

Global coordination on cross-border travel and trade measures crucial to COVID-19 response



When WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC) on Jan 30, 2020, under the provisions of the International Health Regulations (2005) (IHR), it recommended against “any travel or trade restriction”.¹ The recommendation was based on data available at the time, evidence from previous outbreaks, and principles underpinning the IHR. It formed an important part of WHO’s messaging about how states could effectively respond in a coordinated way. Instead, over the following months, according to WHO, 194 countries adopted some form of cross-border measure—eg, travel restrictions, visa restrictions, border closures, among others—with little reproach from WHO or other actors in the international community.² This response is a sharp increase from at most 25% of member states that imposed trade and travel restrictions during the 2009 H1N1 influenza pandemic and the 2013–16 outbreak of Ebola virus disease in west Africa.³ Indeed, WHO’s recommendation against measures such as travel restrictions and border closures became a point of criticism of the organisation’s role at the early stages of the COVID-19 pandemic.⁴

The universal adoption of cross-border measures raises fundamental questions about what coordination means during a pandemic, and what role WHO has in facilitating this. Coordinated action among states in an interconnected world underpins effective prevention, detection, and control of disease outbreaks across countries.⁵ As parties to the IHR, governments agree that coordination is important to ensure that measures do not unnecessarily disrupt international trade and travel. Thus, during major disease outbreaks, part of WHO’s role is to provide evidence-informed guidance on cross-border measures.

A wider range of cross-border measures have been adopted by countries during the COVID-19 pandemic than in past disease outbreaks. Not all these measures fall under the IHR, but patterns of adoption point to several knowledge gaps. First, what measures have been adopted over time and space not only by member states but also by commercial companies such as airlines and cruise ships? Companies do not fall under the remit of the IHR, but their actions have had clear consequences.

There is a need to track the full range of cross-border measures (panel) adopted during the COVID-19 pandemic, the specific requirements they impose, and, for member states, consistency with the IHR.

Second, the impacts of cross-border measures are not well understood. From a public health perspective, research on past outbreaks—and the even more limited research that exists on cross-border measures during COVID-19—has focused on the impact of travel restrictions on the prevention of disease transmission, for which evidence is mixed. Some studies suggest such restrictions can delay disease spread,⁶ whereas other research suggests negligible effects on the overall number of cases.⁷ However, studies have not compared effectiveness of cross-border measures across outbreaks caused by different pathogens and focus only on containment but not the mitigation or suppression phases of an outbreak.^{6,7} Other studies suggest certain cross-border measures are counterproductive because they discourage disclosure of potentially relevant

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Panel: Measures to control cross-border trade and travel related to disease outbreaks

International travel

- Travel warning
- Travel advisory
- Suspend transportation (land, air, and sea)
- Visa requirement or refusal
- Expedite entry of selected foreign nationals (eg, farm labourers, health workers)
- Restrict entry of selected foreign nationals on the basis of nationality, travel history, or health status
- Close national borders in part or whole

International trade

- Restrict import of specific goods from selected country
- Expedite import of selected goods (eg, ventilators, active ingredients for drug manufacturing, personal protective equipment)
- Restrict export of personal protective equipment
- Impose technical requirements for imported goods (eg, labelling, certification)

Entry and exit controls at national borders

- Compulsory temperature measurement
- Compulsory questionnaire (eg, symptoms, travel history, contact tracing)
- Voluntary or compulsory quarantine upon entry
- Voluntary or compulsory testing upon entry
- Distribution of public health information at ports of entry
- Mandatory certification (eg, vaccination, disease free status)
- Vector control and surveillance (eg, spraying at borders or on airplanes)

information by individuals during screening and by governments seeking to avoid being the target of restrictions.⁸ Forced quarantines, visa restrictions, and flight cancellations could hinder the movement of health workers and essential supplies.⁹ Importantly, cross-border measures have economic, social, legal, and ethical impacts that can be inequitably experienced if there is insufficient attention to such impacts. Protectionist trade and travel restrictions might maintain public and investor confidence in some affected countries, but could contribute to economic strain and poorer health outcomes in other affected countries,¹⁰ further hindering response efforts. To date, the extent to which these effects vary in terms of the public health threat and the context in which they occur have not been studied. Probing these effects across different stages of the pandemic is important since COVID-19—and the related cross-border measures—will be with us in some form for longer than other major outbreaks of the recent past.

Third, beyond public health rationales, explanations for why governments adopt travel restrictions are largely limited to economic interests and political pressure to “do something”. However, decision making behind the unprecedented cross-border measures adopted during this pandemic needs fuller explanation. Complex considerations could be at play: evolving knowledge about COVID-19; uncertainty about the source of the outbreak or biases about the origin; insufficient clarity of WHO recommendations;¹¹ timing of the PHEIC declaration; unknown efficacy of specific measures; lack of trust in public health officials; geopolitical dynamics; and epidemiological trends over time. Relatedly, the question of why, when, and how governments decide to lift cross-border measures is largely unexplored in existing research.¹² During the COVID-19 pandemic, most policy attention so far has been on lifting domestic restrictions, but easing cross-border measures—and possibly reintroducing them if there are subsequent waves of new cases—will pose similar challenges for decision makers. Indeed, recent discussion of an Australia–New Zealand “travel bubble”¹³ is one example of the coordination challenge of lifting cross-border restrictions. Protecting public health while minimising unnecessary interference with travel and trade has been a core principle of the IHR since adoption of the International Sanitary Regulations by WHO member states in 1951. This longstanding goal, which

member states collectively supported by signing the revised IHR in 2005, should not be abandoned lightly.¹⁴ Instead, a comprehensive accounting is needed 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. Such information is required to enable evidence-based, real-time decisions on adopting and lifting cross-border measures to mitigate harm during COVID-19 and future outbreaks.

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