US remote health controls: the past and present of externalisation

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Measures to control asylum seekers' entry to US territory during the COVID-19 pandemic reflect a long history of remote border controls.

Powerful States have pushed their border controls deep into the territories of other States, disproportionately affecting asylum seekers and often deliberately targeting them. Yet most remote controls pre-date the international refugee regime and the exceptions in restrictive immigration laws for people seeking sanctuary from violence and persecution.[1] Many remote controls that are used today to keep out asylum seekers – such as carrier sanctions, pre-clearance inspections, deployment of liaison officers in ports of embarkation, mandatory documentation issued abroad, and detention in liminal spaces at the edge of a State's territory – were originally designed as health controls.

Uncovering this history is important for at least three reasons. First, as the COVID-19 pandemic has shown, governments can use remote health controls as a pretext to deter and deport asylum seekers. Second, remote health controls have a long history of being used as tools of ethnic and class selection. Third, the public acceptance and incorporation into the law of measures to ostensibly protect public health make it difficult for asylum advocates to effectively challenge remote control policies.

Roots of US policy

In the late nineteenth century, the US federal government stripped individual states like New York of the authority over health controls for arriving immigrants. The Act of 3rd March 1891 banned the admission of foreigners "suffering from a loathsome or a dangerous contagious disease" and mandated the health inspection of all foreigners arriving at US ports of entry. Over the following 35 years, the government put in place a system of remote control built on five components: penalising private transportation companies that carried diseased passengers; stationing US inspectors abroad to conduct screenings at ports of origin; using neighbouring countries as buffer States to screen transit migrants; detaining migrants in quarantine spaces at the territory's edge (under a legal fiction that they had not entered the State's territory);

and mandating documents, such as visas and health passports, as conditions of travel.

Then, as now, the degree to which powerful States such as the US directly reached into the territories of other States to externalise their controls varied but, whether direct or indirect, most migration control took place thousands of kilometres from US shores. More emigrants were refused embarkation from European ports than were banned from admission at US ports of landing.[2]

Many of the earliest forms of international cooperation around health included remote control provisions through the mechanism of health passports issued in advance of travel. In addition, passenger shipping companies were authorised to issue vaccination cards in another instance of de facto deputisation of migration control to private actors.[3]

In addition to its transatlantic and transpacific remote controls, the United States made Canada a buffer state for US-bound passengers arriving at Canadian ports. Canadian authorities screened passengers in transit and issued those who passed the health criteria with an 'alien certificate' to hand over to US border guards at train crossings into the United States.

In 1892, the US Congress introduced inspection prior to admission at US ports of entry. Passengers suspected of being contagious were held in quarantine and sometimes deported when they were healthy enough to travel. Health controls at both departure and arrival were not applied equally to all. Medical officials gave a cursory inspection of first-class passengers in the privacy of their cabins before they disembarked, while passengers in steerage were subject to much more intensive and public inspections at stations like Ellis Island.[4]

On paper, health controls in the US did not discriminate by race. In practice, however, 10–15% of immigrants arriving at Angel Island from Asia were excluded on health grounds, compared to an annual average of only 1% at Ellis Island, where European inflows dominated. Asian immigrants arriving at Angel Island in second and third class were subject to physical examinations and mandatory overnight detention while they underwent laboratory tests. Officials subjected Mexican immigrants at border stations in Texas to humiliating inspections, showers and delousing. European immigrants were spared the worst of these indignities.

The success of global vaccination programmes loosened US inspections and quarantines. While every ship and aircraft arriving in the US was met by a federal health inspector in 1967, by the mid-1970s these inspections had ended unless the pilot reported an illness onboard.[5] In 2021, only 20 of the 328 ports of entry to the US had quarantine stations. Yet the legal infrastructure for strict externalisation remained in place.

COVID-19

Around the world, States pushed remote controls abroad with new vigour during the COVID-19 pandemic. Restrictions on air travel were especially strict for countries with high levels of outbreaks and new variants of the virus. Yet the controls almost immediately reduced international migration of all types, including flows of asylum seekers and refugees in the process of resettlement.

While mobility controls can be legitimate tools for helping slow the spread of epidemics, the administration of President Donald Trump clearly used the coronavirus pandemic as a pretext to target asylum seekers in particular. On 20th March 2020 the federal Centers for Disease Control and Prevention (CDC) issued an order based on an obscure provision of the Public Health Service Act (1944). Section 265 of Title 42 in the 1944 act authorises the suspension of entry of persons from foreign countries as a means to avoid the spread of communicable disease. The 2020 CDC order suspended entry into the US of people crossing from Canada or Mexico whom US authorities would normally hold in detention if they entered, a scenario that primarily applied to migrants without a US visa.

The large number of exceptions to this order, however, was an immediate clue that the CDC order was not motivated in the first instance by public health concerns. Health experts decried the order in a public letter arguing, "There is no public health rationale for denying admission to individuals based on legal status." They wrote that,

in practice, "The rule is thus being used to target certain classes of noncitizens rather than to protect public health."[6]

Their charges were borne out by subsequent developments. Journalists discovered that the invocation of Title 42 was driven by immigration officials in defiance of the objections of CDC officials who said that the order was an inappropriate use of its authority to protect public health. From the first day of the order, the Border Patrol began expelling people without affording them the opportunity to claim asylum. The Trump administration reached an agreement with the Mexican government to accept the forced return of their own nationals and most Guatemalans, Hondurans and Salvadorans. Almost 15,000 asylum seekers waiting in Mexico to present an asylum case at a US port of entry were denied the opportunity to make their claim. These measures continued the policy of using Mexico as a buffer state. At the same time, thousands of Haitian asylum seekers were forcibly flown back to Haiti without being allowed an asylum hearing. In the first year of the CDC order, the US government expelled more than half a million migrants, many of whom had intended to apply for asylum.[7]

In the final CDC order published on 11th September 2020, the administration made clear that it intended to use the measure to deter and expel asylum seekers. The order rejected the claim that expelling asylum seekers under Title 42 violated US treaty commitments to the 1967 Refugee Protocol or the 1984 Convention against Torture, stating that the 1944 Public Health Service Act did not contain relevant exemptions. The order also rejected the argument that asylum seekers could safely quarantine inside the US, stating that public quarantine facilities were inadequate and many of the foreigners covered by the order "would be asylum-seekers, who by definition lack permanent U.S. residences" where they could self-quarantine.[8]

Civil rights and refugee advocates filed a lawsuit against the administration's use of Title 42 to summarily expel unaccompanied children seeking asylum. A federal district court judge blocked the use of Title 42 for this purpose in November 2020 but the DC Appeals Court stayed the order in January 2021, allowing the policy to remain in effect during litigation.[9] As of October 2021, nine months after entering office, the Biden administration had not lifted the Title 42 order.

Conclusion

As with 'securitised' framings of asylum policy, governments use health justifications to effectuate migration control and ignore rights of asylum seekers. States can externalise their borders in this way with little political or legal resistance because health restrictions are so deeply embedded in the legal and bureaucratic machinery of migration control. Stringent controls can be activated overnight by a president or prime minister's flick of the switch. Short of World War III, it is difficult to imagine another set of circumstances in which States could so quickly stop most international movement and violate core norms of *non-refoulement*.

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