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Between rules and resistance: moving public health emergency responses beyond fear, racism and greed

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ABSTRACT

In times of a public health emergency, lawyers and ethicists play a key role in ensuring that government responses, such as travel restrictions, are both legally and ethically justified. However, when travel bans were imposed in a broadly discriminatory manner against southern African countries in response to the Omicron SARS-CoV-2 variant in late 2021, considerations of law, ethics or science did not appear to guide politicians' decisions. Rather, these bans appeared to be driven by fear of contagion and electoral blowback, economic motivations and inherently racist assumptions about low-income and middle-income countries (LMICs). With a new pandemic treaty and amendments to the WHO's International Health Regulations (IHR) on the near-term horizon, ethics and international law are at a key inflection point in global health governance. Drawing on examples of bordering practices to contain contagion in the current pandemic and in the distant past, we argue that the current IHR is not adequately constructed for a just and equitable international response to pandemics. Countries impose travel restrictions irrespective of their need or of the health and economic impact of such measures on LMICs. While the strengthening and reform of international laws and norms are worthy pursuits, we remain apprehensive about the transformative potential of such initiatives in the absence of collective political will, and suggest that in the interim, LMICs are justified in seeking strategic opportunities to play the same stark self-interested hardball as powerful states.

SUMMARY BOX

⇒ Over the course of the COVID-19 pandemic, states frequently implemented a variety of restrictions on international travel in attempts to control the importation and spread of the virus, often without providing ethical or legal justifications.
⇒ The most glaringly ineffective and non-justifiable of these bans were implemented in response to the emergence of the Omicron SARS-CoV-2 variant in late 2021.
⇒ Contextualised within a broader ethos of colonialism in which global health governance operates, we argue that given the global community's apparent proclivity for running roughshod over international legal agreements, reforms to the International Health Regulations and development of a pandemic treaty are likely to have little influence if states continue to ignore cooperation and solidarity as key normative principles in response to public health emergencies.
⇒ In the absence of international legal instruments capable of producing equitable arrangements, low-income and middle-income countries adversely impacted by unjust travel restrictions are ethically justified in employing options of strategic resistance as a means of protecting their own interests and levelling the uneven power differentials that exist within the structures of global health governance.

INTRODUCTION

In times of a public health emergency, lawyers and ethicists play a key role in ensuring that government responses, such as travel restrictions, are both legally and ethically justified. At the outset of the COVID-19 pandemic, we set out to examine how public health emergency responses could be guided more effectively by considerations of evidence, necessity, proportionality, and fairness derived from law and ethics. Yet, when travel bans were imposed in a broadly discriminatory manner against southern African countries in response to the Omicron SARS-CoV-2 variant in late 2021, considerations of law, ethics or science did not appear to guide politicians' decisions. While Omicron-related travel restrictions were particularly unjustified, other examples during COVID-19 and past epidemics suggest that decisions to implement travel restrictions tend to be driven by fear of contagion and electoral blowback, economic motivations, and even inherently racist assumptions about low and middle-income countries (LMICs), rather than by evidence, fairness or legal obligation.[1–4] It is therefore unclear what role, if any, careful legal and ethical analyses (where the former often

codifies the latter) have to play in guiding decision making around travel restrictions during a public health emergency.

With a new pandemic treaty and amendments to the WHO's International Health Regulations (IHR) a near-term possibility,[5] global health law and governance are fast approaching a key inflection point. The decisions world leaders make today will shape the global response to looming disease outbreaks of tomorrow and may profoundly influence the legitimacy and utility of global health law and global health ethics in the future. In the absence of effective legal reform, and perhaps even with it, we argue that it may be more effective and ethically justifiable for LMICs and civil society to deploy strategic resistance when it comes to activities that may trigger unjustifiable travel restrictions, such as sharing access to pathogens, viral samples and sequencing data. As we explain below, strategic resistance may better influence decision-making than normative criteria from ethics and law (though, such norms will continue to support and justify such actions), thereby better ensuring equitable outcomes for LMICs.

We begin this paper by surveying the colonial underpinnings of infectious disease governance and law. We then argue that the global response to Omicron demonstrates colonialism's continuing impact on global health governance, alongside a host of other economic, political and sociocultural determinants of poor health and poor governance. Omicron has irreversibly presented the world with two possible pathways for improving infectious disease governance: (1) making the consensus-based global health architecture more robust (eg, strengthening enforcement mechanisms) through legal reform and (2) attenuating the influence of carefully negotiated legal and ethical norms and counterbalancing the biases and distortions of global health politics through strategic resistance from key LMIC actors. We conclude that the ineptitude and lack of solidarity shown by wealthier states in pandemic responses justify the provision of advice from legal scholars and ethicists that inverts power structures and levers of influence, even if such strategic resistance might do no better to strengthen international cooperation to protect the world from perilous future pandemics.

CROSS-BORDER INFECTIOUS DISEASE CONTROL: A TAINTED HISTORY

The IHRs were developed over more than a century of multilateral efforts to contain the international spread of infectious diseases while preserving economic flourishing and trade, particularly in Europe.[6] Its precursors, a series of political agreements and international treaties and regulations developed between 1851 and 1944, saw European powers and, progressively, states from other regions agreeing to standardise international quarantine regulations against the spread of specific diseases such as cholera, plague and yellow fever.[7] While diplomats negotiating these precursor agreements often spoke of human vulnerability to infectious disease in 'a shrinking and boundless world',[8] the diplomatic discourse of the International Sanitary Conferences of 1851–1894 was tinged with condescension towards Middle Eastern and Asian countries and preoccupied with protecting Europe from the Asiatic threat of cholera posed by Muslim pilgrims, Indians and others.[9] While the official raison d'être of 19th century cooperation on infectious disease threats was to protect against such threats while minimising disruptions to trade and travel, in practice it was to preserve commercial relations in a world where 'ever larger sums of European money depended on rapid passages across borders'.[8 10 11] Delegates to the sanitary conferences did not really aim to create a borderless world, but rather a world with 'semipermeable membranes' to protect Europe without harming its interests in trade and expansion.[8]

Today, the IHR continues to explicitly pursue a balance between promoting public health and protecting international trade and economic interests[12 13]. The IHR aimed to move beyond this chequered colonial history: unlike the International Sanitary Conferences, which were poorly attended by most countries of the world, versions of the IHR formed under the auspices of the World Health Assembly (WHA) have been negotiated among all WHO Member States. However, the influence of the IHR's antecedents have not been erased. As Ntina Tzouvala has argued, nineteenth century forms of legal reasoning were brought into modernity through the United Nations.[14] Although the IHR prescribe legal parameters for the implementation of travel restrictions in accordance with scientific evidence, WHO recommendations and guidance, and international human rights law, the power to determine what constitutes a legitimate public health response rests primarily with individual countries and, in practice, with countries in the Global North. This relic of international law's colonial origins was laid bare most recently by the world's experience with the Omicron variant, and the discriminatory travel bans imposed on southern African countries in its wake.

THE EMERGENCE OF OMICRON AND THE RAPID IMPLEMENTATION OF TRAVEL BANS

In late November 2021, as the world continued to grapple with the Delta variant, scientists in a private laboratory in South Africa conducting routine genetic sequencing of COVID-19 samples detected genetic mutations unlike those seen previously in SARS-CoV-2.[15] This detection coincided with a sharp uptick in observed cases throughout the country, raising alarm about a potential new variant. Days later, after other laboratories had been notified to watch for this sequence, reports throughout the country rapidly began confirming similar sequences. By 24 November 2021, scientists in South Africa notified

the WHO of their findings.[15] After reviewing the evidence, the WHO quickly designated a new variant of concern (VOC) on 26 November 2021, later named 'Omicron'.[16]

As news broke globally, countries around the world (particularly high-income countries, HICs) quickly instituted travel bans on countries in southern Africa. For example, on the same day that the WHO designated Omicron as a VOC, Canada—and several other HICs in North America, Europe, as well as Australia and New Zealand—banned entry to foreign nationals originating from, or who had recently visited or transited through, several countries in southern Africa. While there were slight variations in the list of specific countries included in the bans, these bans most commonly included South Africa, Eswatini, Lesotho, Botswana, Zimbabwe, Mozambique and Namibia,[17–21] despite no evidence at that stage of Omicron in Zimbabwe or Namibia.[17 18 22] By the end of November, Canada (and several other HICs with Omicron travel bans) added Egypt, Malawi and Nigeria to the list, with no evidence that Omicron was circulating in these countries. In the Canadian context, the federal health minister justified these bans on the presumption that these countries have difficulty tracking what is happening within their countries.[23 24] Statements from other world leaders suggest that similar sentiments were held by other countries implementing these bans. The foregoing reveals that these bans were, at least to some extent, being driven by elements of colonially-derived fear and racism, especially when one considers that Omicron bans were not exacted against HICs, despite evidence that Omicron was already present in, at the very least, the Netherlands before South Africa even informed the WHO, and was circulating in Belgium in mid-November.[17 18 25] Of course, it could be argued that other factors such as geography, local economies, health system capacities and local histories of other infectious disease management may be contributing factors to the decision to implement travel restrictions against some countries over others. While this may be true, it also must be acknowledged that many of these factors are in themselves products of colonialism.

These bans were largely expected to be in place through January 2022.[17 21] However, by early December, many of these HICs began to detect the Omicron variant locally. In most instances, while initial cases were detected in people with recent travel histories, many returning travellers had not visited any of the banned African countries. After realising Omicron was already circulating domestically, many countries lifted their bans earlier than previously stated timelines,[26] with Canada and the USA dropping their bans on 18 and 31 December, respectively, while the European Union (EU) did not drop their ban until 10 January 2022.[26–28]

These bans fell short of IHR article 43's requirement, examined in detail in previous literature, which stipulates that states must base their health measures on scientific principles, evidence, and WHO recommendations and guidance, and that such measures 'not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection.'[12] It defied scientific reasoning, for instance, for states to block the entry of travellers arriving from entire swathes of a continent, including many countries without a single recorded case of the Omicron variant, even as European travellers from countries known to be affected enjoyed unfettered access to travel across the globe. Consequently, the WHO's Emergency Committee reiterated their opposition to blanket travel bans on grounds that they are generally ineffective in mitigating public health emergencies and 'contribute to the economic and social stress experienced by States Parties'.[29] More fundamentally, however, the case of travel bans during Omicron exposed the racist and neocolonial attitudes that lace state responses to an ongoing pandemic, even when beckoned by legal obligation and ethical consideration to do differently.[30 31]

THE FUTURE OF INFECTIOUS DISEASE GOVERNANCE AND LAW

Several proposals are under consideration at the WHO to reform global health governance and law for better pandemic prevention, preparedness response and recovery. Given the global community's apparent proclivity for running roughshod over international legal agreements, we argue that these initiatives are likely to have little influence if states continue to calibrate their response to public health emergencies through unjust power differentials rather than through cooperation and solidarity. Indeed, state behaviour during the COVID-19 pandemic (leading up to and including the response to the Omicron variant), as well as in previous public health emergencies of international concern, persistently demonstrate states' widespread disregard of article 43 of the IHR, despite continued guidance from the international community of legal experts, ethicists and officials at the WHO.[30–33] We envision two different pathways for moving forward: on the one hand, countries may opt for new and reformed legal instruments with strengthened sanctions in the event of non-compliance or consequences for non-compliance. Alternatively (or additionally), any such rules should be approached with a 'realistic' acknowledgement that if we are to make equity, solidarity, and fairness matter in pandemics, we need both better norms and mechanisms for accountability as well as expanded options to enable strategic resistance by LMIC actors when unjust power differentials impede the advancement of their domestic public health interests.

Strengthening IHR article 43 through legal reform and enforcement mechanisms

The multiyear global struggle with COVID-19 has exposed critical IHR weaknesses that long predated the pandemic, and catalysed multilateral interest in (1) reforming the IHR and (2) negotiating an entirely new legal instrument on pandemics. It is worth

reviewing whether either of these proposed pathways has the capacity to resolve longstanding weaknesses in the global response to infectious diseases.

In the early response to COVID-19, IHR reform was a tentative but largely dismissed possibility: in 2021, the expert committee tasked with reviewing IHR performance during COVID-19 recommended strengthening implementation through, *inter alia*, robust accountability, earlier alerts, financing, and cooperation,[34] acknowledging that similar recommendations by three previous IHR review committees had been ignored.[34] The committee's recommendations on travel restrictions were to apply the precautionary principle to 'enable early action against an emerging pathogen with pandemic potential,'[34] even as they acknowledged that "more scrutiny is needed to ensure that public health measures are necessary, proportionate and non-discriminatory."[34]

Meaningful IHR reform was similarly bypassed by the WHO Director-General's Independent Panel for Pandemic Preparedness and Response, which proposed adopting a 'Pandemic Framework Convention' complementary to the IHR to 'address gaps in the international response, clarify responsibilities between States and international organisations, and establish and reinforce legal obligations and norms.'[35] Following a Special Session of the WHA in late 2021, delegates established an Intergovernmental Negotiating Body (INB) tasked with drafting this new legal instrument and identifying its substantive elements through an inclusive yet largely Member State-led process.[36] Since then, indications of potential content have emerged from various proposals issued by WHO Member States, the EU and regional blocs,[37] as well as by the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR), established in 2021 by the WHA, to, *inter alia*, assess the benefits of developing a new WHO legal instrument.[38] The WGPR's May 2022 report to the 75th WHA in particular advised the INB to consider addressing a range of issues within this new legal instrument that complement the IHR, such as adequate investments to build vaccine and therapeutics development and manufacturing capacity, the timely and equitable sharing of data and pathogens and strengthening health systems capacity and universal health coverage.[5] In turn, the INB featured each of these subjects in the early conceptual draft of the treaty, which was released at the time of writing.[39]

More importantly, the WGPR was seized by the most recent WHA to 'work exclusively on consideration of proposed IHR targeted amendments…with a view to their adoption by consensus at the Seventy-seventh (WHA)'.[5] In January 2022, WHO's Executive Board urged Member States to consider potential IHR amendments, including in relation to 'equity, technological or other developments, or gaps that could not effectively be addressed otherwise but are critical to supporting effective (IHR) implementation and compliance… and their universal application for the protection of all people of the world from the international spread of disease in an equitable manner.'[40] Subsequently, the WHO Director-General also expressed formal support for targeted IHR amendments, including by bringing more specificity in relation to information sharing and capacity building obligations, and streamlining the process for future IHR amendments.[41]

Despite expert, Member State and Secretariat views coalescing around the need for IHR amendments, substantive proposals tabled by Member States thus far have not escaped the shackles of global politicking: On 18 January 2022, in accordance with stipulated IHR timelines, the USA proposed a raft of IHR amendments—including some with tangential implications for international travel—for the consideration of the WHA in May 2022.[42] The Russian Federation subsequently introduced its own set of proposed IHR amendments on 31 March—although these were not produced quickly enough to be disseminated at the 2022 WHA.

Owing to a lack of global consensus, neither the US nor any other substantive Member-State proposals made their debut at the 2022 WHA.[43] Discussions on IHR amendments largely centred on reforming the amendment *procedure* codified under IHR Article 59. This now-passed proposal would give Member-States 10 months—instead of 18—to lodge reservations or rejections to any future IHR amendments. It would also imply that amendments approved by the WHA would enter into force within 12 months, as opposed to 24—effectively enabling future reforms to take worldwide effect a year sooner that what current terms would allow.[42]

How, then, to assure that in future pandemics, travel restrictions are held to legal and ethical standards of necessity, proportionality and fairness? With recent empirical evidence suggesting that international treaties lacking in enforcement mechanisms do not achieve intended outcomes,[44] it is probable that holding countries accountable to such standards will require embedding effective sanctions for state non-compliance under the IHR. Yet, as the above analysis suggests, countries are unlikely to reach consensus on meaningful legal reforms of the IHR to incentivise science-based and equity-based travel restrictions. And even if they do, any legal reforms agreed to will require several more years to take effect. Novel pathogens will not wait for international law to change before making their next debut on the global scene. Against this backdrop, an alternative path may be necessary: strategic resistance.

Utilising ethically justified forms of strategic resistance

In the absence of more robust legal mechanisms, countries responding to future health crises in the near-term are likely to continue acting in their own

self-interest irrespective of the cost to LMICs. We thus propose as an alternative (or complement) to existing legal and ethical frameworks, a set of options for strategic resistance that countries commonly on the losing end during global health crises should consider ethically justified to enhance the equity, solidarity, and fairness of such responses. To be clear, we argue that strategic resistance is justified in the context of historical and ongoing inequality (e.g., in vaccine access and distribution), when there is low confidence that cooperation will lead to benefit sharing, when other states are acting in bad faith, and when there is 'path dependency'—that is, when countries continue to engage in the same harmful policy responses (e.g., punitive and discriminatory travel bans) with each new outbreak, rather than exploring a new and solidaristic response.

The COVID-19 pandemic has demonstrated that effective global outbreak management is largely dependent on effective rapid pathogen-sharing between countries and with international organisations, such as the WHO.[45] However, currently, there are no legal obligations for countries to share physical samples or sequencing data. Rather, countries tend to share this information in the spirit of solidarity and scientific progress.[45] Thus, from a global solidarity, cooperation, and open science perspective, despite having no legal obligation to do so and despite the risk of severe repercussions, one should conclude that South Africa acted appropriately in swiftly notifying the WHO of a new variant and sharing viral samples and sequencing data.[46] But what if the country had withheld this information from the global community and used this information as leverage to negotiate fairer terms for access to therapeutics, vaccines, and diagnostics? Where disadvantaged global actors regularly contribute to the common good with little or no commensurate reciprocation, we suggest that it could be ethically justified for them to attempt to shift power differentials by strategically leveraging the power of civil society in human rights spaces and force a rethinking of global governance structures. Sharing data, samples, and other information is ethically justified through appeals to solidarity and reciprocity; however, if such norms are not followed by those in power, there is at least a *prima facie* reason to question whether those countries with traditionally less power are obligated to do so, or at least, in the manner in which this is currently done. This is not to suggest that engaging in strategic resistance does not introduce potential negative consequences or that we should not be concerned that HICs could use strategic resistance to justify non-cooperative behaviour to suit their own ends. As these circumstances would not fit within the conditions outlined above, the use of strategic resistance would not be justified. Moreover, one could argue that there is a tension between engaging in strategic resistance and upholding the values of solidarity and reciprocity. We suggest that solidarity still stands, but it stands among those who are willing to cooperate. More specifically, strategic resistance still realises in-group solidarity as it would promote a solidarity based on reciprocity, or rather, a history of trust and reciprocation.

Strategic resistance by LMICs need not entail a failure to uphold any commitment under the IHR, though if it does, such failures could be considered no worse than the recurring failures of HICs to uphold their own IHR commitments. When HICs prompt a rupturing of *pacta sunt servanda*—the general principle of international law requiring that agreements be upheld—they leave the door open to a range of ensuing arguments for LMICs' non-compliance with legal obligations—from obsolescence of the IHR regime to the necessity to uphold the right to health of their own people (for instance, by demanding benefit-sharing commitments as a precondition to the sharing of information).[47] States could implement strategic resistance through existing power structures, including at the WHO. The WHO has previously opposed travel bans for being ineffective in public health emergencies,[48] a position they reiterated during Omicron when Matshidiso Moeti—WHO's regional director for Africa—called on countries to follow the science and the IHR and to stop unfairly punishing southern African countries with travel restrictions.[49] Moeti further praised South Africa for following the IHR and their expeditious notification of the new variant to the WHO.[49] The WHO is clearly sympathetic to the negative repercussions a country may face for upholding their duty to report. While there are examples of countries withholding samples due to concerns they will be used by companies in wealthy countries to develop products that less wealthy countries cannot afford—Indonesia's 2007 decision to stop sending H5N1 influenza viruses to the WHO's reference lab serving as a prime example[50]—the WHO has yet to support a country doing so on the condition of fair process from the global community; however, it can be argued that there would be significant precedent-setting power in the WHO supporting such a move in the absence of enforceable mechanisms for benefit sharing.

The concept of strategic resistance in the context of infectious diseases is not new. One of the biggest lessons learnt from the HIV/AIDs crisis of the 1980s through to treatment campaigns of the 2000s was a greater understanding of the role that civil society actors can play in advancing rights and equity-based initiatives to advance global health and the interests of the least advantaged.[51–53] Civil society organisations (CSOs) have a strong record of working in spaces where intergovernmental organisations (IGOs), and, to some extent, States, face challenges in balancing mutual and collective interests.[52] Moreover, since the 1990s, there has been growing support within IGOs for involving CSOs in global health governance structures,[54] with Margaret Chan—Former Director General of the WHO—stating in 2007:

> 'Given the growing complexity of these health and security challenges and the response required, these issues concern not only governments, but also international organizations, civil society and the business community. Recognizing this, the World Health Organization is making the world more secure by working in close collaboration with all concerned'.[52]

As CSOs are not beholden to the same balancing of interests, they are positioned to advance equity and rights-based arguments both within these organisations and in the political arena more broadly. We argue that given the increased role of these CSOs in global health governance, the power of CSOs could be further leveraged to support acts of strategic resistance by countries in LMICs during public health emergencies. This resistance will sometimes necessitate opposing hegemonic norms or policies, but it ought not be limited to mere advocacy.

Another form of strategic resistance pushes for a re-thinking of the structures of global health governance. The current system of global health governance is largely determined by inter-governmental and international organisations such as the World Bank, the WHO and the International Monetary Fund. The rules, resources, and institutions of this architecture are often influenced more readily by political and economic power than by global health priorities (and these priorities are skewed accordingly).[54] Given the power wielded by these organisations, those that are willing to work in solidarity with LMICs could use their clout to advance necessary changes by supporting the act of strategic resistance, if required. For example, the WHO provides normative guidance to its Member States. In its normative guidance, the WHO could explicitly support strategic resistance among LMICs to achieve global health aims. Moreover, the push in recent years to decolonise global health methods, institutions and norms emerges in large part from recognition of these power differentials and their historical and contemporary roots in colonialism and neoliberalism.[55 56] If the global health community is to take this decolonisation seriously, we need to ensure that researchers and CSOs from LMICs, who understand their needs and local contexts much better than their counterparts in HICs can ever hope to, are not simply given a seat at relevant tables but that their needs and interests are prioritised and drive agendas. In short—and to extend the metaphor—decolonisation requires a new table, one created by those in LMICs. In such a context, those of us in the HICs must cede space and follow the lead of our colleagues in the South, proffer legal and ethical justifications in support of resistance that strategically leverages their needs and interests, and intervene when called on, not when we think we are needed or when it is convenient for us.

CONCLUSION

Travel restrictions through the pandemic response and especially under Omicron show that the IHR as constructed is not fit for purpose. Countries impose travel restrictions irrespective of their need or health and economic impact on LMICs. These responses during COVID-19 have considerably delegitimised the IHR in many respects, and the need for better and stronger law is evident in ongoing efforts to reform the IHR and create a pandemic treaty. Yet, COVID-19 has also illustrated that while better law is essential for future pandemics, LMICs should consider playing from the same rulebook as HICs if their health interests are to be realised. We realise this approach threatens to exacerbate an already lawless world of self-interest and nationalism. Yet, the predations of COVID-19 suggest that LMICs cannot and should not wait for the creation of utopian laws to protect their interests. Ethics, law, and indeed, global health, requires that LMICs seek strategic opportunities to play the same stark self-interested hardball as powerful states.

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