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The International Health Regulations, COVID-19, and bordering practices: Who gets in, what gets out, and who gets rescued?

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ABSTRACT
It is often said that "diseases know no borders," but COVID-19 has once again shown that policy responses certainly do. Governments have implemented bordering practices in a variety of ways to ensure that their own citizens are protected, even when in direct contravention to the International Health Regulations (IHR) of 2005. The IHR and the World Health Organization (WHO) have a strong preference for borders to remain open. Yet, we argue here, non-compliance by WHO member states is not the only problem with the IHR's treatment of borders. Bringing insights from critical border studies and exploring the varied ways in which the response to the COVID-19 crisis has been "bordered," we argue that a much broader understanding of "borders" is required in the IHR and by the WHO, given that much of the exclusionary bordering we find takes place away from physical points of entry.

One of the most common phrases in the global health literature is that "diseases know no borders." It has been widely noted that in a globalized world, pathogens spread further and faster than ever before, and that it is virtually impossible for any state to isolate itself from the global circulation of viruses and other disease-causing microbes (e.g., Osterholm & Olshaker, 2017). In theory (and to *some* extent in practice), this has been accompanied by a globalization of disease control efforts. Writing at the time of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003, Fidler famously argued that SARS was the first "post-Westphalian" outbreak, as it was "the first pathogen to emerge into a political and governance environment that differs from what existed at the time of earlier outbreaks" (Fidler, 2003, p. 485). Emblematic of the new post-Westphalian governance environment,

for Fidler, were, first, a move away from state-centric approaches toward a new form of "global health governance" in which states are not the only actors that matter (Fidler, 2003, pp. 488–489); and second, a move away from individual states seeking self-protection and toward the pursuit of "global public goods for health," from which all states would benefit (Fidler, 2003, p. 489). Prime examples of such global public goods for health were global arrangements to prevent, detect, and respond to infectious disease outbreaks.

In tandem with this narrative about the globalization of disease outbreaks and the need for greater international cooperation on disease control has been a process of securitization. Governments around the world have increasingly come to see pathogens not only as public health problems, but as national security threats. Many states have incorporated disease threats and responses into their national security strategies, and in the process security policy communities have taken on new and important roles in national-level preparations for (and responses to) pandemics. Elbe (2010), indeed, has persuasively argued that we have seen both a securitization of health and a *medicalization of security* in which security practices have themselves been changed through the incorporation of medical personnel, knowledge, and technologies (for instance the reconceptualization of pharmaceuticals as security-related technologies).

The tension between these two narratives should be immediately clear. On the one hand, we have an apparent push toward greater global cooperation in which national borders become less central to outbreak response and security is best pursued collectively. On the other, we have a national security framing of disease threats in which defending the nation (and therefore its borders) has taken on a new level of importance.

The revised International Health Regulations (IHR) of 2005, agreed by member states of the World Health Organization (WHO) in the aftermath of SARS, attempted to resolve this tension by institutionalizing the concept of "Global Health Security," which stresses that the security of individual states is dependent on the security of all (Rushton, 2011). The revised IHR are designed to "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and *which avoid unnecessary interference with international traffic and trade* [emphasis added]" (WHO, 2008, Article 2). Furthermore, they are to be implemented with "full respect for the dignity, human rights and fundamental freedoms of persons" (Article 3).

It has been widely noted that the revised IHR of 2005 heralded a shift away from the previous framework's focus on national self-protection through border controls and toward instead assisting countries to contain outbreaks at source. The IHR's overall orientation is firmly against the imposition of

border restrictions–and as we will see below, the WHO has consistently advised against travel and trade restrictions throughout the COVID-19 pandemic. The reasons for this are fourfold. First, border controls were seen as ineffective in keeping disease out–at best delaying importation for a short period. Second, one of the problems that the revision of the IHR was attempting to solve was a tendency for governments to keep outbreaks secret for fear of the economic consequences of travel and trade restrictions being placed upon them. The new IHR sought to prevent this by instituting a reciprocal "deal": Openness about outbreaks in exchange for other countries promising not to implement unnecessarily punitive travel and trade restrictions. Third, it was believed that border closures could hamper outbreak response, making it more difficult for vital supplies and personnel to enter the country to help deal with a health emergency. Fourth, border restrictions were thought to raise dangers for human rights and civil liberties, including the potential for discriminatory practices at points of entry and restrictions on free movement that were not justifiable in public health terms.

In this article, we are interested in exploring what the COVID-19 pandemic so far (writing in mid-May 2020) tells us about the ways in which the IHR conceptualizes borders, in particular through examining practices of "bordering" during the pandemic, and where "bordering happens."[1] Whilst it may be true that pathogens do not recognize national borders, we have seen during this pandemic that policy responses certainly do: Owing in part to securitization, this crisis has seen a reinscription of nationalistic responses and many instances of IHR non-compliant bordering, thereby raising doubts about the sustainability of *collective* notions of Global Health Security during a global crisis.

Our argument is *not* that the IHR are wrong to see exclusionary bordering practices as undermining global cooperation, but rather that bordering practices during the COVID-19 pandemic have highlighted some major limitations in the way the IHR (and the WHO) conceptualize the functioning and location of national borders. First, (at the time of writing) border controls *do* seem to have been relatively effective as a form of response in *some* cases such as in Australia and New Zealand (WHO, 2020e). Second, the genuinely global nature of the pandemic has (at least after the very earliest stages of the epidemic in China) mitigated the problem of travel and trade restrictions disincentivizing reporting. Third, the obstacles to outbreak response have been posed less by problems with restrictions on supplies being allowed *into* countries, and more by restrictions on *what gets out* (restrictions that have been implemented via export controls rather than physically securing the border). Fourth, and finally, nationalistic bordering practices that raise concerns around discrimination and undermine international cooperation have been evident, but in some cases through bordering practices occurring away from physical points of entry (in the example examined below, determining *who gets rescued*).

We seek to show here that insights from Critical Border Studies (CBS) can help us better understand the mismatch between the IHR's approach to borders and what we have seen in practice during this pandemic. The IHR, as they stand, approach borders primarily in physical terms–as points of entry, as lines in the sand–and do not grapple with other "virtual" forms of bordered exclusion. Work in CBS, meanwhile, has long attested to the multiple "ways in which borders … are not necessarily where they are meant to be according to the conventional inside/outside model" (Vaughan-Williams, 2008, p. 63; for an overview, see Parker & Vaughan-Williams, 2012). As Jorry (2007) has argued, "The growing interpenetration of 'internal and external security' highlights the evolution of border controls becoming more and more differentiated, detached from the territorial logic and more targeted at specific groups" (p. 1). Speaking specifically about Europe, Guild (2005) notes that in "both law and practice the border for the movement of persons to and within Europe is no longer consistent with the edges of the physical territory of the member-states" (p. 1). In other words, we need to be looking beyond territorial limits to see demarcation and exclusion "working," as borders are in fact enacted "virtually" through bureaucratic routines at least as much as "physically" through controls at points of entry. For the likes of Guild (2005), the border should be understood to mean *any* site in which such bureaucratic routines are enacted.

What we discuss here is consistent with these insights: A "shift from the concept of the border to the notion of bordering practice; and the adoption of the lens of performance through which bordering practices are produced and reproduced" (Parker & Vaughan-Williams, 2012, p. 729). There *are* "traditional" bordering practices in evidence in response to COVID-19, which are taking place "at the border," and thereby negating (or certainly undermining) the IHR's supposed shift toward containment at source. However, as we show, there is far more at play, and COVID-19 highlights the multiplicity of bordering practices in use as states seek to secure themselves before they look to cooperate internationally. In our view, the IHR are right to view self-interested nationalistic responses such as bordering as a threat to achieving collective security goals; but they would benefit from a much broader understanding of how bordering functions and where bordering happens.

The article proceeds in three parts. We first briefly examine the emergence of the concept of "Global Health Security" in the early 2000s, and the ways in which some of its key ideas were encapsulated in the 2005 revision of the IHR. Those regulations, and the recommendations made by WHO in subsequent years, show a clear preference for borders to remain *open*. In the second section, we examine three ways in which bordering practices have been evident in the COVID-19 response, each of which responds directly to one of the reasons for the IHR regime seeking to avoid border controls. These three practices include regulating *who gets in* (which is covered by the

IHR), *what gets out*, and *who gets rescued* (which are not covered by the IHR). Finally, in the conclusion, we reflect on what COVID-19 has to tell us about bordering, Global Health Security, and whether the limited way in which the WHO and the IHR currently conceptualize border practices can help generate a move away from nationalistic self-interested responses to crises.

Global health security, borders, and the IHR

Attention to the national security dimensions of infectious diseases began to increase in the post-Cold War years. From the early 1990s onward, security policy communities became attuned to a considerably broader range of "new security challenges" beyond "traditional" inter-state conflict: Along with the likes of climate change, information technology, and energy, disease made its way on to both national and international security agendas, necessitating "the allocation of resources, the redefinition of policy priorities, and, sometimes, new institutional architectures" (Nunes, 2015, p. 60).

Despite attempts by proponents of human security to construct a different "referent object," for the most part "the foreign and security policy community maintained a robustly state-centric approach in prioritizing the national interest and international stability when discussing health security issues" (McInnes, 2015, p. 8). Disease's bearing on traditional aspects of national security (primarily the protection of domestic populations, the maintenance of international stability, the health of military forces, and the wellbeing of the economy) was the primary concern. The United States developed its own National Health Security Strategy, predicated on an "interdependent relationship between national security, homeland security, and national health security" (United States Department of Health and Human Services [HHS], 2009). Other countries too incorporated disease into their national security strategies (e.g., HM Government, 2015), and internationally bodies such as the United Nations Security Council (UNSC) endorsed the idea that disease is a matter of international peace and security, including in 2000 when it stated that AIDS "if unchecked may pose a risk to stability and security" (UNSC, 2000; see also McInnes & Rushton, 2010), and in 2014 when it formally declared that the Ebola outbreak then underway in West Africa constituted at threat to international peace and security (UNSC, 2014).

Although this relatively narrow national security-based conception of health security has dominated, there were other attempts (aside from human security) to change the referent object–or at least to broaden the scope of what "health security" might mean in practice. Most prominently, WHO has actively promoted the idea of "Global Health Security" since the early 2000s, seeking to forward what is in effect a vision of collective security in which the national security of each member state rests on the security of the whole, and in which international cooperation is key.

In April 2001, the World Health Assembly received a report from the WHO Secretariat on "Global health security – epidemic alert and response" (WHO, 2001). The report set out what had, for those working in the epidemic field, become a familiar set of claims about the relationship between infectious diseases and globalization, arguing that "infectious disease events in one country are potentially a concern for the entire world" (WHO, 2001, p. 1). The main points being made by the report's authors were clear: No country can isolate itself from the global spread of disease (at least, not if it hopes to remain in any way connected to the global economy); and the security of each individual nation, therefore, rests upon *collective* Global Health Security. In pursuit of Global Health Security, the report's authors argued, the IHR–the global agreement, previously revised in 1969, which set out when and how countries should report and respond to outbreaks of certain infectious diseases–needed to be updated and radically strengthened to improve international cooperation in disease surveillance and the containment of outbreaks when they occur (WHO, 2001, p. 2).

SARS in 2003–perhaps the closest recent comparator to COVID-19, even though it was contained much more quickly–served as a dramatic illustration of this Global Health Security narrative. First identified in Hong Kong (although it later transpired that an outbreak of this new viral disease had been underway in southern China for some months previously), SARS spread around the world in a matter of days. It was successfully contained within only a few months, but even so, by the time the outbreak was declared over 8,096 people in twenty-nine countries and territories had been infected. 774 of them had died (WHO, 2003a). National borders had not–*could not*– keep it out.

Many of the most important lessons about international cooperation and Global Health Security that were drawn post-SARS were almost universally agreed upon. There needed to be greater transparency by all countries, avoiding the situation (as happened with SARS in China) where governments try to cover up domestic outbreaks, costing valuable time which could be used for preparing an international response (WHO, 2003b, pp. 78–79). Countries needed to work more closely together, and more closely with WHO, to define common strategies for surveillance and containment (WHA, 2003a). WHO itself needed more authority to be able to investigate outbreaks independently and not be restricted to only using information provided to them by official government sources (WHA, 2003b, paragraph 4). These measures would, it was argued, constitute a major step towards increasing national security through a functioning Global Health Security framework.

Measures designed to address all of these issues were discussed in the post-SARS years as negotiations on revising the 1969 IHR gathered pace. The long process of negotiating the updated IHR has been widely analyzed elsewhere (e.g Fidler, 2005; Kamradt-Scott, 2015) and it is not our intention to rehearse

that history here. The revised IHR were finally adopted by the World Health Assembly in 2005 and came into force on June 15, 2007. Unlike their predecessors, their scope is not limited to any particular list of diseases,[2] but applies to *any* public health event "of international concern" (PHEIC)–including instances of newly emerging diseases such as SARS (and, now, COVID-19). What is important for our purposes in this article is: 1) That the new IHR (in common with its predecessor agreements going back to the nineteenth century) sought to mitigate the risks posed by the cross-border spread of disease in ways that "avoid unnecessary interference with international traffic and trade" (Article 2); 2) that to achieve this, the revised IHR brought about a "paradigm shift" away from border controls as a means of stopping the ingress of disease into individual countries toward a model of "containment at source" (WHO, 2007, p. 11); and 3) that the revised IHR brought a new emphasis on the compatibility of disease control measures with human rights (including, but not only, of travelers) (Article 3(1)).

The requirements for increased international cooperation in the 2005 IHR did not completely remove the role of national borders in the functioning of the agreement. There were, for example, extensive guidelines on what health infrastructure states should put in place at points of entry (WHO, 2008: Part IV); on health screening measures for travelers arriving and departing from a country (WHO, 2008: Part V); and on health documentation in relation to incoming vessels and cargo (WHO, 2008: Part VI). Some of the most significant measures, however, came in Articles 42 and 43. Article 42, in line with the new IHR emphasis on human rights, required that "Health measures taken pursuant to these Regulations shall be … applied in a transparent and non-discriminatory manner." As we discuss in greater detail below, Article 43 put limits on the legitimacy of governments implementing travel and trade restrictions through border closures or controls. WHO would make recommendations on appropriate public health measures at points of entry, and states wishing to exceed these recommendations (for example, by closing their borders against WHO advice) would be required to justify their actions to WHO within 48h (Article 43(5)). Although WHO was not given the authority to prevent governments exceeding its advised measures, under Article 43(4) the WHO "may request that the State Party concerned reconsider the application of the measures."

The regulations themselves, and the recommendations made by WHO in subsequent years, have shown a clear preference for borders to remain open, except where there is a strong scientific basis for the implementation of some form of restriction. This stance flows naturally from the IHR's overall aim of controlling the cross border spread of disease whilst avoiding "unnecessary interference with international traffic and trade." But there were also four more specific reasons during the negotiation and drafting of the 2005 IHR for keeping borders open to the maximum extent possible.

First, the public health evidence at the time was that border controls were not an effective means of preventing the ingress of (particularly respiratory) disease. Indeed, this argument was the very heart of the Global Health Security concept: That in a globalized world, no individual nation could keep a disease out of their territory. Even stringent border controls might, at best, delay the importation of disease by only a few days.

Second, previous versions of the IHR had been plagued by the problem of non-reporting. Countries reporting outbreaks frequently found themselves subjected to economically damaging travel and trade restrictions, creating incentives for governments to keep outbreaks secret (Cash & Narasimhan, 2000). At the heart of the 2005 IHR was a new "deal": That in exchange for open reporting of outbreaks, other countries would promise not to impose unduly punitive travel and trade restrictions on them. Doing so could undermine trust in the regime, and make responding to future international outbreaks far more challenging (Davies, Kamradt-Scott, & Rushton, pp. 65–68).

Third, it was believed that border closures could make it more difficult to respond effectively to outbreaks, by hampering medical supplies and human resources getting into the country–as well as food and other vital resources. This became a particularly prominent issue a decade later, during the Ebola outbreak in Guinea, Liberia, and Sierra Leone. On that occasion a number of neighboring countries did indeed close their borders (in contravention of the WHO's recommendations) and the UNSC called on them "to lift general travel and border restrictions, imposed as a result of the Ebola outbreak, and that contribute to the further isolation of the affected countries and undermine their efforts to respond to the Ebola outbreak" (UNSC, 2014, p. 4).

Fourth, borders were seen as danger zones for discriminatory practices and human rights abuses, with the potential for restrictions to be placed unjustifiably on nationals of certain countries, or according to other characteristics such as ethnicity, religion or sexuality. Given the IHR's overall aim to ensure respect for the dignity, human rights, and fundamental freedoms of persons (Article 3(1)), there was a need to ensure that border did not undermine this principle.

In the next section, we examine practices of "bordering" during the ongoing COVID-19 pandemic. Our argument is not that these four reasons for maintaining open borders are "wrong" (although the first has certainly been called into doubt). Rather, we seek to make the case that the IHR's conceptualization of borders, which focusses almost entirely on points of entry, does not capture the variety of bordering practices in evidence, nor the variety of locations in which bordering takes place.

We believe that at the time of writing it is too early to reach a full judgement on the efficacy of border controls: Whilst it certainly appears that some countries (such as Australia and New Zealand (WHO, 2020e)) which

were quick to implement stringent travel bans have suffered far fewer cases, such judgments are best reached once the pandemic is over. Moreover, whilst "New Zealand [for instance] barred entry to nearly all travelers on March 19 and has seen hardly any coronavirus spread since then" (Saunders, 2020), this would be to ignore the flipside: That other "places [e.g., Hong Kong] have succeeded with the opposite approach, leaving borders at least somewhat open and allowing citizens to return gradually while carefully monitoring the spread of the disease" (Saunders, 2020).

Instead, we focus on the second, third, and fourth reasons for the IHR (2005) and WHO preferring open borders. We have purposively selected three high-profile bordering practices that respond to each of these. On travel and trade restrictions disincentivizing reporting, we show that such restrictions have been hugely widespread, in open defiance of WHO's recommendations, but that in a global pandemic (at least after the very earliest stages) such restrictions may not pose such acute problems of disincentivizing reporting. On interference with disease response, we examine export restrictions on medical technologies and argue that "bordering" has in this case posed an enormous challenge to the ability of countries to respond effectively to their domestic epidemics. But in contrast to the IHR's focus on points of entry, these problematic bordering practices have in fact been enacted through bureaucratic decisions on export controls enacted away from the border, not at points of entry. Finally, on human rights, we examine the "rescue flights" put in place by many countries to airlift their citizens out of Wuhan in the early stages of the pandemic. Here we argue that discriminatory bordering practices were in evidence through the strict enforcement of citizenship requirements for rescue, but again that these practices took place away from points of entry. In the conclusion we return to one of our main claims in the article: That the literature from CBS can help us think through the ways in which the IHR's (and WHO's) conceptualization of "borders" is inadequate in the face of the procedural and geographical variety of state bordering practices.

Bordering the COVID-19 response

The linkages between disease and border controls have a long history (see, for example, Bashford, 2006). But some have always argued that the desire to maintain open borders and international cooperation during a pandemic was doomed to fail. They have suggested that whatever internationalist rhetoric governments engage in, in the face of a crisis this would be likely to evaporate and governments would prioritize the safety of their own citizens, their economic interests, and their own political popularity (Enemark, 2009; Peterson, 2002). There has certainly been some evidence of this in recent outbreak events, with a sizable literature developing on the challenges of ensuring

compliance with the IHR given the widespread use of border controls during the West African Ebola epidemic (e.g., Wenham, 2016).

In this section, we explore three empirical examples of bordering practices that have been prominent in the COVID-19 pandemic, selected to highlight the limits of the IHR's (and WHO's) conceptualization of how and where bordering happens. First, we examine the implementation of travel restrictions by governments around the world; second, we look at the use of export restrictions on vital medical technologies; and third we look at "rescue flights" operated by many governments to repatriate their own citizens (and not others) from Wuhan.

Travel restrictions

Although it has published guidelines for the management of travelers at points of entry (WHO, 2020a), throughout the COVID-19 pandemic WHO, in line with its recommendations in previous "public health emergencies of international concern," has advised "against the application of travel or trade restrictions to countries experiencing COVID-19 outbreaks." In line with the IHR, WHO has justified this by saying that

> In general, evidence shows that restricting the movement of people and goods during public health emergencies is ineffective in most situations and may divert resources from other interventions. Furthermore, restrictions may interrupt needed aid and technical support, may disrupt businesses, and may have negative social and economic effects on the affected countries. However, in certain circumstances, measures that restrict the movement of people may prove temporarily useful, such as in settings with few international connections and limited response capacities.

> Travel measures that significantly interfere with international traffic may only be justified at the beginning of an outbreak, as they may allow countries to gain time, even if only a few days, to rapidly implement effective preparedness measures. Such restrictions must be based on a careful risk assessment, be proportionate to the public health risk, be short in duration, and be reconsidered regularly as the situation evolves. (WHO, 2020b)

As noted in the previous section, under Article 43 of the IHR (2005), governments that decide to deviate from this WHO advice by applying what are referred to as "additional health measures" are required to provide WHO with a public health rationale for doing so (including scientific evidence). This was, at the time of the re-negotiation of the IHR, a central part of the "quid pro quo" at the heart of the agreement (Davies et al., 2015, p. 72): In return for governments openly sharing information about emerging outbreaks of potential international concern, other countries would respond proportionately and in ways that avoided causing unnecessary economic damage to the reporting state.

This has almost completely broken down during the COVID-19 pandemic, with border closures and other travel restrictions being widely imposed

despite WHO's advice against them. In line with WHO's arguments, many international lawyers have condemned these as both ineffective and threatening to the successful operation of the IHR framework (e.g., Burci, 2020; Habibi et al., 2020; Meier et al., 2020).

Accurate data on the countries that have imposed some form of travel restrictions above and beyond the WHO recommendations are hard to find. At the time of writing, a Wikipedia page (Wikipedia, 2020a) (which admits to being incomplete) lists 97 countries and territories that have imposed travel bans on arrivals from all countries, and a further 21 that have imposed bans against travelers from specific countries (Total = 118). Al Jazeera (2020) has compiled a slightly longer list, with details of 145 countries that had imposed some form of entry restriction. These lists include the EU's closure of all of its external borders (Stevis-Gridneff & Pérez-Peña, 2020), and the United States's high-profile banning of arrivals from most of Europe as well as China (Specia, 2020).

Although the IHR (under Article 43) require states to provide WHO with a scientific rationale for imposing additional health measures–and give WHO the right to "request that the State Party concerned reconsider the application of the measures"–the available evidence suggests that this is not being widely adhered to. Since January 22, 2020, WHO has issued daily Situation Reports on COVID-19. In some of these reports (specifically Nos. 18, 39 and 50 (to date)), it has reported on the imposition of additional health measured by member states. On February 7, WHO reported in Situation Report 18 that it had identified 72 States Parties which had imposed travel restrictions, only 23 (32%) of which had reported them to WHO (WHO, 2020c). In its 39th Situation Report, on February 28, 2020, WHO mentioned that a total of 41 states parties had officially reported additional health measures to WHO. The report stated that

> The public health rationale for these additional health measures is mainly linked to vulnerabilities (e.g., lack of capacity for diagnostic and response, small island states context) in receiving countries, and the uncertainties about the virus transmission and disease severity.

> Preliminary analysis of countries reporting cases that have imposed restrictive measures suggest that such measures may have delayed the importation of new cases, but did not prevent the importation of the disease. WHO has emphasized to Member States that additional measures should be proportionate to the public health risk, short in duration, and reconsidered in light of the evolution of the outbreak and the constant advancements of knowledge about the virus and the disease. (WHO, 2020d)

It was not clear from the report whether all 41 had provided a rationale, nor how many states WHO was aware of (remember there were a total of 72 three weeks earlier) which had imposed additional health measures without formally reporting them to WHO and without providing a justification, as required under the IHR.

On 10 March, Situation Report 50 said that 45 states had now officially informed WHO of additional health measures, and noted that while previously those measures had largely been targeted at China, they now tended to be wider in their application (although "The main reasons given for implementing such measures continue to be perceived vulnerabilities/limited country capacity and the nature of the virus epidemiology" (WHO, 2020e)).

There are three conclusions that we can draw from this data. First, that the majority of countries (118 according to the Wikipedia count; 145 according to *Al Jazeera*) have imposed some form of travel restrictions contrary to WHO's advice. Second, that only a relatively small proportion of those (45 as of March 10, 2020) have formally notified WHO of this fact, leaving at least 73 in *breach of the IHR requirements*. And third, that WHO seems to have been powerless either to demand an explanation from non-reporting states, or to challenge the justifications of those who had reported additional health measures.[3]

In this example, we see the most direct form of "bordering," as foreseen in the IHR. WHO has, as would be expected from the IHR and its previous practice, recommended against such restrictions, but has found itself powerless to prevent states from implementing them. Although international lawyers have raised concerns about the effect that the open defiance of WHO's recommendations could have on the sustainability of the IHR regime, we have not seen evidence in this pandemic of such measures disincentivizing reporting. COVID-19 has been a genuinely global pandemic affecting virtually every country in the world–not the kind of epidemic limited to one or a few states, which many had in mind at the time the time of the IHR renegotiation.

Export controls

If travel bans are the most obvious form of "bordering," another form has been the implementation of export bans to prevent certain types of good "getting out" (and, as a consequence, securing their availability domestically). This form of bordering has been particularly evident in the case of medical technologies that are vital for providing treatment and care for those with severe symptoms: equipment such as ventilators and Personal Protective Equipment (PPE), through to altogether more banal products such as face masks, soap, and disinfectant.

Youde (2020) suggested earlier this year that "we are seeing health systems struggle to cope with overwhelming demand for medical equipment and limited or uncertain supplies. This forces serious and often uncomfortable global debates about who should have access to them." Contra Youde, we argue that in fact there has been markedly little evidence of global debate. In fact, quite the opposite is the case so far: Many governments (particularly those from relatively wealthy countries) have introduced export controls on essential medical technologies, and their right to do so has rarely been

openly questioned. Evenett (2020a, p. 5) notes that "As of 21 March 2020, a total of 54 governments have implemented some type of export curb on medical supplies and medicines associated with the COVID-19 pandemic."

The immediate impact of export controls on medical supplies is, of course, on *availability*. The increase in demand for medical equipment has exceeded the capacity of existing supply chains, and export controls have had the effect of exacerbating pre-existing global inequalities. To take the example of medical ventilators (and not accounting for the export of component parts), in 2018 some 25 states exported over $10 million worth of medical ventilators. Of these, only one was in Latin America, and none in Africa, the CIS region, the Middle East, or South Asia (Evenett, 2020a, p. 6). Although some countries in these regions do produce ventilators for domestic use, as Evenett (2020a, p. 6) notes "were every current exporter to ban shipments abroad of medical ventilators, then a significant share of the world's population will be denied access to a key piece of medical equipment during the COVID-19 pandemic."[4] In this sense, export bans as a form of bordering to prioritize domestic needs are depriving many countries–some of which have the most fragile healthcare systems in the world–from much-needed medical technologies.

Export bans during COVID-19 have represented a clear reassertion of sovereignty, demonstrating the continued salience of the linkages between health and national security and the trumping (pun intended) of international cooperation by domestic concerns. Although export bans do not fall under the formal remit of the IHR, that framework does require states to not only meet their *own* core capacities, but also "undertake to collaborate with each other in … the development, strengthening and maintenance of the public health capacities required" (Youde, 2010, p. 165; Wenham, 2016). Previous discussions of public health capacities (e.g., Davies et al., 2015) have almost always assumed that the states that would not have the ability to cope would be poor countries in the Global South. This is no doubt true, but the lack of capacity in some of the richest countries in the world has also been laid bare by the COVID-19 crisis. Export controls have been an expression of that failing.

As we described above, the IHR and WHO discourse certainly recognizes that borders can be an obstacle to the movement of medical equipment and human resources. But the frame of reference for such discussions has previously assumed a situation (as with Ebola in West Africa) where border closures make it more difficult to get such goods to where they are needed. With COVID-19 we have seen a different dynamic: Global competition for limited supplies of resources that are needed everywhere, which export controls being used by producing countries to prioritize their own populations. Crucially– and in line with recent insights from the CBS literature–"bordering" in this case is not done physically "at the border" (i.e., through policing points of entry, upon which the IHR focusses), but rather is a political decision

which is implemented through bureaucratic routines (e.g., the non-issuance of export licence paperwork), with both decision and implementation taking place away from the physical border, in government buildings in capital cities. The IHR has virtually nothing to say about such bureaucratized practices of "bordering" which take place away from the physical border.

The Wuhan evacuations

A third form of "bordering" can be seen in the flights that many countries arranged to "rescue" their citizens from Wuhan (then the epicenter of the outbreak) in late January and early February 2020. These flights were arranged by most countries (at least most high and middle-income countries) which had significant numbers of citizens in Wuhan (list of states available at Wikipedia, 2020b). A number of countries arranged more than one flight.

Such evacuations are common after disasters of all kinds. However, one notable aspect of the evacuation flights from Wuhan were the number of disputes over who could evacuate their citizens (which required permission from the Chinese government, given that airspace was closed[5]), and–more importantly for our discussion here–who was eligible to be evacuated by a particular national government.

In almost all cases, governments strictly imposed citizenship requirements to ensure that they only "rescued" their *own* nationals from Wuhan, and not the nationals of other countries. As a result, there were a number of cases of discriminatory treatment. In the cases of both the American and British evacuations, for example, there were complaints that while citizens were eligible for evacuation, their Chinese national partners were not (e.g., Campbell, 2020; Murray & Standaert, 2020). In Taiwan, meanwhile, there was a debate about whether the mainland Chinese partners of Taiwanese nationals should be evacuated to Taiwan (Chang Chien, 2020). Governments made it clear that they conceptualized their responsibilities at this very early stage of the epidemic (at this point, remember, there had been very limited international spread) as being to their own citizens, and not to citizens of other countries[6].

Whilst generally couched in humanitarian terms of "rescue" rather than explicitly securitized language, the stringent implementation of citizenship requirements for rescue was revealing about who governments were seeking to protect, and where they saw the limits of their responsibility. These evacuation arrangements and the debates they generated represented a different form of "bordering" from travel restrictions at the literal border, but nevertheless, we argue, they demonstrated the prioritization of nationalistic responses over collective ones and highlighted that the kind of discriminatory treatment that the WHO and others feared would happen at points of entry during a pandemic could in fact be "off-shored" to "virtual" border sites away from the physical border.

Conclusion

This article began with the cliché that "diseases know no borders," and that in a world of ever-increasing interconnectedness, communicable diseases are able to spread across the globe in a way that is virtually unstoppable. From this starting point we briefly explored the concept of Global Health Security, embodied and expressed most cogently in the IHR (2005). The IHR ostensibly brought a move away from national self-protection through border controls towards assisting countries to contain outbreaks at source. They introduced new ways of incentivizing cooperation between states, and gave new authority to WHO. Yet, despite these moves, the IHR remain in many respects firmly, to paraphrase Fidler (2003), "Westphalian," with borders (in particular their regulations about points of entry) remaining central to the framework. That said, both the IHR and WHO in their recommendations show a clear preference for open borders and for controls being put in place in only very limited circumstances. In part this is fundamental to the overall aim of the IHR to improve disease control *without* unnecessarily hindering international travel and trade. But there were also some more specific reasons for a negative stance towards travel and trade restrictions, including: their ineffectiveness; their tendency to incentivize cover-ups of outbreaks; the fact that they could hamper outbreak response; and that they can lead to discriminatory practices that raise concerns over human rights.

All of these are legitimate concerns, but our central argument has been that the way the IHR and WHO conceptualize borders and bordering does not fully capture the variety of bordering practices that are used by governments. The three empirical examples we used highlighted this. The first showed that there has been widespread contravention of WHO's recommendations not to implement travel and trade restrictions. WHO lacks enforcement power to remedy this, although in the COVID-19 case–a genuinely global pandemic–the concerns about disincentivizing open reporting may be less acute than in smaller-scale national or regional epidemics. Despite this, international lawyers may be right to worry that such widespread non-compliance will threaten the stability of the entire global health security regime.

Nevertheless, whilst border closures contrary to the letter and spirit of the IHR may be a problem, they are not the only one. In our second and third empirical examples we sought to show that other kinds of bordering practices that are not subject to the IHR can also have significant impacts on the ability to get medical supplies where they are needed (the case of export controls) and can produce exclusionary and discriminatory practices (the case of the Wuhan rescue flights). Crucially, such examples of "bordering" take place away from the physical border, being enacted not through policing of points of entry but through political decisions enacted via bureaucratic

routines at "virtual" national boundaries. These insights build upon the litera- ture from CBS, which has long identified the ways in which contemporary bordering practices have become increasingly "virtual" and detached from the territorial logics of where the border *should* be.

The securitization of disease has a tendency to play into nationalistic "domestic first" responses, undermining the possibilities for international cooperation–perhaps particularly so in times of acute global crisis. Although in previous cases (such as the West African Ebola outbreak of 2014–2016) at least some degree of international solidarity and humanitarian action was in evidence, this has been far less apparent (so far) during COVID-19. No doubt this is due to the vastly different impacts that the two epidemics have had on rich, Western states. From the point of view of Global North governments which find themselves (unusually) at the epicenter of the COVID-19 pan- demic, a prioritization of domestic problems is perhaps understandable. But it poses a formidable challenge to the collective security approach of the Global Health Security regime. The enactment of a variety of exclusionary bordering practices is an important part of that challenge.

To address this, a wider understanding of bordering practices and their impacts on pandemic response is required. WHO and the IHR currently con- ceptualize borders in very narrow, conventional terms: as geographically specific territorial limits. This is not "wrong" in some respects, but generating any actual shift away from disease as a narrow national security concern in which self-interest reigns will require rethinking what borders are (or, rather, how and where bordering is done). A shift towards "true" Global Health Security will entail the development of international norms around other forms of bordering which place national security in tension with collec- tive efforts to detect and respond to infectious disease outbreaks.

Notes

1. In this article we do not cover all of the forms of bordering that have been in evidence. Particularly interesting, although beyond the scope of this article, has been the implementation of internal borders within many countries, divid- ing more-affected from less-affected regions via travel restrictions and other measures. In this article, our focus is on the national level, and the relationship between national bordering practices, the IHR provisions and the recommen- dations of WHO.
2. The IHR of 1969 were intended to monitor and control six "quarantinable" infec- tious diseases: cholera, plague, yellow fever, smallpox, relapsing fever, and typhus.
3. We found no evidence from the publicly available documentation to suggest that in any of these cases had WHO specifically requested a government to reconsider.
4. Aside from evidence of emergent restrictive export policy, working in tandem with this, the COVID-19 pandemic has seen the maintenance and/or introduc- tion of import taxes on key countermeasures globally, including soap, and

disinfectant. The combination of export restrictions with the maintenance/ introduction of tariffs bolsters domestic production (for domestic markets). To illustrate: at a time when maintaining good personal hygiene and hand washing is recommended by the WHO only "9 WTO members allow foreign soap to enter domestic markets duty free … Remarkably, 79 WTO members charge import tariff rates of 15% or more—and 31 governments levy taxes on import soap of 30% or more" (Evenett, 2020b, p. 4).

5. Some of these issues related to pre-existing disputes. For example, according to the government of Taiwan, China initially allowed Taiwan only one evacuation flight, leaving half of the Taiwanese citizens in Wuhan stranded (Hamacher, 2020). China responded by arguing that it was Taipei that had been putting obstacles in the way of further evacuation flights.

6. Even those cases where countries did cooperate with their neighbors – as with Australia and New Zealand, and some EU countries – generally represented pre-existing diplomatic/consular relationships rather than any novel display of solidarity in securing foreign citizens seen as being in harm's way.

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