



LAW AND PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

Lessons from the COVID-19 pandemic

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Law and public health emergency preparedness and response

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ABOUT IFRC DISASTER LAW

IFRC Disaster Law and National Red Cross and Red Crescent Societies have 20 years of experience in providing technical advice to governments to strengthen disaster risk governance through laws and policies, and in building the capacity of domestic stakeholders on disaster law. To date, we have provided support to more than 40 countries to strengthen their disaster laws and we have conducted disaster law activities in more than 90 countries.

IFRC Disaster Law is also a leader in conducting research and developing innovative guidance on domestic best practice. It has produced four key guidance documents:

- the Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance (commonly known as the [IDRL Guidelines](#));
- the Checklist on Law and Disaster Risk Reduction (the [DRR Checklist](#));
- the Checklist on Law and Disaster Preparedness and Response (the [DPR Checklist](#)); and
- the Guidance on Law and Public Health Emergency Preparedness and Response (Pilot Version).

The first three guidance documents have been endorsed by the states parties to the Geneva Conventions and the components of the Red Cross and Red Crescent Movement by resolutions of the International Conference of the Red Cross and Red Crescent. They are used by disaster-related stakeholders as a benchmark for evaluating and strengthening domestic disaster laws. IFRC Disaster Law has also produced numerous implementation tools to facilitate the strengthening of domestic legal frameworks.

The work of IFRC Disaster Law is made possible by the generous support of its partners, who include academic institutions, law firms, governmental authorities and National Red Cross and Red Crescent Societies. If you would like to support IFRC Disaster Law's work, please contact disaster.law@ifrc.org

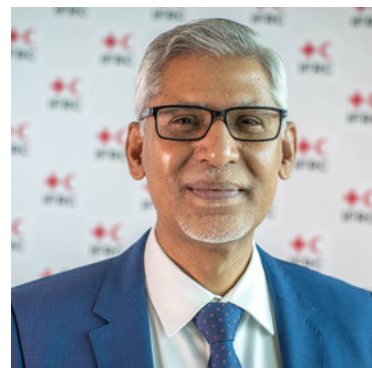
For more information about IFRC Disaster Law, please visit disasterlaw.ifrc.org/

Yemen, 2020. Saara, a Finnish physiotherapist, is in full protective equipment to give physiotherapy to a COVID-19 patient. The rehabilitation of the patient requires Saara to be in close contact with the patient, so it is extremely important that she protects herself.

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FOREWORD



While no one has been spared from the effects of COVID-19, the consequences of this pandemic have not been equally felt. This crisis has been defined by profound and persistent inequities both in terms of who is most at risk, and how the world has responded. We may not have known then the full extent of what was to come, yet we should have been better prepared. If the COVID-19 pandemic has taught us anything, it is the importance of being 'ready', and the central role of law and policy in combatting public health emergencies and in protecting communities.

Too often in this response, the most vulnerable have been left behind due to formal and informal barriers to accessing healthcare, information, financial support, and other essential services. Restrictions introduced to curb the spread of COVID-19 have also impeded the ability of some National Red Cross and Red Crescent Societies, their staff and volunteers to perform their roles as first responders to disasters and emergencies of all kinds, and in providing community-based health and social care.

Legal and policy instruments have underpinned all facets of the COVID-19 response, from unprecedented restrictions on freedom of movement and assembly to, more recently, expedited vaccine approval. Countries around the world have responded to the pandemic by declaring states of emergency or disaster, passing reams of emergency legislation, and dusting off existing laws, policies and contingency plans. Levels of success in using legal and policy instruments to respond to the pandemic have, however, varied widely. In some cases, existing laws and policies have proven to be outdated or inadequate, necessitating the rapid development of new instruments.

In this Report, IFRC Disaster Law builds on its 20 years' experience in conducting leading research and providing technical advice to governments and turns its attention to domestic laws and policies relating to public health emergencies, with a particular focus on the experience and lessons from the COVID-19 pandemic. The Report, which draws on comparative country-level research, provides comprehensive recommendations for strong and effective domestic legal frameworks for public health emergency preparedness and response.

When governments around the world emerge from the current crisis, many will wish to draw on the experience of the COVID-19 pandemic to review and strengthen their legal frameworks for disaster risk management including public health emergencies. This Report and its accompanying guidance document, *Guidance on Law and Public Health Emergency Preparedness and Response*, will provide a valuable resource for governments embarking on this endeavour.

The IFRC with its network of National Red Cross and Red Crescent Societies stand ready to work in close collaboration with governments in this regard to prevent and reduce the impact of disasters and protect the most vulnerable when faced with crisis.

Jagan Chapagain
Secretary General

ABBREVIATIONS AND ACRONYMS

| | |
|----------------------|--------------------------------------------------------------------------------------------------------------------|
| AADMER | ASEAN Agreement for Disaster Management and Emergency Response |
| AMR | Antimicrobial resistance |
| ASEAN | Association of Southeast Asian Nations |
| CARPHA | Caribbean Public Health Agency |
| CDEMA | Caribbean Disaster and Emergency Management Agency |
| CDERA | Caribbean Disaster Emergency Response Agreement |
| COVID-19 | Coronavirus Disease 2019 |
| DM | Disaster management |
| DPR | Disaster preparedness and response |
| DPR Report | Law and Disaster Preparedness and Response: Multi-Country Synthesis Report (IFRC 2019) |
| DRG | Disaster risk governance |
| DRM | Disaster risk management |
| DRR | Disaster risk reduction |
| DRR Report | Effective Law and Regulation for Disaster Risk Reduction: A Multi-Country Report (IFRC and UNDP 2014) |
| EU | European Union |
| FAO | Food and Agriculture Organization |
| GDP | Gross domestic product |
| HIV | Human Immunodeficiency Virus |
| ICCPR | International Covenant on Civil and Political Rights |
| ICRC | International Committee of the Red Cross |
| IDRL | International Disaster Response Law |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| IFRC Network | IFRC and its 192 member National Red Cross and Red Crescent Societies |
| IHR | International Health Regulations (2005) |
| IMO | International Maritime Organization |
| IOM | International Organization for Migration |
| OAS | Organization of American States |
| OHCHR | Office of the United Nations High Commissioner for Human Rights |
| OIEWG | Open-ended Intergovernmental Expert Working Group on Indicators and Terminology Related to Disaster Risk Reduction |
| PHE | Public health emergency |
| PHEIC | Public health emergency of international concern |
| RCRC Movement | Red Cross and Red Crescent Movement |
| SGBV | Sexual and gender-based violence |
| SoE | State of Emergency |
| UNDP | United Nations Development Programme |
| UNDRR | United Nations Office for Disaster Risk Reduction (formerly UNISDR) |
| WASH | Water, sanitation and hygiene |
| WB | World Bank |
| WEF | World Economic Forum |
| WFP | World Food Program |
| WHO | World Health Organization |

TERMINOLOGY

COVID-19 is an infectious disease caused by the coronavirus SARS-CoV-2. It can also be referred to as **coronavirus disease**. The terms have tended to be used interchangeably to describe the virus, the disease and the resulting pandemic. For the purposes of this Report, the terms **COVID-19** and **COVID-19 Pandemic** are used.

Disaster is a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts.¹ While this definition of “disaster” includes PHEs, the legal definition of “disaster” in a number of States either does not include PHEs or is ambiguous as to whether PHEs are included.

Disaster risk is the potential loss of life, injury, or destroyed or damaged assets which could occur to a system, society or a community in a specific period of time, determined probabilistically as a function of hazard, exposure, vulnerability and capacity.²

Disaster management (DM) is the organisation, planning and application of measures preparing for, responding to and recovering from disasters.³

Disaster risk management (DRM) is the application of policies, strategies and other measures to prevent new disaster risk, reduce existing disaster risk and manage residual risk (through disaster preparedness, response and recovery), contributing to the strengthening of resilience and reduction of disaster losses.⁴ DRM is usually interpreted as including DM and in this Report references to, for example, DRM frameworks should be read as references to DRM and/or DM frameworks.

Disaster risk reduction is aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.⁵

Emergency Decree Mapping refers to the country level desktop research commissioned by IFRC Disaster Law at the beginning of the COVID-19 Pandemic to map the legal instruments (legislation, regulations, orders, decrees etc) introduced by States as part of their immediate response to the outbreak of the Pandemic, including travel restrictions, curfews etc. These Mappings were, in particular, sought in the context of Red Cross and Red Crescent Movement components experiencing operational challenges due to COVID-19 restrictions and their impact on the operations of frontline responders. The research focused predominantly on: coordination between different actors; the types of restrictions introduced to curb the spread of COVID-19; and legal facilities for humanitarian actors, including those of the Red Cross and Red Crescent Movement. The Emergency Decree Mappings are available on the [IFRC Disaster Law website](#).

Epidemic is defined by the WHO as “The occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy. The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size, and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence.”⁶

IFRC Network refers to the International Federation of Red Cross and Red Crescent Societies’ Secretariat and its 192 National Red Cross and Red Crescent Societies, acting through their 14 million community-based volunteers.

International Health Regulations or IHR core capacities are the capacities of States to prepare for and respond to PHEs that are required by the International Health Regulations 2005 (IHR). The overarching duties imposed by the IHR require States to: (1) develop, strengthen and maintain the capacity to detect, assess, notify and report public health events;⁷ and (2) develop, strengthen and maintain the capacity to respond promptly and effectively to public health risks and Public Health Emergencies of International Concern (a term defined by the IHR).⁸ The detailed core capacity requirements for surveillance and response and for designated airports, ports and ground crossings are set out in Part A and Part B of Annex 1 to the IHR.

Legal facilities are special legal rights that are provided to a specific organisation (or a category of organisations) to enable it or them to conduct operations efficiently and effectively. Legal facilities may come in the form of positive rights (i.e. to do a particular thing), access to simplified and expedited regulatory processes, or exemptions from ordinary laws.

Legislation, laws, instruments etc. This Report considers the role of law in public health emergencies. This predominately means the **legislation** and/or **legal instruments** (the acts, ordinances, statutes, regulations and orders – often referred to as **hard law**) that create the framework for public health emergency risk management. However, many DRM or public health emergency (PHE) risk management frameworks also include policies, plans and guidance which, although not legislation per se, can often play an important role and are sometimes referred to as **soft law**. All these terms are used interchangeably in the research and literature.

Lockdown is used to refer to the various exceptional, temporary restrictions that have been imposed during the COVID-19 Pandemic which have: prohibited or limited individuals' freedom of movement and assembly; required individuals to quarantine, stay or shelter at home; or created curfews.

Non-PHE disaster is any type of disaster other than a PHE.

One Health is an approach to designing and implementing programmes, policies, legislation and research – communicate and work together to achieve better public health outcomes. The areas of work in which a One Health approach is particularly relevant include food safety, the control of zoonoses (diseases that can spread between animals and humans, such as flu, rabies and Rift Valley Fever), and combatting antibiotic resistance (when bacteria change after being exposed to antibiotics and become more difficult to treat).⁹

Pandemic refers to “the worldwide spread of a new disease”¹⁰ or “a worldwide outbreak of a disease in humans in numbers clearly in excess of normal”.¹¹

Primary PHE is a PHE where the health hazard is the direct or sole cause of the emergency.

Public health is the science of protecting and improving the health of people and their communities. It includes the promotion of healthy lifestyles, research into disease and injury prevention, and the detection, prevention and response to infectious diseases. Overall, public health is concerned with protecting the health of entire populations, although these populations can be as small as a local neighbourhood, or as big as an entire country or global region.

Public health emergency (PHE) One of the issues considered in this Report is what is meant by a public health emergency and, most importantly, how the concept is applied in domestic laws. As a starting point, the WHO definition has been adopted, namely: “an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or pandemic disease, or [a] novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human [fatalities] or incidents or permanent or long-term disability”.¹²

Public health emergency of international concern is a concept introduced by the IHR and is an extraordinary event which is determined by the Director General of the WHO: (i) to constitute a public health risk to other States through the international spread of diseases, and (ii) to potentially require a coordinated response.

Public health emergency risk management (PHE risk management) is used in this Report specifically to refer to the management of PHEs. The term is not in common usage but is used as a means of distinguishing the specific management of PHE risks from other disaster risks. It is intended to have broadly the same meaning in this context as DRM has in relation to disasters. PHE risk management is therefore an umbrella term to refer to all phases of managing PHEs from risk reduction, through to preparedness, response and recovery. However, as the concept of integrated risk management is not yet fully established in relation to PHEs and existing PHE frameworks tend to be directed primarily at preparedness or response, in many cases it might be more accurate to describe the domestic arrangements as PHE management. Nonetheless, PHE risk management is used in this Report for consistency with the wider IFRC disaster terminology. It is also believed to be more in line with the ambition of the Bangkok Principles to integrate health with wider disaster risk reduction and management laws and/or policies.

PHE Mapping refers to the country-level desktop research commissioned by IFRC Disaster Law between August and November of 2020 on legal and institutional frameworks for PHEs and the role of law in mitigating secondary impacts and impacts on vulnerable groups.

Sample States refers to the States which were the subject of the Emergency Decree Mappings and PHE Mappings (although predominantly the PHE Mappings).

Secondary PHE refers to a PHE which arises from another, non-PHE disaster: for example an outbreak of cholera following flooding.

Slow-onset disaster is used to describe a disaster that emerges gradually over time. Slow-onset disasters can be associated with, for example, drought, desertification, sea-level rise, or epidemic disease.

States and **countries**. These terms are used interchangeably. No significance should be attached to the use of one term over the other. Where the Report discusses states within a federal system the distinction is made clear.

States of exception is used to describe collectively the states of emergency, states of disaster and states of PHE that may be declared or determined in response to a PHE.

Sudden-onset disaster is a disaster triggered by a hazardous event that emerges quickly or unexpectedly. Sudden-onset disasters can be associated with, for example, earthquake, volcanic eruption, flash flood, chemical explosion, critical infrastructure failure, transport accident, but also epidemics where their emergence is sudden.

Vulnerability is defined as the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.¹³

Tajikistan, 2021. Tajikistan Red Crescent volunteers distribute essential food items, such as wheat flour, vegetable oil, sugar, rice, tea and salt to vulnerable families affected by the COVID-19 pandemic.

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EXECUTIVE SUMMARY

PART A INTRODUCTION

1. Background and context

This Report has been commissioned by IFRC Disaster Law as part of a Project on Law and Public Health Emergencies (the **Project**). The Project's objective is to examine the law's role in public health emergency (**PHE**) preparedness and response, and to provide guidance specifically in relation to domestic PHE law and policy. This Report draws on country-level desktop research mappings of: (a) the emergency measures taken at the beginning of the COVID-19 Pandemic in 113 States (**Emergency Decree Mappings**); and (b) the legal and institutional frameworks for PHEs and the role of law in mitigating their impacts (**PHE Mappings**) in 36 States or sub-national jurisdictions within federal States (collectively referred to as **Sample States**). It also builds on the IFRC's Law and Disaster Preparedness and Response: Multi-Country Synthesis Report (the **DPR Report**). Detailed information about the methodology for the research underpinning this Report is provided in Chapter 1, Section 1.2.

The Report analyses current domestic laws and policies in the States surveyed and provides recommendations in three main areas: (1) overarching domestic legal and institutional frameworks for PHEs (i.e., the architecture of PHE risk management); (2) legal measures for mitigating both the secondary impacts of PHEs and impacts on vulnerable groups; and (3) legal facilities for humanitarian actors during PHEs. The recommendations provided in this Report have been formulated based on the evidence and good practice disclosed in the Emergency Decree and Public Health Mappings, the literature, previous reviews and enquiries into PHEs, and the experience and knowledge of the IFRC network. They seek to identify the key legal issues that decision-makers need to consider and to provide general guidance on how PHE laws and policies can – similar to more general disaster laws – underpin the key components of effective and equitable preparedness and response.

2. Public health emergencies

Although there are different definitions of PHE, the Project adopts the definition of a “PHE” used by the World Health Organization (**WHO**), namely: “an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or pandemic disease, or [a] novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human [fatalities] or incidents or permanent or long-term disability.”

Another key term for the purposes of this Report is a “public health emergency of international concern” (**PHEIC**), which is defined under the International Health Regulations 2005 (**IHR**) as “an extraordinary event which is determined [by the Director General of the WHO]: (i) to constitute a public health risk to other States through the international spread of disease, and (ii) to potentially require a coordinated response.” States are required to notify the WHO of PHEs that are or may be PHEICs, and the declaration of a PHEIC by the WHO can lead to temporary recommendations being issued to States.

PHEs at a domestic level may be or become PHEICs, but many will not be, and even relatively small outbreaks can have devastating health and economic consequences for those affected. Thus, whilst it is important for States to address PHEICs in their legislation, domestic PHE risk management frameworks need to provide for all levels and types of PHE. Moreover, while the increasing number, frequency and diversity of zoonotic disease outbreaks is a major public health threat, there are many other risks that need to be addressed including bioterrorism and slow-onset risks such as antimicrobial resistance.

PART B LEGAL AND INSTITUTIONAL FRAMEWORKS FOR PUBLIC HEALTH EMERGENCIES

3. Global legal and institutional frameworks

The global context

Although the principal aim of this Report is to analyse domestic legal and institutional frameworks for PHEs, these frameworks are set within and directed by a number of international instruments, in particular the IHR.

In addition to the IHR, a number of international instruments are relevant to PHE risk management. Although not the primary focus of the Sendai Framework for Disaster Risk Reduction 2015–2030 (**Sendai Framework**), public health risks and impacts are addressed in many of the Framework's Global Targets and Priorities for Action. This is supplemented by the Bangkok Principles on the Implementation of the Health Aspects of the Sendai Framework (**Bangkok Principles**), which encourage systematic cooperation, integration and coherence between disaster and health risk management. Improved PHE risk management is essential to achieving Sustainable Development Goal 3 (to ensure healthy lives and to promote well-being for all at all ages) and is an intrinsic part of the Global Health Security Agenda. The threat posed by PHEs, and the role that National Red Cross and Red Crescent Societies can play in PHE preparedness and response, has also been the subject of resolutions of the International Conference of the Red Cross and Red Crescent, in particular Resolution 3 of the 33rd International Conference.

Although the role of regional arrangements in enhancing domestic PHE risk management is recognised by the IHR and the High-Level Panel on the Global Response to Health Crises, and while regional arrangements for generic DRM are well-developed, those for PHE risk management are currently relatively limited.

The International Health Regulations 2005

The most important international instrument relating to PHEs is the IHR, an international treaty that is legally binding on its 196 member States. The IHR provide an overarching framework that defines States' rights and obligations in handling public health events and emergencies that have the potential to cross borders. Most relevantly for this Report, the IHR impose duties on States to develop, strengthen and maintain core capacities, including: (1) the capacity to detect, assess, notify and report public health events; and (2) the capacity to respond promptly and effectively to public health risks and PHEICs. The IHR also require States to: (1) designate or establish a National IHR Focal Point; (2) ensure that effective contingency arrangements to deal with an unexpected public health event are maintained; and (3) ensure that competent authorities communicate with the National IHR Focal Point on relevant public health measures taken.

The impact of the IHR on domestic PHE frameworks

Unfortunately, a series of reviews undertaken under the IHR or at the behest of the WHO between 2011 and 2016 – and the literature – highlight a general failure by States to implement the core capacities required by the IHR. Further, in 2016 the High-Level Panel on Global Response to Health Crises found that the mechanism for monitoring compliance with the IHR core capacity requirements is weak and the lack of independent assessments of compliance affects international efforts to support more vulnerable countries in implementing the capacities.

In response to these findings, the WHO introduced a number of initiatives under its IHR Monitoring and Evaluation Framework, including annual reporting, Joint External Evaluation (**JEE**), simulation exercises and after-action review. JEE, in particular, has considerable potential benefit. States that have completed a JEE have generally taken positive action to address the identified shortcomings in their



Democratic Republic of the Congo, 2018. The 2018 outbreak of Ebola was incredibly complex. It unfolded in a region affected by a two decades-long conflict that has claimed countless lives and deprived millions of even the most basic needs and services. More than 2 million people were screened at a variety of infection prevention and control sites. Wearing protective equipment can look intimidating to communities. Volunteers are writing their names to allow people to identify with someone behind the layers and masks. © IFRC / Corrie Butler

IHR implementation, including developing National Action Plans for Health Security (**NAPHS**). However, JEEs are voluntary and there is no obligation on States to implement their findings. Moreover, the extent to which JEE teams can secure contributions from all relevant actors and stakeholders is not clear, and JEEs may not take into account States' wider disaster risk management (**DRM**) arrangements or the level of coordination and integration between PHE and disaster risk management frameworks and actors. Domestic implementation of the IHR could potentially be strengthened by making JEE (or another external evaluation process) mandatory, ensuring that all relevant actors and stakeholders can contribute to external evaluation, and requiring the development and implementation of post-evaluation plans.

At the domestic level, IHR implementation may be strengthened by States establishing a committee to oversee the implementation and monitoring of the IHR, and by making express provision for the designation and functions of the National IHR Focal Point in their national legislation. Greater scrutiny and transparency regarding domestic IHR implementation could be achieved by the IHR requiring States to deposit copies of laws and/or policies implementing the IHR with the WHO with, in turn, the WHO making those instruments publicly accessible on-line. Finally, legal aspects of PHE and IHR core capacities could be included more regularly within the work of relevant networks, such as the Thematic Platform for Health EDRM.

The IHR as they currently stand are only concerned with notification or early warning being given to the WHO or other States. They do not provide for notification or early warning to key actors, or the general population, of the affected State. Perhaps partly as a result, surveillance and early warning of PHEs is rarely expressly mentioned in domestic PHE laws. There is, therefore, scope for notification and early warning to be enhanced, both through amendments to the IHR itself and domestic law.

4. Domestic legal and institutional frameworks for PHEs

An effective PHE risk management framework – similar to general DRM frameworks – should be comprehensive. It should collectively encompass all jurisdictions (national and sub-national), all types of public health hazards, all functions (policy, operations, monitoring and evaluation etc.) and all phases (risk reduction, preparedness, response and recovery). In addition, it is critical for there to be clarity about the roles of different actors to avoid confusion and unnecessary delays, particularly where immediate assistance is needed to save lives. Consistent with the all-of-society, whole-of-government and One Health approaches, coordination mechanisms should include all relevant actors and stakeholders. Indeed, the large number of actors and stakeholders that can be impacted by, and need to plan for and respond to a PHE, make the need for a comprehensive, all-encompassing framework essential.

Integration

One of the tasks of this Report is to consider the degree to which PHE risk management is separate from or integrated within wider DRM frameworks. This is in part to understand the extent to which the Bangkok Principles' recommendations – that PHE risk management frameworks and DRM frameworks should be better integrated – are currently implemented.

The PHE Mappings reveal that the framework, functions and powers for PHE risk management are derived from three broad categories of laws and/or policies: PHE or public health laws and/or policies; DRM laws and/or policies; and laws which enable and govern states of exception, principally states of emergency (**SoEs**). There are three broad categories of framework for PHE risk management:

1. frameworks based solely on PHE or public health legislation or based solely on such legislation but with the availability of DRM or SoE legislation in extreme circumstances (**'PHE dominant frameworks'**);
2. frameworks that are mainly based on PHE legislation, but with DRM and/or SoE laws supporting and supplementing that legislation to a lesser or greater extent (**'hybrid or combination frameworks'**); and
3. frameworks based solely on DRM legislation (**'DRM dominant frameworks'**).

Overall, the PHE Mappings indicate that hybrid frameworks are the most common. In most cases, PHE or public health legislation identifies the lead authority (usually the minister or ministry of health) and provides the powers and controls to be used in a PHE (such as the ability to make or exercise emergency powers, impose quarantines etc.). In contrast, it is typically DRM legislation or guidance that requires actors to prepare for a PHE or establishes coordination arrangements. There is, therefore, limited evidence of full integration of PHE risk management and DRM laws. There is, however, greater evidence of integration at the policy and planning level through the adoption of genuinely all hazard policies and plans – although this is by no means universal.

Whilst there is an identified need for improved integration and enhanced cohesion between PHE risk management and DRM – which this Report reinforces – there is not yet an identified, common approach as to how exactly this can be achieved. This may, of course, be achieved through a single piece of DRM legislation governing all hazards and all types of disaster, including PHEs. However, the Bangkok Principles do not require this approach and there is (at least at present) no evidence to suggest that this type of framework is *necessarily* more effective than others. In the absence of this evidence, what can instead be said is that, whatever type of framework is adopted, integration requires an absence of gaps, conflict, inconsistency or unnecessary duplication between the powers, roles, responsibilities and other arrangements created by PHE and DRM instruments. The fact that hybrid frameworks appear to be the most common type of arrangement underlines the importance of conducting reviews to identify whether any such issues exist and, if so, how they can be resolved to achieve greater integration.

Mandates for managing PHEs in domestic Law

Although many Sample States have introduced legislation in recent years which recognises the type of modern public health risks that may arise – covering, for example, bioterrorism and AMR – and applies modern concepts of DRM, many have not. The use of relatively old legislation remains widespread. This can have two consequences: (1) the legislation may not apply an all-public health risks approach and the powers to respond to a PHE may be overly restricted, applying only to a prescribed list of diseases (some of which may no longer be prevalent); and (2) the legislation may not make provision for the full risk management continuum and, in particular, the risk reduction and recovery phases may be absent. Many States therefore need to review and update their legislation to ensure that it is fit for modern purpose.

In general, the PHE Mappings provide limited evidence that States' PHE risk management frameworks make provision for all phases of a PHE (i.e. risk reduction, response, preparedness and recovery). PHEs are forecast to become more frequent. Therefore, there needs to be greater recognition of the importance of risk reduction as part of PHE risk management frameworks, taking account of developments such as the One Health approach.

Coordination and leadership

The DPR Report identifies that inadequate coordination is a serious problem in international and domestic disaster response operations and, at the domestic level, highlights: (1) gaps in coordination between different sectoral agencies and/or levels of government; and (2) gaps in coordination between governmental and non-governmental actors, including international actors. Unfortunately, the PHE Mappings suggest a similar picture may exist in relation to the coordination of PHEs.

While the PHE Mappings identify a wide range of PHE coordination mechanisms, most Sample States rely on the use of standing DRM coordination mechanisms for PHE preparedness and response. These mechanisms may not always be constructed to address particular coordination needs in PHEs, including involving the wider range of actors and stakeholders who should be involved. On the other hand, however, the use of existing DRM arrangements avoids duplication and may promote better integration and understanding. Overall, the key is that, regardless of what type of coordination mechanisms are constructed, they are clearly set out in law and/or policy, include all key actors and are well understood by those actors.

The PHE Mappings identify a variety of arrangements for the leadership of a PHE response. Such leadership can have a number of aspects: for example, legal leadership, operational leadership and political leadership. Leadership can also be joint or collegiate. In most of the Sample States legal leadership of the response to a PHE is the responsibility of the minister of health or the health ministry. However, leadership uncertainty may arise where, for example, parallel powers under states of emergency are deployed or political leadership overlaps and/or conflicts with legal powers. For this reason, it is essential for the leadership arrangements (including the functions for which actors have lead responsibility and the points at which those responsibilities arise) to be clearly identified in law and/or policy.

Participation and representation

The Sendai Framework encourages an all-of-State and all-of-society approach to DRM that facilitates the participation of all stakeholders. The COVID-19 Pandemic has shown that a large-scale PHE can impact, or require action from, virtually every tier of government, every sector, every region, every community and every individual. An all-of-government and all-of-society approach is, therefore, arguably even more essential in respect of PHEs than other types of disaster.

Unfortunately, the PHE Mappings indicate that an all-of-State and all-of-society approach to PHE risk management is not yet a reality. Most States have laws and policies which enable the participation of

elements within government and public authorities. There is, though, a focus on departments and agencies that may have a role in preparing for and responding to a non-PHE disaster. As the COVID-19 Pandemic has demonstrated, assuming that only these departments and agencies will be involved in a PHE can lead to the omission of key actors.

More concerningly, the PHE risk management frameworks reported in the PHE Mappings provide little evidence that stakeholders outside government are enabled to participate in PHE preparedness and response. As for other disasters, community involvement is important and, in particular, can improve both surveillance (i.e. identifying outbreaks early) and communication of public health information. The following groups, sectors and interests also need to be included in PHE risk management: One Health actors; development cooperation actors; providers of health and social care (especially those outside the State sector); National RCRC Societies and other humanitarian organisations; schools and school authorities; the financial sector; and manufacturers and suppliers of essential goods and equipment.

PHE preparedness: contingency planning

The PHE Mappings indicate that laws and/or policies generally make provision for PHE preparedness, however this is usually found in wider DRM frameworks rather than in PHE or public health specific instruments. Nonetheless, many States could improve their preparedness arrangements by setting out clearer, more detailed requirements for PHE contingency planning.

Embedding understanding, learning lessons

A key requirement of any PHE risk management framework is that its users understand what it says, how it works and the roles, responsibilities and expectations of each actor and participant. Some PHE Mappings suggest that, where exercises had been undertaken, States were better prepared for the COVID-19 Pandemic. Indeed, communities need to be aware of the risks of PHEs to enable them to recognise and better prepare for those risks and to respond if a PHE occurs. Training and simulation exercises may also help prepare communities for the type of restrictions that may be required.

It is also important to learn lessons during and after PHEs, and to conduct regular reviews to ensure the PHE risk management framework addresses new or emerging public health threats. However, based on the PHE Mappings, it is not evident that regular review in light of new or emerging risks is commonly mandated. States should therefore consider introducing some form of continuous 'lesson learning' process and regular review. Learning the legal lessons from previous PHEs is just as important as the operational lessons. Given the large number of lawyers and legislative counsel who have gained experience in drafting emergency legislation during COVID-19, there is an opportunity for the development of national networks of lawyers to further develop legal knowledge and expertise relating to PHEs.

5. States of exception and emergency powers in a PHE

The source and nature of states of exception and emergency powers

A common mechanism for initiating disaster response is the declaration of a state of emergency or a state of disaster. States of emergency are generally designed for extreme and unforeseeable situations that fundamentally challenge the prevailing legal order such as civil war or widespread civil unrest, although they may be worded broadly enough to apply to any kind of disaster, including PHEs. The effect of declaring a state of emergency is generally to centralise decision-making and enable the exercise of extraordinary, potentially extra-statutory powers, by government or public authorities. In contrast, states of disaster are usually found in DRM legislation and responsibility for declaring a state of disaster may be vested in officials at lower levels of government. The effect of declaring a state of disaster is usually to activate disaster management plans and trigger special governance arrangements and governmental powers that do not otherwise exist, such as powers to evacuate people.

The PHE Mappings indicate that both states of emergency and states of disaster can be used for PHEs. Additionally, in most of the Sample States governments can also declare or determine states of PHE, which trigger powers specifically designed to deal with PHEs. Where states of PHE are provided for in domestic legislation, they tend to be similar to states of disaster in nature and effect. The power to make a declaration of a state of PHE, or the trigger for PHE related emergency powers, is typically found in PHE legislation. In this Report, states of emergency, states of disaster and states of PHE are collectively referred to as **states of exception**.

The risks of over reliance on states of emergency – as opposed to more constrained or prescribed states of disaster or PHE – can be both legal and practical. The legal risks are obvious: the triggering of unnecessary, unlimited or disproportionate emergency powers, which can be exercised without (or with only limited) scrutiny and may lead to the infringement of rights. Use of states of emergency may also have a detrimental impact on operational effectiveness if they introduce exceptional arrangements involving new actors or actors in unfamiliar roles. For this reason, the use of states of disaster or states of PHE should be preferred, although states of emergency – and the more exceptional powers and measures that they trigger – may at times be necessary.

Responsibility for declaring a state of exception

The PHE Mappings indicate that, where declarations of a SoPHE or the trigger for PHE related emergency powers are provided for in PHE legislation, responsibility is normally expressly set out and is usually vested in actors within the health sector. In most cases, an identified person – usually the minister of health or senior official in the ministry of health – is given the responsibility to declare or determine that a state of PHE exists. A similar level of certainty about who is responsible for declaring a state of emergency also usually exists. In a PHE, however, the official responsible for triggering a state of exception may themselves be affected by the relevant health threat. It is, therefore, important to ensure that there is a hierarchy of officials authorised to make a declaration or determination, in case the named official becomes unavailable.

In a number of Sample States, states of exception can only be declared if there has been consultation with, or the agreement of, specified governmental actors such as ministers, sectoral agencies or sub-national governments. This type of requirement constitutes good practice because it may: (1) preclude the concentration of power in the hands of a single person or entity; (2) preserve the autonomy of sub-national jurisdictions; and (3) give appropriate weight to the expertise of relevant sectoral agencies.

Triggering and timing of states of exception and emergency powers

As the DPR Report recognises, it is vital that the law clearly sets out the legal triggers for the declaration or determination of states of exception and the enlivenment of emergency powers. The question of the timing of the trigger is very important. The PHE Mappings indicate that many States' legislation now provides for the trigger to be pre-emptive: that is, the state of exception can be declared or determined when there is an imminent threat. Other States, however, still rely on reactive triggers, requiring a public health risk to have already materialised to some degree before emergency powers can be deployed. It can be challenging to get the timing of a trigger right. If triggers are reactive, by the time a declaration is made, the window for certain preventative or preparatory actions may have closed; if triggers are pre-emptive, emergency powers may be used too soon or unnecessarily. Nonetheless, the speed of the spread of COVID-19 both internationally and domestically supports the view that the law should contain pre-emptive triggers to enable a valuable head-start on a PHE response. With appropriate checks in place, the ability to declare and determine states of exception pre-emptively should form part of a State's arsenal against serious public health threats.

The nature of emergency powers and emergency measures

The emergency powers that may be deployed to respond to a PHE fall into two broad categories: (1) emergency law making powers – usually giving the executive the ability to make legislation (such as decrees, orders or regulations); and/or (b) emergency executive powers – enabling authorities to take actions that would otherwise not be lawful (for example, order evacuation, seize property, restrict movement). Emergency powers of some kind were deployed by every Sample State to respond to the COVID-19 Pandemic. In some cases, emergency legislative powers were used to create new emergency powers. In most cases, however, the emergency powers used were already prescribed to a lesser or greater extent in existing legislation. In general, although it may be appropriate for broader powers to be available in the event of severe PHEs, it is preferable for the law to clearly set out which emergency powers are available in the event of a PHE in a pre-determined, precise and exhaustive list.

The impact of states of exception and emergency powers on human rights

The COVID-19 Pandemic has illustrated that domestic responses to a PHE may involve introducing measures that have human rights impacts, such as restrictions on movement and assembly, curfews, mandatory closure of businesses and schools, mandatory quarantine and compulsory shielding or self-isolation of the most susceptible. In principle, most human rights instruments permit States to limit certain rights in order to take measures dealing with serious threats to the health of the population or individual members of the population. This does not, however, give States the ability to cite health grounds and, as a result, do whatever they wish. Limitations on human rights should be necessary, proportionate and prescribed by law.

Safeguards and scrutiny during states of exception

It should be uncontentious that the declaration or determination of a state of exception and the use of emergency powers should be subject to safeguards, namely in the form of legislative and/or judicial supervision. In relation to legislative supervision, there is a reasonable argument that during a rapidly developing PHE, subsequent (rather than prior) approval of executive action is more appropriate. The PHE Mappings suggest that this approach, involving subsequent ratification of executive action by the legislature, is already the most common approach among the Sample States. The PHE Mappings do not comment specifically on judicial supervision although, with one exception, they do not suggest that this has been excluded. In addition to legislative and judicial supervision, scrutiny of executive action during a PHE can be promoted by transparency measures, such as requiring notice of states of exception and emergency measures to be provided to the widest possible audience, not just in a public register of laws.

Langfang City, China, 2020. The Red Cross emergency rescue volunteer service team is involved in epidemic prevention and elimination work.
© Red Cross Society of China



PART C THE ROLE OF LAW IN MITIGATING SECONDARY IMPACTS OF PHEs AND IMPACTS ON VULNERABLE GROUPS

6. Impact of PHEs on human mobility and migration

Human mobility generally

All disasters can have an impact on human mobility, often leading to forced displacement and, in some cases, planned relocation. Similar to other types of disaster, a PHE may prompt physical flight. Fear of contagion or a desire to avoid lockdown restrictions may drive internal and international movement. PHEs can, however, affect mobility in quite different ways than other types of disaster. In particular, as the COVID-19 Pandemic has shown, restrictions imposed to prevent the spread of disease can create the opposite of forced displacement: forced immobility.

Border closures

Forced immobility was a major consequence of the border closures and travel restrictions adopted by almost all the Sample States. These measures were applied in response to the COVID-19 Pandemic despite WHO IHR temporary recommendations advising against them. They were also potentially in breach of wider international obligations. The International Covenant on Civil and Political Rights, in particular, provides that individuals should be free to leave any country, including their own, and should not be arbitrarily deprived of the right to enter their own country. While border closures and travel restrictions may be a reasonable means of preventing the spread of disease, especially in the early stages of an outbreak, they should be: (1) necessary and proportionate to combating the public health threat; (2) time-bound; (3) prescribed by law; and (4) in compliance with international legal obligations.

Border closures and travel restrictions introduced during COVID-19 had a negative impact on many migrants and expatriate workers wishing to return home. The PHE Mappings report that, in most cases, citizens or permanent residents were exempted from inbound border restrictions and permitted entry, however in some cases restrictions on outbound travel and practical impediments (e.g. a lack of commercial flights) complicated matters. Another badly affected group are the estimated 200,000 seafarers who continue to be trapped on board ships by border restrictions. The PHE Mappings reveal that a number of States did, however, provide positive assistance to individuals wishing to be repatriated. As such problems are likely to arise during future outbreaks of novel diseases, they should be addressed within PHE laws, policies and plans.

Refugees and asylum seekers

The PHE Mappings specifically report on issues facing refugees and asylum seekers during the COVID-19 Pandemic. Two main issues are identified: (1) whether border closures and travel restrictions prohibited entry and/or forced the return of refugees and asylum seekers; and (2) whether applications for asylum were still being processed. With respect to the first issue, at the outset of the COVID-19 Pandemic, the UNHCR estimated that, of the 123 States that had fully or partially closed their borders, 30 States had made no exception for asylum seekers. The PHE Mappings reveal that a number of the Sample States had exceptions for “humanitarian reasons” which, while not specific to asylum seekers and refugees, arguably are applicable. With respect to the second issue, in most Sample States, it is reported that the laws governing refugees and asylum seekers remained in force and were being applied, although some delays in the processing of asylum applications were reported.

7. Shelter and housing

Compared to other types of disaster, PHEs raise quite different questions in relation to housing and shelter, mainly because they are less physically destructive. As demonstrated by the COVID-19 Pandemic, during PHEs the principal concerns are twofold. Firstly, the homeless may be at particular risk, for example, because they lack access to hygiene facilities, treatment or support. Second, the secondary impacts of a PHE on economic activity and livelihoods can increase the number of people at risk of losing their housing.

Homelessness and the homeless

During COVID-19 most of the Sample States introduced measures to provide accommodation for the homeless and/or enhanced sanitation. To achieve this Sample States either introduced new initiatives or programs or relied upon existing ones; legislation was uncommon. A positive benefit was that some States combined the need to find accommodation – to enable self-isolation or effective social-distancing – with longer term plans to reduce homelessness. More typically, the support provided was by way of targeted advice and access to sanitary measures. However, most of the measures taken were reactive, even if built upon pre-existing initiatives. As the potential impact of a PHE on the homeless is now known, it should be addressed in laws, policies and plans relating to PHEs so that States are ready to take the action required to protect and support this group.

Loss of housing

Most of the Sample States recognised from an early stage that the economic impact of the COVID-19 Pandemic could lead to people potentially losing their homes. Many Sample States adopted measures to address housing-related issues, primarily: (1) the inability of tenants and homeowners to pay rent or make mortgage payments; and (2) the need to protect households from eviction or foreclosure where, for COVID-19 reasons, they could not pay their rent or mortgage. A number of Sample States legislated to prohibit or postpone evictions. More common, although by no means universal, was the provision of financial support to tenants and homeowners. Again, most of the legislation appeared to be reactive, with little or no standing legislation enabling action to be taken by governments. Given that similar support may be required in future PHEs, it would be sensible for States to secure standing powers to take such action and to ensure that the type of arrangements required are included in laws, policies and plans for PHEs.

Bangladesh, 2021. A huge fire broke out in the camps in Cox's Bazar on 22 March 2021. IFRC released emergency Disaster Response Emergency Funds to support immediate relief. Teams of volunteers are helping people to access vital services, such as medical care.
© Bangladesh Red Crescent Society



8. The protection of vulnerable groups

Vulnerability in PHEs

As with wider DRM laws, many PHE laws focus on the roles and responsibilities of institutions and actors and make limited reference to affected populations. However, the protection of those potentially affected by a PHE, and especially the most vulnerable, should be the principal aim of PHE risk management frameworks and the laws that underpin them.

The DPR Report identifies eight categories of people who may, depending on the circumstances, be especially vulnerable to disaster impacts: women and girls; children, especially unaccompanied and separated children; older persons; persons with disabilities; migrants; indigenous groups; racial and ethnic minorities; and sexual and gender minorities. It also highlights that other groups (such as religious and political minorities and marginalised classes or castes) may also be disproportionately affected by disasters depending on the local context.

PHEs create additional categories of vulnerability. Most obviously, those susceptible to the disease or infection that causes a PHE will be among the most vulnerable. The nature of PHEs also places those who provide health care at far greater risk. There are also secondary health impacts, including the effect on the mental health of those subject to lockdown and the disruption caused to other health care services. Stigma may be attached to those affected by a disease and PHEs can also cause new or additional social and economic marginalisation.

People at risk from the disease

Those who are most immediately vulnerable to any PHE are those susceptible to the relevant disease (or other public health hazard) itself. Although older people and those with underlying health conditions were particularly susceptible to COVID-19, different diseases can – and will – infect or affect different groups, and the experience of the disease can have very different outcomes for different groups. For example, young adults were at particular risk during the 1918 Influenza Pandemic, while pregnant women and their unborn children were at particular risk during Zika virus outbreaks. It is therefore important that laws, policies and plans relating to PHEs do not assume that any particular group(s) will *necessarily* be vulnerable to future public health hazards and, instead, anticipate various eventualities.

In response to COVID-19, most Sample States recognised the need to provide particular protection to those most at risk of infection or disease. Many different approaches were adopted, including shielding (voluntary or mandatory) and various measures to improve access to services and supplies (e.g. healthcare, COVID-19 testing, medication and sanitary supplies). Measures adopted to protect the most susceptible – such as requirements to shelter at home or undertake compulsory treatment – have to tread a fine line between (1) ensuring that such groups are protected as much as possible and (2) avoiding infringements of their fundamental rights. A balance may be struck by only imposing measures that are proportionate to the health threat, time-bound, prescribed by law and subject to appropriate scrutiny.

Older people and people with disabilities or illness

Older people and people with disabilities or illness may be particularly vulnerable in the event of any disaster. In a PHE caused by an infection or disease, these groups may be additionally vulnerable because their age, disability or illness may make them more susceptible to the disease itself. The PHE Mappings indicate that, during the COVID-19 Pandemic, governments put in place varying types and levels of support packages or assistance for this group. Some PHE Mappings, however, express concern about gaps in care for older persons and persons with disabilities, including accessing their normal health or social care services. Barriers to accessing information and testing are also reported.

This underlines the need for laws, policies and plans for PHE risk management to make provision for the specific needs of older people and people with disabilities or illness during PHEs.

Protecting wider access to health care

COVID-19 has shown that the ability of the wider population to access health care for reasons unrelated to the infection or disease at the centre of a PHE can be significantly impacted during a PHE. Difficulties in accessing health care have been widely reported, with one example being the stalling of malaria programmes. In light of these difficulties, it is important that laws, policies and plans relating to PHEs address continuity of general health care services during a PHE to ensure the population can receive treatment for conditions or illnesses unrelated to the PHE itself.

People at economic and financial risk

Pre-existing economic marginalisation can increase vulnerability to disaster: vulnerable housing and livelihoods can expose people to more severe impacts (e.g. mortality, morbidity, financial loss). In a PHE there are additional factors: for example, transmission may be higher among people with low socio-economic status, poverty may be a barrier to accessing healthcare (especially in States whose health care systems are primarily run by private providers), or measures taken to address the PHE may disproportionately impact those with low or no incomes.

One of the most significant features of the COVID-19 Pandemic has been the financial consequences of the measures taken to minimise the direct impact of the disease, such as business closures and travel restrictions. Virtually all the Sample States responded to the COVID-19 Pandemic by introducing varying packages of financial support for businesses and individuals. The most commonly reported form of assistance was provided to businesses to help them survive any downturn due to the COVID-19 Pandemic and avoid having to lay off employees. However, the type of support varied widely and there were significant distinctions between States with the capacity to provide financial assistance and those which did not have the capacity to offer support.

In most cases, financial support measures had to be created rapidly in response to COVID-19. This points to the need for: (1) the inclusion in PHE preparedness arrangements of agencies or organisations which provide economic or financial support; and (2) standing laws and/or policies that may be triggered when a PHE occurs, rather than having to be created upon the arrival of a PHE.

Protecting those at risk of violence

Incidents of domestic violence (including intimate partner violence and violence against children) increased during the COVID-19 Pandemic. Some of those at risk were unable to escape from violence or abuse or seek protection due to restrictions on movement. In addition, the physical closure of schools removed one of the main protections for children against child abuse: with so many children being educated at home, teachers were not able to monitor their welfare to the same extent (if at all). A number of the Sample States took specific legislative action to address these problems, in particular directing protection agencies to maintain support and/or provide additional resources. Another measure that some Sample States adopted was to provide exemptions from lockdown rules to permit people experiencing, or at risk of, domestic violence to leave and/or remain away from their homes or usual place of residence.

School children

Without exception, schools were physically closed in Sample States at the start of the COVID-19 Pandemic. The COVID-19 Pandemic was not unique in causing school closures: the Ebola outbreak had a significant impact on education in Liberia and Sierra Leone. Schooling can be disrupted during most types of disaster, but the main difference with PHEs is that the disruption can be much more widespread and of much longer duration. If children are out of school for lengthy periods of time,

it can have a significant adverse impact on their education, social development and physical and mental health.

The most obvious consequence of physical school closure, the lack of teaching, was addressed in most Sample States by online teaching or learning and/or home-schooling. In some Sample States, this was facilitated by legislation, while in others legislation did not appear to be required. The move to on-line education was not, however, universal and relied on the following assumptions: (i) the capacity to provide remote learning – a challenge for educational systems that already struggle to provide a universal education; (ii) States and families having the necessary IT infrastructure; (iii) children having the capacity and maturity to adhere to on-line learning – a challenge for very young children; and (iv) families having the capacity and availability to support their children.

Overall, the experience of the COVID-19 Pandemic and previous PHEs, underlines the importance of enabling the participation and representation of schools and school authorities in all phases of PHE risk management, and in requiring contingency planning for educational continuity during PHEs.

Migrants and marginalised racial and ethnic groups

Migrants and marginalised racial and ethnic groups are at risk of being disproportionately impacted by any disaster (including PHEs) due to discrimination and economic marginalisation. Discrimination in disaster preparedness and response may not only be direct, but also may be indirect where programmes and measures are not adapted to the specific needs of these groups – for example, through failure to provide risk information and warnings in diverse languages. Irregular migrants may be at particularly heightened risk due to ineligibility for government programmes and/or an unwillingness to engage with official services out of a fear of enforcement action.

The PHE Mappings reveal that the particular issues affecting migrants during a PHE may include: (1) access to health care; (2) access to financial support; and (3) the consequential impact of travel restrictions on migrants' immigration status. With respect to access to health care, the PHE Mappings indicate that the Sample States adopted a range of approaches from providing full access to health care through to excluding migrants or only providing partial or conditional access. With few exceptions, financial or welfare benefits provided during the COVID-19 Pandemic were only available to citizens or permanent residents.

Access to health care or benefits may, in some immigration systems, also have an adverse impact on immigration status and/or undermine applications for permanent residency. A number of Sample States took specific action to ensure that migrants who accessed COVID-19 support were not prejudiced as a consequence. Another positive measure adopted by some Sample States was to extend or automatically renew visas for migrants whose visas had expired, but who could not return home due to border closures and travel restrictions.

The PHE Mappings tend not to provide information specifically in respect of marginalised racial and ethnic groups. The principal impact reported is that these groups may experience language and cultural barriers to accessing information, health care and other assistance during a PHE. Some Sample States took steps to address language and cultural barriers by, for example, disseminating health information in a variety of languages. The PHE Mappings also contain some limited examples of specific new laws or policies being adopted to address the potential impact of COVID-19 on indigenous groups.

The above findings demonstrate the need – raised throughout the Report – to improve the participation and representation of these groups in PHE risk management. Moreover, they highlight the need to ensure that migrants have full access to health care during a PHE regardless of their immigration status, and to implement measures to remove language and cultural barriers to accessing information, health care and other support.

PART D LEGAL FACILITIES FOR HUMANITARIAN ACTORS

9. Legal facilities for humanitarian actors

Legal facilities

The term legal facilities refers to special legal rights that are provided to a specific organisation (or a category of organisations) to enable it or them to conduct operations efficiently and effectively. Legal facilities may come in the form of positive rights (i.e. to do a particular thing), access to simplified and expedited regulatory processes, or special exemptions from a law or legal requirement that would otherwise apply.

Since its inception in 2001, IFRC Disaster Law has had a strong focus on ensuring that legal facilities are available to certain disaster responders in order to support effective disaster response. The DPR Checklist, which was endorsed by the States parties to the Geneva Conventions and RCRC Movement components in 2019 at the 33rd International Conference of the Red Cross and Red Crescent (International Conference), identifies the legal facilities that are required for domestic humanitarian organisations for disaster preparedness and response. The IDRL Guidelines, which were unanimously adopted by the States parties to the Geneva Conventions and RCRC Movement components in 2007 at the 30th International Conference, include recommendations for minimum legal facilities that should be provided to assisting States and eligible assisting humanitarian organisations for international disaster response.

While not all the legal facilities identified in the DPR Checklist and the IDRL Guidelines may be applicable to a PHE – and are, therefore, not all discussed in this Report – it remains generally advisable for States to develop standing laws and policies that provide the legal facilities identified in the DPR Checklist and the IDRL Guidelines.

The impact of COVID-19 restrictions

In many cases, restrictions introduced in response to the COVID-19 Pandemic had a significant impact on IFRC Network and other humanitarian organisations' operations. In some States, there was uncertainty regarding whether National RCRC Societies were exempt from COVID-19 restrictions on freedom of movement and were, therefore, permitted to move freely throughout the country and access communities. COVID-19 restrictions also meant that the IFRC Network did not have access to its warehouses and pre-positioned stock in some cases. Further, of the 100 pandemic related IFRC Network 'deployments' to the end of September 2020, 86 had to be carried out remotely.

Restrictions having a particular impact on humanitarian assistance (both international and domestic) fell into four broad categories: (1) restrictions on internal movement including shelter-in-place orders and lockdowns; (2) mandatory business closure requirements or restrictions on trading; (3) restrictions that had the effect of preventing or inhibiting the cross-border movement of people including border closures, visa suspensions and quarantine; and (4) the imposition of restrictions on the import or export of goods, including on PPE and medical supplies. In addition, some issues were caused not by the introduction of new restrictions but by the need for – at times, failure of – governments to lift or waive existing requirements to enable operations to be undertaken.

Restrictions on internal movement and business

Many States introduced restrictions on movement (e.g. lockdowns, curfews, shelter-in-place orders) and on business operating hours in order to curb the spread of COVID-19. The Emergency Decree Mappings reveal that it was common for these restrictions to be subject to exemptions for "essential" or "healthcare" workers or services (or similar). However, it was rare for National RCRC Societies and other humanitarian organisations to be expressly included in these categories. While National RCRC Societies and other humanitarian organisations were often impliedly or arguably included, this was not

ideal because it created uncertainty about whether they (and their staff and volunteers) were exempt. It is preferable for National RCRC Societies and other humanitarian organisation to be granted express exemptions from restrictions on internal movement and business operating hours during a PHE, to provide them with certainty to continue their important work.

Border closures and/or restrictions on entry

Despite the WHO having initially advised against border closures, as soon as the threat of global transmission of COVID-19 became apparent, many States closed their borders in an attempt to manage cross-border contamination risks. A number of Sample States provided express exceptions for humanitarian organisations or operations. Other Sample States granted a named official a discretion to grant exceptions, creating the possibility for humanitarian personnel to apply for and be granted an exemption. In some Sample States it was, however, reported that there were no exceptions available for humanitarian personnel. The latter two approaches are in tension with the IDRL Guidelines, which support the principle that States should facilitate the entry of the personnel of eligible assisting humanitarian actors.

Even where borders remained open, a number of States introduced quarantine or self-isolation requirements. These were, in some cases, very strict, requiring individuals to go into government provided quarantine accommodation for a period of time. The risk is that, even if allowed entry, humanitarian personnel are prevented from immediately performing the functions they are entering the country to undertake. This may, for example, frustrate and jeopardise the response to another disaster occurring at the same time as the PHE. Although some States introduced exceptions for humanitarian personnel, they were in the minority.

Professional qualifications

One of the barriers to the provision of disaster assistance identified in the IDRL Guidelines and DPR Checklist is the recognition (or lack thereof) of foreign – or, in the case of federal states, interstate – professional qualifications. While the issue of recognition of professional qualifications is not commented on in the Emergency Decree Mappings, the experience of the COVID-19 Pandemic illustrates that it is highly pertinent to PHEs. For example, in the United States, a large number of “licensure reciprocity” provisions were rapidly introduced during the COVID-19 Pandemic, to permit the temporary recognition of out-of-state medical licences. Consistent with the IDRL Guidelines and DPR Checklist, standing laws and/or policies should provide for automatic or expedited recognition of foreign and/or interstate qualifications and licences in the event of a PHE.

Restrictions on the import or export of goods and equipment

In general, the import and export of goods has been less restricted during the COVID-19 Pandemic than the movement of people. One area where difficulties have arisen is in relation to goods and equipment used to protect against and treat COVID-19. By the end of July 2020, for example, almost 90 States had introduced export restrictions as a result of the COVID-19 Pandemic. Whilst States may wish to control the export of certain supplies during a PHE to meet the needs of their own populations, they should exempt humanitarian organisations from any restrictions that would impede their ability to import or export relief goods and equipment.

Taxes and tariffs

The IDRL Guidelines and DPR Checklist recommend that eligible assisting humanitarian organisations should be exempted from value added and other taxes or duties directly related to the provision of disaster relief. In the context of COVID-19, this recommendation appears to have been followed in a number of the States considered by the Emergency Decree Mappings especially in relation to the import of PPE and pharmaceutical products.

Lebanon, Beirut, 2020. Lebanese Red Cross responded to the needs of the people affected by the devastating explosion on 4 August. Thousands of people were transported to hospital with the help of Lebanese Red Cross volunteers and ambulances.

© Lebanese Red Cross



RECOMMENDATIONS

INTERNATIONAL HEALTH REGULATIONS

Future review of the IHR

1. Any future review of the IHR should consider whether States should be required to:
 - a. establish a committee specifically for overseeing the implementation of their IHR obligations and monitoring ongoing operation and compliance (**IHR monitoring committee**);
 - b. participate in periodic external evaluations of their IHR implementation and prepare and implement post-evaluation actions plans;
 - c. notify or warn key domestic actors and the general population of the occurrence or imminent risk of a PHEIC; and/or
 - d. notify the WHO of domestic instruments that implement the IHR and deposit copies of such instruments with the WHO.
2. Any future review of the IHR should also consider whether it is necessary, or would be beneficial, to include additional provisions clarifying the process and responsibility for States' notification of emerging public health threats to the WHO and other States.
3. The matters identified in (1) and (2) above should also be taken into consideration during the development of any new international treaty concerning PHEs.

Domestic implementation of the IHR

1. States should continue to take steps to ensure that their domestic legislation implements and facilitates the IHR core capacities and meets their obligations under the IHR.
2. Regardless of whether required under the IHR or the IHR Monitoring and Evaluation Framework, domestic laws and/or policies should:
 - a. provide for the establishment of an IHR monitoring committee specifically for overseeing the implementation of their IHR obligations and monitoring ongoing operation and compliance;
 - b. require the production and implementation of post-evaluation actions plans following evaluation of IHR implementation;
 - c. identify the appropriate domestic actor(s) with responsibility for producing a post-evaluation plan and/or contributing to such plans; and
 - d. require the IHR monitoring committee to monitor and/or have oversight of the production of the post-evaluation action plan and its implementation.
3. States should:
 - a. review the designation of the National IHR Focal Point and its functions;
 - b. consider whether implementation of the IHR could be improved by making express provision for that designation and the National Focal Point's functions in domestic laws and/or policies; and
 - c. review whether there are legal obstacles to the National IHR Focal Point sharing information with the WHO and other States and, if so, implement legal reforms to remove those obstacles.

Improving knowledge about legal aspects of IHR implementation

1. Legal aspects of PHEs and the implementation of IHR core capacities should be included within the work of relevant networks and fora, such as the Thematic Platform for Health Emergency and Disaster Risk Management and its associated Research Network.
2. Organisations with an interest in PHE and the implementation of IHR core capacities should consider establishing a network of legal practitioners and academics with a remit to promote the development of improved domestic PHE laws, including those implementing IHR core capacities.

DOMESTIC LEGAL AND INSTITUTIONAL FRAMEWORKS

Mandates for PHE risk management

1. Domestic laws, policies and plans should establish PHE risk management frameworks that:
 - a. adopt an 'all-public health risk' approach;
 - b. make provision for both primary and secondary PHEs; and
 - c. address risk reduction, preparedness, response and recovery.
2. Laws, policies and plans for PHE risk management should strike a balance between providing certainty about the types of public health risks and events that are covered and retaining the flexibility necessary to address novel and emerging public health risks.

Integration with DRM frameworks

Consistent with the Bangkok Principles, laws, policies and plans for PHE risk management should be integrated with general DRM frameworks (including national and local disaster risk reduction strategies). There should be an absence of gaps, conflict, inconsistency or unnecessary duplication between the powers, roles, responsibilities and other arrangements created by PHE and DRM instruments.

Leadership

Laws, policies and plans relating to PHE risk management should ensure that:

1. the person(s) or agency(ies) with lead responsibility for actions before, during and after a PHE are clearly identified (including command and control of an emergency operations centre if there is one);
2. the nature of the leadership role and the functions and powers of the 'leader' are clear and certain; and
3. any potential conflicts between persons or agencies exercising leadership roles are eliminated or minimised.

Coordination

1. Domestic laws, policies and plans for PHE risk management should facilitate coordination:
 - a. horizontally between different sectoral agencies, as well as *within* them (including with the IHR monitoring committee);
 - b. vertically between different levels of government; and
 - c. between governmental and non-governmental actors, including international actors (if relevant).

2. Domestic laws, policies and plans for PHE risk management should therefore:
 - a. establish coordination mechanisms that include representatives from:
 - i. all relevant sectoral agencies;
 - ii. all relevant departments of sectoral agencies;
 - iii. all levels of government; and
 - iv. all relevant non-governmental actors;
 - b. assign all actors clear roles and responsibilities; and
 - c. impose obligations on actors to meet regularly and share information, to ensure that coordination mechanisms are effective.

Participation and representation

1. Laws, policies and plans relating to PHE risk management should adopt:
 - a. an all-of-government and all-of-society approach that allows all actors and stakeholders to participate and be represented; and
 - b. a One Health approach that facilitates the coordination of measures and activities between the animal health, plant health and environmental sectors (and other One Health actors).
2. Given their unique auxiliary role and community-level reach, laws, policies and plans relating to PHE risk management should refer to the role and responsibilities of National Red Cross and Red Crescent Societies.
3. Consideration should, additionally be given to ensuring the involvement of (in no particular order):
 - a. community representatives;
 - b. One Health actors;
 - c. development cooperation actors;
 - d. health and social care providers;
 - e. groups that may be especially vulnerable to the impacts of PHEs;
 - f. humanitarian NGOs;
 - g. schools and school authorities;
 - h. the financial sector; and
 - i. manufacturers and suppliers of essential goods and equipment.
4. Where there is an ongoing presence and need for support from international institutions, consideration should be given to including UN agencies and international nongovernmental organisations.
5. Laws and/or policies should ensure as far as possible that all actors and stakeholders are capable of being effectively represented and can make an effective contribution to PHE risk management.

Contingency planning, education and drills

Domestic laws and policies relating to PHEs should:

1. allocate roles, responsibilities and, where appropriate, enforceable duties for PHE contingency planning, education and drills;

2. require contingency planning to address continuity of the legislature, general health care, schooling and domestic violence services during a PHE;
3. require all potential actors and stakeholders in a PHE (including communities and general DRM actors) to carry out or participate in regular PHE training and simulation exercises;
4. recognise the importance of raising public awareness of the risk of PHEs and their potential consequences; and
5. ensure that communities are provided with the information necessary to enable them to prepare for and respond to PHEs.

Regular review and updating

1. States which have not done so recently should undertake reviews of their laws, policies and plans relating to PHE risk management to ensure that they are fit for modern purpose and, where required, bring forward new or amending legislation as a matter of urgency.
2. Laws and/or policies should ensure that:
 - a. PHE risk management frameworks are reviewed both periodically and after the occurrence of a PHE;
 - b. reviews should consider whether the PHE risk management framework:
 - i. makes provision for all current and emerging PHE risks;
 - ii. is integrated with general DRM frameworks;
 - iii. facilitates the participation and representation of all relevant actors and stakeholders; and
 - iv. performed adequately in any recent PHE;
 - c. the lessons and recommendations from reviews and training and simulation exercises are effectively implemented.

STATES OF EXCEPTION

States of exception for PHEs

1. Laws should establish states of exception for PHEs that are proportionate and tailored to the different types and magnitude of PHE that may occur. Such a system should be designed to operate at the lowest level initially, with escalation to higher levels, characterised by more extensive measures and powers, triggered only when strictly necessary.
2. Where separate mechanisms exist for declaring or determining a state of exception in relation to a PHE, those mechanisms should be compatible with one another and their use should be coordinated.
3. Whatever state of exception is used for PHEs, so far as is feasible (allowing for the unpredictability of emerging health risks), the source of the state of exception, its nature and the powers that it triggers should be clearly set out in law.

Responsibility for declaring or determining a state of exception

Laws that enable the declaration of a state of exception or enable a decision maker to determine that such a state exists in relation to a PHE, should:

1. clearly identify the person who has the authority to make that declaration or determination;

2. where different persons may have that authority – either under different legislation or in different circumstances – ensure that the circumstances in which each can act are clear and that, in the event of any conflict, there is means of identifying or resolving who has the authority; and
3. establish a hierarchy of officials authorised to make the declaration or determination if the named official is unable to act during a PHE.

Consultation

Laws and/or policies should include a requirement that, before any state of exception is declared or determined in relation to a PHE:

1. if the declaration or determination is made by a person other than the minister of health or an official within the ministry of health, the ministry of health should (i) at a minimum be consulted but (ii) should ideally agree or approve the declaration or determination;
2. if the declaration or determination and any proposed emergency powers may affect the functions of a sub-national government or administration, the sub-national government or administration should, at a minimum, be consulted before the declaration or determination is made; and
3. the person making the declaration or determination should consult, so far as is practicable in the circumstances, with the key actors and stakeholders who may be involved in a PHE response.

Trigger and timing

1. Laws should strike a balance between ensuring that the triggers for states of exception or the use of emergency powers applicable to a PHE are: (a) clear and certain; and (b) sufficiently flexible to apply to novel or emerging health risks.
2. Laws should enable a declaration or determination of a state of exception in relation to a PHE to be made pre-emptively.
3. To minimise the risk of pre-emptive powers being used inappropriately, laws should clearly prescribe the circumstances in which pre-emptive declarations and determinations can be made by, for example, requiring the PHE to be imminent, proximate (both temporally and geographically) and/or to have a potentially severe impact.

Emergency powers and measures

1. Laws should clearly specify the governmental powers that arise once a state of exception is declared or determined in respect of a PHE.
2. It is generally preferable for laws to include a pre-determined, precise and exhaustive list of such governmental powers, although it may be appropriate for broader powers to be available in the event of severe PHEs.

Safeguards and human rights

1. Laws should ensure that, during a state of exception for a PHE, safeguards are in place that promote governmental transparency and accountability, maintain the rule of law, preserve democratic institutions and protect human rights.
2. Emergency powers and measures should be consistent with international law, particularly international human rights law.
3. Human rights should continue to be respected during a PHE and States should, therefore, only deploy emergency powers and measures that limit human rights in so far as is necessary, proportionate and prescribed by law.

South Sudan, 2013. Infants being vaccinated against Polio during a government health program, supported by the Red Cross.

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Time limitations

Laws that enable the declaration or determination of a state of exception in respect of a PHE should:

1. include a time limit so that a state of exception will terminate automatically once a specified period has elapsed, unless the state of exception is extended; and
2. clearly specify:
 - a. the circumstances in which a state of exception may be extended;
 - b. the maximum period for which a state of exception may be extended; and
 - c. *either* the maximum number of times that the state of exception may be extended or the maximum period that a state of exception may be in force.

Legislative supervision

Laws that enable the declaration or determination of a state of exception in respect of a PHE should provide that the legislature:

1. must (wherever possible) approve the declaration or determination within a prescribed period of time;
2. must (wherever possible) approve the extension of a state of exception, either prior to the extension or within a prescribed period; and
3. has the power to amend or terminate a state of exception, including power to amend details such as the geographical scope, time period and emergency powers.

Judicial supervision

Laws providing for the declaration or determination of a state of exception in respect of a PHE should ensure that:

1. the declaration or determination, its subsequent extension and any emergency powers or emergency measures made under it can be subject to legal proceedings brought by those affected; and
2. the judiciary have the jurisdiction and power to:
 - a. declare as unlawful a declaration or determination of a state of exception, its subsequent extension and any emergency powers or emergency measures made under it; and
 - b. make appropriate orders to redress such illegality (for example, by way of declaration of invalidity, penalties or compensation).

Transparency

1. The law should require notice of a declaration or determination of a state of exception in response to a PHE (including the detail of emergency powers or measures applying under it) to be published and made accessible to the widest possible audience.
2. The good practice evidenced around the world of publishing legislation during COVID-19 should be continued and all States should seek to publish laws, policies and plans relating to states of exception and PHEs online wherever possible.

THE ROLE OF LAW IN MITIGATING SECONDARY IMPACTS OF PHEs AND IMPACTS ON VULNERABLE GROUPS

Human mobility and migration

1. Domestic laws, policies and plans for PHE risk management should address the potential need for a State to close its borders or impose restrictions on travel in response to the international spread of disease.
2. Laws, policies and plans for PHE risk management should address:
 - a. the potential impact of a PHE on human mobility and the needs of individuals who may wish or need to travel (internationally or internally) as a result (direct or indirect); and
 - b. the potential need for migrants to be repatriated following a PHE and the process for facilitating repatriation.
3. Laws should clearly specify the criteria for border closures and/or restrictions, and how such closures or restrictions will be practically implemented. Any such criteria should be consistent with States' international obligations under the IHR and the ICCPR, including every person's right to leave any country (including their own) and not to be arbitrarily deprived of the right to enter their own country.
4. Laws that regulate border closures or travel restrictions in response to the international spread of disease (or other public health risk) should:
 - a. be compliant with States' international legal obligations towards refugees and asylum seekers, including the duty of non-refoulement;
 - b. include exceptions (subject to appropriate health safeguards) on humanitarian grounds for refugees, asylum seekers and others fleeing irreparable harm; and
 - c. include exceptions (subject to appropriate health safeguards) for migrants that wish to be repatriated.
5. Laws and/or policies should establish contingency arrangements to ensure that the reception of asylum seekers and the processing of asylum claims continues, with priority for the most vulnerable.

Shelter and housing

1. Laws, policies, and plans relating to PHE risk management should recognise and make provisions for the needs of homeless persons.
2. In particular, PHE contingency plans should identify the key actions to be taken to protect homeless persons in the event of a PHE, including provision of accommodation, health care, sanitation, and information.
3. States should consider introducing or amending standing laws, policies and plans to identify the financial and other support to be provided to those at risk of losing their housing during a PHE.
4. Laws, policies and/or plans should ensure that housing and housing support during a PHE are provided based on need rather than tenure status.

The protection of vulnerable groups

General protections

1. Domestic laws, policies and plans for PHE risk management should:

- a. be sufficiently comprehensive and flexible to:
 - i. protect and meet the needs of all who are adversely affected by a PHE; and
 - ii. accommodate the fact that different groups may be particularly susceptible to the relevant public health risk from one PHE to the next;
 - b. provide for the participation and representation in all phases of PHE risk management of:
 - i. groups that may be especially vulnerable to the impacts of PHEs; and
 - ii. agencies or organisations (such as social care agencies and National RCRC Societies) whose role includes the care or protection of such groups;
 - c. prohibit discrimination (direct and indirect) in respect of all elements of PHE risk management; and
 - d. take account of – and, where appropriate, incorporate – existing principles, guidelines, standards and tools developed by the international humanitarian community for the protection and inclusion of vulnerable groups.
2. PHE contingency plans should address the specific and additional needs of vulnerable groups during PHEs.
 3. Laws, policies and practical measures designed to protect those most at risk from the direct impacts of a PHE should:
 - a. take into account and be consistent with the rights of the affected individuals;
 - b. reflect the circumstances of the specific groups being protected; and
 - c. to the extent that they interfere with fundamental rights, be time-bound and proportionate to the public health threat.
 4. PHE preparedness and response activities should be equally accessible to vulnerable groups and, where necessary, adapted to meet the specific and additional needs of vulnerable groups.

Older people and people with disabilities or illness

Domestic laws, policies and plans for PHE risk management should:

1. make provision for the specific needs of older people and people with disabilities or illness in the event of a PHE, regardless of whether these people are:
 - a. at direct risk from the relevant infection or disease itself; or
 - b. at indirect risk from the secondary impacts of a PHE;
2. ensure the participation and representation in all phases of PHE risk management of older people and people with disabilities or illness;
3. ensure that information and support provided during a PHE response is accessible to older people and people with disabilities;
4. make provision for continuity of health and social care for older people and people with disabilities or illness during PHEs; and
5. have regard to relevant existing international standards and guidelines, such as the Humanitarian Inclusion Standards for Older People and People with Disabilities and the Charter on Inclusion of Persons with Disabilities in Humanitarian Action.

People at economic and financial risk

Domestic laws, policies and plans for PHE risk management should:

1. make provision for financial support to be provided to businesses and households (including migrant households) in the event that a PHE has significant economic impacts, with priority for the most vulnerable and economically marginalised; and
2. ensure the participation and/or representation in all phases of PHE risk management of agencies and organisations which may be required to provide economic and financial support during a PHE.

People at risk of violence

1. Laws and/or policies should require agencies responsible for domestic or family violence prevention and protection services to develop contingency plans aimed at ensuring continuity of services during PHEs.
2. PHE risk management frameworks (including laws, policies and contingency plans) should address arrangements for enabling those at risk of domestic violence to access refuges or temporary accommodation and other protection services during a PHE.
3. Laws imposing lockdown restrictions during a PHE should expressly permit those experiencing, or at risk of, domestic violence to:
 - a. leave and/or remain away from their homes or place of residence; and
 - b. access protection services and mental health and psychosocial support.

School children

1. Laws, policies and plans for PHE risk management should:
 - a. establish, and be consistent with, the principle that school closure should be a last resort during PHEs.
 - b. enable the participation and representation of schools and school authorities in all phases of PHE risk management.
2. Laws and/or policies should require school authorities and, where appropriate, individual schools to maintain contingency plans to address issues that may arise during a PHE, including:
 - a. identifying alternative means of providing teaching if schools have to physically close;
 - b. addressing the needs of children who may have difficulties accessing alternative learning; and
 - c. identifying practical measures (e.g. biosecurity protocols) to enable schools to remain open (or to re-open) during a PHE.

Migrants and marginalised racial and ethnic groups

Domestic laws, policies and plans for PHE risk management should:

1. ensure the participation and representation of migrants and marginalised racial and ethnic groups in all phases of PHE risk management;
2. establish measures to remove language and cultural barriers to accessing healthcare, information and other supports during a PHE; and
3. ensure that migrants have full access to health care and other essential services during a PHE regardless of their immigration status.

LEGAL FACILITIES FOR HUMANITARIAN ACTORS

Legal facilities generally

Consistent with the DPR Checklist and IDRL Guidelines, States should develop standing laws and policies that provide legal facilities to: (a) domestic humanitarian organisations for domestic disaster response (including for a PHE); and (b) assisting States and eligible assisting humanitarian organisations for international disaster response (including for a PHE).

Restrictions on movement and business operations

1. Laws that introduce restrictions on internal movement or business operations during a PHE should expressly exempt National RCRC Societies and other relevant humanitarian organisations (subject to appropriate health safeguards).
2. If exemptions are provided for “essential workers” or “essential services”, the definition of this term should be clear and should include staff and volunteers of National RCRC Societies and other relevant humanitarian organisations.

Border closures and/or restrictions on entry

1. Laws that establish border closures or restrictions during a PHE should expressly exempt the personnel of eligible assisting humanitarian organisations (subject to appropriate health safeguards).
2. States considering the introduction of quarantine or self-isolation requirements for travellers entering their territory during a PHE should, wherever possible, exempt humanitarian personnel from these requirements.
3. Where automatic exemptions for humanitarian personnel are not appropriate, laws and/or policies should establish clear and objective criteria for granting exemptions.
4. Consistent with the IDRL Guidelines, laws and/or policies should, wherever possible, waive requirements for, or significantly expedite the provision of, visas and work permits for humanitarian personnel.

Professional qualifications

Consistent with the IDRL Guidelines and DPR Checklist, laws and/or policies should provide for automatic or expedited recognition of foreign and/or interstate qualifications and licences in the event of a PHE or other disaster.

Cross-border movement of goods and equipment

1. States should continue to ensure that laws and/or policies that impose border closures or restrictions in response to a PHE do not restrict the cross-border movement of relief goods and equipment (subject to appropriate health safeguards).
2. Whilst recognising that States may wish to control the export of certain supplies during a PHE to meet the needs of their own populations, States should exempt humanitarian organisations from any restrictions that would impede their ability to import or export relief goods and equipment.
3. In future PHEs, arrangements should be made – building on the example of the World Customs Organization’s database during the COVID-19 Pandemic – to provide up-to-date information on applicable import and export controls worldwide.

Taxes and tariffs

Consistent with the IDRL Guidelines and DPR Checklist, States should exempt eligible assisting humanitarian organisations (both domestic and international) from taxes and duties directly associated with their PHE risk management activities.

PART A

INTRODUCTION



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1 / BACKGROUND AND CONTEXT

1.1 / THE LAW AND PUBLIC HEALTH EMERGENCIES

As at the end of March 2021, the COVID-19 Pandemic has been responsible for over 135 million infections worldwide with, sadly, over 2.9 million reported deaths.¹⁴ Its impact has been felt in virtually every country and across all sectors of society to an extent not seen since the last worldwide public health emergency, the 1918 Influenza Pandemic. In economic terms, the International Monetary Fund has estimated that the global costs of the COVID-19 Pandemic will amount to \$28 trillion in lost output with governments and central banks having to take fiscal action in the region of \$19 trillion. In response to the COVID-19 Pandemic, governments have been forced to introduce legal measures, often relying on emergency powers, to restrict movement and prevent normal personal and business activity. Never before have so many laws been made in so many countries in respect of one event in such a short period of time.

With the global COVID-19 Pandemic focusing attention on public health emergencies (**PHEs**), IFRC Disaster Law decided to embark on a new research project to examine the law's role in enabling or facilitating the preparation for and response to such emergencies. This project, the Law and Public Health Emergencies Research Project (the **Project**), aims to expand the understanding of PHE laws and their relationship with the laws relating to wider disaster risk management and, from this, develop guidance on best practice in domestic PHE law and policy.

IFRC Disaster Law is a leader in developing and disseminating guidance on best practice for domestic disaster law and policy. It assists National Red Cross and Red Crescent Societies to support their authorities in developing and applying state-of-the-art disaster-related legislation, policies and procedures. To date, IFRC Disaster Law has developed guidance on best practice in relation to: (1) the facilitation and regulation of international disaster relief and initial recovery assistance;¹⁵ (2) disaster risk reduction;¹⁶ and (3) disaster preparedness and response.¹⁷

The Project builds on this work and, in addition, has initiated a number of new research streams. At the beginning of the COVID-19 Pandemic, IFRC Disaster Law commissioned country-level desktop research mappings of the emergency measures taken in response to the Pandemic in 113 States (**Emergency Decree Mappings**). This research focused principally on the potential impact of these measures on the operations of the IFRC Network around the world. IFRC Disaster Law subsequently commissioned a second tranche of country-level desktop research concentrating on the legal and institutional frameworks for PHEs and the role of law in mitigating their impacts, especially on vulnerable groups (**PHE Mappings**).

The purpose of this Report is to synthesise the information obtained from this research to provide (1) an analysis of the current legislation and other instruments governing PHEs and (2) develop recommendations on the role of law in preparing for and responding to these types of disasters.

This Report was commissioned at the height of the COVID-19 Pandemic, a once in several generations PHE. The focus of the research is, therefore, naturally on the laws that have enabled States to respond to that Pandemic. However, COVID-19 has not been the only disease which has become a disaster: PHEs have been experienced throughout history from the Plague of Justinian, through to the Black Death and the 1918 Influenza Pandemic to, in more recent times, SARS and Ebola. IFRC Disaster Law therefore intended the Project to look beyond the immediate efforts to manage the COVID-19 Pandemic and to investigate how the law has been used in relation to previous PHEs. However, whilst this Report therefore endeavours to look beyond COVID-19, the Mappings are only able to provide a limited amount of information in respect of the legal measures taken in respect of PHEs other than the COVID-19 Pandemic.

The Mappings and this Report are primarily concerned with domestic PHE legislation. However, no analysis of the laws of PHEs can be undertaken without an understanding of the global legal framework for PHEs, much of which has been adopted in an attempt to improve domestic capacities. The Report therefore also considers the extent to which international instruments direct or influence domestic PHE legal frameworks. The most important of these are the International Health Regulations (IHR), a legally binding instrument 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.”¹⁸ Public health risks and impacts are mentioned in the guiding principles and priorities of the Sendai Framework for Disaster Risk Reduction 2015–2030 (**Sendai Framework**)¹⁹ which have been supplemented by the Bangkok Principles for the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030 (**Bangkok Principles**).²⁰ These Principles place strengthened coordination at the heart of efforts to reduce risk from public health and biological hazards encouraging systematic cooperation, integration and coherence between disaster and health risk management. Nonetheless, as will be seen, there is continuing concern that States’ implementation of their international obligations is variable or is not being given sufficient priority.

As a consequence of the COVID-19 Pandemic, virtually every government across the world has been forced to apply public health legislation – which can often be relatively old – and most have found themselves making new laws to enable or support their response. In addition to the Mappings, in the course of preparing this Report over 1000 pieces of legislation have been considered; they are just a fraction of the PHE laws enacted globally. The COVID-19 pandemic therefore provides a reason and an opportunity to take stock of the current state of laws for PHEs at the international and domestic levels and to consider what improvements to legislation and practice may be required to better prepare for the next PHE.

Unfortunately, the threat of PHEs is increasing. As the World Bank and the WHO Global Preparedness Monitoring Board (GPMB) has reported, developments and innovations over the last century have:

“created unprecedented vulnerability to fast moving infectious disease outbreaks by fueling population growth and mobility, disorienting the climate, boosting interdependence, and generating inequality. The destruction of tropical rain forests has increased the opportunities for transmission of viruses from wild animals to humans. We have created a world where a shock anywhere can become a catastrophe everywhere... Infectious diseases feed off divisiveness; societal divisions can be deadly.”²¹

The GPMB’s warning needs to be taken seriously. In its 2019 Annual Report it offered this advice:

“While disease has always been part of the human experience, a combination of global trends, including insecurity and extreme weather, has heightened the risk. Disease thrives in disorder and has taken advantage--outbreaks have been on the rise for the past several decades and the spectre of a global health emergency looms large. If it is true to say “what’s past is prologue”, then there is a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly 5% of the world’s economy. A global pandemic on that scale would be catastrophic, creating widespread havoc, instability and insecurity. The world is not prepared.”²²

As 2020 has shown, the world was, indeed, not prepared.

1.2 / METHODOLOGY

This Report is based on country-level desktop research ('**Mappings**') undertaken in two tranches.

The first tranche, the mapping of COVID-19 emergency decrees in 113 countries (Emergency Decree Mappings), was completed during the initial stages of the response to the COVID-19 Pandemic in March to May 2020. These Mappings were prompted by IFRC Network components experiencing operational challenges due to COVID-19 restrictions. Accordingly, they focused predominantly on: the emergency decrees and emergency measures enacted to deal specifically with COVID-19; coordination between different actors; the types of restrictions introduced to curb the spread of COVID-19; and legal facilities for humanitarian actors, including IFRC Network components. The reviews themselves can be found on the [IFRC Disaster Law website](#).

The second stage of country-level desktop research (the **PHE Mappings**) comprised more detailed assessment of (a) the legal and institutional frameworks for PHEs and (b) the role of law in mitigating secondary impacts and impacts on vulnerable groups in the countries listed below. The mapped States were selected to provide a broad geographical coverage and different experiences in dealing with COVID-19. For this exercise, IFRC Disaster Law included several countries that had experienced a significant PHE other than COVID-19 (e.g., Zika, Ebola, SARS). The mapping questions were framed to solicit information about those other PHEs, in addition to the COVID-19 pandemic. Most of the responses to the mapping questions did, however, concentrate on the immediate measures taken to manage COVID-19.

The PHE Mappings considered the following States:

- **African Region:** Democratic Republic of the Congo; Liberia; Nigeria; Sierra Leone; South Africa.
- **Americas Region:** Brazil; Colombia; Honduras; Jamaica; and the United States of America (including separate mappings of Florida and New York).
- **Asia Pacific Region:** Australia (including separate mappings of New South Wales and Victoria); China; Fiji; India; Republic of Korea; Marshall Islands; Mongolia; New Zealand; Papua New Guinea; Samoa; Singapore; Solomon Islands; Sri Lanka; Tajikistan; Tuvalu; Vanuatu; and Viet Nam.
- **Europe Region:** Bulgaria; Spain; and the United Kingdom.
- **Middle East and North Africa Region:** Iran and United Arab Emirates

These Mappings can also be found on the [IFRC Disaster Law website](#).

During the development of the COVID-19 Pandemic and the global response, research has been undertaken and analysis and commentary published on a significant scale. Most relates to the scientific and medical issues of the Pandemic or the political or operational response; some though relates to legal and organisational aspects of the response. Where possible, this Report seeks to draw on this additional research. However, due to the large amount of material gradually appearing, this Report cannot claim to offer a comprehensive analysis of this literature. A note of caution needs to be added concerning the mapping exercises. The Emergency Decree Mappings were undertaken at the outset of the COVID-19 Pandemic when States were introducing urgent measures to prevent the spread of the disease. Since then, many States have amended, replaced or relaxed those measures. The measures reported in the Mappings may therefore no longer apply or apply in the same way. Links to legislation provided in the Mappings may no longer function or may now be out of date. Similarly, although the PHE Mappings were undertaken later in the Pandemic, they too may have been overtaken by subsequent events. Consequently, measures referred to in the PHE Mappings –and therefore in this Report – may also have been amended or superseded.

A number of the Mappings were prepared by volunteers working or studying in the State on which they reported, but others were produced by volunteers who were not present in the State. There was therefore a reliance on materials that could be accessed online or through press reports. Whilst

the COVID-19 Pandemic may have been the first disaster in which States used on-line resources to communicate information about the disaster in such a widespread manner, nonetheless, the fact that there may have been limited access to materials in some States needs to be borne in mind when viewing the Mappings and any findings based upon them.

These qualifications are also relevant to references in this Report to specific pieces of legislation or policies. An object of the Project is to identify good practice by identifying legislation which appears to provide a model or precedent. However, there are occasions where potential gaps or conflicts are also identified, and a specific piece of legislation may be cited by way of illustration. It should be noted that in doing this, the Report is not intending to direct any criticism against particular States. That would be unfair given the qualifications noted above regarding the information contained in the Mappings. It would also be unreasonable as the States concerned will not have had any opportunity to explain the legislation or policy. If, therefore, a particular piece of legislation, policy or guidance is perceived as being criticised by this Report, it is not: the intention is that that measure is being used as an illustration of how gaps, conflicts etc *may* arise, but no view is being taken that it is causing any issues or is inappropriate.

This Report is also subject to a more general qualification. The Report has been written in late 2020 and early 2021, when the Pandemic is far from being over. When the Pandemic does end, there will undoubtedly be plenty of analysis and debate about the laws and measures that helped to reduce infection and those which allowed the disease to spread, as well as the laws and measures that had unacceptable impacts or inadvertent consequences. Whilst it would be desirable to offer analysis of which of the laws and measures may have had a beneficial effect, it is not possible for this Report to do so because it is too early to reach such views. Moreover, it would be inappropriate to reach such conclusions based solely on the information available in the Mappings because laws do not operate in a vacuum. The effectiveness of legislation depends just as much on how it is implemented as on its content.

Some States appear to have successfully contained the virus or achieved effective eradication. The legislation that these States used in their COVID-19 response may have contributed to these achievements, but at this stage that cannot be said for certain. There are other States which were perceived to have comprehensive frameworks to prepare them for a PHE yet, on pure statistics (i.e. case numbers and fatalities), some of these States appear to have performed worst of all. The nature of the virus, particular local circumstances, the susceptibility of particular groups, operational delays, ineffective implementation, and the impact of other emergencies or disasters occurring simultaneously may all be factors in the success or otherwise of the measures taken.

Consequently, the Report can only attempt to draw on the information provided in the Mappings to set out a number of observations, suggestions and recommendations. As so much is still to be learned from the COVID-19 Pandemic, many of these can only be preliminary.

Further, there are a number of issues with a legal dimension that are outside the scope of this Report, including some issues that can only be properly analysed at a later stage of the pandemic. Issues that are outside the scope of this Report include: (1) “infodemic” legal issues – including the means by which information is provided during PHEs and how it is presented, especially concerns around the publication of false information; (2) issues related to sanctions for breach of lockdown rules and other emergency measures; (3) governmental mandates on medical and pharmaceutical private sector organisations; (4) tracing requirements and privacy issues (including around apps and, especially, compulsory use and access to data); (5) insurance and access to care by responders (including volunteers); and (6) prioritisation for vaccines, mandatory vaccines and vaccine passports. All these issues will undoubtedly feature in future research.



Netherlands, 2021. The Netherlands Red Cross is supporting the Dutch regional health services to conduct their COVID-19 vaccination program.
© Netherlands Red Cross / Arie Kievit

1.3 / STRUCTURE OF THE REPORT

The Report is divided into four main parts. This Part (Part A) comprises two Chapters. Chapter 1 seeks to explain the background and context to the Project. Chapter 2 considers the nature of PHEs and provides examples of previous PHEs.

Part B considers the existing legal and institutional frameworks for PHEs: the overall architecture of PHE risk management systems. It first examines the global frameworks under which domestic PHE risk management systems should operate (Chapter 3), in particular, the multilateral International Health Regulations. Chapter 4 deals in detail with the domestic legal and institutional frameworks for managing preparedness for, and response to, PHEs. Particular attention is paid to the types of actors involved in preparing for and responding to a PHE and how coordination and collaboration occurs. The Chapter also looks briefly at how to promote key actors' and the general public's understanding of the applicable laws and policies, and how to ensure that lessons are learned from PHEs. Emergency powers and the triggers for their use are considered in Chapter 5, together with the issues raised by the use of declarations (or the equivalent) of PHE, states of disaster (**SoD**) or states of emergency (**SoE**).

Part C considers the role of law in mitigating the impacts of PHEs on vulnerable groups and in mitigating secondary impacts (on, for example, human mobility, housing, livelihoods and education). The IFRC Law and disaster preparedness and response report (DPR Report)²³ considers that a number of vulnerable groups may be particularly at risk from disaster. These include: women and girls (who may experience discrimination and/or sexual and gender-based violence (**SGBV**)), children, older persons, persons with disabilities, migrants (including asylum seekers and internally displaced persons), marginalised racial and ethnic groups and indigenous communities. PHEs may additionally expose vulnerabilities in other groups not typically seen as particularly susceptible to disaster impacts. Using the information provided in the Mappings, Part C therefore explores:

- the impact of PHEs on human mobility, including the effect of PHE-related border closures and travel restrictions;
- the initiatives introduced to address the challenges of PHEs for homeless persons as well as measures introduced to prevent the loss of housing (as a consequence of the economic impacts of a PHE);
- the impact of PHEs on groups with a vulnerability or susceptibility to the relevant illness; and
- the wider societal impact of a PHE, including:
 - the loss of livelihoods and lack of access to basic necessities, including regular health services;
 - the loss of education through school closures and the equity of online based replacements;
 - the increase in domestic violence and child protection issues partly due to 'lockdowns' or 'shelter in place' orders; and
 - whether (and to what extent) there may have been discrimination against minority or marginalised groups (such as migrants, indigenous communities) in relation to access to healthcare and government assistance programmes.

Part D focuses on legal facilities for humanitarian actors and other first responders (both domestic and international). The analysis relies mainly on the COVID-19 Emergency Decree Mappings and their examination of the impact of restrictions imposed on border crossings, internal travel, business activity and the import and export of essential supplies, such as PPE.

1.4 / RECOMMENDATIONS AND FURTHER GUIDANCE

Throughout the Report a number of recommendations are made. These have been formulated based on the evidence and good practice disclosed in the Emergency Decree and Public Health Mappings, the literature, previous reviews and inquiries into PHEs, and the experience and knowledge of the IFRC Network.

As mentioned in the previous sections, the lessons to be drawn from the COVID-19 Pandemic are still in the early stages of being identified and a series of inquiries will inevitably also consider how domestic PHE risk management can be improved. The recommendations in this report are, therefore, preliminary and of a general nature. The recommendations are not highly prescriptive; they do not seek to tell States exactly what type of PHE risk management framework must be adopted. Instead, they seek to identify the key legal issues that decision-makers need to consider and to provide general guidance on how PHE laws can – similar to wider disaster laws – underpin the key components of effective and equitable preparedness and response.

Many States have already adopted a number of the observations and suggestions contained in the Report – indeed, most of the recommendations are based on laws and good practices already being applied. In other States, the recommendations may be inapplicable or already have been considered and alternative approaches chosen.

Although the importance of some recommendations over others may in some cases be obvious, the recommendations have not been given any order of priority. Whilst those which refer to States' existing international legal obligations are clearly of fundamental importance, the order of priority of all the recommendations will depend on the circumstances in individual States, including, for example, each State's system of law, its administrative and governance structures, funding arrangements and capacity. Based on this Report, IFRC Disaster Law will publish a concise guidance document to support governments, National Societies and other stakeholders in strengthening laws relating to PHE preparedness and response. This guidance document will complement and form part of the wider body of guidance issued by IFRC Disaster Law including the IDRL Checklist, the Checklist on Law and Disaster Risk Reduction (DRR Checklist) and the Checklist on Law and Disaster Preparedness and Response (DPR Checklist).

Uganda, 2017. Uganda Red Cross have set up a powerful volunteer system in coordination with the Ministry of Health. This system helps to stop the spread of Ebola by detecting outbreaks early. © IFRC / Corrie Butler



Liberia, 2014. A member of a Red Cross Dead Body Management team prepares to disinfect the home of a suspected Ebola fatality in the West Point area of Monrovia, Liberia.

© IFRC / Victor Lacken



2 / PUBLIC HEALTH EMERGENCIES

2.1 / DEFINITIONS OF PUBLIC HEALTH EMERGENCIES

This Report focuses on the laws relating to a particular type of disaster: public health emergencies (**PHEs**). Usage and understanding of terminology is fundamental. It can affect key actions such as: the triggering of states of exception; the allocation of responsibilities; and, specifically in relation to PHEs, when health events need to be notified to the World Health Organization (**WHO**) or other States. The concept of “public health” itself, though, is not always clear, and different States and actors use various definitions of the term “public health emergency”. Although the recognition of communicable diseases and infections as public health hazards and as causes of PHEs is universal, there is more doubt about other, typically slow-onset public health hazards. Antimicrobial resistance (**AMR**) is one example. This has been identified as a potentially significant public health risk in the long-term but is only included in the PHE plans of a small number of the Sample States.²⁴ In some definitions of PHE, it is not clear if AMR is categorised as a PHE.

Although there has been significant work at the international level on establishing generic disaster terminology, PHEs have not featured prominently in this work. The Report of the open-ended intergovernmental expert working group on indicators and terminology relating to disaster risk reduction (**OEIWG**),²⁵ for example, includes health emergencies within its commentary on the definition of “disaster” but does not identify the exact nature of a health emergency. Likewise, although the proposed definition of disaster adopted by the International Law Commission is broad enough to encompass PHEs,²⁶ it focuses more on other disasters. This is, perhaps, not surprising. While the Sendai Framework has catalysed significant improvement in generic DRM and DRM laws at the domestic level, there appears to have been less momentum and focus on PHE risk management. This is despite the importance of disease (and other public health risks) as a direct disaster risk (**primary PHEs**) as well as a consequential risk following other disasters (**secondary PHEs**).

There is, however, one definition of PHE that is beginning to be more widely accepted. Perhaps not surprisingly, this is the definition adopted by the WHO, which defines a PHE as:

“an occurrence or imminent threat of an illness or health condition, caused by bio terrorism, epidemic or pandemic disease, or [a] novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human [fatalities] or incidents or permanent or long-term disability.”²⁷

Although there are alternative definitions, even within the WHO itself,²⁸ this definition is adopted for the purpose of this Report. This definition is expansive. It covers a pandemic disease and “public health emergencies of international concern”, the term used in the International Health Regulations (see section 3.3). It also covers disease outbreaks of a more localised nature (e.g. outbreaks, epidemics) and releases of agents or toxins.

2.2 / OUTBREAKS, EPIDEMICS AND PANDEMICS

This Report predominantly focusses on the most common types of PHE: outbreaks of infection and disease; epidemics; and, where an epidemic has international spread, pandemics. An epidemic is defined by the WHO as:

“The occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy. The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size, and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence.”²⁹

A pandemic is “the worldwide spread of a new disease”³⁰ or “a worldwide outbreak of a disease in humans in numbers clearly in excess of normal”.³¹

Unlike bioterrorism and AMR, such events are clearly not new. Over the centuries, plague has been the most regular and deadly disease: examples include the Plague of Justinian in AD 540 to 590 and the ‘Black Death’ of the 14th Century. Since the Black Death there have been repeated occurrences of bubonic plague (including the Great Plague of the 17th Century) which continue up to the present day.³² During the 19th Century, cholera and typhoid were prevalent. Outbreaks led to the first concerted and widespread approach to use legislation to deal with communicable disease. For example, the Indian Epidemic Diseases Act 1897, which was used in response to the COVID-19 Pandemic, was enacted following outbreaks of bubonic plague in Mumbai at the end of the 19th Century.

The period from 1918 onwards has been described as the ‘Pandemic Century.’³³ It is no coincidence that this period is also marked as the era of international travel and globalisation. The succession of significant PHEs that occurred are now all too familiar. The 1918 Influenza Pandemic is estimated to have killed at least 40 million people worldwide and infected a third of the world’s population. Other influenza pandemics followed at regular intervals: the pandemics in 1957 and 1968 caused significant illness – mainly in the young and in older people – and an estimated 1 to 4 million deaths worldwide. The H1N1 Pandemic of 2009 was less severe but was the first disease to be declared by the WHO as a Public Health Emergency of International Concern (**PHEIC**).

Over the past 35 years, many newly recognised infectious diseases have been identified. Most new infectious diseases are zoonotic; in other words, they are naturally transmissible, directly or indirectly, between vertebrate animals and humans. One example is Severe Acute Respiratory Syndrome (**SARS**), a viral respiratory illness caused by a coronavirus. A SARS outbreak originating in Asia in November 2002 eventually spread to nearly two dozen countries in Asia, North America, South America, and Europe. By the time the disease was contained in July 2003, over 8,000 people had been affected worldwide, of whom over 750 died.

Another relatively new disease is Ebola virus disease (**EVD**).³⁴ EVD is an acute, serious illness, with an average fatality rate of around 50%. It is believed to be introduced into the human population through close contact with the blood or other bodily fluids of infected animals. Human-to-human transmission of EVD occurs via direct contact with blood or bodily fluids of infected persons. The Ebola Outbreak of 2013–2016 is believed to have started in Guinea in December 2013 and crossed the borders of Sierra Leone and Liberia in late March/early April 2014. On 8 August 2014, the WHO declared a PHEIC. Following the declaration, additional resources were sent to the affected countries by the international community with the Mission for Ebola Emergency Response set up by the UN. The WHO declared the PHEIC at an end in May 2015, by which time there had been approximately 29,000 infections and 11,300 fatalities. Ebola remains a potent threat. An EVD outbreak was declared in North Kivu, DRC, on 1 August 2018. The WHO declared the outbreak a PHEIC on 17 July 2019.³⁵ By the time the PHEIC was declared over on 25 June 2020³⁶ there had been 3,470 cases with 2,287 deaths. Even more recently, the Ministries of Health of the DRC and Guinea have announced new outbreaks of EVD on, respectively, 7 and 14 February 2021.



Brazil, 2016. Members of the Brazilian Red Cross in the state of Rio Grande do Norte learn about Zika virus. © IFRC / Miguel Domingo García

Another notable epidemic was the outbreak of Middle East Respiratory Syndrome (**MERS**), which was first identified in Saudi Arabia in 2012. Caused by the MERS-coronavirus (MERS-CoV), it is believed to originate in bats and be transmitted via camels. About 35% of those diagnosed with the disease die from it, but the virus does not pass easily from person to person unless there is close contact. About 2,500 cases had been reported as of January 2020, with larger outbreaks occurring in the Republic of Korea in 2015 and Saudi Arabia in 2018.³⁷

The Zika virus outbreak occurred in 2015. Originating in Brazil, the virus was carried by mosquitos across South and Central America and into the Caribbean. When transmitted from an infected pregnant woman to her foetus, the disease could cause microcephaly and other severe brain abnormalities in the infant and result in Guillain-Barre syndrome in adults. The outbreak was declared a PHEIC by the WHO in February 2016.

Finally, there is the COVID-19 Pandemic. COVID-19 is caused by a new coronavirus called SARS-CoV-2 which is believed to have originated in Wuhan, People's Republic of China in December 2019. The WHO was notified of the virus on 31 December 2019. As with many of the other disease outbreaks described above, it is believed to have originated in bats and potentially been transmitted via intermediary mammals to humans. As already mentioned, to date there have been over 99 million confirmed cases of COVID-19, with over 2 million fatalities.

These well-known PHEs are, however, only a small sample of the public health events which can have a significant impact on the health and economy of individual countries or regions. An outbreak of plague in Surat, India in 1994 caused the loss of \$260 million in trade, \$420 million of exports, and overall damage to the economy including lost tourism of over \$2 billion.³⁸ Such PHEs are far more common than the general public may realise. An indication of the number of PHEs that occur is provided by the news of disease outbreaks published by the WHO. In 2018, 91 alerts of outbreaks were issued³⁹ and, in 2019, 119.⁴⁰ Up to the end of October 2020, the WHO had issued 64 disease outbreak news alerts, 58 of which concerned diseases other than COVID-19: 29 of these were for Ebola in the DRC; 7 were for MERS; and the rest covered reports of cases of, for example, yellow fever (in French Guiana, Gabon, Togo, Ethiopia, Chile and Uganda), Lassa Fever (in Nigeria), and Dengue Fever and Maya and Oropuche Viruses (in French Guiana).⁴¹

2.3 / BIOTERRORISM

another type of PHE included within the WHO definition is bioterrorism. This is defined as the intentional release of viruses, bacteria, or other germs that can sicken or kill people, livestock, or crops.⁴² Incidents involving the deliberate release of agents and toxins have fortunately been rare. They are not solely a new phenomenon: the indiscriminate use of chemicals, especially gasses, by States in warfare is well documented.⁴³ More recently, malicious attacks by individuals or groups have occurred: for example, the nerve gas attacks by the Aum Shinrikyo cult in Japan in 1994 and 1995, and the sending of anthrax laden letters to media organisations in the USA in 2001, causing 19 and 5 fatalities respectively. As none of the PHE Mappings specifically comment on bioterrorism, it is not considered in detail in this Report.

2.4 / SLOW ONSET AND OTHER PUBLIC HEALTH 'RISKS'

The WHO definition of a PHE does not cover – or at least does not explicitly cover – health issues that are (1) constant and continuously present or (2) slow onset in nature. A crude analogy may be that these are to PHE risk management what climate change is to wider DRM: potentially just as damaging, but unlike imminent or sudden onset disaster, they may not to date have been given the recognition or prominence they deserve in DRM/PHE risk management legislation and frameworks.

The first category includes diseases such as malaria or HIV/AIDS which are endemic (i.e. constantly and generally present).⁴⁴ In 2019, there were an estimated 229 million cases of malaria worldwide, causing 409,000 fatalities.⁴⁵ An estimated 38 million people continue to live with HIV/AIDS.⁴⁶ However, as will be seen in the next Chapter, these types of disease are not “extraordinary” events and are, therefore, not classed as PHEICs. The information in the PHE Mappings suggests that they may also not be considered as PHEs in domestic legislation.

The second category concerns wider public health issues that emerge slowly and pose longer-term risks. Perhaps the most relevant risk in this category is antimicrobial resistance (**AMR**), which refers to drugs becoming ineffective in the treatment of infections caused by micro-organisms such as bacteria, viruses or parasites. If antibiotics become ineffective, minor surgery can become a high-risk procedure, with a risk of severe infection and even death. The need for AMR to be addressed has been acknowledged through the WHO's Global Action Plan on Antimicrobial Resistance⁴⁷ which was endorsed by the UN General Assembly in a political declaration in 2016.⁴⁸ With one exception,⁴⁹ none of the PHE Mappings mention AMR or other slow-onset public health risks and they are, therefore, not considered in detail in this Report. Nonetheless, it can be said that any long-term, all hazard PHE risk management framework should address these risks.



Solomon Islands, 2009. Mosquito nets are delivered in preparation for the malaria season, which runs from December to June and particularly affects children. Red Cross staff attribute the appearance of malaria in Solomon Islands to global warming
© IFRC / Rob Few

PART B

LEGAL AND INSTITUTIONAL FRAMEWORKS FOR PUBLIC HEALTH EMERGENCIES



© Netherlands Red Cross

3 / GLOBAL LEGAL AND INSTITUTIONAL FRAMEWORKS

3.1 / INTRODUCTION

The principal aim of this Report is to analyse the *domestic* legal and institutional frameworks for PHEs. However, although the domestic architecture of PHE may generally be shaped at a national level, global initiatives and instruments have an important influence. This Chapter therefore considers the global background to the development of domestic laws and the impact this may have on the enhancement of domestic PHE capabilities.

As this Report was being finalised, there were calls from a number of world leaders for the creation of a new global pandemic treaty which would help to establish better systems for alerting people about potential pandemics and improve the sharing of data and distribution of vaccines and personal protective equipment.⁵⁰ While the provisions of any new treaty are yet to be determined, the analysis and recommendations in this Chapter and elsewhere in the Report are likely to be highly relevant to such a treaty. In particular, section 3.4 of this Chapter makes a number of recommendations about matters that should be taken into consideration in any future review of the IHR. Many of those matters should also be taken into consideration during the development of any new international treaty concerning PHEs.

3.2 / THE GLOBAL CONTEXT

since long before the appearance of COVID-19, the global community has been addressing the need to improve public health frameworks. At the heart of this activity have been the sanitary and health regulations that have addressed cross-border infection. These culminated in the International Health Regulations 2005 (IHR). The requirements of the IHR and their impact on domestic PHE risk management will be considered in detail later in this Chapter (section 3.3). Before that, though, a number of international instruments and initiatives are considered which illustrate the global effort to secure enhanced domestic PHE laws and policies and place the IHR in context.

3.2.1 / Sustainable Development Goals

One of the principal components of the overarching global framework is the UN's 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs).⁵¹ Improving health care and reducing the risk and effect of PHEs are actions that support the achievement of many of the SDGs, especially SDG 3 (to ensure healthy lives and to promote well-being for all at all ages) and SDG 11 (to make cities and human settlements inclusive, safer, resilient and sustainable). Of particular relevance to this Report is target 3.d, set under SDG 3, which is to "strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks".⁵² The inclusion of this target under SDG 3 underscores that the strengthening of PHE risk management is an aspect of sustainable development, necessitating the support and involvement of development cooperation actors. Other targets under SDG 3 that are relevant to this Report include:

- ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combatting hepatitis, waterborne diseases and other communicable diseases;⁵³
- securing universal health coverage and access to quality essential healthcare services and safe, effective, quality and affordable essential medicines and vaccines;⁵⁴ and
- supporting the research and development of vaccines and medicines for communicable and non-communicable diseases that primarily affect developing countries.⁵⁵



Bangladesh, Cox's Bazar, 2021. Masuda Pervin, a nurse, prepares to deliver a COVID-19 vaccination. In Cox's Bazar, Bangladesh Red Crescent Society, with support from Movement partners, has been working closely with government authorities and other agencies to support preventive and precautionary measures against COVID-19. © IFRC / Ibrahim Mollik

3.2.2 / Global Health Security Agenda

The Global Health Security Agenda (**GHSA**) launched in 2014 provides a partnership between States, international organisations, NGOs and the private sector to “achieve the vision of a world safe and secure from global health threats posed by infectious diseases”.⁵⁶ The GHSA's 2024 Framework “aims to advance a multisectoral approach, support adherence to international human and animal health standards, collaboratively identify and address gaps and priorities in global health security, and advance sustainable financing for global health security efforts for all relevant sectors.”⁵⁷ The GHSA's key goal is “working with relevant partners [to] actively contribute to national, regional, and global efforts to support countries in evaluation, planning, resource mobilization, and implementation of activities that build health security capacity.”⁵⁸ The Framework recognises the need for interface with other global processes and global health security actors including the WHO, the Food and Agriculture Organization, the World Organization for Animal Health, the World Bank Group and the JEE Alliance (a multi-stakeholder alliance formed to support country assessment processes and the resulting work of building country capacity).⁵⁹ The GHSA's target for 2024, which is inextricably linked to implementation of IHR core capacities, is for more than 100 countries to have completed an evaluation of health security capacity and undergone planning and resource mobilisation to address gaps.⁶⁰ States should be able to demonstrate improvements in at least five technical areas as measured by relevant health security assessments such as those within the WHO IHR Monitoring and Evaluation Framework (see 3.3 below).⁶¹

3.2.3 /The Sendai Framework and Bangkok Principles

The Sendai Framework for Disaster Risk Reduction 2015–2030 (**Sendai Framework**)⁶² is at the centre of international efforts to enable enhanced domestic DRR and DRM. The goal of the Sendai Framework is to prevent new and reduce existing disaster risks through the implementation of integrated and inclusive measures that prevent and reduce hazard exposure and vulnerability to disaster. To do this, it adopts a people-centred, all-hazards, and multi-sectoral approach to disaster risk reduction, with the aim of securing engagement from all of society.

Although not the specific focus of the wider DRR principles adopted by the Sendai Framework,⁶³ public health risks and impacts are nonetheless mentioned throughout the Sendai Framework's Global Targets and four Priorities for Action. Four of the Global Targets⁶⁴ have direct links to health, focusing on reducing mortality, population wellbeing, early warning and promoting the safety of health facilities and hospitals. Emphasis is placed on resilient health systems through the integration of DRM into health care provision at all levels. The Sendai Framework also makes explicit reference to the IHR, calling for enhanced cooperation between health authorities and other relevant stakeholders to strengthen country capacity for disaster risk management for health and the implementation of the IHR.

The importance of health as a core dimension of DRR is further emphasised by the **Bangkok Principles**, adopted at the International Conference on the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030, held in 2016 in Bangkok.⁶⁵ The Bangkok Principles place strengthened coordination at the heart of efforts to reduce risk from public health and biological hazards and encourage systematic cooperation, integration and coherence between disaster and health risk management. To achieve this, the Bangkok Principles expand upon the interpretation of the health-related provisions in the Sendai Framework by recommending seven measures to systematically integrate health into national and sub-national DRR policies and plans. Those most relevant to this Report include:

1. the “[promotion of the] systematic integration of health into national and sub-national disaster risk reduction policies and plans and the inclusion of emergency and disaster risk management programmes in national and sub-national health strategies”;⁶⁶
2. enhanced “cooperation between health authorities and other relevant stakeholders to strengthen country capacity for disaster risk management for health, the implementation of the International Health Regulations (2005) and building of resilient health systems”;⁶⁷ and
3. the promotion of “coherence and further development of local and national policies and strategies, legal frameworks, regulations, and institutional arrangements.”⁶⁸

Key actions for States under the Bangkok Principles include:

1. promoting a whole-of-government, a whole-of-society approach, with population at risk and communities at the centre of emergency and disaster risk management measures;
2. developing or revising multi-sectoral policies, integrated plans and programmes for emergency and disaster risk reduction to include the health sector component, and managing health risks of emergencies and disasters with appropriate levels of resources to support implementation; and
3. increasing the participation of health sector representatives in multi-sectoral emergency and disaster risk management committees and platforms at all levels.

The Bangkok Principles build upon the Sendai Framework and, therefore, tend to reflect that Framework's terminology and approach to DRR and DRM. The result is that the Bangkok Principles could potentially be interpreted as promoting not just integration, but almost the merger of PHE risk management frameworks with the wider DRM regime. However, this may go too far. The interpretation adopted in this Report is that whilst the Bangkok Principles seek co-ordination, integration and coherence between PHE risk management and general DRM frameworks, this does not require *one* legal and institutional framework with *one* set of laws and policies. Of course, States may choose to adopt this approach and, as discussed later in the Report, a few have done so. However, the Bangkok Principles are more permissive, implicitly recognising that States may continue to maintain separate laws and/or policies for PHEs. The key message of the Bangkok Principles is that, however States may wish to arrange their PHE and DRM laws and/or policies, those laws and policies should be co-ordinated, integrated and cohesive.

3.2.4 / 33rd International Conference of the Red Cross and Red Crescent

The importance of enhancing measures to address PHEs has also formed a key element of the RCRC Movement's recent work, in parallel with its efforts to improve disaster laws and policies more generally. A key resolution on tackling epidemics and pandemics was passed at the 33rd International Conference of the Red Cross and Red Crescent in 2019. Under Resolution 3, the State parties to the Geneva Conventions, the ICRC, the IFRC and National RCRC Societies:

1. [invited] States to enable and facilitate Movement components, in accordance with their mandates and capacities and with international law, to contribute to a predictable and coordinated approach to epidemics and pandemics, including effective international cooperation and coordination, and engagement with and support to affected communities;
2. [encouraged] States to include National Societies, according to their mandate, capacities and as humanitarian auxiliaries to their public authorities, in national disease prevention and control and multisectoral preparedness and response frameworks and, where possible, to provide funding in support of their role in this regard;
3. further [encouraged] National Societies to offer support to their public authorities, as appropriate, in their State's efforts to strengthen core capacities as part of obligations to comply with the IHR, ensuring that special provisions are effectively in place for the efficient and expedited delivery of a public health response for affected populations during crisis situations, coordinating with other local and international organizations and focusing, in particular, on building early warning and rapid response capacity in hard-to-reach, vulnerable, underserved and high-risk communities with due attention to the varied needs of girls, boys, men and women;
4. [emphasised] the need for promotion of active community engagement in outbreak prevention, preparedness and response, based on a multi-sectoral, multi-hazard and whole-of-society approach, and [encouraged] States and National Societies to build on evidence-based approaches to community-centric outbreak prevention, detection and response;
5. also [encouraged] States and National Societies to further develop innovative tools, guidance and strategies to support implementation of the above measures and to strengthen their capabilities to respond and to utilize data and technology to improve the quality of response to epidemics and pandemics;
6. [reiterated] the importance of prioritizing and investing in prevention and preparedness as well as providing catalytic funding to support early action, including by National Societies;
7. [reiterated] also the importance of mobilizing resources and building capacities to enable developing countries and their National Societies to respond to the epidemic and pandemic threats;
8. [called] upon Movement components, public authorities and all other actors to take appropriate steps, in accordance with their national and regional contexts, to ensure, as far as possible, that the health and safety of their volunteers and staff responding to epidemics/pandemics, including mental health and psychosocial well-being, are adequately maintained."⁶⁹

Many of the themes of this Resolution reflect the global measures mentioned above and are relevant to the analysis of domestic frameworks for PHEs considered in this Report. Their importance has been reinforced by the COVID-19 Pandemic which, as will be seen, has highlighted the role of National RCRC Societies in responding to a PHE, but also the potential impact of a PHE on National RCRC Societies' ability to operate effectively.

3.2.5 / COVID-19 specific arrangements

In relation specifically to COVID-19, the global community has adopted a number of resolutions in response to the Pandemic. The most notable are the UN General Assembly's omnibus resolution "Comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic"⁷⁰ and the World Health Assembly's resolution on the COVID-19 Response (**WHA COVID-19 Resolution**).⁷¹ The UN General Assembly Resolution was followed by a resolution of the UN Security Council which sought a global, general cessation of hostilities and armed conflicts as part of the UN's response to the COVID-19 Pandemic.⁷² The WHA COVID-19 Resolution stressed the need for States to "put in place a whole-of-government and whole-of-society response including through implementing a national, cross-sectoral COVID-19 action plan ...[and] engaging with communities and collaborating with relevant stakeholders".⁷³ It also called on States to put in place "comprehensive, proportionate, time-bound, age- and disability-sensitive and gender-responsive measures against COVID-19 across government sectors, ensuring respect for human rights and fundamental freedoms and paying particular attention to the needs of people in vulnerable situations, promoting social cohesion, taking the necessary measures to ensure social protection and protection from financial hardship, and preventing insecurity, violence, discrimination, stigmatization and marginalization".⁷⁴ This is of relevance to the consideration of vulnerable groups in Part C of this Report. The WHA COVID-19 Resolution also sought to ensure that "restrictions on the movement of people and of medical equipment and medicines in the context of COVID-19 are temporary and specific and that they include exceptions for the movement of humanitarian and health workers, including community health workers, enabling them to fulfil their duties, and for the transfer of equipment and medicines required by humanitarian organizations for their operations."⁷⁵ The extent to which States' COVID-19 responses impacted on such movements can be seen from the Emergency Decree Mappings and is discussed in Chapter 10.

Italy, 2020. Preparation of Italian Red Cross volunteers before an ambulance shift in Florence. © Michele Squillantini



3.2.6 / Regional arrangements

Within a number of the measures discussed above reference is made to the contribution of regional arrangements to improving domestic PHE risk management. The IHR also make express provision for collaboration “through multiple channels, including bilaterally, through regional networks and WHO regional offices”.⁷⁶ The need for improved regional arrangements for PHE was highlighted in the Report of the High-Level Panel on the Global Response to Health Crises (**the High-Level Panel**).⁷⁷ The Panel found that regional and sub-regional organizations “supported the Ebola crisis response with innovative and experienced capacities.” It recommended that “Regional organizations should develop or strengthen standing capacities to assist in the prevention of and response to health crises, with a particular emphasis on areas where they can add significant value to national responses.”

Whilst regional arrangements for generic DRM are well-developed, those for PHE are, perhaps surprisingly, harder to find. An example of a PHE specific exception is European Union (**EU**) Decision No 1082/2013 which addresses serious health threats with cross-border implications and the implementation of the IHR within the EU. The Decision formally establishes the EU’s Health Security Committee and recognises the role of the European Centre for Disease Prevention and Control in epidemiological surveillance and early warning.⁷⁸ There are a number of other regional arrangements which may apply to PHEs mainly based on economic groups or pre-existing generic DRM arrangements: for example, the ASEAN Agreement on Disaster Risk Management and Emergency Response,⁷⁹ the European Union Civil Protection Mechanism⁸⁰ or the Caribbean Disaster Emergency Response Agreement.⁸¹ The PHE Mappings for a number of Pacific Island States refer to the contribution played by regional initiatives including the UN Pacific Strategy⁸² and the Pacific Humanitarian Team COVID-19 Response Plan.⁸³ In general, formal regional institutional arrangements specific to PHEs or public health were not widely reported. An exception is the Caribbean Public Health Agency (**CARPHA**).⁸⁴ CARPHA is a regional public health agency for the Caribbean established by an inter-governmental agreement in 2011.⁸⁵ Its mandate includes (a) leading effective responses to public health crises in the Caribbean and (b) through collaboration with CDEMA, the Pan-American Health Organization and WHO, building regional capacity and the capacity of individual Member States in preparedness, monitoring of potential threats, and responding to any emergency or disaster. CARPHA appears to have played a significant role in the response to COVID-19 in the Caribbean and may, therefore, provide a precedent for the development of other regional PHE arrangements.

3.3 / THE INTERNATIONAL HEALTH REGULATIONS 2005

3.3.1 / Development of the International Health Regulations (IHR)

The IHR 2005 are the latest in a line of instruments which have addressed the problem of cross-border infection. Following the establishment of the WHO in 1946, International Sanitary Regulations were adopted in 1951⁸⁶ which contained preventative measures against three specified diseases: cholera, plague and yellow fever. The 1951 Regulations became the International Health Regulations of 1969.⁸⁷ In 1995, the 48th World Health Assembly called for a revision of the Regulations in response to the growth in international travel and trade and the emergence of new international disease threats. Following the SARS outbreak in 2003, the current IHR were adopted in 2005 and came into force in June 2007.⁸⁸

The purpose and scope of the IHR is “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.”⁸⁹ The 2005 IHR mark a significant change in approach from the previous Regulations by no longer being limited to specific diseases. The 2005 IHR apply to “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans.” The 2005 IHR therefore arguably take an ‘all-public health hazards’ approach.

3.3.2 / WHO's responsibilities under the IHR

The majority of the functions conferred on the WHO are outside the scope of this Report and deal with, for example, the creation of a roster of IHR experts,⁹⁰ the establishment and role of an Emergency Committee⁹¹ and Review Committees,⁹² and the involvement of other international, intergovernmental and specialised agencies.⁹³ Two functions, though, are of relevance: (a) the power to declare public health emergencies of international concern (**PHEIC**);⁹⁴ and (b) where a PHEIC has been declared, the duty to issue temporary recommendations.⁹⁵

Switzerland, 2020. WHO Director-General Dr Tedros Adhanom Ghebreyesus and IFRC Secretary-General Mr Jagan Chapagain sign a memorandum of understanding to cooperate on implementing the Emergency Medical Team (EMT) initiative. © WHO / Chris Black



A PHEIC is “an extraordinary event which is determined [by the Director General of WHO]: (i) to constitute a public health risk to other States through the international spread of diseases, and (ii) to potentially require a coordinated response.”⁹⁶ The process for determination of a PHEIC is detailed in the IHR.⁹⁷ It should follow notification by a State or States of unexpected or unusual public health events within a State’s territory.⁹⁸ An innovation of the 2005 IHR, though, is a power for the WHO to obtain information from other sources which the WHO can use in making a determination.⁹⁹ The IHR make provision for the WHO to share information with other organisations and, when justified by the magnitude of the public health risk, with other States.¹⁰⁰ PHEIC declarations have to date been made in respect of: swine flu or H1N1 flu in 2009; polio and Ebola in 2013; the Zika virus in 2016; Ebola again in 2018; and COVID-19 in 2020 (see section 2.2).

The consequences of a declaration of a PHEIC are that: (1) the WHO may offer further assistance to the affected State and to other States affected or threatened by the PHEIC;¹⁰¹ and (2) the Director-General is under a duty, having first sought the advice of the Emergency Committee, to issue temporary recommendations to States.¹⁰² Temporary recommendations “may include health measures to be implemented by the State Party experiencing the PHEIC, or by other States Parties, regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic.”¹⁰³ Article 18 of the IHR sets out the type of advice that can be included in a temporary recommendation. The type of advice includes: a requirement for medical examination, vaccination or other prophylaxis; the placement of suspect persons under public health observation and the implementation of quarantine or other health measures; the implementation of contact tracing; the refusal of entry of suspect and affected persons, or unaffected persons from affected areas; and the implementation of exit screening and/or restrictions on persons from affected areas.¹⁰⁴ Temporary recommendations are, however, not binding on States.

Kenya, 2019. Community members draw a map of their local villages with key geographic features, including locations of water sources, health facilities, markets and animal migration routes, animal slaughter and burial practices, seasonal disease trends and other risks. These are all necessary for being able to take effective actions to identify the sources of disease outbreaks and contain the spread. © IFRC / Corrie Butler



3.3.3 / State responsibilities under the IHR

The duties conferred on States under the IHR fall into two broad categories. The first category reflects the predecessor instruments to the 2005 IHR and comprises measures that address the spread of disease through international travel and trade.¹⁰⁵ Whilst State action should avoid unnecessary interference with international traffic and trade, the IHR permit States to adopt measures that: (1) can be taken at points of entry to require travellers to provide information or to be medically examined;¹⁰⁶ (2) prevent ships and aircraft from calling at points of entry;¹⁰⁷ and (3) deal with suspect travellers including placing them under public health observation or requiring invasive medical examinations and vaccination.¹⁰⁸

The second category of duties is most relevant to this Report. These are directed at increasing States' capacities to manage public health risks and PHEs and are referred to as the "core capacities".¹⁰⁹ The overarching duties are to:

- **develop, strengthen and maintain** the capacity to detect, assess, notify and report public health events;¹¹⁰
- **develop, strengthen and maintain** the capacity to respond promptly and effectively to public health risks and PHEICS.¹¹¹

The core capacities were required to be put in place within 5 years of the IHR coming into force (i.e. 2012), although States could seek a two year extension and, in exceptional circumstances, a subsequent two year extension.¹¹² However, the ability to seek extensions has now expired and implementation of the core capacities should not, therefore, have been delayed beyond 2016.¹¹³

To improve their core capacities, States are also required to:

- **designate or establish** a National IHR Focal Point and the authorities responsible for the implementation of health measures under the IHR;¹¹⁴
- **ensure competent State authorities** maintain effective contingency arrangements to deal with an unexpected public health event;¹¹⁵
- **require competent authorities** to communicate with the National IHR Focal Point on relevant public health measures taken;¹¹⁶ and
- **notify the WHO** of all events that may constitute a PHEIC.¹¹⁷

States are also required, when requested by the WHO, to provide support to WHO-coordinated response activities to the extent possible.¹¹⁸ States should also collaborate with each other, to the extent possible, in: (1) the detection and assessment of, and response to, public health events; (2) the provision or facilitation of technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities required under the IHR; and (3) the mobilisation of financial resources to facilitate implementation of their obligations under the IHR. Collaboration may be implemented through multiple channels, including bilaterally, through regional networks and WHO regional offices.¹¹⁹

All State functions under the IHR are required to be exercised in a transparent and non-discriminatory manner, with full respect for the dignity, human rights and fundamental freedoms of persons.¹²⁰ States should also report to the World Health Assembly on the implementation of the IHR.¹²¹

3.3.4 / IHR reviews

To date, reviews have been undertaken by Review Committees under the IHR: (1) on the Functioning of the IHR and on Pandemic (H1N1) 2009 (**the H1N1 Review**);¹²² (2) on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;¹²³ and (3) on the Role of the IHR in the Ebola Outbreak and Response (**Ebola Review**).¹²⁴ In addition, in response to the Ebola outbreak of 2013 to 2016, WHO requested an interim assessment by a panel of external independent experts (**Ebola Interim Assessment Panel**).¹²⁵ At the time of writing, the Review Committee has been tasked to undertake a fourth review focusing on the functioning of the IHR during the COVID-19 response.¹²⁶ Also in response to the COVID-19 Pandemic, WHO has established an International Panel for Pandemic Preparedness and Response, and is developing an ongoing 'Universal Health and Preparedness Review' which would operate as a regular and transparent process of peer review, similar to the Universal Periodic Review used by the Human Rights Council.¹²⁷

The three reviews conducted to date differed in their assessment of the effectiveness of the IHR. The Ebola Interim Assessment Panel found weaknesses in the IHR: "The Ebola crisis not only exposed organizational failings in the functioning of the WHO, but it also demonstrated shortcomings in the [IHR]. If the world is to successfully manage the health threats, especially infectious diseases that can affect us all, then the [IHR] need to be strengthened."¹²⁸ The H1N1 Review Committee saw less reason to criticise the IHR finding that the IHR had helped "make the world better prepared to cope with public health emergencies."¹²⁹ The Ebola Review considered that "the failures in the Ebola response did not result from failings of the IHR themselves".¹³⁰

All the reviews, however, highlighted that a main issue is a failure by States to implement the core capacities required by the IHR.¹³¹ The H1N1 Review found that "The world [was] ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency."¹³² The Ebola Interim Assessment Panel considered the situation "in which the global community does not take seriously its obligations under the [IHR] – a legally binding document – to be untenable." The Ebola Review agreed concluding that "Full implementation of the IHR must be the urgent goal of all countries as this is the collective means to improve global public health preparedness and improve the safety of the world's population...".¹³³

In 2015, the UN Secretary-General appointed the High-Level Panel on Global Response to Health Crises, which issued its final report in January 2016.¹³⁴ The High-Level Panel made 27 recommendations for action at the national, regional and international levels, including measures that cut across governance levels and required engagement with all sectors of society. The High-Level Panel found that "the mechanism for monitoring compliance with the IHR core capacity requirements is weak. The lack of independent assessments affects international efforts to support more vulnerable countries in implementing preparedness, surveillance, detection and response capacities." It concluded that there was an urgent need to establish a "stronger periodic review of compliance with the IHR core capacity requirements."

The High-Level Panel was especially critical that "More than three years after the original deadline for compliance with the IHR core capacity requirements (and the granting of two extensions), only one third of the State parties to IHR have declared that they have met the IHR core capacity requirements".¹³⁵ Commenting that "The local community is on the front line of any outbreak, and the State is the primary actor responsible and accountable for issuing appropriate alerts and responding to a crisis", the High-Level Panel recommended that:

"all countries must meet the full obligations of IHR. Where capacities are lacking, support should be provided to urgently implement a core set of measures. These measures should be under the direct authority of the Heads of Government and should include the establishment of pandemic preparedness and response mechanisms, with clear command and control; hiring and training health professionals and community health workers; and building a comprehensive surveillance system with a national laboratory."¹³⁶

The High-Level Panel's four recommendations directed at the national level reflected the need for key measures implementing the IHR core capacities: building an effective health workforce; addressing governance challenges; improving community engagement; and addressing the gender aspects of health crises.¹³⁷ The Panel's first recommendation was that "By 2020, States parties to IHR, with appropriate international cooperation, are in full compliance with the IHR core capacity requirements." To enable compliance, the Panel considered that States should take actions, including:

- incorporating planning for health crisis responses into national disaster risk-reduction preparedness and response mechanisms and plans;
- engaging all relevant stakeholders to identify response capacities and resources;
- developing pandemic plans and carrying out simulation exercises for all relevant responders, including security forces;
- establishing a "One Health" surveillance mechanism to collect and analyse public health information in near-to-real time, combining data from all segments of society; and
- ensuring immediate notification of all unusual health events to the WHO Regional Director and the WHO Programme for Outbreaks and Emergencies Management.¹³⁸

To address governance challenges, including ensuring greater transparency, the High-Level Panel recommended that "planning for health crises as well as regular surveillance be carried out as part of the national disaster risk reduction, preparedness and response mechanisms –with input from representatives from different ministries and NGOs."¹³⁹ Governments and responders were also recommended to strengthen and streamline community engagement and the promotion of local ownership and trust.¹⁴⁰

3.3.5 / WHO initiatives to improve domestic implementation

In response to these reviews, the WHO has established a number of initiatives designed to secure greater national implementation of the IHR. The initiatives principally involve the four core elements of the WHO's IHR Monitoring and Evaluation Framework:¹⁴¹ (1) State Parties Self-Assessment Annual Reporting; (2) Joint External Evaluation (JEE); (3) simulation exercises; and (4) after action (and more recently, intra-action)¹⁴² review.

With respect to the first core element, the State Party Self-Assessment Annual Reporting Tool (**SPAR**)¹⁴³ has been developed to support States to fulfil their obligation to report annually to the World Health Assembly on the implementation of capacity requirements under the IHR. SPAR consists of 24 indicators for the 13 IHR capacities needed to detect, assess, notify, report and respond to public health risk and acute events of domestic and international concern. A key indicator under SPAR is 'Legislation and Financing'. This indicator seeks to assess whether States "have an adequate legal framework in all relevant sectors to support and facilitate the effective and efficient implementation of all of their obligations and rights under the IHR."¹⁴⁴ The aim of this indicator is to enable States to (1) identify if new or modified legislation is required or existing legislation merits revision and (2) ensure that legislative frameworks institutionalise "essential public health functions to sustain the continuous preparedness process for responding to public health events."¹⁴⁵

The second element, Joint External Evaluation (JEE), is a "voluntary, on-going process to support States to evaluate country capacity to prevent, detect and rapidly respond to public health threats independently, by measuring country-specific status and progress in achieving the IHR targets". Joint External Evaluations are conducted using the JEE tool,¹⁴⁶ which has 49 indicators grouped under 19 technical areas. The first indicator in the JEE tool is "national legislation, policy and financing", with the JEE tool noting that the term "legislation" refers to the broad range of legal, regulatory, administrative, or other governmental instruments which may be available for States Parties to implement the IHR. The JEE tool provides that this indicator can be achieved by States assessing, adjusting and aligning their domestic legislation, policies and administrative arrangements in all relevant sectors to enable compliance with the IHR.¹⁴⁷

In 2019, the WHO released the WHO Benchmarks for International Health Regulations (IHR) Capacities (**WHO Benchmarks**).¹⁴⁸ The WHO Benchmarks address the 13 IHR capacities described in the SPAR and the 19 technical areas described in the JEE tool.¹⁴⁹ Similar to the JEE, the first benchmark focuses on “national legislation, policy and financing”:

“An adequate legal framework for States Parties is essential to support and enable the implementation of all their obligations and rights of (sic) the IHR. This can include the creation of new legislation and/or the revision of existing legislation, regulations or other instruments to facilitate implementation and compliance with IHR (2005). A lack of appropriate legislation or policy can be a major barrier to implementation and should be considered a priority to enable other technical areas to be implemented effectively.”¹⁵⁰

In both the JEE tool and WHO Benchmarks, five levels of capacity ranging from 1 (“No Capacity”) through to Level 5 (“Sustainable Capacity”) can be measured. Level 5 can only be achieved if a State has “[confirmed] that relevant legislation, laws, regulations, policy and administrative requirements cover all aspects of IHR implementation based on the risk profile of the country”.¹⁵¹

To support and monitor the implementation of the recommendations of the High-Level Panel, the Global Health Crises Task Force was established in 2016 and produced its final report in 2017.¹⁵² Although some of the WHO initiatives mentioned above were not in place before the Task Force reported, the Task Force recognised that one key achievement in supporting States was the development of the IHR Monitoring and Evaluation Framework. Nonetheless, the Task Force pointed out that it was “not enough just to diagnose the problems: they must be remedied. Gaps identified in the joint external evaluations as well as in after-action reviews and simulation exercises need to be prioritised and incorporated within the national health action plans and addressed through the provision of technical and financial assistance to the country”.¹⁵³

Although the subsequent programme will undoubtedly have been affected by the COVID-19 Pandemic, as at 26 October 2020, 79 JEE mission reports had been published. Although possibly reflecting prioritisation of particular regions, the spread of evaluations is not equal across the WHO regions. The African Region has seen most evaluations undertaken with 44 in total. Seventeen evaluations have been carried out in the Eastern Mediterranean Region, 14 in the European Region, 11 in the Western Pacific Region and 8 in the South East Asia Region. Apart from the USA and Canada, no reports have been published for the Region of the Americas. Since 2016, the WHO has also been working closely with many countries and its partners to support the development of National Action Planning for Health Security (**NAPHS**). This is a country owned, multi-year, planning process designed to accelerate the implementation of IHR core capacities, and is based on a One Health for all-hazards, whole-of-government approach.¹⁵⁴ NAPHS also provides an overarching process to capture all national ongoing preparedness initiatives and the governance mechanism for emergency and disaster risk management. NAPHS for ALL - A Country Implementation Guide for NAPHS¹⁵⁵ provides guidance at each step of the NAPHS framework, and the necessary tools and templates for developing and implementing national action plans. One key benefit is that the document targets all relevant stakeholders of health security.

In 2019, the WHO also produced a Health Emergency and Disaster Risk Management Framework¹⁵⁶ designed to provide “a common language and a comprehensive approach that can be adapted and applied by all actors in health and other sectors who are working to reduce health risks and consequences of emergencies and disasters.”

Finally, three toolkits have been produced by the WHO to assist States to implement the IHR through national legislation:

- IHR (2005): A brief introduction to implementation in national legislation (**IHR: A Brief Introduction**);¹⁵⁷
- IHR (2005): Toolkit for implementation in national legislation - The National IHR Focal Point (NFP);¹⁵⁸ and
- IHR (2005): Toolkit for implementation in national legislation: Questions and answers, legislative reference and assessment tool and examples of national legislation.¹⁵⁹ (This includes, in Part III, examples of legislation, regulations and other instruments adopted by States Parties which refer to the IHR)

IHR: A Brief Introduction provides guidance about how an assessment of national legislation may be conducted.¹⁶⁰ It recommends preparing for the legislative assessment by first establishing an intersectoral committee to conduct the assessment and contacting other States undertaking a similar assessment. Regarding the assessment process itself, it provides recommendations about what functions and legislation need to be identified, ensuring that priority subject areas for IHR implementation are covered, and how the assessment should be followed-up.¹⁶¹

3.4 / THE IMPACT OF THE IHR ON DOMESTIC PHE FRAMEWORKS

3.4.1 / Core capacities

Although the IHR form an essential part of the global PHE framework, for the purposes of this Report, their most important influence is on the development of the identified domestic core capacities. Through developing these capacities, States should be better prepared for PHEs.

Unfortunately, as Bartolini concludes, “such obligations, some of which are among the most innovative elements of the 2005 IHR, suffer from various shortcomings, and approximately two-thirds of States parties to the instrument have failed to implement measures due to low or moderate levels of national preparedness.”¹⁶² The main method of monitoring IHR core capacity implementation is the annual State reporting and the JEE process. Although improved performance across all key capacities has been reported, of the 96 States evaluated up to 2020 less than half had taken action to develop capacity for IHR legislation compliance.¹⁶³ The Review Committees and the High-Level Panel and Task Force made similar findings. As Negri summarises, “These review bodies brought out a number of critical issues and shortcomings adversely impacting on the successful performance of the IHR (2005) and strongly undermining their effectiveness. In particular, they found that the overarching challenges and structural shortcomings consist in poor implementation and lack of enforceable sanctions.”¹⁶⁴ The lack of enforceable sanctions¹⁶⁵ will no doubt form part of the forthcoming reviews of the IHR,¹⁶⁶ but improved implementation of the IHR’s core capacities through domestic legislation¹⁶⁷ should assist States to attain much more integrated and effective domestic PHE risk management frameworks.



RECOMMENDATION

States should continue to take steps to ensure that their domestic legislation implements and facilitates the IHR core capacities and meets their obligations under the IHR.

3.4.2 / Monitoring and evaluation

As discussed above,¹⁶⁸ the WHO has already responded to earlier reviews by introducing initiatives under its IHR Monitoring and Evaluation Framework. As the UN Global Health Crises Task Force found, there is no question that these initiatives have started to bring about improvements in States' implementation of their IHR responsibilities.

Of the four elements within the IHR Monitoring and Evaluation Framework, only annual reporting is currently mandatory. However, Bartolini considers that this element still has shortcomings because it relies on self-assessment and “fails to contribute to the identification of what is expected in terms of the core capacities”.¹⁶⁹ Nonetheless, a high percentage of States do submit returns.¹⁷⁰

In contrast to annual reporting, JEE is voluntary and the number of States undergoing a JEE is limited. It is indicative of this that of the 36 States within the PHE Mappings only 16 had undergone a JEE. Moreover, as Bartolini comments, JEE suffers from “its deference to states as a result of its being based on self-assessment.”¹⁷¹ Bartolini considers that a reform of the monitoring system could permit more effective scrutiny of States' compliance with the obligations related to core capacities. He reports that the Global Preparedness Monitoring Board has advocated amending the IHR to include “mechanisms for assessing IHR compliance and core capacity implementation, including a universal, periodic, objective, and external review mechanism.”¹⁷²

The problem of effective scrutiny is not unique to the IHR. However, there are precedents of States agreeing to be subject to mandatory monitoring, audit or verification procedures in relation to their compliance with international legal instruments. Such procedures, albeit with varying degrees of compulsion and effectiveness, exist across many international law instruments, including in the fields of international human rights law, international environmental law and weapon control regimes.¹⁷³ One example that may offer a precedent for enhancing the provisions of the IHR is found in six international maritime conventions agreed under the aegis of the International Maritime Organization (IMO) and covered by the IMO Instruments Implementation Code (the **III Code**).¹⁷⁴ As with the IHR, a system of voluntary evaluations or audits had been in place but proved to be ineffective in securing implementation of the conventions. Consequently, the III Code was adopted to “further assist Member Governments to improve their capabilities and overall performance in order to be able to comply with the IMO instruments to which they are party; [and] conscious of the difficulties some member states may face in complying fully with all the provisions of [those instruments].”¹⁷⁵ States agreed to submit to periodic mandatory audits by the IMO (through a system of peer auditors) to verify their compliance with, and implementation of, the six conventions. As part of these audits, States are required to draw up corrective action plans that are verified by subsequent audit.¹⁷⁶ The mandatory external evaluation regime created by the III Code may be a useful precedent to consider in relation to any future amendment of the IHR.

Given the reported benefits of external evaluation and the need for enhanced scrutiny to improve domestic IHR implementation,



RECOMMENDATION

Any future review of the IHR should consider whether the IHR should impose an obligation on States to participate in periodic external evaluations of their IHR implementation.

3.4.3 / Participation in evaluations

A key theme running through this Report – and recognised by the Sendai Framework and Bangkok Principles – is the need for an all-of-society, multisectoral and integrated approach to PHE risk management. This is also a fundamental aspect of the One Health concept. Bartolini, albeit primarily in the global context, identifies the need to involve a wider range of institutional actors.¹⁷⁷ This, it is submitted, should apply equally to any evaluation of a State's implementation of the IHR. The evaluation team should be able to secure input from all relevant actors and stakeholders. Further, having regard to the Bangkok Principles, any evaluation should also consider a State's wider DRM framework and the level of coordination or integration between PHE risk management frameworks and wider DRM frameworks.

3.4.9 The role that can be played by National RCRC Societies in evaluations (and follow up NAPHS) could also be more effectively recognised. In a number of States, National RCRC Societies are already included in DRM frameworks, however this occurs to a lesser extent in PHE risk management arrangements. Resolution 3 of the 33rd International Conference (see section 3.2.4) encourages “States to include National Societies, according to their mandate, capacities and as humanitarian auxiliaries to their public authorities, in national disease prevention and control and multisectoral preparedness and response frameworks and, where possible, to provide funding in support of their role in this regard”. It also encourages National Societies “to offer support to their public authorities, as appropriate, in their State's efforts to strengthen core capacities as part of obligations to comply with the IHR ...”¹⁷⁸ This support could be provided through National RCRC Society participation in evaluation exercises and, indeed, any of the other elements of the IHR Monitoring and Evaluation Framework.

More detailed analysis of the JEEs and NAPHS may show that the approaches mentioned above have, in fact, already been adopted to some extent. However, the PHE Mappings that refer to JEEs (and follow up NAPHS) do not indicate that this has occurred in the Sample States.



RECOMMENDATION

1. In any future review or updating of the JEE regime, consideration should be given to ensuring that all relevant actors and stakeholders are able to participate and contribute.
2. In particular, having regard to the auxiliary role played by National RCRC Societies in both DRM and PHE risk management, domestic laws and/or policies should enable National RCRC Societies to participate in IHR monitoring and evaluation, including JEEs.
3. Having regard to the Bangkok Principles, any evaluation at either the global or domestic level, should take into account the wider DRM frameworks and the level of coordination and integration between PHE risk management and DRM frameworks (including national and local disaster risk reduction strategies).

As a means of encouraging implementation of the IHR, Argentina's Ministry of Health established a Commission for the Implementation and Monitoring of the International Health Regulations and Basic Capacities. Through the Commission the Ministry of Health coordinates action with other ministries, Argentinian provinces and key non-State actors regarding the implementation of strategies to respond to PHEs. Apart from being a means to coordinate the response to PHEs, this Commission is designed to operate within the GHSA and demonstrates commitment to implementation of the IHR.¹⁷⁹

The idea of States developing strategies and coordinating strategy bodies for the implementation of international instruments has been used in other areas. For example, under the IMO's III Code (see 3.4.6 above), States are recommended to:

1. develop an overall strategy to ensure that its international obligations and responsibilities...are met;
2. establish a methodology to monitor and assess that the strategy ensures effective implementation and enforcement of relevant international mandatory instruments; and
3. continuously review the strategy to achieve, maintain and improve the overall organizational performance and capability....¹⁸⁰

A number of States have established strategy committees or their equivalent to undertake this function. Such committees are encouraged to include a broad range of government departments, industry representatives and other stakeholders with relevant interests. A number of States have established strategy committees or their equivalent in accordance with the recommendations of the III Code.

The establishment of a central strategic body, task force or working group has also been a recommendation of previous IFRC Disaster Law reports and guidance as a means of securing enhanced DRM.¹⁸¹ It is recommended too for PHE risk management. Having regard to the Bangkok Principles, any strategic body for implementing the IHR should include DRM actors and it is essential for any integrated PHE risk management strategy to be coordinated with existing DRM arrangements.

The potential role of National RCRC Societies in IHR evaluation is mentioned above. The experience of National RCRC Societies and their ability to access the support of the wider IFRC Network also makes them a key participant in any central strategic body for IHR implementation. Participation in such bodies would further fulfil the aim of Resolution 3 of the 33rd International Conference for National Societies "according to their mandate, capacities and as humanitarian auxiliaries to their public authorities" to be included in multisectoral preparedness and response frameworks.¹⁸²



RECOMMENDATION

1. Any future review of the IHR should consider whether the IHR should include an obligation on States to establish a committee specifically for overseeing the implementation of States' IHR obligations and monitoring ongoing operation and compliance (IHR monitoring committee).
2. Regardless of whether required under the IHR, domestic laws and/or policies should provide for the establishment of an IHR monitoring committee.
3. The IHR monitoring committee should include all relevant actors and stakeholders, including the private and public sectors and community representatives.
4. In particular, as auxiliaries to their public authorities in the humanitarian field, National RCRC Societies should be invited to participate in the IHR monitoring committee.

3.4.4 / Post evaluation action

As the Global Health Crises Task Force noted, however, evaluation is only a first step; what can be more important is how States respond to the evaluation. Currently, even if a JEE is undertaken, there is no obligation on States to take action in response to its recommendations. The PHE Mappings do not address this specifically and there has been relatively little time since many of the JEEs for much action to be taken, especially with the arrival of COVID-19. Only a couple of States are reported as having taken follow up action. Where States had done this, they appeared to have developed a significant

range of policies or plans. For example, Sri Lanka,¹⁸³ Nigeria¹⁸⁴ and Sierra Leone produced a NAPHS in response to their JEEs, with Sierra Leone also producing a One Health National Emergency Risk Communication Strategic Plan, which was used during the COVID-19 Pandemic.¹⁸⁵ However, there is no duty as such for States to produce a NAPHS or provide a remedial strategy if gaps in implementation are identified by a JEE.

Bartolini suggests that States unable to comply with core capacities should be required to develop domestic implementation instruments, taking advantage of models such as the NAPHS to set proper milestones and a masterplan.¹⁸⁶ Again, there are precedents from other branches of international law. Returning to the maritime conventions mentioned above, as part of the mandatory III Code audit, States are required to draw up corrective action plans that will be verified by subsequent audit.¹⁸⁷



RECOMMENDATION

1. In any future review of the IHR or the JEE regime, consideration should be given to requiring the production and implementation of post-evaluation action plans.
2. Regardless of whether required under the IHR or JEE regime, domestic laws and/or policies should:
 - a. require the production and implementation of post-evaluation actions plans;
 - b. identify the appropriate domestic actor or actors with responsibility for producing a post-evaluation plan and/or contributing to such plans; and
 - c. provide for the IHR monitoring committee to monitor and/or have oversight over the production of the post-evaluation action plan and its implementation.

3.4.5 / Transparency of PHE laws

An understanding of the legislation that States have put in place to meet their commitments under the IHR is important to enable monitoring of implementation. If corrective legislative action is required following an external evaluation, it is also important for that legislation to be published in order to show that action has been completed. Access to legislation is also important from the practical or operational perspective in a PHE for other States and humanitarian organisations. However, as the research for this Report demonstrates, accessing States' legislation is not always easy. Under the IHR there is currently no obligation for States to publish or, for example, provide copies of implementing instruments to the WHO. This contrasts with a number of other international instruments which expressly require States to provide copies of implementing domestic instruments to the responsible Secretariat.¹⁸⁸



RECOMMENDATION

Any future review of the IHR should consider whether States should be required to notify WHO of domestic instruments which implement the IHR and to deposit copies of such instruments with the WHO. Any future review should also consider whether the WHO should be required to make copies of deposited instruments publicly accessible on-line.

3.4.6 / Capacity to implement IHR core capacities

Difficulties in implementing the IHR core capacities can be a consequence of a lack of financial and technical assistance.¹⁸⁹ Financial assistance, and in particular the lack of an international financing regime, is outside the scope of this Report. Nonetheless, given that the World Bank has quantified the annual global investment needed to strengthen core capacities to be between US \$1.9 and 3.4 billion, the lack of financial capacity is a significant obstacle to effective IHR implementation. Despite initiatives such as the World Bank's Pandemic Emergency Financing Facility,¹⁹⁰ the Global Fight for Aids, Tuberculosis and Malaria,¹⁹¹ the GAVI Vaccine Alliance,¹⁹² and the Coalition for Epidemic Preparedness Innovation¹⁹³ and other public-private partnerships, funding remains insufficient.

In addition to financial capacity, another consideration is how the capacity to make implementing legislation can be enhanced. In other contexts, international organisations have, for example, established technical cooperation schemes to support national lawyers drafting domestic implementing legislation.¹⁹⁴ There appear to be no such schemes in relation to the IHR, although the WHO has provided some guidance through, for example, its IHR (2005): Toolkit for implementation in national legislation: Questions and answers, legislative reference and assessment tool and examples of national legislation.¹⁹⁵

The WHO Thematic Platform for Health EDRM and its associated Research Network is a dedicated group of stakeholders from a wide range of disciplines and entities (governmental, academic etc) which focuses on research, policy and practice in Health Emergency and Disaster Risk Management for Health (**Health EDRM**).¹⁹⁶ This research encompasses emergency and disaster medicine, disaster risk reduction, multi-hazard emergency preparedness, humanitarian response and health systems strengthening. At its most recent expert meeting, although research questions in five major areas for Health EDRM were identified, there was no discussion of law, legislation, policies or regulation.¹⁹⁷

The lack of focus on legal issues in the Health EDRM Research Network is at odds with the importance attached to national legislation in improving core capacities in the JEE tool and WHO Benchmarks. Given that COVID-19 has, unlike any previous event, led to lawyers across the world becoming experienced in researching, drafting and applying PHE laws, there is an opportunity for the Health EDRM Research Network, and other key WHO fora, to initiate research and discussion on the legal aspects of IHR implementation and the wider practice of PHE law.



RECOMMENDATION

1. Legal aspects of PHEs and the implementation of IHR core capacities should be included within the work of relevant networks and fora, such as the Thematic Platform for Health Emergency and Disaster Risk Management and its associated Research Network.
2. Organisations with an interest in PHE and the implementation of IHR core capacities should consider establishing a network of legal practitioners and academics with a remit to promote the development of improved domestic PHE laws, including those implementing IHR core capacities.

3.4.7 / Notification and early warning

Finally, consideration is given to two key specific elements of IHR core capacities: the national IHR focal point and notification of public health events.¹⁹⁸

Under Art 4(1) of the IHR, States have a duty to designate a National IHR Focal Point. The majority of the Sample States appear not to have made express provision for this role in their domestic legislation. An

exception is Brazil where legislation designates the Secretariat of Health Surveillance as WHO's National Focal Point for the IHR (2005)¹⁹⁹ and, perhaps more importantly, determines the basic operational structure for the National IHR Focal Point and its functions. Details are included concerning notification, the exchange of information and the dissemination of information concerning the IHR within Brazil. In most cases, there is less specificity and, although a focal point may have been designated, this is more commonly done via an administrative act rather than via legislation. Although legislation is not strictly required, it may assist in making clear provision for the role of the National IHR Focal Point and its mandate, and in giving due prominence to the role.

A role of the National IHR Focal Point under the IHR is to notify the WHO of all events that may constitute a PHEIC within the Focal Point's territory.²⁰⁰ A specific issue addressed in most of the PHE Mappings is whether domestic law requires governments to notify the WHO of any such event.

In the majority of cases no such laws are found. An exception is Switzerland, where the Federal Act on the Control of Communicable Human Diseases explicitly requires the Federal Office for Public Health to notify the WHO of events which may lead to a PHEIC.²⁰¹ A frequent comment in the PHE Mappings is that no express measure is required as a State is obliged to notify the WHO by virtue of the binding nature of the IHR. This may be correct as a matter of principle, and there is no evidence to suggest that a failure to notify has ever been due to a lack of an express duty in domestic law. However, as the DPR Report identifies, clarity and certainty are critically important in early warning or notification arrangements to minimise delay. Setting out an express duty in domestic legislation may create greater certainty about who is responsible for notifying the WHO²⁰² and when notification is required. What is also important is that domestic legislation contains provisions necessary to ensure that: (1) the relevant domestic actors are under a duty to provide timely notification of a public health event which may constitute a PHEIC to the National IHR Focal Point; and (2) the National IHR Focal Point has the authority and ability to notify the WHO (and any other potentially affected State) within the timescale provided by the IHR.²⁰³ This includes ensuring that the National IHR Focal Point is authorised to share all relevant information and is not constrained by other laws. For example, the Australian National Health Security Act 2007 ensures that the Australian (Commonwealth) Minister for Health may disclose personal or commercial information that would otherwise be protected to the WHO or another State for the purpose of giving effect to the IHR.²⁰⁴



RECOMMENDATION

1. Any future review of the IHR should consider whether it is necessary or would be beneficial to include additional provision in the IHR clarifying the process and responsibility for States' notification of emerging public health threats to the WHO and other States.
2. States should:
 - a. review the designation of the National IHR Focal Point and its functions;
 - b. consider whether implementation of the IHR and PHE risk management could be improved by making express provision for that designation and the National Focal Point's functions in domestic laws and/or policies; and
 - c. review whether there are legal obstacles to the sharing of information with the WHO and other States and, if so, implement legal reforms to remove those obstacles.

The IHR as they currently stand are only concerned with notification or warning being given to the WHO or other States. They do not provide for notification or warning to organisations within, or the population of, the affected State.



Comoros, 2021. Taking care of older people is essential as they are more vulnerable to COVID-19 and its side effects. Volunteers from the Comoros Red Crescent visit older people, talk with them and monitor their health status. © Comoros Red Crescent

Recent developments in general DRM law are, however, moving towards the creation of duties to provide early warning of natural hazards and the occurrence of a disaster.²⁰⁵ (Early warning as used here refers to taking action prior to a hazard materialising on the basis of risk information and warnings, rather than providing warnings only once the hazard materialises.) One of the seven global targets of the Sendai Framework is to substantially increase the availability of and access to multi-hazard early warning systems and disaster risk information and assessments.²⁰⁶ The ILC Draft Articles for the Protection of Persons in the Event of Disaster propose a duty to install and operate early warning systems as part of the wider duty on States to reduce the risk of disasters.²⁰⁷ In its commentary on the existence of a duty of cooperation in response to disasters, the ILC provides the example of a duty on an affected State “to inform or notify, at the onset of disaster, other States and other assisting actors that have a mandated role to gather information, [and] provide early warning”.²⁰⁸

In its Chapter entitled “Early Warning, Early Action”, the DPR Report deals in detail with developing law and/or policy with regard to early warning systems in the wider DRM context.²⁰⁹ It recommends that “In order to create an effective multi-hazard early warning system, law and/or policy should clearly stipulate the roles and responsibilities of all actors involved in: developing disaster risk knowledge; monitoring and forecasting hazards; and generating and issuing early warnings.”²¹⁰ It further recommends that “law and/or policy should: establish standard processes for generating and issuing warnings; require warnings to contain impact information and clear practical guidance; [and] require the agencies that are responsible for issuing warnings to: (i) use a wide variety of communication channels to disseminate warnings; (ii) develop and implement feedback mechanisms to verify warnings are received; [and] (iii) develop and implement plans to reach the most at-risk and remote populations”.²¹¹ These same principles should apply to warning of PHEs – both PHEICS and PHEs that do not meet the IHR criteria. Providing warnings of PHEs may already be mandated in some States through domestic DRM laws, but there is limited evidence in the PHE Mappings of duties on public authorities to notify or warn actors and citizens specifically of the risks or occurrence of a PHE.



RECOMMENDATION

1. Any future review of the IHR should consider the extent to which obligations should be placed on States to notify or warn key domestic actors and the general population of the occurrence or imminent risk of a PHEIC.
2. Domestic laws should require the relevant public authorities to notify or warn all key domestic actors and the general population of the occurrence or imminent risk of a PHE.

4 / DOMESTIC LEGAL AND INSTITUTIONAL FRAMEWORKS FOR PHEs

4.1 / INTRODUCTION

Having considered the global legal frameworks within which they must be constructed, this Chapter examines the domestic legal frameworks for PHE: their nature, their sources and their core components.

The DPR Report considers how States develop arrangements for disaster preparedness and response within wider DRM frameworks. Its findings and recommendations are just as relevant to PHEs. Accordingly, the starting point for an effective domestic DRM framework (and therefore for a PHE risk management framework too) is as follows:

“It is ... important that, when viewed collectively, the mandates of a country’s institutions are comprehensive. That is, they should collectively encompass all jurisdictions (national and sub-national), all types of hazards (slow and sudden onset; natural and manmade) and all functions (policy, operations, monitoring and evaluation etc). In addition, experience demonstrates that it is critical for there to be clarity about the roles of different institutions in order to avoid confusion and unnecessary delays, particularly where immediate assistance is needed to save lives.”²¹²

To enable all governmental and non-governmental actors to be included, the DPR Report also emphasises the importance of establishing effective coordination mechanisms.²¹³ It recommends that:

“Effective disaster preparedness and response requires coordination both horizontally between different sectoral agencies, and vertically between different levels of government. Further, it requires coordination between governmental and non-governmental actors, including international actors.

Given that coordination continues to be a serious problem in international and domestic disaster response operations, decision-makers should ensure that the law establishes coordination mechanisms that include representatives from all sectoral agencies, all levels of government and all types of non-governmental actor. In order to be effective, coordinating bodies should be required to meet regularly (including when there is no active response operation), and participants should be assigned clear roles and responsibilities.”²¹⁴

Reflecting the fact that coordination for PHEs may fall outside the coordination mechanisms established by generic DRM, a further recommendation of the DPR Report is that:

“Given that disaster laws and policies may not apply to some situations such as health and nuclear emergencies, decision-makers should also ensure that the law establishes multisectoral and multi-stakeholder coordination mechanisms for these types of emergencies.”²¹⁵

The principles expressed in the DPR Report are therefore just as important to an effective PHE risk management framework. The breadth of the potential actors, the levels of society that can be impacted and the sectors of society that need to plan for and respond to a PHE can, though, make the need for a comprehensive all-encompassing framework even more essential. Responsibilities for public health

and PHEs tend to be more devolved (in both the legal and practical senses) than other disasters: health care, even in countries with centralised health systems, is not just the responsibility of governments and national public authorities, it can involve health care organisations at all levels – public and private – and should involve members of all communities that might be affected. Further, consistent with the One Health approach animal health, plant health and environmental organisations have an important role to play.

In light of the foregoing, the legal and institutional frameworks for PHE risk management can be more diverse and complex than other DRM arrangements. The need for the frameworks to be comprehensive, clear, certain and well-understood by all is therefore even more fundamental. So too is the need for effective co-ordination mechanisms and, as the Bangkok Principles recognise, integration between PHE risk management and generic DRM.

Using the information provided by the PHE Mappings, this Chapter therefore analyses the following issues relating to domestic PHE risk management frameworks:

- the extent to which domestic PHE risk management frameworks are integrated with or separate from general DRM frameworks;
- the clarity of the mandate given to relevant government institutions for preparedness and response for PHEs;
- the degree to which domestic PHE risk management frameworks encompass all phases of risk management (i.e. risk reduction, preparedness, response and recovery);
- the extent to which clear roles and responsibilities are assigned to all relevant actors and stakeholders (both governmental and non-governmental);
- whether effective coordination mechanisms are established that include and integrate all relevant actors and participants;²¹⁶
- whether a particular actor has overall command and control of the PHE response, and how that role may be discharged;
- whether existing PHE risk management frameworks reflect an all-of-society and all-of-State approach to PHE; and
- contingency planning within PHE risk management frameworks.

Yemen, 2020. Yemen Red Crescent implements COVID-19 prevention and control measures during the final school exam period.
© Yemen Red Crescent / Nesreen Ahmad



4.2 / INTEGRATION

4.2.1 / Bangkok Principles and integration

One of the tasks of this Report is to consider the degree to which PHE risk management is separate from or integrated within wider DRM frameworks. This is in part to understand the extent to which the Bangkok Principles' recommendations – that health should be integrated into disaster risk reduction policies and plans and vice versa – are currently implemented.

The Bangkok Principles and their purpose is discussed in section 3.2. The first Bangkok Principle promotes “systematic integration of health into national and sub-national disaster risk reduction policies and plans and the inclusion of emergency and disaster risk management programmes in national and sub-national health strategies.”²¹⁷ The Bangkok Principles also seek to enhance cooperation between health authorities and other relevant stakeholders to strengthen country capacity for disaster risk management for health, the implementation of the IHR and building resilient health systems.²¹⁸

The PHE Mappings reveal that the framework, functions and powers for PHE risk management are derived from three broad categories of laws and/or policies: PHE or public health laws and/or policies; DRM laws and/or policies; and laws which enable and govern states of exception, principally states of emergency (**SoEs**). There are wide variations, however, in which type of laws apply to particular aspects of the PHE risk management continuum, at what time during a PHE and to which actors. Overall, the PHE Mappings indicate that the most common approach is for PHE risk management frameworks not to be derived from laws and/or policies within one single regime (PHE or DRM) but to be established by a combination of regimes (PHE *and* DRM – as well as SoEs, where these are distinct from DRM).

Although the majority of frameworks are comprised of a combination of PHE and DRM instruments, there are considerable differences between States. The frameworks may be conceptualised as existing on a spectrum, with those at one end based solely on PHE or public health laws and policies, and those at the other end based solely on DRM laws and policies. In between these two outer points of the spectrum lies an assortment of hybrid arrangements which, as noted above, is the most common approach. This ‘spectrum of frameworks’ can be divided into three categories:

1. (1) frameworks based solely on PHE or public health legislation or based solely on such legislation but with the availability of DRM or SoE legislation in extreme circumstances (**PHE dominant frameworks**);
2. (2) frameworks that are mainly based on PHE legislation, but with DRM and/or SoE laws supporting and supplementing that legislation to a lesser or greater extent (**hybrid or combination frameworks**); and
3. (3) frameworks based solely on DRM legislation (**DRM dominant frameworks**).

4.2.2 / PHE dominant frameworks

Although the majority of Sample States rely on PHE or public health legislation to some extent to create their frameworks, only a few are solely reliant on public health laws. Even these States, however, usually retain some ability to fall back on wider DRM or SoE legislation if the powers in the PHE legislation are insufficient. In the UK, for example, PHEs are expected to be dealt with by regulations made under, or powers contained in, its public health legislation.²¹⁹ In extreme circumstances, however, the government can fall back on its main piece of DRM legislation, the Civil Contingencies Act 2004²²⁰ if its PHE powers are insufficient. A similar approach applies in Australia where, at both Commonwealth and State level, public health legislation²²¹ and plans should be sufficient to deal with most PHEs. Again, there is the ability to resort to more generic powers in DRM legislation if necessary. Likewise, in Brazil, the main laws relating to PHEs are found in public health legislation: Ordinances of the Ministry of Health deal with the declaration of public health emergencies of national importance and establish

PHE operation centres.²²² These enabled the establishment of an Interministerial Executive Group on Public Health Emergencies of National and International Importance to address COVID-19.²²³ In Liberia, a country with experience of the Ebola Outbreak, although a state of emergency was declared in response to COVID-19, the legal powers for responding to the COVID-19 Pandemic appear to have been derived from its comprehensive Public Health Law.²²⁴ Notwithstanding these examples, PHE dominant frameworks are in the minority.

4.2.3 / Hybrid or combination frameworks

Hybrid or combination frameworks are by far the most common type of arrangements reported in the PHE Mappings. Typically, the majority of the provisions required to respond to a PHE (and, albeit to a lesser extent, for PHE preparedness) are contained in PHE laws and policies, but DRM legislation or policies are used to: (1) supplement those provisions, typically by establishing the administrative or operational arrangements (such as requirements for participation or coordination); and/or (2) provide enhanced powers, for example, through the declaration of a state of disaster.

One example of a hybrid framework is China (although its framework is towards the PHE-dominant end of the spectrum). Its response to PHEs should be determined through the Law of the PRC on the Prevention and Treatment of Infectious Diseases, its Regulation on Responses to Public Health Emergencies and a National Contingency Plan for Public Health Crises. However, these instruments can be – and were during COVID-19 – complemented by measures adopted under the Law of the PRC on Responses to Emergencies and a Notice of the General Office of the State Council on issuing the Measures for the Administration of Emergency Response Plans.²²⁵ Similarly, the response to COVID-19 in the Republic of Korea appears to have been governed by public health legislation,²²⁶ but within the framework set by its generic Framework Act on the Management of Disasters and Safety.²²⁷ In Sri Lanka, responses to PHEs are directed by both public health laws and DRM laws.²²⁸

Colombia's PHE Mapping is also illustrative of significant hybridity. The main focus of its PHE response is found in its public health laws, including the functions relating to monitoring epidemics, controlling sanitation of ports, ships and vehicles²²⁹ and declaring a state of health emergency.²³⁰ However, reliance is also placed on DRM legislation, including decrees and laws establishing Colombia's National Calamity Fund²³¹ and its National Risk Management Policy,²³² as well as powers under the Constitution to declare a state of emergency.²³³ Moreover, the actual operational management of the response appears to have been undertaken by its generic DRM organisations.

The above are examples of what might be termed *horizontal* hybridity, meaning that powers at the national level are found across both PHE and DRM laws. There are also examples of *vertical* hybridity. This occurs where powers at the local or sub-national level may be found in PHE legislation but, if additional powers are required or the PHE exceeds the capacity of the local or subnational government, national DRM legislation may be used. An illustration of this type of structure the USA where initial action is taken at state level under public health laws. If the combined response capabilities of states or tribal governments are exceeded, the President may take action under the Federal Robert T Stafford Disaster Relief and Emergency Assistance Act to declare a major disaster or emergency.²³⁴

4.2.4 / DRM dominant frameworks

Very few Sample States have DRM dominant frameworks. The only Sample States which fall within this category are South Africa, Honduras and Jamaica. South Africa's Disaster Management Act²³⁵ is an all-risk instrument and PHEs, including the response to the COVID-19 Pandemic, were reported as being managed within the powers in that Act and its associated regulations. The Honduras PHE Mapping reports that the principal laws relating to PHEs are found in its Laws of National Contingencies,²³⁶ which covers all or most risks. Under these Laws, the Minister of Public Health is empowered to take disaster related actions, including declaring epidemiological emergencies and carrying out health related threat and vulnerability evaluations.²³⁷ In Jamaica, the Disaster Preparedness and Emergency Management

Act 1993 adopts an all-hazard approach and enables preparedness for and response to all disasters, including PHEs.²³⁸

4.2.5 / Existing integration

The only conclusion that can be drawn from the PHE Mappings is therefore that, with few exceptions, virtually all the Sample States' frameworks involve elements from PHE/public health and DRM laws. In most cases, PHE/public health legislation identifies the lead authority (usually the minister or ministry of health) and provides the powers and controls to be used in a PHE (such as the ability to make or exercise emergency powers, impose quarantines etc.). In contrast, it is typically DRM legislation or guidance that requires actors to prepare for a PHE or establishes coordination arrangements.

This outcome may be by design. However, especially where frameworks have not been recently reviewed, it is more likely to be due to either: (1) PHE risk management and DRM having previously been seen as separate and undertaken in separate 'silos'; and/or (2) the age of some PHE/public health legislation, which does not reflect more contemporary views on comprehensive disaster risk management and the need to adopt an all hazards approach.

There is therefore limited evidence of integration of laws, at least in the sense of incorporation or amalgamation, whereby one piece of legislation contains the provisions necessary to deal with all types of disaster, including PHEs. At the policy level, however – in so far as the PHE Mappings comment on this – there is greater evidence of overarching, all hazard plans having been adopted. These can either be: (1) all encompassing (i.e. a single policy/plan that provides for all hazards); or (2) separate PHE policies/plans which feed into broader, more general policies or plans. These underlying policies or plans can, therefore, be seen as creating a degree of integration between PHE risk management and DRM.

4.2.6 / Future integration

Whilst there is a need for improved integration, as the Bangkok Principles recommend, there is not yet an identified, common approach as to exactly how this can be achieved. The integration of all hazards and types of disaster within one set of laws and one framework is undoubtedly an option. However, the Bangkok Principles' ambition of greater coherence between legal frameworks²³⁹ may be secured in other ways. As the PHE Mappings demonstrate, PHE and DRM frameworks are sometimes already integrated or combined to a certain extent through policies and plans, even if not in laws. If soft laws – such as policies and plans – are effectively integrated, this may potentially suffice.

Indeed, the Bangkok Principles do not demand that PHE risk management is wholly subsumed within DRM legislation (although they also do not preclude it). The examples where this is the case, such as Jamaica and South Africa, warrant further study after COVID-19 to assess the practical and operational advantages and disadvantages of such an approach. There are potential downsides to relying on a single comprehensive piece of legislation. A danger of total integration is losing or overlooking specific elements of the regime being integrated and – as is seen in this Report – there are many aspects of PHE risk management that are unique to public health.

Given the hybrid nature of the current arrangements in most of the Sample States, achieving total integration may require a significant change in culture and approach and, in many cases, wholesale legislative reform. This is not itself a reason not to change if there is firm evidence supporting the benefit, but that evidence simply does not exist (at least yet). It would be inappropriate, based on a desktop review comprising (for reasons mentioned in Chapter 1), a restricted snapshot of current frameworks to reach any conclusion as to what integration requires in *every* State. More importantly, whether a framework achieves effective integration can only be assessed in the round and, in particular, by analysing how it works operationally. The experience of COVID-19 will provide much needed evidence of the way different types of framework have coped, which may serve as the basis for further analysis.



Bagram, Afghanistan, 2020. Afghan Red Crescent Society's Parwan branch mobile health team educates local community members on how to prevent spreading COVID-19 and other diseases. © Meer Abdullah

While it is not possible to state that integration requires one particular type of domestic legal framework, it can be said that integration requires an absence of gaps, conflict, inconsistency or unnecessary duplication between the powers, roles, responsibilities and other arrangements created by PHE and DRM instruments. The fact that hybrid frameworks appear to be the most common type of arrangement underlines the importance of conducting reviews to assess whether any such issues exist and, if so, how they can be resolved to achieve greater integration.

Moreover, regardless of which type of framework is used, it is equally (if not more) important that it establishes and facilitates the key aspects of effective PHE risk management. These aspects, which are discussed in the remainder of this Chapter, include (but are not limited to): a comprehensive all hazard, all-of-government, all-of society approach; clear mandates for PHE risk management (including the necessary legal authorities and all phases of the PHE risk management continuum); clear roles and responsibilities for actors and stakeholders that are well understood; and the participation of all relevant actors and stakeholders in a coordinated manner.



RECOMMENDATION

1. Laws, policies and plans for PHE risk management should:
 - a. have the key features identified in the recommendations in this Chapter;
 - b. be consistent with and implement relevant international instruments, including the IHR, Sendai Framework and Bangkok Principles; and
 - c. be integrated with general DRM frameworks (including national and local disaster risk reduction strategies) in the sense that there is an absence of gaps, conflict, inconsistency or unnecessary duplication between the powers, roles, responsibilities and other arrangements created by PHE and DRM instruments.
2. States undertaking a review of their laws, policies and plans for PHE risk management should, as part of that review, consider whether the laws, policies and plans for PHE are integrated with general DRM frameworks in the sense outlined in (1)(c) above.

4.3 / MANDATES FOR MANAGING PHEs IN DOMESTIC LAW

4.3.1 / The public health risks managed

A key theme of the DPR Report is that mandates for DRM frameworks must be clear. To ensure clarity, it is important to identify and understand the risks being managed. Uncertainty over definitions can have consequences in terms of failing to identify: (1) responsible actors and their mandates; (2) the point at which those mandates might arise; and (3) the measures that might be taken and under what authority. That applies equally to PHE risk management frameworks, but the PHE Mappings suggest that the identification and understanding of public health risks can be more problematic. This can be for two reasons: (1) the definition of a PHE and, especially in older laws, provide restrictive interpretations of public health risk; and (2) a tendency for PHEs to have been seen as a secondary or consequential to other disasters.

In Chapter 2 above, the international concept of the PHEIC is considered and the WHO definition of a PHE set out. Many States' laws adopt these definitions. Many do not. The PHE Mappings reveal a degree of inconsistency in the terminology used to describe the 'health events' in respect of which preparedness is required and response action is triggered. This inconsistency is apparent between States but can also be found in different pieces of legislation *within* a State.

The first issue this can raise is to restrict the 'health events' to which PHE powers apply. This tends to be more a feature of older laws. In some legislation identified in the Emergency Decree and PHE Mappings, PHEs are defined by reference to a list of specified diseases. The legislation typically requires notification to the relevant authorities if one of those diseases is detected, and measures can *only* be taken in response to an outbreak of those specific diseases. The powers do not apply to other types of public health risk. The problems this may cause can be mitigated. In many cases, it is possible for the list of diseases to be expanded. For example, in Tuvalu's Public Health Act 2008, although a number of diseases are specified as "infectious diseases", the Minister of Health may add to those specified.²⁴⁰ However, this often requires formal action; for example, making an order to amend the legislation. Moreover, this approach is also inconsistent with the 'all-public health risks' approach now advocated by the IHR.

The risks of an overly restrictive approach are threefold: (1) where a response to a novel disease is required, it may first be necessary for an instrument to be made adding the new disease to the list – potentially delaying the response; (2) if a disease is only specified once it has emerged, the ability to prepare for an outbreak of that disaster may be limited; and (3) a prescriptive listing of infectious or communicable diseases carries the risk of ignoring public health risks that are not diseases as such. Such legislation may, therefore, not cover some elements in the WHO PHE definition such as bioterrorism, the release of agents or toxins or AMR.

The method of listing diseases is generally a feature of older legislation. Older legislation can also cause wider problems in preserving outdated approaches to PHEs, especially where those approaches are inconsistent with the IHR. In a number of the Sample States, the main PHE or public health legislation is very old. In India, for example, the response to PHEs remains based on its Epidemic Diseases Act 1897 which was first enacted following an outbreak of bubonic plague in Mumbai in the 1890s.²⁴¹ A number of States still use acts from the 1930s: for example, Uganda's Public Health Act 1935²⁴² and Zambia's Public Health Act 1930.²⁴³ Quarantine legislation can also be relatively old. Examples include Nigeria's Quarantine Act 1926²⁴⁴ and Grenada's Quarantine Act 1947.²⁴⁵ Sri Lanka's Quarantine Ordinance is of the same age. Lesotho²⁴⁶ and Liberia²⁴⁷ rely on more recent legislation, but this still dates from the 1970s.

The fact that a law is old does not *necessarily* make it bad, and the legislation identified above may have been amended more recently than the date of the legislation suggests. However, concepts of public health and communicable diseases from the 19th or early part of the 20th Centuries are very different to those of today. A number of laws still make provision in respect of no longer prevalent diseases, for example, smallpox. This legislation is also from a time before international travel became common and migration and environmental and climate factors were barely considered, and bioterrorism or AMR were unknown. There is, therefore, a question whether provisions fit for modern day concepts of epidemiology and circumstances can realistically be found in such legislation or can be built upon such foundations. Even where laws are more modern, it is important – as new health risks emerge and the measures to combat them change – for legislation to be regularly reviewed to ensure that it remains fit for modern purpose.

Legislation which better reflects modern concepts of PHE is found throughout the PHE Mappings. Many Sample States have adopted a more flexible or ‘all-public health risk’ approach in laws or policies, which is in line with the current IHR approach. In Singapore, for example, the Infectious Diseases Act operates on the basis of a list of prescribed diseases but includes a general catch-all clause that extends the Act’s powers to emerging risks.²⁴⁸ There is therefore no need for a formal amendment or addition to the list of prescribed diseases before a novel disease can be managed within the terms of the Act. In the Republic of Korea, the issue is addressed by prescribing groups of disease but with an ability for non-specified diseases to be designated by an official if they are “feared to be suddenly transmitted into or prevalent in the Republic of Korea and are necessary for urgent prevention and control”.²⁴⁹

An alternative approach is to include PHEs within a general definition of ‘disaster’ or ‘emergency’, either by: (1) listing epidemics and outbreaks as one of a number of hazards that may cause a disaster or emergency; or (2) defining a disaster or emergency by reference to the magnitude of the threat, disruption or harm to the community (regardless of its cause). This is also consistent with an all-public health risks approach because it does not restrict emergency powers and arrangements to specific health hazards. For example, the Marshall Islands Emergencies Act refers to “a grave emergency [existing] whereby life, health or property is endangered”,²⁵⁰ a definition which is broad enough to encompass a PHE. In Australia, under both Victoria’s and New South Wales’ DRM legislation, the definition of “emergency” extends to PHEs with the consequence that the powers in this legislation are available, where necessary, to deal with a PHE.²⁵¹

Whilst the exact method of implementing an all-public health risk approach in laws and/or policies will depend on each State’s circumstances, nonetheless the PHE Mappings therefore disclose various ways in which States ensure that as wide a range of public health risks as possible are brought within their PHE risk management frameworks.

4.3.2 / Secondary PHEs

Another issue identified in relation to the concept of PHEs is a tendency to see PHEs as secondary or consequential disasters, rather than primary ones. They may not be viewed in this way any longer as a result of COVID-19, but past preparedness for PHEs has viewed them principally as events arising from other disasters. The Iran PHE Mapping provides an example of this phenomenon. In Iran, plans for the prevention and containment of communicable diseases are generally geared towards the spread of diseases in the wake of a disaster caused by natural hazards and not in response to a pandemic or other PHE itself.²⁵² PHEs can obviously arise out of, or occur simultaneously with, other types of disaster, but they equally need to be considered in their own right. The UNDRR considered this issue as part of its Review of COVID-19 Disaster Risk Governance in Asia-Pacific. The Review highlights the limited attention given to the management of biological hazards and emergencies and the focus on natural hazards in most DRR strategies in Asia Pacific. As a result, the Review emphasises the need for a genuinely multi-hazard approach to all risk management.²⁵³ It follows that PHE risk management frameworks should encompass both primary and secondary PHEs.



RECOMMENDATION

1. States which have not done so recently should undertake reviews of their laws, policies and plans relating to PHE risk management to ensure that they are fit for modern purpose and bring forward new or amending legislation as a matter of urgency where required.
2. Domestic laws, policies and plans should establish PHE risk management frameworks that enable preparedness for and response to as wide a range of public health risks as possible by adopting an 'all-public health risk' approach in line with the IHR.
3. Domestic laws, policies and plans should ensure that PHE risk management frameworks and/or DRM frameworks make provision for both primary and secondary PHEs as part of a multi-hazard approach.
4. All such laws and/or policies should provide:
 - a. (a) certainty about the types of public health risks and events for which preparedness and response functions are mandated; and
 - b. (b) flexibility to ensure that preparedness and response functions will apply to novel and emerging public health risks.
5. There should be regular reviews of domestic laws, policies and plans relating to PHEs to ensure that they continue to remain fit for purpose and make provision for all current and emerging PHE risks, including novel viral diseases, agents and toxins and hazards such as antimicrobial resistance.

4.3.3 /The phases of PHE risk management

A further requirement of a comprehensive, integrated PHE risk management framework is that it applies to all phases of PHE risk management. The concept of disaster risk *management* or disaster risk *governance* has changed significantly in recent years, principally driven by the Sendai Framework. DRM is no longer seen as being simply about disaster planning and response, but instead equally about disaster risk reduction and recovery. A comprehensive DRM framework, especially an integrated one, must therefore take account of all the DRM phases, namely:

- Disaster risk reduction (**DRR**): measures aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.
- Disaster preparedness: the knowledge and capacities developed by governments, response and recovery organisations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent or current disasters.
- Disaster response: actions taken directly before, during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected; and
- Disaster recovery; the restoring or improving of livelihoods and health, as well as economic, physical, social, cultural and environmental assets, systems and activities, of a disaster-affected community or society, aligning with the principles of sustainable development and "build back better", to avoid or reduce future disaster risk.²⁵⁴

A comprehensive PHE risk management framework should also address these four key phases. This Report principally focuses on PHE preparedness and response – and these phases are addressed elsewhere in detail – but it would be remiss not to mention PHE risk reduction and recovery, however briefly. This is especially important as, although the Sample States have laws in place to deal with PHE response, the PHE Mappings suggest that existing frameworks for PHE risk management are not as well constructed or integrated across all four phases.

Indonesia, 2019. Many communities are vulnerable to disasters and health outbreaks across Indonesia. Disasters often trigger disease outbreaks, many of these are zoonotic diseases, caused by infections that spread between animals and people. Communities in rural areas are often at higher risk where agriculture is a livelihood.

© IFRC / Corrie Butler



As noted, the powers to undertake and facilitate the *response* to a PHE are, in the vast majority of cases, found in PHE or public health legislation or under SoE powers. As this Report identifies, legal arrangements for PHE response are not without flaws, but nonetheless they are clearly in place. The preparedness phase – and contingency planning in particular – is considered in section 4.6. The manner in which this phase is addressed is less comprehensive but, nonetheless, whether in laws or policies most Sample States do have some form of PHE planning process.

Provision for PHE risk reduction and recovery, on the other hand, is noticeably absent from the laws and policies identified in many of the PHE Mappings. This may be due to the age of much of the PHE legislation. If the legislation was enacted before the development of the Sendai Framework and the more modern understanding of comprehensive DRM, it tends not to refer to risk reduction or recovery. If the source of PHE laws is public health legislation, as opposed to DRM legislation, again, these elements may not be included (possibly because these concepts are not yet fully embedded in the public health domain, as the Bangkok Principles recognise). Nevertheless, it is important for States that have not done so to incorporate the risk reduction and recovery phases within their PHE risk management frameworks.

PHE risk reduction

If not widely understood before, COVID-19 has raised awareness of the serious risks posed by zoonotic diseases. It is estimated that more than 6 out of every 10 known infectious diseases in people can be spread from animals, and 3 out of every 4 new or emerging infectious diseases in people are zoonotic.²⁵⁵ A major risk factor for zoonotic disease is “the unregulated expansion of livestock farming which encroaches on pristine habitats, pushing domestic animals, human and wildlife into closer and more frequent contact.”²⁵⁶ Changes in travel, tourism and trade have also impacted on the epidemiology of zoonotic diseases.²⁵⁷ Effectively addressing the risks posed by zoonotic disease requires a One Health approach characterised by the involvement and coordination of the public, animal and plant health sectors, as well as the environmental sector. Another major public health risk, which should also be considered as part of the risk reduction phase, is antimicrobial resistance (**AMR**). Just as climate change presents a longer term, slower developing risk in the wider DRM sphere, AMR presents a similar risk in the health domain.

No framework for PHE risk management can ignore the root causes such as these. Some frameworks do already recognise this. The North American Plan for *Animal* and Pandemic Influenza (emphasis added), for example, was created after the United States, Canada and Mexico reflected on the spread and potential problems seen from the H1N1 pandemic of 2009.²⁵⁸ In England and Wales, animal health legislation requires the maintenance of national contingency plans and specific provision is made for the control of zoonoses.²⁵⁹ The Liberian Public Health Act also makes provision to deal with zoonotic diseases²⁶⁰ and specifically refers to the One Health Platform.²⁶¹

The limited nature of the analyses of risk reduction in the PHE Mappings means that this Report can make little comment on States’ laws or policies for reducing the risk of PHEs.²⁶² Further research and reports will undoubtedly investigate this aspect of PHEs in detail. Nonetheless, in terms of the laws and/or policies which can enable the establishment of comprehensive PHE risk management frameworks, the literature and reporting of the COVID-19 Pandemic has stressed the need to reduce the risk of future PHEs. The One Health initiative also already emphasises the need to incorporate and/or coordinate with animal health, plant health and environmental actors throughout the PHE risk management/DRM continuum.

PHE recovery

As with risk reduction, the recovery phase of a PHE is not addressed specifically in the PHE Mappings. The PHE Mappings do discuss the role of law in mitigating the impacts of PHEs, and this includes some discussion of initial measures to start the recovery process after COVID-19. In addition, a number of the economic, social and educational measures adopted to mitigate the immediate impact of the COVID-19 Pandemic may provide post-pandemic recovery support.

However, given the lack of information about recovery in the PHE Mappings, all that can be said at this stage is that, as with risk reduction, if States are to establish comprehensive PHE risk management frameworks, *all* phases within the risk management continuum should be incorporated, including the recovery phase.



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should:
 - a. take account of broader developments in PHE risk management such as the One Health approach and the increasing recognition of the importance of risk reduction measures;
 - b. make provision for reducing the risk of PHEs, including by ensuring the coordination of measures and activities with the animal health, plant health and environmental sectors (and other One Health actors); and
 - c. address the recovery phase by including provisions to enable and support recovery from PHEs.

4.4 / COORDINATION AND LEADERSHIP ²⁶³

4.4.1 / Coordination

The DPR Report considers that, in relation to wider DRM, “inadequate coordination continues to be a serious problem in international and domestic disaster response operations.” An IFRC survey of disaster management and humanitarian professionals undertaken at the same time identifies that:

“inadequate coordination is the most common regulatory issue in international and domestic disaster response...and the regulatory issue that has the greatest impact on the efficiency and effectiveness of disaster response operations. Two different types of coordination problems at the domestic level were identified: gaps in coordination between different sectoral agencies and/or levels of government; and gaps in coordination between governmental and non-governmental actors, including international actors”.²⁶⁴

Unfortunately, the PHE Mappings suggest a similar picture exists in relation to the coordination of PHEs. This may be an even more worrying finding given – as COVID-19 has demonstrated – the very large number of actors from different sectors whose activities need to be coordinated. In addition, the PHE Mappings show that in a PHE the number of agencies involved within a sector, in particular the health sector, add a further type of coordination issue: not only must there be coordination *between* sectors but there needs to be coordination mechanisms *within* sectors and even within particular agencies.

The PHE Mappings report a wide range of coordination mechanisms and, similar to the overarching legal frameworks for PHEs (see section 4.2), the coordination mechanisms can be divided broadly into three categories: PHE dominant; hybrid and DRM dominant. However, in contrast to the overarching legal frameworks, the majority of PHE Mappings indicate that the main coordination arrangements used for PHEs are found in generic DRM laws and/or policies. In Colombia, for example, a detailed system of coordination is described, established under Colombia’s DRM legislation.²⁶⁵ Similarly, in South Africa coordination of the COVID-19 response appears to be organised through the Disaster Management Center in accordance with its wider DRM arrangements.²⁶⁶

Even in countries which have PHE dominant legal *frameworks* the preference appears to be for the use of standing DRM coordination mechanisms for PHE response. Within these there may be PHE specific sub-mechanisms – for example, sub-committees of main committees – but these still operate

within the generic DRM arrangements. In Australia, the main coordination arrangements are based on generic DRM frameworks. In the United Kingdom, which has a predominantly PHE dominant risk management framework, the coordination of the preparedness and response arrangements for PHEs is mandated through the legislation dealing with general contingencies and its generic Emergency Response Concept of Operations guidance.²⁶⁷ Similarly, in the UAE, where the powers to respond to a PHE are found in the Law on the Control of Communicable Diseases, PHE response is coordinated through the National Emergency, Crisis and Disasters Management Authority, which is tasked with managing all disasters.²⁶⁸

Few Sample States appear to have purely public health coordination mechanisms. Where these are found, it tends to be because the States established specific coordination mechanisms for COVID-19, rather than relying on standing coordination mechanisms. In Bulgaria, for example, a COVID-19-specific mechanism was created because, it is reported, no permanent coordination arrangements are in place.²⁶⁹ In Sierra Leone, coordination efforts were led by the ministry of health, although these are reported as being very inclusive, inviting participation from key One Health entities, all political parties and the Ebola Response Team that led the response to the Ebola Outbreak of 2013–2016.²⁷⁰ In only a few cases, therefore, do Sample States appear to rely on standing PHE specific coordination mechanisms.

The same categorisation applies to the arrangements for coordination during the preparedness phase. Requirements to assess risk and prepare plans are therefore more commonly found in generic DRM legislation. In the United Kingdom, for example, under its generic contingency planning legislation, each health care organisation responsible for responding to a PHE is under a duty to assess the risks of PHEs and maintain plans for these risks.²⁷¹

The broad picture is therefore that the arrangements for coordinating or otherwise managing (1) PHE preparedness and (2) PHE response are most commonly found in generic DRM legislation and/or policies. However, it should be stressed that this is a very broad assessment based solely on the content of the legislation and plans identified in the PHE Mappings. Further, the fact that coordination mechanisms for PHEs are usually prescribed by generic DRM laws or policies does not mean that DRM agencies are in charge of PHE response. Instead, in the event of a PHE, those laws or policies frequently provide for another actor – most commonly the Minister of Health – to lead the response and, for example, head up the emergency operations centre or its equivalent. It is not possible from the Mappings alone to reach a view on how these arrangements are operating in practice or, for example, how emergency or disaster operations centres function in a PHE. However, it can be said that it is essential that coordination mechanisms are clearly set out and understood.

An advantage of relying on DRM provisions for PHE coordination is that they may already address some of the well-established and widely understood coordination challenges identified in the DPR Report. If separate PHE-specific coordination mechanisms are established, there could be a danger of ‘re-inventing the wheel’ and the potential for duplication and/or conflict. Whilst PHE-specific coordination mechanisms might enable better identification of health sector participants, there is a danger it would be too focused on the sector and not take account of the wider issues – and involve the wider range of participants – that COVID-19 has shown are relevant to a PHE.

There is limited reference in the PHE Mappings to the second type of coordination: intra-sectoral or intra-organisational co-ordination. This is especially relevant in health care structures involved in PHEs. While the PHE Mappings contain examples of provisions that require coordination between the health ministry and other ministries, there is little mention of laws requiring the health ministry to coordinate the response within its own departments or agencies. This may be less of an issue where there is one central ‘health authority’ but may be critical where responsibility for different aspects of public health is devolved or shared between several departments, units, or agencies. There are examples of laws or policies which seek to address this but, even under these arrangements, there are gaps: for example, not all those involved in the provision of wider health services, such as pharmacists, care home operators or medicine or PPE suppliers, may have direct access to the arrangements.

Overall, while the PHE Mappings do not report on the effectiveness of the coordination mechanisms for PHEs, they nonetheless illustrate the importance of the principles and recommendations for coordination outlined in the DPR Report²⁷² relating to, for example, the need for clarity and (as also identified in section 4.5 below) the need to include all appropriate participants.



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should facilitate coordination:
 - a. horizontally between different sectoral agencies, as well as within them;
 - b. vertically between different levels of government; and
 - c. between governmental and non-governmental actors, including international actors (if relevant).
2. Domestic laws, policies and plans for PHE risk management should therefore:
 - a. establish coordination mechanisms that include representatives from:
 - i. all relevant sectoral agencies,
 - ii. all relevant departments of sectoral agencies,
 - iii. all levels of government, and
 - iv. all relevant non-governmental actors;
 - b. assign all actors clear roles and responsibilities; and
 - c. impose obligations on actors to meet regularly and share information, to ensure that coordination mechanisms are effective.

4.4.2 / Leadership and lead responsibility

Closely linked to effective coordination, but of importance more generally across PHE risk management frameworks, is leadership. The PHE Mappings show that leadership or lead responsibility is interpreted in different ways. First, there is *legal* leadership where laws²⁷³ expressly state who has principal responsibility and can, for example, make emergency regulations or exercise key emergency powers. This responsibility is most commonly conferred in PHE laws on the minister for health (or equivalent), the ministry of health or senior officials within that ministry. However, *operational* leadership may not always be vested in the same actor. In some cases, this responsibility is given to a generic disaster management office or department, but in others it can be conferred on a specific department or officer within the ministry of health. There are also many examples where leadership – both legal and operational – could be shared or even be collegiate (for example, through a council or committee).

In a number of cases, the leadership role in response to COVID-19 is undertaken by the President or Head of Government, especially where a SoE is declared. This raises another issue, the potential conflict between the *legal* responsibility for leading a response and the *political* leadership. With a PHE on the scale of COVID-19, it would be wholly unrealistic for the Head of State or Head of Government not to be in charge of the response, yet – except where an SoE is declared – the laws normally confer the legal powers on a minister or official. There are exceptions: for example, in New Zealand, the Prime Minister is expressly given authority - in consultation with the Minister of Health - to issue formal notices that trigger emergency powers.²⁷⁴ Nonetheless, in the majority of cases there is evidence of potentially overlapping responsibility. The PHE Mappings do not comment whether this became a reality and further research would be required to confirm this, however as a matter of principle confusing or uncertain responsibilities should clearly be avoided.

Overlapping – potentially conflicting – responsibilities can also be an issue where a number of bodies are given lead responsibilities. Shared responsibility is not in itself necessarily an issue. In the majority of PHE Mappings, PHE laws give the health minister or health ministry (in some guise or other) the *main* lead role. However, most of the Mappings identify other actors as having *some* role in leading the COVID-19 response. The leadership can be shared horizontally (i.e. between government departments) or, especially in federal or quasi-federal States, vertically. With a PHE on the scale of the COVID-19 Pandemic, the latter may not be such an issue: the response needs to be led at the national level. A number of States, though, operate a ‘bottom-up’ approach which can mean that in the case of a geographically confined epidemic, other leadership arrangements may apply. The problems that can arise if there is a lack of clarity as between tiers of government are illustrated by one PHE Mapping which refers to a dispute over jurisdiction for public health matters between the President and provincial governors. The governor of one province unilaterally placed his province into lockdown, but the decision was challenged by the *national* Minister of Health, who claimed that he alone had responsibility for managing the response to COVID-19.²⁷⁵

The Mappings also identify the potential for leadership to change during the course of a PHE or to differ depending on the powers being exercised and/or the legislation in which they are contained.

Which person(s) or office holder(s) are responsible for leadership before, during and after a PHE is clearly a matter for each State to determine: the approach chosen will depend on each State’s circumstances; the way functions are assigned; the constitutional framework; and what powers need to be exercised and at what point. What does matter – and this repeats a central theme of this Report – is that the leadership arrangements, the functions for which actors have lead responsibility, and the points at which those responsibilities arise are clearly identified, ideally before any PHE occurs.



RECOMMENDATION

Laws, policies and plans relating to PHE risk management should ensure that:

1. the person(s) or agency(ies) with lead responsibility for actions before, during and after a PHE are clearly identified (including command and control of an emergency operations centre if there is one);
2. the nature of the leadership role and the functions and powers of the ‘leader’ are clear and certain; and
3. any potential conflicts between persons or agencies exercising leadership roles are eliminated or minimised.

4.5 / PARTICIPATION AND REPRESENTATION

4.5.1 / Introduction

The DPR Report recommends that, when establishing or reforming disaster preparedness and response institutions, decision-makers should adopt an all-of-society and all-of-State approach that allows all stakeholders to participate in institutions: “An all-of-society and all-of-State approach allows all available resources to be harnessed and promotes the protection and inclusion of vulnerable groups.”²⁷⁶ The Sendai Framework encourages such an all-of-society approach and the Bangkok Principles reinforce it.

The COVID-19 Pandemic has brought home to all States that a large-scale PHE can impact, or require action from, virtually every tier of government, every sector, every region, every community and every individual. Every one of those tiers, sectors, regions, communities and individuals therefore has a role and interest in the management of all phases of a PHE (risk reduction, preparedness, response and recovery). An all-of-society and all-of-State approach is, therefore, arguably even more essential in respect of PHEs, compared to other types of disaster. Unfortunately, the PHE Mappings indicate that an all-of-society approach to PHE risk management is not yet a reality.

4.5.2 / All-of-state approach

The PHE Mappings indicate that a very broad range and large number of governmental or public departments, organisations and agencies may be involved in the management of a PHE. For example, the Brazil PHE Mapping refers to the National Agency of Sanitary Surveillance, the Secretariat of Health Surveillance, the Rapid Response Center for Epidemiological Emergencies as well as the National Health Foundation all participating in PHE management.²⁷⁷ In the majority of Sample States, PHE response involves the minister and ministry of health and chief medical officers. In some Sample States centres of disease control have a key role: for example, the Republic of Korea Center for Disease Control.²⁷⁸

In virtually all Sample States, general DRM departments or agencies have a role, although that role can vary depending on the category of framework (see section 4.2) and the coordination mechanisms (see section 4.4) in place. The Colombia PHE Mapping describes one of the more detailed structures, the National System for Disaster Risk Management (*Sistema Nacional de Gestión del Riesgo de Desastres*). This identifies in detail the key governmental actors from the President of the Republic down to the Director of the National Unit for Disaster Risk Management (UNGRD).²⁷⁹ A less structured but just as extensive list of actors is also seen in Papua New Guinea’s PHE Mapping. This Mapping reports that the following have roles in responding to PHEs in Papua New Guinea: the National Executive Council; Emergency and Temporary Emergency Committees; the Head of State; the National Control Centre; the Controller and Deputy Controller appointed by the Head of State; the Technical Advisory Council; Provincial Control Centres; Provincial Administrators; Provincial Advisory Committees; the Defence Force and a Finance and Procurement Committee.²⁸⁰

Given the many different types of measures taken to respond to or mitigate the effects of the COVID-19 Pandemic (many of which are discussed in Part C), it is clear that an all-of-State approach is required for PHEs. In addition to health and general DRM governmental actors, a much wider range of ministries or authorities need to be involved. Illustrations of the important roles of other types of ministries or authorities are given throughout the PHE Mappings. For example, in Korea the Ministry of the Interior and Safety collects risk related data and information including information on “social accidents” (which encompass infectious diseases) and has responsibility for a Safety Index for local governments.²⁸¹ The Liberian Environmental Protection Agency is responsible not just for environmental hazards but situations which may pose a serious threat to public health.²⁸² Elsewhere interior or justice ministries have responsibility for enacting some of the restrictions required or at least securing their enforcement.

Ministries of education have worked to close schools and provide alternative learning; finance ministries have developed schemes to protect businesses, support continuing employment or, where that is impossible, provide welfare benefits; and ministries of transport and foreign ministries have closed borders, supported repatriation efforts and determined quarantine requirements.

A large-scale PHE can also involve all tiers of government. It is therefore important to recognise the role of local government structures and, in federal or quasi-federal states, the roles and responsibilities of state governments. That is particularly relevant where States, in principle at least, have adopted a bottom-up, rather than top-down approach to both planning and response.²⁸³ Indeed, as many PHEs are likely to be localised in nature (at least at the onset), local government actors should be among the first actors included in any PHE risk management framework.

4.5.3 / All-of-society approach

The PHE Mappings indicate that PHE risk management frameworks are principally framed around the governmental actors who may need to act in response to a PHE – the *all-of-State* concept – rather than non-governmental actors or those who may be affected or impacted by a PHE. There is, unfortunately, limited evidence in the PHE Mappings that States have yet adopted an *all-of-society* approach to PHE risk management. This is particularly evident where frameworks are PHE-dominant and/or based on relatively old public health laws. In Sample States where there is greater integration of PHE risk management within generic DRM frameworks and/or the frameworks have begun to adopt the Sendai Framework principles, there is some evidence of recognition being given to the need to involve a wider range of participants, such as National RCRC Societies.

The involvement of the full range of stakeholders, especially representatives of communities and vulnerable groups, remains an issue in most Sample States. Identifying appropriate representation of particular communities or groups may be an issue – and governments (central or local) may consider that they already represent their populations. Nonetheless, the Sendai Framework encourages wider community engagement and there are numerous examples throughout the literature, the DPR Report and a number of the PHE Mappings of the potential benefits of ensuring the participation of more informal community groups. Involving the whole community can also improve both surveillance (i.e. identifying outbreaks early) and communication. Early and continuing engagement can help ensure that accurate information about the public health risks and the management of the PHE is received by communities.

The failure to adopt a genuinely all-of-society approach can mean not only (1) that those who have a significant interest in ensuring effective response arrangements are excluded or left uninformed, but (2) also that groups which can make an important contribution to PHE risk management do not have an opportunity to do so. Notwithstanding this general trend, there are some exceptions. In Colombia, a National Sub-system of Volunteers for First Response (*Subsistema Nacional de Voluntarios de Primera Respuesta*) has been established,²⁸⁴ which includes members of the Civil Defense, the National System of Firefighters, and the Colombian Red Cross.²⁸⁵ The Philippines National Disaster Risk Reduction and Management Council comprises representatives from several national government departments, the military, the police, representatives from the Philippine Red Cross, community service organisations, the private sector and four levels of sub-national government, as well as a representative from the Philippine Commission on Women. The law requires this institution to be replicated in every province, city, municipality and barangay, ensuring broad stakeholder participation at all levels of government.²⁸⁶ Nonetheless, such exceptions are rare.

The DPR Report concludes that:

“An all-of-society and all-of-State approach allows all available resources to be harnessed, and promotes the protection and inclusion of vulnerable groups. Stakeholders that should be involved and represented in disaster preparedness and response include, but are not limited to: relevant governmental actors from all levels of government (e.g. meteorological institutions; health, education and housing departments; the military and the police; national human rights institutions; ombudsmen); National Societies; private sector entities (e.g. telecommunications and power companies); academic and research institutions; CSOs; religious institutions (where appropriate); and government or non-governmental organizations that have a mandate to represent or advocate for particular vulnerable groups (e.g. national women’s rights commissions; disability rights organizations). Where there is an ongoing presence and need for support from international institutions, it may also make sense to include UN agencies and international nongovernmental organizations.”²⁸⁷

These recommendations are as valid in respect of a PHE as in respect of any other disaster. Indeed, the very broad range of stakeholders with an interest and a role in PHE risk management points to the need for an even more inclusive approach.

The COVID-19 Pandemic has shown that there are particular sectors or groups – which may not previously have been seen as integral to DRM or PHE risk management arrangements – that can play critical roles in, or be disproportionately affected by, PHEs. The remainder of this section discusses some of these particular sectors and groups.

4.5.4 / One Health and development cooperation actors

While One Health actors may have an especially key role in PHE risk reduction, their input can also be essential in preparing for a PHE. They are also well-placed to provide early warning of a PHE by detecting outbreaks early. The PHE Mappings suggest, however, that the concept of One Health is not yet fully embedded in domestic PHE risk management frameworks. It should be, and ensuring that One Health actors are included as participants in PHE risk management frameworks is necessary to promote this.

Another important group of actors which are not always fully integrated within domestic PHE risk management frameworks are development cooperation actors. Yet, similar to One Health actors, development cooperation actors have a key role to play in PHE risk reduction and preparedness by for example: supporting the development of strong and resilient healthcare systems; investing in improved access to clean water, sanitation and hygiene; and strengthening domestic capacities to detect, assess and respond rapidly to public health events. Indeed, this forms part of achieving SDG 3 (to ensure healthy lives and to promote well-being for all at all ages) and specifically target 3.d (to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks).²⁸⁸

4.5.5 / Carers

The PHE Mappings suggest that government departments or public authorities responsible for providing *health care* are generally included within PHE risk management frameworks. They do not, however, indicate that: (1) departments or public authorities responsible for providing *social care*;²⁸⁹ or (2) carers outside the public sector or formal structures who provide either *health care* or *social care* are included to the same extent. There is anecdotal evidence that, despite such carers having a key role in protecting people from COVID-19, they have been overlooked during the response. Carers are also disproportionately likely to be marginalised and have vulnerabilities themselves. These care providers should be included in any PHE risk management framework, particularly in order to support their

ability to: (1) continue to provide health and social care during a PHE and (2) adapt that care should a particular PHE result in higher risk to the population for which they are caring.

4.5.6 / National RCRC Societies and other humanitarian organisations

National RCRC Societies have a unique legal status as auxiliaries to their public authorities in the humanitarian field.²⁹⁰ The auxiliary role of National Societies is commonly recognised in domestic Red Cross or Red Crescent laws, which often identify one of a National RCRC Society's objects as the prevention of disease, the promotion of health and social welfare, and providing assistance to victims of disasters and emergencies.²⁹¹ As discussed in Chapter 3, by adopting Resolution 3 at the 33rd International Conference held in 2019, the States parties to the Geneva Conventions specifically recognised the role of National RCRC Societies in supporting public authorities to tackle epidemics and pandemics, including in building early warning and rapid response capacity in hard-to-reach, vulnerable, underserved and high-risk communities.

National RCRC Societies play a significant role in PHEs and have played a major role during the COVID-19 Pandemic. This is evident from the Emergency Decree Mappings, which provide many examples of the contribution of National RCRC Societies. For example, the Haiti Red Cross Society conducted ongoing activities in respect of COVID-19, including creating a working group/task force to enhance monitoring and preparedness. Dominican Red Cross coordinated work on creating a humanitarian corridor to improve the procurement of items in the Dominican Republic.²⁹² The Sudanese Red Crescent undertook awareness campaigns and worked to improve access to water for improved sanitary measures by repairing handpumps and accelerating urban water projects in Darfur, Blue Nile and South Kordofan.²⁹³ As a non-COVID-19 example, the Guinea Emergency Decree Mapping records that the Red Cross Society of Guinea and British Red Cross played a role in the Ebola crisis including working with communities to help them understand how they could protect themselves from Ebola and to prevent its spread.²⁹⁴

The Emergency Decree Mappings also disclose a number of initiatives involving other humanitarian agencies. For example, in Guinea, a UNICEF Guinea COVID-19 Task Force was established.²⁹⁵ In Sudan, the UN supported the Federal Ministry of Health with setting up intensive care units in Khartoum, providing medical supplies and procuring and disseminating infection prevention and control materials among a range of collaborative workstreams. Also in Sudan, UNICEF and UNHCR allocated and mobilised resources to support COVID-19 preparedness and the UN Population Fund worked with the temporary quarantine teams to ensure that women and girls of reproductive age received dignity kits and that visibly pregnant women received clean delivery kits.²⁹⁶ A common type of assistance was seen in Trinidad and Tobago, where UNICEF supported enhanced accessibility of the Ministry's online education platform.

Notwithstanding the important role of National RCRC Societies in the COVID-19 response, very few of the Emergency Decree Mappings report that they were explicitly mentioned in COVID-19 emergency decrees. This was also true for other humanitarian organisations. A practical challenge arising from the omission of National RCRC Societies and other humanitarian organisations in emergency decrees was uncertainty about whether they were exempt from restrictions, classified as 'essential services' or 'front line workers' and, therefore, able to continue operations. There were exceptions where National RCRC Societies were specifically mentioned in COVID-19 emergency decrees. For example, the Bahamas Red Cross was identified and recognised as an essential service exempted from shelter in place procedures and restrictions on business operations²⁹⁷ and, in Guatemala, travel and movement restrictions were expressly excluded from applying to the Guatemalan Red Cross.²⁹⁸ Nonetheless, these were in the minority.

The Emergency Decree Mappings do, however, report more frequent references to National RCRC Societies (and, to a lesser extent, other humanitarian organisations) in standing DRM legislation. For example, a typical provision is that found in Zambia's Disaster Management Act. This specifies that the National Disaster Management Technical Committee and local level district management

committees should include a representative of the Zambia Red Cross.²⁹⁹ More commonly, National RCRC Societies – and other agencies – are given an express role in underlying DRM plans, policies or guidance. For example, in Nigeria, the National Disaster Response Plan describes the Nigerian Red Cross Society as responsible for coordinating the use of “Federal mass care resources”;³⁰⁰ and the National Disaster Framework states that State (i.e. sub-national) emergency management agencies should include one representative from the Nigerian Red Cross Society.³⁰¹

Nonetheless, the Emergency Decree Mappings indicate that the inclusion of National RCRC Societies and other humanitarian organisations in general DRM frameworks – and especially DRM legislation – is not universal and, even where provided, varies in the degree of prominence given. There is even less evidence that, where public health legislation establishes PHE risk management frameworks, National RCRC Societies and other humanitarian organisations are expressly mentioned, allocated roles and responsibilities and/or included in key decision-making and coordination bodies. Given the vital role these organisations play, this is an area where PHE risk management frameworks could be significantly strengthened.

4.5.7 / Schools³⁰²

Without exception, in every Sample State, schools physically closed for a period and an alternative education modality had to be offered.³⁰³ The impacts of physical school closure, and the measures taken to mitigate these impacts, are considered in section 8.7. As a general principle, the DPR Report recommends that legislation should address preparedness and response to emergencies and disasters in schools.³⁰⁴ It is unclear from the PHE Mappings whether the education crisis during the COVID-19 Pandemic was foreseen and included in any preparedness measures. The limited reference to such planning, though, suggests that it was not. Many schools and school authorities responded rapidly, but anecdotally there are suggestions that things could have worked better with more proactive thinking. There is also now the recognition that schools can be an important part of enabling recovery from disaster: if children are not at school, parents may not be able to return to work. Consequently, schools – or those able to represent them – should be included in PHE planning and response arrangements.

4.5.8 / Financial sector

As the COVID-19 Pandemic has demonstrated, PHEs can have significant financial, business and employment consequences which can require fiscal stimulus and changes to economic policies. The variety of social security schemes and funding programmes established during the Pandemic is considered in section 8.5, which provides an illustration of the breadth of financial support provided.³⁰⁵ Yet, in many of the PHE Mappings there is little or no mention of the involvement of government financial departments or central banks, let alone private banks and other financial institutions, within PHE risk management frameworks. Given the critical role that these institutions can play in responding to a PHE, this seems a serious omission.

4.5.9 / Manufacturers and suppliers of essential goods and equipment

The next group comprises the manufacturers, suppliers and distributors of essential goods and those otherwise involved in the supply chain. These will usually be commercial entities, but they can range in size from multi-nationals to single person enterprises. Protecting the supply chain for essential goods – whether food, PPE or vaccines – has been shown by COVID-19 to be a critical part of any response and should, therefore, be planned for accordingly. Again, the PHE Mappings do not provide much information and the sector may be well represented in other, more informal ways. There are examples of the involvement of infrastructure and utility businesses in contingency planning which may offer a precedent.³⁰⁶ The potential size and diversity of this group – multi-nationals to single person enterprises – may make identifying the right participants or representatives of this group a challenging task. However, it is something that States should consider to avoid issues that may be experienced around, for example, manufacturing capacity, raw material supply, distribution and obstacles created by competition laws.



Liberia, 2015. Students return to class in Buchanan, Liberia. Schools throughout Liberia were closed during the Ebola epidemic of 2014–2015.
© IFRC / Rob Few

4.5.10 / Representation

An issue related to participation is representation. In the DPR Report, representation is considered principally from the perspective of enhancing the participation of stakeholders from outside government in order to promote an all-of-society approach. The Report therefore encourages the inclusion of a wide range of stakeholders to secure the representation of the widest possible range of groups and sectors in DRM.³⁰⁷

Representation can, though, also be about ensuring that the right person within an organisation, sector or group participates. This can be as applicable to governmental organisations as to non-governmental ones. The complicated and expansive nature of many health structures reported in the PHE Mappings³⁰⁸ suggests that this issue may be particularly relevant to PHEs. Although a ministry of health (or equivalent) may be at the core of most PHE risk management frameworks, it is rare for only one department or unit within that ministry to deal with all aspects of a PHE. A number of PHE Mappings show that even within the 'public health' element of a ministry of health, there can be a number of units or individuals that need to be involved. In Brazil, for example, the list includes the National Agency of Sanitary Surveillance, the Secretariat of Health Surveillance, and the Rapid Response Centre for Epidemiologic Emergencies.³⁰⁹ Within the health sector more generally, there can also be a range of providers: hospitals, general practitioners, mental health services, pharmacists, private sector health care providers and, as discussed above, those responsible for providing social care. The same issue may arise outside the health care sector: in a number of Sample States local authorities, for example, are reported as being responsible for a number of quite distinct functions which might all be relevant in a PHE, such as emergency planning, police, social care, education, transport, providing benefits, and providing housing etc.

Afghanistan, 2020. The kind hearted and disabled volunteers of Afghan Red Crescent Society. © Afghan Red Crescent Society / Meer Abdullah



In light of the above, even where legislation or policies provide for a representative to participate on behalf of a sector or an organisation, there may be a question whether one representative can effectively represent the whole sector or organisation. It is, of course, not uncommon for representatives to speak on behalf of many others and for practical purposes not every group or organisation can participate fully in every aspect of risk management. There is therefore no question that representatives are necessary – anything else would be unworkable. The issue is finding – especially across a wide and multi-functional sector or organisation – how to ensure that representation is effective.



RECOMMENDATION

1. Laws, policies and plans relating to PHE risk management should adopt an all-of-government and all-of-society approach that allows all actors and stakeholders to participate and be represented.
2. States should review (especially drawing on their experiences during the COVID-19 Pandemic) the domestic stakeholders that should be involved in PHE risk management.
3. Consideration should, in particular, be given to ensuring the involvement of: community representatives (including minority or marginalised communities); One Health actors; development cooperation actors; health and social care providers; National RCRC Societies and other humanitarian organisations; schools and school authorities; the financial sector; manufacturers and suppliers of essential goods and equipment; and legislators.
4. Where there is an ongoing presence and need for support from international institutions, consideration should be given to including UN agencies and international nongovernmental organisations.
5. Laws and/or policies should ensure as far as possible that all actors and stakeholders are capable of being effectively represented and can make an effective contribution to PHE risk management.
6. States should take account of the role of National RCRC Societies as auxiliaries to their public authorities in the humanitarian field, and as first responders to disasters of all kinds, including PHEs.
7. Domestic laws, policies and plans for PHE risk management should:
 - a. recognise the role of National RCRC Societies and other relevant humanitarian organisations and the support that they can be asked to provide during a PHE; and
 - b. facilitate the participation of National RCRC Societies and other humanitarian organisations in all phases of PHE risk management, including through:
 - i. allocation of clear roles and responsibilities; and
 - ii. inclusion in coordination mechanisms and decision-making bodies.

4.6 / PHE PREPAREDNESS: CONTINGENCY PLANNING

Preparedness for PHEs requires governments, non-governmental actors and communities to develop the knowledge and capacities needed to anticipate, respond to and recover from the impacts of likely, imminent and current PHEs. Multi-hazard PHE preparedness should include systems for assessing vulnerability and exposure of specific groups, with an explicit requirement to assess the vulnerability of groups based on different factors, including age, sex, disability, ethnicity, and social and economic status, both at the outset and continually throughout a PHE. With PHEs, in particular, there should be no presumption that any one group is more at risk.

A key aspect of PHE preparedness is contingency planning and the creation of contingency or emergency plans. The DPR Report contains a dedicated section on contingency planning,³¹⁰ which explains contingency planning as identifying: “the concrete actions that are necessary to take when a major emergency is predicted or begins to unfold, despite best efforts to reduce risk and mitigate the effects of hazards before they occur.” It further explains that:

“Developing a contingency plan is a preparedness process that involves the analysis of risk vis a vis the potential impacts of crises should they occur [and] an establishment of procedures for timely, appropriate and effective responses to help mitigate or avoid altogether, the impacts of these disasters.”³¹¹

Contingency plans should reflect the context in which they are developed, that is, the national, municipal and organisational resources and capacities available to respond to the disaster, and they should be informed by risk mapping and/or risk assessments.³¹² Plans should establish operational procedures for response, based on anticipated resource requirements and capacity. This includes identifying what human and financial resources will be required and how they should be managed, ensuring availability of emergency supplies, setting up communication procedures and being aware of a range of technical and logistical responses (and identifying any potential technical and logistical challenges). Plans should also identify vulnerable groups and outline measures designed to address their specific needs. The DPR Report concludes by commenting that: “Time invested in contingency and response planning pays dividends in reduced damage and loss of life and more effective delivery of response and recovery services.”³¹³ Again, the same principles are applicable to PHE contingency planning.

Unfortunately, the PHE Mappings provide less information on preparedness and contingency planning than on response. It is harder to find legislation, in particular, that mentions preparedness and planning for PHEs. There are, however, exceptions: for example, in Honduras, one of the prescribed tasks of the Minister of the Office of Public Health is to carry out Health-Related Threat and Vulnerability evaluations (EDAN-SALUD).³¹⁴ New Zealand’s Epidemic Preparedness Act 2006 by its title indicates its purpose to enable effective preparation.³¹⁵ In Switzerland, the Federal Act on the Control of Communicable Human Diseases 2012 sets out requirements which must be met in preparation for PHE crises.³¹⁶

The lack of legislation does not mean that the Sample States do not have arrangements in place for PHE preparedness. In the majority of cases, PHE preparedness is governed by provisions in generic DRM laws or policies. An illustration of expressly mandated PHE preparedness within generic DRM laws can be found in the United Kingdom. Under its civil contingencies legislation, key actors (including health authorities) are required to prepare, maintain and review emergency plans relating to their functions and in respect of risks included in national and local risk registers. The registers recognise pandemic influenza and other infectious diseases as risks.³¹⁷

One set of actors that may not typically be considered in contingency planning and preparedness are legislators. Although, in some jurisdictions and circumstances, emergency laws may be made without the legislature’s approval, in many of the Sample States the legislature was still required to approve SoEs or enact urgent legislation to respond to COVID-19. However, legislators are not immune to disease and may be drawn from groups (for example, community elders) with a particular susceptibility to the

relevant health risk. During the COVID-19 Pandemic some of the Sample States took steps to enable their legislatures to function even during lockdown. For example, Singapore amended its Constitution to allow its Parliament and its committees “to sit, meet and dispatch business with Members of Parliament being present at 2 or more appointed places and in contemporaneous communication with one another,” (i.e. remotely).³¹⁸ Given the importance of the legislature being available to pass and scrutinise emergency legislation, contingency planning and preparedness activities should address legislative continuity during PHEs.

Contingency planning and preparedness is also an area where coordination is key. How laws address coordination is considered in more detail in section 4.4 above, but ensuring that there is coordination of planning and preparedness activities is clearly important to ensuring an effective response. For example, in the case of a PHE, coordination of preparedness activities may include deciding which agencies are responsible for stockpiling PPE and other key supplies, and for implementing simulation exercises, education and training.

One of the DPR Report’s conclusions is that a clear mandate for preparedness and contingency planning is vital. One way of achieving this is to ensure that there are: (1) clear functions for planning and preparing; and (2) clarity on the responsibility for performing those functions. The PHE Mappings suggest that clarity in respect of PHE preparedness could be improved and that there may be scope for clearer and/or more detailed allocation of responsibilities.



RECOMMENDATION

Domestic laws and policies relating to PHEs should:

1. make provision for preparedness measures and activities, including contingency planning;
2. ensure multi stakeholder participation in PHE contingency planning, including the public and private sectors and community involvement;
3. ensure that the roles and responsibilities for preparing for PHEs (including producing, maintaining, and reviewing contingency plans) are clearly expressed; and
4. where appropriate, allocate enforceable planning and preparedness duties to key actors.

4.7 / EMBEDDING UNDERSTANDING, LEARNING LESSONS

A key requirement of any risk management framework is that its users understand what it says, how it works and the roles, responsibilities and expectations of each actor and participant. However good a risk management framework is, it will be of little value if those who need to use it are unfamiliar with its contents or do not understand how it should operate.

Many of the coordination mechanisms mentioned in the PHE Mappings should achieve some of these objectives. If there are regular meetings of potential actors and participants in advance of disaster, this should enhance their knowledge of their respective roles. However, there are additional ways in which understanding can be enhanced.

Embedding understanding among actors and participants is a common feature of many DRM frameworks, mainly through training and simulation exercises. In some States, explicit duties to conduct training and/or simulation exercises are imposed in legislation; in others, the requirements or encouragement can be found in plans and guidance. However, there is no evidence from the PHE Mappings that any such requirements are set out specifically in relation to PHEs or to the health sector.

The DPR Report comments that awareness at all levels of society is a crucial component of preparedness.³¹⁹ It recommends that legislation should provide for and set out “the minimum standards and content in line with international best practice for training programmes and drills...” and “provide for simulation exercises and drills involving professional rescue staff and relief staff and the community”.³²⁰ A similar message is conveyed in the DPR Checklist which emphasises the importance of training, education, simulation exercises and drills.³²¹

Some PHE Mappings suggest that, where exercises had been undertaken, States were better prepared for the COVID-19 Pandemic: for example, the Republic of Korea’s pre-COVID-19 exercise was hailed as a reason why the COVID-19 Pandemic’s impact was minimised.³²² The use of exercises and training as a means of embedding understanding and increasing preparedness is therefore just as important with PHEs as with other disasters.

Involving communities in exercises is a way of enhancing their understanding. Communities need to be aware of the risks of PHEs to enable them to better recognise and prepare for those risks, and to respond if a PHE occurs. Involving communities in exercises may also help to prepare them for the type of restrictions that might be required.³²³ The PHE Mappings provide few examples of community involvement in exercises, but ensuring wider understanding among communities is important, especially in light of the challenge of combating misinformation. Involving local media in this awareness raising would also appear to be a priority.

As important as training exercises is the need to learn lessons and embed that learning into PHE risk management frameworks. The perceived advantage to the Republic of Korea from its previous experience managed SARS has been mentioned above. Sierra Leone’s coordination efforts for COVID-19 were guided by the Sierra Leone Government’s experience during the Ebola outbreak.³²⁴ A conclusion emerging from the COVID-19 Pandemic may therefore be that one of the most important lessons to be learned is to learn lessons.

Lessons can be learned in many ways. Formal inquiries are typically held following a disaster and will no doubt follow COVID-19. In the past, the WHO has used its Review Committee to investigate the handling of PHEICs³²⁵ and has already tasked the Review Committee with conducting a review on the functioning of the IHR during the COVID-19 response. There have been relatively few domestic inquiries relating to PHEs. There were official inquiries into SARS in 2003 followed by the publication of detailed reports.³²⁶ The absence of much investigation into the H1N1 Pandemic, other than by the WHO, may be explained by the limited impact of the disease (although there were some domestic inquiries³²⁷). There are also other types of formal review worth noting, such as coronial inquests and litigation.

Lessons are not, however, only learned through formal processes. Much can be learnt from informal exchanges of information or knowledge sharing. Another important point is that learning should not wait until after the event. Thus, whatever formal reviews States may wish to consider introducing, they nonetheless should ensure that some form of continuous ‘lesson learning’ process is adopted that can be used by all actors and participants in a PHE framework. WHO has recently published a useful guide to undertaking reviews *during* a PHE: *Guidance for Conducting a Country COVID-19 Intra-Action Review*.³²⁸ The Guidance unfortunately does not include legislation within the subjects to be reviewed, an important omission, but it does include country-level coordination, planning and monitoring.

Lessons learned have also in the past tended to focus on operational issues. Learning the legal lessons – or, indeed, training exercises for the legal aspects of disaster – occur less commonly. Nonetheless, lawyers who are involved in managing a PHE and developing relevant laws can benefit from exercises and learning from experiences as much as any other sector. IFRC Disaster Law has developed a legal simulation exercise focused on a disaster following a natural hazard and is also developing a scenario including a PHE. Given the amount of legislation required to respond to COVID-19, there is now a large number of lawyers and legislative counsel, in particular, who are experienced in drafting emergency legislation. It is important that this experience is not lost. In section 3.4 above,

this Report recommended the creation of networks of lawyers at the international level to assist implementation of the IHR. Developing networks at the national level could be equally beneficial. States may therefore wish to consider establishing such networks of lawyers to help preserve and further develop legal knowledge and expertise for future PHEs. National Societies or IFRC Disaster Law may be able to facilitate such networks.



RECOMMENDATION

1. Laws, policies and plans for PHE risk management should:
 - a. recognise the importance of raising public awareness of the risk of PHEs and their potential consequences;
 - b. ensure that communities are provided with the information necessary to enable them to prepare for and respond to PHEs; and
 - c. require all potential actors and stakeholders in a PHE (including communities) to carry out or participate in regular PHE training and simulation exercises to enhance their understanding of:
 - i. the PHE risk management framework;
 - ii. the key actions to be taken to prepare and respond to a PHE; and
 - iii. the current level of preparedness for PHEs.
2. Although training and simulation exercises should have a PHE focus, all actors and stakeholders within the wider DRM framework should be able to participate to increase their familiarisation with the specific PHE arrangements.
3. Simulation exercises should be designed to test, amongst other things, the legal elements of the PHE risk management framework and legal readiness for PHEs.
4. Laws and/or policies should ensure that:
 - a. PHE risk management frameworks are reviewed:
 - i. periodically (especially to evaluate whether the framework addresses new or emerging public health threats); and
 - ii. after the occurrence of a PHE to evaluate the effectiveness of the framework in action and to identify lessons; and
 - b. the lessons and recommendations from reviews and training and simulation exercises are effectively implemented.

5 / STATES OF EXCEPTION AND EMERGENCY POWERS IN A PHE

5.1 / INTRODUCTION

a common mechanism for initiating disaster response is the declaration of a state of emergency (**SoE**) or a state of disaster (**SoD**). As the DPR Report notes, the normal function of either is to cause “a switch to an emergency legal modality in which special governance arrangements apply and special government powers are available.”³²⁹ The rationale is that, unless authorities have access to special powers and arrangements, a disaster may exceed the ‘situation-normal’ response capacities – for example, the legal powers available or the resources that can be called upon.³³⁰

The DPR Report identifies that the power to declare an SoE is usually established by a country’s constitution and vested in persons or entities at the highest level of government. SoEs are generally designed for extreme and unforeseeable situations that fundamentally challenge the prevailing legal order such as civil war or widespread civil unrest, although they may be worded broadly enough to apply to any kind of disaster, including PHEs. The effect of declaring an SoE is generally to centralise decision-making and enable the exercise of extraordinary, potentially extra-statutory powers, by government or public authorities. The declaration of an SoE often also permits governments to limit or derogate from fundamental constitutional and/or human rights.

SoDs, in contrast, are usually found in DRM legislation and responsibility for declaring a SoD may be vested in officials at lower levels of government.³³¹ The effect of declaring a SoD is usually to activate disaster management plans and trigger special governance arrangements and governmental powers that do not otherwise exist, such as powers to evacuate or to quarantine people. The governmental powers and governance arrangements that apply during a SoD are usually pre-defined and more tightly constrained than those available in a SoE.

In terms of legal powers, the effect of a declaration may be twofold: (1) it may trigger emergency law making powers – usually giving the executive the ability to make legislation (such as decrees, orders or regulations); and/or (b) it may enable authorities to exercise emergency powers (for example, order evacuation, seize property, restrict movement). The former may be used to create the latter, or the latter may already exist in standing legislation. A declaration of a SoE or SoD may also act as a trigger for the mobilisation of resources, infrastructure and funding. It is important to note that, in some jurisdictions, a formal declaration of a SoE or SoD is not required. Instead, an official may be responsible for *determining* that a SoE or SoD exists. Another variation is that emergency powers may be enlivened simply by the existence of certain specified circumstances, without a need for a declaration or determination of a SoE or SoD.

There is an important distinction between: (1) the special emergency law making powers mentioned above, which are usually conferred on and exercised by the executive; and (2) emergency laws that are enacted by legislatures in the ‘normal’ way. In many of the Sample States, specific COVID-19 legislation was enacted – often at great speed and using accelerated legislative procedures – which was new and could be described as ‘emergency legislation’, but nonetheless, in principle, enabled scrutiny by the legislature.³³² Although there may be concerns about whether there can be effective scrutiny of legislation passed so quickly, this type of emergency legislation is not the primary focus of this Chapter. Instead, the main focus is on the emergency law making powers and emergency powers conferred on and exercised by the executive.



Mbusa Mukomba Gambalien is one of the many Red Cross volunteers responsible for conducting safe and dignified burials in Bunia, Democratic Republic of the Congo. Bodies infected with Ebola are most contagious upon death.
© IFRC / Corrie Butler

From the PHE Mappings, it is clear that both SoEs and SoDs are available in relation to PHEs. In PHEs, there may be an additional means of triggering emergency powers: a declaration of a state of public health emergency (**state of PHE** or **SoPHE**).³³³ This kind of declaration performs a similar legal function as SoEs and SoDs but is specific to PHEs and is typically found in PHE legislation. For the purposes of this Chapter, SoEs, SoDs and states of PHE are collectively referred to as **states of exception**.)

In broad terms, the use of emergency powers in a PHE – as in any other disaster – raises (at least) six main issues: (1) the source and nature of the emergency powers; (2) who is responsible for triggering or exercising the powers; (3) when the powers can be triggered and the period for which they exist; (4) the nature of the powers or measures that are created; (5) the consequences of the use of emergency powers on, for example, human rights; and (6) the safeguards that are applied to the exercise of the emergency powers or measures.

5.2 / THE SOURCE AND NATURE OF STATES OF EXCEPTION AND EMERGENCY POWERS

The PHE Mappings indicate that there is significant variation in the legal source of the emergency powers and states of exception for responding to a PHE. There is also variation in the levels – i.e. national, regional or sub-national – at which emergency powers are used and states of exception declared. This is evidenced by how the Sample States were reported to be responding specifically to the COVID-19 Pandemic. In the majority of Sample States, some form of declaration of a state of exception or the exercise of emergency powers was reported. However, there was no unanimity as to how this was achieved: SoEs, SoDs and SoPHEs were all being used during the response to COVID-19.³³⁴ Of the 36 Sample States, 19 had a SoPHE in place, although a formal declaration of a SoPHE was made in only half of these States. In the other half, a SoPHE or the powers available in a PHE could take effect by virtue of the existence of a PHE, or a PHE above a certain threshold, without the need for a formal declaration. A similar number of PHE Mappings report that SoEs were declared in relation to the COVID-19 Pandemic. However, this did not mean that half the Sample States opted to use a SoPHE and the other half opted to use a SoE. Rather, a number of Sample States used *both* a SoPHE and a SoE. A declaration of a SoD under DRM legislation was reported in only six of the Sample States. This suggests that, if powers are available in PHE specific legislation, they will be used for a PHE even if a SoD could be declared under DRM legislation.

SoPHEs are not specifically discussed in the DPR Report. From the PHE Mappings it appears that they are seen either as a sub-category of SoDs or, more commonly, a mechanism in their own right. Where SoPHEs are provided for in domestic legislation, they tend to be similar to SoDs in nature and effect. The power to make a declaration of a SoPHE or the trigger for PHE related emergency powers is typically found in PHE legislation.

In some cases, there is a suggestion that SoEs may be used in response to PHEs even where sufficient powers are available either under a SoD or SoPHE. As the DPR Report recognises, states of exception may be declared for reasons other than purely legal effect. A SoE, in particular, may be declared to “communicat[e] the seriousness of a threat to the public and DPR actors and thereby encourage[e] them to implement appropriate preparedness and response measures”³³⁵ or to demonstrate that the government is taking the threat seriously. In some cases, especially in a federal or quasi-federal State, a declaration of SoE may be required simply to release funds or when the resources in a particular locality are exceeded.³³⁶

In practice, as the DPR Report acknowledges and the PHE Mappings suggest, it may be difficult to draw clear distinctions between the different types of states of exception, especially due to the inconsistent use of the terms ‘state of disaster’ and ‘state of emergency’ between States. Ultimately, all states of exception (other than those which are used simply to access funding) are a mechanism for switching “from normal to emergency legal modalities” and may be conceptualised as existing on a spectrum,

rather than in clearly defined categories. Nonetheless, as the DPR Report recognises, “In the majority of disasters, it will be more appropriate to declare a state of disaster, rather than an SoE (presuming that both forms of declaration are available). This is because the majority of disasters are not sufficiently severe to endanger the prevailing legal order, or to warrant the centralization of decision-making, and interference with constitutional and human rights.”³³⁷ This comment, in principle, applies equally to PHEs. In general, the use of SoDs or SoPHEs should be preferred, although SoEs – and the more exceptional powers and measures that they trigger – may at times be necessary.

The dangers of over reliance on SoEs – as opposed to more constrained or prescribed SoDs or SoPHEs – can be both legal and practical. The legal concerns, as the DPR Report and other reports³³⁸ have highlighted, are obvious: the triggering of unnecessary, unlimited or disproportionate emergency powers, which can be exercised without (or with only limited) scrutiny and may lead to the infringement of rights. It is recognised that some emergency measures may necessitate exceptions or derogations from human rights laws, however such measures and the period that they are in force must be both necessary and proportionate to the public health threat. In addition, as the Wallenberg Institute Report helpfully comments, “Having in place a comprehensive pandemic preparedness and response framework can reduce the perceived need to derogate from international standards, as these standards will be built into the framework.”³³⁹

There is also a more pragmatic, practical objection to an over reliance on SoEs. By their very nature, SoEs create an exceptional situation and are designed to introduce exceptional powers and measures. Governmental actors from outside the PHE risk management or DRM sectors may be given the authority to exercise those powers, without necessarily being familiar with the organisational or operational context in which they are required to act. This, in turn, may have a detrimental impact on operational effectiveness. In contrast, provided that SoDs or SoPHEs are made in circumstances where their use and the consequences of their use are more clearly set out – as the Wallenberg Institute Report suggests, in comprehensive pandemic preparedness and response frameworks – the risks both legal and practical can be minimised.

It is acknowledged that achieving a balance can be difficult. As the DPR Report recognises,³⁴⁰ it may not always be feasible or appropriate to foresee or cover all eventualities emerging from a PHE, especially one as severe as the COVID-19 Pandemic, in advance. The fallback of an SoE and the powers and measures that such a state can trigger may at times, therefore, be necessary.



RECOMMENDATION

1. Laws should establish states of exception for PHEs that are proportionate and tailored to the different types and magnitude of PHE that may occur. Such a system should be designed to operate at the lowest level initially, with escalation to higher levels, characterised by more extensive measures and powers, triggered only when strictly necessary.
2. Where separate mechanisms exist for declaring or determining a state of exception in relation to a PHE, those mechanisms should be compatible with one another and their use should be coordinated.
3. Whatever state of exception is used for PHEs, so far as is feasible (allowing for the unpredictability of emerging health risks), the source of the state of exception, its nature and the powers that it triggers should be clearly set out in law.

5.3 / RESPONSIBILITY FOR DECLARING A STATE OF EXCEPTION

The DPR Report recommends that laws should clearly specify who has authority to make a declaration of a state of exception.³⁴¹ It also recommends establishing a hierarchy of declarants, in case a named office holder or individual is indisposed or unavailable. It also advises that a declarant should be required to take advice from other agencies – or act only on the request of another agency – before making a declaration.³⁴² The PHE Mappings suggest that PHE legislation already adopts some of these principles.

Where declarations of a SoPHE or the trigger for PHE related emergency powers are provided for in PHE legislation, responsibility is normally expressly set out and is usually vested in actors within the health sector. In most cases, the PHE Mappings show that an identified person – usually the minister of health (or equivalent) or senior official in the ministry of health – is given the responsibility to make a declaration of a state of PHE or, if such declarations are not used, to otherwise determine that a prescribed level of PHE exists. For example, in Brazil the Minister of Health may declare a public health emergency of national importance.³⁴³ In Singapore, the Director of Medical Services, with the approval of the Minister of Health, may formulate emergency measures.³⁴⁴ In New Zealand, the Prime Minister, with the agreement of the Minister of Health, may make the relevant declaration.³⁴⁵ In China, responsibility for declaring a state of PHE rests with the National Assembly Standing Committee.³⁴⁶

If, instead, reliance is placed on a declaration of a SoE, there is normally similar certainty over the identification of the person responsible: usually the President (or equivalent).³⁴⁷ In some cases, the use of both declarations of SoE and SoPHE may mean that responsibility rests with different individuals – either within national government (for example, president and minister of health) or between different levels of government in a federal or devolved structure (for example, Regional Governor and President). There is no evidence that this caused actual problems during the COVID-19 Pandemic but, nonetheless, it is an issue that can be mitigated by ensuring that laws clearly identify the person responsible for making a declaration.



RECOMMENDATION

1. Laws that enable the declaration of a state of exception or enable a decision maker to determine that such a state exists, should:
 - a. clearly identify the person who has the authority to make that declaration or determination; and
 - b. where different persons may have that authority – either under different legislation or in different circumstances – ensure that the circumstances in which each can act are clear and that, in the event of any conflict, there is means of identifying or resolving who has the authority.

The DPR Report also recommends that States should establish a hierarchy of declarants, in case a named office holder or individual is indisposed or unavailable.³⁴⁸ This is probably even more important where officials have to take action in response to a disease that may affect them. It is not, however, evident that such arrangements are in place among the Sample States. In some States, constitutional arrangements may already provide such contingencies. For example, any minister may be able to exercise powers of another minister or, if a President is incapacitated, constitutions may provide for the continuity of his or her functions. In other States, where officials are named, their deputies may also be permitted to act. Overall, the PHE Mappings do not indicate that much consideration has been given to contingency arrangements for the unavailability of the responsible person. Given the potential during a serious PHE for ministers or officials to be affected, this is something that States should consider. Consequently, the DPR Report's recommendation is repeated.



RECOMMENDATION

States should establish – in law if necessary to ensure legal authority is conferred on the substitute – a hierarchy of officials authorised to make a declaration or determination of a state of exception in order to anticipate the possibility that named officials may be unable to act during a PHE.

The DPR Report also suggests that requirements should be introduced for the person declaring a state of exception to “act on advice” or “upon the request” of another entity (e.g. disaster management institutions or sub-national governments). The rationale is that this type of requirement may: (1) preclude the concentration of power in the hands of a single person or entity; (2) preserve the autonomy of sub-national jurisdictions; and (3) give appropriate weight to the expertise of relevant sectoral agencies.³⁴⁹ The PHE Mappings indicate that such provisions already exist in some Sample States. For example, in Colombia, the President can only declare a SoE after obtaining signatures from all the Ministers and the approval of the Constitutional Court.³⁵⁰ In New Zealand, where the Prime Minister has responsibility for declaring a SoPHE, she or he can only do so with the agreement of the Minister of Health.³⁵¹ In Papua New Guinea, the Head of State can only declare a SoE on the advice of the National Executive Council which, in turn, must first consult the statutory Emergency Committee.³⁵²

Even where the responsibility for making a declaration or determination of a state of exception resides within the sectoral ministry with principal responsibility for public health (typically, the ministry of health), there may be substantial benefit if there is some form of consultation. As previously noted, the number of actors involved in a PHE – even the number of departments within one ministry that may be involved – can be very large, and the factors that may need to be considered across sectors may not always be within knowledge of one official or department. Seeking advice or consulting in advance with other actors may also bring the benefit of providing advance warning to those other actors and enabling them to comment on the suitability or operability of any proposed measures. It can also be important that sub-national or local governments which may be required to act under, or implement, a state of exception are also involved prior to a declaration. The potential speed of spread of PHEs has to be recognised and it may not always be practicable to undertake a significant consultation. It may therefore at times be more beneficial to have already engaged actors at earlier stages in considering the implications of states of exception and the likely actions or powers that may be required. Nonetheless, a number of Sample States adopt such a requirement for consultation.



RECOMMENDATION

Laws and/or policies should include a requirement that, before any state of exception is declared or determined in relation to a PHE:

1. if the declaration or determination is made by a person other than the minister of health or an official within the ministry of health, the ministry of health should (i) at a minimum be consulted but (ii) should ideally agree or approve the declaration or determination;
2. if the declaration or determination and any proposed emergency powers may affect the functions of a sub-national government or administration, the sub-national government or administration should, at a minimum, be consulted before the declaration or determination is made; and
3. the person making the declaration or determination should consult, so far as is practicable in the circumstances, with the key actors and stakeholders who may be involved in a PHE response.

5.4 / TRIGGERING AND TIMING OF STATES OF EXCEPTION AND EMERGENCY POWERS

As the DPR Report recognises, it is vital that the law clearly sets out the legal triggers for the declaration or determination of states of exception and the enlivenment of emergency powers. For each state of exception that exists, its trigger should be tailored to the degree(s) and type(s) of disaster that the state of exception is designed to address. Legal triggers for SoEs might justifiably be broadly worded “to provide government with sufficient flexibility to respond to exceptional and unforeseeable events, but states of disaster [and it would follow, states of PHE] should have much more precise triggers”.³⁵³

Indonesia, 2019. The Indonesian Red Cross (PMI), with the support of the International Federation of Red Cross and Red Crescent Societies (IFRC), and funding from USAID, has been helping communities prepare for and prevent the spread of diseases through the epidemic and pandemic preparedness programme (CP3). © IFRC / Corrie Butler



The question of the timing of the trigger is very important. If triggers are reactive only (i.e. the ability to make a declaration or determination is only triggered after a PHE emerges or reaches a particular level of severity) by the time a declaration is made the window for certain preventative or preparatory actions may have closed. Reactive triggers may pose a particular problem in relation to PHEs for at least two reasons: (1) if there is an infectious disease outbreak in another State, waiting for it to arrive before any action can be taken could frustrate necessary preparatory action; and (2) infectious diseases may spread extraordinarily quickly and, arguably, even more quickly than other types of disaster. COVID-19 has certainly shown that fast and extraordinary measures can be required during PHEs. However it is important to acknowledge that there are some risks associated with pre-emptive triggers, namely that emergency powers may be used too soon or unnecessarily.

Unfortunately, not all the PHE Mappings comment on the timing requirements for declarations or determinations of states of exception or the use of emergency powers. Where the PHE Mappings do include information, the majority of responses indicate that there is recognition that the trigger needs to be pre-emptive and not only reactive. For example, Liberia's Constitution specifically allows a declaration of a SoE to be made where an event is *threatened*. In Colombia, a declaration of a state of PHE can be made when conditions *threaten* the welfare of persons etc.³⁵⁴ In the United Kingdom, emergency regulations to deal with a PHE can be made in response "to a serious and *imminent* threat to public health".³⁵⁵ In Bulgaria, the Minister of Health's emergency powers may be exercised in the presence of an "imminent threat" to citizens' lives and health resulting from an epidemic of a communicable disease.³⁵⁶ In Singapore, a Minister may declare a PHE if "satisfied that there is an outbreak or *imminent* outbreak of an infectious disease that poses a substantial *risk* of a significant number of human fatalities or incidents of serious disability in Singapore".³⁵⁷ Notwithstanding these good examples, a large amount of legislation is still worded to permit action only once an event has occurred or started to cause harm. This may be due to the age of the legislation in some cases, or it may be due to concern that a pre-emptive approach may lead to declarations being made too early.

Overall, the speed of the spread of COVID-19 both internationally and domestically confirms the DPR Report's recommendation that pre-emptive declarations and determinations should be permitted to enable a "valuable head-start"³⁵⁸ on a PHE response. Although there are risks that such an approach may lead to premature or unnecessary triggering of states of exception, as long as appropriate checks are in place, the ability to declare or determine states of exception pre-emptively should form part of a State's arsenal against serious public health threats.



RECOMMENDATION

1. Laws should strike a balance between ensuring that the triggers for states of exception or the use of emergency powers applicable to a PHE are: (a) clear and certain; and (b) sufficiently flexible to apply to novel or emerging health risks.
2. Laws should enable declarations or determinations of states of exception in respect of a PHE to be made pre-emptively.
3. To minimise the risk of pre-emptive powers being used inappropriately, laws should clearly prescribe the circumstances in which pre-emptive declarations and determinations can be made by, for example, requiring the PHE to be imminent, proximate (both temporally and geographically) and/or to have a potentially severe impact.

5.5 / THE NATURE OF EMERGENCY POWERS AND MEASURES

The emergency powers that may be deployed to respond to a PHE fall into two broad categories: (1) emergency law making powers (referred to as “emergency legislative powers”); and (2) emergency executive powers (referred to simply as “emergency powers”). Emergency powers may already exist in standing legislation or may be created through or under instruments made using emergency legislative powers. The PHE Mappings show that a combination of these two types of emergency powers were used during the COVID-19 Pandemic, although there is significant variation in terminology and practice between States.

As noted above, in some jurisdictions emergency powers may be enlivened by the existence of certain specified circumstances, without a need for a declaration or determination of a SoE, SoD or SoPHE. Indeed, emergency powers of some kind were deployed by every Sample State to respond to the COVID-19 Pandemic, even if a state of exception had not been declared or determined. In some cases, emergency legislative powers were used to create new emergency powers. In most cases, however, the emergency powers used were already prescribed to a lesser or greater extent in existing legislation.

As mentioned in Chapter 1, it is outside the scope of this Report to analyse the effectiveness and appropriateness of the COVID-19 measures that were implemented using emergency powers. Moreover, the majority of PHE Mappings tend to provide information about the legal source of the emergency powers used, rather than information about the nature of the measures introduced using those powers (although some of the Emergency Decree Mappings did identify some of the emergency measures introduced during the initial stages of the COVID-19 Pandemic). Most of the emergency measures introduced will by now be familiar to all readers and include the following:

- border closures;
- restrictions on international travel;
- compulsory quarantine or self-isolation³⁵⁹ of arriving travellers, at home or in hotels or State provided accommodation;
- restrictions on internal movement;
- closure of businesses, schools and sports and entertainment venues;
- prohibition on social gatherings, including religious worship;
- compulsory social distancing and other preventative measures such as the mandatory wearing of facemasks;
- testing and tracing of those who may be infected, including the compulsory use of smartphone applications and the sharing of data;
- compulsory self-isolation or quarantine for those displaying symptoms or those who may be asymptomatic but potentially infected;
- compulsory shielding – or in effect, isolation or quarantining – of the most vulnerable, especially older persons or those with underlying health conditions, even if they did not have the disease; and
- compulsory treatment, in some cases potentially including vaccination.

The detailed analysis of the effectiveness of these emergency measures will, when it can take place, provide a very useful tool for States to understand what specific emergency legislative powers and emergency powers may be required for future PHEs (and for other disasters as well). In the meantime, the recommendations of the DPR Report³⁶⁰ may assist in identifying how laws should approach the formulation and deployment of emergency powers.



RECOMMENDATION

1. Laws should clearly specify the governmental powers that arise once a state of exception is declared or determined in respect of a PHE.
2. It is generally preferable for laws to include a pre-determined, precise and exhaustive list of such governmental powers, although it may be appropriate for broader powers to be available in the event of severe PHEs.

5.6 / THE IMPACT OF STATES OF EXCEPTION AND EMERGENCY MEASURES ON HUMAN RIGHTS

As the DPR Report finds, it is common for domestic DRM laws to authorise measures that impact human rights, especially during or under states of exception. The experience of the COVID-19 pandemic illustrates that the issue of human rights impacts also arises in the PHE context. Measures introduced in response to COVID-19 that raise human rights issues include (but are not limited to): lock downs; the mandatory closure of businesses; mandatory quarantines or self-isolation of those infected or potentially infected, especially if the criteria are subjective or vague;³⁶¹ and the compulsory shielding or self-isolation of the most susceptible to the disease. Many of the mitigating measures taken (or not taken) in respect of the vulnerable groups discussed in Part C also have human rights implications. A detailed study of the human rights impacts of COVID-19 emergency measures is beyond the scope of this Report, however this topic has already generated many blog posts and articles³⁶² and is likely to be one of the most discussed aspects of the Pandemic. Key issues of discussion are whether the types of restrictions imposed, the length of time for which they are in force, and enforcement measures are proportionate to the nature and severity of the public health threat.

Despite the nature of the measures taken in response to COVID-19, most States have not felt the need to derogate formally from respecting human rights. It appears that only 13 countries gave notice of derogation from the ICCPR in relation to their COVID-19 response measures: Armenia, Chile, Colombia, Ecuador, El Salvador, Estonia, Georgia, Guatemala, Kyrgyzstan, Latvia, Palestine, Peru, and Romania.³⁶³ This is, perhaps, surprising given the number of other States that used emergency powers and introduced measures in ways which could have the effect of suspending fundamental human rights. As the Wallenberg Institute Report records, some States “introduced measures effectively derogating from international obligations, but without complying with substantive and procedural requirements. The risk that arises when derogations from international obligations do not comply with substantive or procedural requirements is that the essential safeguards that are in place to prevent violations are set aside without an assessment of the necessity or proportionality of the measures, significantly increasing the risk of a violation of human rights.”³⁶⁴

Most human rights instruments provide that States may limit certain rights in order to take measures dealing with serious threats to the health of the population or individual members of the population. This does not, however, give States the ability to cite health grounds and, as a result, do whatever they wish. Limitations on human rights should be necessary, proportionate and, perhaps most importantly, *prescribed by law*. The Syracuse Principles³⁶⁵ further establish that such measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured, and that due regard must be had to the IHR³⁶⁶ as well as the more general principles of necessity and proportionality. The importance of the requirement for any limitation to be prescribed by law was shown in the recent New Zealand case of *Borrowdale v Director General of Health and Others*.³⁶⁷ The New Zealand High Court accepted that New Zealand’s COVID-19 restrictions were necessary, reasonable and proportionate. However, it held that restrictions that limited freedoms of movement, peaceful assembly and association were contrary to the New Zealand Bill of Rights Act 1990 for a period of time when the restrictions were not contained in legislation. That is, they were not therefore prescribed by law. Once the restrictions were set out in legislation, the High Court considered them properly imposed.



South Africa, 2020. Volunteers at the Twin City Mall explain how to curb the spread of COVID-19, starting with social distancing and the importance of washing hands regularly. © IFRC / Moeletsi Mabe

As none of the PHE Mappings mention any court cases, it is not clear how extensive litigation regarding the human rights impacts of COVID-19 restrictions has been, or how courts have dealt with such cases. In judgments reported in common law jurisdictions, it appears that the courts are prepared to allow governments a degree of discretion and flexibility when dealing with a PHE. In *Dolan v Secretary of Health and Social Care*,³⁶⁸ the English High Court, in a decision upheld on appeal, dismissed a challenge against regulations requiring individuals to stay at home. The basis for the decision was that a prohibition on a person leaving their home to stay overnight at a place other than their residence did not amount to a deprivation of liberty. Nor did stay-at-home restrictions amount to a breach of the right to respect for private and family life. In relation to a challenge against restrictions on movement, the Court accepted that they did involve a restriction on the freedom of assembly and association. However, it concluded that “in the context of a global pandemic where a novel, highly infectious disease capable of causing death was spreading and was transmissible between humans”, no court could find the restrictions disproportionate. It was notable, however, that review provisions were built into the relevant regulations and, at the time of the judgment, the relevant regulations had been superseded. Whether such decisions are the norm will no doubt be subject to much scrutiny and analysis.

In the meantime, as the DPR Report and many others have pointed out, the fact that some courts may offer governments a margin of appreciation should not detract from the more fundamental principle that States must continue to respect human rights even during a severe PHE.



RECOMMENDATION

1. Laws should ensure that, during a state of exception for a PHE, safeguards are in place that promote governmental transparency and accountability, maintain the rule of law, preserve democratic institutions and protect human rights.
2. Emergency powers and measures should be consistent with international law, particularly international human rights law.
3. Human rights should continue to be respected during a PHE and States should, therefore, only deploy emergency powers and measures that limit human rights in so far as is necessary, proportionate and prescribed by law.

5.7 / SAFEGUARDS AND SCRUTINY DURING STATES OF EXCEPTION

It should be uncontentious that the declaration or determination of a state of exception should be subject to safeguards. The DPR Report recommends that the law should provide for judicial and/or legislative supervision of SoEs and high-level SoDs with respect to: the initial declaration of an SoE/SoD (including any powers specified); decisions or actions taken during an SoE/SoD; and any decision to extend or terminate an SoE/SoD. These principles also apply to a state of exception triggered for a PHE. Although limited information is provided in the PHE Mappings on supervision, it is possible to find some form of legislative or judicial supervision in most Sample States.

5.7.1 / Legislative supervision

The PHE Mappings indicate that there is significant variation in how legislatures exercise supervision over the declaration or determination of states of exception or the emergency measures adopted.

The strongest form of supervision is where law making is still undertaken by the legislature, not the executive. As already noted, in most cases legislatures were still able to function during the COVID-19 Pandemic and enacted many of the laws used by government for the response, even if using accelerated procedures and timeframes. The supervisory role of the legislature is more limited where the executive possesses and exercises emergency law-making powers.

As the DPR Report recognises,³⁶⁹ a balance needs to be struck between speed of action and appropriate scrutiny, especially where legislatures may not be in session. There is, therefore, a reasonable argument that during a rapidly developing PHE, subsequent (rather than prior) approval of executive action is more appropriate. Subsequent ratification appears to be the more common approach adopted in the Sample States both in relation to: (1) declarations of states of exception for PHEs (on first making or when renewal is required); and (2) delegated or subsidiary legislation made by the executive. For example, in the Democratic Republic of Congo, once a SoE has been declared by the President, the Constitution requires the two legislative houses to pass legislation to regulate the application of the SoE.³⁷⁰ In Papua New Guinea, specific provision is made for Parliament to meet to consider initial declarations of national emergency and extension. Where a subsequent declaration of emergency is sought it can only be made through “an absolute majority” vote of the Parliament.³⁷¹ In New Zealand, modification orders enabling the use of special powers during an epidemic can be made but must be presented to the House of Representatives as soon as practicable after they are made for parliamentary scrutiny.³⁷²

A state of exception declared or determined in relation to a PHE has the potential to be in force for a much longer period compared to other types of disaster. The result may be a protracted period where extraordinary powers and restrictions are in force, with serious impacts of the type considered in Part C. In order to ensure that extraordinary powers and restrictions are only in force for as long as is necessary and proportionate to the public health threat, states of exception applicable to PHEs should be time-bound and their extension should be subject both to clearly specified criteria and legislative supervision.³⁷³ In some cases, a lesser condition can be set such as a requirement for the government to report to the legislature explaining why emergency powers are still required.

It is important to recognise that legislative scrutiny requires the legislature to continue to function during a PHE. In section 4.6, the Report highlights the need for contingency arrangements to enable legislatures to continue operating during a PHE.



RECOMMENDATION

1. Laws that enable the declaration or determination of a state of exception in respect of a PHE should provide that the legislature:
 - a. must (wherever possible) approve the declaration or determination within a prescribed period of time; and
 - b. has the power to amend or terminate a state of exception, including power to amend details such as the geographical scope, time period and emergency powers.
2. Laws that enable the declaration or determination of a state of exception in respect of a PHE should include a time limit so that a state of exception will terminate automatically once a specified period has elapsed, unless the state of exception is extended.
3. Laws that enable the declaration or determination of a state of exception in respect of a PHE should clearly specify:
 - a. the circumstances in which a state of exception may be extended;
 - b. the maximum period for which a state of exception may be extended; and
 - c. either:
 - i. the maximum number of times that the state of exception may be extended; or
 - ii. the maximum period that a state of exception may be in force.
4. Laws that enable the declaration or determination of a state of exception in respect of a PHE should require any extension of a state of exception to be subject to approval by the legislature (wherever possible), either prior to the extension or within a prescribed period.

5.7.2 / Judicial supervision

The second main form of supervision or scrutiny is through the courts. The ability to challenge a declaration or determination of a state of exception is not, however, universal. The International Law Association considers that courts should have jurisdiction to determine whether:

- emergency declarations and legislation accord with the law in terms of procedures and conditions, and proportionality and necessity;
- legal instruments permitting limitations of and derogations from rights are lawful and properly enacted;
- any non-derogable rights have been violated; and
- laws outside of emergency measures continue to be in effect, with a presumption that they are in effect unless explicitly repealed.³⁷⁴

The PHE Mappings do not suggest that judicial review has been excluded, although they do not comment specifically on this issue. The biggest challenge to judicial scrutiny during COVID-19 may not have been legal but practical, with many courts closing as part of wider restrictions. Only in the Indian PHE Mapping is there a report of legislation ousting a court's jurisdiction to intervene in respect of COVID-19 response measures.³⁷⁵



RECOMMENDATION

Laws providing for the declaration or determination of a state of exception in respect of a PHE should ensure that:

- a. the declaration or determination, its subsequent extension and any emergency powers or emergency measures made under it can be subject to legal proceedings brought by those affected; and
- b. the judiciary have the jurisdiction and power to:
 - i. declare as unlawful a declaration or determination of a state of exception, its subsequent extension and any emergency powers or emergency measures made under it; and
 - ii. make appropriate orders to redress such illegality (for example, by way of declaration of invalidity, penalties or compensation).

5.7.3 /Transparency

An additional safeguard recognised in the DPR Report is publicity: ensuring that notice of states of exception is provided to the widest possible audience, not just in a public register of laws. This is clearly important and, although not recorded in the PHE Mappings, there is evidence of States making use of other methods of communication, including social media, to provide information about the measures put in place in response to COVID-19.³⁷⁶ What is also interesting is the use of websites to provide greater access to the legislation used in the response. Many governments have set up dedicated 'COVID-19 law' websites or have created pages on their main 'Laws websites' for COVID-19 materials. These websites are not always very user friendly but this may be due to the sheer amount of legislation and revisions, amendments or repeals, which can make it very difficult to keep track of the current laws. Nonetheless, the existence of these type of websites improves access to the laws and, conversely, where this type of service is not provided, accessing the laws can be very difficult.



RECOMMENDATION

1. The law should require notice of a declaration or determination of a state of exception in response to a PHE (including the detail of emergency powers or measures applying under it) to be published and made accessible to the widest possible audience.
2. The good practice evidenced around the world of publishing legislation during COVID-19 should be continued and all States should seek to publish laws, policies and plans relating to states of exception and PHEs online wherever possible.

PART C

THE ROLE OF LAW IN MITIGATING SECONDARY IMPACTS OF PHEs AND IMPACTS ON VULNERABLE GROUPS



© Syrian Arab Red Crescent

This Part (Part C) addresses the role of law in mitigating the secondary impacts of PHEs and the impacts on marginalised and vulnerable groups.³⁷⁷ It follows the structure of the DPR Report by focusing on the following broad topics: (1) human mobility;³⁷⁸ (2) shelter and housing;³⁷⁹ and (3) the protection of vulnerable groups.³⁸⁰ It supplements the existing recommendations on these topics in the DPR Report, by providing guidance on these topics specifically in the PHE context.

The PHE Mappings provide an extensive picture of the social, economic and health measures taken to mitigate the impact of the COVID-19 Pandemic and, therefore, offer an illustration of the types of support States may need to establish in response to a future PHE. The analysis in this Part focuses on these measures although, as many of the measures were introduced without the need for law or policy, this Part focuses specifically on the measures introduced using law or that raise legal issues.

6 / IMPACT OF PHEs ON HUMAN MOBILITY AND MIGRATION

6.1 / HUMAN MOBILITY GENERALLY

disasters can have short- and long-term impacts on human mobility. The DPR Report examines these in relation to disasters generally and identifies two principal aspects: (1) planned relocations, either preventive or responsive; and (2) disaster displacement, which is unplanned and responsive with people forced to leave their homes as a result of disaster. The DPR Report recommends the need for comprehensive legal and policy frameworks for undertaking planned relocations where necessary and to protect those subjected to involuntary displacement.³⁸¹

Similar to other types of disaster, PHEs may prompt physical flight: fear of contagion may be a powerful motivator. In other cases, a wish to avoid lockdown restrictions introduced in response to a PHE may be a sufficient reason to move, whether internally or internationally. However, the COVID-19 Pandemic has illustrated that PHEs can affect human mobility in additional ways. In the case of visitors or migrants there may be a desire to return 'home', perhaps to help or to be with family. Loss of jobs and changes in economic opportunities may also provide a reason to move. In India, for example, the negative impacts of COVID-19 restrictions on activity and livelihoods in urban areas resulted in mass interstate migration, predominantly from urban to rural areas.³⁸²

Such movement can be disrupted by restrictions on travel or border closures, both international and internal. During COVID-19 the majority of States closed their borders to incoming travellers at some point; in some States, border closures also prevented – in law or in effect – outbound travel.³⁸³ Border closures and travel restrictions led to altered migration routes. For example, it is reported that migrants from West Africa, unable to reach the European Union via the North African coast, are now using the more dangerous Atlantic route via the Canary Islands. Border closures and travel restrictions also created the very opposite of forced displacement: forced immobility. The consequences of forced immobility can be very serious for people in particular situations, such as those experiencing persecution, loss of livelihood or irregular or uncertain migration status (e.g. expired visas). As the Honduras PHE Mapping reported, Honduras was faced with both a return of asylum seekers from the USA, but also by the arrival of a caravan of migrants heading towards the USA. Combined with restrictions on internal movement, the effect of border closures and actions by other States left a significant number of migrants, in effect, stranded.³⁸⁴

6.2 / BORDER CLOSURES

with the exceptions of the Republic of Korea and the United Kingdom, all of the Sample States introduced border closures or the effective equivalent, such as prohibitions on arriving air or sea transport. The clear aim was to limit human mobility for the purpose of stopping the spread of COVID-19 (although the extent to which this works is unclear and modelling has shown that, although travel restrictions may work early in a pandemic, they subsequently become less effective³⁸⁵). In a number of Sample States, absolute border closures were not immediately introduced. Instead, border closures were phased, beginning initially with restrictions or prohibitions on travellers from cities or countries where the pandemic originated or had initially spread. For example, New Zealand first prohibited travellers from China before later adopting a complete border closure.³⁸⁶ Liberia initially suspended travel to and from all countries with 200 or more COVID-19 cases.³⁸⁷ Other States initially focused restrictions on travellers arriving in modes of transport that were potential sources of major transmission. For example, Australia's first steps were to prohibit international cruise ships from entering Australian territory.³⁸⁸

The actual means of closing borders took a number of forms and varied depending on the nature of the border (i.e., land, sea or air). In some cases, foreign or unapproved aircraft and ships were prohibited from entering a country's territory. More commonly, ships and aircraft were not prohibited as such, but passengers were prohibited from disembarking unless they fell within an exception. In Colombia, for example, all international air travellers were prohibited from arriving in or transiting via Colombia, except (1) where humanitarian emergency or "force majeure or Act of God" exceptions applied or (2) with prior authorisation. The rules for land borders differed slightly, permitting access for the transportation of cargo and merchandise.³⁸⁹ This type of exception applied in many of the Sample States: whilst passengers were widely prohibited, it was recognised that goods, especially essential supplies such as PPE, still needed to be imported.³⁹⁰ Exceptions for humanitarian assistance also appeared in a number of Brazil's border closure decrees. In Liberia – which closed some of its borders during the Ebola Outbreak, with others only open with screening centres – all its borders with neighbouring countries were closed and commercial flights were suspended by decree, except for cargo, chartered and special flights.³⁹¹ Similarly, Sierra Leone, which also experienced of Ebola, closed its borders and suspended inbound flights, except those transporting essential cargos.³⁹²

These border closures were introduced despite being inconsistent with WHO IHR temporary recommendations (which advised against the application of travel or trade restrictions³⁹³) and, as the DPR Report records,³⁹⁴ the vast majority of States having committed to the Global Compact for Safe, Orderly and Regular Migration. The Global Compact requires the development of "coherent approaches to address the challenges of migration movements in the context of sudden-onset and slow-onset natural disasters"³⁹⁵ and, therefore, covers PHEs.

It was not clear from the PHE Mappings whether the legal measures adopted to close borders or restrict travel were pre-planned. In some cases, they may have been based on precedent or the experience of previous PHEs. It appears, however, that many of the laws were rushed through in response to the perceived need to rapidly prevent the movement of infected individuals. The degree to which consideration was given to States' international obligations, or to the broader consequences of such prohibitions and restrictions, is not addressed in the PHE Mappings, but it seems that these considerations were not at the forefront of all governments' thinking.

The introduction of border closures and travel restrictions – and their consequential effects, such as the reduction in the availability of commercial flights (at least on certain routes) – had a major impact on efforts to repatriate individuals. It is not clear if States that imposed restrictions took account of the fundamental rights that these steps could infringe. In particular, under the International Covenant on Civil and Political Rights (ICCPR) "Everyone shall be free to leave any country, including his own"³⁹⁶ and "No one shall be arbitrarily deprived of the right to enter his own country."³⁹⁷



Honduras, 2021. The Honduran Red Cross provides support to migrants travelling through the country in a 'migrant caravan'. Humanitarian Service Points established along the migration route are used to provide essential services and supplies, such as water, face masks, pre-hospital care, and information about safety, security and COVID-19 prevention. © Johannes Chinchilla / IFRIC

Initially, the focus was on securing the return of tourists, including those on cruise ships. As the COVID-19 Pandemic progressed, significant issues were then experienced with the repatriation of the crews of both passenger and cargo ships that, due to lack of business, were forced to lay up offshore. By July 2020, it was estimated that 200,000 seafarers were stranded at sea.³⁹⁸ Difficulties with repatriating migrant workers also became apparent as the COVID-19 Pandemic progressed and the impact on their employment worsened: for example, Sri Lanka, which had over one million of its citizens working abroad before the COVID-19 Pandemic, had at one point more than 50,000 Sri Lankan citizens waiting to be repatriated.³⁹⁹

The problems of repatriation were exacerbated where border closures applied to returning citizens. In most cases, citizens or permanent residents were permitted entry. For example, New Zealand's PHE Mapping explains that borders were closed to all but returning citizens and permanent residents. However, in a few Sample States even citizens were expressly or, in practice, barred from returning. Australia's international borders were closed to all but citizens and a number of limited categories of individual. The number of citizens that could return was, however, in practice limited by the imposition of a daily or weekly cap on the number of arrivals at Australia's international airports. An inability to obtain a flight therefore became a barrier to some Australian citizens being able to return home. The use of the arrivals cap led to a number of complaints to the Australian Human Rights Commission.⁴⁰⁰

Most border closures were for inbound travel. In some cases, however, borders were also closed to outbound travel. The Tajikistan PHE Mapping provides an example of the problems this caused, recording that many Tajik migrant labourers were unable to return to Tajikistan from Russia after Russia's borders closed to outbound travel. From its PHE Mapping, Australia appears to have adopted some of the most stringent regulations relating to outbound travel. These prohibited Australian citizens and permanent residents from leaving Australia on any aircraft or vessel,⁴⁰¹ subject to being granted permission on the basis of falling within one of a number of specific exemptions. An exemption was available for persons ordinarily resident in a country other than Australia (although people in this category faced the difficulty of finding flights, given the cap on flights into Australia's international airports). In some

Sample Countries, although there may not have been a general exception, a foreign citizen could apply for permission to leave, for example in Mongolia from the State Special Commission.⁴⁰² The PHE Mapping for Mongolia is silent on whether such requests were granted or whether conditions might have been imposed. In general, restrictions on outbound travel interfere with the right under the ICCPR to be free to leave any country (including one's own) and, therefore, raise a question of whether such restrictions are necessary and proportionate to the public health threat.

A number of the PHE Mappings report on how governments assisted foreign citizens to be repatriated if they wished. This tended to take two forms: (1) as discussed above, ensuring that any prohibitions on outbound travel contained appropriate exemptions; and (2) positively assisting in the repatriation of 'trapped' foreign citizens. Examples of positive assistance to ease the return of migrants are more common, although these tend to be applied under policies rather than laws. The governments of both UAE and Sri Lanka, for example, facilitated flights for foreign workers wishing to return⁴⁰³ and the International Organization for Migration (**IOM**) assisted the return of Tajik migrants stranded at the Kazakhstan and Uzbekistan borders.⁴⁰⁴



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should address:
 - a. the potential need for a State to close its borders or impose restrictions on travel in response to the international spread of disease;
 - b. the potential impact of a PHE on human mobility and the needs of individuals who may wish or need to travel (internationally or internally) as a result (direct or indirect); and
 - c. the potential need for migrants to be repatriated following a PHE and the process for facilitating repatriation.
2. Laws should clearly specify the criteria for border closures and/or restrictions, and how such closures or restrictions will be practically implemented. Any such criteria should be consistent with States' international obligations under the IHR and the ICCPR, including every person's right to leave any country (including their own) and not to be arbitrarily deprived of the right to enter their own country.

6.3 / REFUGEES AND ASYLUM SEEKERS

at the start of the COVID-19 Pandemic, the United Nations High Commissioner for Refugees (**UNHCR**) issued key protection messages designed to address the vulnerability of asylum seekers, refugees and internally displaced persons that was foreseen as likely to arise during the Pandemic.⁴⁰⁵ These messages were that:

1. States can and should ensure access to asylum while also protecting public health;
2. Even where a State has closed its borders, reception of asylum seekers and the processing of asylum claims should continue, with priority for the most vulnerable;
3. Restrictions on freedom of movement should not be arbitrary nor discriminatory;
4. Restrictions on the exercise of rights should be maintained for no longer than necessary;
5. Public health and other responses should address the particular risks affecting refugees, the internally displaced, and other marginalized groups.

The PHE Mappings specifically report on issues facing refugees and asylum seekers during the COVID-19 Pandemic. Two main issues are identified: (1) whether border closures and travel restrictions prohibited the entry and/or forced the return of refugees and asylum seekers; and (2) whether applications for asylum were still being processed.

At the outset of the COVID-19 Pandemic, the UNHCR estimated that, of the 123 States that had fully or partially closed their borders, 30 States had made no exception for access for asylum seekers.⁴⁰⁶ The PHE Mappings provide further insight into this issue. In Australia, the strict border closures applied equally to asylum seekers and holders of refugee and humanitarian visas who had not travelled to Australia (although discretionary exemptions could be granted by the Commissioner of the Australian Border Force).⁴⁰⁷ In other Sample States with closed borders, there were no exemptions specifically for asylum seekers, but a number had more general exemptions or exceptions which permitted entry for “humanitarian reasons” (for example, Brazil, Colombia and China). Arguably, this could apply to persons seeking asylum. In Spain, there were exceptions for “persons who evidence reasons of force majeure or situations of need, or whose entry is permitted for humanitarian reasons.” The latter exception is understood to have existed to accommodate asylum seekers.⁴⁰⁸ Although not specifically mentioned in the PHE Mappings, another important issue is whether border closures and restrictions may have amounted to refoulement.⁴⁰⁹ This was identified as a risk by the UNHCR in the event that States turn asylum seekers away at their borders.⁴¹⁰

The other main reported impact on asylum seekers is delay in processing their applications. In the Republic of Korea, for example, while asylum procedures were not suspended, there were reports of delays in refugee status determination procedures (including cancellation of asylum interviews and postponement of court hearings).⁴¹¹ In many cases, such delays may have been due to the difficulties in reorganising administrative tasks during the Pandemic. However, the impacts of delays can be significant if, for example, asylum seekers are unable to apply for jobs until their status is confirmed or access government support, such as a national emergency disaster relief payment,⁴¹² or if the delay prevents or obstructs family reunification.



RECOMMENDATION

1. Laws that regulate border closures or travel restrictions in response to the international spread of disease (or other public health risk) should:
 - a. be compliant with States’ international legal obligations towards refugees and asylum seekers, including the duty of non-refoulement; and
 - b. include exceptions (subject to appropriate health safeguards) on humanitarian grounds for refugees, asylum seekers and others fleeing irreparable harm.
2. States should ensure access to asylum during a PHE. Laws and/or policies should establish contingency arrangements to ensure that the reception of asylum seekers and the processing of asylum claims continues, with priority for the most vulnerable.

7 / SHELTER AND HOUSING

7.1 / INTRODUCTION

The DPR Report identifies the principal issues relating to housing and shelter during disasters as: (1) inequitable access to emergency shelter assistance; (2) a lack of available land and buildings for emergency and transitional shelter assistance; and (3) educational disruption due to the use of schools as evacuation centres or post-disaster shelters.⁴¹³ PHEs raise quite different questions in relation to housing and shelter mainly due to the fact that they are less physically destructive. As demonstrated by the COVID-19 Pandemic, during PHEs the principal concerns are twofold. Firstly, homeless persons may be at particular risk, for example, because they (a) may be crowded into an environment where a disease may spread more easily or (b) lack access to hygiene facilities, treatment, or support. Second, the secondary impacts of a PHE on economic activity and livelihoods can increase the number of people at risk of losing their housing. Nonetheless, the issues identified in the DPR Report can also arise if another disaster occurs at the same time as a PHE, which indeed has happened during the COVID-19 Pandemic.

7.2 / HOMELESSNESS AND THE HOMELESS

Although a few of the PHE Mappings, including China, Liberia and Sri Lanka, report that no action needed to be taken in respect of the homeless during the COVID-19 Pandemic, most States introduced measures to provide accommodation for the homeless and/or enhanced sanitation. The measures taken fall into two broad categories: (1) legislative measures or new programmes or initiatives providing enhanced protection for the homeless; and (2) informal efforts to ensure that the homeless could benefit from other sanitary measures.

Overall, the use of legislation or other legal instruments appears to be relatively uncommon, although some instances were reported. In Mongolia, the Government is required to provide shelter, food and clean drinking water to homeless and extremely poor people and to organise activities to prevent infection.⁴¹⁴ Legislation is also found at the state level in federal jurisdictions: for example, in the Brazilian state of São Paulo, legislation permitted homeless people to occupy hotel rooms.⁴¹⁵

Providing accommodation for the homeless during the COVID-19 Pandemic is a relatively common action but to achieve this most Sample States either introduced new initiatives or programs, or relied upon existing ones, rather than legislating. Spanish regional governments (Autonomous Communities) established shelters to house the homeless with support from local charitable foundations and organisations such as the Spanish Red Cross and the Caritas Relief Agency.⁴¹⁶ In South Africa, the South African Social Security Agency was tasked with identifying temporary shelters for homeless persons with the necessary hygiene standards. A pre-COVID-19 example is provided by Sierra Leone which offered public housing for its citizens to decrease exposure to Lassa fever.⁴¹⁷

Other States appear to have combined the need to find accommodation – in part to enable self-isolation or effective social-distancing – with longer term plans to reduce homelessness. In New Zealand, the Government made motels and other residential units available for the homeless in accordance with its Homelessness Action Plan 2020.⁴¹⁸ In the Australian state of Victoria, the state government transitioned over 2,000 people experiencing homelessness to accommodation in hotels.⁴¹⁹ This package was extended to enable those affected to transition to long-term housing.⁴²⁰

More typically, the support provided to the homeless by the Sample States was targeted advice and access to sanitary measures. The Honduran government established a social program called “Operación Honduras Solidaria” to distribute food rations to those vulnerable due to COVID-19, as well

as antibacterial gel and masks.⁴²¹ The Spanish Defense Ministry's Special Medical Unit provided the homeless with special hygiene kits and food rations on a daily basis, as well as medical services and general information.⁴²² In the Republic of Korea, the government worked with NGOs to identify gaps in care provided to homeless people and residents of informal settlements. Community volunteers also stepped in to provide additional support where local governments lacked the capacity to do so..⁴²³

Finally, even where no formal programmes are recorded, some PHE Mappings comment that governments are encouraging the homeless and those in informal settlements to maintain good sanitation practices. For example, in Liberia hand-washing services in public areas were instituted and the Liberian Government updated its existing Water, Access, Sanitation, and Health initiative ("WASH")⁴²⁴ to include COVID-19 messaging.⁴²⁵

As with many of the measures taken to mitigate the impact of COVID-19, the number of initiatives introduced to support the homeless in a relatively short space of time is noteworthy. However, most of the measures were reactive, even if built upon pre-existing initiatives. As the potential impact of a PHE on the homeless is now known, it should be addressed in laws, policies and plans relating to PHEs. This should ensure that during future PHEs States will be ready to implement the lessons from the COVID-19 Pandemic and take the action required to protect and support this group. As shown, it is not strictly necessary for this to be in legislation, but it should nonetheless be addressed in other instruments, especially contingency plans.



RECOMMENDATION

1. The needs of homeless persons should be recognised and provided for in domestic PHE risk management frameworks, including laws, policies, and plans.
2. PHE contingency plans should identify the key actions to be taken to protect homeless persons in the event of a PHE, including provision of accommodation, health care, sanitation, and information.

7.3 / LOSS OF HOUSING

Most of the Sample States recognised from an early stage that the economic impact of the COVID-19 Pandemic could lead to people not only losing their livelihoods but potentially their housing as well. A number of Sample States adopted measures to address housing-related issues, primarily: (1) the inability of tenants and homeowners with a mortgage to pay rent or make mortgage payments; and (2) the need to protect households from eviction or foreclosure where, for COVID-19 reasons, they could not pay their rent or mortgage. In addition, in a number of Sample States, housing policy was used as a way to provide additional protection to those at risk from domestic violence. This is discussed further in section 8.6.

Some form of prohibition or grace period on evictions was introduced through legislation in Australia, Colombia, New Zealand, Spain, the United Kingdom, Florida, and New York. More common, although by no means universal, was financial support to households and tenants. Spain was typical in providing a package of support including the suspension of rental payments, the automatic renewal of expiring tenancies and micro-loans to support tenants unable to pay rent.⁴²⁶ Similar measures were put in place in Colombia, with a specific decree⁴²⁷ extending lease agreements and requiring landlords and tenants to reach agreement on rental payments. At the time of its PHE Mapping, the Sri Lankan government was exploring debt moratoriums on loans and leasing rentals⁴²⁸ and in Honduras financing fees were frozen.⁴²⁹ A number of States also established funds to provide assistance for housing costs, or as part of wider support packages, for example, the Solidarity Program under Decree 518 of 4 April 2020 in Colombia.⁴³⁰



South Africa, 2020. South African Red Cross Society COVID-19 activities in Bloemfontein, Free State include a variety of initiatives such as mobile kitchens, social grants, screening, and testing and tracing. In Ricklands, the Bloemfontein branch have set up a shelter for homeless people at the Rocklands Hall, where they also provide meals from breakfast to dinner. © IFRC / Moeletsi Mabe

In contrast to the measures introduced to assist homeless persons, all these measures required legislation. However, most measures appear to have been reactive with little or no standing legislation enabling this action to be taken by governments. As a result of COVID-19, more legislation will now be in place, but the PHE Mappings suggest much of the legislation is specific to COVID-19 and would, therefore, not automatically applicable to a future PHE. Again, given that similar support may be required in future PHEs, it would be sensible for States to secure standing powers to take such action and to ensure that the type of arrangements required are included in laws, policies and/or plans for PHEs.

It is also important to recognise the differences in land and home tenure across the Sample States. As pointed out in a number of PHE Mappings,⁴³¹ the informality or lack of regulation of tenure in some countries may be a barrier to the introduction of more positive measures. The DPR Report recommends that law and/or policy should provide for emergency (i.e. temporary) shelter assistance to be provided for disaster affected persons on the basis of need rather than pre-disaster tenure status.⁴³² That principle should apply in terms of other types of housing assistance provided during a PHE.



RECOMMENDATION

1. States should consider introducing or amending standing laws, policies and plans to identify the financial and other support to be provided to those at risk of losing their housing during a PHE.
2. Laws, policies and/or plans should ensure that housing and housing support during a PHE are provided based on need rather than tenure status.

8 / THE PROTECTION OF VULNERABLE GROUPS

8.1 / VULNERABILITY IN PUBLIC HEALTH EMERGENCIES

This Chapter focuses on the protection of specific groups which may be especially vulnerable to the impacts, including secondary impacts, of a PHE. The IFRC defines vulnerability as “the diminished capacity of an individual or group to anticipate, cope with, resist and recover from the impact of a natural or man-made hazard.”⁴³³ The concept of vulnerability is relative and dynamic. Although often associated with poverty, vulnerability may also arise “when people are isolated, insecure and defenceless in the face of risk, shock or stress” or have “a lack of capacity or resources to deal with a disaster.” Physical, economic, social and political factors – including racism, discrimination and other forms of exclusion – are important determinants of people’s level of vulnerability and the extent of their capacity to resist, cope with and recover from hazards.⁴³⁴

The DPR Report⁴³⁵ identifies eight groups of people who may, depending on their particular circumstances, be especially vulnerable to disaster impacts: women and girls; children, particularly unaccompanied and separated children; older persons; persons with disabilities; migrants; indigenous groups; racial and ethnic minorities; and sexual and gender minorities. It also highlights that other groups (such as religious and political minorities and marginalised classes or castes) may be disproportionately affected by disasters depending on the local context. The DPR Report suggests that there are at least four underlying factors that cause vulnerable groups to experience disproportionate disaster impacts: (1) direct and indirect discrimination in preparedness and response activities due to pre-existing social marginalisation; (2) vulnerable housing and livelihoods due to pre-existing economic marginalisation; (3) physical, intellectual, psychosocial and sensory impairments that make it harder to escape, or take shelter from, physical hazards during a disaster; and (4) exposure to a heightened risk of violent, exploitative or otherwise harmful behaviours during disasters.⁴³⁶

The groups identified in the DPR Report are potentially just as vulnerable during a PHE as in other types of disaster. As the COVID-19 Pandemic has illustrated, transmission of, and serious illness from, a new disease may be much higher among vulnerable groups, such as racial and ethnic minorities, indigenous communities, migrants, and people with lower socio-economic status as a result of increased exposure, decreased access to (appropriate and adapted) public health measures and/or pre-existing health inequalities.

PHEs may, however, also create additional categories of vulnerable person. Most obviously, those that are particularly susceptible to the specific disease (or other health risk) that causes the PHE will be among the most vulnerable. The nature of PHEs also places those who provide health and social care at far greater risk. Although school children were generally unlikely to be at risk of severe illness from COVID-19, the Pandemic demonstrates the serious impact that a PHE can, nonetheless, have on this group if schools are physically closed. Finally, a PHE can have an impact on migrants and marginalised racial and ethnic groups, who may encounter difficulties in accessing health care and support.

All these groups and more will be considered in turn in this Chapter. However, as the DPR Report sets out,⁴³⁷ there are a number of principles and recommendations that apply generally to the protection of vulnerable groups. These principles apply equally to PHEs. Further, they apply equally to both the eight vulnerable groups identified in the DPR Report and the additional groups identified in this Chapter. A number of the principles have already been mentioned in the context of key elements of a PHE risk management framework (Chapter 4) and the following recommendations, therefore, overlap to some degree with the recommendations made there.



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should:
 - a. be sufficiently comprehensive and flexible to protect and meet the needs of all who are adversely affected by a PHE;
 - b. provide for the participation and representation in all phases of PHE risk management of:
 - i. groups that may be especially vulnerable to the impacts of PHEs; and
 - ii. agencies or organisations (such as social care agencies, National RCRC Societies) whose role includes the care or protection of such groups;
 - c. prohibit discrimination (direct and indirect) in respect of all elements of PHE risk management; and
 - d. take account of – and, where appropriate, incorporate – existing principles, guidelines, standards and tools developed by the international humanitarian community for the protection and inclusion of vulnerable groups.
2. PHE contingency plans should address the specific and additional needs of vulnerable groups during PHEs.
3. PHE preparedness and response activities should be equally accessible to vulnerable groups and, where necessary, adapted to meet the specific and additional needs of vulnerable groups.

The DPR Report also makes specific, detailed recommendations in respect of each of the vulnerable groups it identifies. Given their length and complexity, these recommendations are not all repeated in this Report, but they are equally applicable where the particular groups are affected by a PHE. Where relevant, these recommendations are repeated in this Chapter.

8.2 / PEOPLE AT RISK FROM THE DISEASE

those who are most immediately vulnerable during any PHE are, of course, the individuals who are susceptible to the disease (or other health risk) itself. Although older people and those with underlying health conditions are particularly susceptible to COVID-19, different diseases can – and will – infect or affect different groups. For example, young adults were at particular risk during the 1918 Influenza Pandemic, while pregnant women and their unborn children were at particular risk during Zika virus outbreaks. Other diseases, such as the Ebola virus disease, have been less selective in their impact. AMR is an example of a health hazard that is indiscriminate, with the potential to affect whole populations rather than specific groups. It is, therefore, important that PHE risk management frameworks are sufficiently flexible to accommodate the fact that different groups may be particularly susceptible to the relevant public health risk from one PHE to the next. (Although, as discussed above, it is predictable that certain ‘known’ vulnerable groups will usually be disproportionately impacted.)

The PHE Mappings provide information on the laws and policies governments introduced to protect people that were particularly susceptible to COVID-19.⁴³⁸ The PHE Mappings show that most Sample States recognised the need to provide particular protection to those most at risk of infection or disease, although many different approaches were adopted. They also show that measures adopted to protect the most susceptible groups have to tread a fine line between (1) ensuring that such groups are protected as much as possible and (2) avoiding infringement of their fundamental rights. Shielding, or the voluntary or mandatory isolation of those at risk during the COVID-19 Pandemic, is where this

balancing act was most evident. The state of New York implemented “Matilda’s Law” which required individuals aged 70 and older, and those with compromised immune systems or underlying illnesses, to stay at home. While such measures are obviously taken in the medical interests of those protected, they do raise issues about the rights to freedom of movement, association and family life of those affected.

In other Sample States, a less directive approach was taken to protecting vulnerable groups during the COVID-19 Pandemic. This was sometimes achieved through laws, but more often through the introduction of policies offering enhanced support, such as home delivery of medications to older people, people with chronic illnesses, and those living alone.⁴³⁹ In Brazil, measures were introduced enabling State employees in at-risk groups to work from home. Ordinances were introduced⁴⁴⁰ to protect Brazilian indigenous people, a particularly susceptible group owing to factors such as lifestyle, lack of access to effective monitoring and early-warning systems, and inadequate health and social services. The Ordinances introduced increased restrictions on access by external visitors to indigenous areas, the setting up of temporary hospitals near indigenous communities, faster access to COVID-19 tests, and the donation of hygiene products.⁴⁴¹



RECOMMENDATION

1. Laws, policies and plans relating to PHEs should be sufficiently flexible to accommodate the fact that different groups may be particularly susceptible to the relevant public health risk from one PHE to the next.
2. Laws, policies and practical measures designed to protect those most at risk from the direct impacts of a PHE should:
 - a. take into account and be consistent with the rights of the affected individuals;
 - b. reflect the circumstances of the specific groups being protected; and
 - c. to the extent that they interfere with fundamental rights, be time-bound and proportionate to the public health threat.

8.3 / OLDER PEOPLE AND PEOPLE WITH DISABILITIES OR UNDERLYING HEALTH CONDITIONS

two groups identified by the DPR Report⁴⁴² as particularly vulnerable in the event of a disaster are older persons and people with disabilities or illness.⁴⁴³ Although these groups have distinctive characteristics and needs, they are considered together as many of the issues identified in respect of a PHE are common to both groups. In the case of non-PHE disasters, older people or people with disabilities or illness may be more vulnerable because their needs have been overlooked in disaster planning and response. Factors associated with their age, disability or illness may also place them at more significant risk of being impacted by a disaster. These factors include physical mobility, diminished sensory awareness, special nutritional needs, social isolation and economic constraints.⁴⁴⁴

In addition, in a PHE caused by an infection or disease, these groups may be additionally vulnerable because their age, disability or illness may make them more susceptible to the disease itself. Some of the measures taken to protect individuals from a PHE – such as shielding or compulsory stay at home orders – may also disproportionately affect older people or people with disabilities or illness. Even if unaffected by the relevant disease itself, as has been seen during the COVID-19 Pandemic these groups may be particularly affected by an inability to access their normal health or social care services.

The PHE Mappings provide some information about the impact of PHEs (although in the majority of cases, only COVID-19) on older persons and persons with disabilities or illness. It appears that new laws

have not generally been required during the COVID-19 Pandemic. Instead, governments put in place varying types and levels of support packages or assistance. In Brazil, for example, financial assistance was provided by the Federal Government to nursing homes, rest homes and other institutions dedicated to the care of older people.⁴⁴⁵ In Spain, a contingency fund of € 300,000,000 was earmarked to guarantee care, support, security, and access to food, especially for older persons and persons with disabilities.⁴⁴⁶ In Colombia, people with disabilities are subject to special constitutional protections⁴⁴⁷ to guarantee access to healthcare. Accordingly, “Guidelines for prevention of infection of COVID-19 and health care for people with disabilities, their families, care takers of people with disabilities, and actors in the health sector” were published.⁴⁴⁸ In Sierra Leone, the National Commission for Social Action distributed bags of rice, small payments and other equipment to people with disabilities in district headquarter towns and outreach to people with disabilities continues. The most extensive packages of measures were probably those reported in Australia,⁴⁴⁹ although these did not appear to depend on legislation.

Some of the responses in the PHE Mappings are not, however, as positive. Some PHE Mappings express concern about gaps in care for older persons and persons with disabilities (not just in relation to COVID-19, but in previous PHEs too). In particular, they identify barriers to accessing information, health care and testing during the COVID-19 Pandemic. The UAE sought to mitigate these problems by arranging mobile testing labs and putting in place a programme of home medical visits for people with chronic illnesses. It also initiated a national video awareness campaign with sign language instructions and Braille prints for the blind in both Arabic and English.⁴⁵⁰ In other States, however, people with disabilities are identified as particularly cut off and, in Liberia, are described as suffering food insecurity as a consequence of COVID-19.⁴⁵¹ Finally, an issue identified in a number of States is the treatment of older people in care homes and their restricted ability to access health services or, in one case, be admitted to hospital.

As the DPR Report records,⁴⁵² the humanitarian standards expected for the treatment of older people and people with disabilities during disaster are outlined in the Humanitarian Inclusion Standards for Older People and People with Disabilities.⁴⁵³ Where appropriate, these standards should apply equally to PHEs.



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should:
 - a. make provision for the specific needs of older people and people with disabilities or illness in the event of a PHE, regardless of whether these people are:
 - i. at direct risk from the relevant infection or disease itself; or
 - ii. at indirect risk from the secondary impacts of a PHE;
 - b. ensure the participation and representation in all phases of PHE risk management of older people and people with disabilities or illness;
 - c. ensure that information and support provided during a PHE response is accessible to older people and people with disabilities;
 - d. make provision for continuity of health and social care for older people and people with disabilities or illness during PHEs; and
 - e. have regard to relevant existing international standards and guidelines, such as the Humanitarian Inclusion Standards for Older People and People with Disabilities and the Charter on Inclusion of Persons with Disabilities in Humanitarian Action.

8.4 / PROTECTING WIDER ACCESS TO HEALTH CARE

COVID-19 has shown that the ability of the wider population to access health care for reasons unrelated to the infection or disease at the centre of a PHE can be significantly impacted during a PHE. While this disproportionately affects older people and people with disabilities or illness, it can be an issue for all who need to access health care. One example is the reported stalling of malaria programmes during the COVID-19 Pandemic.⁴⁵⁴ Somewhat surprisingly, the PHE Mappings report say that there were no major problems regarding access to general health care during COVID-19. This may be because the Mappings focused on the laws in place, which may not have contained restrictions on access to health care. Problems in accessing health care have, however, been widely reported throughout the COVID-19 Pandemic as a result of the re-prioritisation or diversion of health care services to focus on COVID-19, fears about contracting COVID-19 in health care environments and lockdown restrictions.

It may be that the issue is not the *presence* of laws, but rather a *lack* of laws protecting the right to health. The right to health is, in fact, mentioned in few of the PHE Mappings. It applies in respect of treatment for the infection or disease at the heart of a PHE itself, but it also has much broader application. The International Covenant on Economic Social and Cultural Rights recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” including a requirement on States to take steps necessary for the prevention, treatment and control of epidemic, endemic, occupational and other diseases and to “assure to all medical services and medical attention in the event of sickness.”⁴⁵⁵ The WHO Constitution provides that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” The extent to which this right is recognised in domestic laws and PHE risk management frameworks is unclear from the PHE Mappings, however it is an essential factor for States to consider as part of PHE risk management.

Informal barriers to accessing health care are reported in the PHE Mappings, although, as these primarily relate to minority groups, they are considered in section 8.8 below. More general barriers were, however, also identified. The increasing use of technology and social media to provide health information to the public potentially disadvantages those without access to the technology or those unfamiliar with its use. A suspicion of health care professionals is another informal barrier. For example, the DR Congo PHE Mapping, reported that individuals’ willingness to engage with healthcare authorities had been hindered by experiences during the Ebola outbreak in 2018.⁴⁵⁶



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should:
 - a. address continuity of general health care services during a PHE to ensure the population can receive treatment for conditions or illnesses unrelated to the PHE;
 - b. have regard to the importance of access to health care and the right to health;
 - c. establish measures to minimise informal barriers to accessing health care.

8.5 / PEOPLE AT ECONOMIC AND FINANCIAL RISK

The DPR Report recognises that pre-existing economic marginalisation can increase vulnerability to disaster: vulnerable housing and livelihoods can expose people to more severe impacts (e.g. mortality, morbidity, financial loss).⁴⁵⁷ In a PHE, there are additional factors: for example, transmission may be higher among people with low socio-economic status, poverty may be a barrier to accessing healthcare (especially in States whose health care systems are primarily run by private providers), or measures taken to address the PHE may disproportionately impact those with low or no incomes. An illustration provided by the Honduras PHE Mapping is how the lack of refrigerators among low-income households, and the resulting inability to store food, means such households are disproportionately affected by curfews and lockdown. If people in such households cannot leave their home, they cannot obtain fresh food and are more likely to run out of food.⁴⁵⁸

The COVID-19 Pandemic has shown that PHEs have the potential to have an economic impact beyond that envisaged in the DPR Report. One of the most significant features of the Pandemic has been the financial consequences of the measures taken to minimise the direct impact of the disease. Lockdowns, curfews, limitations on operating hours and travel restrictions have had severe economic impacts on businesses and workers. In April 2020, the International Labor Organization forecast that globally COVID-19 could cause the equivalent of 195 million job losses.⁴⁵⁹ It assessed that almost 2.7 billion workers were affected by lockdowns, with the sectors most badly affected being: food and accommodation, retail and wholesale, business services and administration and manufacturing. There was particular concern about the impact on the 2 billion people globally who work in the informal economy.⁴⁶⁰ These figures reflect the global nature of the COVID-19 Pandemic, but the economic impact of much more localised PHEs can be just as severe for the communities affected. For example, the World Bank estimated that the Ebola outbreak nearly halved the number of Liberians in employment.⁴⁶¹ In the Caribbean, the United Nations Development Programme (**UNDP**) estimated in 2017 that lost revenue from tourism because of the Zika virus could amount to \$10.5 billion over three years, with the main impact falling disproportionately on the poorest countries in the region.⁴⁶²

Almost without exception, the PHE Mappings show that the Sample States responded to the COVID-19 Pandemic by putting in place varying packages of financial support for businesses and individuals. The sheer number of different measures reported means that – although the PHE Mappings provide important evidence of the types of support offered – a comprehensive analysis of the measures introduced is beyond the scope of this Report, especially as most were not introduced using legislation or other legal instruments.

The most commonly reported form of support was provided to businesses to help them survive any downturn due to the COVID-19 Pandemic and avoid having to lay off employees. Furlough schemes were introduced in a number of Sample States and their detail can be seen in the PHE Mappings.⁴⁶³ Other government acts included waiving or deferring tax payments. In South Africa, for example, a Disaster Management Tax Relief Administration Bill provided for the deferral of provisional tax by qualifying taxpayers and micro businesses, with no penalties or interest levied by the South African Revenue Service as a result of the reduced payment. Less direct interventions were also achieved through governments working with banks to provide new forms of finance, often on advantageous terms, or to relax existing loan or credit agreements. The Liberia PHE Mapping reported specific measures to address a global fall in remittances paid by migrants as a result of COVID-19,⁴⁶⁴ to mitigate COVID-19's impact on the agricultural industry, and, in turn, the livelihoods of most Liberians.

As discussed in section 7.3 above, a flow on consequence of the economic impacts of COVID-19 was on households' ability to continue making rental or mortgage payments. In response, some form of prohibition or grace period on evictions was introduced through legislation in several of the Sample States. In addition, according to the World Bank, 81 countries enacted utility and financial obligation support including waivers and postponements⁴⁶⁵ and the International Labor Organization recorded

that 86 countries had offered social protection housing measures by, for example, providing amnesties for water and electric bills.⁴⁶⁶

In most cases, these measures had to be created rapidly in response to COVID-19. Although there will inevitably have been flaws in these initiatives, the number that were put in place and the speed with which they were established is remarkable. This does, however, point to the need – as already recommended elsewhere in this Report – for: (1) the inclusion of agencies or organisations which may be called upon to provide economic or financial support in PHE preparedness arrangements; and (2) standing laws and/or policies to be established that may be triggered when a PHE occurs, rather than having to be created upon the arrival of a PHE. For example, in a couple of the Sample States,⁴⁶⁷ permanent arrangements for emergency relief funds are in place which were activated when required during the COVID-19 Pandemic.



RECOMMENDATION

1. Domestic laws, policies and plans for PHE risk management should:
 - a. make provision for financial support to be provided to businesses and households in the event that a PHE has significant economic impacts, with priority for the most vulnerable and economically marginalised; and
 - b. ensure the participation and/or representation in all phases of PHE risk management of agencies and organisations which may be required to provide economic and financial support during a PHE.

8.6 / PROTECTING THOSE AT RISK OF VIOLENCE

Most of the PHE Mappings record that incidents of domestic violence (including intimate partner violence and violence against children) increased during the COVID-19 Pandemic. This is largely based on press reports of an increase in the number of cases reported to the police or other authorities and/or calls to domestic violence support organisations.⁴⁶⁸ As the China PHE Mapping comments, many people were unable to escape from violence or abuse or seek protection from their family and friends due to restrictions on movement. In addition, the closure of schools may have removed one of the main protections for children against child abuse: with so many children being educated at home, teachers were not able to monitor their welfare as easily, if at all, and spot and report any signs of abuse. Although very few PHE Mappings comment on the situation in previous PHEs, the Sierra Leone PHE Mapping notes that the Ebola outbreak had a significant detrimental impact on children's lives. Thousands of young girls were left vulnerable due to the very harsh economic impacts of the pandemic, leading to transactional sex for food and other essentials, rape and other forms of abusive sex, and a surge in teenage pregnancy.

A number of the Sample States took specific legislative action to address these problems. Colombia's Decree 460 of March 22, 2020 provided for Family Stations (*Comisarias de Familia*) to tackle family violence during the state of emergency.⁴⁶⁹ Colombia's mayors and governors were directed to provide resources for those seeking assistance and to respond to domestic violence and child abuse cases "in the most immediate fashion".⁴⁷⁰ Brazil's Law 14.222 of 7 July 2020 was implemented in response to an increase in domestic violence following the COVID-19 outbreak. It sought to guarantee public services to tackle domestic violence and to provide assistance to people experiencing domestic violence, even if on a remote basis. The law also categorised as "urgent" any matters related to domestic violence and/or child protection issues during the COVID-19 emergency in order to speed up assistance and support.⁴⁷¹ Likewise, in Mongolia, the Government was required to take measures to intensify the prevention of

domestic violence, provide services to those affected, and make necessary investments in temporary shelters and 24-hour telephone funding.⁴⁷²

Other States appear to have taken less formal steps, most commonly relying on existing legislation or programmes or by providing additional funding. Spain, for example, relied mainly on its existing mechanisms against gender violence. In Australia, funding was provided by the federal government to support people experiencing domestic, family and sexual violence during COVID-19. In Honduras, resources were mobilised to support people experiencing violence, mostly led by the United Nations Populations Fund and supported by public institutions and non-profit organisations. In the DR Congo, in response to the increase in sexual and gender-based violence (**SGBV**), the UNHCR reinforced specific awareness-raising measures, including messaging on SGBV protection and how those affected could access services.

One of the most significant issues facing those affected by domestic violence and abuse is ensuring the ability to escape during compulsory shelter at home or lockdown. Some of the Sample States included exemptions from lockdown rules to permit those at risk to move from their home and, also, where this was otherwise prohibited, stay away from their place of residence.⁴⁷³ In the United Kingdom, for example, the original legislation implementing its lockdown restrictions included an express exemption permitting a person to leave their home to “avoid injury or illness or to escape a risk of harm”.

The child protection risk from school closures is not mentioned in the PHE Mappings except for the Sierra Leone PHE Mapping. Drawing on previous experience with the Ebola outbreak, Sierra Leone produced a COVID-19 Education Emergency Response Plan which included strategies aimed at countering child protection risks that follow school closures (e.g. increased violence against children, gender based violence, sexual exploitation and child marriage).⁴⁷⁴ The negative impacts of physical school closures on children is discussed further in section 8.7 below.

The DPR Report acknowledges the propensity for domestic violence to increase during disasters and to strain existing protection services. It refers to research finding that protection services tend, however, not to have contingency plans in place to ensure continuity of services during disasters. The DPR Report makes several recommendations based on these findings.⁴⁷⁵ As noted above, the risk of increased domestic violence can be even greater in a PHE, compared to other types of disasters. Consequently, the recommendations in the DPR Report are also relevant to PHEs, albeit arguably even more important in this context.



RECOMMENDATION

1. Laws and/or policies should require agencies responsible for domestic or family violence prevention and protection services to develop contingency plans aimed at ensuring continuity of services during PHEs.
2. PHE risk management frameworks (including laws, policies and contingency plans) should address arrangements for enabling those at risk of domestic violence to access refuges or temporary accommodation and other protection services during a PHE.
3. Laws imposing lockdown restrictions during a PHE should expressly permit those experiencing, or at risk of, domestic violence to:
 - a. leave and/or remain away from their homes or place of residence; and
 - b. access protection services and mental health and psychosocial support.

8.7 / SCHOOL CHILDREN

Schooling can be disrupted during most types of disaster. Schools can be used as shelters during disasters, and they can also be physically damaged by disasters. Countries are – or should be – used to managing the impact of an emergency or disaster on schools and the disruption to education that can result. The main difference with PHEs, as has been illustrated by COVID-19, is that the disruption can be much more widespread and of much longer duration.

Without exception, the Sample States physically closed schools at the start of the COVID-19 Pandemic and most moved to on-line teaching. UNESCO reported that by May 2020 there were country wide school closures in 160 countries impacting on over 1.15 billion learners.⁴⁷⁶ The COVID-19 Pandemic was not unique in causing school closures. The Ebola outbreak had an impact on education in Liberia and Sierra Leone and may well have influenced the measures those States took during the COVID-19 Pandemic. For example, during the COVID-19 Pandemic the Sierra Leone government established an Education Emergency Task Force to mitigate the impact of the Pandemic on children and learning and produced a COVID-19 Education Emergency Response Plan relatively early.⁴⁷⁷ The Plan aimed, among other things, at promoting continuity of learning. It outlined strategies to decrease dropouts and to counter child protection risks that follow school closure (e.g. increased violence against children, gender based violence, sexual exploitation and child marriage). The Ministry of Education in DR Congo, with support from UNICEF, also drafted a national education response plan.⁴⁷⁸

The most obvious impact of school closure, the lack of teaching, was addressed in most Sample States by online teaching or learning. How this was achieved, however, varied from State to State. In some States, legislation was used to facilitate the transition to home learning. For example, in Brazil, Ordinance 343 of 17 March 2020 provided for the temporary replacement of in person classes with virtual teaching within the national education system, allowing children continuous access to school content.⁴⁷⁹ In Mongolia, a resolution suspended classroom-based training at all levels of educational institutions until 1 September 2020.⁴⁸⁰ In other States, however, a move to on-line learning was achieved without the need for legislation.

The move to on-line learning was not universal. First, it relied on an assumption that there was a capacity to move from physical to remote learning. This is unlikely to be an option where, as the Honduras PHE Mapping reports, the country's education system was already struggling to provide a universal education. Second, on-line learning requires equipment and infrastructure. The development, at speed, of comprehensive digital learning resources requires access to the necessary technology. In Honduras, it was estimated that of the 2.9 million students, about half were not receiving any classes at all during the COVID-19 Pandemic due to lack of computers or an internet connection at home.⁴⁸¹ Sample States adopted a number of measures to address these issues, such as the loan of laptops or the use of communication methods (e.g. radio) that were not dependent on modern technology.⁴⁸²

It is important to acknowledge that, even where home learning is in place, if children are unable to physically attend school for significant periods of time, it can have significant adverse impacts on their education, social development and physical and mental health. Children who rely on free or discounted school meals for food and healthy nutrition may particularly suffer. Parents with limited education and resources, or who have to telework, may struggle to facilitate or support home learning, and young children may lack the maturity and capacity to adhere to online learning. It also potentially exposes children to an increased risk of abuse because they may be forced to spend all day in an abusive household and they are no longer in classes where teachers can monitor their welfare. A further consequence of school closures – and hence the fundamental importance of integrating education into planning or preparedness for PHEs – is the impact of school closures on parents who may be unable to work or obtain essential supplies if they have to stay home to care for or educate their children. For these reasons, the position of WHO, UNICEF and UNESCO – as well as many national governments – is that schools should be the last place to close and the first to reopen.

This Report has already considered the importance of including the education sector – and the school sector in particular – in PHE risk management frameworks to ensure that impacts on education are anticipated and planned for in PHE preparedness activities (see section 4.5). The analysis above reinforces those recommendations.



RECOMMENDATION

1. Laws, policies and plans for PHE risk management should establish, and be consistent with, the principle that school closure should be a last resort during PHEs.
2. Domestic laws, policies and plans for PHE risk management should enable the participation and representation of schools and school authorities in all phases of PHE risk management.
3. Laws and/or policies should require school authorities and, where appropriate, individual schools to maintain contingency plans to address issues that may arise during a PHE, including:
 - a. identifying alternative means of providing teaching if schools have to physically close;
 - b. addressing the needs of children who may have difficulties accessing alternative learning; and
 - c. identifying practical measures (e.g. biosecurity protocols) to enable schools to remain open (or to re-open) during a PHE.

8.8 / MIGRANTS AND MARGINALISED RACIAL AND ETHNIC GROUPS

the DPR Report considers that migrants and marginalised racial and ethnic groups are at risk of being disproportionately impacted by a disaster due to discrimination and economic marginalisation. Discrimination in disaster preparedness and response may not only be direct, but also may be indirect where programmes and measures are not adapted to the specific needs of these groups – for example, through failure to provide risk information and warnings in diverse languages. Irregular migrants may be at particularly heightened risk due to ineligibility for government programmes and/or an unwillingness to engage with official services out of a fear of enforcement action.⁴⁸³ The potential for these groups to have difficulty accessing necessary health care or other government support during a PHE, although not expressly identified in the DPR Report, is something to which its recommendations may nonetheless be relevant.

The PHE Mappings tend to provide information primarily on the impact of PHEs – and COVID-19 in particular – on migrants. There is, unfortunately, less information on the impacts on marginalised racial and ethnic groups. Consequently, this section will first consider the impacts on migrants and then briefly discuss the impacts of PHEs on the other groups.

8.8.1 / Migrants

The DPR Report recommends that disaster preparedness and response activities should be designed to address the specific needs of migrants, including ensuring that information is accessible to migrants and that irregular migrants are given access to disaster preparedness and response activities.⁴⁸⁴ It recommends that laws and/or policies should draw on the Guidelines to Protect Migrants in Countries Experiencing Conflict or Natural Disaster which provide comprehensive guidance on protecting and including migrants.⁴⁸⁵

The PHE Mappings suggest that particular issues affecting migrants during a PHE include: (1) access to health care; (2) access to support if they find themselves unemployed, possibly homeless; (3) repatriation; and (4) the consequential impact of travel restrictions on migrants' immigration status.

With respect to access to health care, the PHE Mappings reveal a broad range of approaches from States that provide full access to health care through to those which exclude migrants from health care services or only provide partial or conditional access. In many cases, the differential treatment reported may be due to underlying 'situation normal' laws or policies, rather than necessarily being due to COVID-19-specific measures. Overall, the majority of Sample States do permit – or permitted during the COVID-19 Pandemic – access to health care for migrants, albeit in some cases only upon payment or in a restricted form. The approaches to health care provision fall into five broad categories:

- 1. No access to health care.** For example, in Tajikistan refugees were reported to have been deprived of any state benefits and subsidies for vulnerable social groups.⁴⁸⁶
- 2. Access to health care, but for a charge.** For example, in Sri Lanka migrant workers pay to access the private health network. Charges are generally also made for all medical care in Sierra Leone (subject to exceptions for pregnant and lactating women and children under five), although this is in the context of severe shortages of basic medical drugs and equipment⁴⁸⁷ and a health system which, according to its PHE Mapping, faces challenges due to underfunding, a heavy disease burden and vastly insufficient numbers and skewed distribution of skilled health workers.⁴⁸⁸
- 3. Access to health care where a charge would normally be levied but there are specific exceptions.** This is the approach in the United Kingdom which has a list of diseases for which charges cannot be imposed. This list was amended to include COVID-19.⁴⁸⁹ Similar arrangements appear to have been made in New York where receiving COVID-19 care was deemed not to make an individual a 'Public Charge' and/or affect their ability to apply for more permanent immigration status.
- 4. In principle, full access to health care although in practice the ability to receive treatment may be limited.** The limitation may arise because of the need to provide identification documents. This is mentioned in the Brazil and South Africa PHE Mappings. The South Africa PHE Mapping reported undocumented migrants facing significant challenges accessing healthcare (and other assistance) in the absence of government issued social security and identification papers. In China, while basic health services are seen as an essential right, in practice, such services can be less accessible to migrant workers if they do not purchase social insurance.⁴⁹⁰ Alternatively, the principle of full access may be restricted by demand: in Liberia during the Ebola outbreak, although there was no disenfranchisement to healthcare, a lack of resources meant that priority was given to local communities.⁴⁹¹
- 5. Full access on the same basis as nationals.** An example is provided by Spain which recognises access to the national health system as a fundamental right of every person in Spain, with all foreign persons in Spain (including those not registered or authorised as residents) having the right to healthcare under the same conditions as Spanish nationals.⁴⁹² Similarly, in Colombia under the Constitution and Law 100 of 1993⁴⁹³ emergency health access is guaranteed to anyone living in Colombian territory regardless of their immigration status.⁴⁹⁴

Migrants' access to more general support is not as frequently mentioned in the PHE Mappings. However, access to social security, welfare payments and other types of economic assistance can often depend upon an individual's immigration status, including the exact type of visa held. The majority of the PHE Mappings suggest that most financial or welfare benefits provided during the COVID-19 Pandemic were only available to citizens or permanent residents. For example, in the Republic of Korea, the majority of migrants (including undocumented migrants, refugees and asylum seekers) did not have the same entitlements as citizens and residents in respect of emergency disaster relief payments.⁴⁹⁵ There were, however, exceptions to the general approach. In South Africa, for example, refugees, asylum seekers



Bosnia and Herzegovina, 2020. Bosnia and Herzegovina Red Cross provides warm clothing, food, bedding and hot tea to migrants that were forcibly moved after the Lipa camp in the north west of the country burned down. © Bosnia and Herzegovina Red Cross

and certain special permit holders were eligible to claim the South African COVID-19 Social Relief of Distress grant. In New Zealand, a Foreign National Support Programme was established which could be accessed by foreign nationals unable to return to their home country due to COVID-19 restrictions.⁴⁹⁶

In other States, the PHE Mappings suggest assistance was more limited or problematic. In Colombia, the country with the highest number of Venezuelan immigrants,⁴⁹⁷ there were some reports of Venezuelans not receiving assistance,⁴⁹⁸ despite other reports that Colombia had sought urgent international support and set aside funds to support these migrants.⁴⁹⁹ By the time of writing, however, Colombia had announced that it would register hundreds of thousands of Venezuelan migrants and refugees currently in the country without papers, in a bid to provide them with legal residence permits and facilitate their access to health care and legal employment opportunities.⁵⁰⁰ In Honduras, the Center for Help for Returned Migrants was closed by the government because of concerns regarding the spread of the virus when accepting returning migrants from countries with soaring infection rates. There were reports that migrants from El Salvador or Nicaragua making their way through Honduras, on their way to the United States, were left to fend for themselves with no government plan in place for migrants.⁵⁰¹

Access to benefits may, in some immigration systems, have an adverse impact on immigration status and/or undermine applications for permanent residency. In New York, this problem was avoided by certain COVID-19 related services or support – such as COVID-19 testing, health care services, food assistance, unemployment benefits, tenant protection and legal help – being deemed not to negatively affect applications for a US Green card.⁵⁰²

An additional aspect of a serious PHE – as shown by the COVID-19 Pandemic – is that widespread closures of other countries' borders may create problems for migrants: (1) who wish to be repatriated; and/or (2) whose visas may have expired but who are physically unable to leave the country. The first issue has been considered in Chapter 6. With respect to visa expiries, in many of the Sample States, this was addressed by the relaxation of visa requirements. For example, the Colombian Government

allowed individuals with expired immigration documents to remain in the country pending the health emergency and until their visa status could be resolved.⁵⁰³ Similarly, in the UAE, periods of leave were extended, and exemptions issued for visa violations arising as a result of the Pandemic. Tourist, visitor or resident visas that had expired were granted an automatic extension.⁵⁰⁴

8.8.2 / Marginalised racial and ethnic groups

As noted already, the PHE Mappings tend not to provide information specifically in respect of marginalised racial and ethnic groups. The principal impact reported is that these groups may experience language and cultural barriers to accessing information, health care and other assistance during a PHE. For example, the Colombia PHE Mapping reports that Romani could not be treated by health care workers of the opposite sex.⁵⁰⁵ Some of the Sample States took steps to address language and cultural barriers. For example, in the UAE, authorities published public awareness literature in a number of languages (Arabic, Urdu and English).⁵⁰⁶ In Australia, the Commonwealth government funded a national communication campaign to provide COVID-19 information in more than 20 languages.⁵⁰⁷

The PHE Mappings also contain some limited examples of specific new laws or policies being adopted to address the potential impact of COVID-19 on indigenous groups. Brazil took steps to protect its indigenous population⁵⁰⁸ and Australia issued determinations restricting access to its remote indigenous communities to minimise the risk of transmission. The Australian government also established the Aboriginal and Torres Strait Islander Advisory Group on COVID-19 to advise the Department of Health on COVID-19 related health issues and assist with the flow of information within the Aboriginal and Torres Strait Islander health sector.⁵⁰⁹ The Advisory Group implemented a newly created Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19).⁵¹⁰



RECOMMENDATION

Domestic laws, policies and plans for PHE risk management should:

1. ensure the participation and representation of migrants and marginalised racial and ethnic groups in all phases of PHE risk management;
2. establish measures to remove language and cultural barriers to accessing healthcare, information and other supports during a PHE;
3. ensure that migrants have full access to health care during a PHE regardless of their immigration status;
4. address issues for migrants arising due to travel restrictions and border closures during a PHE including:
 - a. extending permissions and visas for migrants who are unable to leave; and/or
 - b. providing exceptions to travel restrictions and border closures (subject to appropriate health safeguards) to enable migrants to be repatriated.

PART D

LEGAL FACILITIES FOR HUMANITARIAN ACTORS



© Philippine Red Cross Society

9 / LEGAL FACILITIES FOR HUMANITARIAN ACTORS

9.1 / INTRODUCTION

The final Part of this Report deals with an initial reason for the initiation of the Law and PHE Project: the impact of the COVID-19 Pandemic on the ability of the IFRC Network and other humanitarian organisations, both domestic and international, to provide support to those affected by the Pandemic and impacted by other disasters occurring during its course.

The practical impact of the COVID-19 Pandemic on humanitarian operations was considerable. As discussed in section 9.3.1, in some States there was uncertainty regarding whether National RCRC Societies were exempt from COVID-19 restrictions on freedom of movement and were, therefore, permitted to move freely throughout the country and access communities. In some States, COVID-19 restrictions meant that the IFRC Network did not have access to its warehouses and pre-positioned stock. Further, of the 100 pandemic related IFRC Network ‘deployments’ to the end of September 2020, 86 had to be carried out remotely.

To investigate the impact of the COVID-19 Pandemic on National RCRC Societies and other humanitarian actors, IFRC Disaster Law commissioned the Emergency Decree Mappings at the start of the Pandemic. The Mappings were mainly produced between March and May 2020 and focus predominantly on legal facilities for humanitarian actors as well as coordination between different actors and the type of restrictions introduced to curb the spread of COVID-19. As the Project developed, this was expanded to include (1) all types of PHE, not just COVID-19 and (2) the facilities available to ‘first responders’,⁵¹¹ both domestic and international.

As mentioned at the start of this Report, while the Emergency Decree Mappings are a valuable source of information, they do have limitations. Firstly, as they were prepared at the start of the COVID-19 response, they can only provide a snapshot of the situation at this point in time. Second, the Emergency Decree Mappings focus predominantly on the effect on IFRC Network components and contain less information on other humanitarian organisations. Third, as the Mappings focus on COVID-19, analysis or lessons drawn from them may not necessarily be relevant to PHEs that are much smaller in scale or different in nature.

9.2 / LEGAL FACILITIES

The focus of this Chapter is legal facilities for humanitarian actors, both domestic and international. The term legal facilities refers to special legal rights that are provided to a specific organisation (or a category of organisations) to enable it or them to conduct operations efficiently and effectively. Legal facilities may come in the form of positive rights (i.e. to do a particular thing), access to simplified and expedited regulatory processes, or special exemptions from a law or legal requirement. Since its inception in 2001, IFRC Disaster Law has had a strong focus on ensuring that legal facilities are available to certain disaster responders in order to support effective disaster response.

It is first and foremost the responsibility of the government of the affected state to address the humanitarian needs caused by a disaster within its borders. National RCRC Societies and other domestic humanitarian organisations in the affected state play a critical supporting role in domestic disaster response operations. In order to perform this role efficiently and effectively, National RCRC Societies and other domestic humanitarian organisations require legal facilities. The DPR Checklist, which was

endorsed by the States parties to the Geneva Conventions and RCRC Movement components in 2019 at the 33rd International Conference of the Red Cross and Red Crescent (International Conference), identifies the types of legal facilities that are required. This includes (but is not limited to): exemptions from taxes levied on relief activities, goods and equipment (including customs duty and VAT); liability protections for staff and volunteers; and automatic or fast-track recognition of professional qualifications across sub-national boundaries.

In the event that a disaster exceeds domestic response capacity, international assistance may be required. The IDRL Guidelines,⁵¹² which were unanimously adopted by the States parties to the Geneva Conventions and RCRC Movement components in 2007 at the 30th International Conference, include recommendations for minimum legal facilities that should be provided to assisting States and eligible assisting humanitarian organisations for international disaster response. This includes (but, again, is not limited to): expedited and simplified customs clearance processes for relief goods and equipment; the expedition of visa processing for relief personnel; the facilitation of relief transport; exemptions from taxes, duties and fees on relief activities; and simplified means for humanitarian organisations to acquire temporary domestic legal personality in order to operate legally in States. There is significant overlap in the legal facilities identified by the IDRL Guidelines and DPR Checklist including, for example, in relation to tax exemptions and recognition of professional qualifications.

While not all the legal facilities identified in the DPR Checklist and the IDRL Guidelines may be applicable to a PHE – and are, therefore, not all discussed in this Part – it remains generally advisable for States to develop standing laws and policies that provide the legal facilities identified in the DPR Checklist and the IDRL Guidelines. This is an important aspect of legal preparedness for disasters generally, and not solely for PHEs.



RECOMMENDATION

Consistent with the DPR Checklist and IDRL Guidelines, States should develop standing laws and policies that provide legal facilities to: (a) domestic humanitarian organisations for domestic disaster response (including for a PHE); and (b) assisting States and eligible assisting humanitarian organisations for international disaster response (including for a PHE).

Mozambique, 2019. Local staff working at the cholera treatment centre that's part of the Red Cross field hospital in Nhamatanda. The cholera treatment area is a fenced and secured area where one gets in and out only through chlorine spraying points.

© Finnish Red Cross / Saara Mansikkamäki



9.3 / THE IMPACT OF COVID-19 RESTRICTIONS

Restrictions were introduced by virtually all governments in response to COVID-19. In many cases, these had a significant impact on IFRC Network and other humanitarian organisations' operations. Such restrictions were not always compatible with the IHR's requirements of avoiding unnecessary interference with international traffic, nor with the temporary recommendations issued by the WHO at the outset of the Pandemic. The potential impact of these restrictions was recognised early on in the Pandemic and prompted the World Health Assembly to call on States:

“to ensure that restrictions on the movement of people and of medical equipment and medicines in the context of COVID-19 are temporary and specific and that they include exceptions for the movement of humanitarian and health workers, including community health workers, enabling them to fulfil their duties, and for the transfer of equipment and medicines required by humanitarian organizations for their operations”.⁵¹³

The restrictions introduced fall into four broad categories: (1) restrictions on internal movement including shelter-in-place orders and lockdowns; (2) mandatory business closure requirements or restrictions on trading; (3) restrictions that had the effect of preventing or inhibiting the cross-border movement of people including border closures, visa suspensions and quarantine; (4) the imposition of restrictions on the import or export of goods, including on PPE and medical supplies. In addition, some issues were caused not by the introduction of new restrictions but by the need for – at times, failure of – governments to lift or waive existing requirements to enable operations to be undertaken. Here, areas identified in the IDRL Guidelines and DPR Checklist are relevant, such as the authorisation or licensing of personnel and the exemption of medical supplies from tariffs and taxes. These various issues are considered in turn below.

9.3.1 / Restrictions on internal movement and business

Restrictions on internal movement were enacted in several ways. In some States, they were found in shelter-in-place orders: people were ordered to remain in their place of residence. In others, movement was restricted to a certain distance around a home or to particular sub-national or local government areas. Elsewhere, movement could be permitted at certain times, but curfews were otherwise imposed. In all cases, the potential obstacles for health care, emergency and humanitarian workers are self-evident.

In the majority of cases, States recognised the need for certain services to be provided notwithstanding these restrictions. Laws therefore frequently included exceptions for certain categories such as emergency service personnel, health care workers or, under a more general heading, those providing “essential services”. In Colombia, for example, provision was made to ensure that the full exercise of rights by medical personnel and any other person related to the health service should not be impeded or obstructed.⁵¹⁴ In Venezuela, public and private actors in the health sector were exempted.⁵¹⁵ Healthcare workers in Jordan were exempted from curfew rules to keep healthcare facilities functioning and ready for patients;⁵¹⁶ and in Kenya, medical professionals and health workers were exempted from the national curfew.⁵¹⁷ Kenya also provided an exemption for “critical and essential services providers”,⁵¹⁸ while South Africa enabled individuals to leave their place of residence “strictly for the purpose of performing an essential service”.⁵¹⁹ In other countries, standing arrangements cut across any specific restrictions. For example, the United States' Emergency Management Assistance Compact ensures that all states can receive aid from other US states during emergencies.⁵²⁰

Where exemptions were available for “essential workers” or “essential services” (or similar), these terms were sometimes defined in the legislation. However, in many cases the definitions were dealt with in policies or guidance, not all of which were accessible to the mappers. The Emergency Decree Mappings also report considerable variation in the definitions. Even where “health care” workers or services were included as essential workers, it was not always clear exactly what this meant and what

health care services were covered. This can be a particular issue for National RCRC Societies and other humanitarian organisations: a number of Mappings report that they were *impliedly* included in exceptions. Relying on implied exceptions is, however, not ideal: it creates uncertainty about whether organisations (and their staff and volunteers) are exempt and may ultimately leave the decision in the hands of enforcement officials.

Some of Sample States⁵²¹ had provisions specifically excepting National RCRC Societies. In the Philippines, for example, a “strict home quarantine” was introduced for the entirety of Luzon. Health workers and volunteers of the Philippine Red Cross were designated as “health and emergency frontline workers”, preserving their ability to travel within Luzon and conduct their activities. More generally, national legislation introduced to facilitate the response and recovery from the COVID-19 pandemic recognised the Philippine Red Cross as “the primary humanitarian agency that is auxiliary to the government in giving aid to the people, subject to reimbursement, in the distribution of goods and services incidental in the fight against COVID-19”.⁵²² Such provisions were, however, unusual: few of the exceptions for “essential workers” specifically referenced National RCRC Societies or other humanitarian organisations.

Another main type of restriction introduced was mandatory business closures or limitations on the ability of businesses to trade. It is rare to find a report of an absolute prohibition on activity. Instead, the measures tended to be directed at non-essential businesses. In the majority of cases “essential businesses” were able to operate, albeit subject to conditions.⁵²³ As with restrictions on movement, there are limited examples of National RCRC Societies and other humanitarian organisations being expressly exempted from this type of restriction. Again, this meant that National RCRC Societies and humanitarian organisations needed to be satisfied that they fell within the range of permitted or excepted essential activities such as health care and residential care services,⁵²⁴ social relief or relief of distress provided to older persons,⁵²⁵ disaster management,⁵²⁶ emergency activities,⁵²⁷ or more generally performing an “essential service”. Colombia offered an exception: its restrictions included express exceptions for the work of all international health organisations.⁵²⁸ The lack of express exemptions and consequent uncertainty had a major impact on National RCRC Societies and led to a significant loss of income. While the latter may have been addressed by government financial support programmes, any uncertainty over the ability of National RCRC Societies and other humanitarian organisations to continue operating is problematic and should be avoided.



RECOMMENDATION

1. Laws that introduce restrictions on internal movement or business operations during a PHE should expressly exempt National RCRC Societies and other relevant humanitarian organisations to enable them to continue to perform their functions (subject to appropriate health safeguards).
2. If exemptions are provided for “essential workers” or “essential services”, the definition of this term should be clear and should include staff and volunteers of National RCRC Societies and other relevant humanitarian organisations.

9.3.2 / Border closures and/or restrictions on entry

Despite the WHO having initially advised against border closures, as soon as the threat of global transmission of COVID-19 became apparent, many States closed their borders in an attempt to manage cross-border contamination risks.⁵²⁹ In some States, closure was not due to direct government action but was a result of transport operators cancelling services. In other States, while borders remained open, governments limited the number of travellers able to enter and/or arriving travellers were subject to quarantine or self-isolation requirements. Only in a very few States were borders kept fully open and

travellers allowed to enter without restriction.⁵³⁰ In the latter case, there should have been no issue for humanitarian personnel seeking entry, subject to any immigration or visa requirements (see below). In all other cases, however, border closures or restrictions on entry could have a significant impact on providing humanitarian relief.⁵³¹

A number of Sample States included express exceptions for humanitarian organisations or operations. In Guinea, for example, humanitarian flights were permitted to operate normally despite the closure of the international airport under a SoE.⁵³² Similarly, in Sudan, the Aviation Authority granted exceptions for humanitarian and medical assistance flights.⁵³³ Although not specifically stated, it is assumed that the exceptions granted to flights would also cover personnel on board. Both Angola and Uganda expressly exempted UN and humanitarian organisations from the prohibitions on entry.⁵³⁴ In other States, exceptions were provided but their application to humanitarian organisations had to be inferred or implied. The Netherlands, for example, permitted entry to “persons with a function or a reason” which extended to international and humanitarian organisations.⁵³⁵ Nigeria granted exceptions to “emergency” and “essential” flights,⁵³⁶ terminology used in a number of other States.

Other States’ laws granted a specified official a discretion to grant exceptions to border closures or restrictions. In these cases, there was typically a general prohibition on the entry of any non-national, but an exception could be granted by a minister or official, normally by application in advance. In Australia, for example, the Chief of the Australian Defence Forces and the Commissioner of the Australian Federal Police⁵³⁷ could permit entry on an exceptional basis. In Poland, the Commander in Chief of the Border Guard could grant foreigners permission to enter.⁵³⁸ Such provisions undoubtedly offer flexibility and they may even have been created to cover the need for entry by humanitarian organisations. However, such discretionary powers raise the risk of delay due to the need for an application to be made and considered. Further, although the Emergency Decree Mappings do not provide evidence to suggest that this occurred during COVID-19, there is also the potential for such discretionary powers to be exercised arbitrarily or to be abused.

Discretionary exceptions, while subject to these limitations, do at least offer some prospect of humanitarian actors gaining entry. In a number of States, it was reported that there were no exceptions available for humanitarian personnel. Cambodia, Thailand and Haiti were, for example, reported to have put in place border closures or entry restrictions without any provision for exceptions to be granted.⁵³⁹ It was also noted that in response to Tropical Cyclone Harold in the Pacific international agencies were unable to enter affected States to provide support.⁵⁴⁰

Both absolute closures and closures subject to discretionary exceptions are in tension with the IDRL Guidelines, which support the principle that States should facilitate the entry of the personnel of eligible assisting humanitarian actors. They clearly have the potential to detrimentally impact the provision of international assistance during a PHE whether in respect of the PHE itself or any other disaster that may occur during the PHE.



RECOMMENDATION

Laws that establish border closures or restrictions during a PHE should expressly exempt the personnel of eligible assisting humanitarian organisations (subject to appropriate health safeguards).

Another restriction on entry can arise where, even if a border remains open, quarantine requirements are imposed. These can be strict, requiring individuals to go into government provided quarantine accommodation for a period of time. Myanmar, for example, required all foreign nationals, not only to provide evidence of absence of infection, but also to undergo quarantine in a Myanmar government

facility for 14 days.⁵⁴¹ Similar requirements were imposed by the Kenyan government.⁵⁴² Other requirements could be less formal, requiring individuals to self-isolate in locations of their choosing.

The risk here is that, even if allowed entry, humanitarian personnel are prevented from immediately performing the functions they are entering the country to undertake. This may be in relation to the PHE but may also frustrate the response to another disaster occurring at the same time. In many cases, there were powers to enable waiver of quarantine requirements, usually at the discretion of medical officers. For example, in the Republic of Korea exemption from the mandatory 14-day quarantine period could be granted to humanitarian personnel through the issue of an Isolation Exemption Certificate.⁵⁴³ Such discretionary exceptions enable States to take a view on the risk posed by incoming humanitarian personnel based on the nature of the particular disease and its prevalence in the country of origin, and to balance this risk against the impact of delaying humanitarian assistance. Membership of a humanitarian organisation does not give an individual immunity from disease and States may therefore legitimately wish to ensure that those coming to their aid will not introduce or transmit disease, especially where – as with COVID-19 – tests do not offer full guarantees that a person is not infected or unable to transmit the disease.



RECOMMENDATION

1. States considering the introduction of quarantine or self-isolation requirements for travellers entering their territory during a PHE should, wherever possible, exempt humanitarian personnel from these requirements.
2. Where automatic exemptions for humanitarian personnel are not appropriate, laws and/or policies should establish clear and objective criteria for granting exemptions.

Another form of restriction on entry is immigration and visa requirements. The IDRL Guidelines recommend that States should grant visas and any necessary work permits, ideally without cost, for the time necessary to carry out disaster relief or initial recovery activities.⁵⁴⁴ A number of the Emergency Decree Mappings record that, although border restrictions were not imposed in response to COVID-19, the suspension of normal visa rules achieved a similar effect. In Indonesia, for example, visas of foreigners who had ever lived in China were the first suspended, followed shortly afterwards by the suspension of all visa free travel for foreigners.⁵⁴⁵ India similarly suspended the visas of foreigners.⁵⁴⁶

There was some evidence of States taking measures to enable access by foreign specialists. For example, the European Commission released guidelines in response to COVID-19 which advised Member States to facilitate border crossing for health professionals and to allow them unhindered access to work in a healthcare facility in another Member State.⁵⁴⁷ Most OECD countries have exempted health professionals with a job offer from visa restrictions and/or travel bans. Most of these relaxations applied only to medical personnel. Humanitarian operations are not, however, normally limited to medics but usually involve other personnel. Further, the Emergency Decree Mappings suggest significant inconsistency in approach across States.

The entry of international personnel may also be facilitated through bilateral agreements: Liechtenstein, Switzerland and Austria, for example, are reported to have entered into an agreement to provide mutual help in crises and catastrophes⁵⁴⁸ which allowed humanitarian actors and first responders to enter countries quickly, bypassing any travel restrictions. Similarly, Armenia has an arrangement with Iran and Indonesia for the deployment of health personnel during PHEs.⁵⁴⁹ These examples suggest that further research could be undertaken to identify when such arrangements exist and explore the increased utilisation of such models to assist the movement of personnel during future PHEs.



RECOMMENDATION

Consistent with the IDRL Guidelines, laws and/or policies should, wherever possible, waive requirements for, or significantly expedite the provision of, visas and work permits for the personnel of eligible assisting humanitarian organisations.

9.3.3 / Professional qualifications

One of the barriers to the provision of disaster assistance identified in the IDRL Guidelines and DPR Checklist is the recognition (or lack thereof) of foreign – or, in the case of federal states, interstate – professional qualifications. In recognition of the importance of this issue, the WHO provides guidance on how countries can allow medical professionals from other regions or jurisdictions to practise in high-need areas, and its JEE Tool scores States on how well they implement systems for sending and receiving medical personnel during an emergency. In the EU, legislation enables professional qualifications for doctors, nurses and veterinarians, among others, to be recognised throughout the EU.⁵⁵⁰ This “free movement of professionals” is not specific to PHEs but is available to be used in an emergency.⁵⁵¹ In the United States, many states’ emergency laws contain “licensure reciprocity” provisions which recognise out-of-state (but not foreign) medical licences for the limited duration of a declared emergency or disaster.⁵⁵² A large number of new provisions of this kind have been rapidly introduced via emergency laws in order to respond to the COVID-19 pandemic.⁵⁵³ While the issue of recognition of professional qualifications is not commented on in the Emergency Decree Mappings, the experience of the COVID-19 Pandemic illustrates that it is highly pertinent to PHEs. The recommendation of the IDRL Guidelines and DPR Checklist on this topic is highly relevant to PHEs and is, therefore, repeated here.



RECOMMENDATION

Consistent with the IDRL Guidelines and DPR Checklist, laws and/or policies should provide for automatic or expedited recognition of foreign and/or interstate qualifications and licences in the event of a PHE or other disaster.

9.3.4 / Restrictions on the import or export of goods and equipment

In general, the import and export of goods has been less restricted during the COVID-19 Pandemic than the movement of people. The Emergency Decree Mappings report very few examples of border closures affecting the movement of goods and equipment. For example, South Africa closed all its land borders but continued to permit the transport of fuel and essential goods.⁵⁵⁴ Similarly, Rwanda permitted the arrival of goods and cargos despite its border closures⁵⁵⁵ and Colombia and Peru allowed any cargo to enter.⁵⁵⁶ Indeed, virtually all the Emergency Decree Mappings referred to borders, ports and airports being open for cargoes, which would in almost all cases have permitted the cross-border movement of humanitarian goods and equipment.⁵⁵⁷

The one area where difficulties have arisen is in relation to goods and equipment used to protect against and treat COVID-19. By the end of July 2020, almost 90 States had introduced export restrictions as a result of the COVID-19 Pandemic.⁵⁵⁸ The USA, for example, issued a temporary rule banning the export of certain goods and equipment, including respirators, surgical masks and medical gloves, without explicit approval from the US Federal Emergency Management Agency.⁵⁵⁹ The European Union introduced export controls on PPE used by doctors and nurses, face masks, face shields, surgical gowns, gloves and other equipment to non-EU countries, without express authorisation.⁵⁶⁰ These types of restrictions could also affect the transit of goods through third party countries.



Bangladesh, Cox's Bazar, 2017. Finnish-Norwegian field hospital in the Rubber Garden, Kutupalong. © Finnish Red Cross

On the other hand, a number of initiatives waived pre-existing restrictions or facilitated the movement of goods and equipment. The WTO Trade Facilitation Agreement (TFA), for example, contains provisions expediting the movement, release and clearance of goods and those in transit. The UN Conference on Trade and Development (UNCTAD) urged countries to address trade facilitation.⁵⁶¹ At the regional level, initiatives are reported, such as the Sistema de la Integración Centroamericana, established to expedite or facilitate the transit of humanitarian relief items shipped by land across all seven Central American states and the Central American Protocol for the Shipment, Transit and Reception of Humanitarian Assistance.

One difficulty evident from the Emergency Decree Mappings is a lack of central information about the various trade restrictions that had been put in place. At times it appears it was difficult for the mappers to identify what import or export restrictions were in force at a particular point in time. Legislation or policy announcements were generally accessible but there was no certainty that those were always up to date. In the absence of consolidated official sources of information, a number of very useful private initiatives filled some of the gaps.⁵⁶² The World Customs Organization published a regularly updated list of States that had adopted temporary export restriction measures for medical supplies in response to COVID-19.⁵⁶³ It is clearly beneficial for humanitarian organisations to have access to up-to-date information on any export restrictions. The creation of a more permanent database may not be practicable as the type of import and export controls mentioned tend to be decided spontaneously in response to specific emergencies. Nonetheless, the provision of information on export and import controls seems a vital tool and probably should not be left to private actors.



RECOMMENDATION

1. States should continue to ensure that laws and/or policies that impose border closures in response to a PHE do not restrict the cross-border movement of relief goods and equipment.
2. Whilst recognising that States may wish to control the export of certain supplies during a PHE to meet the needs of their own populations, States should exempt humanitarian organisations from any restrictions that would impede their ability to import or export relief goods and equipment.
3. States should develop standing laws and policies to facilitate the cross-border movement of relief goods and equipment for international disaster response operations, drawing on the IDRL Guidelines and Guideline 17 (goods and equipment) and 18 (goods and equipment) in particular.
4. In future PHEs, arrangements should be made – building on the example of the World Customs Organization’s database during the COVID-19 Pandemic – to provide up-to-date information on applicable import and export controls worldwide.

9.3.5 / Taxes and tariffs

The IDRL Guidelines and DPR Checklist recommend that eligible assisting humanitarian organisations should be exempted from value added and other taxes or duties directly related to the provision of disaster relief.⁵⁶⁴ In the context of COVID-19, this recommendation appears to have been adopted in a number of the States considered by the Emergency Decree Mappings, especially in relation to the import of PPE and pharmaceutical products. For example, the government of DR Congo exempted the import and sale of pharmaceutical products, as well as medical materials and equipment linked to the pandemic from all duties, taxes, levies and fees.⁵⁶⁵ Singapore exempted the import of listed COVID-19 related goods from the payment of customs.⁵⁶⁶ The Chinese Government similarly exempted materials and goods imported directly by its Health Department for use in the prevention and control of the COVID-19 Pandemic from duties. It also expanded the scope of exemptions for import duties, import value added tax and consumption tax for goods donated to the cause of disease prevention and control.⁵⁶⁷ Venezuela likewise exempted any imports of materials necessary for the manufacture of medicine, polymers, spare parts for machinery and refrigeration equipment as well as specific foods from value added tax.⁵⁶⁸



RECOMMENDATION

Consistent with the IDRL Guidelines and DPR Checklist, States should exempt eligible assisting humanitarian organisations (both domestic and international) from taxes and duties directly associated with their PHE response activities.

APPENDIX 1

EMERGENCY DECREE MAPPING QUESTIONS

1. Is there coordination between state and non-state actors, e.g. through a national emergency response mechanism?
2. Is there mention of the role of Red Cross (RC) or humanitarian actors? In what areas/sectors? What responsibilities are ascribed to RC?
3. Are there exceptions to travel restrictions that will facilitate the movement of RC/humanitarian relief teams and/or aid across borders? What (if any) quarantine requirements or other conditions are attached?
4. Are there exceptions to quarantines, curfews and other restrictions on movement that allow RC/humanitarian organizations access to vulnerable populations (including for psychosocial or non-medical aid)?
5. Have any special legal facilities or exemptions been put in place for the importation of medical aid or other relief items or personnel (International Disaster Response Law)? What (if any) quarantine requirements or other conditions are attached?
6. Is the RC (or humanitarian organizations) categorized as 'essential' or 'emergency' services, for the purposes of exemptions to restrictions on business operations and opening hours?
7. What other measures are provided in the emergency decrees? (for governmental actors, for communities, for health workers, etc).
8. Have restrictions been adopted or put in place that ban the export of protective medical equipment?

APPENDIX 2

PUBLIC HEALTH EMERGENCIES MAPPING QUESTIONS

Legal and institutional frameworks for Public Health Emergencies

1. Please prepare a list of the main laws, policies, strategies and plans relating to public health emergencies (including pandemics or epidemics). For each instrument, please:
 - a. provide the name and date of the instrument;
 - b. identify the main topics it addresses; and
 - c. provide an official copy of the instrument and, if possible, an English translation.
2. Please prepare a list of the main laws, policies, strategies and plans relating to other types of emergencies/disasters (e.g. floods, earthquakes, chemical spills, dam failures, tsunami etc). For each instrument, please:
 - a. provide the name and date of the instrument;
 - b. identify the main topics it addresses; and
 - c. provide an official copy of the instrument and, if possible, an English translation.
3. Does the government have special emergency powers for responding to public health emergencies? If yes:
 - a. What are the government's powers?
 - b. Which government authorities can exercise the powers?
 - c. In what circumstances can the powers be exercised?
 - d. What law are the powers located in? (e.g. Constitution, Emergency Decree, Public Health Act, Disaster Management Act, a combination thereof)
4. Does the government have special emergency powers for responding to other types of disasters/emergencies? If yes:
 - a. What are the government's powers?
 - b. Which government authorities can exercise the powers?
 - c. In what circumstances can the powers be exercised?
 - d. What law are the powers located in? (e.g. Constitution, Emergency Decree, Public Health Act, Disaster Management Act, a combination thereof)
5. Which government and non-government actors does the law identify as responsible for responding to public health emergencies? Please list each relevant actor and describe their roles and responsibilities (as reflected in relevant laws, policies, strategies or plans).

6. Which government and non-government actors does the law identify as responsible for responding to other types of emergencies/disasters? Please list each relevant actor and describe their roles and responsibilities (as reflected in relevant laws, policies, strategies or plans).
7. Is there a coordination mechanism for the actors that are involved in responding to public health emergencies? If yes:
 - a. Who is included in the coordination mechanism?
 - b. Which government actor has overall command and control of the response?
8. Is there a coordination mechanism for the actors that are involved in responding to other types of emergencies/disasters? If yes:
 - a. Who is included in the coordination mechanism?
 - b. Which government actor has overall command and control of the response?
9. What is the role of the National Disaster Management Office/Civil Protection Agency (or equivalent) in relation to public health emergencies? How does this compare to its role in relation to other types of emergencies/disasters?
10. What is the role of the Ministry of Health in relation to public health emergencies? How does this compare to its role in relation to other types of emergencies/disasters?
11. Does the law require government to notify the World Health Organization of any event which may constitute a public health emergency of international concern?

Legal and institutional frameworks in COVID-19

12. Please prepare a list of the main legal and policy instruments the government is using to respond to the COVID-19 pandemic. For each instrument, please:
 - a. provide the name and date of the instrument;
 - b. indicate whether it pre-dated COVID-19 or was introduced in response to COVID-19;
 - c. identify the main topics it addresses; and
13. provide an official copy of the instrument and, if possible, an English translation. Is the government using special emergency powers to respond to the COVID-19 pandemic? If yes:
 - a. What are the government's powers?
 - b. Which government authorities are exercising the powers?
 - c. What law are the powers located in? (e.g. Constitution, Emergency Decree, Public Health Act, Disaster Management Act, a combination thereof)

NOTE: Where possible, when answering questions 14 to 26 below please include information about COVID-19 and one other public health emergency that has affected your country (e.g. Zika, Ebola, SARS, MERS, measles).

Human mobility

14. Has COVID-19 or any other public health emergency in your country led to border closures or restrictions? If yes, were the border closures or restrictions subject to an exception for people seeking asylum?
15. Has COVID-19 or any other public health emergency in your country led to changes in the content or implementation of laws governing asylum seekers and refugees? If yes, what kinds of changes?

For example: suspension of asylum and other procedures; forced returns at borders; non-admission of people seeking international protection; expulsion of refugee and asylum seekers; cessation of search and rescue at sea; refusal to disembark persons rescued at sea.

16. Has COVID-19 or any other public health emergency led to changes in migration patterns in your country?

For example: migrants wishing to be repatriated due to the public health situation in the country or, alternatively, migrants wishing to avoid being repatriated when their visas expire due to the public health situation in their country of origin.

17. If the answer to question 16 is 'yes', did government implement or introduce laws or policies to support:
- a. the repatriation of migrants who wished to return to their country of origin; and/or
 - b. the continued stay of migrants who did not wish to return to their country of origin?

Shelter and housing

18. Has COVID-19 or any other public health emergency in your country led to people losing, or being at risk of losing, their housing? If yes, did government implement or introduce laws or policies to assist people in this situation?

For example: moratoria on evictions; 'pauses' or 'freezes' on rental or mortgage payments; or emergency accommodation

19. During COVID-19 or any other public health emergency in your country, did government implement or introduce laws or policies to assist homeless people and residents of informal settlements to follow public health measures (e.g. handwashing, using mosquito nets, sheltering in place)?

Protection of vulnerable groups

20. Has COVID-19 or any other public health emergency in your country led to widespread loss of livelihoods? If yes, did government implement or introduce laws or policies to provide financial assistance to people that lost their livelihoods? Or, alternatively, to prevent people from losing their livelihoods?
21. Has COVID-19 or any other public health emergency in your country led to an economic downturn? If yes, did government implement or introduce laws or policies to:
- a. Provide financial assistance to struggling businesses; or
 - b. temporarily suspend or relax insolvency/bankruptcy laws?

Would any such laws or policies apply to your country's Red Cross /Red Crescent Society or to other non-profit organisations?

- 22.** During COVID-19 or any other public health emergency in your country, have migrants (including undocumented migrants) been legally entitled to access healthcare and government assistance programs? If yes, did they have the same type of entitlements as citizens/residents?
- 23.** During COVID-19 or any other public health emergency in your country, have internally displaced persons (IDPs) faced discrimination (direct or indirect) in accessing medical care and other forms of assistance?
- 24.** Has COVID-19 or any other public health emergency in your country led to a reported increase in domestic violence and/or child protection issues? If yes, was this addressed by scaling up existing systems or by introducing new laws or policies?
- 25.** During COVID-19 or any other public health emergency in your country, did government implement or introduce laws or policies to protect people that were particularly susceptible to the relevant illness or disease? (e.g. older persons in the case of COVID-19; women of child-bearing age in the case of Zika)
- 26.** During COVID-19 or any other public health emergency in your country, did government introduce or implement laws or policies to ensure that older persons and persons with disabilities had continued access to healthcare, other essential services and essential supplies (e.g. food, medicine)?
- 27.** During the COVID-19 pandemic, have “triage” policies been implemented to govern the allocation of ventilators to patients? If yes, which entity developed the triage policy? Which patients were given priority access to ventilators?
- 28.** During COVID-19 or any other public health emergency in your country, did government implement or introduce laws or policies to mitigate the disruption of schooling for children and to provide safe spaces for children who may be at risk of abuse or neglect at home?
- 29.** During COVID-19 or any other public health emergencies in your country, were there any groups that faced informal barriers to accessing information, healthcare and other assistance? For example: language barriers; cultural barriers; inability to physically access services
- 30.** In the event that an effective vaccine for COVID-19 is developed, are there any laws or policies that would:
 - a.** promote or guarantee the availability of the vaccine to all persons, regardless of factors such as financial means, migration status, age, race etc;
 - b.** make vaccination compulsory or a pre-requisite for attending work or school?

ENDNOTES

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- 159 <https://www.who.int/ihr/publications/WHO_HSE_IHR_2009.3/en/>.
- 160 WHO, 'IHR: A Brief Introduction', p 8.
- 161 Ibid, pp 8 and 9.
- 162 Bartolini, p 233.
- 163 WHO, 'Annual report on the implementation of the International Health Regulations (2005)' A73/14 <https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_14-en.pdf>.
- 164 Stefania Negri, 'Communicable Disease Control' in Gian Luca Burci and Brigit Toebe (Eds), Research Handbook on Global Health Law (Edward Elgar, 2018).
- 165 The lack of enforceable sanctions was described by the H1N1 Review Committee as "The most important structural shortcoming of the IHR ... For example, if a country fails to explain why it has adopted more restrictive traffic and trade measures than those recommended by WHO, no legal consequences follow". H1N1 Review Committee, para 24.
- 166 WHO has already established a Review Committee and an Independent Panel for Pandemic Preparedness and Response to evaluate the global response to COVID-19: see World Health Assembly Resolution WHA73.1, (73rd Session, 19 May 2020) <https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf>; and see 'Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 response' <<https://www.who.int/teams/ihr/ihr-review-committees/covid-19/>>; and 'Independent evaluation of global COVID-19 response announced', (WHO, 9 July 2020); <<https://www.who.int/news/item/09-07-2020-independent-evaluation-of-global-covid-19-response-announced>>.
- 167 Lack of finances, including the lack of an international financing regime or the ability to offer States incentives to implement the IHR have also been cited as factors in States' difficulties in implementing the IHR. However, as the PHE Mappings did not address this, the Report has not considered the financing of implementing measures in detail.

168 See section 3.3.5.

169 Bartolini, p 239 -240.

170 In 2018, 191 States submitted reports. For 2019, the number dropped to 166 (or 84%) but this may have been due to the impact of the COVID-19 Pandemic: see WHO, Annual Report on the Implementation of the International Health Regulations (2005) (2020 IHR Annual Report), 12 May 2020 A73/14, para 9 <https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_14-en.pdf>.

171 Bartolini, p 244.

172 Ibid, p 247; and see Global Preparedness Monitoring Board, A World in Disorder, p 43.

173 See, for example, JH Ausubel and DG Victor, 'Verification of International Agreements' Annual Review of Energy and the Environment 17: 1–43 1992 Rockefeller University <<https://phe.rockefeller.edu/publication/verification-international-environmental-agreements/>>.

174 The International Convention for the Safety of Life at Sea 1974, 1184 UNTS 3; the International Convention for the Prevention of Pollution from Ships 1973/1978, 1340 UNTS 16; the International Convention on Tonnage Measurement of Ships 1969, 1291 UNTS 3; the International Convention on Load Lines 1966, 640 UNTS 133; the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers Convention 1978, 1361 UNTS 2; and the International Regulations for Preventing Collisions at Sea 1972, 1050 UNTS 16.

175 III Code, Preamble.

176 IMO, Auditor's Manual for the IMO Member State Audit Scheme, section 12.

177 Bartolini, p 247.

178 Resolution 3 of the 33rd International Conference, para 3(2) and (3).

179 Argentina Emergency Decrees Mapping, Q1.

180 IMO III Code, para 3.

181 See, for example, IFRC and UNDP, 'The Handbook on Law and Disaster Risk Reduction', 2015, p 21 <<https://disasterlaw.ifrc.org/media/1349>>.

182 Resolution 3(2) of the 33rd International Conference.

183 Sri Lanka PHE Mapping, Q1.

184 Nigeria PHE Mapping, QIV.1.

185 Sierra Leone PHE Mapping, Q1 and Q7.

186 Bartolini, p 247.

187 IMO, Auditor's Manual for the IMO Member State Audit Scheme, section 12.

188 For example, the International Convention on the Safety of Life at Sea requires "parties to communicate to, and deposit with, the Secretary-General of the IMO the text of laws, decrees, orders and regulations and other instruments which have been promulgated on the various matters within the scope of [the Convention]." Protocol of 1988 relating to the International Convention on the Safety of Life at Sea, Art III. Other maritime conventions contain similar provisions: see, for example, the International Convention for the Prevention of Pollution from Ships, Art 11(1)(b) and the International Convention on Standards of Training, Certification and Watchkeeping of Seafarers, Art III(1)(a). The IMO enables States to upload national maritime legislation onto the publicly accessible areas of its Global Integrated Shipping Information System <<https://gis.imo.org/Public/Default.aspx>>.

189 See Bartolini, p 248.

190 See <<https://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-financing-facility>>.

191 See <<https://www.theglobalfund.org/en/>>.

192 See <<https://www.gavi.org>>.

193 See <<https://cepi.net>>.

194 See, for example, <<https://www.imo.org/en/OurWork/TechnicalCooperation/Pages/Default.aspx>>.

195 <https://www.who.int/ihr/publications/WHO_HSE_IHR_2009.3/en/>.

196 See <<https://www.who.int/hac/techguidance/preparedness/WHO-Thematic-Platform-Health-EDRM-Research-Network-2018.pdf?ua=1>>.

197 WHO Thematic Platform for Health Emergency and Disaster Risk Management Research Network (TPRN): Report of the Kobe Expert Meeting. Int. J. Environ. Res. Public Health 2019, 16, 1232 <doi:10.3390/ijerph1607123>.

198 A number of regional early warning systems that are in place to warn of disasters more generally may also apply to PHEs: for example, within the EU and ASEAN.

199 Brazil PHE Mapping: Order No. 1865 of 10 August 2006. See WHO, International Health Regulations (2005): Toolkit for implementation of national legislation, p 136.

200 IHR, art 7(1). The National IHR Focal Point should act in accordance with the IHR decision instrument and also notify WHO of any health measure implemented in response.

201 Switzerland PHE Mapping, Q12; art 80(3) Federal Act on the control of communicable human diseases, 28 September 2012.

202 This may be especially true if there is doubt who is responsible. As an example, PHE Mappings pointed to the disputed role of central and provincial governments in declaring a PHE.

203 See further, Chapter 4.

204 Australia PHE Mapping: National Health Security Act 2007 (Australia), section 19.

205 For a general discussion of these developments, see S. Whitbourn, 'The 'Protection of Knowing': The Evolving Concept of Early Warning and States' Obligations to Inform of Disaster Risk and Warn of Disaster', The Cambridge Handbook of Disaster Risk Reduction and International Law, Eds KLH Samuel, M Aronsson-Storrier and K Nakjavani Bookmiller (Cambridge University Press, 2019), pp131 -149.

206 Sendai Framework, para 18(g).

207 ILC, Draft articles on the protection of persons in the event of disasters, with commentaries, 2 May to 10 June and 4 July to 12 August 2016, A/71/10 <https://legal.un.org/ilc/texts/instruments/english/commentaries/6_3_2016.pdf>, draft art 9(1).

208 Ibid, commentary on draft art 8.

209 DPR Report, Chapter 4, p 67.

210 Ibid, p 77.

211 Ibid.

- 212 Ibid, p 29.
- 213 Ibid, p 33.
- 214 Ibid, p 37.
- 215 Ibid, p 37.
- 216 How to describe those involved in PHE risk management is an issue in itself. Some of the terminology used can in itself be perceived as excluding certain groups or individuals or suggesting that those groups or individuals have a lesser role than should be the case. However, a distinction can perhaps be made between (1) those – typically public authorities – who have specific duties assigned to them, usually in legislation, and (2) those who may not be at the core of the response but can nonetheless make a contribution by providing support, resources or advice or by representing others who may be affected. In recognition of this distinction, this Report uses the term “actor” to describe the key organisations which may exercise executive functions, while the terms “stakeholder” or “participant” are used to describe the wider pool of those involved in PHE risk management.
- 217 Bangkok Principles, Principle 1.
- 218 Ibid, Principle 2.
- 219 United Kingdom PHE Mapping, Q1. See, for example, in England and Wales, the Public Health (Control of Diseases) Act 1984 <https://www.legislation.gov.uk/ukpga/1984/22/contents>. The United Kingdom though also had to pass urgent legislation, the Coronavirus Act 2020, to fill particular gaps and grant enhanced powers, but this still could be described as public health legislation.
- 220 Ibid, Civil Contingencies Act 2004 (United Kingdom) <https://www.legislation.gov.uk/ukpga/2004/36/contents>.
- 221 Australia PHE Mapping, Q2.1. See Biosecurity Act 2015 (Australia Cth), National Health Security Act 2007 (Australia, Cth); Public Health and Wellbeing Act 2008 (Victoria); Public Health and Wellbeing Regulations 2019 (Victoria); Public Health Act 2010 (New South Wales); Public Health Regulations 2012 (NSW).
- 222 Brazil PHE Mapping, Q1 and Q12 and see Ordinance 188 of 3 February 2020.
- 223 Ibid, Decree No 10.211 of 30 January 2020.
- 224 Liberia PHE Mapping: Public Health Law as Revised (2019) (Liberia) http://www.moh.gov.lr/wp-content/uploads/FINISHED-DRAFT-REVISED-PUBLIC-HEALTH-LAW-REPUBLIC-OF-LIBERIA-2019_Validation.pdf.
- 225 China PHE Mapping, Q1 and Q2.
- 226 Republic of Korea PHE Mapping Q2.1; and see Quarantine Act (Act No 9846) (ROK) http://elaw.klri.re.kr/eng_service/lawView.do?hseq=53531&lang=ENG and Infectious Disease Control and Prevention Act (Act No. 17067) (ROK) http://elaw.klri.re.kr/eng_service/lawView.do?hseq=53530&lang=ENG.
- 227 Ibid: Framework Act on the Management of Disasters and Safety (Act No. 15344) http://elaw.klri.re.kr/eng_service/lawView.do?hseq=46614&lang=ENG.
- 228 Sri Lanka PHE Mapping, Q1: for example, Quarantine Ordinance 1897, Constitution of Sri Lanka, Public Security Ordinance 1947 and Disaster Management Act 1947.
- 229 Ibid: Law No. 9 of 24 January 1979 pursuant to which sanitary measures are issued (Colombia).
- 230 Colombia PHE Mapping: Law 1753 of 2015 (Colombia).
- 231 Ibid: Decree 1547 of 21 June 1984 pursuant to which the National Calamity Fund is established and rules are issued for its organisation and operation.
- 232 Ibid: Law No. 1523 of 24 April 2012 pursuant to which the National Risk Management Policy for disasters is adopted and pursuant to which the national system of risk management of disasters and other provisions are made (Colombia).
- 233 Ibid: Constitution of Colombia https://www.constituteproject.org/constitution/Colombia_2005.pdf.
- 234 USA PHE Mapping, Q3.
- 235 South Africa PHE Mapping: Disaster Management Act 57 of 2002 (South Africa) https://www.gov.za/sites/default/files/gcis_document/201409/a57-020.pdf.
- 236 Honduras PHE Mapping: Legislative Decree No. 9-90E, “Law of National Contingencies” (“Ley de Contingencias Nacionales”) (Honduras), December 18, 1990; Legislative Decree No. 217–93, “Law of National Contingencies” (“Ley de Contingencias Nacionales”), October 13, 1993, amending Legislative Decree No. 9-90E (Honduras).
- 237 Ibid, Executive Accord Q32–2010, July 30, 2010 (Honduras).
- 238 Disaster Preparedness and Emergency Management Act 1993 (Jamaica) <https://moj.gov.jm/sites/default/files/laws/The%20Disaster%20Preparedness%20and%20Emergency%20Management%20Act.pdf>.
- 239 See Bangkok Principles, Principle 7.
- 240 Tuvalu PHE Mapping: Public Health Act 2008, s 2.
- 241 It is understood that the Indian Government introduced a Public Health (Prevention, Control and Management of Epidemics, Bio-terrorism Amendment Disaster) Bill in 2017 to make comprehensive provision but the Bill appears not to have become law. See Parikshit Goyal, ‘The Epidemic Diseases Act 1897 Needs an Urgent Review’, Economic and Political Weekly Vol.55, Issue No 45, 7 November 2020 <https://www.epw.in/node/157579/pdf>.
- 242 Uganda Emergency Decree Mapping: https://www.kcca.go.ug/uDocs/public%20health%20act%20Chapter_281.pdf.
- 243 Zambia Emergency Decree Mapping: <http://www.parliament.gov.zm/sites/default/files/documents/acts/Public%20Health%20Act.pdf>. Nigeria>
- 244 Nigeria PHE Mapping: <http://lawsfnigeria.placng.org/laws/Q2.pdf>.
- 245 Grenada Emergency Decree Mapping.
- 246 Lesotho Emergency Decree Mapping: Public Health Order 1970 (Lesotho).
- 247 Liberia PHE Mapping: Public Health Laws 1976 (Liberia).
- 248 Singapore PHE Mapping: Infectious Diseases Act (Singapore), s 2. Although the Act contains a list of specified diseases disaster, it also includes “any other disease that is: (i) caused or is suspected to be caused by a micro-organism or any agent of disease; (ii) capable or is suspected to be capable of transmission by any means to human beings; and (iii) that the Director [of Medical Services] has reason to believe, if left uninvestigated or unchecked, is likely to result in an epidemic of the disease.”
- 249 Republic of Korea PHE Mapping: Infectious Disease Control and Prevention Act (Korea), Art 2(5)

250 Marshall Islands PHE Mapping: Emergencies Act 1979 (Marshall Islands), s 1102 <http://www.vertic.org/media/National%20Legislation/Marshall_Islands/MH_Emergencies_Act.pdf>.

251 Australia PHE Mapping: see Emergency Management Act 1986 (Victoria); State Emergency and Rescue Management Act 1989 (NSW).

252 Iran PHE Mapping, Q2.

253 UNDRR, 'Review of COVID-19 Disaster Risk Governance in Asia-Pacific: Towards Multi-Hazard and Multi-Sectoral Disaster Risk Reduction', 2020 <<https://www.undrr.org/publication/review-covid-19-disaster-risk-governance-asia-pacific-towards-multi-hazard-and-multi>>.

254 UNDRR's Online Glossary <<https://www.undrr.org/terminology>>.

255 Centre for Disease Control and Prevention (USA) Zoonotic Diseases <<https://www.cdc.gov/onehealth/basics/zoonotic-diseases.html>>.

256 <<http://www.fao.org/3/al868e/al868e00.pdf>>.

257 Preneshni R Naicaker, 'The impact of climate change and other factors on zoonotic diseases', Archives of Clinical Microbiology, 2011 <<https://www.acmicrob.com/microbiology/the-impact-of-climate-change-and-other-factors-on-zoonotic-diseases.pdf>>.

258 USA PHE Mapping: North American Plan for Animal and Pandemic Influenza, 33–35, 2 April 2012 <<https://www.phe.gov/Preparedness/international/Pages/napapi.aspx>>.

259 United Kingdom PHE Mapping, Q2: Animal Health Act 1981 ss 29 and 30; and Animal Health Act 2002 (England and Wales).

260 Liberia PHE Mapping: Public Health Act (Liberia), Chapter 17.

261 Ibid: Public Health Act (Liberia), s 17.3. A focal person is appointed to fulfil zoonotic regulatory duties. Risk reduction measures include powers of inspection of places where zoonotic diseases might be harboured.

262 An exception was in the Republic of Korea PHE Mapping where the principal PHE legislation, the Infectious Disease Control and Prevention Act, by its very title makes clear that it is concerned with PHE prevention as well as control.

263 Although coordination and collaboration is considered as a separate topic here, it is closely linked to, and overlaps with, the issues of leadership, participation and representation discussed elsewhere.

264 DPR Report, p33.

265 Colombia PHE Mapping, Q5.

266 South Africa PHE Mapping, Q 2,3,7 and 8.

267 UK PHE Mapping, Q5-7.

268 UAE PHE Mapping, Q7.

269 Bulgaria PHE Mapping, Q7 and 8.

270 Sierra Leone PHE Mapping, Q7

271 UK PHE Mapping: Civil Contingencies Act 2002 (Contingency Planning) Regulations 2005 (United Kingdom).

272 DPR Report, p 37.

273 The PHE Mappings disclose some variations in the way that leadership roles were identified: in some cases, there was express provision in legislation; in others, it was left to plans, policies or guidance.

274 New Zealand PHE Mapping: see Epidemic Preparedness Act 20026 (New Zealand), s 5.

275 DR Congo PHE Mapping.

276 DPR Report, p36.

277 Brazil PHE Mapping, Q5.

278 Republic of Korea PHE Mapping, Q2.5.

279 Colombia PHE Mapping, Q5.

280 Papua New Guinea PHE Mapping, Q3.

281 Republic of Korea PHE Mapping, Q2.5(a): Korea's Safety Index for local governments makes information directly available to citizens through Public Safety Maps accessible on the internet and via a mobile app. It is designed to strengthen citizens' risk awareness and provide an alarm service with real time information using GPS from mobile devices. It also includes a category for public health risks.

282 Liberia PHE Mapping, Q5 and 6.

283 See, for example, the UK PHE Mapping. In the United Kingdom there is an emphasis on planning at the local government level as the cornerstone of DRM See the Civil Contingencies Act 2004 and the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005. Under this system, local responders, principally the emergency services, but also local authorities and agencies with a local presence, are subject to duties to assess risk and prepare emergency plans. Significantly, local health authorities and bodies representing doctors are covered by these duties and are required to collaborate with the other responders through local resilience forums ('LRFs').

284 Colombia PHE Mapping, Q2.7: Law 1505 of 5 January 2012.

285 Ibid. The system also provides incentives for volunteering, such as providing members with social security benefits, educational opportunities and allowances for living expenses.

286 DPR Report, p 32.

287 DPR Report, p 36.

288 SDG Target 3.d.

289 "Social care" is used to cover care provided to individuals, whether older people, people with disabilities or children. It can be provided formally by organisations or informally by communities, families or individuals.

290 Geneva Conventions; Statutes of the International Red Cross and Red Crescent Movement adopted by the 25th International Conference of the Red Cross at Geneva in 1986, amended in 1995 and 2006; Resolution 2 of the 30th International Conference and Resolution 4 of the 31st International Conference.

291 The objects clauses in such legislation are normally phrased so as to include carrying on and assisting in work on, for example, "the improvement of health and the prevention of disease;" or, a common formulation, "in the case of catastrophes or public disasters, to provide victims with relief."

292 Haiti Emergency Decree Mapping, Q2; and IFRC, 'COVID-19 Outbreak Operational Update #9', April 2, 2020.

293 Sudan Emergency Decree Mapping, Q2.

294 Guinea Emergency Decree Mapping, Q2.

295 Guinea Emergency Decree Mapping, Q2.

296 Sudan Emergency Decree Mapping.

297 Bahamas Emergency Decree Mapping, Q2.

298 Guatemala Emergency Decree Mapping, Q2.

299 Zambia Emergency Decree Mapping, Q2.

300 Nigeria Emergency Decree Mapping: see Art. 1(B)(3), National Disaster Response Plan (National Emergency Management Agency) (2002) (Nigeria) <<https://www.refworld.org/docid/5b3f83af4.html>>.

301 Nigeria Emergency Decree Mapping, Q2.

302 The focus of this section is on schools. It should be noted that in many States universities and colleges can be impacted by a PHE and many were during the COVID-19 Pandemic. However, the PHE Mappings were not asked to report on these institutions or their students

303 By the end of April 2020, schools had been required to close in 190 countries, interrupting the education of approximately 1.58 billion learners or just under 92% of the total number of pupils and students. See UNESCO, <<https://en.unesco.org/news/unesco-figures-show-two-thirds-academic-year-lost-average-worldwide-due-covid-19-school>>.

304 DPR Report, p 66.

305 The International Monetary Fund's World Economic Outlook Report published in October 2020 commented in relation to the COVID-19 Pandemic that "Many countries have taken ... fiscal actions amounting to \$11.7 trillion to contain the pandemic and its damage to the economy, as well as central bank actions amounting to over \$7.5 trillion." IMF, World Economic Outlook, October 2020: A Long and Difficult Ascent <<https://www.imf.org/en/Publications/WEO/Issues/2020/09/30/world-economic-outlook-october-2020>>. The overall economic and social burden of the Ebola epidemic/pandemic of 2013 to 2016 was estimated \$53.19 billion. See Caroline Huber, Lyn Finelli, Warren Stevens, The Economic and Social Burden of the 2014 Ebola Outbreak in West Africa, *The Journal of Infectious Diseases*, Volume 218, Issue Supplement_5, 15 December 2018, Pages S698–S704 <<https://doi.org/10.1093/infdis/jiy213>>. See also: World Bank Blogs, Estimating the Economic Cost of Ebola <<https://blogs.worldbank.org/developmenttalk/estimating-economic-cost-ebola>> and US Center for Disease Control and Prevention, 'Cost of the Ebola Epidemic' <<https://www.cdc.gov/vhf/ebola/pdf/cost-ebola-multipage-infographic.pdf>>. The lost GDP in 2003 for the economies of Hong Kong, Singapore and Taiwan as a result of SARS was estimated by the World Bank to have been in the region of \$13 billion, or 1.1% of GDP. The same report estimated the impact of the much more localised outbreak of plague in Surat, India, in 1994 which led to a loss of \$260 million in trade, a loss of exports of \$420 million, and overall economic losses including lost tourism of over \$2 billion. See World Bank Policy Research Working Paper 4466, Milan Brahmabhatt, Arindam Dutta, 'On SARS Type Economic effects during Infectious Diseases Outbreaks, January 2008, p 8 <<http://documents1.worldbank.org/curated/en/101511468028867410/pdf/wps4466.pdf>>.

306 For example, in the UK. See UK PHE Mapping, Q6.

307 DPR Report, p 36.

308 See, for example, the UK PHE Mapping, Q5. The English health care structure includes government departments; a quasi-governmental arm's length national health service; local authorities; clinical commissioning groups; general practitioners and primary care contractors; hospital, mental health, community care and ambulance trusts; private health care providers; and public and private social care providers. And see Nuffield Trust: <<https://www.nuffieldtrust.org.uk/chart/the-structure-of-the-health-and-social-system-in-england>>.

309 Brazil PHE Mapping, Q5.

310 DPR Report, p 59.

311 Ibid, p 59.

312 Ibid, p 60.

313 Ibid, p 61.

314 Honduras PHE Mapping, Q2: Executive Accord 032–2010, July 30, 2010 (Honduras).

315 New Zealand PHE Mapping, Q1.

316 Switzerland PHE Mapping, Q1.

317 UK PHE Mapping, Q5.

318 Singapore PHE Mapping, Q13: Constitution of the Republic of Singapore, Art 64A, as inserted by the Constitution of the Republic of Singapore (Amendment) Act 2020 (No 24 of 2020); <<https://sso.agc.gov.sg/Act/CONS1963#pr64A>>.

319 DPR Report, p 63.

320 Ibid, p 66.

321 DPR Checklist, item 3 and pp 18 and 19.

322 Republic of Korea PHE Mapping: and, for example, Hyonhee Shin, 'South Korea's emergency exercise in December facilitated coronavirus testing, containment', Reuters, 30 March 2020 <<https://www.reuters.com/article/us-health-coronavirus-southkorea-drills-idUSKBN21H0BQ>>.

323 The India PHE Mapping, for example, comments that blanket protections afforded to the Indian government under its legislation (in effect preventing legal proceedings in respect of actions taken in response to a PHE) were met with opposition and controversy, particularly as the imposition of quarantines had been widely viewed as a measure that adversely affected fundamental rights of free movement. It was also noted that the nationwide lockdown was announced with little advance consultation or notice, creating the impression that the central Government had effectively bypassed proper procedure: see India PHE Mapping, Q13.

324 Sierra Leone, PHE Mapping.

325 Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, 5 May 2011, A64/10 <https://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1>; Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, 16 January 2015, EB136/22 <https://apps.who.int/gb/ebwha/pdf_files/EB136/EB136_22Add1-en.pdf>; Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, 13 May 2016 <https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_21-en.pdf?ua=1>; Report of the Ebola Interim Assessment Panel, July 2015 <<https://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf>>.

326 See SARS Expert Committee, 'SARS in Hong Kong: From Experience to Action', October 2003 <<https://www.coronavirus.gov.hk/eng/sars-expert-committee.html>>; and 'Independent SARS Commission Report', December 2006, Ontario <http://www.archives.gov.on.ca/en/e_records/sars/report/index.html>.

327 See, for example, United Kingdom Cabinet Office, 'The 2009 Influenza Pandemic - An independent review of the UK response to the 2009 influenza pandemic', July 2010 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61252/the2009influenzapandemic-review.pdf>.

328 WHO 'Guidance for Conducting a Country COVID-19 Intra-Action Review (IAR)' (WHO, 23 July 2020) <<https://apps.who.int/iris/handle/10665/333419>>.

329 DPR Report, Chapter 5, pp 79 – 91.

330 Ibid, p 80.

331 Ibid, p 79.

332 See, for example, Switzerland PHE Mapping, Q12: Federal Act on the Statutory Principles for Federal Council Ordinances on Combating the COVID-19 Epidemic and Ordinances 1, 2, 3 on Measures to Combat the Coronavirus (COVID-19); Mongolia PHE Mapping, Q11: Law of Mongolia on the Prevention and Fight against COVID-19 Coronavirus Infection and Minimising the Effect on Social Amendment Economic Development; UK PHE Mapping, Q11: Coronavirus Act 2020; and see Q11 or Q12 generally in most of the other PHE Mappings.

333 In some States a formal declaration is not always required in order to trigger emergency powers during a PHE. In these it can be enough that a decision maker is satisfied of the existence of a PHE or that a PHE meets certain pre-prescribed criteria.

334 The reported exceptions were in the Republic of Korea and the United Arab Emirates, although this may reflect the differing meanings of 'emergency powers' across the Sample States.

335 DPR Report, p 80.

336 An example is found in the USA PHE Mapping in the Robert T Stafford Disaster Relief and Emergency Assistance Act 1988 (US).

337 DPR Report, p 79.

338 See, for example, Raoul Wallenberg Institute, 'Pandemic preparedness and response: National COVID-19 Law and policy in human rights perspective', Consultation Draft, 28 January 2021, p 63 <<https://rwi.lu.se/wp-content/uploads/2021/01/Pandemic-preparedness-and-response-in-human-rights-perspective-final-report.pdf>> (The Wallenberg Institute Report).

339 Ibid, p 63.

340 DPR Report, p 83.

341 Ibid, p 90.

342 Ibid, p 90.

343 Brazil PHE Mapping, Q7: Decree No 7.616 of 17 November 2011 (Brazil).

344 Singapore PHE Mapping, Q3: Infectious Diseases Act 1977 (Singapore), s 58.

345 New Zealand PHE Mapping, Q3: Epidemic Preparedness Act 2006 (New Zealand), s 5.

346 Vietnam PHE Mapping, Q3: Law on Prevention and Control of Infectious Diseases 2007 (Vietnam), art 42.

347 For example, the Presidents in Liberia and DR Congo; the State Council in China.

348 DPR Report, p 90.

349 Ibid.

350 Colombia PHE Mapping, Q3: Constitution of Colombia, art 215.

351 New Zealand PHE Mapping, Q3: Epidemic Preparedness Act 2006 (New Zealand), s 5.

352 Papua New Guinea PHE Mapping, Q2: Constitution of PNG, s 228.

353 DPR Report, p 89.

354 Colombia PHE Mapping, Q1.4: Law 1523 of 24 April 2012 National Risk Management Policy for Disasters (Colombia).

355 E.g., UK PHE Mapping Q1: Public Health (Control of Diseases Act 1984 (England and Wales), s 45D.

356 Bulgaria PHE Mapping, Q3: Health Act (Bulgaria), art 63.

357 Singapore PHE Mapping: Infectious Diseases Act (Chap. 137) (Singapore), s 17A <<https://sso.agc.gov.sg/Act/IDA1976#pr17A->>.

358 DPR Report, p 81.

359 The terms appear to have been used inter-changeably in domestic laws but not necessarily consistently with international law definitions, especially in the IHR. A question for further research may be whether there is any material difference or whether distinctions in usage may have substantive legal consequences.

360 DPR Report, p 90.

361 The criteria for self-isolating, especially compulsory quarantining or self-isolation seemed to vary significantly. Some legislation required there to be reasonable grounds that a person was infected; some required there to be just a suspicion that a person was infected; in others, self-isolation could be compelled where there were reasonable grounds that a person had come into contact with an infected individual, whilst in others the threshold for, in effect, house or hotel arrest could be that an enforcement officer suspected a person of being infected or of recently being exposed to the risk of infection.

362 See, for example, Griffiths News 'A timeline of COVID 19 and Human Rights: Derogations in time of public emergency', Griffiths University, 5 May 2020 <<https://news.griffith.edu.au/2020/05/05/a-timeline-of-covid-19-and-human-rights-derogations-in-time-of-public-emergency/>>; Natasha Holcroft-Emmess, 'Coronavirus: States Derogating to Suspend Human Rights Obligations', Oxford Human Rights Hub, 27 March 2020 <<http://ohrh.law.ox.ac.uk/coronavirus-states-derogating-to-suspend-human-rights-obligations/>>; Karima Bennoune, "Lest We Should Sleep": COVID-19 and Human Rights' (American Journal of International Law, Vol 114, Issue 4) <<https://doi.org/10.1017/ajil.2020.68>>; the Wallenberg Institute Report.

363 'OHCHR & Human Rights Committee Address Derogations During Covid-19', 29 April 2020 <<https://ijrcenter.org/2020/04/29/ohchr-human-rights-committee-address-derogations-during-covid-19/>>; and see UN Doc. CCPR/C/128/2, 24 April 2020.

364 Wallenberg Institute Report, p 63.

365 American Association for the International Commission of Jurists, 'Syracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights', 1985 <<https://www.icj.org/wp-content/uploads/1984/07/Syracusa-principles-ICCPR-legal-submission-1985-eng.pdf>>.

366 Ibid, para 25.

367 *Borrowdale v Director General of Health and Others* [2020] NZHC 2090 <https://www.courtsofnz.govt.nz/assets/cases/Borrowdale-v-D-F-of-Health-V_1.pdf>.

368 Dolan v Secretary of Health and Social Care [2020] EWHC 1786 (Admin) <<https://www.judiciary.uk/wp-content/uploads/2020/07/DolanJudgment-FINAL-003-1-1.pdf>>. The English Courts have been less willing to dismiss challenges to restrictions on religious worship: see The Queen (on the application of Hussain) v Secretary of Health and Social Care [2020] EWHC 1392 (Admin) <<https://www.judiciary.uk/wp-content/uploads/2020/06/Transcript-of-Judgment-CO-1846-2020-Hussain-v-SS-for-Health-Social-Care.pdf>>.

369 See DPR Report, p 88.

370 DR Congo PHE Mapping, Q3.

371 Papua New Guinea PHE Mapping, Q; Constitution of PNG, ss 238 and 239.

372 New Zealand PHE Mapping: Epidemic Preparedness Act 2006 (New Zealand), s 16

373 Little mention is made in the PHE Mappings of time limited powers. This may be because COVID-19 Pandemic legislation was amended or replaced so frequently that expiry clauses in many cases were redundant.

374 International Law Association, 'Paris Minimum Standards of Human Rights Norms in a State of Emergency'. See, for example, Richard B. Lillich, 'The Paris Minimum Standards of Human Rights Norms in a State of Emergency' (1985) 79 Am.J.Intl.L. 1072 <<https://doi.org/10.2307/2201848>>.

375 India PHE Mapping, Q13.

376 A downside is that it is not always easy to refer back to Facebook posts or Twitter if it is necessary to access details of the legal measures adopted, so there still remains a place for more formal registering of materials.

377 The analysis in this Part is based on the answers provided in the PHE Mappings. Although the Mapping questions sought information on all PHEs, the majority of the answers are directed solely at the impact of COVID-19. This means that the analysis too is predominately based upon – and records – the laws and policies adopted by States in response to the COVID-19 Pandemic. There are some exceptions but the PHE Mappings therefore provide limited information on measures that may have been taken before 2020. For that reason, some caution needs to be exercised in making too many generalisations about all PHEs based solely on the COVID-19 Pandemic.

378 DPR Report, Chapter 7.

379 DPR Report, Chapter 8.

380 DPR Report, Chapter 9.

381 DPR Report, pp 104 – 105.

382 India PHE Mapping, Q16.

383 This was despite the Emergency Committee under the IHR initially declining to recommend such restrictions on the grounds that, in general, evidence had shown that restricting the movement of people and goods during PHEs may be ineffective, divert resources from other interventions, interrupt needed aid and technical support, disrupt businesses, and have negative effects on the economies of countries affected by the emergencies. WHO, Emergency Committee, Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), 30 January 2020 <<https://reliefweb.int/report/world/statement-second-meeting-international-health-regulations-2005-emergency-committee>>. In certain specific circumstances, though, it was recognised that measures that restrict the movement of people may prove temporarily useful, such as in settings with limited response capacities and capabilities, or where there is high intensity of transmission among vulnerable populations.

384 Honduras PHE Mapping, Q14-17

385 See, for example, Nature, 'What the data says about border closures and COVID spread', 22 December 2020 <<https://www.nature.com/articles/d41586-020-03605-6>>.

386 New Zealand PHE Mapping, Q15.

387 Liberia PHE Mapping, Q14.

388 Australia PHE Mapping, Q3.1.

389 Colombia PHE Mapping, Q 12 and 14.

390 Colombia PHE Mapping, Q14.

391 Liberia PHE Mapping, Q14.

392 Sierra Leone PHE Mapping, Q14.

393 WHO, 'Updated WHO recommendations for international traffic in relation to COVID-19 outbreak', 29 February 2020 <<https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak>>.

394 DPR Report, p 101.

395 IOM, Global Compact for Safe, Orderly and Regular Migration <<https://www.iom.int/global-compact-migration>>.

396 ICCPR, Art 12(2).

397 Ibid, art 12(4).

398 See UK Department for Transport, 'New international commitment to improve seafarers' rights, 9 July 2020, <<https://www.gov.uk/government/news/new-international-commitment-to-improve-seafarers-rights>>.

399 Sri Lanka PHE Mapping, Q16.

400 'Australia's cap on arrivals during Covid pandemic may break international laws', The Guardian, Australia, 22 October 2020 <<https://www.theguardian.com/australia-news/2020/oct/22/australias-cap-on-arrivals-during-covid-pandemic-may-break-international-laws>>.

401 Australia PHE Mapping: and see the Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requirements) Determination 2020.

402 Mongolia PHE Mapping: the Law of Mongolia on the Prevention and Fight against (Covid-19) Coronavirus Infection and minimising the effect on Social and Economic Development (29 April 2020).

403 UAE and Sri Lanka PHE Mappings.

404 Tajikistan PHE Mapping.

405 UNHCR, 'The COVID-19 Crisis: Key Protection Messages', 31 March 2020 <<https://data2.unhcr.org/en/documents/download/75555>>.

406 Ibid.

407 Australia PHE Mapping, Q4.1.

408 Spain PHE Mapping, Q14.

409 Refoulement is an act by a State which results in the expulsion or return of a refugee in any manner whatsoever to the frontiers of territories where their life or freedom would be threatened on account of the refugee's race, religion, nationality, membership of a particular social group or political opinion: see Art 33(1) of the United Nations Convention relating to the Status of Refugees (Refugee Convention), 28 July 1951 <<https://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx>>. The obligation of non-refoulement also arises under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Article 3) and the International Convention for the Protection of All Persons from Enforced Disappearance (Article 16). Equally, an obligation of non-refoulement has been read into the International Covenant on Civil and Political Rights (Articles 6 and 7) and corresponding provisions in regional human rights treaties.

410 UNHCR, 'The COVID-19 Crisis: Key Protection Messages', p 2.

411 Republic of Korea PHE Mapping: <<https://www.nocutnews.co.kr/news/5364399>; <http://futurechosun.com/archives/46950>>.

412 Ibid: <<https://www.nocutnews.co.kr/news/5364399>>; <http://www.hani.co.kr/arti/society/society_general/951608.html>.

413 DPR Report, p 18 and Chapter 8.

414 Mongolia PHE Mapping, Q18.

415 Brazil PHE Mapping, Q19.

416 Spain PHE Mapping, Q19: Progressive Spain, "Regions shelter homeless during coronavirus lockdown" <<http://progressivespain.com/2020/03/24/regions-shelter-homeless-during-coronavirus-lockdown/>>.

417 See Kelly, J. et al. 'Housing equity for health equity: a rights-based approach to the control of Lassa fever in post-war Sierra Leone', BMC International Health and Human Rights, vol. 13, no. 1, 2013.

418 New Zealand PHE Mapping, Q20.

419 Australia PHE Mapping, Q5.2: 'Homes for Homeless Victorians During Pandemic and Beyond', <<https://www.premier.vic.gov.au/homes-homeless-victorians-during-pandemic-and-beyond>>.

420 Ibid: Together Home Program, <https://www.coronavirus.dcj.nsw.gov.au/_data/assets/pdf_file/0006/783366/Together-Home-Program-fact-sheet.pdf>.

421 Honduras PHE Mapping, Q19 & 24.

422 Spain PHE Mapping, Q19.

423 Korea PHE Mapping, Q2.19: <<https://www.japantimes.co.jp/opinion/2020/05/05/commentary/world-commentary/south-korea-stopped-covid-19-early/#.X0fHW8hKhPY>>.

424 Liberia PHE Mapping, Q19: <https://www.unicef.org/evaldatabase/files/Liberia_2010-001_LBR201001_Assessing_WASH_Package_Interventions_in_5_Counties.pdf>.

425 Ibid: <<https://reliefweb.int/sites/reliefweb.int/files/resources/MDR00005OU6.pdf>> page 9.

426 Spain PHE Mapping, Q18.

427 Colombia PHE Mapping, Q18: Decree 579 of 15 April 2020.

428 Sri Lanka PHE Mapping, Q18.

429 Honduras PHE Mapping, Q18.

430 Colombia PHE Mapping, Q18.

431 See, eg, Sierra Leone PHE Mapping, Q18.

432 DPR Report, p 111.

433 IFRC, 'What is Vulnerability?' <<https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/what-is-vulnerability/>>. The UNDRR defines vulnerability as "the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards." UNDRR, Terminology <<https://www.undrr.org/terminology/vulnerability>>. In so far there is any material difference, the IFRC definition is adopted for the purposes of this Report.

434 Ibid.

435 DPR Report, p 18 and Chapter 9.

436 Ibid, p 18–19.

437 DPR Report, pp 114 – 116, and 125 – 129.

438 PHE Mappings generally, Q25.

439 Brazil PHE Mapping, Q23.

440 Ibid: Ordinance 413, from 13 March 2020 and 419 from 17 March 2020.

441 Ibid: Law 14.021.

442 DPR Report, pp 120 – 122.

443 The definition of disabilities used in the Charter on Inclusion of Persons with Disabilities in Humanitarian Action (para 1.3) is used here: "persons with disabilities include those who have long-term physical, psychosocial, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in, and access to, humanitarian programmes.": <<http://humanitariananddisabilitycharter.org>>.

444 In the case of people with disabilities, the Charter on Inclusion of Persons with Disabilities in Humanitarian Action recognises that "persons with disabilities are disproportionately affected in situations of risk and humanitarian emergencies and face multiple barriers in accessing protection and humanitarian assistance, including relief and recovery support." (para 1.5). The Charter provides that "principled and effective humanitarian action will only be realized if humanitarian preparedness and response becomes inclusive of persons with disabilities, in line with the humanitarian principles of humanity and impartiality, and the human rights principles of inherent dignity, equality and non-discrimination?" The Charter applies to situations of risk, including humanitarian emergencies and the occurrence of natural disasters, and at all phases of a humanitarian response, from preparedness and crisis onset through transition into recovery (paras 1.1. and 1.4).

445 Brazil PHE Mapping, Q24.

446 Spain, PHE Mapping Q25: ENI CBC Med, '[TEC-MED] COVID-19 in Spain: impact on the elderly population' <<http://www.enicbcmad.eu/tec-med-covid-19-spain-impact-elderly-population>>.

447 Colombia PHE Mapping, Q23 and 24: Statutory Law 1751 of 2015 (Ley Estatutaria 1751 de 2015), El Congreso de Colombia (Feb 16, 2015), (Available in Spanish): <https://www.minsalud.gov.co/Normatividad_Nuevo/Ley%201751%20de%202015.pdf>.

- Colombia PHE Mapping, Q24.1: Guidelines for prevention of infection of COVID-19 and health care for people with disabilities, their families, care takers of people with disabilities, and actors in the health sector (Mar. 2020), (Available in Spanish): https://ccong.org.co/files/924_at_TEDS02%20-%20Minsalud.pdf. An example given of actions triggered as a result, was the Colombian National Institute of the Blind translating COVID-19 measures into Braille, and providing specific recommendations, such as frequent disinfection of canes, not touching guiders' hands or elbows when they are being guided, and regularly cleaning their guide dog's paws. UN alert regarding protection of people with disabilities (La alerta de la ONU sobre la protección a personas con discapacidad), El Tiempo (Apr. 16, 2020), (Available in Spanish): <https://www.eltiempo.com/politica/onu-alerta-sobre-situacion-de-discapacitados-durante-pandemia-485112>.
- See Australia PHE Mapping, Q6.6.
- UAE PHE Mapping, Q25: https://fcsa.gov.ae/en-us/Lists/D_Reports/Attachments/49/UAE%20Gov%20Initiatives%20to%20Combat%20Covid-19%20-%20En.pdf.
- Liberia PHE Mapping, Q26.
- DPR Report, p 132.
- Sphere, 'Humanitarian Inclusion Standards for Older People and People with Disabilities', 2018 <https://www.spherestandards.org/resources/humanitarian-inclusion-standards-for-older-people-and-people-with-disabilities/>.
- UN News, 'COVID-19 threatens global progress against malaria, warns UN health agency', 30 November 2020 <https://news.un.org/en/story/2020/11/1078752>.
- International Covenant on Economic Social and Cultural Rights, art 12.
- DR Congo PHE Mapping, Q26: Cellule d'Analyse en Sciences Sociales, 'Social Science Support for Covid-19: Lessons Learned Brief 4', 22 May 2020 <https://www.unicef.org/drcongo/media/4141/file/CASS-Brief4-barriers.pdf>, Human Rights Watch, Ida Sawyer, 'Congo's Ebola fight Has Lessons for Covid-19', 26 March 2020, <https://www.hrw.org/news/2020/03/26/congos-ebola-fight-has-lessons-Covid-19>. The principal barriers were (1) a fear of being sent to an Ebola treatment centre: a lack of understanding of Ebola's symptoms led to widespread belief that regardless of infection status, all symptoms would be diagnosed as Ebola, and all sick individuals would be transferred to a centre, even those with only a slight fever; (2) a mistrust of health care workers: this was often related to the perceived high salaries of health care workers and a belief they received payments for transferring patients to centres and, as a result, were betraying their community; and (3) a perceived reduction in health care services.
- DPR Report, p15.
- Honduras PHE Mapping, Q26.
- International Labor Organization, 'COVID-19: impact could cause equivalent of 195 million job losses, says ILO chief' <https://news.un.org/en/story/2020/04/1061322>.
- Ibid.
- The Socio-Economic Impacts of Ebola in Liberia, World Bank, 2015 <https://www.worldbank.org/en/topic/poverty/publication/socio-economic-impacts-ebola-liberia>.
- UNDP, in partnership with the IFRC, 'A Socio-Economic Impact Assessment of the Zika Virus in Latin America and the Caribbean: with a focus on Brazil, Colombia and Suriname', April 2017 <https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/a-socio-economic-impact-assessment-of-the-zika-virus-in-latin-am.html>.
- See Questions 18 to 21 in most of the PHE Mappings.
- https://www.ipsos.com/sites/default/files/ct/publication/documents/2020-05/liberia_report_0.pdf, page 5.
- World Bank, 'Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures', 22 May 2020 <http://documents1.worldbank.org/curated/en/127921590528612831/pdf/Social-Protection-and-Jobs-Responses-to-COVID-19-A-Real-Time-Review-of-Country-Measures-May-22-2020.pdf>.
- International Labour Organization, 'ILO Monitor: COVID-19 and the World of Work, 4th Edition , Updated Estimates and Analysis', 27 May 2020 https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_745963.pdf.
- See, for example, Republic of Korea PHE, Q2.20.
- In Victoria, Australia, a survey of practitioners responding to women experiencing violence stated that 59% reported an increase in the frequency, and 50% an increase in the severity, of violence against women due to COVID-19 (Australia PHE Mapping Q6.5). In Colombia, Line 155 (Linea 155), a 24/7 national, governmentally instituted hotline for women experiencing domestic violence, reported a tripling in the of number of calls relating to violence directed at children: see Colombia PHE Mapping, Q22. In New York, domestic violence reports were up 30% compared to 2019; and in Spain calls to the government's helpline for people experiencing domestic violence rose by 12.4% with a 270% increase in visits to the helpline's website and an 11.6% rise in the proportion of children reporting violence at home. In Tajikistan, a threefold increase was reported in applications to its Gulrukshor Crisis Centre for women who have experienced domestic violence. In the DR Congo, UNHCR recorded 4,463 human rights violations in March 2020, compared to 2,236 violations in February 2020. This included 952 cases of SGBV in March, compared to 714 in February: see UNHCR, 'Update on Covid-19 Response: Democratic Republic of the Congo', July 2020, <https://data2.unhcr.org/en/documents/details/77850>.
- Colombia PHE Mapping: <https://www.minjusticia.gov.co/Portals/0/Normatividad1/ActosAdministrativos/Decretos/2020/DECRETO%20460%20DEL%2022%20DE%20MARZO%20DE%202020.pdf>.
- Ibid: <https://www.minjusticia.gov.co/Portals/0/Normatividad1/ActosAdministrativos/Decretos/2020/DECRETO%20460%20DEL%2022%20DE%20MARZO%20DE%202020.pdf>.
- Brazil PHE Mapping, Q22.
- Mongolia PHE Mapping, Q23.
- Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, Regulation 6 (UK PHE Mapping, Q28).
- Sierra Leone PHE Mapping, Q24: <https://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/sierra-leone-covid19-education-response-plan.pdf.pdf>.
- DPR Report, p 116 – 117 and 129.
- UNESCO, COVID-19 Impact on Education <https://en.unesco.org/covid19/educationresponse>.
- Sierra Leone PHE Mapping Q24 and 25.
- DR Congo PHE Mapping, Q25.
- Brazil PHE Mapping, Q25.

- 480 Mongolia PHE Mapping, Q27: Article 1, Resolution Number 139, Measures to be implemented in the education sector for the prevention of Coronavirus infection (Covid-19).
- 481 Honduras PHE Mapping, Q25: Agencia EFE, 'La mitad de los alumnos en Honduras sin clases por COVID-19 están rezagado' (Trans: 'Half of the students in Honduras without classes are being left behind') <<https://www.efe.com/efe/america/sociedad/la-mitad-de-los-alumnos-en-honduras-sin-clases-por-covid-19-estan-rezagados/20000013-4236192>>.
- 482 With the experience of the Ebola Outbreak, the Liberian authorities launched a radio school initiative. In the DR Congo, the Ministry of Education produced several radio and television advertisements and messages about COVID-19 prevention and distance learning aimed at students and parents. It has also promoted a partnership with Vodacom for the internet-based platform VodaEduc. UNICEF also launched a call on social media asking organizations to share their distance learning initiatives. A dozen organizations responded, and some of them have content based on the Congolese school curriculum. UNICEF is in the process of compiling these learning initiatives and its financial support is also intended to facilitate the translation and recording of additional content for television and radio-based learning packages.
- 483 DPR Report, p 122.
- 484 Ibid, p 135.
- 485 Migrants in Countries in Crisis Initiative, 'Guidelines to Protect Migrants in Countries Experiencing Conflict or Natural Disaster', 10 June 2016 <<https://reliefweb.int/report/world/guidelines-protect-migrants-countries-experiencing-conflict-or-natural-disaster>>.
- 486 Tajikistan PHE Mapping, Q21.
- 487 Sierra Leone PHE Mapping, Q22: <https://archive.is/20110511054708/http://www.kambia.org.uk/information_about/sierra_leone.htm#s-election-921.0-921.208>.
- 488 The Sierra Leone government is reported to have launched the Sierra Leone Social Health Insurance (SLeSHI) in 2018 to improve financial accessibility to health care <https://apps.who.int/iris/bitstream/handle/10665/136868/ccsbrief_sle_en.pdf?sessionid=1CA4D41723C5DC297EECC1F450C53667?sequence=1>; and free health care services are provided in rural areas through the International Organization for Migration's project 'Strengthening Sierra Leonean National Health Care Capacity through Diaspora Engagement' <<https://www.iom.int/news/sierra-leone-diaspora-health-professionals-offer-free-medical-services-rural-communities>> (Sierra Leone PHE Mapping, Q22).
- 489 See, for example, UK PHE Mapping, Q22: the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2020 <<https://www.legislation.gov.uk/uksi/2020/59/contents/made>>.
- 490 China PHE Mapping, Q21: See <<https://clb.org.hk/content/china%E2%80%99s-social-security-system>>.
- 491 Liberia PHE Mapping, Q21.
- 492 Spain PHE Mapping, Q22: Royal Decree Law 7/2018 on Universal Access to the National Health System ("RDL 7/2018"), of 27 July 2018, (Spanish) <https://www.boe.es/diario_boe/txt.php?id=BOE-A-2018-10752>.
- 493 Colombia PHE Mapping, Q21: Pursuant to which the comprehensive social security system is created and other provisions are issued (Por la cual se crea el sistema de seguridad social integral y se dictan otras disposiciones), 23 December 1993 <http://www.secretariasenado.gov.co/senado/basedoc/ley_0100_1993.html>.
- 494 Ibid: 'Migration and health: the national challenge during the age of coronavirus' (Migración y salud: el reto nacional en época de coronavirus), Pontificia Universidad Javeriana Colombia) (Apr. 21, 2020) (Available in Spanish): <<https://www.javeriana.edu.co/pesquisa/migracion-y-salud-el-reto-nacional-en-epoca-de-coronavirus/>>.
- 495 Republic of Korea PHE Mapping, Q21: <<https://www.nocutnews.co.kr/news/5364399>>.
- 496 New Zealand PHE Mapping, Q23.
- 497 Colombia PHE Mapping, Q21: 'Colombia asks for international support to take care of Venezuelan immigrants during the pandemic', Apr. 13, 2020 <<https://www.infobae.com/america/agencias/2020/04/13/colombia-pide-apoyo-internacional-para-atender-migrantes-venezolanos-ante-pandemia/>>.
- 498 Ibid: UNDP, 'Situation of migrants in Latin America within the COVID-19 context', May 19, 2020 <<https://www.latinamerica.undp.org/content/rblac/en/home/blog/2020/la-situacion-de-los-migrantes-en-america-latina-en-el-contexto-d.html>>.
- 499 Ibid: 'Colombia asks for international support to take care of Venezuelan immigrants during the pandemic' (Colombia pide apoyo internacional para atender migrantes venezolanos ante pandemia), infobae, Apr. 13, 2020 <<https://www.infobae.com/america/agencias/2020/04/13/colombia-pide-apoyo-internacional-para-atender-migrantes-venezolanos-ante-pandemia/>>.
- 500 <<https://apnews.com/article/access-to-health-care-health-statutes-colombia-venezuela-7767509edf281a6e0b394d4b0b187eca>>.
- 501 Honduras PHE Mapping, Q21.
- 502 New York PHE Mapping, Q22.
- 503 See Colombia PHE Mapping, Q16 and 17.
- 504 UAE PHE Mapping, Q17.
- 505 Colombia PHE Mapping, Q26.
- 506 UAE PHE Mapping, Q17: <https://fcsa.gov.ae/en-us/Lists/D_Reports/Attachments/49/UAE%20Gov%20Initiatives%20to%20Combat%20Covid-19%20-%20En.pdf>.
- 507 Australia PHE Mapping, pp. 99
- 508 Brazil PHE Mapping, Q 23: See Ordinances 413 of 13 March 2020 and 419 of 17 March 2020.
- 509 Australia PHE Mapping: <<https://www.health.gov.au/committees-and-groups/aboriginal-and-torres-strait-islander-advisory-group-on-covid-19>>.
- 510 Ibid, Q6.10: <<https://www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19>>.
- 511 This term covers a number of actors and includes: (a) professional state or public authority employed emergency personnel – such as fire and police agencies but in the context of PHEs mainly health service workers such as ambulance personnel and paramedics, (b) volunteer community responders; as well as (c) National Red Cross or Red Crescent Societies and other reputable domestic humanitarian personnel, whether professional or volunteer.
- 512 IDRL Guidelines: <<https://disasterlaw.ifrc.org/media/1327>>.
- 513 73rd World Health Assembly, COVID-19 Response, 19 May 2020, WHA73.1 <https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf>.
- 514 Colombia Emergency Decree Mapping, Q3 and see Decree 531 of 8 April 2020.
- 515 Venezuela Emergency Decree Mapping, Q2.

516 Al-Tammemi, AB, 'The Battle Against COVID-19 in Jordan: an Early Overview of the Jordanian Experience', *Frontiers in Public Health*, May7, 2020
[-https://www.frontiersin.org/articles/10.3389/fpubh.2020.00188/full>.](https://www.frontiersin.org/articles/10.3389/fpubh.2020.00188/full)

517 Kenya Emergency Decree Mapping, Q4.

518 Ibid, Q4.

519 South Africa Emergency Decree Mapping, Q4.

520 Stier, D, 'Mutual Aid Agreements: Essential Legal Tools For Public Health Preparedness and Response', *Am J Public Health*. 2007 Apr, 97(Suppl 1)
[-https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1854975/>.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1854975/)

521 Other examples include the Bahamas, Jamaica and Guatemala.

522 See the Philippines Emergency Mapping Decree.

523 See, for example, Ghana Emergency Decree Mapping, Q4.

524 See, for example, Antigua Emergency Decree Mapping, Q6.

525 See, for example, South Africa, Q4.

526 See, for example, South Africa, Q4.

527 Colombia Emergency Decree Mapping, Q4.

528 Colombia Emergency Decree Mapping, Q4.

529 OECD Policy Responses to Coronavirus (COVID-19) No policy maker is an island: The international regulatory co-operation response to the COVID-19 crisis (June 8, 2020) [-http://www.oecd.org/coronavirus/policy-responses/no-policy-maker-is-an-island-the-international-regulatory-co-operation-response-to-the-covid-19-crisis-3011ccd0/>.](http://www.oecd.org/coronavirus/policy-responses/no-policy-maker-is-an-island-the-international-regulatory-co-operation-response-to-the-covid-19-crisis-3011ccd0/)

530 At the time of the Emergency Decree Mappings, Mexico, Zimbabwe and the United Kingdom, for example, appear not to have adopted any COVID-19 related prohibitions.

531 One upside of the restrictions on international workers was that it forced agencies to allow more leadership of local actors, thereby (unintentionally) addressing previous complaints that the excessive volume of international deployments displace and dis-empower local responders. Nonetheless, blanket bans are the not the preferred way of achieving this result because it also blocked some expertise and goods that were really needed. See, for example, IFRC Pacific National Societies respond to Cyclone Harold in the Time of COVID-19, 29 April 2020 [-https://media.ifrc.org/ifrc/2020/04/29/pacific-national-societies-respond-cyclone-harold-time-covid-19/>.](https://media.ifrc.org/ifrc/2020/04/29/pacific-national-societies-respond-cyclone-harold-time-covid-19/) and Australian Red Cross, Humanitarian Advisory Group and the Institute for Human Security and Social Change La Trobe University, A Window of Opportunity: Learning from COVID-19 to Progress Locally Led Response and Development Think Piece', November 2020 [-https://humanitarianadvisorygroup.org/wp-content/uploads/2020/12/A-Window-of-Opportunity-COVID-think-piece-24-November-2020.pdf>.](https://humanitarianadvisorygroup.org/wp-content/uploads/2020/12/A-Window-of-Opportunity-COVID-think-piece-24-November-2020.pdf)

532 Guinea Emergency Decree Mapping, Q3.

533 Sudan Emergency Decree Mapping, Q3.

534 Uganda Emergency Decree Mapping, Q3: COVID-19 Prohibition Regulations 2020 (Uganda), regulation. 3(a); Angola Emergency Decree Mapping, Q3. This may, however, have been under more generic rules for the entry and movement of UN personnel, for example, based on the 1946 Convention on the Privileges and Immunities of the United Nations.

535 Netherlands Emergency Decree Mapping, Q3.

536 Nigeria Emergency Decree Mapping, Q3.

537 BDO in Australia, 'Travel Exemptions – COVID-19 Border Measures', 27 July 2020 [-www.bdo.com.au/en-au/insights/migration-services/articles/travel-exemptions-covid-19-border-measures>.](http://www.bdo.com.au/en-au/insights/migration-services/articles/travel-exemptions-covid-19-border-measures)

538 Poland, Emergency Decree Mapping, Q3.

539 Cambodia, Thailand and Haiti Emergency Decree Mappings, Q3.

540 See, for example, IFRC Pacific National Societies respond to Cyclone Harold in the Time of COVID-19, 29 April 2020 [-https://media.ifrc.org/ifrc/2020/04/29/pacific-national-societies-respond-cyclone-harold-time-covid-19/>.](https://media.ifrc.org/ifrc/2020/04/29/pacific-national-societies-respond-cyclone-harold-time-covid-19/)

541 Myanmar Emergency Decree Mapping, Q3.

542 Kenya Emergency Decree Mapping, Q3.

543 Republic of Korea Emergency Decree Mapping, Q1.3.

544 IDRL Guidelines, para 16.

545 Indonesia Emergency Decree Mapping, Q3.

546 India Emergency Decree Mapping, Q3.

547 Guidelines on EU Emergency Assistance in Cross-Border Cooperation in Healthcare related to the COVID-19 crisis, European Commission, April 2020 [-https://ec.europa.eu/info/sites/info/files/guidelines_on_eu_emergency_assistance_in_cross-bordercooperationin_healthcare_related_to_the_covid-19_crisis.pdf>.](https://ec.europa.eu/info/sites/info/files/guidelines_on_eu_emergency_assistance_in_cross-bordercooperationin_healthcare_related_to_the_covid-19_crisis.pdf)

548 WHO, Joint External Evaluation of IHR Core Capacities of the Swiss Confederation and The Principality of Liechtenstein, World Health Organization (November 2017) [-https://apps.who.int/iris/bitstream/handle/10665/274958/WHO-WHE-CPI-2018.26-eng.pdf?ua=1>.](https://apps.who.int/iris/bitstream/handle/10665/274958/WHO-WHE-CPI-2018.26-eng.pdf?ua=1)

549 WHO, Joint External Evaluation of IHR Core Capacities of the Republic of Armenia, World Health Organization (August 2016). [-https://apps.who.int/iris/bitstream/handle/10665/254745/WHO-WHE-CPI-2017.14-eng.pdf?sequence=1>.](https://apps.who.int/iris/bitstream/handle/10665/254745/WHO-WHE-CPI-2017.14-eng.pdf?sequence=1)

550 Directive 2005/36/EC on recognition of professional qualifications.

551 European Commission, 'Internal Market, Industry, Entrepreneurship, and SMEs: Recognition of professional qualifications in practice' [-https://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition_en>.](https://ec.europa.eu/growth/single-market/services/free-movement-professionals/qualifications-recognition_en)

552 See Institute of Medicine of the National Academies, "Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response" (The National Academies Press, 2012), p 57.

553 See also Federation of State Medical Boards, 'U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19', 26 May 2020 [-https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensure-requirements-covid-19.pdf>.](https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensure-requirements-covid-19.pdf)

554 South Africa Emergency Decree Mapping, Q3.

555 Rwanda Emergency Decree Mapping, Q3.

- 556 Colombia and Peru Emergency Decree Mappings, Q3.
- 557 More generic regional or bilateral instruments not included in the Emergency Decree Mapping may also have enabled more flexible arrangements for the supply, transit or receipt of goods and equipment.
- 558 World Trade Organization, 'COVID-19 and world trade', 2020 <https://www.wto.org/english/tratop_e/covid19_e/covid19_e.htm>.
- 559 Ibid.
- 560 EU Commission Implementing Regulation (EU) 2020/568 of 23 April 2020 making the exportation of certain products subject to the production of an export authorization: <<https://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1587740775954&uri=CELEX:32020R0568>>.
- 561 UNCTAD, 'How Countries Can Leverage Trade Facilitation to Defeat the COVID-19 Pandemic', <https://unctad.org/en/PublicationsLibrary/dtlinf2020d2_en.pdf>.
- 562 See, for example, Arent Fox 'Reference Guide: Worldwide Export Controls on Face Masks and Other Medical Personal Protective Equipment' <<https://www.arentfox.com/perspectives/alerts/reference-guide-worldwide-export-controls-face-masks-and-other-medical-personal>>.
- 563 COVID-19 - WCO updates <<http://www.wcoomd.org/en/topics/facilitation/activities-and-programmes/natural-disaster/coronavirus.aspx>>.
- 564 IDRL Guidelines, para 21; DPR Checklist, Question 6.
- 565 KPMG, 'Democratic Republic of Congo (DRC): Tax developments in response to Covid-19', 3 April 2020 <<https://home.kpmg/xx/en/home/insights/2020/04/democratic-republic-of-congo-tax-developments-in-response-to-Covid-19.html>>.
- 566 Singapore Emergency Decree Mapping.
- 567 China Emergency Decree Mapping, Q5.
- 568 Venezuela Emergency Decree Mapping, Q4.



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