The International Health Regulations, COVID-19 and National Borders: Pursuing Health Security in a Globalized World

By Simon Rushton and Adam Ferhani

Synopsis

The International Health Regulations, last revised by Member States of the WHO in 2005, are the primary global agreement governing the international response to global health emergencies. The primary aim of the IHR, under Article 2, is to control the cross-border spread of disease in ways that "avoid unnecessary interference with international traffic and trade." During the COVID-19 pandemic there has been widespread flouting of the IHR rules and the WHO advice, with the majority of countries imposing tough travel and trade restrictions that appear to be contrary to both the letter and the spirit of the IHR. At the same time, there has been emerging evidence to suggest that such restrictions at the border have- at least in some cases- played a part in helping control domestic outbreaks. This has led to a debate over whether the IHR 2005 and the WHO have the correct approach in their preference for borders remaining open, and whether the regulations should be revised in advance of future health emergencies. In this article, we argue that it is important that participants in these discussions remember why the IHR take the approach that they do. Much of the current debate focuses on the effectiveness of border controls in keeping disease out, and the supposed trade-offs between health security and the economy. Yet the human rights and international cooperation rationales for the WHO (and IHR) preferring open borders should not be forgotten. Drawing the lesson from COVID-19 that the WHO/IHR are wrong to warn against disease-related travel and trade restrictions risks forgetting the lessons of the past - and may set us up poorly for dealing with future disease emergencies.
About the Authors

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What should be the role of border controls in pandemic response? The lessons from COVID-19 are not yet clear, and opinion remains divided. We can point to the fact that some island nations (for example New Zealand, Cuba and Taiwan) have fared relatively well in terms of disease control, with far lower rates of infection and death than other nations with similar characteristics. But elsewhere, island nations such as the UK have performed poorly - suggesting that what happens within a country’s borders is at least as important as what happens at them.

The International Health Regulations (IHR), last amended in 2005, are the primary international instrument providing for international cooperation during ‘Public Health Emergencies of International Concern’ (PHEICs). The IHR give the World Health Organization (WHO) a leading role in coordinating international responses to disease events and put a number of obligations on national governments to detect, report and contain disease outbreaks that threaten to spread internationally. Yet, in terms of borders, there is a tension at the heart of the IHR framework that COVID-19 has laid bare.

On the one hand, the 2005 revision of the IHR was in part a recognition of the fact that borders cannot prevent the spread of disease in a globalized world: in the words of the WHO itself, the 2005 version of the IHR represented a “paradigm shift” as compared to their predecessors, away from border controls as the primary means of stopping the ingress of disease towards a model where much greater emphasis was placed on “containment at source.” Importantly, this move away from a reliance on border controls was not merely an admission of the futility of trying to keep disease out: it also responded to more normative considerations (including the fact that immigration measures are often applied in ways that are discriminatory and raise human rights concerns, and that border closures can undermine international cooperation), as well as practical issues (that restrictions at borders can often make it more difficult to move the necessary health personnel, equipment and supplies around during a disease emergency).

On the other hand, borders remain fundamental to the IHR; indeed the regulations only come into play when a disease threatens to cross a border. The IHR require surveillance infrastructure to be put in place at points of entry. And they do in certain circumstances allow states to enact scientifically justified border controls of various kinds in response to a disease emergency. But even so, the IHR framework sees travel and trade restrictions as the exception, not the rule. During a PHEIC, the WHO advises governments what measures they should put in place (generally - as during COVID-19 - with a strong preference for borders remaining open). Under Article 43, any government that wishes to enforce more restrictive travel and trade measures than those WHO recommends is required to provide WHO with a scientific rationale for doing so. Under the 2005 version of the IHR, then, border controls do still have some role to play, but they are not seen as a particularly effective way of achieving ‘health security’ and because of their significant downsides, the assumption is that they should be used sparingly.

Compliance with the IHR rules on travel and trade restrictions has been seen as vital both because it supports the central objective of the IHR (“to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade”) and because it avoids creating disincentives for WHO member states reporting outbreaks. Governments have often tried to keep outbreaks secret out of fear of economically damaging trade and travel restrictions being placed upon them (including China during the SARS outbreak of 2002/3). The IHR’s promise that other states will ensure that their responses to an outbreak “are not more restrictive of international traffic and trade and are not more intrusive to persons than reasonably available alternatives” (Article 17) was supposed to provide reassurance that a country would not be victimized for being a good international citizen and alerting the outside world to the emergence of a disease-related threat.

All of these rules have been routinely ignored during the COVID-19 pandemic. The vast majority of governments have put in place some form of travel and/or trade restrictions in excess of those recommended by WHO, generally without bothering to provide the WHO with any scientific justification for doing so. They have

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suffered no adverse political or legal consequences as a result. International lawyers have condemned these flagrant breaches of the IHR as being threatening to the stability of the IHR framework.  

At the same time, evidence has begun to emerge on the (partial) effectiveness of border controls. Studies early in the pandemic suggested that, although they did not ultimately stop the spread of the virus, international travel restrictions did slow it down in the early months, buying valuable time to scale up domestic responses.  

Chaudry and colleagues found that countries that had been slower to implement border controls suffered increased COVID-19 caseloads. A review of 29 studies conducted by Grepin and colleagues similarly found evidence that, at least in the early stages, travel restrictions had made a difference. As they pointed out, this challenged “a widely-held belief that travel measures were unlikely to play much of a role in curbing the spread of the virus.” In a global crisis it is perhaps to be expected that governments will react by trying to secure the ‘inside’ from what is seen as a dangerous ‘outside’. But in other respects, the choice taken by most governments to restrict international movement has been a surprise. As Steven Hoffman says, “We had no idea that governments around the world would be willing to impose total border closures and related measures that would cost the global economy some US$400 billion every month.”

Several ‘lessons learning’ investigations have already started considering whether the WHO’s preferred position of keeping borders open during health emergencies is the right one - and if it is, what can be done about the widespread flouting of the IHR rules. The recent identification of new ‘variants of concern’ in the UK, South Africa and Brazil have prompted a new wave of tougher border measures, suggesting that (whether rightly or wrongly) governments believe that such measures have at least some degree of effectiveness. Meanwhile, the start of vaccine roll-out provides opportunities for new types of more fine-grained travel-related restriction - including proposals by the airline industry for the implementation of a ‘vaccine passport’ system (IATA 2020).

In considering whether border controls are ‘right’ or wrong, however, it is important to remember why the IHR take the approach that they do - and to look both before and beyond the current pandemic crisis. Much of the current debate around COVID-19 restrictions of all kinds has focused upon the supposed trade-offs between public health and economies - and the impacts of border restrictions on international travel and trade have been no exception. Yet the human rights and international cooperation rationales for preferring open borders should not be forgotten as a result of focusing only on the current PHEIC.

First, although there have been issues - especially in the early stages where the virus was perceived as a threat coming from China - the human rights objections to border restrictions have not been quite as acute during this health emergency as previous ones. Parly this is because the virus was quickly in all countries, and partly because, at the individual level, it is not (in most countries) especially stigmatized. But this has not been the case with other diseases. In the case of HIV, for example, many states have (and in some cases continue to) put discriminatory immigration restrictions on people living with HIV which have restricted the ability of individuals to travel and increased stigma. During the 2014-16 Ebola outbreak in West Africa, there were numerous reports of racial profiling at points of entry, affecting many Africans (and people of African descent) who had not been anywhere near the Ebola-affected regions. If selective border restrictions become seen as a

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primary part of national pandemic response, it seems likely that similar instances of discrimination will arise in future disease emergencies.

Second, we have seen border measures being an obstacle to effective international cooperation during COVID-19. On the one hand, there have been political disputes between states over targeted travel restrictions, and many cases of ‘tit for tat’ measures. On the other, there have been tensions over attempts by governments to control what leaves their borders, with export bans being imposed on a variety of medical goods (including PPE and ventilators), limiting the ability of other countries to access these essential products. At the time of writing, the EU is threatening measures to limit the export of the AstraZeneca vaccine, in a move that would further undermine international cooperative efforts to ensure global vaccine availability.

To focus only on the economic pros and cons of implementing disease-related border controls is to narrow the terms of the debate too far. Drawing the lesson from COVID-19 that the WHO/IHR are wrong to warn against disease-related travel and trade restrictions risks forgetting the lessons of the past, and may set us up poorly for dealing with future disease emergencies. A return to a borders-first response strategy also risks obscuring the lesson that what happens within a country’s borders ultimately contributes more to disease control than what happens at them.

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