

Comment

Coordination remains critical to effective global response to COVID-19

Kelley Lee
Faculty of Health Sciences
Simon Fraser University
Blusson Hall, 8888 University Drive
Burnaby, BC V5A 1S6 Canada
Email: kelley_lee@sfu.ca

Catherine Worsnop
University of Maryland School of Public Policy
2101 Van Munching Hall
College Park, Maryland 20742 USA
Email: cworsnop@umd.edu

Karen Grépin
School of Public Health
University of Hong Kong
UB/F, Patrick Manson Building, 7 Sassoon Road
Pok Fu Lam, Hong Kong
Email: kgrepin@hku.hk

Adam Kamradt-Scott
Centre for International Security Studies
University of Sydney
Sydney NSW 2006 Australia
Email: adam.kamradt-scott@sydney.edu.au

Corresponding author: Kelley Lee

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Declaration of Interests

KL was a member of two donor-funded reviews of WHO in 1995 and 1997. She has previously received funding from WHO to conduct research on global health governance and global tobacco control, and review evidence on the impacts of globalization and infectious diseases. CZW was a member of a WHO guideline development group and technical consultation in 2019. AKS served as a volunteer with the WHO in 2018, and WHO committee on travel and trade issues during outbreaks.

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Comment

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When the World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak as a public health emergency of international concern (PHEIC) on 30 January 2020, under the provisions of the International Health Regulations (IHR), it recommended against “any travel or trade restriction”.¹ The recommendation, based on data available at the time, evidence from previous outbreaks, and key principles underpinning the IHR, formed an important part of WHO’s messaging about how states could effectively respond to the emerging risk in a coordinated fashion. Instead, over the following two months, all 194 member states adopted some form of cross-border travel restriction, with little reproach from WHO or other actors in the international community.² This is a sharp increase from the 25% of countries that did so during the H1N1 (2009) and Ebola (2014) virus outbreaks.³ Indeed, WHO’s recommendation against such restrictions became a point of criticism of the organization’s role at the early stages of the pandemic.⁴

The universal adoption of travel restrictions raises fundamental questions about what coordination means during a pandemic, and what role WHO can play in facilitating this. It is widely agreed that coordinated action among states, in an interconnected world, underpins effective prevention, detection and control of outbreaks across countries. Governments also agree that coordination is critical to ensure that measures do not unnecessarily disrupt international trade and travel.⁵ Thus, during major outbreaks, part of WHO’s role is to provide evidence-informed guidance on cross-border measures.

A wider variety of cross-border measures have been adopted by a higher number of countries during COVID-19 than past outbreaks. Though not all technically fall under the IHR, these patterns of adoption point to several knowledge gaps. First, what measures have been adopted over time and space, not only by member states, but companies such as airlines and cruise ships? While companies do not fall under the remit of the IHR, their actions have had clear consequences. There is need to track the full range of cross-border measures (Table 1) adopted during the pandemic, the specific requirements they impose, and (for member states) consistency with the IHR.

Second, the diverse impacts of cross-border measures are not well-understood. From a public health perspective, the focus has been on the impact of travel restrictions on preventing disease transmission for which evidence is decidedly mixed. Some studies suggest restrictions can sometimes delay spread,⁶ while others report negligible effects on overall cases.⁷ However, studies have not compared effectiveness across outbreaks caused by different pathogens and focused only on containment, but not the mitigation or suppression phases of an outbreak. Other studies suggest certain measures can

be counterproductive by discouraging disclosure of potentially relevant information, by individuals during screening, and by governments wishing to avoid being the target of restrictions.⁸ Forced quarantines, visa restrictions and flight cancellations may hinder the movement of health workers and essential supplies.⁹ Importantly, cross-border measures have wider economic, social, legal and ethical impacts. Protectionist trade and travel restrictions may maintain public and investor confidence in some affected countries, but may contribute to economic strain and poorer health outcomes in other affected countries, further hindering response efforts. To date, the extent to which these effects vary, by nature of the public health threat and the context in which it occurs, has not been studied.

Third, beyond public health rationales, explanations for why governments adopt cross-border are limited to two broad perspectives: economic interests and political pressure to “do something”. However, decision-making behind the unprecedented number and range of cross-border measures adopted during this pandemic needs fuller explanation. Complex considerations may be at play - the perceived nature of the outbreak; evolving knowledge about the pathogen; lack of clarity of WHO recommendations; timing of the PHEIC declaration; uncertainty over the efficacy of specific measures; trust in public health officials; geopolitical dynamics; and epidemiological trends over time.

Protecting public health while minimising unnecessary interference with travel and trade has been a core principle of the IHR since adoption by WHO member states in 1951. This longstanding goal – which member states collectively supported by signing onto the revised IHR (2005) - should not be abandoned lightly.¹⁰ Instead, assessing the future of this principle under the IHR requires a comprehensive accounting of what cross-border measures have been adopted during the COVID-19 and past outbreaks, how these measures impact on public health and wider society, and what factors influence decision making.

TABLE 1: TYPOLOGY OF CROSSBORDER MEASURES

International Travel	International Trade	Entry and Exit at National Border
travel warnings	new technical requirements for imported goods (e.g. labelling)	compulsory temperature measurement
travel advisories	expedited importation of selected goods (e.g. ventilators, drugs, PPE)	compulsory questionnaire (e.g. symptoms, travel history)
transportation suspensions (e.g. land, air and sea)	relaxation of regulatory requirements for selected imported goods	voluntary or compulsory quarantine
visa requirement	restrict export of PPE	vector control and surveillance (e.g. spraying)
visa refusal	restrict imports of goods from selected country	distribution of public health information
entry restriction targeting specific population based on travel history, nationality, ethnicity, disease status		mandatory certification (e.g. vaccination, disease free)
entry restriction to all non-nationals		testing
border closures (except essential travel)		

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