase, the writer stress: "[t]herefore, we must be equally active in finding and treating people who suffer from post-traumatic stress, as to find those who suffer from infectious diseases" [my translation] (Sarkadi 2016).

The aim of this thesis is not to discuss the extent of migrants' right to health, but this is still a common theme in the newspapers. The articles with this focus address the extent of that right and argue for adequate health care also for undocumented migrants. Health screening is in this case a subordinate clause: "[i]t is inhuman not to give these children *the right to* vaccination and *health check-ups* to detect diseases" [my translation, emphasis added] (Olofsson & Wetterling 2015). Providing health care for all is also mentioned as a protection against infectious diseases (Pehrson 2005).

Human rights are also mentioned as a hindrance to conduct mandatory screening:

> The *voluntariness* is basically about respect for people's personal integrity and *the right to* be spared from forced medical examination – unless special reasons exists [my translation, emphasis added] (Helsingborgs Dagblad 2016).

This quote expresses that it is not allowed to force anyone to medical treatment in Sweden, regulated in the Patient Act (SFS 2014:821). One exception though is if a patient suffers from a disease that constitute a public danger, such as sexually transmitted diseases or tuberculosis. In this case, the patient is required to undergo treatment and assist the authorities to trace possible transmissions (Miörner & Hagstam 2016, 1177 Vårdguiden). In other words, if a migrant undergoes health screening and is diagnosed with tuberculosis he or she must undergo treatment, but the person cannot be forced to participate in the health screening in the first place. This is questioned in the following quote, calling for changed legislation:

> *The Constitution* should of course be honored. But should the interest of integrity *stand in the way of* what must be considered best for the patient and the society? On this point the answer must be no [my translation, emphasis added] (Tunström 2016).

5.1.1 Summary remarks on migrants' right to health

The lack of implementation of human rights is a major problem, and migrants are denied their declared rights. WHO's documents are underpinned by the right to health, but the organization lacks effective measures for implementation and to act against violations. One problem with the implementation is uncertainty what the right to health entails – is it just care that cannot be postponed as in Sweden or does it include *all* health services? Countries have interpreted this differently and

WHO recognize that national legislation govern the access, which could be interpreted as acceptation of cultural relativism. It is in other words uncertain if all countries agree on the cosmopolitan premises of the human right to health, which naturally have implications for the respect of it. The *Universal Declaration of Human Rights,* establish that countries have obligations to their own citizens as well as other people within their territory, which should mean that migrants, refugees and asylum seekers are included (UNGA 1948 217 A (III)).

On the contrary, the editorials and debate articles represent a communitarian ethical approach, meaning that the moral obligations stay within the community (society, country, nation etc.). This is reflected by the focus on the risk for spread of diseases in Sweden due to immigration.

The focus on human rights in the WHO documents is an evident reflection of the organization's mission: the role of WHO is to advance international health and is governed by its constitution declaring health as a fundamental human right. It is therefore natural that WHO's discourse on migration and health is dominated by the rights perspective. Similarly, it is not surprising that debate articles written by a member of the Swedish Democrats does not foremost promote the rights of migrants but rather protection of the host population.

5.2 Discourse of securitization and global health security in WHO and Swedish media

The operationalization of securitization theory and global health security is present in both sets of materials, it is the dominating discourse in the newspapers while it is not in the WHO documents.

In the WHO documents, migration as a threat to public health is vaguely mentioned in subordinate clauses without further specifications or explanation, as in the following examples: "[l]ate or denied treatment may be discriminatory, contravene human rights principles and *threaten public health*" [emphasis added] (WHO 2016:EB140/24 paragraph 10) and "WHO works with the International Organization for Migration and the UNHCR, among others, to understand the health needs and to improve the health status of displaced populations worldwide *while protecting the health of host communities*" [emphasis added] (WHO 2016:A69/27, paragraph 4). The words in italics – threat and protecting – derive from securitization theory and indicate speech acts of security, but it is not explained what this threat consists of or its severity. Also, the first quote does not say it is the migrants that threaten public health – but the lack of health care provided to the group. I consider this an important difference regarding the source of the threat.

Migration and the effects on public health is discussed in other documents as well:

> An important health dimension *is the health risks that migrants carry with them and the public health implications*. […] *Also, they carry the vulnerability present*

> *in their original communities.* […] Similarly, if the prevalence of a given communicable disease or any neglected disease is higher in the country of origin or return, *there is an increased likelihood among migrants of being affected by the condition and/or transporting it across borders* [emphasis added] (WHO 2008: WHA61/12, paragraph 14).

The paragraph discusses the health *risks* associated with migration but do not describe it as a threat to the host population, which is an important difference in wording. My interpretation is that the word *risk* is not as strong as the word *threat*. Also, the potential health risks are presented as quite evident without blaming the migrants – it is simply stated to be expected that the prevalence of diseases in the country of origin are present among migrant groups in the host country. As I see it, the problem is not if it is stated that migrants carry diseases but if the debate is dominated by a discourse on migrants as a threat to public health and not as individuals with the right to health care. In addition, it is only a threat if the health system cannot handle the contagions, which is not the case in Sweden.

On a similar note, in the following paragraph from the Strategy the *movements* of refugees, asylum seekers and migrant, not the people themselves, constitute a *challenge,* not necessarily a threat:

> The *movements* of refugees, asylum seekers and migrants *constitute a challenge to communicable disease surveillance and contro*l, equivalent to that presented by the general population, and should be dealt with using the national and international framework and principles established by the *International Health Regulations* (2005) [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 51).

I consider this an important use of vocabulary that signals the absence of securitization and my analysis is that the health of migrants is not directly securitized; instead the documents calls for *attention* towards the potential risks and for improving the health care services for migrants. However, the vague references to migration as a threat to public health is problematic since it could contribute to stigmatization of migrants. It is especially problematic since it does not explain what constitute the threat – there is a risk that the lack of explanation creates speculations that are not evidence based.

The operationalization of securitization theory ties into the presence of a global health security discourse in the WHO documents. The words for operationalization of the theoretical framework of global health security are present in the material and there are calls for improved health security. The health security language is mostly present in the Strategy, as in the following examples:

> This document considers the public health concerns associated with large scale arrivals, which *could potentially constitute a crisis* for host and recipient countries in the event of a *lack of preparedness* or due to limited resources, and calls for *urgent action* and a concerted and coordinated response based on solidarity among Member States [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 8).

> Public health preparedness is not optimal in many countries, with improvements needed in multisectoral approaches and health systems capacity to address the health needs of large influxes of refugees, asylum seekers and migrants, including in *preparedness, surveillance and response* […] [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 38).

These examples indicate that the health of migrants is partly put into a global health security frame, but it is for prevention – not because there is a threat already. Therefore, I interpret it more as a general call for strengthening the health systems to avoid disease outbreaks than defense against an existing threat to the host populations. This is further established in a later paragraph, regarding health screening, stating that "[i]n general, refugees, asylum seekers and migrants do not pose an additional health security threat to host communities" (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 60).

The security aspect of migration and health does not receive any attention during the formal discussions in the governing bodies. Nepal mentioned that *migrants* are at increased risk for communicable diseases but not that it would be a threat to the host population (WHO 2017:EB140/PSR/17). However, the impression of the Counsellor in Geneva is that some countries may think in security terms and consider migrants a threat to the public health. No country has stated it explicitly, but it is suspected to be an underlying opinion (Interview).

The situation is different when reading the editorials and news articles on health screening in Swedish newspapers; these focus on protection from infectious diseases and migrants are framed as an already existing health threat. Sweden has experienced an increase in diseases such as tuberculosis, HIV/AIDS and MRSA, an increase connected to immigration in the articles is: "[a] few years later – 2013 – a school at Lidingö was subjected to an outbreak of TB. By 2015, the number of cases increased by 22 percent and that it is entirely dependent on the increasing immigration" [my translation] (Boman et al. 2016). Another article continues along the same line: "[t]he risk for spread of infection is great in the light of the very large inflow of asylum seekers to our country" [my translation] (Zaar et al. 2016).

Boman et al. also stresses that "[a] disease that once again has begun to get a hold in Sweden is tuberculosis (TB), that in addition exist in so called multiresistant strains *against which the most effective drugs against tuberculosis do not help*" [my translation, emphasis added] (Zaar et al. 2016). The quote shows tendencies of a speech act of security as viewed by the Copenhagen School, which is also expressed in the following quote: "[t]here are also doubts regarding how well an already strained *health system would handle* a demanding outbreak of tuberculosis, especially in its resistant forms – a possibly unlikely but not impossible scenario" [my translation, emphasis added] (Helsingborgs Dagblad 2016). The sentences in italic express the gravity of the situation – the drugs may not help and the disease can become impossible to treat and the ability to handle an outbreak is questioned. It is very alarming messages of *survival* that evoke fear. The severity of the threat posed by the emerging diseases is also expressed by referring to the situation globally:

> Ten million people fall ill every year [in tuberculosis, my comment]. One and a half million people die annually due to the disease. According to a research report from last year, even more people are estimated to die in the suites of it the coming three decades, up till four million per year, because of the increasing antibiotic resistance [my translation] (Vetlanda-Posten 2016).

The operationalization of securitization theory is also evident in the quote below by the references to *urgency*:

> It may seem understandable that the authorities cannot easily devote themselves to a quick fix. But is it not exactly such a *fast track that should be created*? The *lack of speed* shows the same pattern as elsewhere in the public sector: one has not been a step ahead, or not even in line with, the current refugee crisis. When it comes to health issues, *such a slow start can be serious for the individual as well as for the society"* [my translation, emphasis added] (Borg 2016).

The writer argues for *exceptional measures*, she wants the authorities to set aside their normal procedures and react to the threat. She also argues for rapid response, in line with a global health security discourse. The demand for exceptional measures is also expressed by Tunström when discussing that the constitution prevents forced health screening and argues for overriding it, which I consider a quite exceptional measure (Tunström 2016).

An example of global health security language is: "The preparedness against TB is based on three pillars: 1, early detection and treatment of infectious patients. 2, identifying chains of transmission. 3, preventative treatment of latent TB." [my translation] (Miörner & Hagstam 2016). Words such as *identifying chains of transmission, surveillance, detection, preventative work, rapid response* and *preparedness* are also repeatedly used (see for example Borg 2016, Helsingborgs Dagblad 2016, Katrineholms-Kuriren 2013, Kornemalm & Wagnell 2014, Miörner & Hagstam 2016, Vetlanda-Posten 2016).

Preparedness is also connected to securitization theory in general and its demand for defense, since preparedness is a defense against diseases. The lack of it, expressed in several articles, is therefore a lack of defense, and a threat to the survival of the state (see for example Borg 2015, Miörner & Hagstam 2016, Rayman 2014, Vetlanda-Posten 2016).

All articles argue for the importance of health screening of all migrants and four argue for mandatory screening. Only one suggests that there should be a connection between screening and the possibility to get residence permit:

> DNA testing should be conducted in connection to the health screening and should be mandatory for all asylum seekers. If you for some reason do not want to submit to this condition, you may assume that the person has something that he or she wants to hide. In that case, *the asylum application shall not be granted before health screening is done* [my translation, emphasis added] (Kornemalm – Wagnell 2014).

On another note, the discussion on securitization as a negative concept includes the risk of creating an enemy and creating a division between *us and them* (see 3.1.2). There are signs of this division in the material; the most obvious

example is that diseases uncommon in Sweden are emerging and people born abroad are accused for it. The perceived threat is simply coming from the outside.

Even though securitization-efforts are the dominating theme in the articles, there are efforts to desecuritize or nuance the threat posed by especially tuberculosis and urges people not to panic. An example is the headline of one of the articles: “Don’t get TB-panic!” [my translation] (Pehrson 2005).

The desecuritization-proponents stress that the increase of some infectious diseases is not a severe threat to the public health in Sweden. Their argument goes that it is true that tuberculosis, HIV/AIDS and MRSA is increasing, but it is not a threat because the health system is well functioning and can handle the increase and there is not a risk for a widespread outbreak (Miörner & Hagstam 2016).

5.2.1 Summary remarks on the securitization of migrants’ health and global health security

Firstly, I want to address if there actually is a speech act of security taking place. Based on the official documents from WHO the answer is a firm no – no speech act of framing migrants as a threat to the survival of the state is taking place. The documents rather try to desecuritize the issue by urging WHO and Member States to work against xenophobia and misinformation concerning the effects of migration on public health, since it could potentially rake the ring for securitization. However, as previously mentioned, the impression of the Counsellor in Geneva is that some countries may think in security terms, but this is not verbalized and can therefore not be considered a speech act (Interview).

Some of the editorials and debate articles include a speech act of security and address migrants as a potential threat to the survival of the state (given that disease is accepted as a threat to the state). So a securitizing move takes place, but is it successful, in the sense that securitization is accomplished? My analysis concludes that it is not, based on the lack of consensus and acceptance from the audience. The response by the audience is however difficult to judge, since it is not possible to analyze the response on the articles. This is a clear limitation with the study. Still, I interpret the lack of consensus regarding mandatory health screening expressed in the articles as a sign that the securitizing actor has not convinced the audience fully, which is a prerequisite for accomplished securitization.

In the theoretical framework, I discussed facilitating factors for success with a securitization move, and the securitizing actors in the newspapers partly “succeed” with the internal factors[15] but “fail” in the external ones[16]. There is not enough conviction of the nature of the threat – that migrants really pose a threat to the public health and in the long run to the survival of the state. Maybe this is due to that the securitizing actor lack authority in the field? I argue that it would be

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[15] Construction of the speech act itself – references to existential threats, point of no return etc.

[16] Social capital of the securitizing actor and the nature of the threat.

more probable to “succeed” with securitization if it was the Public Health Agency of Sweden or another institution with authority in the health sector proclaiming securitization, and not politicians or someone from the public. Also, if the official WHO documents had proclaimed securitization and presented strong evidence for the threat to public health posed by migrants, I believe the response had been different and maybe it would have been a “successful” securitization.

The last point regarding securitization I wish to address is *aggregated security,* meaning that a security issue cannot be analyzed in isolation since the context is important for a successful securitization. This is related to the discursive practice in Fairclough’s three-dimensional model. When starting this project, I thought that since migration is sometimes argued to be securitized (see 3.1.1 on societal security and migration) and health and especially infectious diseases are increasingly put in a security frame, the health of migrants would be as well. The security complex built up by different sectors would facilitate the securitization of health of migrants. This was partly correct, since the fear of xenophobia is addressed in the official WHO documents and the increase of infectious diseases potentially due to migration is dominating the editorials and debate articles. However, since I do not consider the issue fully securitized the hypothesis is still not true.

What is the situation regarding global health security? I would like to start the discussion by referring to Susan Peterson’s work on health and military conflict (see 3.2). I consider it unlikely that military conflict would ensue because of the health of migrants since there are no signs of threats of violence in the material and the member states of WHO express high level of consensus in the issue, at least in the formal discussions. However, if a country adopted policies that violated migrant’s right to health it might evoke a reaction from other member states that could lead to conflict. Also, if migrants’ rights are severely violated it could create tensions between migrants and the host population that could lead to radicalization, uprising or other internal conflicts. I consider it unlikely that this would happen only based on the lack of access to health care, but it could be a contributing factor to general dissatisfaction. Furthermore, if migrants were in fact a threat to public health by spreading infectious diseases to an extent that the health system could not handle, there could potentially be a risk of conflict because of the effects on society. But once again, I consider this unlikely.

Moreover, the global health security discourse is expressed a bit differently in the two sets of materials. The WHO documents discuss it without blaming anyone for the need of increased surveillance and preparedness, while some of the editorials and debate articles picture migrants as guilty for the situation. As I see it, this reflect the underlying discourse dominating the material, the dominance of human rights in the WHO documents make the global health security language less threatening, while the underlying securitizing move in the newspapers influence the discussion on global health security.

I also like to point out that global health security is not necessarily negative. Actions to improve the global health security, such as preparedness towards disease outbreaks and surveillance of the health issues among migrants, can be a way to secure their human rights. Health screening is a good example when

surveillance also benefit the human right to health, if conducted correctly with respect for the dual purpose. As discussed in the theoretical framework, one should not automatically consider a security frame negative.

5.3 Fairclough's three-dimensional model and the discourse on migration and health

It is now time to move to Fairclough's three-dimensional model (discursive practice, textual dimension and social practice) and study its relevance for the material.

5.3.1 Discursive practice in the material

The analysis of the discursive practice in the material has been based on the questions in 4.2.1. I have already addressed that the differences in consumption, production, distribution and purpose with the material have implications for the analysis (see 5) and I will therefore focus on other aspects of the discursive practice in this section.

Intertextuality is present in all WHO documents; they start with a direct reference to other documents that are important for the current one, such as the words in italic in the following quote: "[t]he Executive Board, taking note of the report on promoting the health of migrants, *recalling resolution WHA61.17 (2008)* on the health of migrants, and *reaffirming the New York Declaration for Refugees and Migrants* […]" [emphasis added] (WHO 2017:EB140(9)). The documents also partly consist of the exact same language. It is common to use language from already adopted resolutions in new ones since the language has already been accepted by the member states (WHO 2017:EB140(9), WHO 2016:EB140/24, WHO Regional Office for Europe 2016:EUR/RC66/R6, WHO 2016:WHA69/27, WHO 2015:EB138/26, WHO 2008:WHA61.17).

Intertextuality is present in the newspapers as well but mostly as vague references to ongoing discussions in media, such as "[t]uberculosis has recently received great attention in Swedish media" [my translation] (Miörner & Hagstam 2016). However, one debate article is a direct response to another in the material (Sarkadi 2016), and one article is a direct response to a specific debate in the county council (Sjöstedt 2015).

Interdiscursivity is partly present in the WHO documents with references to other discourses such as xenophobia. The member states and WHO address concern that xenophobia might affect the discussions on health of migrants and call for preventive action. Xenophobia is in other words not *expressed* in the documents but the fear that it will influence the issue is pointed out (WHO 2016:EB140/24, WHO Regional Office for Europe 2016:EUR/RC66/8, WHO 2016:EB138/2016/REC/2, WHO 2016:WHA69/2016/REC/3, WHO

2017:EB140/PSR/17). One example is "[…] conduct advocacy and public education efforts, particularly within the health sector, *to counter xenophobia and build support and promote wide participation among the public*, government and other stakeholders, and reduce stigmatization and discrimination;" [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 30). Interdiscursivity in the newspapers is constituted by the securitization theory and the security discourse (defense, threat etc.), brought into the discourse on health screening, as well as xenophobia influencing the expressions the Swedish Democrats.

Force of text is also relevant for the analysis of the material, which is connected to social practice (see 0). Force of text is the action-oriented part of a text; it is the speech act for action. Since the WHO documents are decisions by the governing bodies on the future work of WHO or produced to inform decisions, it is quite natural that the documents include several speech acts. The purpose with the resolution and the decision, for example, are to *call* on member states for specific actions and *request* the Director General (or Regional Director) to act, meaning that the organization is requested to work on an issue. The call for increased defense (preparedness) against infectious diseases and increased numbers of health screenings expressed in the newspapers (see for example Kornemalm & Wagnell, 2014, Miörner & Hagstam 2016, Pethrus, 2016, Rayman 2014, Tunström 2016, Vetlanda-Posten) are examples of the force of text in this part of the material. One example is: "[t]ake your responsibility, introduce mandatory health screening for all at reception of asylum seekers" [my translation] (Kornemalm & Wagnell 2014).

As a last comment, the interpretation of the texts is dependent on the context of the text as well as the author. Some of the debate articles are written by Swedish Democrats, a political party known for xenophobia and political proposals to reduce immigration to Sweden. This is inevitably influencing my reading of their debate articles. The article *Health screening for asylum seeking pre-school children* [my translation] (Boman et al. 2016) is an example of potentially biased interpretation. The article starts with "[c]hildren's health is important no matter what country you were born in" (Boman et al. 2016), which sounds like true concerns. However, the article has a strong inside-outside perspective talking about *them and us*; *they* have diseases that might spread to *our* children *here*. Combined with awareness of the party's opinions, the expressed concern for all children's right to health is somewhat hard to believe.

5.3.2 Textual dimension in the material

The analysis of the textual dimension has been based on the questions in 4.2.2. Vocabulary is interesting in relation to the discussions of association between migration and public health in the WHO documents. Instead of being described as a threat, which would probably be the case if migrations and health were securitized, the connection is described as a *risk* or a *challenge* (see 5.2 for an extensive discussion on vocabulary).

Text structure is relevant for analysis of the focus in the documents, for example if the needs of migrants or host populations are mentioned first in sentences and documents. This indicates who is prioritized, and in the WHO documents it is the needs of migrants that are addressed first in all the documents. One example is: “calling for short- and long-term public health interventions aimed at protecting and promoting the physical and mental health of *refugees, asylum seekers and migrants, as well as that of host communities*;” [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/R6, p. 2). The situation is different in the newspapers. A majority of articles mention the importance of health screening for society before the individual’s needs as in the example below. Coincidence or not, it could indicate the focus of the writers.

> The missed health screenings are problematic *from a communicable disease control perspective* and *for the individual* to get adequate care and treatment if needed. If these are not implemented it is a risk that diseases that we eradicated hundred years ago will return [my translation, emphasis added] (Pethrus 2016).

This also ties into the transitivity in the documents, which means the agency in the text. The format of the WHO documents quite naturally gives agency to WHO and the member states and not to migrants, refugees or asylum seekers. Migrants, refugees and asylum seekers are subject to action, not agents themselves. However, it is mentioned in some documents that they should be included in the policy-development so that their needs and opinions are taking into regard (WHO Regional Office for Europe 2016:EUR/RC66/8, WHO 2016:WHA69/27).

Even though migrants are not pictured as agents, they are clearly favored in the documents, which is evident both through the text structure and the dominance of a human rights perspective. In addition, the whole purpose with the documents is to improve the health of migrants and fulfill their health needs, indicated by title of the reports for the governing bodies in 2016 and 2017, *Promoting the health of migrants* (WHO 2015:EB138/26, WHO 2016:WHA69/27, WHO 2016:EB140/24).

In the newspapers, the pattern is different and the host population is favored before migrants, exemplified by *us and them* (see 5.2) and that it seems more important that host population is not infected by diseases than migrants themselves. More focus is directed towards the cases of for example tuberculosis when people working with migrants have been infected (see for example Helsingborgs Dagblad 2016, Tunström 2016, Vetlanda-Posten 2016, Zaar et al 2016). An example is the following quote:

> In the summer, several cases of TB were detected at an accommodation for asylum seekers and among people working with asylum seekers. For example, it appeared to be the case that four employees at the social resource management in the City of Malmö hade tested positively for tuberculosis. *All of them had been in contact with unaccompanied children*. It turned out that four in the staff at a residential care home for children and young persons [unaccompanied children live in these homes, my comment] in Småland were affected by latent tuberculosis. A boy in an accommodation for unaccompanied children in Växjö fell ill in tuberculosis this summer. *There are suspicions that he has infected others* [my translation, emphasis added] (Vetlanda-Posten 2016).

This quote personates unaccompanied children as guilty for the transmission, almost as criminals suspected for a crime. Emphasis is on the innocent staff being affected and not on the asylum seekers. Non-migrants are clearly favored in the text.

Modality deals with the writer's commitment to the text and is useful to study in relation to how human rights and the association between migration and public health is discussed in the documents. Among the WHO documents, the Strategy signal lack of commitment to health as a human right by referring to the role of national laws: "[t]his document acknowledges that the entitlement of and access to health services by refugees, asylum seekers and migrants *varies across countries and is determined by national law.* The Strategy and action plan will be implemented taking account of the specific country situation and *in accordance with national legislation, priorities and circumstances*" [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 14). The words in italics signal permission not to implement the recommendations and to restrict access to health service. WHO cannot override national legislation and wordings like this is common in resolutions and other documents, but it still expresses less commitment to human rights. However, the modality in the rest of the documents does not indicate lack of commitment to human rights. The situation is different concerning the public health implications of migration.

"*In general,* refugees, asylum seekers and migrants *do not pose* an additional health security threat to host communities" [emphasis added] (WHO Regional Office for Europe 2016:EUR/RC66/8, paragraph 60). The wording *in general* in the quote is an example of a hedge that is used to show moderation and that there are uncertainties regarding the truth of one's statement. The writer put a distance to the statement and express less committment. In this case, it means that migrants *probably* do not pose a threat put it is not completely sure. This can be compared to a quote from the report to the World Health Assembly in 2008, stating that "[t]here is also a *strong associati*on between population movements and the spread of disease" (WHO 2008:WHA61/12, paragraph 5). This is a truth claim that shows a strong commitment to the statement – it is stated as a matter of fact.

The modality in the newspapers was analyzed in relation to the claims of a connection between increase of infectious diseases and immigration, and some of the writers clearly state the connection while others are more nuanced. "*The cause* of the return of tuberculosis is the increasing immigration" [my translation, emphasis added] (Vetlanda-Posten 2016), compared to "[t]he increase is *almost* entirely due to immigration from countries where the disease is widespread, such as Afghanistan and Somalia" [my translation, emphasis added] (Helsingborgs Dagblad 2016). The writer of the first quote expresses strong commitment to the utterance by using a truth claim. The words in italics in the second quote is however an example of hedges and the writer do not make as strong claims about the connection to migration.

5.3.3 Social practice in the material

As with the two other dimensions in Fairclough's three-dimensional model, the analysis of the social practice in the material has been based on the questions in 4.2.3. The hegemonic discourse in the WHO documents is health as a human right and the need to respect it. Human rights are as discussed in the theoretical framework (see 2) derived from cosmopolitan ideology and universalism, and the discourse is thereby influenced by a cosmopolitan ideology calling for universal rights. The cosmopolitan ideology is further emphasized by the discourse on humanitarianism and solidarity that also underpin the WHO documents.

Even though human rights is the hegemonic discourse, it does not stand without competition from for example xenophobia (see interdiscursivity, 5.3.1). The interview with the Counsellor in Geneva strengthens the impression that a discourse of migrants as a threat and a problem for health systems and societies very well could follow. No country *expressed* an opinion regarding migrants as a security issue, but the impression was that the opinion is an underlying agenda for some, and that it affects the negotiations subconsciously (Interview).

When it comes to the newspapers there is an actual xenophobic ideology underpinning the discourse, as previously discussed in relation to the Swedish Democrats (see 5.3.1). It is difficult to be concrete on this point since it is more a general impression and knowledge of the Swedish Democrats. The clearest examples are the use of *us and them;* that focus is on *us* and *they* are the once carrying the disease (Vetlanda-Posten 2016, Zaar et al. 2016).

What social practice are then connected to the discourses in the material. A substantial part of the WHO documents consists of calls for action by Member States and WHO. It is therefore partly social practice since it is a speech act for action, but the action has not yet taken place. Nevertheless, there are also examples of already conducted social practice in relation to the discourse – the demonstration of the work by WHO in the reports and country statements in the summary records. WHO's work has included actions to promote access to health care for migrants, refugees and asylum seekers; developed evidence on the health challenges associated with migration and health security actions to prevent disease outbreaks (WHO 2015:EB138/26, WHO 2016:WHA69/27, WHO 2016:EB140/24). Also, WHO has since March 2016 changed their focus from a humanitarian-based approach to migration and health to an approach based on strengthening health systems and promotion of universal health coverage, which I interpret as a social practice influenced by the right to health (WHO 2016:EB140/24). The statements by countries in the governing bodies are strongly focused on presenting their practice regarding securing the right to health (WHO 2016:EB138/2016/REC/2, WHO 2016:WHA69/2016/REC/3, WHO 2017:EB140/PSR/17).

As previously mentioned, the hegemonic discourse in the newspapers is that migrants are responsible for the increase of some infectious diseases. The efforts to increase the reach of health screening is a social practice deriving from this discourse, with the demands for mandatory screening as the clearest example. Another example is interpellation to politicians about their efforts to stop the

spread of tuberculosis (Zaar et al. 2016). Also, the Swedish Democrats assented to a proposal for introductory nursery school for asylum seeking children, stating the public health perspective as their reason (Boman et al. 2016). The Public Health Agency of Sweden, as discussed by Borg 2016 in relation to the increase of tuberculosis among people born abroad, are also issuing social practice: "[t]he Public Health Agency of Sweden is *now proposing to introduce a special national vaccination program for children in the risk group*. The risk for spread of disease in the population is decreasing as practice is now formalized" [my translation, emphasis added] (Borg 2016).

6 Conclusion

To conclude this thesis, I will return to the main research question and address the implications of the different discourses on migration and health, as well as give suggestions for further research.

The answer to my main research question is yes – there is a conflict between a human rights based and a security based approach to health in relation to migration. The approaches are driven by different values and these have implications on the discourse as well as on the policies and actions regarding the health of migrants. The best way to summarize this conflict is by addressing the last sub question – the implications of the different approaches.

The discourse in WHO is dominated by a human rights perspective, and the parts on global health security is expressed in such a way that it appears to be harmless in the sense that it does not blame migrants or frame them as a threat. WHO's work on migration and health has similarly involved actions on both perspectives; promote access to health care, show respect for migrants' human rights as well as prevent disease outbreaks. Their work therefore reflects what I anticipate from a human rights perspective – focus on the needs of the individuals foremost and treatment of both acute infectious diseases and noncommunicable ones (including psychological illness). Furthermore, while a security approach give priority to short-term solutions, a human rights perspective probably look at long-term solutions instead to ensure migrants health, which means offering preventative care and not only emergency care as well as addressing the underlying social determinants of health. This is reflected in WHO's change of focus from a solely humanitarian-based approach to an approach based on health systems strengthening and to promote universal health coverage.

The implication of a security approach to migration and health is visible in the editorials and debate articles, which favors the host population before migrants and are dominated by securitization moves. The result is that focus is directed to protecting the Swedish population and not to ensure access to health care for migrants. Also, migrants are blamed for the increase of infectious diseases such as tuberculosis, with stigmatization and discrimination as potential consequences.

I have discussed two problems with a security framing of health – that it might encourage skewed interest and national self-interest. An anticipated example of this could be that priority is given to diseases that can pose a danger to others and not to the disorders of most importance for migrants themselves – which is confirmed by the report mentioned in the introduction (see 1) investigating asylum seekers experience of health screening in Sweden. They experience that the health screening mostly focus on potential infectious diseases and not on their primary needs. Similarly, the interest in the editorials and debate articles are clearly directed towards infectious diseases.

Finally, it cannot be denied that efforts to securitize migrants' health and the following self-interest could have positive affects for their access to health care. The incentive to provide health care to migrants probably increases if the lack of it is a threat to the public health in the host community. This is also what I perceive to be the overall claim in the securitization debate – that in a perfect world, securitization is not desirable. But we do not live in a perfect world – so therefore securitization might be a necessary evil to deal with the challenges we face? However, this of course needs to be done with caution to avoid stigmatization and discrimination, which might be a superior challenge in this case when human beings and the human body constitute the perceived threat. It is therefore crucial to separate the disease from the person so that the *disease* becomes the threat and not the person carrying it, and I find it questionable if the news articles succeed with this. As I see it, the problem is not if it is stated that migrants carry diseases but if the debate is dominated by a discourse on migrants as a threat to public health and not as individuals with the right to health care.

I want to conclude by looking forward to potential future project. I would find it interesting to compare the discourse in Swedish media with other countries and study if the discourse on migrants as disease carriers is shared with others. It would also be interesting to get more insight in the informal discussions in the governing bodies of WHO as well as the discourse within the organization itself. Lastly, migrants' own experience of health challenges, securitization and their right to health should be encompassed in future studies, to partly change the agency from host populations, states and WHO to the people actually affected. But then again, these projects belong to the future.

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