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Articles

Immunization of mobility, "health corridor" and movement control in times of COVID-19

Inmunización de la movilidad, "corredor sanitario" y control del movimiento en tiempos de COVID-19

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Abstract

This article aims to analyze certain changes experienced in movement control policies in the South American space in times of border closures produced by the arrival of COVID-19. Specifically, it investigates the emergence and political production of the air "sanitary corridor". It is argued that the main transformations have been associated with the deployment of a variety of *immunization of mobility* practices aimed at classifying, filtering and channeling *immunized mobilities* and *infectious mobilities* in a context of border closures. Through a qualitative methodology that articulates documentary analysis and an interview with an official of Administración Nacional de Aviación Civil (Argentina), it shows that the legitimization of the "sanitary corridor" has been associated with its production as a response to the COVID-19 "crises" and its capacity to attend the mandate of "global health security", the economic narratives in favor of the reactivation of mobility, and the nationalist logics that consider the virus as a threat to security and public health.

Keywords: borders, mobilities, migration, control, immunization of mobility, COVID-19.

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Resumen

El objetivo de este artículo es analizar ciertos cambios experimentados en las políticas de control del movimiento en el espacio sudamericano en tiempos de cierres de fronteras producidos con la llegada del COVID-19. Específicamente indaga el surgimiento y la producción política del "corredor sanitario" aéreo. Sostiene que las principales transformaciones se asocian al despliegue de diversidad de prácticas de *inmunización de la movilidad* orientadas a clasificar, filtrar y canalizar las *movilidades infecciosas* en un escenario de cierres de frontera. Mediante una metodología cualitativa que articula análisis documental y una entrevista con una funcionaria de la Administración

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Nacional de Aviación Civil (Argentina), muestra que la legitimación del "corredor sanitario" se asocia a su producción como respuesta a las "crisis" del COVID-19 y su capacidad de atender al mandato de la "seguridad sanitaria mundial", las narrativas económicas a favor de la reactivación de la movilidad, y las lógicas nacionalistas que consideran al virus como una amenaza para la seguridad y la salud pública.

Palabras clave: fronteras, movilidades, migración, control, inmunización de la movilidad, COVID-19.

Introduction

Mobility restrictions and border control have been central to global strategies to address the spread of COVID-19 since its official declaration as a pandemic in March 2020. Following the confirmation of the first case of infection in Brazil at the end of February 2020, South American governments declared a health emergency and, in mid-March of the same year, began to modify their migration and border control policies and implemented total and partial border closures, restrictions on entry into the territory of non-resident foreigners, and suspension of flights with exceptions linked to the fulfillment of essential functions or humanitarian reasons. Since then, successive measures to close and open borders have been linked to the fears associated with the imminent entry of the virus, its uncontrollable spread, and its mutations through new waves and strains. With restrictions on entry by country of origin based on international classifications, based on national infection rates combined with other selectivity criteria (Domenech, 2020), South American countries began to progressively open their air borders by mid-2020. In most States in the region, lifting air travel restrictions was concomitant with decisions on the continued closure of land and river borders underpinned by rationales focused on the health care of *travelers*, *nationals*, and *residents*.

This article addresses certain transformations and innovations in the policies and measures of movement control that occurred after the emergence of COVID-19, which inaugurated a "third stage in the South American migration and border regime" (Domenech in Instituto de Investigaciones Gino Germani, 2021). The notion of *immunization of mobility* is proposed to account for a particular form of mobility control that took place during the management of SARS-CoV-2, based on the rollout of a diversity of measures aimed at classifying and filtering this mobility as *immunized* and *infectious* according to the prevailing medical-epidemiological parameters. At the empirical level, the emergence of the air health corridor, one of the main initiatives proposed globally and in South America to *promote*, *facilitate* and *channel* air mobility in border closures as a response to the pandemic, is analyzed.

This article assumes the notion of "health corridor" as an institutional category to be questioned and specifically inquires into this concept's political production process. It shows that the legitimization of the health corridor as a possible and authorized form of crossing in times of closed borders was associated with its production as a

response or solution to the "crises" generated by the pandemic and its ability to address three intertwined issues: the mandate of "global health security"; the fundamentally economic imperatives that underpin many of the narratives that justify, at different scales, the reactivation of mobility; and the state and nationalist ideologies that consider the virus as a threat to security and public health.

According to Domenech (2019), the transformations that have taken place in migration and border control policies and measures in South America during the last two decades can be understood within the framework of the progressive formation of a "South American migration and border regime" that recognizes different stages. The first stage was during the first decade of the century, marked by the predominance of intra-regional immigration, significant emigration to Europe and the United States, the recognition or extension of rights to migrants in national migration policies, and the implementation of traditional migration control measures. A second stage began with the arrival of extra-regional immigration from the Caribbean and sub-Saharan Africa in the early 2010s and intensified with the "massive outflow" of migrants from Venezuela in 2015. These movements provoke new destabilization in the South American migration and border regime. This period sees an intensification of state violence and the emergence of new means of movement control associated with digitalized methods of mobility and border control (Domenech, 2019, pp. 3-4). With the outbreak of COVID-19, a new stage in the South American migration and border regime was inaugurated, characterized by the political use of the pandemic as a pretext for the reinforcement and legitimization of migration and border control (Domenech in Instituto de Investigaciones Gino Germani, 2021).

The differentiated treatment of decisions on opening land and air borders during the pandemic increased South America's prevailing selectivity of migratory and border controls. Ecuador and Brazil authorized some international flights in early June 2020, followed by Colombia, Bolivia, and Uruguay in September. Colombia sought to position itself as one of the main countries interested in establishing air health corridors, and in July 2020, representatives of the Colombian government began to hold conversations with some countries in the region to establish agreements once travel restrictions were lifted; this intention was confirmed in September 2020 (OACI, 2020f). Paraguay implemented the so-called bubble flights with Uruguay in September and reopened air borders, as did Peru and Chile in October 2020, while Venezuela and Argentina authorized international flights in November.

At the same time, as the collective project (Im)mobility in the Americas and COVID-19 has shown,[1] in the face of the struggles for movement undertaken by various migrant groups and national collectives in the Americas because of the border closures, governments deployed multiple strategies and measures to control *irregularized* migration. Just to illustrate, in August 2020, land "humanitarian corridors" were canceled, such as the one established by Colombia and Venezuela to enable the passage of migration coming from the latter country over the Simon Bolivar International

[1] For more information on this collective project carried out by researchers from the Americas, see: https://www.inmovilidadamericas.org/

Bridge, with the rationale of "avoiding bottlenecks and possible health emergencies in the region" and ensuring the "integrity and health of all individuals who are in the border area" ("Colombia", 2020). Also by air, deportations of illegalized migrants continued not only in a north-south direction from the United States to Guatemala, El Salvador, Haiti, Colombia, and Ecuador ((In)movilidad en las Américas, 2020b; Álvarez & Berg, 2020; Joseph, 2020), but south-south, such as those undertaken by Chile to Colombia, Ecuador, Venezuela, and Haiti under the so-called Humanitarian Plan for Orderly Return, 2018, even when commercial flights were suspended.

The consequences and effects of border closures and movement restrictions on the daily lives of migrants, asylum seekers, and refugees have been widely addressed in the Latin American literature on mobility control during COVID-19. It has been documented how irregularized migrants have been hindered in their access to services and rights and have been exposed to greater possibilities of infection and death in the framework of what has been called "COVID-19 necropolitics" (Estévez, 2020).

Research aimed at understanding the tension between mobility and control in the context of the pandemic (Álvarez Velasco, 2020) has pointed to the emergence of different combinations of "mobility in immobility" (Herrera, 2020) and has reported on processes associated with the mobility of "walkers" on Colombia's borders with Venezuela and Panama (Ceballos Medina et al., 2021), the "reverse migration" or "return migration" of internal and international migrants of different nationalities (Herrera, 2020; Joseph, 2020), the redefinitions of "transit" in the framework of the intensification of Haitian mobility in the region (Trabalón, 2021) and certain "interruptions and alterations" in the mobility of particular cross-border regions, such as the triple Paraná Border, due to border closures (García, 2022).

The situations of mandatory quarantines, stranded migrants, expulsions or "agreed deportations" based on public health reasons ((In)movilidad en las Américas, 2020a; Prunier & Salazar, 2021), and the experiences of entrapment and waiting in different border spaces as a result of the transformations undergone by asylum and refugee policies have also been called into question in different national contexts (Candiz & Basok, 2021; Iturralde & Piñeiro, 2021; Miranda & Silva Hernández, 2022; Pérez Martínez, 2021; Silva & Burgess, 2021). At the same time, various forms of protests against migration and border controls of migrants and asylum seekers were analyzed within the framework of reflection on migrant struggles (Alvites Baiadera et al., 2021; París-Pombo & Varela-Huerta, 2021), the practice of care and self-care by migrant women in transit (Álvarez Velasco & Varela-Huerta, 2022), and certain political uses of the figure of the "migrant mother" in border struggles to negotiate crossings during border closures (Biondini, 2022).

This analysis draws on those critical studies that have inquired into the reintroduction and multiplication of historical and emergent measures of movement control in COVID-19 times and their coordination through *hygienic*, *humanitarian*, and *securitarian* logics (Aradou & Tazzioli, 2021; Bigo et al., 2021; Domenech, 2020; Tazzioli & Stierl, 2021b). Several pieces of research conducted in the regional and international context

have remarked on how the pandemic and the narratives of protection against the risk of the spread of the virus have operated as a *pretext* and have created the conditions to exacerbate and legitimize multiple forms of violence and punitive methods of control directed in particular toward migrants, asylum seekers, and refugees (Candiz & Basok, 2021; Domenech, 2020; Stierl & Dadusc, 2022; Tazzioli, 2021). Likewise, the present article seeks to contribute to the understanding of certain changes in the control of movement in a pandemic context through an inquiry into forms of regulation and control that go beyond punitive or restrictive measures, an issue practically absent in the research carried in the region. On the other hand, part of what is developed in this article is inspired by works that have recently called into question the political uses that the so-called crises (such as "migration crises", "refugee crises", and "humanitarian crises") have received in the control of mobility and borders (Herrera & Berg, 2019; Dias & Domenech, 2020; Domenech et al., 2022).

In theoretical terms, the text is located in the intersection of critical studies on migration, mobility, and borders, and pays special attention to how borders are activated or not for different individuals and population groups according to the construction of classifications based on criteria of "risk" and "trust" (Guild & Bigo, 2003). The notion of "regime" in the senses in which it is used in critical studies on migration and borders is adopted as a lens for the identification and analysis of the diversity of actors, ideology, policies, and scales involved in the processes of (in)mobility unleashed by the regulation of the COVID-19 pandemic. According to Hess (2012), the "migration regime" includes a multiplicity of actors in the management of mobility and borders whose methods of control are related but not organized from a central rationale. In this regard, the role of expert knowledge produced by actors whose acts exceed national frameworks, linked to international health regulations and transnational political spaces aimed at regulating the spread of diseases through the control and surveillance of international air movements, is particularly significant (Collier & Lacoff, 2008; Salter, 2008).

The methodology used in this article is qualitative and focuses on the analysis of documents produced by state and non-state actors of different scales and dedicated or linked to the production of air health corridors. The documentary analysis was guided by a socio-anthropological approach that seeks to denaturalize the ways of thinking, categories of intervention, and narratives of justification and legitimization contained in institutional policies and measures that regulate populations (Shore & Wright, 1997). The documents reviewed are mainly policy reports, plans, programs, and recommendations produced by International Civil Aviation Organization (ICAO) experts on international air mobility regulation, "health security", and "risk management" in epidemic and pandemic scenarios, with emphasis on the context of the COVID-19 pandemic.

Among the most significant materials analyzed are the virtual meetings of directors general of civil aviation (RVDGAC) of the South American region on the response to COVID-19 held between April 2020 and August 2021, official statements, communications to States, and key documents such as "roadmaps" and health protocols for the opening of air borders. The article takes up some national provisions

related to border closures in South America and specific documents devised by the International Organization for Migration (IOM) and the World Tourism Organization (UNWTO) that make it possible to question certain narratives of justification involved in the governance of mobility and the search for the opening of air borders. At the same time, the analysis includes a virtual interview with a high-ranking official of the Argentine National Civil Aviation Administration (ANAC, by its Spanish acronym from Administración Nacional de Aviación Civil), given the involvement of this public agency in the phenomenon under study.

This article is organized into five sections: the first presents what is understood here as *immunization of mobility* based on key theoretical concepts that guide the proposed analysis. In the second, some key elements linked to a transnational field of global control of *infectious mobilities* that are productive when analyzing the transformations in the policies and methods of movement control in the context of epidemics and pandemics were reconstructed. In the following three sections, processes, actors, spaces, scales of action, and narratives of justification involved in the genealogy and production of the health corridor are reported and analyzed. Finally, some conclusions and reflections arising from the contents of the article are presented.

The *immunization of mobility*

The *immunization of mobility* reflects the multiplicity of ideas and measures of control and hygienic-sanitary surveillance of movement implemented by governmental and non-governmental actors located at different scales and spaces of action, aimed at producing *immunized mobilities* that is, individuals on the move represented as medically fit to cross international borders and move within national territories once they manage to demonstrate that they do not constitute a "risk" or a "threat" of contagion according to the prevailing medical-epidemiological definitions.

The construction of representations of certain individuals and groups in a situation of mobility as virus-free is a central element of the immunization of mobility, which requires in parallel the production of *infectious mobilities* that embodies the danger of contagion to the national population. In the age of the COVID-19 pandemic, the immunization of mobility has involved the implementation of measures that include, to name a few, health requirements for entry, such as affidavits of the traveler's health status, vaccination against SARS-CoV-2, virus detection mechanisms (testing), health insurance with COVID-19 coverage, the creation of isolation areas for suspected or confirmed cases of infection and confinement measures for migrants and asylum seekers, and the development of surveillance and movement tracking technologies, among others.

Conceiving *immunity* as the body's defensive reaction against the danger of contagion (Esposito, 2002), the *immunization of mobility* is formed and derived from the need to combat the risk of infection not only through the inoculation of "the common" but of everything "foreign" coming from the outside. Since the negative constitutes the effectiveness of healing, the mechanism of immunity reproduces

the risk of infection in a controlled way to function (Esposito, 2002, pp. 17-18). In Esposito's words, the fight against the risk of infection is not carried out through a "frontal counter position, but through neutralization" by confronting the malady within one's confines. Incorporating a fragment of what is to be avoided reveals the "structurally aporetic character of the immune procedure" in that life can only be prolonged on condition that it is continually made to taste death (Esposito, 2002, pp. 18-19). These reflections help to understand certain ways in which the "risk of infection" is central to the immunization of mobility.

If the immunity mechanism requires the reproduction of risk to operate, in pandemic scenarios in which life in motion itself represents that which denies it and at the same time prolongs it, the foreigner is a "biological risk" (Esposito, 2002) and becomes the figure from which it is necessary to protect oneself, but also an essential element for the continuity of national life. The first of the meanings associated with these representations of "the foreigner" has taken precedence in the unprecedented manifestation of the widespread border closures once COVID-19 was declared a pandemic. The second has emerged through the various measures that many governments around the world have adopted to regulate, for example, the entry of foreign health personnel, whose mobility has come to be considered a valuable resource essential to national public health, or the entry of investors who are of high value to the economy. Seen in this way, the immunization of mobility is an essential mechanism of the *productive* function of borders, associated with limiting movement, as well as its ordering and filtering (Mezzadra & Neilson, 2017).

The immunization of mobility is based on the challenge and need to manage risk to keep borders open while controlling individuals on the move and keeping spaces "safe" (Bigo, 2014). In this sense, the immunization of mobility is related to "processes of (in)securitization" (Bigo, 2002) that construct mobility as a threat to "health security" based on the risk of contagion it poses, which creates discomfort and uncertainty in the population. This process legitimizes and feeds back into the constant demand for security through various processes and technologies of health and prophylactic control. These processes are associated, in turn, with historical but still valid constructions of the figure of the "sick" foreigner-immigrant as an *undesirable* subject due to the suspicions and problems that their presence generates for the so-called receiving societies (Sayad, 2010), as well as with humanitarian narratives and discourses that support the control of people on the move supposedly for their care and protection.

The immunization of mobility is aimed, then, at *promoting* and *facilitating* the movement of those who are figured as presumably healthy and at *stopping, rejecting, delaying, or channeling* the border crossings of those represented as potentially infected or sick.

The immunization of mobility is thus coordinated with "mobility regimes" (Glick Schiller & Salazar, 2013) that normalize certain movements and criminalize and obstruct others, producing "(relative) (in)mobilities (Adey, 2006) resulting from the constant struggle between control and freedom of movement in the face of which

some people manage to move while others are immobilized (Adey, 2006; Cresswell, 2010; Urry, 2007). Hence, the immunization of mobility implies and has as an effect a hierarchical and stratified treatment of individuals regarding their border crossings. Within the framework of the movement controls imposed to contain COVID-19, the hierarchization and stratification of mobility have been expressed, among other forms of violence, in the waiting of individuals and groups of migrants or specific national groups at border crossings and in the delays, restrictions, or exclusions from access to international protection measures such as asylum or refugee status.

Linked to the discourse on the search for a balance between the protection of health and life, on the one hand, and the risk of economic recession, on the other (Bigo et al., 2021), the immunization of mobility is closely associated with the definitions around the conditions of essentiality and exceptionality officially required for the exercise of international mobility in times of border closures, as well as with the implementation of "precautionary risk transfer technologies" (Aradou & Van Munster, 2007) against the mobile individuals themselves as a form of (economic) protection of States against the possible occurrence of unmanageable risks. In other words, in the framework of border closures ordered by the various governments, entry into national territories and sometimes exit have been subject to access to an open, changing, and disputed set of classifications and state categories focused on the essential nature of the individual's labor for the development of life and the economy, or on the possibility of access to health permits to cross borders on an exceptional basis.[2] Later, in times of gradual and even total reopening of borders, several countries have limited access to international mobility to the taking out of covid insurance as part of their strategies to regulate uncertainty and manage the costs derived from potentially catastrophic damage.[3]

In the South American region, the immunization of mobility was first experienced in air travel, given that the opening of borders followed temporal factors characterized by the *prioritization* of certain air movements in contrast to land, sea, and river movements, except for those officially qualified as humanitarian reasons or exceptional situations, as mentioned in the introduction to this article. Within the schemes of the gradual and selective opening of borders and because of the concern for the reactivation of mobility for the benefit of the economy, a few months after the pandemic was declared, some countries in the region began to suggest the implementation of bilateral or multilateral agreements for the establishment of health corridors. At the global level, initiatives such as bubble flights or travel bubbles began to be proposed, legitimized by the idea that air travel between countries with similar risk levels and response strategies was

[2] As an example, Argentine Provision 3763/2020 on border closures established the prohibition of entry into the national territory of foreigners not residing in the country, to reduce the possibility of contagion. At the same time, DNU 260/2020 authorized, on an exceptional and temporary basis, the hiring of health professionals and technicians qualified abroad whose degree was not recognized to practice in Argentina, for the performance of essential functions. Decree 814/20 empowered the National Directorate of Migration to make exceptions for the entry of foreigners in order to meet circumstances of need.

[3] Decree No. 99/2021 (Chile); Decree No. 4481 (Bolivia); update of 07/04/2021 on "sanitary requirements for entry into the country and compliance with isolation or quarantine" (Paraguay); Decree No. 167/2021 (Argentina); among others.

advisable (OIM, 2020b). Many of the immunization of mobility measures implemented in the context of the COVID-19 pandemic have been presented as concessions by States to safeguard and protect national public health from the threat of contagion while allowing controlled and protected access by foreign nationals.

Global control of *infectious mobilities* through risk: "health security" and "new threats"

In the last two decades, the political treatment of mobility and borders in the context of epidemics and pandemics has been inseparable from the contents of current schemes of "precautionary governance through risk" (Aradou & Van Munster, 2007). Risk understood as a particular way of ordering the world through the management of possible future appearances of "social problems" turned into risks (Aradou & Van Munster, 2007, pp. 97-98), has become a constitutive element of contemporary security policies (Bigo, 2002, 2014). According to Aradou and Van Munster, the risk mechanism constitutes a heterogeneous set of discursive and material elements for the *prediction*, *surveillance*, and *response* to the occurrence of future dangerous events, at the heart of which is located a precautionary rationale expressed through policies that actively seek to prevent situations from becoming unmanageable or catastrophic at some undefined point in the future (Aradou & Van Munster, 2007, pp. 91-105). The mandates of "global health security" and the "biosecurity" field, among which the immunization of mobility makes sense, are integral to the heterogeneous forms of governance through risk.

Proposed as a "new framework for action" in response to an emerging "health threat" landscape, "global health security" (Organización Mundial de la Salud [OMS], 2007) identified the international movement of people, animals, products, knowledge, and technologies as a preeminent source for the spread of diseases and infections across borders. Biosecurity, officially defined as a series of technical and political efforts to protect health and life by preventing, managing, and combating various risks (OMS, 2005), has become a central component of responses to so-called health threats. As Collier and Lacoff (2008) have pointed out, biosecurity measures, rather than stable or determined strategies, constitute overlapping and constantly changing areas that bring together experts and organizations from the fields of health and security in different initiatives and at different scales of action, and exceed the budgets of national security and public health.

Various policy measures deployed on a global scale to address epidemics and pandemics, including COVID-19, have highlighted that the global governance of movement and borders in contexts conceived as health threats take place in a transnational field of global control of *infectious mobilities* conceived as a problem of "(in)security"[4] (Bigo, 2002) associated with the "risks" and "threats" that the spread of

[4] The use of the notion of (in)security in this article is based on Bigo's conceptualization of security as the result of processes of both securitization and insecuritization, in which the production of (in)security takes place from the formation of transnational fields in which professionals, migration control and surveillance measures, and humanitarian or human rights-related discourses interact (Bigo, 2002).

certain viruses through human movement poses to the continuity of life and national and international "health security". A variety of actors from different backgrounds and scales of action, including international and supra-state organizations such as WHO, *ICAO*, the International Organization for Migration (IOM), the International Maritime Organization (IMO), the World Tourism Organization (UNWTO), national civil aviation authorities, the International Air Transport Association (IATA), health and safety agents and officials, and academics, among others, produce, discuss and circulate specific ideas, knowledge and measures related to the need to prevent and combat the risk of infection. Although with different agendas and motivations, their actions converge in the assertions that there are risks and threats that they can manage together and that *preparedness*, *anticipation*, and *coordination* of actions (Bigo, 2002) in a "common strategic framework" are key to respond to the "challenges" posed by the *global scale*, *pathogenicity*, and *mutability* of the "new health threats" (Collier & Lacoff, 2008).

In conjunction with the WHO, ICAO has become a central player in producing expertise and guidelines on air mobility management in the face of "health threats". Based on a consensus-based international aviation governance model, ICAO makes recommendations that are then approved and promulgated by national aviation administrations and defines, together with IATA and Airports Council International (ACI), the "global best practices" to be followed by States and airport authorities (Salter, 2008), which have the autonomy to apply their own national and local regulations. Since the mid-20th century, ICAO and WHO have promoted the creation of a multiplicity of civil aviation agreements, common areas of action, policy guidelines, and health regulations aimed at controlling the spread of diseases. Many proposed innovations have been influenced by the international spread of SARS-Cov in 2002-2004 and the H1N1 influenza subtype in 2009.

Within the framework of the international civil aviation governance model based on risk management and aviation safety (Salter, 2008), ICAO created the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) following the SARS-CoV epidemic of 2002. CAPSCA constitutes a multisectoral platform proposed as a space for coordination between sectors of the aviation industry and health to mitigate the impacts of outbreaks and epidemics in aviation under the premise of not losing sight of "flight safety" (OACI, 2020c).

The International Health Regulations (IHR) of 2005, whose main objectives are to prevent multiple "global public health risks" and "stop diseases at international borders" (OMS, 2007, p. 9), crystallized efforts to achieve global standardization of the means of controlling the spread of infectious diseases through different biosurveillance technologies. Accordingly, the 2005 IHR obliged States to report emerging outbreaks and implement protocols for action in the event of suspected infection in air navigation. As suggested by Budd et al. (2011), the multiple health security measures implemented to contain the spread of infectious diseases have transformed the actions and spatial scope of border health control based on the reinforcement of biosurveillance techniques implemented before, during, and after air travel.

Mobility as a solution to the COVID-19 "crises"

The decisions related to the control and regulation of mobility that most States around the world and in South America have implemented since the expansion of COVID-19 have been characterized by the preeminence of the medical-epidemiological discourse focused on prevention and combating the spread of the virus. Health discourses have been underpinned by a "precautionary principle that privileges a policy of *speed* based on the sovereign decision of dangerousness" (Aradou & Van Munster, 2007, p. 107). In the context of the COVID-19 pandemic, state bureaucracies have considered the virus as a security hazard, and states have organized the management of health emergencies according to the rules of the "national security" game (Bigo et al., 2021).

Nevertheless, since the adoption of government decisions on the suspension of global mobility, national and international actors involved in the governance of mobility have made efforts to show the negative effects of border closures and travel restrictions, arguing that these measures would further deepen the existing health, economic, and humanitarian crises caused by the pandemic. In the face of the centrality acquired by the medical-epidemiological discourse, the disputes over mobility control deepened and highlighted key aspects of the political generation of (in)mobility. From mobility and health governance schemes, the key question for experts and decision-makers has been how to manage the risk of infection. In other words, how and under what conditions to promote international mobility, which endangers national life at the same time as it makes it possible.

During the pandemic, the narratives on the risk of infection by COVID-19 came into competition with others associated with a "continuum of risks" (Aradou & Van Munster, 2007), configured based on different representations of the problems to be managed. The decline in passenger traffic and flights leading to a decrease of economic income for airlines and airports (OACI, 2021b), the effects of monetary losses on the tourism industry for national economies (OMT, 2020), or the impacts that mobility restrictions would cause concerning the "risk" of increased "irregular and unsafe" migration and conditions of "vulnerability" of migrants and asylum seekers or refugees (OIM, 2020a, p. 1) were raised as priorities to be addressed. As expressed by a high-ranking ANAC official:

> What *the pandemic* did, from the moment the WHO established that covid is a pandemic and has a worldwide impact, *triggered all countries' decisions*. In aviation, what it did was that the president signed a decree within a bunch of decisions. One of the definitions was *"all aircraft on the ground". From that moment on, it was zero hour (…) The aeronautical authority was no longer the competent authority in decisions on aero-commercial matters, but, as in the rest of the activities and industries, the axis around which everything revolved was the health authority (…) The main challenge for the aeronautical authority was to recover the air authority because the consequences are many; I mean, there are consequences that nobody imagines*. To

> keep or maintain their license and be authorized to fly, pilots must have... I will give you an example because there are hundreds (...) what they call "recent experience". If you don't fly, you lose that recent experience. By losing recent experience over an extended period, you lose many pilots who are not available. You don't have pilots to bring vaccines; you don't have pilots to bring respirators, to bring medical supplies. So, *our fight... "the fight", no, not a fight, no... The challenge, our goal, was to restart activity.* (ANAC Argentina official, virtual interview, 04/18/2022, emphasis added)

With a rationale similar to that of catastrophic risk, on which border closures and suspensions of mobility were based, there were arguments for their reactivation, directly linked to the concern to regain control of mobility and based on the know-how of "professionals in the management of concerns" (Bigo, 2002, 2014) in charge of establishing a certain truth about threats and how to anticipate and prevent them.

As part of the need to minimize or control the detrimental impacts caused by movement restrictions, mobility was represented by migration, aviation, and tourism stakeholders as a necessity for the prevention of new and more risks and as part of the *solution* to the "challenges" and "crises" generated by the responses adopted to face the pandemic. As has been proposed from the autonomy of migration, "crises" have become a powerful instrument of governance insofar as they serve to legitimize political and economic decisions (Agamben, 2013 in Heller et al., 2016), which gives an insight into the political uses that "crises" can serve as a pretext for (Heller et al., 2016). For the IOM, for example,

> *the COVID-19* crisis is a wake-up call, *an opportunity to rethink how we see migration, as the dependence on human mobility for healthy economies and societies has never been clearer. This should translate into smarter policies*, revising the public discourse on migration and greater international cooperation so that we can collectively better *recover from COVID-19 and reap the benefits of facilitating orderly, safe, regular, and responsible migration.* (OIM, 2020a, p. 5, emphasis added)

Within the framework of the "crises" unleashed by the pandemic and under fundamentally economic considerations, aviation emerged as the "engine of economic recovery" (OACI, 2021b, p. 4), tourism as a "reliable partner for the recovery of society and communities" (OMT, 2020) and migration as a better "opportunity to recover" from COVID-19 (OIM, 2020a). Taking advantage of the benefits of mobility to face the pandemic's negative effects was at the core of multiple declarations and technocratic strategies implemented by various actors interested in deploying it. The dominant narratives constructed from the fields of aviation, tourism, and migration were coupled with the imperative of health security with public health risk assessment from which States proposed schemes of gradual and protected reopening of borders and a selective lifting of travel restrictions.

ICAO expertise and the emergence of the "health corridor"

In the context of the need to generate *consensus* on the importance of government adoption of strategies to facilitate air mobility based on border closures, ICAO played a central role in mobilizing working groups and in creating spaces and tools to address the risk of infection by COVID-19 in air travel as a health (in)security problem. Faced with the irrefutable health discourse on the threat posed by SARS-CoV-2, the production of *risk experts* on the transmission of the virus in air travel was part of ICAO's measures aimed at offering States alternatives to the nationalist measures adopted to suspend mobility. As a technique that generates authority to produce knowledge, the "expert panel" enables claims for resources and security technologies that it offers to manage the risk produced (Salter, 2008).

As shown by the following guidance statements on COVID-19 and civil aviation, ICAO proclaimed itself as an actor with legitimate authority to demand that States implement international legal instruments related to the facilitation of air transport[5] and the incorporation of multisectoral spaces for the "safe" treatment of outbreaks and epidemics in the field of aviation:

> *ICAO itself has been working closely with government and industry stakeholders* (...) *to guide aviation authorities, airlines and airports and advise individuals on appropriate measures to protect travelers' health and reduce the risk of transmission* (...) The ICAO communication to States *directly urges national governments to implement the relevant provisions of Appendix 9 to the Convention on International Civil Aviation* (Chicago Convention), *formalize their membership of CAPSCA, allocate more funding for the preparation of responses to communicable diseases, and establish a national air transport facilitation committee* (...) Stopping the spread of the virus is the top priority. (OACI, 2020a, emphasis added)

Creating new spaces and work teams dedicated to producing specific expert knowledge to propose alternatives for the reactivation of flights was the immediate reaction of ICAO to the declaration of the pandemic. The Council Aviation Recovery Taskforce (CART) was formed, composed mostly of representatives from member states and international, regional, and industry organizations. The CART oversaw defining strategies and recommending global policies to guide States and the aviation industry to seek solutions through immediate actions and operated closely with the aforementioned CAPSCA. According to the ANAC Argentina official:

> *The Argentine Republic planted the seed of the so-called CART*, the document in which the ICAO made certain suggestions... *to facilitate air transportation.* Nevertheless, since the health authority was at the center of the decisions, it would always be the health authority that defined the standards and criteria. (ANAC Argentina official, virtual interview, 04/18/2022, emphasis added)

[5] Appendix 9 of the Convention on International Civil Aviation (1944) refers to the standards and methods recommended to States regarding minimum and maximum requirements for the entry and exit of persons and aircraft, including travel documents, vaccination or prophylaxis certificates, and visas, among others.

The role of "double agent" (Dezalay & Garth, 2017) from the combination of positions of authority in governmental and private sectors and in national, regional, and international spaces—and the establishment of transnational corporate professional alliances to strengthen the credibility of the ideas and proposals for the management of concern inside States (Bigo, 2014)—constitute central elements of the initiatives proposed by ICAO to achieve the resumption of mobility. In South America, the Virtual Meeting of Directors General of Civil Aviation of the ICAO South American Region (RVDGAC, by its Spanish acronym from Reunión virtual de directores generales de la aviación civil) promoted the formation of a working group dedicated to advancing according to the guidelines for an "orderly, harmonized, progressive and safe response" to the reactivation of flights (OACI, 2020d).

At RVDGAC meetings since the beginning of the pandemic, the need for "coordination" between States and international "cooperation" of public health and aviation authorities to facilitate air transport has been emphasized. From the RVDGAC and based on a proposal by the Argentinean working group, a request was made to the Panel of Experts in Aeromedicine of the Regional System of Cooperation for the Surveillance of Operational Safety (SRVSOP for its Spanish acronym from Sistema Regional de Cooperación para la Vigilancia de la Seguridad Operacional) for a health control protocol that could be implemented by all the States of the region (SRVSOP, 2020). Although based on the need to prevent the entry of the virus, implementing a standardized sanitary protocol was intended to reduce the barriers to the initiation and diversification of flights that could result from the differentiated application of sanitary requirements by the States. Implementing a health protocol was directly associated with the emergence of air health corridors. According to the official interviewed:

> How is it possible to restart activity? Well, the idea was to ensure that until there was a treatment or a vaccine to *prevent the entry of the virus from abroad. How can it be prevented? Healthcare is added to the controls that are usually part of the activity of an airport,* in entry from abroad. *In 2001, with the Twin Towers, many more controls were added from a security standpoint. This pandemic has added new controls, such as sanitary controls.* As not all airports were prepared to carry out these sanitary controls, it was determined that, among other things, it was necessary to have a PCR test before boarding the plane, to complete an affidavit to establish if you had symptoms or not, if you had any close contact with any person with coronavirus.
>
> Nevertheless, what was also decided here in Argentina, as in other countries, was to establish a test for those entering from abroad. *That is where the concept of safe corridors was born.* That suggestion came from us (...) *All Latin American countries adopted the safe corridor strategy because somehow they had to stop them from entering... or try to prevent infected passengers from entering the country...* Perhaps it implied different things, not in every country did it imply the authorization of a laboratory to test those who entered the country. In other countries, it

> involved other issues, but the concept of the safe corridor, yes, yes, of course. (ANAC Argentina official, virtual interview, 04/18/2022, emphasis added)

Civil aviation representatives of the Argentine government suggested through ICAO's cart the implementation of health corridors inspired by the "safe corridor" category that Argentina incorporated into the regulations adopted to address COVID-19. In contrast to the notion of air health corridors disseminated by international civil aviation agencies and industry with the promotion and facilitation of flights, the safe corridor was the category on which the Argentine government based its policies and measures for the control and regulation of air, land, and river mobility and borders using the Decree of Necessity and Urgency (DNU) of Health Emergency of March 12, 2020. From this date until the beginning of April 2022, when government authorities decreed the total opening of borders, decisions regarding the opening and closing of borders were subsumed to the concept and strategy of the safe corridor, defined as the "entry points, routes and places that could bring together the best basic capabilities to respond to the health emergency" (Poder Ejecutivo Nacional, 2020).

As the official's account shows, the pandemic favored "the re-establishment of sanitary controls that had been eliminated from the admission and permanence criteria or displaced in the face of other 'security' threats such as terrorism, drug trafficking and smuggling" (Domenech, 2020, p. 19). According to Domenech (2020), in the history of migratory controls in the South American region, the relationship between safeguarding the health of national populations and border control is inseparable and dates to the beginning of the 20th century, a time when hygienism and eugenics promoted the establishment of restrictions on entry justified by the detection of chronic or infectious diseases. In the "new hygienism" (Domenech, 2020) that arose after the expansion of the pandemic, the health protocols constituted by the requirement of affidavits on health status, implementation of testing mechanisms, vaccination against COVID-19, and mutual recognition of vaccines between States, among other measures, operated explicitly as sanitary passports and as legitimate means of authorization, prohibition, or rejection of international movements of people. Under the cloak of the language of "care" and "protection" crystallized in health protocols, health controls reemerged condensed in strategies such as those of the health corridor.

In international air mobility, the health corridor concept first appeared in the CART report *Implementing a Public Health Corridor to Protect Flight Crew During the COVID-19 Pandemic,* May 2020. Within the diversity of materials produced by ICAO during the pandemic, the document *Take-off: Guidance for Air Travel through the COVID-19 Public Health Crisis* was presented as the "roadmap" for the global implementation of CART recommendations for the "resumption, recovery and resilience of civil aviation in the aftermath of the COVID-19 outbreak" (OACI, 2020e). The health corridors proposed by ICAO were initially oriented to the mobility of flight crews defined as essential personnel. It was then suggested for aircraft maintenance, positioning and delivery of aircraft, and humanitarian, repatriation, and regular flights for transporting individuals.

ICAO's work, concerning the production and transnationalization of the health corridor in response to the health (in)security associated with international mobility as a threat of spreading COVID-19, was reflected in a "new package of security measures" (Bigo & Tsoukala, 2008) provided through multiple reports, guidance documents, and training measures. The ICAO *Manual of Cross-Border Risk Management Measures and Diagnostic Tests* (OACI, 2020b), known as The Manual, and the *Health Corridor Implementation Packages* (*I-Packs*) are among the most significant initiatives. The ICAO I-Packs provided nation-states with technical assistance visits, customized workshops, webinars, and practical exercises for implementing health corridors.

The hygienic-sanitary control of international mobility during the pandemic was carried out by all the States of the South American region independently of the adoption of the notion of the health corridor or the acquisition of the I-Packs proposed by ICAO, since ICAO recommendations did not constitute mandatory standards.[6] Along with the I-Packs, ICAO made available a mobile application contained in the *COVID-19 Response and Recovery Implementation Centre* (CRRIC-ICAO), with a model bilateral or multilateral agreement on health corridors. With a "practical sense of traceability in real time" and the rationale of building a "preventive agenda" (Bigo, 2014), this application was fed by epidemiological data provided by the WHO and by the national States themselves, who were asked to share information on cases of infection, vaccinated population, and health infrastructure, among other issues, supported by the importance and the need for reciprocal recognition of the health situation of each State for the possible establishment of health corridors.

"Protected passengers, connected world and contained virus": health corridor, risk management, and creation of trust in mobility

According to the ICAO CART definition, "a health corridor is created when two or more States recognize the health risk mitigation measures that each State has implemented on one or more routes between those States" (OACI, 2020c). Faced with the reduction or stoppage of flights, the health corridor proposes the reestablishment or creation of specific routes and transforms them in its interior, playing an immunizing role through measures aimed at making the borders as impermeable as possible to the virus. Risk minimization and other forms of risk management that include contingency planning to avoid the catastrophe that will ensue at any time (Aradou & Van Munster, 2007) is the core element of ICAO's health corridor concept. Although it is not considered feasible to eliminate the risk of contracting COVID-19 in air travel, it is feasible to mitigate it through specific measures (OACI, 2020c). According to ICAO, the "risk" focused approach involves:

[6] According to official icao information, in the various meetings of civil aviation directors of the South American region held throughout 2020, countries such as Bolivia, Colombia, and Argentina called attention to the importance of establishing health corridors to facilitate air travel (OACI, 2020g). Nonetheless, by August 2021, no country had acquired the I-Pack of health corridors (OACI, 2021a).

> The principles of *safety management* where the key is the use of "*clean*" *crews,* "*clean*" *aircraft and* "*clean*" *airport facilities, and the transportation of a* "*clean*" *user public.* In this context, "*clean*" refers to the *application of measures aimed at eliminating, to the greatest extent possible, the presence of COVID-19 in the air transport sector.* (OACI, 2020c)

If the main route of transmission of COVID-19 is the body in motion, eliminating as far as possible the presence of the virus in air transport requires a labor of immunization of mobility for which the health corridors provide the necessary conditions to achieve it. The exercise of hygienic-sanitary controls of mobility in these corridors would guarantee, according to the official discourse, a decrease in the possibilities of contagion and entry of the virus into national territories:

> *Health and safe corridors are synonymous because... what does it mean? A gateway into or out of the country that can manage passengers from a sanitary point of view.* In addition, of course, it is taken for granted that all migration, customs, and anti-illicit migration security services are also complied with. (ANAC Argentina official, virtual interview, 04/18/2022)

The apparent neutrality of "health management" relativizes the control of mobility, which is exercised in response to the will and concerns, mainly of States and certain national and international organizations, whether to prevent the entry of the virus by stopping or restricting movement or to implement mobility and take advantage of the benefits and profits (mainly economic and political) it brings. At the same time, the idea of health management reflects the depoliticization of the notions of health and borders contained in the concept of health corridors: health is reduced to the absence of infection or disease and perceived as something that can be managed by combining movement control methods and technologies with health diagnostic tools, which serve the function of identifying and selecting individuals suitable for border crossing according to health parameters. To this end, the representation of the health corridor as an entrance or exit door overlooks the multiplicity of processes and measures of frontierization and ordering of spaces (Van Houtum & Van Naerssen, 2002) that intervene in the hierarchization of individuals and groups in a situation of mobility.

The control measures implemented during the arrival and movement of individuals through airports (in check-in services, migration, customs, waiting rooms, baggage handling and loading processes, boarding), disembarkation and transfer and accommodation in case of suspicion or confirmation of COVID-19 (SRVSOP, 2020) have been part of the construction of representations on the *safety* of mobility that are adjusted and channeled in the health corridors. At the same time, although the sanitary control of movement would seem to be carried out from arrival at the airport through sanitization and testing measures, the "virtualization of borders" (Bigo, 2014) has been a key component of the immunization of mobility.

The qualification and classification of "safe" or "unsafe" countries, according to epidemiological criteria based on infection rates and the use of COVID-19 (Domenech, 2020) as a selectivity criterion for the establishment of "routes between States", has been part of the measures of (in)securitization of mobility through the creation of profiles of "unreliable" travelers according to national origin and has made it possible to account, following Domenech (2020), for the strengthening of the remote control that took place during the pandemic.

As has been shown, ICAO carried out a multiplicity of measures involved in the production, legitimization, dissemination, and transnationalization of this new form of immunization of mobility defined as health corridors. To persuade and get States to reopen, even partially, their borders, the health corridor was presented as a mechanism capable of restoring confidence in the resumption of travel (OACI, 2021b). Thus, a series of characteristics or virtues centered on "preparedness", "prevention", and "protection" were attributed to the health corridor strategy. In scenarios characterized by the production of fear in the face of the uncontrolled spread of COVID-19 and uncertainty about the occurrence of new waves and mutations, managing discomfort by "reassuring" (Bigo, 2020) individuals and States about the safety of travel and the spaces through which individuals could transit during their border crossings was an inescapable requirement for "take-off". As Dijstelbloem and Walters (2019) have pointed out, the design of spaces to foster feelings is an essential component in regulating migration, where the mood is the object of struggle. Within this framework, the triad of "protection" of travelers and States against contagion, global "connection", and "containment" of the virus was the premise that guided ICAO's actions:

> *Stopping the spread of the virus is the top priority* (...) *IATA and the airlines are working closely with the* WHO, *ICAO and Airports Council International to ensure that harmonized and updated procedures are implemented to keep passengers protected, the world connected, and the virus contained. Travelers should be reassured* that the industry is *prepared* to deal with communicable diseases based on the experience of previous outbreaks. The *WHO International Health Regulations* are the foundation for coordinated global initiatives to be implemented by all parties concerned. (OACI, 2020a, emphasis added)

In the disputes over the control of mobility, the idea of preparedness of the aviation industry to face the spread of the virus based on the experience of previous outbreaks was used as an element that produced and legitimized confidence in the possibility of achieving *immunized mobility*. Thus, using specific shared knowledge about the ability to foresee the future and be able to modify it (Bigo, 2020), the health corridor was produced as a strategy that allowed the development of flights with minimal restrictions (OACI, 2020c, pp. 1-2), fulfilling the triple mandate of keeping "passengers protected, the world connected, and the virus contained".

Conclusions

This article has addressed certain transformations in the field of movement and border control that took place in the South American region with the advent of COVID-19 in the framework of what it is proposed here to call the *immunization of mobility*. The analysis of the emergence and political production of the concept of the health corridor has revealed that the immunization of mobility operated as a particular form of movement control during the pandemic, characterized by the rollout of ideas and measures aimed at producing *immunized mobilities* as a solution to the need to reactivate movement, especially air transport. In a situation of border closure, the health corridor was produced as the most appropriate and feasible alternative for the continuity of travel based on its function of identifying, filtering, and channeling *immunized* and *infectious mobilities*. The production of representations on the safety of certain mobilities to be achieved through the strategy of health corridors operated as a tool for the possibility of prolonging land and river border closures once the restrictions on air travel were lifted, justified by the impossibility of guaranteeing the sanitary conditions necessary to contain the spread of the virus, with effects on the hierarchization and stratification of mobility.

This article has sought to show and call into question concrete ways in which mobility control policies and measures aimed at restricting the aerial mobility of viruses and diseases occur in a context of global control of infectious movement and reflect the emergence and participation of a diversity of actors (such as ICAO) involved in mobility and border control regimes, which have been little addressed in critical research on movement, migration, and borders in the region. Accordingly, this text has drawn attention to the need to understand the "new hygienism" that took place with the outbreak of COVID-19, and which inaugurated a third stage in the South American migration and border regime, hand in hand with the reconfiguration that the mandate of "global health security" has imprinted on the policies and measures of mobility and border control. Within the disputes over control and freedom of movement in the context of the COVID-19 pandemic, the construction and valorization of expert knowledge organized around a specific use of multiple crises to be resolved through infection risk management has played a prominent role. To this end, the production and promulgation of confidence in the existence of "clean" forms of mobility and spaces, understood as virus-free, was at the heart of the strategies carried out for the selective opening of borders through the strategy of health corridors.

The analysis developed throughout this text has sought to account for certain transformations in the control of movement in the South American region, associated with more subtle and perhaps less violent border measures than the image of total closure or militarization of borders, but no less effective for the governance of mobility and migration. Through health corridors, the "risk" device has operated as an organizing criterion for the hierarchization of movement and various forms of spatial segregation produced by implementing circuits and spaces of mobility and differential conduits for possible carriers and non-carriers of COVID-19. To this end, health corridors show forms of control associated both with the stoppage of movement and its facilitation: the use of instruments such as COVID-19 tests, which operate as barriers to movement, is combined with spaces, conduits, and circuits specifically created for the acceleration, slowing down, and redirection of mobility. The investigation of the

manifestations and specific political uses of the "health corridors" and "safe corridors" implemented by some South American countries for the differentiated management of their borders in the context of the pandemic opens lines for further deepening the understanding of the transformations in the field of mobility control, migration, and borders, associated with the emergence of new forms of movement containment as part of the emerging ways of reimagining and reordering borders and spaces (Tazzioli & Stierl, 2021a) deployed under the COVID-19 pretext.

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