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

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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, and the WHO’s own guidelines. Therefore, Canada’s actions were not based on reasonable public health rationales and thus could not be justified under the IHR.

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
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.

**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 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.

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recommendations aim to prevent and control the disease’s international spread while avoiding “unnecessary interference with international traffic and trade.”

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. 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. 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.

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.
8 IHR, supra note 3, art 43.
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

\(^10\) IHR, supra note 3, art 2.
\(^12\) IHR, supra note 3, art 5.
\(^13\) WHO, supra note 4.
\(^16\) IHR, supra note 3, art 43(1).
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 trav-
elers, 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 Act22 on 31 October 2014.23
The government required Citizenship and Immigration Canada (CIC; now
Immigration, Refugees and Citizenship Canada) to stop processing tem-
porary and permanent residence visa applications from foreign nation-
als who had been in Ebola-affected states within three months before
their application date.24 The CIC also stopped processing visa applica-
tions 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
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.
states — Sierra Leone, Guinea, and Liberia — in the previous twenty-one days before arriving in Canada for full health screening and temperature checks.  

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.  

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.  

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.  

Public health authorities


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.” Instead, President Kim added: “[W]e’ve got to get back to putting out the fire.”

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. 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.” 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. 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. 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.” 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.”


Ibid.


Quoted in ibid.


Ibid.

Branswell, supra note 32.
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. 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. 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. 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. Similarly, the study found that implementing travel restrictions after an outbreak would likely delay disease transmission without reducing the total number of people affected. Even a 90 percent reduction in travel would merely slow the spread of the disease by a few days to weeks. 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. Researchers observed that this drop in travel only delayed the infection’s arrival in other states by an average of less than three days. Projections of a 90 percent reduction of travel would delay the infection’s arrival by approximately two weeks.

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38 Ibid.


40 Ibid at 1832.


42 Ibid.

43 Ibid at 5938.


45 Ibid.

46 Ibid.
Despite these travel restrictions, researchers noted that “no containment was achieved … and the virus was able to reach pandemic proportions in a short time.”\footnote{Ibid.} 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.\footnote{Patricia C Priest et al, “Thermal Image Scanning for Influenza Border Screening: Results of an Airport Screening Study” (2011) 6:1 PLoS ONE 1.} 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.\footnote{Ibid.} 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.\footnote{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>.} 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.\footnote{Ibid.} 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.”\footnote{Ministeral Instructions, supra note 7.} It argued that the entry of persons from the affected regions into Canada may introduce or contribute to the spread of Ebola.\footnote{Ibid.} 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.\footnote{Ibid.} Despite Canada’s commitment to “evidence-informed approaches,” epidemiology studies

\footnote{Ibid.}
\footnote{Patricia C Priest et al, “Thermal Image Scanning for Influenza Border Screening: Results of an Airport Screening Study” (2011) 6:1 PLoS ONE 1.}
\footnote{Ibid.}
\footnote{Ibid.}
\footnote{Ministeral Instructions, supra note 7.}
\footnote{Ibid.}
\footnote{Government of Canada, supra note 26.}
International Law and the 2014–16 Ebola Outbreak

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.\textsuperscript{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.”\textsuperscript{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\textsuperscript{57} and that human-to-human transmission, absent direct contact with an infected person, has not been demonstrated.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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 \textit{IHR} by significantly interfering with international travel and trade.


\textsuperscript{57} \textit{Ibid}.

\textsuperscript{58} \textit{Ibid}.

\textsuperscript{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>.

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.”\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{64} In fact, travel restrictions impeded relief efforts by denying travel visas to 165 Cuban medical professionals\textsuperscript{65} and a WHO Global Outbreak Alert and Response Network Team.\textsuperscript{66} In response, the IHR Emergency Committee consistently urged states parties to repeal their unhelpful additional measures.\textsuperscript{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.\textsuperscript{68} Canadian representatives explained that the


\textsuperscript{64} Ibid.


\textsuperscript{67} WHO, supra note 63.

\textsuperscript{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/>.
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. 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.

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. 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).

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

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72 Rhymer & Speare, *supra* note 6 at 12.
**Table 1:** Travel Restrictions against Foreign Nationals during the 2014–16 Ebola Outbreak

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<tr>
<th>Country</th>
<th>Income classification</th>
<th>Entry restrictions</th>
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*Continued*
Table 1: Continued

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<td>South Africa</td>
<td>Upper middle income</td>
<td>No entry</td>
</tr>
<tr>
<td>South Sudan</td>
<td>Low income</td>
<td>No entry</td>
</tr>
<tr>
<td>Suriname</td>
<td>Upper middle income</td>
<td>No entry</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>High income</td>
<td>No entry</td>
</tr>
<tr>
<td>Turkmenistan</td>
<td>Upper middle income</td>
<td>Exclude if no certificate</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>Upper middle income</td>
<td>Exclude if no certificate</td>
</tr>
<tr>
<td>Zambia</td>
<td>Lower middle income</td>
<td>No entry</td>
</tr>
</tbody>
</table>


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
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

74 IHR, supra note 3, art 2.
75 Fidler, supra note 72.
76 WHO, supra note 14 at 12.
78 WHO, supra note 14 at 12.
formal arrangements to trigger necessary UN assets to respond to pandemics.\textsuperscript{80} Examples such as UN Security Council Resolution 2177,\textsuperscript{81} which urged an immediate global response to Ebola, and UN General Assembly Resolution 69/1,\textsuperscript{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 \textit{IHR} structure to avoid another prolonged revision process.\textsuperscript{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.\textsuperscript{84} Others encourage states parties affected by travel restrictions to engage in the existing dispute resolution mechanisms under Article 56 of the \textit{IHR}, although these mechanisms have been criticized in light of their sparse use,\textsuperscript{85} and some have long recommended ways of strengthening them.\textsuperscript{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 \textit{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{89} Though reasons for failing to meet these

\begin{thebibliography}{99}
\bibitem{Chan} Chan, \textit{supra} note 67.

\bibitem{UNSCOR} UN Security Council Resolution 2177, UNSCOR, UN Doc S/RES/2177 (2014).

\bibitem{UNGAOR} UN General Assembly Resolution 69/1, UNGAOR, 69th Sess, UN Doc A/69/L.2 (2014).


\bibitem{Gostin2} Gostin, \textit{supra} note 82 at 2225.


\bibitem{Hoffman} Hoffman, \textit{supra} note 76.

\bibitem{WHO} WHO, \textit{supra} note 14 at 10.

\bibitem{Fidler} Fidler, \textit{supra} note 72.

\bibitem{Ibid} \textit{Ibid}.
\end{thebibliography}
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.  

Legal scholars argue that such capacity issues often arise when international agreements require states parties to fulfil affirmative obligations.  

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. 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.” As a state party and global health leader, Canada must do its part to help poorer countries develop these core public health capacities.

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.

93 IHR, supra note 5, art 44.
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. 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.