Law, Disasters and Public Health Emergencies in the Pacific

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Address: Chemin des Crêts 17, Petit-Saconnex, 1209 Geneva, Switzerland

Postal address: P.O. Box 303, 1211 Geneva 19, Switzerland

T +41 (0)22 730 42 22 | **F** +41 (0)22 730 42 00 | **E** disaster.law@ifrc.org | **W** disasterlaw.ifrc.org

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 our partners, who include academic institutions, law firms, governmental authorities and National Red Cross and Red Crescent Societies.

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Pacific Resilience Partnership
Technical Working Group on Risk Governance

The Pacific Resilience Partnership Technical Working Group on Risk Governance brings together Pacific Island risk management practitioners, law and policy makers as well as regional partners. The working groups seeks strengthened risk governance for resilient development in the Pacific through strengthening regional collaboration, promoting best practices, providing guidance for national policy and legislation development processes and facilitating exchange of lessons learned with an initial focus on the development and implementation of climate smart disaster risk management legal frameworks

www.resilientpacific.org/pacific-resilience-partnership/

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Foreword

Underpinning all aspects of the COVID-19 response around the world are laws and policies. Laws and policies have enabled states of emergencies to be declared, lockdowns to be imposed, and more recently, expedited vaccine approval.

In many countries, old laws and contingencies plans have been dusted off, sometimes proving to be outdated or inadequate, requiring the rapid development of new laws and regulations. Never before have so many laws been made in such a short time.

Law and policy form the foundation of disaster risk management, regulating how, when and by whom emergency response activities are carried out. Without a strong legal base, preparedness and response activities can be uncoordinated and ineffective, often delaying urgent help to the people that need it most.

Domestic legal preparedness for disasters needs to include and integrate public health emergencies to best help keep communities safe, protects the most vulnerable and save lives.

Our new report, Law, Disasters and Public Health Emergencies in the Pacific looks at the intersection of public health emergencies and conventional disaster risk management approaches in the Pacific.

The Pacific is home to many natural hazards and the harsh reality of climate change, and therefore home to many experienced national and local responders with tried and tested disaster management systems. Many of these systems were put to the test during COVID-19, not only in response to the pandemic but also for various weather-related disasters during this period. This experience demonstrated the need for integrated and well-coordinated responses to multiple hazards.

These challenges and the identified need to strengthen health systems across the Pacific region meant that the consequences of COVID-19 outbreaks were potentially disastrous. The memory of the 1918 flu epidemic in the region, when over 20 per cent of the Samoan population died, remains strong, and the Samoan measles outbreak in 2020 is a recent reminder of the consequences of disease spreading in an unvaccinated vulnerable population.

For this reason, states across the Pacific region, including New Zealand and Australia, adopted a strategy of isolation and elimination. This was in direct contrast to the rest of the world who largely adopted a policy of disease management. This policy was made possible by the oceanic nature of these states and early decisions to close the international borders, in some cases completely.

As a result of this early action and intentional policy decisions, most of the Pacific remained free of COVID-19 for a long period. During this period, the region and the states studied did not experience the virus in terms of a health crisis. Instead, this prolonged isolation caused severe social and economic impacts, requiring an all of government and society approach.

This situation has now changed in some Pacific countries, showing the consequences of adopting a disease management approach in a region such as the Pacific and providing evidence for the validity of the region's unique 'isolate and eliminate' strategy.

The Pacific's response to COVID-19 was resilient, with a sense of solidarity and ingenuity, and as a result, there are many lessons to learn from their experiences both in terms of multi-hazard response and how that has been formalised in relevant laws, policies and plans.

However, the experiences have also exposed significant weaknesses and gaps, both in terms of policy and practice. If the COVID-19 pandemic has taught us anything, it is the importance of being ready for the challenges a pandemic creates. Part of this requires effective public health emergency law and policy, as part of a wider disaster law framework.

When Pacific governments emerge from the current crisis, many will wish to draw on the experience of the COVID-19 pandemic to review and strengthen their domestic legal frameworks.

As the global leader in disaster law, with 20 years of experience developing and implementing law and policy, we stand ready to work with Pacific National Red Cross Societies, the Pacific Resilience Partnership and Pacific governments to prevent and reduce the impact of disasters and protect the most vulnerable.

Katie Greenwood

Head of Delegation, IFRC Country Cluster Delegation for the Pacific

Executive Summary

Law, Disasters and Public Health Emergencies in the Pacific, analyses laws, policies, and to the extent possible, practice between the level of integration and cohesion between disaster risk management and public health emergency frameworks across eight Pacific countries; Fiji, Papua New Guinea, Samoa, Solomon Islands, Marshall Islands, Tonga, Tuvalu, and Vanuatu.

The research was carried out in partnership with the Pacific Resilience Partnership (PRP) Technical Working Group on Risk Governance[v] and the International Federation of Red Cross and Red Crescent Societies (IFRC).

The report provides regional analysis, country-level mappings, and recommendations on how to future-proof disaster law frameworks to better integrate public health emergency measures.

The main frame for reference and assessment for the research is the Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction (the Bangkok Principles). The Bangkok Principles provide a blueprint for integrating health and disaster management planning, policy, and law. They emphasize the commonalities between health risks (biological hazards) and natural hazards, and the need for them to be addressed through disaster risk management approaches, risk assessments, surveillance, and early warning systems.

The report finds that, like other countries around the world, there is a level of formal disconnect between public health emergency and traditional disaster risk management in the Pacific Island states studied. However, the research also demonstrates that Pacific Island states have proved adept at responding to the very different nature of COVID-19 in the region. In many cases, Pacific Island states have effectively coordinated responses regardless of gaps in the relevant legal frameworks.

Law, Disasters and Public Health Emergencies in the Pacific provides comments on the future direction of law and public health emergencies and that integration between health and the disaster risk management law and policy framework appears higher than the global average.

However, the continued use of parallel planning and response structures needs to be examined. This is particularly in the light of COVID-19, where the biological hazard, although requiring a significant role for the health sector, has largely led to an economic and social disaster in the Pacific context, requiring a coordinated logistical, economic and social response.

As witnessed in the region and globally, every sector of society has been impacted by this pandemic. Often the pandemic has played out against the dual impact of other hazard events, such as Tropical Cyclone Harold, which drove a destructive path through the Pacific at the outset of COVID-19 in 2020. This has further highlighted the need for multi-hazard approaches to be entrenched in domestic preparedness and response systems, including an all of government – and all of society – coordination mechanisms.

This calls into question the need for greater clarity and leadership roles for disaster risk management practitioners in the prevention, preparedness and responses to public health emergencies. While there are some limitations in the Pacific, there are also many examples of good and innovative practices which can inspire as we look to strengthen legal preparedness for future disasters in the Pacific – be they geological, meteorological or biological.

Regional, national and local partners across the Pacific are encouraged to use this Report's findings and recommendations to support more inclusive and coherent approaches in laws and policies for disaster events in the region.

Key Findings

- The majority of Pacific Island states examined, formally operate hybrid frameworks (frameworks mainly based on public health emergency legislation, but with disaster risk management and/or SoE laws supporting and supplementing that legislation to a lesser or greater extent).

- In practice, however, most have a separate and parallel structure for biological hazards/ health risks in contrast to hazards that are geological or meteorological in nature.

- The disaster risk management framework plays a larger role in Pacific hybrid frameworks than in other global examples.

- The existence of hybrid frameworks did allow states to adapt to the very different requirements of the global pandemic in the Pacific.

- A role for the National Disaster Management Office is common in the health emergency structure in the Pacific. This proved vital in allowing multi-hazard responses to cope with the pandemic.

- Most Pacific Island states appear to have developed models to allow some level of integration of health and other disasters, beyond that seen in many non-Pacific models (and in metropolitan Pacific states).

- The regional framework played a key role in the Pacific response through the Pacific Humanitarian Pathway – COVID-19. It showed the potential for more formalised regional approaches to coordination for disasters and emergencies in the region.

- The legal gap around the realities of COVID-19 meant that the legal frameworks existing in almost all the Pacific Island states studied were exposed.

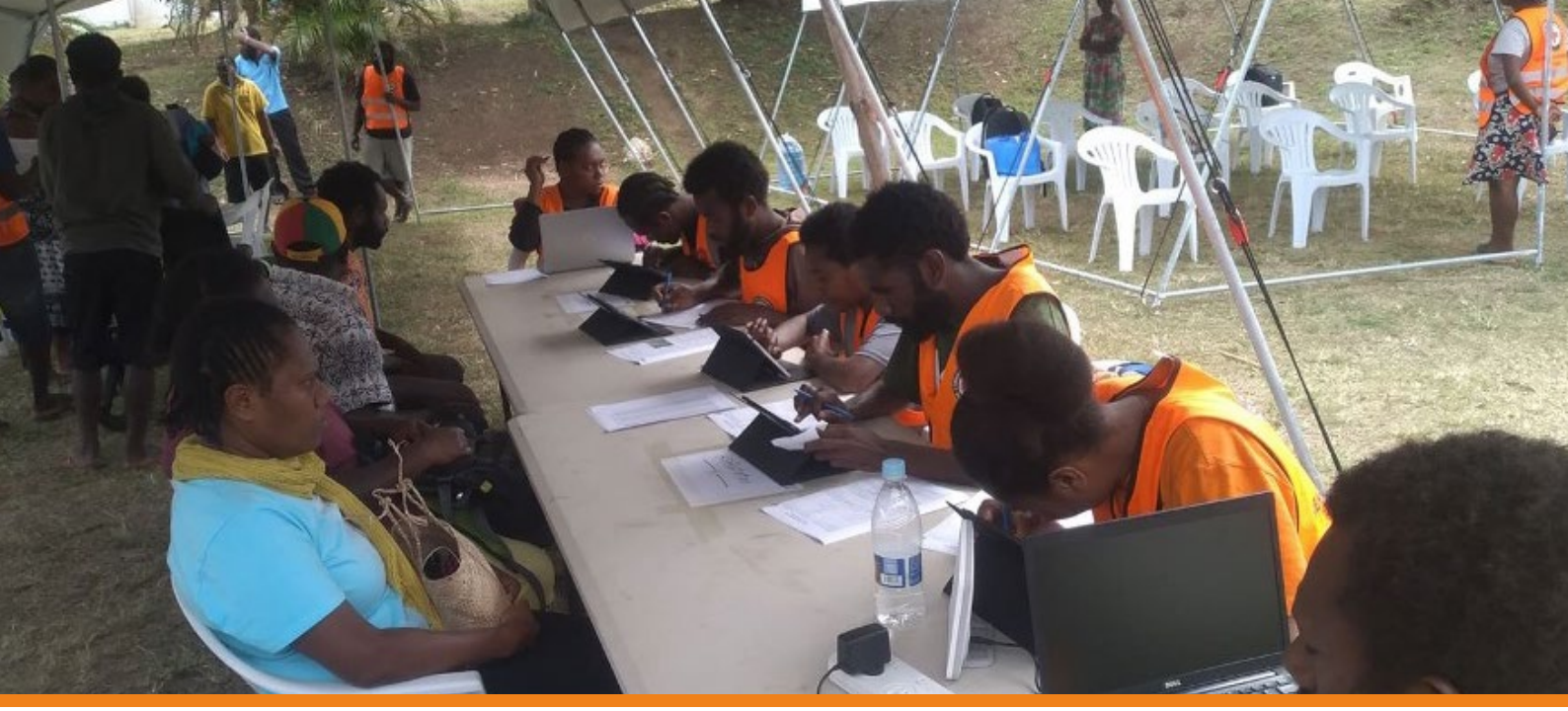
- This resulted in new emergency regulations and long states of exception (emergency/ disaster, etc.) in many states.

- This normalisation of the exceptional has led inexorably to executive creep and the normalisation of exceptional measures. This has created wider constitutional issues in many Pacific Island states.

- Without culturally relevant checks and balances, some states risk living in a semi-permanent state of exception and emergency given the likelihood of continued crisis in the wake of climate change and future pathogen driven disasters.

Key Recommendations

- The creation of single statute disaster law frameworks (to include public health emergencies) in those states where no such statutory framework exists.
- The creation of clear statutory frameworks around public health emergencies (identified as such) as part of a wider disaster law framework to address the regulatory needs of public health emergencies.
- Coherence between legal frameworks on disaster preparedness, response and recovery, across all hazards, including public health emergencies
- The streamlining of disaster law and public health emergency frameworks, with an emphasis on local relevance, simplicity and clarity of operation.
- The creation of legal frameworks to address long duration disasters, while complying with the rule of law and democratic principles, without the need to utilise long term states of exception.
- Explicit and improved integration of NDMOs into the public health emergency law framework
- The establishment of regional/international legal arrangements around logistical cooperation in national, regional and global disasters leading to long term isolation for Pacific Island states.
- Greater consideration of the role and protection of vulnerable groups (and individuals) within Pacific disaster law frameworks, particularly in relation to long term disasters (such as public health emergencies).
- The further development and formalisation of regionally led disaster and public health cooperation mechanisms under the Pacific Forum's Boe Declaration.



Methodology

A desktop study examining the legal and policy frameworks around health and other disasters was undertaken.

The assessment questions for this were framed within the context of the IFRC's global research, *Laws and Public Health Emergency Preparedness and Response: Lessons from the COVID-19 Pandemic.*[vi]

Eight Pacific Island states were chosen for in-depth analysis:

- **Fiji**
- **Papua New Guinea**
- **Samoa**
- **Solomon Islands**
- **Marshall Islands**
- **Tonga**
- **Tuvalu**
- **Vanuatu**

These reflect the current members of the Technical Working Group on Risk Governance (TWG) under the Pacific Resilience Partnership.[vii]

Unfortunately, COVID-19 restrictions in the Pacific meant that fieldwork was impossible but a series of interviews were conducted with Pacific governments (primarily National Disaster Management Officers, NDMOS), other relevant practitioners and NGO representatives, in addition to a virtual Pacific Risk Governance technical working group meeting to provide feedback on draft national reports. The limited nature of the interactions between the research team and practitioners means that the overall depth is not at the level that the research team would like to have achieved.

Nevertheless, the report presents eight national studies examining both the legal and policy frameworks which apply in each of the states studied and a series of policy focussed summaries on the practical implementation of multi-sectoral responses to health emergencies and other natural disasters. A separate chapter examines the operation of regional cooperation mechanisms in multi-hazard and multi-sector disaster response, with a particular focus on the current COVID-19 crisis.

Based on these reports, drafts of which were circulated to the government departments and agencies concerned, the final section of the report provides a brief overview and analysis of the state of integration between health and disaster law frameworks/institutions.

Laws, Disasters and Public Health Emergencies:

An Overview of Institutional Frameworks

Laws and governance systems for natural hazards and biological hazards, usually styled as public health emergencies have traditionally operated independently from each other. Although clearly connected, there has been a tendency to treat these two aspects of disaster risk management differently. There are a number of reasons for this, not least of which is that on a daily basis the health system performs a role that is far larger, and more central, than that of disaster risk reduction and management agencies. The size and centrality of health systems require a significant bureaucracy to manage the business-as-usual operations they undertake. Agencies charged with disaster risk reduction and disaster risk management , by contrast, tend to be smaller and seen as less central to the operation of the state, only rising to prominence in the event of a disaster. This disparity in size and importance has consequences for their integration in the event of disasters.

Firstly, the size and importance of health systems mean that they develop a bureaucracy capable of managing their operations that, while central to response, can be disconnected from the wide disaster management process. In addition, the institutions of disaster risk reduction and disaster risk management being side-lined by the behemoth of health even in disaster situations. This domestic disparity and problems of domestic administrative politics are exacerbated at the international level by parallel governance systems. International health governance (including public health emergency) is largely managed through the structures and practices of the World Health Organisation (WHO) while disasters and emergencies sit within the framework of the UN Office of Disaster Risk Reduction (UNDRR) and in practical response terms, that of UN Office for the Co-ordination of Humanitarian Affairs.

Although there is potential for significant overlap between the responsibilities of these two international agencies, in practice UNDRR has largely concerned itself with natural hazards leaving the WHO to manage public health emergencies. The legal consequence of this sees the disaster risk reduction sector focus primarily upon the Sendai Framework for Disaster Risk Reduction,[viii] action which provides an international touchstone for all hazard disaster management and risk reduction, while the public health sector looks to the International Health Regulations (IHR), the key international legal document for the management of public health emergencies.[ix] While the IHR, unlike Sendai, is a formally binding treaty it is far narrower in its scope focussing purely upon the international spread of disease. In addition, such restrictions must be explicitly charged with avoiding unnecessary interference with international traffic and trade.[x] By contrast, Sendai, although a soft-law instrument has a far broader and deeper remit. As well as being applicable to disasters caused by natural or man-made hazards, as well as related environmental, technological and biological hazards and risks the framework applies to all disasters, both domestic and international.[xii] This division between the WHO and UNDRR has practical consequences as few of those who work within public health emergency legal frameworks even have knowledge of the Sendai Framework and the wider landscape of disaster law in which it sits.

The challenges posed by the operation of parallel legal frameworks around the management of public health emergencies, in contrast to natural hazards (caused by meteorological and geological events) have increasingly been recognised at the international level. As a result, the Sendai Framework makes specific references to health and its importance throughout the document, in contrast to the Hyogo Framework for Action that preceded it. Priority three (i) in particular emphasises the need to;

> ".. enhance the resilience of national health systems, including by integrating disaster risk management into primary, secondary and tertiary health care, especially at the local level; developing the capacity of health workers in understanding disaster risk and applying and implementing disaster risk reduction approaches in health work; promoting and enhancing the training capacities in the field of disaster medicine; and supporting and training community health groups in disaster risk reduction approaches in health programmes, in collaboration with other sectors, as well as in the implementation of the International Health Regulations (2005) of the World Health Organization"

These sentiments were put into practice through the adoption of the Bangkok Principles,[xiii] at the International Conference on the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction in 2016. These principles aim to address the problems created by the continued operation of parallel international legal frameworks for disasters triggered by public health emergencies and those driven primarily by other hazards. As such, they provide an international framework to advance and improve the level of co-ordination between the health and disaster risk reduction sectors and encourage the integration of public health emergencies into the wider framework of disaster risk management (and vice versa). These seven principles, provide a framework for improved coordination of efforts to reduce risk from biological hazards and call for an inter-operable, multi-sectoral approach to promote systematic cooperation, integration and, ultimately, coherence between disaster and health risk management.[xiv] These sentiments are to be welcomed and as the current international legal document on the subject they form the basis of the following analysis. However, as the following makes clear, it is not, as yet, obvious that these principles are having much specific traction.

Contextualising the COVID-19 Response in the Pacific

COVID-19 has played out very differently in the Pacific, thus far, to most other parts of the globe as most Pacific Island states (with the exceptions of Fiji, Papua New Guinea and now French Polynesia[xv]) have remained, largely, COVID-19 free. For most of the Pacific, the COVID-19 disaster has thus primarily been an economic and social one. As a region facing huge logistical challenges, hazards in this part of the world often play out quite differently. This tyranny of distance in the *Blue Pacific* means that logistics always plays a significant role in any disaster response.

For this reason, a global hazard often leads to quite a different form of disaster response in the Pacific region. This is particularly true for multi-hazard disasters and has been clearly exposed in the recent COVID-19 pandemic. In this latter example, the health emergency has driven a series of other consequences, many of which are far removed from the health aspects of the disaster. These have included severe economic hardship, populations stranded outside the state, severely limited internal movement, lack of basic supplies and an inability of citizens of these states to undertake their usual work overseas (with the subsequent loss of remittances). Mitigating these impacts has required the development of legal frameworks far outside those expected for health emergencies. Many states have struggled with their existing legal frameworks to implement these response mechanisms, however, the high level of integration experienced in a number of Pacific state disaster law mechanisms has allowed for a level of co-ordinated response across government and non-government that has not always been evident in other parts of the world and even in the metropolitan states in the Pacific region.

A key feature of these positive experiences is the embedding of the NDMO planning and systems for all-hazard planning. Despite this, the tendency to silo and inadequately integrate health aspects into the disaster management architecture remains an issue in a number of states in the Pacific. However, the holistic and multi hazard approach to hazards has predominantly stood the island states in good stead and has provided them the flexibility to incorporate public health emergencies when faced with multi-hazard and health emergencies in the modern era.

This has seen administrative agencies operating across sectors in a way that has not always been experienced outside the Pacific Island states. For example, although New Zealand has been lauded for its strong political response to COVID-19, the administrative gap left by no overall co-ordinating administration and the focus on health as the lead agency has, at times, led to a number of fundamental missteps around logistical issues relating to managed isolation, the testing of border workers and the enforcement of lockdown measures (amongst other examples).[xvi] These failures of horizontal co-ordination and coherence have occurred due to a lack of cross-sector awareness from those involved in decision making. In Australia, similar issues have occurred but these have been most visible vertically, between the levels of the federal system. In the Pacific most island states (although not all), by contrast, do not appear to have experienced such issues with a relatively smooth legal implementation of desired policies. That this has occurred despite the limitations of the multi-hazard legal framework in many states leads to the conclusion that the relatively integrated institutional networks that exist have played a role. It is also perhaps notable that Papua New Guinea's struggles with the second wave of coronavirus are in the context of a disaster law framework that is possibly the least integrated and least developed in the region.[xvii]

Working Together as a Region

The economic and social impacts of the COVID-19 response are such that few nation-states can hope to mitigate its impact without international cooperation. This is increasingly true of disasters as a whole, particularly as they become increasingly multi-hazard. The pandemic of 2020/2021 is merely one example of this but its severity and impact on the Pacific states led to a level of regional cooperation beyond that normally experienced. Despite strong rhetoric on regional cooperation for disaster response, prior to COVID-19, practical developments in this regard had been disappointingly slow. However, in 2020 one notable regional initiative was launched to provide trans-regional support in the wake of COVID-19.

In March, the Pacific Island Forum launched the Pacific Humanitarian Pathway on COVID-19 ('PHP-C') which aimed to expedite requests for medical supplies, technical expertise, and humanitarian assistance made by Forum members.[xviii] The PHP-C was designed to complement and coordinate existing bi-lateral relationships with development partners and regional or international humanitarian organisations rather than replace them. However, the swift development of regional protocols around customs, biosecurity, immigration, the repatriation of foreign nationals and diplomatic clearances for aircraft and ships transporting medical or humanitarian assistance was a significant achievement in a field which has traditionally required individual state protocols and where no standard regional SOPs currently exist.[xix]

Implementation of the PHP-C was overseen by a Forum Ministerial Action group with a Regional Task Force to oversee its operation. This was a significant development given the traditional emphasis on national sovereignty in the field of Pacific disaster management. The PHP-C thus represented an important shift in practical efforts to tackle disaster risk management as a region, in line with the Boe Declaration and the Action Plan published in 2019.[xx] It is also significant that the response was Pacific Island-led, demonstrating the capacity for cooperation outside of the ambit of development partners (although the delivery of some PHP-C initiatives relied heavily upon external assistance).

One issue of particular significance for the Pacific Island states was the suspension of commercial air services, which created significant challenges for supply chains across the region. This gap was filled by the establishment of the Pacific Humanitarian Air Service under the PHP-C which ensured that commercial flight suspensions did not impede the delivery of urgently required personnel, equipment and supplies.

These regional cooperation mechanisms clearly provided a blueprint for future more formalised disaster preparedness and response cooperation. Utilising the commitments made in the Boe Declaration and its action plan which authorises the development of such regional initiatives, such frameworks could be established pre-event and incorporate both traditional disaster response initiatives (such as the provision of assistance) with the multi-hazard response requirements seen in the case of COVID-19. These require cooperation far beyond that normally envisaged in disaster response and include cooperation with front line and border agencies to find solutions for immigration clearance for returning nationals, facilitation of expedited humanitarian assistance, the establishment of logistical links and shelter for trapped nationals, among many others more traditional elements of International Disaster Response Law. It is also critical that these regional initiatives are translated into national laws, policies and systems to ensure that domestic front line agencies have clear mandates to work with their regional partners.

As well as being flexible enough to cope with the wide range of issues that multi-hazard and long duration disaster response requires, such a regional disaster response mechanism must also have the administrative capacity to ensure such a response can be delivered. They thus must incorporate the administrative infrastructure currently lacking at the Pacific regional level as well as the political leadership found in the PHP-C. In addition, given the fundamental role played by NGOs in the

region, it must have a formal role for them within the structure. This is particularly true of the Red Cross, whose role is statutorily recognised in many Pacific Island states.

The PHP-C initiative thus provides something for the region to build upon, but it seems unlikely that the ad-hoc approach of the PHP-C will be enough in the future, given the stormy seas that surely lie ahead for the region.

Public Health Emergency Laws in the Pacific

Public Health Emergency laws in the Pacific region are not particularly well developed and in many cases are quite dated. In general, they form part of laws dealing with public health as business as usual and have few references to emergencies and pandemic response. In many cases, this is a reflection of their age, with many of these laws decades old and reflecting past practices and threats (see figure 1). In some cases, notable in Solomon Islands, the relevant act provides such minimal detail around response to public health emergencies as to be largely irrelevant in the current pandemic. In the Marshall Islands the relevant act provides very limited details with heavy reliance upon executive discretion. This is a feature of Marshall Islands's approach to disaster management in general.

With these two exceptions, all states in the Pacific do utilise specific acts (or sections of acts) in the management of public health emergencies. However, all such acts are not created equal. In Papua New Guinea for example the key powers relating to pandemic response are found in the Public Health Act 1973 which refers primarily to the actions required to address wider issues of public health rather than public health emergencies and certainly not the needs of a novel coronavirus pandemic. Similarly, limited powers enabling quarantine and other limits upon personal liberty are found in the even older Quarantine Act of 1953. These are also largely focussed on small, local restrictions rather than the widespread restrictions deemed necessary in global pandemics. Papua New Guinea is, however, not alone in possessing an ageing public health emergency law. Fiji's pandemic response has also been limited by the Public Health Act (a piece of pre-independence legislation enacted in 1935) which largely provides powers to be used only once an outbreak has occurred. However, as the discretion provided is extensive, it has proved capable of providing the government with the necessary powers despite its limitations.

Figure 1: Public Health Emergency Laws in the Pacific

	Public Health Emergency Law Date	New Public Health Emergency Act?
Fiji	1935	Minor amendments only
Papua New Guinea	1973	Yes
Marshall Islands	1966	No
Samoa	1959	No
Solomon Islands	-	Yes
Tonga	2008	No
Tuvalu	2008	No
Vanuatu	1995	Yes

Of the eight states studied, only Tonga and Tuvalu possess recently introduced Public Health laws which include standard powers for the management of infectious diseases, including isolation, segregation and a range of broad discretionary powers. The limited nature of Pacific public health emergency legal frameworks led directly to three Pacific states (Papua New Guinea, Solomon Islands and Vanuatu) introducing new public health emergency acts during the COVID-19 pandemic. In other cases, existing laws remained in use but were supplemented by extensive use of secondary legislation and emergency powers exercised under the wider disaster law framework, either through

constitutional powers of emergency or through declarations of states of emergency under relevant disaster management laws.

However, notwithstanding the adequacy of the current public health emergency laws in individual states, all of the states studied made extensive use of laws outside the public health framework. This was because for the Pacific Island states (in common with a number of other states in the Asia-Pacific region) the explicit policy aim has been to avoid the virus through isolation and if necessary eliminate any incursions.[xxi]

This places the Asia-Pacific region at odds with much of the rest of the world where attempts to manage the virus have been the norm. As a result of this, six out of the eight jurisdictions studied remain COVID-19 free and thus the global pandemic remains an external rather than an internal threat. Pacific states adopted this policy actively and not, as is often assumed by those outside the region, as a consequence of their isolation. In fact, many Pacific Island states rely heavily upon external links for economic survival and are directly linked by air to states outside the region (in fact such links are stronger than inter-regional ones). This meant that many Pacific Island states were vulnerable to a global pandemic, with direct flights from Pacific states to COVID-19 hotspots providing an easy method of entry for the virus. However, as only one of the states studied has a land border (Papua New Guinea) this particular vulnerability could be addressed through closing air and sea access. That Pacific Island states chose to do so reflected a policy choice, despite the economic and social pain that this would cause.

As a result, the public health emergency legal frameworks in six of the eight states studied were not fully tested. In just two examples (Fiji and Papua New Guinea) the policy of isolation failed when put to the test. The salutary lesson in both these cases is that the public health emergency frameworks proved problematic and the virus spread more quickly than the policy responses introduced to contain it. In Papua New Guinea the virus now appears endemic and little testing is being undertaken. In Fiji, the ongoing partial-lockdown measures appear to be managing the outbreak but case numbers remain high. Although the problematic legal frameworks cannot be blamed for the outbreaks, they did not assist governments in containing them once the isolation policy has failed.

This policy of isolation and strict prevention was undertaken due to the weak nature of health services within these states and the perceived vulnerability of Pacific Island communities, some of whom had recently experienced the 2019 Measles Epidemic and where past pandemics cast a long shadow.[xxii] However, despite this being a health driven response, the methods of achieving it are not to be found in public health emergency laws. This has led Pacific Island states to utilise emergency powers and the wider disaster law framework to develop policy tools capable of managing this level of isolation and social disruption.

Disaster Law and Public Health in the Pacific

Clear laws, policies and plans provide the foundation for effective preparedness and response at national, subnational and community levels. Regardless of whether the emergency is caused by meteorological or geological hazards, such as cyclones, earthquakes and floods, or a biological hazard (such as virus or toxin that can adversely affect human health), it is critical that laws clarify who should be doing what, establish coordination mechanisms, enable an all of society approach and direct the use and limits of emergency powers.

At the onset of COVID-19 in early 2020 and with the dual impact of a destructive Tropical Cyclone hitting the region, many Pacific Island states faced considerable challenges. In additional to operational issues, the lack of legal clarity about lead agencies, coordination mechanisms for a wide and diverse array of actors, and balancing response with non-movement orders proved problematic.

Although pandemics are defined as disasters in the disaster management law of every Pacific Island state (and internationally),[xxiii] as already explored above, pandemic response has not traditionally seen as the core business of National Disaster Management Organisations (NDMOs) either in Pacific or elsewhere. For reasons that are beyond the scope of this report, NDMOs have tended to be seen as the key players when the hazard which creates the disaster is meteorological or geological, rather than biological. As a result, most Pacific states use a hybrid model of public health and disaster risk management law to respond to public health emergencies (as is common global practice). However, in contrast to the predominant global model, recognised in the global IFRC research, public health emergency legislation in the Pacific states studied sits within a loose framework provided by generic disaster law.

This approach is not necessarily disaster law dominant (although the lack of public health emergency law in some states meant that COVID-19 responses in these examples, was primarily disaster law driven), with public health emergency law providing the key details. This role for public health emergency law within a disaster law framework appears to reflect a Pacific way of managing public health emergencies and would appear to reflect Pacific islands' focus on all-hazard approaches to disasters as well as the practical consequence of such states being in a constant state of response. In the states studied health hazards are part of the normal business as usual disaster experiences of these states.

	Public Health Emergency Dominant	Hybrid	Disaster Risk Management Dominant
Fiji		X	
Papua New Guinea			X
Marshall Islands		X	
Samoa		X	
Solomon Islands			X
Tonga		X	
Tuvalu		X	
Vanuatu		X	

Figure 2: Legal Frameworks for the Management of Public Health Emergencies

The problem, as COVID-19 in the Pacific made abundantly clear was that, although COVID-19 was a biological hazard, requiring leadership and direction from the health sector, the emergency response required was often social, economic and logistical, something that health agencies are typically ill-equipped to address. The decision by Pacific Island states to adopt a policy of elimination through isolation made this issue even more stark. In most Pacific states (and 6 of the 8 studied) the COVID-19 pandemic has led to an economic and social disaster not (as yet) a health one.[xxiv] The need to manage such isolation has also complicated disaster response more generally. In most cases, public health legislation has not been required (or at least it not been at the centre of the response). Instead, prevention measures have been introduced to maintain isolation and reduce spread to a manageable level should cases arrive. These have required the use of the wider disaster law framework.

Disaster law frameworks across the Pacific vary dramatically. At the lower end of the spectrum are Solomon Islands, Papua New Guinea and Marshall Islands, but for very different reasons. Papua New Guinea suffers from a limited and outdated legal framework for disaster response which dates to 1984 (the Disaster Management Act).

Solomon Islands suffers from similar issues around the ageing nature of its disaster law framework. In this case, the National Disaster Council Act dates from 1989 and like the Papua New Guinea example, does not reflect current best practice around disaster management.

The Marshall Islands also suffers from a weak disaster law framework which provides for very little legal certainty around disaster response. Instead, structures are provided by planning and policy documents with extensive use of executive decrees in the event of a disaster. The governance structure is complex and not clear to the outside observer.

At the other end of the scale, Vanuatu possessed a comprehensive disaster management law which, as explored below, possibly exhibits the greatest level of integration with public health emergencies. Somewhere in the middle lie Tuvalu, Samoa, Fiji and Tonga. These three states have disaster law frameworks based upon laws established in the mid-2000s, each of which includes health emergencies, although in these cases, health events are categorised separately.

As the discussion below shows, the relative modernity of these latter disaster management systems allowed them to address the requirements of the pandemic response, without the need for amendment, although even here limitations in the legal frameworks has required extensive use of emergency decrees over long periods of time to impose the levels of social regulation required in a global pandemic.

The use of disaster law frameworks in public health emergencies emphasises both the need for their co-ordination and for pre-event planning to ensure that such powers are available as part of the disaster law toolbox. Unfortunately, this was not the case in many Pacific Island states, which resorted to long term states of exception and rushed (and often controversial) legislation as a result. The consequences of this for the states concerned will likely long outlive the pandemic.

Integration of Public Health Emergency and Disaster Law in the Pacific:

Comparative Country Analysis

The integration of health into the wider field of disaster risk management is a recognised priority under the Bangkok principles. They recognise the need to:

> "Promote 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."[xxv]

To achieve this, the principles recognise a series of action points, including the promotion of a whole-of-government, a whole-of-society approach supported by commitment to the promotion of coherence and further development of local and national policies and strategies, legal frameworks, regulations, and institutional arrangements. Along with other action points contained within the principles, these emphasise the accepted need for increased integration of health response into wider disaster risk reduction and management frameworks.

Although, health services clearly provide a crucial element of the response framework, this is often perceived as being delivered as an adjunct to the exceptional elements of disaster management. This tendency to treat health as something of an outsider in disaster management is increasingly untenable alongside current approaches to holistic disaster risk reduction as championed by the Sendai framework. However, domestic health systems and their infrastructure are big players in domestic government and thus do not sit well with the smaller and usually less influential disaster risk management institutional cousins.

Whilst there is an identified need internally for improved integration and enhanced cohesion between public health emergency management and disaster risk management – which this Report reinforces – there is not yet an identified, common approach as to how exactly this can be achieved. Many states have also recognised the need for greater coherence between disaster risk management and health laws and systems domestically, however, have struggled to make this happen in practice.

Despite the legal disconnect, however, this seems to have been less problematic for disaster response in the states studied. The vulnerability of these states to both health emergencies (such as the measles epidemic in 2019) and other disasters makes multi-hazard events relatively commonplace. In addition, the risk of geologically or meteorologically triggered disasters, morphing into public health emergencies is ever present given the vulnerability that health systems in these states face. It is for this reason, perhaps, that integration between sectors appears more advanced than the global norm. In addition, although the legal and institutional frameworks in some of the Pacific Island states studied still suffered from a degree of institutional isolation, there was a clear recognition of the problem and in some cases, attempts to undertake reform, even in the midst of the pandemic.

While some Pacific Island states would benefit from greater legal and institutional integration of their public health emergency and disaster management systems, the picture is far from universal and, while some states would clearly benefit from improved legal frameworks generally (many of which are now showing their age), there is still much that the Pacific Island states can teach each other and the wider world about the management of multi-hazard disasters and the integration of health into the wider disaster risk management framework.

Across the eight states studied, levels of integration of both the formal legal frameworks and their related policy/planning structures varies dramatically. In practice, two states (Solomon Islands and Marshall Islands) operate what could be classified as disaster risk management dominant frameworks (almost solely based up disaster risk management legislation). In practice this is due to the paucity of public health law in these states. However, the reasons for this varies. At the start of the pandemic Solomon Islands had a public health law which made little or no reference to emergencies, leading to the need to utilise the disaster law framework as an alternative, while Marshall Islands continues to rely heavily upon executive discretion and secondary legislation to manage disasters generally, including those classed as public health emergencies. The dominance of disaster risk management legal frameworks during public health emergencies (as seen during the COVID-19 response) reflects the limitations of the existing emergency frameworks in these states.

In **Solomon Islands** the National Disaster Council Act 1989 only specifically mentions meteorological and geological hazards leaving the situation in relation to public health emergencies unclear. However, as the act only specifically excludes civil disorder, war and industrial disputes, by implication public health emergencies are included. This is particularly important as the Solomons lacks any meaningful public health emergency legislation.

However, in practice, the National Disaster Management Plan nominates the Ministry of Health as the lead agency, in public health emergencies. In all other cases, the NDMO is the lead agency although in all cases, the NDMO operates the National Emergency Operations Centre which provides co-ordination facilities at the national and provincial levels. This has activated during the current COVID-19 crisis with Health remaining the lead agency in the response. The NDMP appoints the Director of the NDMO as the Disaster Co-ordinator even in health disasters, despite the fact that Health remains the lead agency but it is unclear whether this has occurred during the current pandemic. This lack of clarity is not limited to the NDMP and is found through the legislation and associated policies. The plans in particular seem to contain contradictory statements as to the level of co-ordination required.

What is clear is that existing legislative framework in the Solomon Islands has struggled to cope with the needs of the current crisis. This has seen extensive use of the Emergency Powers Act to expand the legal framework, as a means to responding to COVID-19 (and one assumes in other health or multi-hazard emergencies). This has seen a plethora of different regulations introduced to manage different parts of the response. This has required that a state of Emergency remain in place during the duration of the COVID-19 response. The consequences of this are discussed further below.

In the **Marshall Islands** the pandemic response seems to have largely fallen to the Ministry of Health despite the NDMO formally being given a co-ordinating rule within the policy documentation. In terms of health disasters, specific limited provisions do exist under the Public Health, Safety and Welfare Act, but do not provide a role for the NDMO. Given that this act dates back to the 1960s, it is hardly surprising that its provisions do not accord with best practice envisaged by more recent disaster law frameworks.

As explored above, the remaining six of the Pacific states studied, there is some form of specific Public Health Emergency Law.[xxvi] Using the IFRC global report's typology, these could be classified as public health emergency dominant models with the health agency driving the response, although within a disaster law framework. However, this classification is problematic, at least in a Pacific context. The health driven response, while clearly appropriate for the immediate requirements of epidemic control within the community, are not appropriate when the consequences are logistical or economic as in most Pacific Island states during COVID-19. These latter issues, although driven by a biological hazard, require a response which is not traditionally associated with health agencies. It is thus essential that co-ordination occurs with other agencies using the existing disaster management mechanism, which traditionally focus on the NDMO as the key

linking agency. The issue is therefore less around who dominates the model but whether the model provides the level of coordination required to ensure an effective and multi-faceted response. In practice, although the formalities of this are not always evident in the Pacific states studies, some form of practical hybrid model, with a significant role of the wider disaster law framework appears to be the norm. This suggests the need for a fourth typology in the Pacific where a disaster risk management led public health emergency hybrid appears to be the norm.

The six hybrid public health emergency models still operate some form of parallel structure for public health emergency and natural hazard response, with none having a fully integrated model. The most cohesive framework is seen in **Vanuatu,** where the new Disaster Risk Management Act (2019) provides an integrated legal framework across all disasters, including those defined as being public health disasters. The framework established under this act creates a National Disaster Committee, the NDMO, the National Emergency Operation Centre (NEOC) a national Cluster system and provincial/municipal committees. However, even in Vanuatu, this, Sendai and Bangkok compliant, integrated model sat rather uncomfortably alongside a rather dated Public Health Act (1995) which proved problematic at providing the legislative basis during the COVID-19 response. This led to the enactment of the Public Health (Amendment) Act in 2020.[xxvii]

However, other relatively modern legal frameworks also exhibit apparent low levels of integration with the health and disaster risk management frameworks operating under separate administrative structures. Samoa, for example possesses a relatively modern disaster risk management framework, underpinned by the Disaster and Emergency Management Act, enacted in 2007 This sees the Ministry of Health designated as the key institution for health disasters with the NDMO performing the role otherwise. More detail is provided under the National Disaster Management Plan with practical guidance provided by National Emergency Operations Centre, the physical hub for disaster response, being managed by the NDMO. The limited level of integration is at least partially explained by the fact that Samoa, although operating a relatively modern disaster law framework still relies upon old (at times pre-colonial) laws around public health.

A similar situation exists in Fiji where the roles of the NDMO and the Ministry of Health operate in parallel, although in theory they are managed by a single National Disaster Management Act. However, Fiji's pandemic response has been limited by the Public Health Act (a piece of pre-independence legislation enacted in 1935) which largely provides powers to be used only once an outbreak has occurred. However, as the powers under the act are particularly extensive, it has proved capable of providing the government with extensive powers to respond to COVID-19 declare a state of emergency (except in limited cases). The occurrence of cyclone Harold during the early stages of the pandemic exposed the challenges of having two lead agencies in multi-hazard events, something that is being re-considered as part of Fiji's ongoing review of its disaster legislation.

Tonga operates a similar level of integration a single framework for disaster response in practice operating parallel models for health and other hazards. Although human disease is specifically recognised as one of the hazards capable of triggering the emergency/ disaster framework outlined in the Emergency Management Act (2007), within this single framework a distinction is made between human epidemics and other disasters in terms of co-ordination within the National Emergency Plan. In the former case the Ministry of Health takes on the role of the lead agency. However, even in this case, the NDMO provides support for the National Emergency Management Committee (chaired by the Minister for Emergency Management) and retains a co-ordinating role. However, the relatively broad nature of the generic disaster planning documentation means that it is not entirely clear how the co-ordination and planning mechanisms work in practice for public health emergencies and multi-hazard response.

Tuvalu's legal framework also clearly distinguishes health emergencies from other disasters with the Emergencies and

Threatened Emergencies Act providing wide emergency powers through regulations when a state of emergency in place. This Act works alongside the National Disaster Management Act (2008) which provides for disaster management, including in pandemic situations. In the health sphere the Public Health Act (PHA) (2008), associated PHA regulations and the Quarantine Act are the key pieces of legislation. These acts are complemented by an aging National Disaster Management Plan (which is over 20 years old). This document places the NDMO as the key agency for all disaster response. The NDMP makes mention of the National Co-Ordination Centre to manage disaster response, but the role played (if any) in the current public health emergency response is unclear.

Tuvalu's limited policy capacity and outdated response plans was exposed by the COVID-19 pandemic and at the early period of the 2020 epidemic, it requested a risk assessment from the WHO. This has provided the basis for the COVID-19 response in the islands. The authors of the report understand that a new draft response plan has been formulated and utilised during the current epidemic, although it has not been formally adopted.

The variations in integration between public health emergency and disaster law legal frameworks is at least partially a function of age. In **Papua New Guinea,** for example, although he legislation (under the DMA) the National Disaster Centre provides the co-ordination mechanism for all disaster response legal integration is weak with a parallel health framework existing alongside that for disaster risk management. In addition, the two parallel frameworks have limited formal methods of connection. This low level of integration is merely one aspect of the outdated legal disaster law framework (dating to 1984) which currently operates in Papua New Guinea. This is widely recognised within the country and plans are afoot to modernise this framework.[xxviii]

As a result, new legislation was introduced in 2020, notably the controversial Emergency (General Provisions) (COVID-19) Act 2020 (EGPC). The disparate nature of the existing legal response framework led to the creation of a new system of co-ordination under a new set of regulations, introduced under the EGPC. This created an Emergency Controller with extensive powers across a wider range of services, reporting directly to the National Executive Council (the Papua New Guinea Cabinet). This system is more extensive than that envisaged for non-health disasters and demonstrates the dangers of not having clear and comprehensive laws from the outset, which allows for the ushering in of ad hoc approaches and potential politicisation of a response.

However, Papua New Guinea was not alone and as the above has made clear, the realities of a global level pandemic exposed the gaps in the legal frameworks across Pacific Island states. Although these gaps have led to legislative changes in jurisdictions across the globe, in the Pacific the needs were particularly acute as the impacts, and thus the disaster response, of the health emergency have not been health related. As the region has struggled to cope with the logistical challenges created by COVID-19 amid the need to manage inter-state travel, the relevant health acts proved incapable of providing the necessary legal basis and the health agencies are poorly equipped to manage them. This led to increasing reliance upon disaster management frameworks which had only partially been established to resolve these issues and where integration with the wider health emergency framework remained less than ideal. The lack of administrative integration was mitigated by effective political and administrative leadership in a number of states. However, such informal measures are imperfect and incapable of delivering the social regulation needed in a pandemic.

As a result all the states examined utilised states of exception to create new legal frameworks to govern almost all aspects of the COVID-19 pandemic. This has led to extensive use of new legal frameworks, not seen in previous multi-hazard disasters. As we shall see, this has proved extremely problematic with such acts often being ill considered and many accused of subverting the Rule of Law in a number of states. Perhaps as concerning, many have been passed as emergency regulations, requiring an ongoing state of emergency for their validity (e.g., Vanuatu). For this reason, some Pacific Island

states due to the lack of a mainstreamed approach to multi-hazard and public health disaster management, have found themselves in long-term states of emergencies (many for over a year). In a part of the world which is no stranger to unconstitutional government, this failure to provide integrated frameworks capable of responding to the multi-sectoral challenges of a global pandemic may have long term consequences for the stability of the region.

States of Exception and Multi-Sectoral Disaster Response Law

The use of either public health legislation, with limited integration with disaster risk management frameworks, or disaster risk management law designed for non-health emergencies has had the same impact in a number of the states studied. The limited number of integrated tools to address the multifaceted nature of health emergencies was a legal and constitutional weakness that has been exposed by the extreme nature of the pandemic. In the cases where limited or no public health emergency acts existed, the disaster risk management framework was not designed to cope with slow-burn, long term disasters. In addition, the Public Health Acts (or equivalent) in all the states studied, primarily envisaged local epidemics with tools and powers to match. The age of some of these acts (some dating back to the 1930s) means that they reflect a very different understanding of pandemics. In addition, the powers which are included within them reflect an early 20th century understanding of the role of the state and do not envisage the type of global interconnectedness that has become the norm across many parts of the Pacific. In those islands, economically dependent upon tourism, the economic impacts of health emergencies are the key disaster impacts not (as yet)[xxix] the pathogen itself. In addition, managing the import of essential supplies and personnel become essential when travel becomes highly regulated. This is a particularly acute issue for many Pacific Island states where such external supplies have become essential to daily life. The logistical lifelines are thus complex and have increasingly relied upon commercial providers, who are no longer able to operate. If this was not enough, the fact that many Pacific Island workers rely upon temporary overseas work opportunities (in the shipping, hospitality and horticulture industries for example) has meant that the health emergency requires the need to manage immigration (both from those trapped overseas and those wishing to work outside the state), travel and logistics in a way that the public health acts did not envisage. For this reason, many of the states studied (but not all) have found it necessary to introduce new legislation to address these issues. This has created a number of problems as the following explores.

Across the region, the limited effective powers available to governments in health emergencies led to states of emergencies (or equivalent) being declared and maintained for long periods of time. Vanuatu, Samoa, Tonga, Solomon Islands, Marshall Islands, Papua New Guinea and Tuvalu all declared a state of emergency (or equivalent) in March 2020. Fiji followed suit in April. In all these states, with the exception of Papua New Guinea and Fiji these have remained in place during the entire period of the global COVID-19 pandemic. Fiji has relaxed its COVID-19 related State of Emergency but applied an additional state of natural disaster in response to cyclone events that occurred during the pandemic.

These long term emergencies have been necessary due to weaknesses within the institutional and legal framework for the type of long-term multi-hazard disasters that COVID-19 exposed. The limited level of integration between disaster law generally and health requirements, means that a number of measures not envisaged by the disaster frameworks had to be introduce. For example, in Solomon Islands the Emergency Powers Act has been the main vehicle for the legal framework created in response to COVID-19. This has seen a plethora of different regulations introduced to manage different

parts of the response, including the Emergency Powers (COVID-19) Regulations 2020. As one might imagine this regulation allows for mandatory quarantine upon entry to Solomon Islands (and prohibition of entry) as well as powers to restrict assembly, movement and temporarily close public places.

However, it also includes powers to suspend media outlets, trade unions and prohibitions on the spreading of rumours and false information.[xxx] This regulation has proved controversial in Solomon Islands as has the extension of the State of Emergency which has been needed to keep the regulations in place. The bundling of the logistical requirements with controversial powers around freedom of expression is particularly concerning and appears to have a been consequence of Parliament being removed from the process by the use of emergency powers.[xxxi] In Vanuatu the need to introduce novel regulations around lockdowns and border closures has again required a long state of emergency for them to be in force. As in Solomon Islands the emergency regulations empower the government with the power to censor COVID-19 information, although as yet this has not caused controversy.

Other states such as Tonga and Samoa have also remained under long-term states of emergency, despite being COVID-19 free. In the case of Tonga this has been necessary to allow the provisions passed under the Emergency Management Act to remain in force. However, the powers are particularly extensive and arguable not directly connected to the emergency itself. For example, although Tonga remains COVID-19 free, a night time curfew remains in force at the time of writing.[xxxii] In Samoa, the more modern legislative frame has required less regulatory provisions, however, the state of emergency has still been utilised to allow executive decision making around external travel restrictions and limits on activities with the state (including restrictions around alcohol sales and shop opening).

Not all states have utilised long term emergencies to allow exceptional restrictions, but this in itself has proved problematic. The weakness of the Papua New Guinea disaster response framework led in June 2020, to enactment of the National Pandemic Act. This introduced a number of important co-ordination mechanisms, through the National Control Centre along with a number of emergency response restrictions. These have included internal and external travel restrictions, border surveillance measures and rules around quarantine. A number of additional emergency regulations were also issued under the act.[xxxiii] However, concern exists within Papua New Guinea, particularly amongst the Parliamentary opposition, as to the level of powers conferred and its constitutional status. These criticisms have been supported by human rights organisations which have argued that the Act was rushed through parliament without adequate consultation with the opposition or civil society and that it contains various provisions that could restrict human rights without adequate oversight.[xxxiv] In effect, although Papua New Guinea, rescinding the state of emergency in June 2020, the NPA now allows for exceptional executive powers to be exercise outside the framework of emergencies envisaged by the constitution.

These issues have come to a head most clearly in Samoa where the overwhelming parliamentary majority of the Human Rights Protection Party (which had no official opposition in the Samoan Parliament until 2021), was dramatically overturned as a direct result of disquiet amongst Samoans (and the former deputy Prime Minister herself) towards the HRPP's actions during the pandemic, particularly in passing controversial laws unconnected to the pandemic. This led to allegations that the crisis is being used to drive reforms that should be considered more fully in normal times.[xxxv]

The need for Pacific Island states to enact emergency regulations and maintain states of emergency for long period is not healthy for the constitutional systems of the states concerned. This normalisation of the exceptional leads inexorably to executive creep and it can become difficult for systems to return to normal. It therefore seems essential that longer term reform of legal frameworks be contemplated in Pacific Island states where the COVID-19 example is unlikely to become an exception. Legal frameworks which allow for the sort of measures required in such complex responses need to be mainstreamed within legal frameworks, particularly in states where democratic frameworks and the rule of law are fragile. Without culturally relevant checks and balances, such states risk living in a semi-permanent state of exception and emergency given the likelihood of continued crisis in the wake of climate change and future pathogen driven disasters.

Regional Mechanisms to Facilitate Humanitarian Assistance in Disaster and Health Emergencies

In the Pacific, a number of regional mechanisms have developed in the recent past to encourage co-ordination and move towards a Pacific way in the field of disaster response. These have not been focussed upon public health emergencies but their development clearly played a role in allowing for an effective level of regional cooperation particularly in the face of the challenges posed by the COVID-19 pandemic. A key element of this was the commitment by Pacific leaders to deeper levels of regional disaster response cooperation through an expanded concept of security under the 2018 Boe Declaration.[xxxvi] In 2019 these high-level political statements were given practical form through the Boe Declaration Action Plan which provided a framework for the implementation of the declaration across a number of areas, including disaster response and mitigation.[xxxvii]

Although the plan commits member states to modernise their existing disaster management frameworks[xxxviii] perhaps the most important pledge is to develop a regional coordination mechanism for disaster preparedness and response.[xxxix] Although the specific targets that have been identified by the plan include the development of Standard Operating Procedures for regional response, the regional COVID-19 response has driven the Forum leaders towards the cooperation necessary to deliver this goal and will perhaps provide then with the impetus to take these commitments forward. Another example of regional cooperation for resilience building is the Pacific Resilience Partnership (PRP) which was established in 2019. This has provided a mechanism for greater civil-society/state cooperation across the region on disaster and climate resilience, and supporting implementation of the Framework for Resilient Development in the Pacific. Both these mechanisms have proved themselves during the current health crisis.

Pacific Humanitarian Pathway for COVID-19 ('PHP-C')

The geography of the Pacific region make it particularly vulnerable to logistics and transport challenges around the delivery of medical and humanitarian assistance (as well as other more ordinary supplies). The elimination of COVID-19 from most of the region meant that these issues, rather than the virus itself became the main focus.

In March 2020, Pacific Island Forum Foreign Ministers invoked the Biketawa Declaration to establish the Pacific Humanitarian Pathway on COVID-19 ('PHP-C'), a Pacific-led initiative which aimed to expedite forum members' requests for medical supplies, technical experts, and humanitarian assistance.[xl] The PHP-C was designed to coordinate existing humanitarian relationships with regional and international organisations and development partners. It specifically focused on establishing common regional protocols around the deployment of technical personnel; customs and biosecurity; immigration; repatriation of foreign nationals and diplomatic clearances for aircraft and ships transporting medical or humanitarian assistance.[xli]

A Ministerial Action group was established by the Forum Foreign Ministers, along with a Regional Task Force to oversee the implementation of the PHP-C. This was a significant development given the traditional emphasis on national sovereignty and bi-lateral links in the field of disaster management. The PHP-C thus represented an important shift in practical efforts to tackle

disaster risk management as a region, in line with the Boe Declaration and the Action Plan published in 2019.[xlii] It is also significant that the response was Pacific Island-led, demonstrating the capacity for cooperation outside of the ambit of development partners (although the delivery of some PHP-C initiatives relied heavily upon external assistance).

The PHP-C created a political environment where cooperation could take place and allowed coordination to complement existing humanitarian response. Most importantly it provided a single mechanism to facilitate Forum member state requests for assistance from both regional and regionally based international organisations as well as development partners. The PHP-C operates under a political leadership provided by the Ministerial Action Group (MAG), established in April 2020. This comprises representatives from nine Forum members (50% of the membership) Australia, Cook Islands, Fiji, Nauru, New Zealand, Republic of Marshall Islands, Tonga, Tuvalu and Vanuatu. This political leadership was complemented by a Regional Task Force comprising representatives of the PIF members states, PIF Secretariat, The Pacific Community (SPC), Pacific Chiefs of Police, Pacific Immigration Development Community, Oceania Customs Organisation, Pacific Islands Legal Officers Network, Pacific Aviation Security Office, representatives from the WHO-led Joint Incident Management Team and the World Food Programme.

In addition to providing a single point of contact for assistance, the PHP-C also provided a mechanism to map regional resources and ascertain the level of assistance required in the context of the COVID-19 pandemic (and multi-hazard events occurring in the context of COVID-19). The PHP-C established an online platform to facilitate information exchange for planning purposes and manage requests for assistance and coordinate responses between both Forum members and assistance agencies. This level of regional cooperation which had not been seen prior to the COVID-19 pandemic but in practice reflects the commitments to regional level mapping and delivery of assistance made under the Boe Declaration. COVID-19 and its multi-sector response requirements seems to have provided a practical incentive to drive regional cooperation in the field.

One other focus of the PHP-C was the development of common regional protocols to facilitate requests for humanitarian assistance, again something envisaged under the action plan of the Boe declaration. Although quite high level, the establishment of these protocols could nevertheless be a starting point for the establishment of regional benchmarks for the provision of an all hazards preparedness and response mechanism in the future. Nevertheless, although the establishment of these under the PHP-C marks a watershed for the Pacific, the soft law nature of the protocols should be noted.

Thus, the protocols are:

> "guidance only and expressly subject and intended to be applied only to the extent permissible under the laws, policies, operational and risk management frameworks of Members …".[xliii]

Bearing in mind these limitations, the protocols, are still impressive in their coverage and utility, particularly as they were drawn up within three months of the establishment of the PHP-C. The protocols themselves currently cover the following areas:

- Deployment of technical personnel to and between Forum nations: outlines a precautionary approach to deployment of technical personnel with a focus on pre-travel, transit, in-country and departure measures.[xliv]

- Customs and biosecurity: sets out guidelines for a consistent approach on customs and biosecurity including that relief consignments for export, transit, temporary admission and import require priority treatment and actions.[xlv]

- Immigration: sets out guidance regarding immigration control and visa policy to facilitate the entry, stay and departure of foreign health and other related aid and relief personnel working within the PHP-C.[xlvi]

- Repatriation of forum nationals: provides guidance on a common approach for repatriation of Forum Member nationals present in other Forum countries.[xlvii]

- Clearances for aircraft and ships transporting medical and humanitarian assistance, technical personnel and repatriating nationals: provides guidance for diplomatic clearances to state aircraft and ships, and commercial clearances to other aircraft and ships to facilitate the transportation of medical and humanitarian assistance, technical personnel and the repatriation of national under the PHP-C.[xlviii]

Pacific Humanitarian Air Service

The other practical assistance most obviously provided through the offices of the PHP-C was the establishment of the Pacific Humanitarian Air Service. This was a practical response to the particular logistical problems experienced by the Pacific Island states due to the collapse of the passenger travel across the region and the suspension of commercial air services as a consequence. This created significant challenges for logistics and supply chains across the region. The gap was filled by the establishment of Pacific Humanitarian Air Service which ensured that commercial flight suspensions did not impede the delivery of urgently required personnel, equipment and supplies.

This service, established with the financial assistance of development partners (particularly Australia, which provided AU$3.5M to assist its establishment service) provided for the provision of air transport services to allow the movement of urgently required cargo and to ensure that humanitarian personnel and supplies are not restricted by commercial transport closures.

The service did not replace the commercial sector but acted as a safety net for the provision for air transport where no viable commercial options were available.

The regional nature of service meant that its use (which was provided free of charge) was managed regionally, with requests for services being managed by the Pacific Logistics Cluster, with requests from Pacific governments coming via the PHP-C. Modelled on the World Food Programme's United Nations Humanitarian Air Service (UNHAS), the PHAS has carried personnel and cargo through the pandemic when such deliveries cannot feasibly be delivered by commercial means in the required timeframe, is humanitarian or medical in nature and requests come from an eligible entity (a recognised humanitarian organisation or pacific government via the PHP-C). [xlix] The first flight of the PHAS, from Fiji to Papua New Guinea, took place on 6 August 2020 and delivered 44 cubic metres of essential medical supplies.[l] The service is ongoing.

Technical Cooperation: The Pacific Resilience Partnership

The Pacific Resilience Partnership (PRP) has also played an increasingly prominent role, particularly in the wake of the ongoing pandemic response under the Framework for Resilient Development in the Pacific: An Integrated Approach to Address Climate Change and Disaster Risk Management (FRDP).[li] The FRDP provides high level strategic advice to a broad range of stakeholders on how to enhance climate change and disaster resilience through integrated approaches that are embedded in sustainable development.[lii] It was endorsed by Pacific Forum Leaders in 2016.[liii] One of its key principles is to strengthen and develop partnerships across countries and territories, including sharing of lessons learned and best practices (though without compromising sovereignty and related

considerations).[liv] The FDRP and the Technical Working Groups within it have provided regular meetings to enhance coordination between states and allow for a degree of regional learning to take place in the wake of the current crisis.

The importance of the role of local leadership in the region has been highlighted in the context of the COVID-19 pandemic, and is particularly reflected in the surge in activity of the PRP's Technical Working Group on Localisation since the onset of the pandemic. There is a strong perception that reduced international presence in the region has strengthened local ownership of disaster preparedness and response. In July 2020, the localisation working group carried out a mapping of local actors working in the Pacific to identify the impacts of the COVID-19 pandemic across humanitarian and development sectors with the aim of developing an understanding of what support local actors need.[lv] The results of this survey were compiled into a report that was published in March 2021.[lvi] Key findings indicate that 90% of local actors engage across different levels of coordination in humanitarian response in the Pacific, however it is noted that further work is needed to translate this engagement into meaningful joint collaboration and partnerships. Specifically, local actors indicated they wished to increase their knowledge of disaster risk reduction policies so they could participate more meaningfully during crises. The survey also found that the pandemic has resulted in new modalities of work and technical collaboration and a general increase in the use of digital platforms, which has increased regional technical virtual support. Developing a strategy to capitalise on this was identified as crucial.

NGO and UN Cooperation: OCHA Pacific Humanitarian Team (PHT)

Alongside the PRP, the UN Office for the Coordination of Humanitarian Affairs (OCHA) continues to support the PHT to ensure regional and global NGOs cop-operate in the provision of humanitarian assistance in Pacific disasters.[lvii] The PHT which comprises UN agencies, red cross, regional and bilateral organisations, national and international NGOS, faith based and community based organisations and donor partners has played a significant role in the COVID-19 response through the creation of the PHT COVID-19 Humanitarian Response Plan (HRP).[lviii] The PHT COVID-19 HRP maps current humanitarian responses in the region and seeks to apply additional resources to ensure that urgent needs arising as a direct result of COVID-19 are addressed, and existing humanitarian multi-hazard responses are maintained in the context of the COVID-19 restrictions. It covers all humanitarian sectors except immediate health response, which is guided by a separate plan coordinated by the WHO-led Pacific Joint Incident Management Team for COVID-19.

The HRP provides a regional overview with the intention that country consultations can provide detailed requirements to be matched to humanitarian assistance response capabilities as the context has become clearer. PHT member organisations are thus able to utilise the PHT as a basis for developing specific bilateral proposals and cluster responses. This HRP is regularly updated to reflect the evolving situation of COVID-19 in the context of other hazards and disaster responses.

The Health Emergency Context: The WHO-led Pacific Joint Incident Management Team for COVID-19

In addition to the above regional cooperation agreements for states and NGOs, which operate in the disaster risk reduction/ management space, the World Health Organisation has operated a parallel Joint Incident Management Team (Joint IMT) based at the WHO office in Suva, Fiji.[lix] This group includes representatives from a wider group including the Asian Development Bank (ADB), the Australian Department of Foreign Affairs

and Trade (DFAT), the IFRC, the International Organization for Migration (IOM), New Zealand Ministry of Foreign Affairs and Trade (MFAT), the Pacific Island Forum Secretariat, Pacific Island Health Officers' Association (PIHOA), the Pacific Community (SPC), the United Nations Population Fund(UNFPA), the United Nations Children's Fund (UNICEF),The United Nations Office of the Resident Coordinator (UNRCO), United Nations Development Programme(UNDP), UN Women the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), The U.S. Agency for International Development (USAID), United States Center for Disease Control and Prevention (CDC), the U.S. Embassy Suva, the World Food Programme (WFP) and the World Bank.

Unlike the PHP-C, this is a global NGO and development partner framework designed to coordinate external partners to provide technical advice to assist in delaying the spread of the virus and mitigate the various socioeconomic impacts of the pandemic. This has included training and technical guidance, procuring the critical laboratory access and medical supplies needed to test and treat cases as well as ensuring adequate supplies of personal protective equipment.

The Joint IMT collaborates closely with Ministries of Health across the Pacific and partners from other clusters through the OCHA PHT regional cluster system. It is not clear how it works with the PHP-C, however. Nevertheless, the Joint IMT has provided assistance in addressing critical supply, including laboratory supplies and personal protective equipment (PPE) as well as the provision of technical advice on a range of public health measures, including screening at points of entry, isolation and quarantine facilities, developing case management protocols and strengthening communications to raise public awareness around appropriate pandemic response measures.

To facilitate these measures the Joint IMT developed a six month plan in the early stages of the pandemic to assist partners in coordinating their activities and to ensure regional access to expert guidance and the necessary supplies to deliver an effective health based pandemic response.[lx] The COVID-19 Pacific Health Sector Support Plan was drafted in parallel to the PHT COVID-19 Humanitarian Response Plan. There is a close coordination between the Joint IMT and the PHT

Regional Co-ordination and Cooperation in Public Health Emergencies

The mechanisms outlined above have provided a degree of regional cooperation across the region in the COVID-19 pandemic and reflect a level of institutionalised regional cooperation that has not been common in either public health emergencies or natural disasters in recent times. This is to be welcomed and it is hoped that the gains made through the PHP-C and the PRP in particular will be built upon in the post-pandemic era. However, it still remains a concern that regional responses remain disparate and to a degree, fragmented. In addition, the operation of parallel health and non-health frameworks does not assist co-ordination, particularly in a region where administrative capacity is limited. If regional disaster response is to truly reflect the needs of the Pacific region more streamlined and integrated frameworks seem a logical step. In addition, the Pacific led nature of the PHP-C in particular could provide the embryonic model for the level of disaster response and risk reduction cooperation envisaged in the Boe declaration.

How do things measure up against the Bangkok Principles?

The Pacific Island states in their governance of disasters appear to make little reference to the Bangkok principles and it is not clear that they have been a formal part of disaster law planning and policy in the states examined. Nevertheless, the majority of the states examined have certainly shown commitments to their implementation, even if this is not explicit.

The systematic integration of health into the disaster risk and risk management programmes (principle 1) is clearly far from complete across the Pacific region but there is clearly a level of integration that can be built upon. In particular, the inclusion of public health emergencies as part of the wider disaster law framework, evident in the majority of the states studied, is to be commended and the authors would suggest that this should become standard practice across the region. One aspect of concern that does need to be addressed, is the lack of specific consideration of vulnerable groups and the failure to mainstream this into disaster law frameworks. Few states applied such considerations as a matter of course which risks isolating already vulnerable communities, particularly in events such as COVID-19 where the impact of freedoms, such as travel or association could be disproportionate when applied to vulnerable groups. Anecdotal evidence from across the region suggested that there is a real risk of this occurring as formal mechanism failed to incorporate vulnerable group NGOs or interest groups into their response considerations.

Coordination between health authorities and other relevant stakeholders (principle 2) is something that the states studied engaged in but the exact level is unclear from the primarily desktop studies undertaken for this work.

Where the cluster model is integrated into the disaster response framework, the possibility of such cooperation across the NGO and state health sectors is clearly enhanced (as in Tonga and Samoa for example) but it is difficult to ascertain the exact nature of such cooperation without more in country analysis. However, formal cooperation with a clear co-ordination role for a single agency (in practice, a properly resourced NDMO, as envisaged by principle 3) operating across a cluster model as practiced in several of the countries studied is the model most capable to responding to the multi-sector requirements of public health and multi-hazard emergencies.

Principles 4-6 which focus on data sharing and training across sectors are difficult to assess given the nature of this study, but again the mainstreaming of the health sector into disaster risk reduction and disaster risk management capacity is the only method of achieving this. In all but Papua New Guinea and Marshall Islands, this appears to be the case, although further study to ascertain the practical delivery of these goals is required.

Finally, the promotion of coherence [in]... national policies and strategies, legal frameworks, regulations, and institutional arrangements (principle 7) is something that clearly varies across states. It is clearly something that all the states examined wish to pursue but given that only one (Vanuatu) has formally developed a coherent single integrated model of cross-hazard disaster response it is not clear that this is being pursued in practice. However, discussions with a number of stakeholders across a number of states (including Samoa and Fiji) suggest that recent experiences have led to a realisation that parallel disaster response systems are not sustainable in an environment where multi-

sectoral and multi-hazard disasters are likely to increase.

In Fiji, it is understood that the current review of the Disaster Management Act, will now take this into account and ensure that a single nested management structure exists in future. It is hoped that Papua New Guinea too, which is currently undertaking a review of its dated disaster law framework, takes this into account. It is important to note that this recommendation does not deny the importance of recognising the specific nature of health emergencies, many of which require long-term response phases, but that such specific health expertise must be nested within legal frameworks that recognise the multi-faceted nature of health response.

Although health emergencies are driven by a biological hazard and thus must have health at the core of the response, many aspects of that response (control of movement, provision of resources, logistical management, etc) are part of standard disaster responses. When a volcano erupts we look to vulcanologists or to inform us of the hazard and the likely impacts, we don't get them to manage the logistics of the response effort. In multi-hazard events and particularly public health emergencies, that division of labour and responsibility must be made clear in a single, coherent disaster law framework, tailored to the needs to specific community it serves. Creating parallel legal response frameworks does not achieve this end.

In conclusion, despite the lack of formal reference to the Bangkok principles by the Pacific Island states examined, the Pacific region appears to be on a journey to implement their spirit, if perhaps unintentionally. The current levels of integration, while less than ideal, are still in excess of those seen in some other, more developed states, which have struggled with the complexity of the multi-sectoral approach required by COVID-19. However, the limits of the Pacific state legal frameworks have been exposed by the need for many to adopt new laws and retain them under emergency powers for long periods. Overall, the systems studied have managed to respond to the requirements of the COVID-19 pandemic, at times alongside other disasters, in a way that many developed states could learn from. It is the recommended that Pacific Island states learn from those which have adopted highly integrated models and for non-island states to learn from their success. As such the lessons of COVID-19 will allow Island states to cope with the increased level of disaster response that surely lies ahead.

Summary of Conclusions and Recommendations

The disconnect between NDMOs and health emergencies is well known. Although clearly a disaster, as defined internationally,[lxi] and despite acceptance of the 2016 Bangkok principles,[lxii] pandemics remain outside the core business of National Disaster Management Organisations. The COVID-19 pandemic exposed the weakness of this approach. This issue was particularly noticeable in the Pacific Island states where the COVID-19 disaster has often been experienced through the economic and logistical consequences of the pandemic rather than the health impacts of the disease itself.

Findings:

The majority of Pacific Island states examined formally operate hybrid frameworks (frameworks that are mainly based on public health emergency legislation, but with disaster risk management and/or SoE laws supporting and supplementing that legislation to a lesser or greater extent).

In practice, however, most have a separate and parallel structure for biological hazards/ health risks in contrast to hazards which are be geological or meteorological in nature.

The disaster risk management framework plays a larger role in hybrid frameworks than in other global examples

The existence of hybrid frameworks did allow states to adapt to the very different requirements of the global pandemic in the Pacific.

A role for the NDMO is common in the health emergency structure. This proved vitally important in allowing multi-hazard responses to cope with the pandemic.

Most Pacific Island states appear to have developed models to allow some level of integration of health and other disasters, beyond that seen in many non-Pacific models (and in metropolitan Pacific states).

The regional framework played a key role in the Pacific response through the PHP-C and shows the potential for effective regionally managed disaster response.

The legal gap around the realities of the global pandemic meant that the legal frameworks existing in almost all the Pacific Island states studied were exposed.

This resulted in new emergency regulations and long states of exception (emergency/ disaster, etc) in many states.

This normalisation of the exceptional had leads inexorably to executive creep and the normalisation of exceptional measures. This has created wider constitutional issues in many Pacific Island states

Without culturally relevant checks and balances, some states risk living in a semi-permanent state of exception and emergency given the likelihood of continued crisis in the wake of climate change and future pathogen driven disasters.

Disaster and Public Health Emergency Frameworks in the Pacific

Recommendations

The creation of single statute disaster law frameworks (to include public health emergencies) in those states where no such statutory framework exists.

The creation of clear statutory frameworks around public health emergencies (identified as such) as part of a wider disaster law framework to address the regulatory needs of public health emergencies.

The integration of legal frameworks to manage disaster response and recovery, across all hazards, including public health emergencies.

The streamlining of disaster law and public health emergency frameworks, with an emphasis on local relevance, simplicity and clarity of operation.

The creation of legal frameworks to address long duration disasters, while complying with the rule of law and democratic principles, without the need to utilise long term states of exception.

Explicit and improved integration of NDMOs into the public health emergency law framework

The establishment of regional/international legal arrangements around logistical cooperation in national, regional and global disasters leading to long term isolation for Pacific Island states.

Greater consideration of the role and protection of vulnerable groups (and individuals) within Pacific disaster law frameworks, particularly in relation to long term disasters (such as public health emergencies).

The further development and formalisation of regionally led disaster and public health cooperation mechanisms under the Pacific Forum's Boe Declaration.

Appendix – Research Questions

Institutional Frameworks for All-Hazard Disaster Preparedness and Response

Consider the following in the light of recent examples

What are the main laws, policies, strategies and plans relating to:

- public health emergencies/disasters (including pandemics or epidemics)?
- other types of emergencies/disasters (e.g. floods, earthquakes, chemical spills, bio hazards and tsunami etc).
- Were any changes introduced in response to COVID-19?

Explain the nature of special emergency powers the government has for responding to both public health and other emergencies/disasters? Include reference to:

- which government authorities can exercise the powers?
- in what circumstances can the powers be exercised
- where the legal powers are located (e.g. Constitution, Emergency Decree, Public Health Act, Disaster Management Act, a combination thereof)
- If special emergency powers for responding to emergencies are provided for outside of the Disaster Management Act, how do they link to the Disaster Management Act?
- Powers to create legislation and subsidiary legislation during an emergency.

Describe the roles and responsibilities of each government and non-government actor (as reflected in relevant laws, policies, strategies or plans) for responding to:

- public health emergencies/disasters?
- other emergencies/disasters?

Is there a coordination mechanism for the actors that are involved in responding to public health and other emergencies/disasters? If yes;

- Who is included in the coordination mechanism?
- Which government actor has overall command and control of the response?

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?

What is the role of the Ministry of Health in relation to:

- public health emergencies?
- other types of emergencies/disasters? (particularly health hazards which follow other disaster events)

Does the law require the government to notify any international organisation;

- of any event which may constitute a public health emergency of international concern (including the WHO)?
- of any emergency or a disaster beyond the example of Health?

Regional Mechanisms

- Explain how regional arrangements have been or could be developed to facilitate humanitarian assistance (under the Pacific Humanitarian Pathway for COVID-19 for example)?
- Explain how the Pacific Humanitarian Pathway for COVID-19 has been implemented in domestic arrangements at the national level?

In COVID-19

- Other examples

Financial Response Tools

- What is the legal framework around the provision of financial support (including changes to tax and other Government regimes for charges or levies) for widespread loss of livelihoods?

Human Mobility (Internal and External)

- How are border closures related to a disaster managed? Are there any recent examples of a disaster or emergency (including COVID-19) which have led to border closures or restrictions? (including for migrants, tourists, transit passengers)

How are internal restrictions and lockdowns managed?

- Any assistance to persons locked out of their residential areas/homes?
- How were supplies and necessities for those in lock down managed?).
- How were exceptions to restrictions during curfews and in lockdown areas managed?
- Were there any measures for facilitating movement of goods or supplies transiting through lockdown area?

Shelter and Housing

- What is the legal framework for the provision of shelter and housing in the event of a disaster or emergency? (including for homeless, residents of informal settlements).
- Were there any measures taken to address persons being displaced from their homes due to effects of COVID-19 (in addition to those relating to question 12)? (e.g. eviction of tenants who can't pay rent due to inability to find work or being laid off from work due to COVID-19)

Protection of Vulnerable Groups

- During an emergency or disaster event how is particular vulnerable groups protected? Consider in particular:
- non-residents/citizens (including undocumented migrants) legally entitled to access healthcare and government assistance programs?
- How are the needs of persons with Disabilities addressed?

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[x] IHR, Article 2.

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[xii] It should also be noted that the "hard law" nature of the IHR has made little difference to their implementation, which remains problematic. See for example, Annual Report on the Implementation of the International Health Regulation (2018), A71/7, 5 April 2018, s28. https://apps.who.int/iris/bitstream/handle/10665/276299/A71_7-en.pdf?sequence=1&isAllowed=y

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[xix] See further Pacific Islands Forum, Pacific Humanitarian Pathway on COVID-19 (PHP-C) Common Protocols, available at https://www.forumsec.org/2020/08/04/20774/.

[xx] Boe Declaration Action Plan, 2019

[xxi] E.g. New Zealand, Taiwan and Singapore,

[xxii] The 2018/19 flu pandemic killed over 20% of the popluation of Samoa

[xxiii] https://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/

[xxiv] The unfortunate exceptions to this are now Fiji and Papua New Guinea.

[xxv] Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction 2015-2030, Principle 1.

[xxvi] We have excluded

[xxvii] Public Health (Amendment) Act 2020

[xxviii] The need to modernise existing legal frameworks was recognised by a number of contributors to this report. However, many also commented that as many NDMOs are in a "constant state of response" few have time and resources to properly undertake such legal work.

[xxix] This work was primarily undertaken prior to the growth of cases in PNG and the 2021 outbreak in Fiji.

[xxx] Emergency Powers (COVID-19) Regulations 2020 - LN 29, 2020, s24

[xxxi] See https://www.rnz.co.nz/international/pacific-news/422202/call-for-new-COVID-19-emergency-legislation-in-solomon-islands

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[xxxiv] See further https://monitor.civicus.org/updates/2020/08/25/new-png-pandemic-law-puts-rights-risk-while-groups-protest-against-mine-and-domestic-violence/.

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[xlviii] Available at: https://www.forumsec.org/wp-content/uploads/2020/08/PHP-C-Protocol-on-PHP-C-CLEARANCES.pdf

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