Canada's Violation of International Law during the 2014–16 Ebola Outbreak

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La violation du droit international par le Canada lors de l'épidémie d'Ébola de 2014–16

ALI TEJPAR AND STEVEN J. HOFFMAN

Abstract

The devastating 2014–16 West African Ebola outbreak challenged the authority of the World Health Organization (WHO) to enforce the legally binding *International Health Regulations* (*IHR*) that govern pandemic responses. Under Article 43 of the *IHR*, states parties can only implement additional health measures beyond the WHO's recommendations if public health rationales or scientific evidence justify such measures. Yet at least fifty-eight states parties enacted additional health measures, mainly travel restrictions to or from Ebola-affected countries. This article explains why Canada's visa restrictions targeting Ebola-affected countries failed to meet the *IHR*'s requirements and therefore violated international law. Specifically, Canada's response went against public health authorities' consensus views, the best available scientific evidence on disease transmission,

Résumé

L'épidémie dévastatrice d'Ébola de l'Afrique de l'Ouest en 2014–16 a remis en doute l'autorité de l'Organisation mondiale de la santé (OMS) pour faire respecter le *Règlement sanitaire international* (*RSI*), instrument juridiquement contraignant qui régit les réponses aux pandémies. En vertu de l'article 43 du *RSI*, les États parties ne peuvent mettre en œuvre des mesures en matière de santé au-delà de celles recommandées par l'OMS que si des motifs de santé publique ou des preuves scientifiques justifient de telles mesures supplémentaires. Or, au moins 58 États parties ont adopté des mesures de santé supplémentaires, principalement des restrictions de voyage vers ou à partir des pays touchés par l'Ébola. Ce commentaire explique pourquoi les restrictions de voyages imposées par le Canada à l'endroit des pays touchés par l'Ébola n'ont pas répondu aux

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and the WHO's recommendations. In light of its traditional role as a global health champion, Canada must lead by example and abide by international law, including the *IHR*, instead of picking and choosing which rules to follow and thereby encouraging other countries to do the same.

exigences du *RSI* et ont donc violé le droit international. Les mesures imposées par le Canada étaient contraires au consensus d'opinion des autorités de santé publique, aux données scientifiques les plus récentes sur la transmission des maladies, et aux recommandations de l'OMS. Vu son rôle traditionnel de champion mondial de la santé, le Canada doit mener par l'exemple et respecter le droit international, y compris le *RSI*, plutôt que de respecter certaines règles au choix et ainsi encourager d'autres pays à faire de même.

Keywords: International health law; global health governance; Ebola; infectious diseases; pandemic responses; *International Health Regulations*; World Health Organization.

Mots-clés: Droit international de la santé; gouvernance mondiale de la santé; Ébola; maladies infectieuses; réponses pandémiques; *Règlement sanitaire international*; Organisation mondiale de la santé.

Introduction

The 2014–16 Ebola outbreak in West Africa was by far the most severe spread of the disease on record.[1] The World Health Organization (WHO) described the virus as one of the most challenging global health threats the United Nations (UN) agency has ever faced, with 28,646 people diagnosed and 11,323 dead at the outbreak's conclusion on 29 March 2016.[2] After widespread criticism by civil society groups like Médecins Sans Frontières about delays, WHO Director-General Margaret Chan finally declared the Ebola outbreak a "public health emergency of international concern" (PHEIC) under the legally binding *International Health Regulations* (*IHR*) on 8 August 2014.[3] On recognizing a "public health risk to other States through the international spread of disease," the WHO director-general can declare a PHEIC and then issue temporary recommendations for an internationally coordinated response to prevent and reduce the disease's spread.[4] As affirmed in the *IHR*, these temporary

[1] World Health Organization (WHO), *Fact Sheet: Ebola Virus Disease* (January 2016), online: <http://www.who.int/mediacentre/factsheets/fs103/en/>.

[2] WHO, *Ebola Situation Report* (30 March 2016), online: <http://apps.who.int/ebola/ebola-situation-reports>.

[3] WHO, *supra* note 1. WHO, *International Health Regulations*, WHA 58.3, 2d ed (Geneva: WHO, 2005) [*IHR*].

[4] WHO, *IHR Procedures and Implementation* (2005), online: <http://www.who.int/ihr/procedures/en/>.

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recommendations aim to prevent and control the disease's international spread while avoiding "unnecessary interference with international traffic and trade."[5]

During the Ebola outbreak, the WHO's authority to enforce the *IHR* was called into question. At least fifty-eight WHO states parties adopted additional health measures beyond the director-general's temporary recommendations that interfered with international traffic and trade.[6] Despite Canada's leadership on pandemic preparedness after the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) and the country's championship of revising the *IHR* in 2005, Canada stood out during the 2014–16 Ebola outbreak as one of the very few high-income countries to implement restrictive travel measures. Specifically, Canada cancelled and suspended processing visa applications from foreign nationals who had been in Ebola-affected states within three months of their visa application date.[7] Canada also stopped processing visa applications from foreign nationals intending to travel to Ebola-affected states. Under Article 43 of the *IHR*, states can only implement additional health measures in response to PHEICs if such measures are supported by (1) public health rationales; (2) scientific principles and evidence; or (3) WHO guidance and advice.[8]

This article assesses Canada's response to the West African Ebola outbreak and whether it violated international law by examining whether Canada complied with the *IHR*'s criteria under Article 43 and avoided significant interference with international traffic and trade. We find that Canada's cancellation and restriction of travellers' visa applications from Ebola-affected states clearly breached the *IHR* and hindered global health efforts. Specifically, Canada's response went against public health authorities' consensus views, the best available scientific evidence on disease transmission, and the WHO's recommendations. Given that at least fifty-eight states parties enacted some form of Ebola-related travel and trade restrictions — at least several of which probably constituted violations of the *IHR* — we further argue that the WHO's ability to monitor and enforce *IHR* compliance requires a thorough re-evaluation.

[5] *IHR*, *supra* note 3, art 2.

[6] Wendy Rhymer & Rick Speare, "Countries' Response to WHO's Travel Recommendations during the 2013–2016 Ebola Outbreak" (2017) 95 Bulletin of the World Health Organization 10 at 11.

[7] *Ministerial Instructions* (31 October 2014) Canada Gazette I (*Immigration and Refugee Protection Act*), online: <http://www.gazette.gc.ca/rp-pr/p1/2014/2014-10-31-x8/html/extra8-eng.php>.

[8] *IHR*, *supra* note 3, art 43.

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The *IHR* and Canada's Response to the Ebola Outbreak

Under Article 21 of the WHO's Constitution, the World Health Assembly can adopt regulations on specific issues that are legally binding on its member states by a majority vote.[9] As one such example, the *IHR* is a binding set of international rules that aim "to prevent, protect against, control and provide a public health response to the international spread of disease."[10] The *IHR*'s 2005 revision expanded its original scope from three diseases (that is, cholera, plague, and yellow fever) to address any disease deemed to be a PHEIC.[11] The *IHR* imposes positive obligations on states parties to develop core health capacities to detect, assess, and report diseases to the WHO.[12] The *IHR* also establishes global health emergency response procedures. Specifically, after assembling an Emergency Committee, the WHO director-general can declare a PHEIC and issue temporary recommendations to all states parties that align with scientific principles and evidence, consider risks to international public health, and minimally interfere with international traffic and trade.[13] While health is the "sovereign responsibility of countries,"[14] the fact that 196 states parties have adopted the *IHR* illustrates widespread recognition of the importance of international cooperation in preventing and controlling the spread of infectious diseases in an increasingly globalized world.[15]

States parties' responses to PHEICs are legally constrained by the *IHR*. Under Article 43, states parties may implement additional measures that achieve the same or greater levels of health protection than the WHO director-general's recommendations, but only if such measures are otherwise consistent with the *IHR*.[16] The *IHR* emphasizes that such additional measures "shall not be more restrictive of international traffic" than other "reasonably available alternatives that would achieve the appropriate level

[9] *Constitution of the World Health Organization,* 22 July 1946, 14 UNTS 185.

[10] *IHR*, *supra* note 3, art 2.

[11] Adam Kamradt-Scott, "The Evolving WHO: Implications for Global Health Security" (2011) 6:8 Global Public Health 801 at 804.

[12] *IHR*, *supra* note 3, art 5.

[13] WHO, *supra* note 4.

[14] WHO, *Report of the Ebola Interim Assessment Panel* (July 2015), online: <http://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/>.

[15] Steven J Hoffman, "The Evolution, Etiology and Eventualities of the Global Health Security Regime" (2010) 25:6 Health Policy and Planning 510 at 517; Steven J Hoffman, "How Many People Must Die from Pandemics before the World Learns?" (2017) 1:1 Global Challenges 30.

[16] *IHR*, *supra* note 3, art 43(1).

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of health protection."[17] This essential revision in 2005 ensured that states parties would not be discouraged from reporting potential PHEICs due to fears of travel and trade restrictions, a revision that Canada championed after the WHO slapped a travel advisory against Toronto during the 2003 SARS outbreak that caused severe economic injury.[18] For additional health measures to be permissible, they must be supported by (1) public health rationales; (2) scientific principles and evidence; or (3) WHO guidance and advice.[19] States parties implementing additional health measures that significantly interfere with international traffic or trade must provide the WHO with their rationales. The *IHR* defines significant interference with international traffic as "refusal of entry or departure of international travelers, baggage … or their delay, for more than 24 hours."[20] As with other binding international instruments, states parties must fulfil and abide by their international legal obligations. As the Ebola outbreak demonstrated, however, the WHO has no effective mechanisms to enforce compliance with the *IHR*. Instead, the WHO can request that states parties reconsider their additional health measures or submit to a dispute resolution process — the latter of which would be extremely difficult for WHO staff to initiate and, consequently, has thus far never happened.[21]

In the Canadian context, the Conservative federal government responded to the Ebola outbreak by issuing ministerial instructions under section 87.3 of the *Immigration and Refugee Protection Act*[22] on 31 October 2014.[23] The government required Citizenship and Immigration Canada (CIC; now Immigration, Refugees and Citizenship Canada) to stop processing temporary and permanent residence visa applications from foreign nationals who had been in Ebola-affected states within three months before their application date.[24] The CIC also stopped processing visa applications from foreign nationals seeking to travel to Ebola-affected states.[25] The Canada Border Services Agency additionally enhanced border controls by referring all passengers who travelled to the three most-affected

[17] *Ibid.*

[18] Christopher W McDougall & Kumanan Wilson, "Canada's Obligations to Global Public Health Security under the Revised International Health Regulations" (2007) 16:1 Health Law Rev 25 at 30.

[19] *IHR*, *supra* note 3, art 43(2)–(3).

[20] *Ibid*, art 43(3).

[21] *Ibid*, art 56.

[22] *Immigration and Refugee Protection Act*, SC 2001, c 27, s 87.3.

[23] *Ministerial Instructions*, *supra* note 7.

[24] *Ibid.*

[25] *Ibid.*

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states — Sierra Leone, Guinea, and Liberia — in the previous twenty-one days before arriving in Canada for full health screening and temperature checks.[26]

Canada's visa restrictions ultimately prevented foreign nationals who had been in Ebola-affected states within three months from entering, transiting, visiting, or living in Canada. Similarly, Canada's visa restrictions on foreign nationals intending to travel from, or transit through, Canada to Ebola-affected states halted access to West Africa. In this regard, Canada's three-month requirement for visa applications significantly interfered with international traffic by restricting entry and travel beyond the *IHR*'s twenty-four-hour limit. For Canada to justify its additional health measures under Article 43, it should have proven that: (1) public health rationales supported its actions; (2) the best available scientific evidence on disease transmission encouraged travel restrictions; or (3) the WHO recommended or advised such restrictions. Canada's response met none of these requirements.

Applying Article 43 of the *IHR* to Canada's Additional Health Measures

public health rationales

Public health experts have spoken out about the typical ineffectiveness of international travel restrictions to control disease transmission and about how they can be detrimental to disease prevention efforts.[27] For example, challenges in tracking disease transmission are further exacerbated when individuals resort to illegal and unmonitored travel methods that prevent data collection on transnational movements.[28] Dr. Thomas Frieden, director of the US Centers for Disease Control and Prevention during the 2014–16 Ebola outbreak, further argued that isolating states would actually increase the risk of disease transmissions because states might hide cases to avoid the economic consequences of travel restrictions.[29] Public health authorities

[26] Government of Canada, *The Health Portfolio: Framework for Action on the 2014 Ebola Virus Disease Outbreak* (2014), online: <https://www.canada.ca/en/public-health/services/diseases/ebola/health-professionals-ebola/health-portfolio-framework-action-2014-ebola-outbreak.html>.

[27] Isabelle Nuttall, *Ebola Travel: Vigilance, Not Bans*, Commentary (5 November 2014), online: WHO <http://www.who.int/mediacentre/commentaries/ebola-travel/en/>.

[28] Julia Belluz & Steven Hoffman, "The Evidence on Travel Bans for Diseases like Ebola Is Clear: They Don't Work," *Vox* (18 October 2014), online: <http://www.vox.com>.

[29] Thomas Frieden, "CDC Director: Why I Don't Support a Travel Ban to Combat Ebola Outbreak," Commentary (13 October 2014), online: Centers for Disease Control and Prevention <http://www.blogs.cdc.gov>.

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also requested that borders remain open, especially so that health care workers and supplies could reach affected regions. World Bank President Jim Kim described how limiting travel and closing borders was akin to being in a burning house and "putting wet towels under the door to keep the smoke from coming in."[30] Instead, President Kim added: "[W]e've got to get back to putting out the fire."[31]

Critics of Canada's response argued that the government went against the consensus views of public health authorities in an attempt to win public support.[32] Former Member of Parliament Libby Davies contended that the "government [seemed] more interested in public relations than in acting on recommendations from public health experts."[33] Canada's framework for action on Ebola illustrated this possibility by expressly including considerations of "public reaction and risk perceptions into communications" as part of Canada's "evidence-informed approaches" to the Ebola outbreak.[34] Given heavy media attention on the disease and public demands for resolute government action, the Conservative government at the time faced significant pressure to act in order to make Canadians feel safe. Unfortunately, the government ignored public health rationales and implemented ineffective policies designed to appeal to public expectations of a decisive response.

Ironically, Canada previously rallied against its own WHO-imposed travel advisory that was slapped against Toronto during the 2003 SARS outbreak. Former Ontario Minister of Health Tony Clement travelled to Geneva to protest the WHO's travel advisory against Toronto, which was estimated to have cost the city approximately $2 billion and resulted in 28,000 layoffs.[35] In defending against criticisms of Canada's Ebola-related travel restrictions, Clement, who by this time was a federal Cabinet minister, stated that Canada was "a sovereign nation with a duty to protect citizens."[36] This inconsistency was not lost on critics. David Fidler of Indiana University said Canada's actions were at odds with its historic role as a "champion of well-informed, scientifically based, evidence-solid policies."[37]

[30] Anna Yukhananov, "Ebola Must Be Stopped at Source, Not via Travel Bans: World Bank's Kim," *Reuters* (16 October 2014), online: <http://www.reuters.com>.

[31] *Ibid.*

[32] Helen Branswell, "Ebola: Canada Suspending Visas for Residents of Outbreak Countries," *CBC News* (31 October 2014), online: <http://www.cbc.ca>.

[33] Quoted in *ibid.*

[34] Government of Canada, *supra* note 26.

[35] Helen Branswell, "WHO Asks Canada to Justify Visa Ban for Residents of Ebola-Affected Countries," *Globe and Mail* (5 November 2014), online: <http://www.theglobeandmail.com>.

[36] *Ibid.*

[37] Branswell, *supra* note 32.

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Canada's response to Ebola was also considered to have diminished its previous contributions to strengthening the *IHR* in the 2005 revision process after the SARS outbreak.[38] As a whole, Canada failed to consider lessons learned from past outbreaks or to consider scientific evidence in advancing its decidedly untenable public health rationale for its travel restrictions during the 2014–16 Ebola outbreak.

SCIENTIFIC PRINCIPLES AND EVIDENCE

The best available scientific evidence manifestly demonstrates that the harms of travel restrictions outweigh their benefits. A study of the temporary flight bans in the United States following the terrorist attacks of 11 September 2001 provided researchers with a natural experiment for examining the influence of air travel on the spread of influenza.[39] Researchers discovered that the reduced population movement did not stop that season's flu outbreak but, instead, delayed it in the United States by approximately one month — a delay that was not observed in France where no flight bans were instituted.[40] While flight restrictions may delay the spread of diseases, they do not eliminate the risk. A later 2006 study relied on epidemiological simulations to evaluate ways to stem the spread of H5N1 avian flu.[41] Similarly, the study found that implementing travel restrictions after an outbreak would likely delay disease transmission without reducing the total number of people affected.[42] Even a 90 percent reduction in travel would merely slow the spread of the disease by a few days to weeks.[43] After the 2009 H1N1 flu outbreak, several states imposed travel restrictions to and from Mexico where the disease originated, reducing overall travel volume by 40 percent.[44] Researchers observed that this drop in travel only delayed the infection's arrival in other states by an average of less than three days.[45] Projections of a 90 percent reduction of travel would delay the infection's arrival by approximately two weeks.[46]

[38] *Ibid.*

[39] John S Brownstein, Cecily J Wolfe & Kenneth D Mandl, "Empirical Evidence for the Effect of Airline Travel on Inter-Regional Influenza Spread in the United States" (2006) 3:10 PLoS Med 1826.

[40] *Ibid* at 1832.

[41] Timothy C Germann et al, "Mitigation Strategies for Pandemic Influenza in the United States" (2006) 103:15 Proceedings of the National Academy of Sciences 5935.

[42] *Ibid.*

[43] *Ibid* at 5938.

[44] Paolo Bajardi et al, "Human Mobility Networks, Travel Restrictions, and the Global Spread of 2009 H1N1 Pandemic" (2011) 6:1 PLoS ONE 1.

[45] *Ibid.*

[46] *Ibid.*

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Despite these travel restrictions, researchers noted that "no containment was achieved … and the virus was able to reach pandemic proportions in a short time."[47] Canada's adoption of travel restrictions to reduce the spread of Ebola was therefore contrary to the scientific evidence on disease transmission.

With respect to airport screening, a 2011 study examined the use of infrared thermal image scanners in airports to detect travellers with influenza.[48] Researchers concluded that using technology to detect high body temperature rates was not reliable, especially as none of the later-identified thirty influenza-positive travellers were febrile and detected by the scanners.[49] Reports by the Public Health Agency of Canada (PHAC) described similar findings. From the estimated 6.5 million airport screenings across Canada during the 2003 SARS outbreak, approximately 9,100 travellers were referred to quarantine officers for further assessment, none of whom were found to have SARS.[50] At the time, PHAC advised the Canadian government to re-evaluate its screening procedures based on the lack of evidence to support using screening technologies and their overwhelming financial costs.[51] Like Canada's travel restrictions, the government implemented unproven screening techniques during the Ebola outbreak that were not grounded in scientific evidence.

The Canadian government justified its additional health measures and travel restrictions to prevent "the transmission and spread of the Ebola Virus Disease in Canada."[52] It argued that the entry of persons from the affected regions into Canada may introduce or contribute to the spread of Ebola.[53] Specifically, the Canadian government's framework for action on Ebola committed to "evidence-informed approaches" that considered advances in science and medicine, lessons-learned from previous outbreaks, and an understanding of public accountability.[54] Despite Canada's commitment to "evidence-informed approaches," epidemiology studies

[47] *Ibid.*

[48] Patricia C Priest et al, "Thermal Image Scanning for Influenza Border Screening: Results of an Airport Screening Study" (2011) 6:1 PLoS ONE 1.

[49] *Ibid.*

[50] National Advisory Committee on SARS and Public Health, "Learning from SARS: Renewal of Public Health in Canada" (2003), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/sars-sras/naylor/index-eng.php>.

[51] *Ibid.*

[52] *Ministeral Instructions*, *supra* note 7.

[53] *Ibid.*

[54] Government of Canada, *supra* note 26.

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show that the total annual air travel volume from Ebola-affected states amounts to only 0.05 percent of international air travel volume, with only 0.9 percent of that 0.05 percent travelling to Canada in any given year.[55] The resulting likelihood of a person infected with Ebola travelling to Canada, particularly given the substantial cancellation of flights in the region, was remarkably minimal. PHAC's Infection Prevention and Control Expert Working Group even observed that "the risk of transmission of EVD [Ebola virus disease] in Canada [was] considered to be very low."[56] This projection accounted for the fact that Ebola is transmitted through direct contact with an infected individual's blood and other bodily fluids rather than through airborne routes[57] and that human-to-human transmission, absent direct contact with an infected person, has not been demonstrated.[58]

Canada's travel restrictions have been further criticized as being overly broad and irrational. The Canadian government stopped processing visa applications from anyone who had been in Ebola-affected states within three months prior to their application date. Yet this three-month period was more than four times longer than the twenty-one-day upper limit of the virus's incubation period and, therefore, unnecessarily restrictive on international travel.[59] What is more, Canadian travellers from West Africa were exempt from these restrictions, as if the Canadian government believed its citizens were immune to carrying the virus, leading one US news media outlet to label Canada's visa restrictions as "dumb, xenophobic and illegal."[60] Canada's rhetoric around using evidence and lessons learned from previous outbreaks to inform its policies were at stark odds with its disproven and overbroad measures like travel restrictions and airport screenings. Even with a broad interpretation of "evidence-based approaches," Canada's response to the Ebola outbreak violated the *IHR* by significantly interfering with international travel and trade.

[55] Isaac I Bogoch et al, "Assessment of the Potential for International Dissemination of Ebola Virus via Commercial Air Travel during the 2014 West African Outbreak" (2015) 385 The Lancet 29.

[56] Public Health Agency of Canada, "Infection Prevention and Control Expert Working Group: Advice on Infection Prevention and Control Measures for Ebola Virus Disease in Healthcare Settings" (2014), online: <http://www.phac-aspc.gc.ca/id-mi/vhf-fvh/ebola-ipc-pci-eng.php>.

[57] *Ibid.*

[58] *Ibid.*

[59] Michelle Hayman, "Fear above Science: Canada's Ebola Related Visa Restrictions," *University of Toronto Faculty of Law International Human Rights Program* (blog), online: <http://ihrp.law.utoronto.ca/fear-above-science-canadas-ebola-related-visa-restrictions>.

[60] Julia Belluz, *Canada's Ebola Visa Ban Is Dumb, Xenophobic, and Illegal* (2014), online: *Vox* <https://www.vox.com/2014/11/5/7159705/canada-visa-ebola-virus-outbreak>.

WHO's GUIDANCE OR ADVICE

On the question of whether the WHO provided guidance or advice on travel restrictions, the WHO's *IHR* Emergency Committee regarding Ebola clearly asserted to all states parties that "there should be no general ban on international travel or trade."[61] This guidance remained consistent from the *IHR* Emergency Committee's first Ebola statement on 8 August 2014 to its last statement on 29 March 2016.[62] The *IHR* Emergency Committee began expressing its deep concern in January 2015 that over forty states had by that time taken additional health measures that significantly interfered with international trade and travel.[63] The committee further detailed the dire consequences that such travel restrictions would have on affected states, including hindering medical relief groups from travelling to affected areas; preventing access to supplies, food, and medical equipment; causing economic hardships on affected states; exacerbating uncontrolled migration; and fuelling disproportionate fear and stigma.[64] In fact, travel restrictions impeded relief efforts by denying travel visas to 165 Cuban medical professionals[65] and a WHO Global Outbreak Alert and Response Network Team.[66] In response, the *IHR* Emergency Committee consistently urged states parties to repeal their unhelpful additional measures.[67]

When the WHO asked Canada to justify its travel restrictions in a teleconference on 9 November 2014, Canada insisted its measures did not constitute a general ban.[68] Canadian representatives explained that the

[61] WHO, *Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa* (8 August 2014), online: <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.

[62] WHO, *IHR Emergency Committee Regarding Ebola* (8 August 2014), online: <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>; WHO, *IHR Emergency Committee Regarding Ebola* (29 March 2016), online: <http://www.who.int/mediacentre/news/statements/2016/end-of-ebola-pheic/en/>.

[63] WHO, *Statement on the 4th Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa* (21 January 2015), online: <http://www.who.int/mediacentre/news/statements/2015/ebola-4th-ihr-meeting/en/>.

[64] *Ibid.*

[65] David L Heymann et al, "Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic" (2015) 385 The Lancet 1884.

[66] Margaret Chan, "WHO Director-General Addresses Institute of Medicine Ebola Workshop," Speech (1 September 2015), online: WHO <http://www.who.int/dg/speeches/2015/18months-after-ebola-outbreak/en/>.

[67] WHO, *supra* note 63.

[68] Helen Branswell, "WHO Objects to Canada's Ban on Visas to Residents of Countries Affected by Ebola," *iPolitics* (9 November 2014), online: <http://ipolitics.ca/2014/11/09/who-objects-to-canadas-visa-ban-for-countries-affected-by-ebola/>.

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visa policy did not apply to Canadians involved in humanitarian efforts in Ebola-affected states or individuals with previously issued visas. Although a senior WHO official stated that Canada's measures "do not represent a general travel ban," Dr. Isabelle Nuttall, the WHO's director of Global Capacities, Alert and Response, argued that Canada's restrictions violated the *IHR*'s spirit.[69] She responded: "[W]e will continue to state loudly that WHO is against [Canada's response]" and clearly recognized that a real problem remains in enforcing the *IHR*.[70]

Canada's actions were not just against the *IHR*'s spirit. Canada could only lawfully enact its additional health measures if public health rationales, scientific evidence, or the WHO's guidance or advice supported such measures. To take advantage of the third option, the WHO would have had to give a positive recommendation to enact additional health measures — which it did not do — rather than merely abstain from issuing a negative recommendation against its measures. The latter is what Canada improperly relied on during its 9 November 2014 teleconference to argue that its actions did not constitute a "general ban."

Canada Was Uniquely Culpable in Its Violation of the IHR

Canada's additional health measures failed to meet any of the three requirements to lawfully enact additional health measures during PHEICs. As a result, during the thirteen months when Canada had its travel restrictions in place, Canada was in breach of its international legal obligations under the *IHR* and contributed to undermining the authority of international law more broadly.[71] Among at least fifty-eight WHO states parties that implemented additional health measures, Canada stood out as one of the very few high-income countries that imposed sufficiently restrictive travel measures to constitute a breach of international law. States parties' measures implemented under Article 43 of the *IHR* varied across the globe in their degree of interference with international traffic and trade (see Table 1).[72] States like Australia, Antigua and Barbuda, and Jamaica banned all travel from Ebola-affected states. Others, like Afghanistan and Indonesia, implemented visa entry requirements. The United States allowed entry but rerouted flights to major airports. Though Canada did not wholly ban travel from Ebola-affected states, Canada was uniquely culpable in violating

[69] *Ibid.*

[70] *Ibid.*

[71] *Ministerial Instructions* (19 December 2015) Canada Gazette I (*Immigration and Refugee Protection Act*), online: <http://gazette.gc.ca/rp-pr/p1/2015/2015-12-19/html/notice-avis-eng.php#ne1>.

[72] Rhymer & Speare, *supra* note 6 at 12.

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Table 1: Travel Restrictions against Foreign Nationals during the 2014–16 Ebola Outbreak

Country	Income classification	Entry restrictions
Afghanistan	Low income	Exclude if no certificate
Algeria	Upper middle income	Exclude if no certificate
Antigua and Barbuda	High income	No entry
Australia	High income	No entry
Bahrain	High income	No entry
Belize	Upper middle income	No entry
Botswana	Upper middle income	No entry
Cabo Verde	Lower middle income	No entry
Cameroon	Lower middle income	No entry
Canada	High income	No entry
Central African Republic	Low income	No entry
Chad	Low income	No entry
Colombia	Upper middle income	No entry
Dominica	Upper middle income	No entry
Dominican Republic	Upper middle income	No entry
Equatorial Guinea	Upper middle income	No entry
Gabon	Upper middle income	No entry
Gambia	Low income	No entry
Guyana	Upper middle income	No entry
Haiti	Low income	No entry
Indonesia	Lower middle income	Exclude if no certificate
Iraq	Upper middle income	Exclude if no certificate
Jamaica	Upper middle income	No entry
Kazakhstan	Upper middle income	Exclude if citizen of Ebola-affected country
Kenya	Lower middle income	No entry
Kiribati	Lower middle income	Entry but mandatory quarantine
Korea (Democratic People's Republic of)	Low income	Entry but mandatory quarantine
Korea (Republic of)	High income	Entry but mandatory quarantine
Kuwait	High income	No entry
Maldives	Upper middle income	No entry
Mauritania	Lower middle income	No entry
Mauritius	Upper middle income	No entry
Micronesia (Federated States of)	Lower middle income	No entry
Mongolia	Lower middle income	No entry
Namibia	Upper middle income	No entry
Nauru	High income	No entry
Nepal	Low income	Exclude if no certificate

Continued

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Table 1: *Continued*

Country	Income classification	Entry restrictions
Nicaragua	Lower middle income	Entry but mandatory quarantine
Panama	Upper middle income	No entry
Peru	Upper middle income	Exclude if no certificate
Philippines	Lower middle income	Entry but mandatory quarantine
Qatar	High income	No entry
Romania	Upper middle income	No entry
Rwanda	Low income	No entry
Saint Kitts and Nevis	High income	No entry
Saint Lucia	Upper middle income	No entry
Saint Vincent and the Grenadines	Upper middle income	No entry
Sao Tome and Principe	Lower middle income	No entry
Saudi Arabia	High income	No entry
Serbia	Upper middle income	Entry but mandatory quarantine
Seychelles	High income	No entry
South Africa	Upper middle income	No entry
South Sudan	Low income	No entry
Suriname	Upper middle income	No entry
Trinidad and Tobago	High income	No entry
Turkmenistan	Upper middle income	Exclude if no certificate
Tuvalu	Upper middle income	Exclude if no certificate
Zambia	Lower middle income	No entry

Notes: Adapted from Wendy Rhymer & Rick Speare, "Countries' Response to WHO's Travel Recommendations during the 2013–16 Ebola Outbreak" (2017) 95 Bulletin of the World Health Organization 10 at 12; World Bank, *World Bank Country and Lending Groups* (2017), online: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519>.

the *IHR* given its status as a high-income country, a previous champion of revising the *IHR* in 2005 to include the exact provisions the country subsequently violated, and as a global health leader that other countries routinely watch and follow.

Re-Evaluating the *IHR*

Following the 2005 *IHR* revision, states parties cannot unnecessarily interfere with international traffic and trade and can only implement additional health measures beyond the WHO's recommendations if justified under Article 43 of the *IHR*. This international legal instrument aims to strike a balance among states parties: in order to avoid disincentivizing affected states from underreacting and failing to report PHEICs, unaffected states are required to avoid overreacting and significantly interfering with

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international traffic and trade. The Ebola outbreak, however, demonstrated major weaknesses in the *IHR*'s ability to maintain this balance.

Observers seem to unanimously note that the Ebola outbreak was a "disaster" for the *IHR*'s legal and moral authority.[73] Many states parties deviated from the spirit if not also the letter of the legally binding *IHR*, particularly Article 2 that requires state parties to avoid unnecessary interference with international traffic and trade.[74] Canada's, and probably several other states parties', additional health measures violated Article 43's requirements that such measures only be adopted when supported by public health rationales, scientific principles and evidence, or by the WHO's guidance or advice.[75] The final report of the WHO's Ebola Interim Assessment Panel consequently suggested bolstering the WHO's authority to enforce *IHR* compliance, including proposals to sanction violating states.[76] This echoes the *IHR* Review Committee's previous suggestions in 2011 to address the *IHR*'s "lack of enforceable sanctions" and analyses from scholars identifying mechanisms for doing so.[77] Regrettably, WHO member states did not implement these repeated recommendations before the 2014–16 Ebola outbreak.

To address the need for increased *IHR* compliance, the Ebola Interim Assessment Panel's final report requested that the *IHR* Review Committee for Ebola and the UN Secretary-General's High-Level Panel on the Global Response to Health Crises examine options for implementing sanctions, similar to those of the World Trade Organization, to deter *IHR* violations.[78] The panel's other suggestions included procedures for the UN Security Council to enforce *IHR* compliance under Chapter VII of the *UN Charter* for outbreaks deemed to be threats to international peace and security.[79] The WHO director-general similarly reiterated her support for creating

[73] David P Fidler, *Ebola Report Misses Mark on International Health Regulations*, Commentary (17 July 2015), online: Chatham House <http://www.chathamhouse.org/expert/comment/ebola-report-misses-mark-international-health-regulations>.

[74] *IHR*, *supra* note 3, art 2.

[75] Fidler, *supra* note 72.

[76] WHO, *supra* note 14 at 12.

[77] WHO, *Report of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009* (5 May 2011), online: <http://apps.who.int/iris/bitstream/10665/3350/1/A64_10-en.pdf>; Steven J Hoffman, *"Making the International Health Regulations Matter*: Promoting Compliance through Effective Dispute Resolution" in Simon Rushton & Jeremy Youde, eds, *Routledge Handbook on Global Health Security* (Oxford: Routledge, 2014); Trygve Otterson, Steven J Hoffman & Gaëlle Groux, "Ebola Again Shows the International Health Regulations Are Broken" (2016) 42:2–3 Am J L Med 356.

[78] WHO, *supra* note 14 at 12.

[79] *Ibid; Charter of the United Nations*, 26 June 1945, 59 Stat 1031.

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formal arrangements to trigger necessary UN assets to respond to pandemics.[80] Examples such as UN Security Council Resolution 2177,[81] which urged an immediate global response to Ebola, and UN General Assembly Resolution 69/1,[82] which established the UN Mission for Emergency Ebola Relief, bode well for this proposal. International legal scholars have additionally recommended operational reforms within the current *IHR* structure to avoid another prolonged revision process.[83] Namely, experts suggest that the WHO engage in explicit "naming and shaming" of violating states parties and publicly demand justifications for additional health measures.[84] Others encourage states parties affected by travel restrictions to engage in the existing dispute resolution mechanisms under Article 56 of the *IHR*, although these mechanisms have been criticized in light of their sparse use,[85] and some have long recommended ways of strengthening them.[86]

Beyond travel restrictions, the Ebola outbreak highlighted states parties' widespread failure to develop core public health capacities that are also legally required under the *IHR*. The WHO Ebola Interim Assessment Panel's final report noted that, of 196 states parties, sixty-four informed the WHO that they had achieved the minimum standards for core capacities, eighty-one requested deadline extensions, and forty-one failed to communicate their progress.[87] The absence or breakdown of these core public health capacities in Ebola-affected states gave other states parties further incentives to ignore the WHO's recommendations against travel and trade restrictions.[88] As a result, states parties like Canada might have had little sympathy for the WHO's reprimands when other states failed to meet their core public health capacity obligations.[89] Though reasons for failing to meet these

[80] Chan, *supra* note 67.

[81] UN Security Council Resolution 2177, UNSCOR, UN Doc S/RES/2177 (2014).

[82] UN General Assembly Resolution 69/1, UNGAOR, 69th Sess, UN Doc A/69/L.2 (2014).

[83] Lawrence O Gostin, Mary C Debartolo & Eric A Friedman, "The International Health Regulations 10 Years On: The Governing Framework for Global Health Security" (2015) 386 The Lancet 2222; Steven J Hoffman & John-Arne Røttingen, "Split WHO in Two: Strengthening Political Decision-Making and Securing Independent Scientific Advice" (2014) 128:2 Public Health 188.

[84] Gostin, *supra* note 82 at 2225.

[85] Lane Feler, "Ebola Postmortem: Treating the World Health Organization's Regulatory Maladies" (2015) 54 Colum J Transnatl L Bulletin 13 at 26.

[86] Hoffman, *supra* note 76.

[87] WHO, *supra* note 14 at 10.

[88] Fidler, *supra* note 72.

[89] *Ibid.*

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core standards vary, one major barrier is a lack of financial and technical capacity to develop core disease surveillance and monitoring infrastructure in low- and middle-income countries.[90]

Legal scholars argue that such capacity issues often arise when international agreements require states parties to fulfil affirmative obligations.[91] In response, multilateral institutions like the WHO, the World Bank, and G20, as well as civil society organizations like the Bill and Melinda Gates Foundation and the Rockefeller Foundation, can help coordinate financial and technical support to develop these capacities.[92] Article 44 of the *IHR*, in fact, requires all states parties to "collaborate with each other" to provide or facilitate "technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities required under these Regulations" and to mobilize "financial resources to facilitate implementation of their obligations under these Regulations."[93] As a state party and global health leader, Canada must do its part to help poorer countries develop these core public health capacities.[94]

Conclusion

The severity of the 2014–16 Ebola outbreak caused widespread fear and panic, motivating some countries to enact overly broad travel restrictions in breach of the *IHR*, a legally binding instrument that the WHO was unable to enforce. At least fifty-eight states parties implemented additional health measures, of which at least those of Canada and probably several others violated the *IHR*. Specifically, Canada failed to comply with the criteria required under Article 43 of the IHR to institute additional health measures. The Canadian government implemented travel restrictions and airport screening policies contrary to the consensus views of public health authorities, the best available scientific evidence on disease transmission, and the WHO's guidance or advice.

[90] Colin McInnes, "WHO's Next? Changing Authority in Global Health Governance after Ebola" (2015) 91:6 International Affairs 1299 at 1314.

[91] Abram Chayes & Antonia Handler Chayes, "On Compliance" (1993) 47:2 International Organization 193.

[92] Kumanan Wilson, John S Brownstein & David P Fidler, "Strengthening the International Health Regulations: Lessons from the H1N1 Pandemic" (2010) Health Policy and Planning 1 at 4.

[93] *IHR*, *supra* note 5, art 44.

[94] JS Edge & Steven J Hoffman, "Strengthening National Health Systems' Capacity to Respond to Future Global Pandemics" in S Davies & J Youde, eds, *The Politics of Surveillance and Responses to Disease Outbreaks* (Surrey, UK: Ashgate Publishing, 2015) 157.

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Although the *IHR* is an admittedly weak international legal instrument that lacks effective compliance mechanisms, it is still a part of international law and imposes binding legal obligations on its 196 states parties. Canada breached this international legal instrument during the Ebola outbreak and undermined international law more broadly. The fact that several countries probably violated the *IHR* during the Ebola outbreak reinforces the need to craft and implement stronger enforcement mechanisms.[95] This problem, however, may also be symptomatic of deeper systemic issues facing the *IHR* regime. The troubling reality that approximately 70 percent of WHO states parties have not developed core public health capacities to monitor and prevent diseases — as legally required by the *IHR* — demands urgent action to coordinate and finance the necessary health infrastructure to prevent future outbreaks. Article 44 of the *IHR*, in particular, requires that states parties work together to fill gaps in financial and technical resources. Now, more than ever, historic global health champions like Canada must demonstrate their leadership by respecting international health law and assisting efforts to develop global disease surveillance capacities before the next deadly outbreak strikes.

[95] Steven J Hoffman et al, "International Law's Effects on Health and Its Social Determinants: Protocol for a Systematic Review, Meta-Analysis, and Meta-Regression Analysis" (2016) 5:64 Systematic Reviews 1; Steven J Hoffman, Lathika Sritharan & Ali Tejpar, "Is the UN Convention on the Rights of Persons with Disabilities Impacting Mental Health Laws and Policies in High-Income Countries? A Case Study of Implementation in Canada" (2016) 16:1 BMC International Health and Human Rights 1; Steven J Hoffman et al, "Strategies for Achieving Global Collective Action on Antimicrobial Resistance" (2015) 93:12 Bulletin of the World Health Organization 867; Steven J Hoffman, John-Arne Røttingen & Julio Frenk, "Assessing Proposals for New Global Health Treaties: An Analytic Framework" (2015) 105:8 American Journal of Public Health 1523; Steven J Hoffman & John-Arne Røttingen, "Assessing the Expected Impact of Global Health Treaties: Evidence from 90 Quantitative Evaluations" (2015) 105:1 American Journal of Public Health 26; Steven J Hoffman & Trygve Ottersen, "Addressing Antibiotic Resistance Requires Robust International Accountability Mechanisms" (2015) 43:2 Journal of Law, Medicine & Ethics 53; Steven J Hoffman & John-Arne Røttingen, "Assessing Implementation Mechanisms for an International Agreement on Research and Development for Health Products" (2012) 90:11 Bulletin of the World Health Organization 854.