2020

VOLUME 3 ISSUE 1 & 2
APRIL & NOVEMBER

# FIMT LAW JOURNAL

# RETHINKING REFUGEE LAWS IN LIGHT OF A GLOBAL PANDEMIC

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*Refugees are extremely vulnerable persons who flee from their countries of origin on account of a well-founded fear of persecution. Most nation states across the globe are reluctant to allow the entry of refugees into their territories owing to a fear of draining of capital and resources. Refugees are therefore persons who are not warmly welcomed, and instead repelled by most. Public International Law recognizes the rights of Refugees through a separate Convention that caters to their needs. This Convention casts responsibility on host states who welcome Refugees into their territories. The Rights guaranteed to Refugees by virtue of the said Convention does not include a Right to Health. This non-existing Right is rendered crucial in light of an epidemic that conquers the entire Globe. This paper grapples with the implications of the absentia of the Right to Health both for Refugees and for Nationals of a nation-state. In doing so, this paper highlights the loopholes contained in the Convention explicitly pertaining to Refugees and offers recommendations to remedy the loopholes. Furthermore, it calls attention to other Rights of the Refugees and the challenges for their realization.*

## INTRODUCTION

The Rights of Refugees are governed by the stipulations of the Convention and Protocol relating to the Status of Refugees, 1951 (hereinafter 'the 1951 Convention.')[1] Article 1 of this Convention provides that a refugee is any person who "has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion."[2] In light of the said fear of persecution, refugees are either unable to return to their country of origin or exhibit reluctance to return. The said country of origin pertains to the country of nationality of the refugee or a place of habitual residence.[3] Article 3 of the 1951 Convention prohibits discrimination on the grounds of 'race, religion, or country of origin.' In the host states.[4] For any person claiming

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[1] Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137 (Refugee Convention).

[2] Ibid Article 1.

[3] Ibid.

[4] Ibid Article 3.

the status of a refugee under the 1951 Convention, it is necessary that they may have crossed international borders. In other words, they must have necessarily left their country of origin.[5]

The Convention envisages several rights for refugees in their host countries and also imposes various obligations on the host countries. Of the rights guaranteed to refugees, two rights in particular warrant an explicit mention for the purposes of this paper. These include – voluntary repatriation and non-refoulment.[6] Voluntary repatriation pertains to return of refugees to their country of origin by their own free volition after the earlier threat of persecution has ceased. Non-refoulment on the other hand is a right of the refugees to not be returned to the country of origin where the threat of persecution looms large. It is both a principle of customary international law and a right guaranteed by the Convention. As per this right, a duty is cast upon host states to not redirect refugees to the country of origin against their will under any circumstance.

This paper is aimed at shedding light on the impact of global pandemics such as Covid'19 and Ebola on the lives of refugees. This impact must be understood in the context of the rights and obligations envisioned in the 1951 Convention. The purpose of this paper is to highlight the implicit loopholes in the 1951 Convention and the policies adopted by nation states worldwide specifically pertaining to refugees. The said implicit loopholes have been rendered explicit owing to the global Corona virus pandemic. In highlighting the shortcomings in the 1951 Convention and policies of nation states, this paper attempts to stipulate recommendations for policy changes at the national and transnational level. Furthermore, this paper will also attempt to propose amendments in the 1951 Convention in order to safeguard the rights of refugees. These recommendations are framed keeping in mind the plight of refugees and their vulnerability during extenuating and unprecedented circumstances.

It is the central thesis of this paper that the rights contained in the 1951 Convention must be expanded further and the scope be broadened. The 1951 Convention ought to cast a duty on host states to safeguard the health of Refugees. This argument is advanced in view of the fact that health is a global public good and that only collective health can mitigate the effects of a global pandemic. By ignoring the plight of refugees, nation states not only jeopardize the health of refugees, but also their own citizens. These assertions are put forth from a logical and ethical standpoint.

[5] M. Afzal Wani, 'Refugee Crisis and the Universal Human Rights Instrument: An overview of Fifty Years of Development' (1999) ILI 201, 211.
[6] Refugee Convention (n 1) Article 33.

The right to voluntary repatriation and non-refoulement also needs to be reconsidered and well thought out. During a public health emergency, most nation states seal off their borders and impose travel restrictions on persons including citizens of their own states. This leaves people stranded in foreign territories. For most people, this may be an innocuous consequence; however, for vulnerable persons like refugees, it is important that they are able to return to safer harbors. This paper sheds light on the Right to Return and Non-Refoulment in this light and seeks to recommend certain policy changes.

This paper is split into three parts. The first part introduces the Right to Health of Refugees and the need for this Right to be explicitly recognized by the 1951 Convention. This part is further split into two parts – first, it calls attention to the policies that have been adopted by nation states in relation to the health services that are rendered to refugees; and secondly, it foregrounds the argument of the right to health in the concept of a 'global public good.' In light of this argument, this paper asserts that Health is not a market commodity but a global public good and thus, there is a need to safeguard the health of all.

Part II of this paper examines the scope of the Right to Voluntary Repatriation and Non-Refoulment. These rights are elaborated upon in the context of a global pandemic and how the same are hindered during unprecedented times. Further, this section highlights the loopholes in the definition of the 'country of origin' as contained in the 1951 Convention, and the subsequent implications of the same. Part III reiterates the key recommendations highlighted in this paper.

## THE RIGHT TO HEALTH

The 1951 Convention does not recognize a Right to Health of Refugees. Of all the obligations imposed upon nation states, the duty to provide health services to those who seek refuge in their territories is not one of them. There is considerable debate surrounding the Right to Health of Refugees in light of the fact that providing healthcare services to refugees imposes an undue financial burden on host states and drains them of their financial resources and also other resources. Therefore, across the globe, most nation states have incorporated limiting provisions in their domestic legislations to provide only for emergency services to refugees. Nation states only wish to render services to those who are nationals and strive to drive out all outsiders.

In the Preamble of the WHO, a Right to health has been envisaged for every human being who walks the surface of the earth.[7] The Right envisaged therein encompasses both physical and mental

[7] Constitution of the World Health Organization 1946.

wellbeing and also social wellbeing. The importance attributed to the Right to Health also finds space in Human Rights Law. The Universal Declaration of Human Rights (UDHR) of 1948 contemplates a Right to Health through Article 25[8], which stipulates the Right to an adequate standard of living. It must be noted that the stipulations enshrined in the Preamble of the WHO and also Article 25 are not binding in nature. Compliance with the stipulations of the Right to Health have been made binding in the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1996[9]. It is pertinent to mention that under all of these Conventions, the member States are obliged to recognize the right of "everyone" to health and not just their citizens. Consequently, protection should be extended to everyone regardless of whether they are a foreigner or a national. Sadly, this is not the case. States in most circumstances discriminate on the basis of the status of the individual as a national or an outsider.[10]

The Global Compact on Refugees is a framework for "more predictable and equitable responsibility-sharing" and was designed to enhance the quality of lives of refugees.[11] The main objective of this framework *inter alia* is to improve the kind of services provided by host states by reducing their burden. It also sought to ensure self-reliance and independence of refugees.[12] It must be noted that this framework, introduced in 2018, contemplates a Right to Health for refugees. It provides that nation states must strive to improve the health services they are offering, and the health care systems must be made accessible to refugees. Additionally, host states have also been called upon to extend services pertaining to "disease prevention, immunization services, and health promotion activities."[13]

Public International Law recognizes health as being a central tenet of Human Rights. It is important to consider that non-discrimination is a significant element contained in all the principles that are enshrined in Human Rights Law.[14] International Law has recognized both a positive as well as a negative obligation when it comes to the Right to Health. The positive obligation pertains to undertaking measures to secure the health of persons, whereas the negative

[8] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III) (UDHR), Article 25.
[9] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR).
[10] Michael Krennerich, 'The Human Right to Health. Fundamentals of a Complex Right' in Sabine Klotz and others (eds), *Healthcare as a Human Rights Issue* (Transcript Verlag 2017).
[11] 'The Global Compact on Refugees' (*UNHCR| India)* <https://www.unhcr.org/the-global-compact-on-refugees.html> accessed April 2019.
[12] Ibid.
[13] 'Proposed Health Component in the Global Compact for Safe, Orderly and Regular Migration (World Health Organization) <https://www.who.int/migrants/about/gcm-health-component/en/> accessed April 2019.
[14] Patricia Illingworth and Wendy E. Parmet, *The Health of Newcomers* 99 (New York University Press 2017).

obligation calls upon states to not interfere with persons health in an unwarranted manner. States are obligated to provide for health services irrespective of whether the recipient has the ability to pay for the services that have been rendered.[15] This Right is however not absolute which means that International Law is cognizant of the inherent limitations of nation states. These limitations allude to the financial abilities of states and the resources available to them. In light of these limitations, International Law stipulates that states must make necessary arrangements and render services to the best of their abilities and must stive to *progressively realize* their obligations.[16]

### 1. Nation States and their Discriminatory Policies

As mentioned above, nation states have incorporated limiting provisions in their domestic legislations that qualify refugees for availing only emergent services. It is argued that the said limiting provisions warrant criticism for two main reasons – first, they violate the human rights of refugees that have otherwise been recognized by other Conventions; and secondly, providing only emergency services to persons is actually more financially detrimental for host states in the long run. Providing emergency related services only exacerbates the financial costs of providing services to people because the ailments suffered by them escalate to such a level that they start to require services of experts and high-level treatment to cure their ailments. Thus, in the long run it becomes counterproductive and the financial resources that the host states so seek to conserve, they end up depleting them. When healthcare is extended only in situations of acute illnesses it results in greater financial burdens for host states as opposed to situations in which early treatment is given.

Providing access to only emergency services can be dangerous even for the citizens of the host states. This is because, if a refugee is suffering from a communicable and contagious disease and is compelled to wait until their health deteriorates further, they might end up putting others in their vicinity at risk. It is also extremely problematic considering that for most diseases (even Ebola) the incubation period is very long. Hence, severe symptoms may not show up for at least ten to fifteen days. This will result in the disease aggravating and the person becoming worse off than they were, if they are compelled to wait for their illness to become "acute." In most circumstances, diseases once they become acute prove to be fatal.[17] Therefore, the limited security offered to refugees has a tendency to do more harm than good for the refugee as well as the surrounding people.

[15] Parmet (n 14) 98.
[16] Ibid. emphasis supplied.
[17] Krennerich (n 10).

Nation states have often asserted that if the health services offered are expanded to include treatment even for non-emergent cases, it would give an impetus to undocumented migrants and other persons who do not have a valid claim for asylum. However, such an assertion has not been backed by any empirical evidence. It is widely recognized that most persons migrate for better employment opportunities, or to flee persecution in states of origin. At this stage, it is important to note that there is a general sentiment dominant amongst migrants of distrust towards western medicine. Refugees are of the opinion that the services offered are also not culturally accommodating and therefore exhibit a great reluctance before availing them.[18]

From a very long-time refugees have often been vilified and regarded as being the carriers of germs and microorganisms. This has resulted in most nation states sealing off their international borders for refugees and asylum seekers during times of pandemics to prevent both the immigrants as well as germs and microorganisms from entering their territory. During times of normalcy, many are denied asylum on grounds of their ailing health and they are granted entry only when their health further deteriorates and goes south because provisions exist only in relation to emergency related health services.[19] Such policies give rise to the belief that by controlling the movement of immigrants, the movement of germs can also be regulated without giving regard to the fact that germs do not aspire to respect international borders. This is most definitely true for the present era of Globalization and interconnectedness.[20]

There is empirical evidence that establishes that states have rejected claims of asylum since time immemorial. In 1906, Italy rejected 25000 immigrants for medical reasons and in 1907 more than 35,000 immigrants were rejected. Refugees have also been subjected to a great deal of humiliation with the way they are treated during their medical examination.[21]. In 1903 the Immigration Act was enacted by the United States of America, which categorized immigrants into classes which were then made excludable on the grounds of hexalth of people.[22] This further reinforced the hierarches and stigmatization to which the immigrants are subjected to across the globe. Even in contemporary times, nation states continue to view immigrants as carriers of dangerous diseases and contagions of epidemics and deter them from entering their borders by subjecting them to immense stigmatization and very difficult asylum policies. When refugees and immigrants are

[18] Parmet (n 14) 111.
[19] Ibid 27.
[20] Ibid 32.
[21] Ibid 34.
[22] Ibid 35.

subjected to this kind of despicable treatment, host states violate several of their obligations enshrined in Public International Law.

It is important to reiterate that discrimination on account of health of refugees is dangerous for other reasons as well. These reasons are not restricted to the well-being of refugees alone but also include safety and well-being of citizens of a nation state. Discriminatory and stigmatizing policies of nation states may be used to treat immigrants as scapegoats in order to shift the blame of states' personal failures in combating pandemics and other related threats.[23] When the blame is shifted on to these immigrants it consequently shifts the attention of the globe from the real dangers to the health of the people. This allows states to believe that by preventing immigrants, the threats that were initially looming large have been assuaged. This has deleterious consequences not only for refugees but also for nation states themselves. If the diseases are not curbed at their roots and the collective health of people is not secured, then these diseases turn into global pandemics which then endanger the security of the entire globe.[24]

Furthermore, when refugees are subjected to repeated stigmatization and humiliation, they are discouraged from revealing to the official entities the true state of their physical health. This not only puts refugees at risk but also several others such as citizens of the host states. Such policies also render refugee's hostile to the policies and programs rolled out by nation states in general and increases the distrust among them. What is therefore needed is more liberal and respectful policies and programs to be introduced by nation states. This will ensure greater cooperation and allow for mutual respect to be shared between persons.

In addition to the aforementioned reasons cited by host states, perhaps the most dominant sentiment amongst host states while denying health services to non-citizens is "not my problem." Health is viewed as a private service and an individual right offered to those who can pay and hence refugees are not entitled to. The next sub-section examines the merits of this contention.

### 2. Is Health a Global Public Good or a Private Right?

The argument of "not my problem" pertains to nation states viewing health as a private service which is conferred upon persons as a privilege and not as a right. Only the select few who have the capacity to pay for this private and privileged service may be allowed to avail the benefits. The remaining people should be hindered from accessing health services. This kind of reasoning has

[23] Ibid 50.
[24] Ibid.

been constantly advanced by nation states to absolve themselves of any liability when it comes to refugees. Nation states only wish to concern themselves with the health of their own citizens and not those who may be residing in other parts of the world. This position has attracted widespread criticism. Such criticism is premised on the fact that if nation states attempt to safeguard the health of persons in one state, they also indirectly extend the benefits of the same to their own territories.[25]

The criticism is advanced in light of the nature of the 21st century and the era of Globalization. In view of this, it is asserted that health is a "Public Good." Public goods have been defined as possessing two key characteristics – (1) the benefits of the good are "non-rivalrous in consumption."[26] This means that consumption of the good by one person does not decrease the availability of it for another; and (2) public goods are nonexcludable, which means that one cannot prevent another from enjoying it. Air is both a non-excludable as well as a non-rivalrous good.[27]

It may be argued that health services are not non-rivalrous in consumption owing to the limited availability of resources. Furthermore, health may be denied from being considered as a public good by grounding the argument in the principle of unjust enrichment. This principle enshrines that one should not benefit unjustly at the expense of another.[28] In the context of health, this would mean that in situations of limited availability of resources, only those who can pay for the resources should be permitted to avail them. But this grounding of health in the principle of unjust enrichment considers health to be a market commodity.[29]

However, health is regarded as a public good from a moral and ethical perspective and this understanding also takes into account the fact that a public good benefits people collectively and not individually.[30] Thus, in public goods, there is ever present an element of "universality."[31] Individual health and collective health are concomitant, and one cannot be safeguarded without simultaneously safeguarding the other. In this era of Globalization and interconnectedness, when one individual is treated for a communicable disease, it in turn safeguards the health of all those who live in close proximity to the patient.[32] Similarly, when residents of one nation are plagued by a deadly disease, the health and security of other nations is also threatened. It can be argued that such a nation should ideally seal off their international borders, and travel restrictions can be

[25] Ibid 115.
[26] Ibid 116.
[27] Ibid.
[28] Graham Virgo, 'The Principle of Unjust Enrichment' in 'The Principles of the Law of Restitution' (OUP 2017).
[29] Parmet (n 14) 117.
[30] Ibid 119.
[31] Ibid.
[32] Ibid 120.

imposed by other nations, however this solution is not feasible in the long run. Nation states are dependent upon each other for economic activities and thus sealing off the borders is not a practical exercise.

From a moralistic and ethical viewpoint, it is important to take into account the environmental and social factors that lead to poor health of persons in developing countries. It is a recognized fact that activities undertaken by developed countries in the developing ones have adversely impacted the environment of these developed states.[33] Moreover, there has been a great deal of depletion of resources available to developing countries owing to actions of developed countries. Our health is shaped not only by individual life choices but also by social determinants which include the conditions in which people lead their lives, their surroundings, age, the work undertaken by them, etc.[34] Most of these social determinants are beyond the control of individuals. Most of the developed countries acquire their cheap labor from developing countries to conduct activities that have significant health risks such as mining in coal plants, etc. These activities directly and adversely impact the lives of people who undertake them. Thus, the developed countries sustain their economies by exploiting the resources of developing states and should therefore not hesitate in providing health services to the same people in times of need by citing financial constraints.[35] The developed countries also contribute to the medical brain drain in developing states and must therefore compensate for the lack of resources by extending their health services to nonresidents.[36]

To further substantiate the claim that health is a global public good, it is pertinent to mention that health has been regarded as people centric and not border centric.[37] Thus when emphasis is laid on borders and financial and social capital the results are often devastating for collective health of the globe. The International Health Regulations of 1969 (IHR) were framed with a view to secure the collective health of the international community. They provide for the rights and obligations of member states in relation to situations that endanger the collective health of all persons.[38] In essence, they provide for the mitigation and prevention of collective health risks to the international community.[39] These were broadened post the 2003 outbreak of the SARS i.e. the

[33] Ibid 123.
[34] Ibid 125.
[35] Ibid.
[36] Ibid 131.
[37] David L Heymann, et al. 'Global health security: the wider lessons from the west African Ebola virus disease pandemic' (*The Lancet*, 09 May 2015) < https://doi.org/10.1016/S0140-6736(15)60858-3> accessed April 2019.
[38] World Health Organization, International Health Regulations, available at <https://www.who.int/health-topics/international-health-regulations#tab=tab_1> accessed August 2020.
[39] Heymann (n 37) 1884.

Severe Acute Respiratory Syndrome. In the present understanding, the IHR require that any public health emergency of international concern be immediately reported. Further, there has to be a concerted attempt by all affected governments and the WHO to engage in dialogue and take adequate measures to safeguard the health of all. It is pertinent to mention that these regulations are legally binding on several countries.

It is only through a concerted effort that the risks of a global pandemic can actually be mitigated. In the past, the globe has been able to achieve success to eradicate diseases like tuberculosis and smallpox only because the international community has come together to fight the said disease. It was recognized by all nation states, especially the global north that without a concerted effort it would be impossible to fight a global pandemic. In the era of interconnectedness and interdependence, all risks must be understood and assessed collectively. For this reason, it is significant that health is not relegated to the position of a market commodity. Until and unless the non-derogable link between collective and individual health security is realized, the international community will not be able to contain a public health emergency. It is for this reason that any response to a public health emergency is inclusive in nature and not exclusive with only certain persons reaping the benefits of available resources.

Refugees must be included in the preparedness plans that are chalked out by the international community. To ensure that host states are not overburdened, and their resources are not drained, a Right to Health must be guaranteed to all refugees. This Right to Health of refugees ought to be realized in the same way as is realized for citizens of nation states. Thus, health is arguably a global public good and must be safeguarded in every way possible. Refugees must not be denied entry or deported back to the country of origin against their will under the garb of security of host state. It is in this light that the Rights to voluntary repatriation and non-refoulment must be understood. The next section of this paper sheds light on the stipulations of these two rights and the changes required therein.

## REPATRIATION AND NON-REFOULMENT

Voluntary repatriation of refugees has been considered to be one of the most durable solutions for the problem of refugees faced by the world. It entails the return of refugees by their own volition to the country of origin after the threat of persecution has ceased. The 1990s was an era of repatriation.[40] A refugee is the best adjudicator of deciding whether or not the threat of

[40] Megan Bradley, 'Rethinking Refugeehood: statelessness, repatriation and refugee agency' [2014] 40(1) Review of International Studies 101 <https://www.jstor.org/stable/24564382?seq=1> accessed July 2020.

persecution has passed, and the movement back to the country of origin is assisted by International organizations like the UNHCR. Most host states too prefer repatriation over resettlement because of the fear of an increase in financial burden. Non-Refoulment pertains to the Right of refugees to not be returned to the country of origin against their will. It is envisaged under Article 33 of the 1951 Convention.[41] The Right imposes an obligation on all host states who are prohibited from returning refugees to the country where they may face persecution.

Hannah Arendt in *The Origins of Totalitarianism*[42] has stated that for most refugee's repatriation is simply not an option. They must therefore be allowed to resettle in other territories. Some have held this view to be anachronistic in light of the changing global circumstances. Others have criticized this view from the perspective of the host states who do not intend on allowing refugees to resettle in their territories.

The concept of repatriation or the right to return needs to be understood in light of the situations arising during a global pandemic. During public health emergencies, most nation states impose travel restrictions and seal off their borders. There have been several instances in which even citizens of the given nation states are not permitted to enter into the territory of the country. The result of this is that most persons end up being stranded wherever they are. For most persons, this might not be a very precarious position to be in. However, for persons like refugees who are extremely vulnerable and are not even given access to health services in host states, such a situation can be perilous.

The Right to Return or Voluntary Repatriation can be regarded as a principle of Customary International Law. It is not just restricted to refugees but can be extended to others as well. It is recognized by several Conventions that are contained in the compendium that formulates Public International Law. These includes Article 4(1) of the International Covenant on Civil and Political Rights (ICCPR) and many regional instruments such as the African Charter on Human and People's Rights, Article 12(2).[43] Article 4(1) of the ICCPR stipulates that no one must be arbitrarily denied the "right to enter his own country." This Right has been made derogable in situations where the life of the nation is in fact threatened and there is a national emergency in place.[44] A public health emergency amounts to a non-traditional threat to the security of a nation. Thus,

[41] Refugee Convention, Article 33.
[42] Hannah Arendt, *Origins of Totalitarinism* (Schocken Books, 1951).
[43] Marjoleine Zieck, 'Voluntary Repatriation of Refugees: Paradigm, Pitfalls, Progress' [2004] 23(3) Refugee Survey Quarterly 123 <https://doi.org/10.1093/rsq/23.3.33> accessed January 2021.
[44] Ibid 121.

during a global pandemic, such exceptions may be relied upon by nation states to deny entry to persons.

Sealing off of international borders and imposing travel restrictions not only has implications on the movement of people, but also that of goods and services. Travel restrictions result in alienation of states and may deprive them of medical resources and services that are essentially the need of the hour.[45] In 2014, when nation states in West Africa were impacted by the deadly Ebola crisis, states like Cote d'Ivoire flouted the principles of non-refoulment and voluntary repatriation. In the case of Liberia in 2014, the United Nations Security Council called upon member states to lift general travel and border restrictions, but the same was not adhered to.[46]

The World Health Organization has observed that trade and travel restrictions are not long-term durable solutions in mitigating a public health emergency. If such measures are taken recourse to, they must only be adopted for short term.[47] These measures are only important in so far as they allow states to envisage a preparedness plan to fight an epidemic. Beyond this preparedness plan, states must strengthen their systems and more efficient surveillance systems.[48] It is imperative that in such situation's states are not further alienated from the international community, as there is a dire need for exchange of medical supplies and also trained medical personnel and other important things that might be required.[49] This is especially in the cases of developing countries that lack the requisite resources to deal with such situations.

Nation states have argued that public health emergencies may trigger mass scale migration to developed countries. However, this assertion is not backed by empirical evidence.[50] Furthermore, such an assertion ignores the fact that refugees are actually wary of western medicines and cultures. Most refugees are often compelled to embark upon treacherous journeys and flights to escape

[45] Heymann (n 37).
[46] United Nations Security Council, Resolution 2177 (2014) <https://www.securitycouncilreport.org/atf/cf/%7B65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9%7D/S_RES_2177.pdf> accessed May 2019.
[47] Updated WHO Recommendations for international traffic in relation to COVID 19 outbreak (*World Health Organization*, 29 February 2020) <https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak> accessed January 2021.
[48] ibid.
[49] Gian Luca Burci and Jakob Quirin 'World Health Organization and United Nations Documents on the Ebola Outbreak in West Africa' [2015] 54(3) <https://www.cambridge.org/core/journals/international-legal-materials/article/abs/world-health-organization-and-united-nations-documents-on-the-ebola-outbreak-in-west-africa/E3C27D20F081DAEED64A5BB17B71B2CA> accessed July 2020.
[50] Heymann (n 37) 1896.

persecution and reach host states. Therefore, persons would only be willing to undertake these risks when they *absolutely* have to and not to exploit the resources of developed countries.[51]

Thus, it is important that nation states rethink their policies when it comes to the Right to Return and Non-Refoulment. In imposing travel restrictions and ousting persons from their territories, nation states stand in violation of principles of Customary International Law. In Liberia, repatriation of Ivorian refugees came to a complete standstill for one complete year in July 2014 following the outbreak of Ebola.[52] Such happenings must be avoided at all costs, because until a Right to Health is guaranteed to refugees, they will be denied welfare in host states. Additionally, refugees may also end up becoming a victim to people's xenophobia and may be targeted in host states. Refugees should therefore be allowed to return to countries of origin, should they wish in these unprecedented circumstances.

Recalling from Part I of this paper, refugees and outsiders are often vilified and subjected to a great deal of humiliation. They are made scapegoats for the personal failures of states pertaining to curbing an epidemic. The 1951 Convention only recognizes persecution in the country of origin and not in the host states. Refugees therefore do not have a remedy and in case of flight from the host state on account of persecution, may not qualify as a refugee in a third country. This is because the 1951 Convention recognizes the country of origin as being the country of nationality or a country of habitual residence.[53] If refugees spend a considerable time in the host state, but are yet to be naturalized, then there is a possibility that they are stripped of their identity relating to the country of nationality already. Whether they will be considered as being habitual residents of the host states is debatable and will depend upon the individual policies of nation states. Some states do not wish to allow persons who have fled in the past to enter their territories again and also do not regard them as citizens. Bhutan is a case in point.[54] Whether persons will be able to qualify as refugees for the purposes of a third country by virtue of being habitual residents in host states, will depend upon individual cases. To remedy this problem, what is required is the expansion of the meaning of the country of origin. This expanded definition ought to have a clearer meaning of the terms 'habitual residence' accompanied by a stipulated time period. Alternatively, the 1951 Convention may be amended to include 'host states' within the meaning of 'country of origin.'

[51] Emphasis supplied.
[52] Diana Diaz 'Ivorian returns resume from Liberia after Ebola outbreak' (*UNHCR| INDIA,* 18 December 2015) <https://www.unhcr.org/news/latest/2015/12/5674384d6/ivorian-returns-resume-liberia-ebola-outbreak.html> accessed April 2019.
[53] Refugee Convention, Article 1(A) (2).
[54] Marjoleine Zieck (n 43), 134.

The Corona virus pandemic has exposed the pitfalls of the capitalistic world that intends to prioritize profits and capital gain at every step. However, these profits and capitalistic gains cannot help in curbing the impact and risks of epidemics. With every country swiftly sealing off its borders and attempting to revive a slowly dying economy, the risks must be mitigated at both a micro and macro level. Germs and microorganisms do not honor international boundaries and laws, nor do they respect national or foreign identities. Any concerted attempt by the international community must have a similar approach to fight the epidemic. The starting point of adopting such an approach can be changes in the domestic policies and in Public International Law.

## CONCLUSION AND KEY RECOMMENDATIONS

As is evident, refugees continue to face several issues all over the globe especially in regard to their health both physically and mentally. There is a very desperate need for coordinated efforts of the entire international community to not only reduce the pressures on host countries, but also to deliberate and discuss durable solutions to deal with the problem at hand. Refugee laws must be deliberated upon and the loopholes be filled and remedied to provide sustainable and durable solutions. These solutions are significant not only for the well-being of refugees but the entire international community.

It is pitiable that even after the Globe has already witnessed the impact of diseases like HIV/AIDS and H1NI flu in the past, it has been unable to come up with durable solutions yet to ensure that the horrors of the past are not repeated again. If concerted actions are not taken, the risks of pandemics like the Ebola crisis and Covid 19 cannot be mitigated. This is not the last time the globe will ever witness such unprecedented and extenuating circumstances. Therefore, it is necessary that we face the next like situation being more prepared. In order to safeguard collective global health and security, the author of this paper reiterates the following recommendations for policy makers to deliberate upon:

a) Given the fact that health is a global public good and not a market commodity, the 1951 Convention must be amended and an Article guaranteeing the Right to Health to refugees must be incorporated. The following provision may be inserted in the 1951 Convention – "The Contracting States shall accord to a refugee treatment as favorable as possible and, in any event, not less favorable than that accorded to nationals generally in the same circumstances, as regards to providing access to health and medical services." It is important that access to services is

expanded from the last stage to initial stages as well to ensure that treatment is not delayed.

b) The meaning of 'country of origin' as contained in Article 1 of the 1951 Convention must be expanded further to include persecution in host states. The meaning of habitual residence must be made clearer with a stipulated time period. Alternatively, the meaning of 'country of origin' should be amended to include 'host states.'

c) The Right to Return/Voluntary Repatriation and Non Refoulment must be protected. Nation states should not be permitted to take recourse to the exceptions envisaged under ICCPR, Article 4(1) very loosely. Any kind of restrictions imposed upon the Right to Return must only be for a short duration and not be prolonged.