



GUIDANCE ON LAW AND PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE

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Disaster Law

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ABOUT IFRC DISASTER LAW

IFRC Disaster Law and National Red Cross and Red Crescent Societies (**National Societies**) have 20 years of experience in providing technical assistance to governments to strengthen their disaster laws, and in building the capacity of domestic stakeholders on disaster law. To date, the IFRC network has assisted more than 40 countries to strengthen their disaster laws and has conducted disaster law activities in more than 90 countries.

The IFRC network's mandate on disaster law derives from several resolutions of the [International Conference of the Red Cross and Red Crescent](#) (International Conference), passed by the states parties to the Geneva Conventions and the components of the Red Cross and Red Crescent Movement. These resolutions mandate:

- National Societies to provide advice and support to their governments in the development and implementation of effective legal and policy frameworks relevant to disaster and emergency management at all levels; and
- IFRC to support states and National Societies in the area of disaster law, through technical assistance, capacity building, the development of tools, models and guidelines, advocacy and ongoing research.

To this end, IFRC Disaster Law has produced three key guidance documents that have been endorsed by resolutions of the International Conference:

- the [Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance](#) (the **IDRL Guidelines**);
- the [Checklist on Law and Disaster Risk Reduction](#) (the **DRR Checklist**); and
- the [Checklist on Law and Disaster Preparedness and Response](#) (the **DPR Checklist**).

These guidance documents are used by the IFRC network and other stakeholders as a benchmark and tool for evaluating and strengthening domestic disaster-related laws.

The work of IFRC Disaster Law is made possible by the generous support of its partners, including academic institutions, law firms, governmental authorities and National Societies. If you would like to support IFRC Disaster Law's work or request technical disaster law assistance please contact disasterlaw@ifrc.org.

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

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Thanks are also owed to those who contributed to the report entitled Law and Public Health Emergency Preparedness and Response: Lessons from the COVID-19 Pandemic (IFRC, 2020) upon which this Guidance is based. Those individuals are acknowledged in that report.



TERMINOLOGY

Actors is an umbrella term for the very broad range of governmental and non-governmental entities that play a role in PHE risk management. This includes (but is not limited to): governmental actors that are primarily responsible for PHE risk management (usually health and disaster management authorities); governmental actors responsible for essential non-health services (e.g. housing, education, social care, domestic violence prevention and response); private sector actors, especially medical and social care providers and manufacturers of essential goods and equipment; non-governmental and civil society organisations; and community leaders and groups.

COVID-19 is an infectious disease caused by the coronavirus SARS-CoV-2. The term has been used somewhat interchangeably to refer to the virus, the disease and the pandemic. This Guidance uses the terms **SARS-CoV-2 virus**, **COVID-19** and **COVID-19 Pandemic** to refer, respectively, to the virus, the disease and the pandemic.

Disaster is a serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts.¹

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

Disaster risk management (DRM) is the application of policies, strategies and other measures to prevent new disaster risk, reduce existing disaster risk and manage residual risk (through disaster preparedness, response and recovery), contributing to the strengthening of resilience and reduction of disaster losses.³

Disaster risk reduction (DRR) is aimed at preventing new and reducing existing disaster risk and managing residual risk, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development.⁴

Epidemic refers to the occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy.⁵

Legal facilities are special legal rights that are provided to an organisation (or a category of organisations) to enable it (or them) to conduct operations efficiently and effectively. Legal facilities often take the form of exemptions from a law or legal requirement that would otherwise apply or access to simplified and expedited regulatory processes.

Legal preparedness for disasters and emergencies refers both to a *process* and an *outcome*. As a *process*, legal preparedness refers to reviewing and strengthening legal instruments to ensure they: (i) provide an enabling environment for effective and efficient disaster risk management; and (ii) mitigate the common legal problems that arise during disasters and emergencies. It also includes implementing existing legal arrangements through developing operational procedures and plans, training actors (especially concerning their roles and responsibilities), and dissemination and awareness raising for the general public. As an *outcome*, legal preparedness refers to the state of being legally prepared, meaning having in place well-designed, well-understood and well-implemented laws, regulations, procedures and plans relating to disasters and emergencies.

One Health is an approach to designing and implementing laws, policies, programmes and research that recognises the health of people is closely connected to the health of animals, plants and the environment. The One Health approach is characterised by communication and collaboration between the different actors responsible for human, animal, plant and environmental health with the aim of achieving better public health outcomes. The areas of work in which a One Health approach is particularly relevant include food safety, the control of zoonoses and vector-borne diseases, and combatting antibiotic resistance.⁶

Pandemic refers to an epidemic occurring over a very wide area, crossing international boundaries, and usually affecting a large number of people.⁷

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

Public health emergency (PHE) is, according to the World Health Organization, an occurrence or imminent threat of an illness or health condition, caused by bioterrorism, epidemic or pandemic disease, or a novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human fatalities or incidents or permanent or long-term disability.⁸

Public health emergency of international concern (PHEIC) is a concept introduced and defined by the International Health Regulations. It means an extraordinary event which is determined by the Director General of the World Health Organization: (i) to constitute a public health risk to other states through the international spread of disease; and (ii) to potentially require a coordinated international response.⁹

Public health emergency risk management (PHE risk management) is an umbrella term to refer to all key aspects of managing PHEs from risk reduction, through to preparedness, response and recovery.

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

Sexual and gender-based violence is a composite term used within the Red Cross Red Crescent Movement to refer to two distinct but overlapping phenomena: (i) sexual violence; and (ii) gender-based violence.¹⁰

States of exception is an umbrella term for states of emergency, states of disaster and states of public health emergency.

Vulnerability means the conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards.¹¹

Democratic Republic of the Congo, 2018

Barnabe Looma, Chief of Office Volunteer with the DRC Red Cross runs a team of volunteers who conduct safe and dignified burials in the community surrounding Mbandaka, DRC.

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INTRODUCTION

Background to this Guidance

The domestic regulation of public health emergencies (**PHEs**) is inextricably linked to the regulation of other types of disaster. PHEs are usually governed *at least partly* by general disaster and emergency laws. Moreover, there is significant overlap in the legal mechanisms used to respond to PHEs and other types of disaster, including the declaration of a state of disaster or emergency and the use of emergency powers. Even where PHEs are regulated by separate instruments, those instruments must surmount many of the same policy and practical challenges as general disaster laws, such as finely balancing competing considerations (e.g. speedy response versus due process), facilitating the coordination of a multitude of actors, and protecting the most vulnerable within society. Finally, many contemporary developments in disaster risk management (**DRM**), such as a greater emphasis on risk reduction and preparedness, are just as pertinent to PHEs as to other types of disaster.

IFRC Disaster Law and National Societies have 20 years of experience in providing technical assistance to governments to strengthen their disaster laws and in developing guidance on domestic best practice for the regulation of disasters. Noting the inextricable links between the domestic regulation of PHEs and other types of disaster, this Guidance builds on IFRC Disaster Law's existing body of work, especially [The Checklist on Law and Disaster Preparedness and Response](#)¹² (**DPR Checklist**) and its accompanying [Multi-Country Synthesis Report](#)¹³ (**DPR Report**). This Guidance is equally informed by a report entitled [Law and Public Health Emergency Preparedness and Response: Lessons from the COVID-19 Pandemic \(PHE Report\)](#).¹⁴ The PHE Report, which is based on country-level desktop research and a literature review undertaken in 2020, provides detailed comparative analysis of domestic legal frameworks for PHE preparedness and response. This Guidance reflects the recommendations of both the PHE Report and the DPR Report.

Purpose and scope of this Guidance

The COVID-19 Pandemic has underlined the importance of being *legally prepared* for PHEs. A key finding of the PHE Report is that a significant number of the countries surveyed have relatively old laws and policies for PHEs, which do not reflect a contemporary, all-public health risks approach. The PHE Report consequently recommends that laws, policies, and plans relating to PHEs should be reviewed and updated regularly. The purpose of this Guidance is to serve as an assessment tool to support the review and updating of laws, policies and plans relating to PHEs. This may include instruments dedicated specifically to PHEs, as well as more general disaster and emergency laws, policies and plans. The Guidance has been designed to assist domestic decision-makers to identify critical legal and policy issues for consideration, and to evaluate how well those issues are currently addressed by existing instruments. The guidance provided in this document is intended to be high-level and non-prescriptive; it should be interpreted in light of each country's specific constitutional, legal, political, institutional, and operational arrangements.

It is essential that domestic legal and policy frameworks address: reducing the risk of PHEs occurring in the first place (**PHE risk reduction**); ensuring countries are prepared to respond to PHEs (**PHE preparedness**); effectively responding to PHEs (**PHE response**); and supporting recovery from the impacts of PHEs (**PHE recovery**). These four key aspects are referred to collectively in this Guidance as **PHE risk management**. However, like the PHE Report and the DPR Report, this Guidance focuses predominantly on PHE preparedness and response. Accordingly, there are important topics that fall

beyond the scope of this Guidance, for which it is hoped that research and guidance will be forthcoming in the wake of the COVID-19 Pandemic. These topics include (but are not limited to): the role of law in facilitating the surveillance and control of zoonotic disease; authorisation of medical countermeasures and regulation of associated liability risks; legal standards for laboratory biosafety and biosecurity; and legal regimes for biological sample sharing.

The International Health Regulations (2005)

The most important international instrument relating to PHEs is the International Health Regulations (2005) (**IHR**), an international treaty that is legally binding on 196 states. The IHR predominantly address the sharing of information between states and the World Health Organization (**WHO**), the development of domestic capacities for surveillance and response to public health events, and the implementation of public health measures at points of entry (i.e., international airports, ports, ground crossings). While implementation of the IHR through national laws is critically important, it is not sufficient to achieve legal preparedness for PHEs. This is because the IHR addresses only a subset of the domestic arrangements necessary for the effective management of PHEs. This Guidance addresses many additional components of a comprehensive PHE risk management system including institutional arrangements, early warning of public health risks, the facilitation of humanitarian assistance, the protection of vulnerable groups and the use of state of disaster/emergency mechanisms and powers.

Question 3 of this Guidance addresses the domestic implementation of the IHR. It should be noted that the WHO has developed the following more detailed guidance on this specific topic:

- [International Health Regulations \(2005\) – A Brief Introduction to Implementation in National Legislation](#); ¹⁵
- [International Health Regulations \(2005\) – Toolkit for Implementation in National Legislation: The National IHR Focal Point \(NFP\)](#); ¹⁶ and
- [International Health Regulations \(2005\) – Toolkit for Implementation in National Legislation: Questions and Answers, Legislative Reference and Assessment Tool and Examples of National Legislation](#). ¹⁷

This Guidance should be read in conjunction with the above documents.

How to use this Guidance to support a legislative review process

This Guidance comprises a list of nine key questions which are designed to provide governmental officials, and those supporting them, with a structure for reviewing existing laws, policies and plans relating to PHEs. For each question in this Guidance, there is a brief rationale, a set of more targeted sub-questions and a list of possible laws and policies to consider in the review process. There is also an indication about where to find further information on the topic. Each question and sub-question should be considered in turn. For each sub-question, it is recommended to undertake the following three-step analysis.

1. Do provisions of relevant laws address this issue adequately?
2. If not, does a non-legal document (e.g. policy, strategy, plan) address this issue adequately, so that legal provisions are unnecessary?
3. Are the relevant provisions, whether in law or policy, adequately implemented in practice?



Sierra Leone 2014 Australian nurse Anne Carey joined the fight against Ebola, working at the Red Cross treatment centre in Sierra Leone.
© Michael Duff / IFRC

This three-step analysis permits reviewers to identify: the strengths and gaps in the existing legal and policy framework; whether new or updated laws and policies are required; and whether a greater focus is needed on implementation of existing laws and policies.

To answer the questions as fully as possible, reviewers should implement a consultative process involving a wide range of actors and stakeholders, including all relevant ministries and levels of government, subject matter experts and practitioners, the private sector, civil society organisations, the National Red Cross or Red Crescent Society, community leaders and representatives of vulnerable groups. It is also strongly recommended to include disaster law and public health law experts in consultations. This should ideally include public health law experts with experience in the domestic implementation of the IHR. A key focus of consultations should be to discuss the practical challenges that actors and stakeholders have experienced in recent PHEs and to identify whether any of these challenges are due to gaps or weaknesses in the existing legal and policy framework or deficiencies in its implementation.

Every legal and policy framework relating to PHEs will have its strengths, gaps and weaknesses. Where gaps or weaknesses are identified, countries may wish to consider amending existing laws, policies and plans, or developing new ones. Countries should, once again, involve a wide range of actors and stakeholders in this process including, where possible, disaster law and public health law experts. Following the enactment of legal or policy reforms, countries should also consider developing an implementation plan to address: training for actors on new provisions, especially concerning their roles and responsibilities; dissemination and awareness raising for the general public; the timeframe and key milestones for implementing the new instruments; and responsibility for monitoring and evaluating implementation.

Nepal 2021 Nepal Red Cross volunteers are providing support at more than 350 vaccination centres around the country, largely focusing on data entry and crowd control. There are 38 vaccination centres, like this one, in Bhaktapur. © Nepal Red Cross



GUIDANCE QUESTIONS

1 / Do your country's laws and policies establish a strong institutional framework for managing PHEs?

It is critical that a country's laws and policies relating to PHEs establish a strong institutional framework. Key components of a strong institutional framework include: the allocation of clear and comprehensive mandates, roles and responsibilities to appropriate actors; effective coordination mechanisms that permit horizontal and vertical coordination; and the participation of all actors and stakeholders as part of a One Health, all-of-society and all-of-state approach.

Clear and comprehensive mandates, roles and responsibilities

Laws, policies and plans should allocate clear mandates, roles and responsibilities for PHE risk management to relevant actors. It is important for these mandates, roles and responsibilities to be comprehensive: firstly, they should encompass risk reduction, preparedness, response and recovery; and second, they should reflect an 'all public health risks' approach that encompasses all types of health hazards that may cause a PHE, including novel and emerging risks and slow-onset risks (e.g. anti-microbial resistance).

In many cases mandates, roles and responsibilities will be tied to the definition of a 'public health emergency'. Where this is the case, it is critical that the definition is clear, comprehensive and used consistently in different legal instruments. The definition of public health emergency should also reflect an all public health risks approach and be broad enough to encompass both primary and secondary PHEs. Further, it should clearly identify the nature and severity of the circumstances that constitute a public health emergency (e.g. number of fatalities or cases, geographical extent).

In a PHE, different types of leadership will be required: for example, legal leadership, operational leadership and political leadership. Laws, policies and plans relating to PHEs should clearly identify the nature of the leadership roles in a PHE and the functions and powers associated with each leadership role. Further, they should avoid or mitigate any potential conflicts or unnecessary duplication of leadership roles.

Effective coordination mechanisms

The effective participation of a multitude of actors requires strong coordination. Coordination is required *horizontally* between different governmental actors. Coordination is also required *vertically* between different levels of government, especially in federal states and states that have adopted a decentralised approach to PHE or disaster risk management. Finally, coordination is also required between governmental and non-governmental actors. Law and policy can facilitate effective coordination by establishing coordination mechanisms, specifying which actors are included, and imposing obligations on participants to meet regularly and share information with one another.

Participation of all actors and stakeholders

A large-scale PHE can require action from virtually every tier of government, every sector, every region, every community, and every individual. A One Health, all-of-society and all-of-state approach that facilitates the participation of all actors and stakeholders is, therefore, essential. When implemented effectively, this approach can harness the knowledge, capacities and resources of all actors and stakeholders, while also promoting the protection and inclusion of at-risk communities and vulnerable groups.

It is critical to enable the participation of the following actors and stakeholders in PHE risk management: One Health actors (i.e. public health, animal health, plant health and environmental actors); non-health governmental actors (e.g. disaster management, education, housing); the private sector (e.g. private medical and social care providers; manufacturers and suppliers of essential goods and equipment); non-governmental organisations and civil society organisations; community leaders (e.g. traditional, religious or elected leaders); and representatives of vulnerable groups. The participation of these actors and stakeholders can be achieved through allocation of appropriate roles and responsibilities, inclusion in coordination mechanisms and consultation requirements.

PHE risk management can also be strengthened by implementing the Risk Communication and Community Engagement (**RCCE**) approach, which involves two-way communication and engagement directly with affected populations so that they can take informed decisions to protect themselves.¹⁸ The RCCE approach is critical to countering misinformation, confusion, and mistrust, thereby promoting increased community uptake of public health measures. It can be promoted by laws and policies through, for example, a requirement to develop and implement plans for engaging and communicating with affected populations.

Auxiliary role of National Red Cross and Red Crescent Societies

Each National Society has a unique legal status as ‘auxiliary to the public authorities in the humanitarian field’.¹⁹ The auxiliary role of a National Society entails a specific and distinctive partnership with its public authorities.²⁰ While it is the primary responsibility of public authorities to provide humanitarian assistance to vulnerable people in their territory, National Societies supplement their public authorities in the fulfilment of this responsibility, including by providing a wide range of health-related services.²¹

The role of National Societies in the response to epidemics and pandemics is acknowledged by Resolution 3 of the 33rd International Conference of the Red Cross and Red Crescent which calls on states to, amongst other things, include National Societies in national disease prevention and control and multisectoral preparedness and response frameworks.²² For National Societies to effectively perform their auxiliary role in the context of PHEs, their roles and responsibilities need to be clearly defined in laws, policies and plans. Moreover, these instruments should provide for them to be included in relevant coordination bodies.

Guiding sub-questions

Clear and comprehensive mandates, roles and responsibilities

1. Do laws, policies and plans assign relevant actors clear mandates, roles and responsibilities for PHE risk management?
2. Do the mandates, roles and responsibilities encompass risk reduction, preparedness, response and recovery?
3. Do the mandates, roles and responsibilities reflect an 'all public health risks' approach that encompasses *all* types of health hazards that may cause a PHE?
4. If there is a legal definition of 'public health emergency', does the definition:
 - a. reflect an 'all public health risks' approach;
 - b. encompass both primary and secondary PHEs; and
 - c. clearly identify the nature and severity of the circumstances that constitute a PHE?
5. If there is a legal definition of 'public health emergency', is this definition used consistently in *all* instruments?
6. Do laws, policies and plans clearly identify the nature of the leadership roles in a PHE and the functions and powers associated with each leadership role?
7. Do laws, policies and plans avoid or mitigate any conflict or unnecessary duplication of leadership roles in a PHE?

Effective coordination mechanisms

8. Do laws, policies and plans relating to PHEs facilitate coordination:
 - a. *horizontally* between different governmental actors;
 - b. *vertically* between different levels of government; and
 - c. between governmental and non-governmental actors?
9. Do laws, policies and plans relating to PHEs establish coordination mechanisms that include representatives from:
 - a. all relevant sectoral departments;
 - b. all relevant units/divisions *within* sectoral departments;
 - c. all levels of government; and
 - d. all relevant non-governmental actors?
10. Do laws, policies and plans impose obligations on actors to meet regularly and share information with one another?

Participation of all actors and stakeholders

11. Do laws, policies and plans relating to PHEs adopt a One Health, all-of-society and all-of-state approach?

12. Do laws, policies and plans relating to PHEs facilitate the participation of the following actors and stakeholders:
 - a. One Health actors (i.e. public health, animal health, plant health and environmental actors);
 - b. non-health governmental actors (e.g. disaster management, education, housing);
 - c. the private sector (e.g. private medical and social care providers; manufacturers and suppliers of essential goods and equipment);
 - d. non-governmental organisations and civil society organisations;
 - e. community leaders (e.g. traditional, religious or elected leaders);
 - f. representatives of vulnerable groups?
13. If there is an ongoing presence or need for support from UN agencies, international non-governmental organisations and/or development cooperation actors, do laws, policies and plans facilitate their participation in PHE risk management?
14. Do laws, policies and plans relating to PHEs adopt the Risk Communication and Community Engagement (**RCCE**) approach?
15. Do laws and policies relating to PHEs designate who is responsible for developing and implementing plans for engaging and communicating with affected populations during a PHE?

Role of National Red Cross and Red Crescent Societies

16. Do laws, policies and plans relating to PHEs acknowledge the auxiliary role of the country's National Society?
17. Do laws, policies and plans relating to PHEs clearly outline the National Society's roles and responsibilities for PHE preparedness and response?
18. Do laws, policies and plans relating to PHEs provide for the National Society to be included in coordination mechanisms for PHE preparedness and response?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection
- Red Cross or Red Crescent Law



Further information and guidance:

[PHE Report Chapter 4](#)

[DPR Report Chapter 1](#)

[DPR Checklist Question 1](#)

[Resolution 2 of the 30th International Conference of the Red Cross and Red Crescent](#)

[Resolution 3 of the 33rd International Conference of the Red Cross and Red Crescent](#)

[Guide to Strengthening the Auxiliary Role through Law and Policy](#)



Mongolia 2021 Tserennadmid Tseren lives alone in his small home in Tuv province, central Mongolia. Mongolian Red Cross staff and volunteers visit the 85-year-old's yurt each month as part of their home care project. They helped him get his three COVID-19 vaccine doses and brought food parcels during lock-downs in the province.

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2 / Are your country's PHE laws and policies integrated and coherent with broader disaster laws and policies?

In most countries around the world, there is a main disaster risk management (**DRM**) law which governs a broad range of hazards and disasters. In some countries, PHEs fall within the scope of the main DRM law and are governed by this law and related DRM instruments such as policies and plans. In other countries, PHEs are regulated separately to non-PHE disasters, through a set of parallel instruments and arrangements dedicated specifically to PHEs. By far the most common scenario is, however, that PHEs are governed by a *combination* of general DRM and PHE-specific instruments. Where this is the case, it is critical that the DRM and PHE instruments are coherent and integrated with one another, rather than creating contradictory or duplicative arrangements.

The importance of integration is recognised by the Bangkok Principles for the Implementation of the Health Aspects of the Sendai Framework (**Bangkok Principles**), which call for coherence and alignment between national DRM frameworks and those related to emergency and disaster risk management for health.²³ Whilst there is an identified need for coherence and integration, there is a lack of practical guidance about what exactly this means and how it can be achieved in practice. This Guidance posits that DRM and PHE instruments are coherent and integrated with one another when certain key features are present. Firstly, DRM and PHE instruments should reflect the same overarching principles and approach to risk management and, when viewed collectively, should provide a foundation for all key risk management activities for PHEs and non-PHE disasters. That is, there should be no gaps in terms of what actors are required or permitted to do to reduce the risk of, prepare for, respond to, and recover from PHEs and non-PHE disasters.

There should also be clarity about the leadership arrangements, mandates, roles, responsibilities, and coordination mechanisms that apply to PHEs and non-PHE disasters. Importantly, there should be no conflicts or unnecessary duplication in the respective mandates, roles and responsibilities of health and DRM actors in PHEs and non-PHE disasters. Equally, there should be no conflicts or unnecessary duplication in the leadership arrangements for PHEs and non-PHE disasters. Leadership arrangements, mandates, roles and responsibilities will often be tied to the definition(s) of 'public health emergency' and/or 'disaster'. It is, therefore, critical that these definitions are clear and indicate precisely which hazards and types of emergencies they encompass. Recognising the health dimensions of non-PHE disasters and the relevance of DRM resources and capacities to PHEs, health and DRM actors should have clear roles and responsibilities in both PHE and non-PHE disasters. Finally, to the extent that different coordination mechanisms are used for PHEs and non-PHE disasters, health actors and DRM actors should be included in both types of coordination mechanism.

Coherence and integration between DRM and PHE instruments can be strengthened by analysing whether these key features are present and, to the extent they are absent, introducing appropriate legal and policy reforms. Achieving greater integration and coherence may only require targeted amendments to existing instruments; alternatively, it may require significant reforms such as the repeal and redrafting of instruments. Equally, non-legal measures may be appropriate such as training actors to better understand their respective roles and responsibilities or implementing measures to strengthen relationships between different actors.

Guiding sub-questions

1. What laws, policies and plans are used to manage health hazards and PHEs in your country?
2. What laws, policies and plans are used to manage other types of hazards and disasters in your country?
3. Do the instruments identified in questions 1 and 2 reflect the same overarching principles and approach to risk management?
4. When viewed collectively, do the instruments provide a foundation for all key risk management activities for PHEs and non-PHE disasters?
5. Do the instruments clearly outline the leadership arrangements, mandates, roles, responsibilities and coordination mechanisms that apply to PHEs and non-PHE disasters?
6. Do the instruments reveal any potential conflicts or unnecessary duplication in the mandates, roles and responsibilities of health and DRM actors in PHEs or non-PHE disasters?
7. Do the instruments reveal any potential conflicts or unnecessary duplication (as between health and DRM actors) in terms of the leadership arrangements in PHEs or non-PHE disasters?
8. If there is a legal definition of 'public health emergency' and/or 'disaster', do the definitions indicate precisely which hazards and types of emergencies they encompass?
9. Do the instruments allocate health actors clear roles and responsibilities in both PHE and non-PHE disasters?
10. Do the instruments allocate DRM actors clear roles and responsibilities in both PHE and non-PHE disasters?
11. If different coordination mechanisms are used for PHEs and non-PHE disasters, are health and DRM actors included in both types of coordination mechanism?
12. What (if any) legal and policy reforms could be implemented to improve coherence and integration between DRM and PHE instruments?
13. What (if any) practical measures could be implemented to improve coherence and integration between PHE risk management and DRM?

Check laws and policies related to:

- Disaster risk management/emergency management/civil protection
- Public health/health hazards/public health emergencies



Further information and guidance:

[PHE Report Chapter 4](#)

3 / Do your country's laws implement and support ongoing compliance with the International Health Regulations?

The most important international instrument relating to PHEs is the International Health Regulations (2005) (**IHR**), an international treaty that is legally binding on 196 states. The IHR establish a set of rights and obligations relating to public health risks and public health emergencies of international concern. The term 'public health emergency of international concern' (**PHEIC**) is defined by the IHR as an extraordinary event which is determined by the Director General of the WHO: (i) to constitute a public health risk to other countries through the international spread of disease; and (ii) to potentially require a coordinated international response.²⁴

The IHR require states parties to develop, strengthen and maintain the domestic capacities: to detect, assess, notify and report 'events', meaning the manifestation of disease or an occurrence that creates potential for disease; and to respond promptly and effectively to public health risks and PHEICs.²⁵ These capacities are commonly known as the **IHR core capacities**; Annex 1 to the IHR outlines exactly what is required to meet the core capacities. While the IHR core capacities are designed with the international spread of disease in mind, in practice several of the actions required are just as relevant to detecting and responding to more localised or less severe public health risks and PHEs that occur on a sub-national or national scale. For example, one of the IHR core capacities is to establish, operate and maintain a national public health emergency response plan.²⁶

The IHR also establishes a detailed information-sharing regime to ensure the sharing of information regarding events that may constitute a PHEIC between the WHO, the affected state and other states parties.²⁷ The obligations imposed on states parties as part of this information-sharing regime include a duty to:

- designate or establish a **National IHR Focal Point**, meaning the national centre that gathers information from domestic authorities and communicates it to the WHO, and also disseminates information from the WHO to domestic authorities;²⁸
- notify the WHO—within 24 hours of assessment of public health information—of all events that may constitute a PHEIC within its territory and any health measures implemented in response to such events;²⁹ and
- continue to communicate to the WHO timely, accurate and sufficiently detailed public health information on the notified event such as case definitions, laboratory results, number of cases and deaths, and health measures employed.³⁰

The fulfilment of these obligations can be supported by domestic laws that clearly designate the National IHR Focal Point, outline its roles and responsibilities, and permit it to collect and share information with the WHO, as required by the IHR.



Afghanistan 2019 Conflict-induced displacement, the devastation of the COVID-19 pandemic, serious drought, acute food shortages, a fractured health system have converged on the people of Afghanistan. Afghan Red Crescent is providing support in some of the hardest hit provinces, including through their mobile health care teams. Afghan Red Crescent's mobile clinics continue to provide critical healthcare and lifesaving treatment for children and women in regional and remote areas of Afghanistan. © Afghan Red Crescent / Meer Abdullah

Unfortunately, as the PHE Report finds, there have been widespread deficiencies in states' implementation of the IHR, especially the core capacities described above.³¹ The WHO has sought to promote domestic implementation of the IHR core capacities through its IHR Monitoring and Evaluation Framework, which includes: annual reporting; Joint External Evaluation; simulation exercises; and after-action (and, more recently, intra-action) review. While Joint External Evaluation (JEE), in particular, has considerable potential benefit, it is voluntary and there is no obligation on states to implement findings or develop post-evaluation action plans. This is something that may be remedied through domestic laws and policies that mandate the development and implementation of post-evaluation action plans following a JEE or any other form of evaluation. More generally, a good practice identified in the PHE Report is establishing a committee or other body responsible for overseeing the domestic implementation of the IHR or, alternatively, allocating this responsibility to an existing domestic authority.

The WHO has developed detailed guidance on the domestic implementation of the IHR in national legislation. This guidance, which is identified below, should be directly consulted when reviewing and updating domestic laws, policies and plans relating to PHEs. Further, where possible, countries should seek the advice of a public health law expert with experience in the domestic implementation of the IHR.

Guiding sub-questions

1. Does law and/or policy clearly designate the National IHR Focal Point and set out the Focal Point's role, responsibilities and powers?
2. Does the law provide the National IHR Focal Point with sufficient authority and powers to perform its functions, including authority to collect and disclose information that may otherwise be subject to confidentiality or data protection laws?
3. Does the law require relevant actors to provide the National IHR Focal Point with the information the Focal Point needs to determine whether and when to notify the WHO of an event that may constitute a PHEIC?
4. Do laws, policies and plans implement the core capacities outlined in Annex 1 to the IHR?
5. Do laws and/or policies clearly identify who is responsible for overseeing implementation of the IHR and monitoring ongoing compliance?
6. Do laws and/or policies require the production and implementation of post-evaluation action plans following evaluation of domestic IHR implementation?
7. Do laws and/or policies clearly identify the domestic actor(s) with responsibility for producing a post-evaluation action plan and monitoring its implementation?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection



Further information and guidance

[PHE Report Chapter 3](#)

[WHO, International Health Regulations \(2005\) - A Brief Introduction to Implementation in National Legislation](#)

[WHO, International Health Regulations \(2005\) - Toolkit for Implementation in National Legislation: The National IHR Focal Point \(NFP\)](#)

[WHO, International Health Regulations \(2005\) - Toolkit for Implementation in National Legislation: Questions and Answers, Legislative Reference and Assessment Tool and Examples of National Legislation](#)

[WHO, Benchmarks for International Health Regulations \(IHR\) Capacities](#)

4 / Do your country's laws and policies facilitate PHE preparedness, early warning and early action?

A core feature of an effective framework for managing disasters and emergencies is the preparation and planning undertaken in advance. Preparedness refers to the development of the knowledge and capacity to effectively anticipate, respond to and recover from the impacts of likely, imminent and current disasters.³² Key preparedness activities include contingency planning, education, training, drills and simulation exercises. It also includes the development of an effective early warning system that prompts early action. These preparedness measures are just as important for PHEs as for other types of disaster.

Contingency planning is the process of analysing disaster risks and identifying and recording the concrete actions that will be taken by different actors to respond to those risks if they materialise. It is essential that there are clear legal duties to conduct contingency planning for PHEs, and that the contingency planning process provides opportunities for consultation with all actors and stakeholders. Contingency plans should be based on risk assessments that consider the vulnerability of different groups and should reflect the resources and capacities available in the local context. Importantly, contingency planning should be mandated not only for public health and DRM actors, but for all sectors of government to ensure continuity of essential services during a PHE, including for: general health care; schooling; prevention and response services for sexual and gender-based violence; and health and social care for older people and people with a disability or chronic illness.

For contingency plans to be effective, they need to be well understood and well implemented by the actors to whom they assign roles and responsibilities. This can be achieved in several ways, including by requiring actors to ensure that their personnel receive appropriate education and training, and participate in regular drills and simulation exercises. Drills and simulation exercises also provide an important opportunity to test the appropriateness of planned arrangements and update them if required. While drills and simulation exercises typically focus on operational issues, it is also important to use them as an opportunity to ensure actors understand key elements of the applicable legal framework and to test legal preparedness for PHEs.

Another key preparedness activity is the development of an effective early warning system (**EWS**) that prompts early action. An effective early warning system has four key interrelated components: (1) developing risk knowledge through the systematic collection of data and preparation of risk assessments; (2) monitoring hazards using accepted scientific methodologies; (3) communicating and disseminating authoritative, timely, accurate, clear and actionable warnings; and (4) preparedness at all levels to respond to the warnings received.³³ The law can facilitate the development of an effective early warning system for PHEs by clearly allocating roles and responsibilities for each of these four components.

Of particular importance, the law should require a specified governmental actor (e.g. health department or disaster management office) to provide early warning of health hazards to the general population. For early warnings to translate into early action there needs to be awareness and readiness to act at all levels of society and in all communities. Education and training can promote the general population's ability to respond promptly and appropriately to warnings. It can be made available to a broad segment of the population through incorporation into the school curriculum and/or through the efforts of local government authorities, civil society organisations and community leaders.

Guiding sub-questions

1. Do the main actors that are responsible for PHE preparedness and response have a legal duty to produce and maintain contingency plans for PHEs?
2. Do laws and/or policies require these actors to ensure their personnel receive appropriate education and training and participate in regular drills and simulation exercises?
3. Do education, training, drills and simulation exercises test legal preparedness for PHEs and promote understanding of the legal framework applicable to PHEs?
4. Do sectoral departments have a legal duty to produce and maintain contingency plans for continuity of essential services during PHEs and non-PHE disasters?
5. Do laws and/or policies require consultation with a broad range of actors and stakeholders in the development of contingency plans?
6. Do laws and/or policies clearly outline roles and responsibilities for implementing an earlywarning system for PHEs including:
 - a. developing risk knowledge (including data collection and risk assessment);
 - b. monitoring health hazards; and
 - c. disseminating warnings?
7. Do laws require a specified governmental actor (e.g. health department or disaster management office) to issue early warnings of health hazards to the general population?
8. Do laws and/or policies provide for education and training for the general population regarding PHEs including on how to respond to early warnings?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection



Further information and guidance

[PHE Report](#) Chapters 3 and 4

[DPR Report](#) Chapter 3

[DPR Checklist](#) Question 3

5 / Do your country's laws establish 'state of exception' mechanisms that support effective response to PHEs?

A common legal mechanism used to respond to a PHE is a declaration of a state of emergency, state of disaster or state of public health emergency (collectively referred to as **states of exception**).

A declaration of a state of exception causes a switch to an emergency legal modality, which is usually characterised by the availability of special emergency powers. Emergency powers fall into two broad categories: (1) emergency law-making powers, which usually give the executive branch of government the ability to make laws, decrees, orders or regulations to address the disaster or emergency; and/or (2) pre-determined emergency powers such as powers to order evacuations, expropriate property, or restrict movement. The declaration of a state of exception may also trigger special governance arrangements or the release of funds and other resources.

It is common for countries to have two or more types of state of exception designed to be used in different circumstances. Indeed, a country should ideally have a variety of states of exception that are proportionate and tailored to the different types and magnitude of disaster that may occur, including PHEs.³⁴ Such a system should be scalable depending on the severity and geographic scope of a disaster or emergency, with higher level states of exception — characterised by more extensive emergency powers and/or broader geographic coverage — used only when strictly necessary. A scalable system can promote the rule of law and government accountability, by permitting only the minimum necessary departure from normal legal arrangements.

For a state of exception mechanism to help rather than hinder the response to a PHE, it should have several key features.

- **Declarant:** The law should clearly identify the person who has the authority to make the declaration and establish a hierarchy of officials authorised to make the declaration if the named official is unavailable. If more than one person can make a declaration of a state of exception in relation to a PHE (e.g. under different sectoral legislation or at different levels of government), the law should clearly set out the circumstances in which each person can make a declaration, identify who has primacy in the event of a conflict, and require those persons to coordinate with one another.
- **Criteria:** The law should clearly identify the criteria for making a declaration of a state of exception in relation to a PHE. To facilitate anticipatory action, the criteria should enable a declaration to be made *pre-emptively* where, for example, a health hazard is sufficiently serious, likely to materialise and proximate (temporally and geographically).
- **Emergency powers:** The law should clearly specify the emergency powers that arise once a state of exception is declared in relation to a PHE. It is generally preferable for laws to include a pre-determined, precise and exhaustive list of emergency powers, although broader powers may be necessary for very severe or large-scale PHEs.

Emergency powers and measures implemented during a state of exception may have significant human rights impacts. Any limitation or derogation from human rights should be consistent with international human rights law and applicable regional human rights treaties. It is also critical that safeguards and



Syria 2021 639 children attended health awareness sessions by Syrian Arab Red Crescent. SARC volunteers have developed educational sessions to be carried out and raise health awareness of as many children as possible. © Syrian Arab Red Crescent

transparency measures are in place during states of exception to maintain the rule of law and promote government accountability. The following safeguards and transparency measures may be implemented.

- **Judicial supervision:** provision for the judiciary (i.e. the courts) to review the legality of the declaration or extension of a state of exception and action taken during a state of exception and to make orders to redress action that is unlawful.
- **Parliamentary supervision:** provision for parliament to ratify the declaration of a state of exception, to approve or ratify the extension of a state of exception, and/or to amend or terminate a state of exception (including power to amend details such as the geographical scope, time period and emergency measures in force).
- **Consultation and advice:** a requirement for the person who is authorised to make a declaration of a state of exception to consult with or act on the advice of: (a) other key government officials (e.g. the health minister; heads of affected sub-national jurisdictions); and/or (b) relevant experts or expert bodies (e.g. national scientific or medical advisory committees). A requirement to consult or act on advice may also apply in relation to the determination of emergency measures.
- **Time limits:** a limit on the period that a state of exception may remain in force, whether expressed as an overall time limit or a limit on the number and length of extensions.
- **Publication:** a requirement for declarations of states of exception, emergency decrees or regulations, and the details of emergency measures to be published and made available to the widest possible audience.

Guiding sub-questions

States of exception generally

1. Does the law establish a variety of states of exception that are proportionate and tailored to the different types and magnitude of disaster that may occur in your country, including PHEs?

Responsibility for declaring a state of exception

2. Does the law clearly identify the person(s) who has the authority to make a declaration of a state of exception in relation to a PHE?
3. If more than one person can make a declaration of a state of exception in relation to a PHE (e.g. under different sectoral legislation or at different levels of government), does the law:
 - a. clearly set out the circumstances in which each person can make a declaration;
 - b. identify who has primacy in the event of a conflict; and
 - c. require those persons to coordinate with one another?
4. Does the law establish a hierarchy of officials authorised to make a declaration of a state of exception if the named official is unavailable?

Criteria for declaring a state of exception

5. Does the law clearly identify the criteria for making a declaration of a state of exception in relation to a PHE?
6. Do the criteria enable a declaration of a state of exception in relation to a PHE to be made pre-emptively where a health hazard is sufficiently serious, likely to materialise and proximate (temporally and geographically)?

Emergency powers

7. Does the law clearly specify the emergency powers that arise once a state of exception is declared in relation to a PHE?
8. Are the emergency powers that arise pre-determined, precise and exhaustive?

Judicial and legislative supervision

9. Does the law ensure that the judiciary has the jurisdiction and power to:
 - a. review the legality of a declaration of a state of exception, its subsequent extension and any action taken during a state of exception; and
 - b. make appropriate orders to redress any illegality (for example, by way of declaration of invalidity, penalties or compensation)?
10. Does the law require the legislature to:
 - a. ratify the declaration of a state of exception; and
 - b. approve or ratify the extension of a state of exception?
11. Does the law empower the legislature to amend or terminate a state of exception, including power to amend details such as the geographical scope, time period and emergency measures in force?

Consultation and advice

12. Does the law require the person who is empowered to declare a state of exception and/or to determine emergency measures in relation to a PHE to consult with or act on the advice of:
- key government officials such as the health minister or heads of affected sub-national jurisdictions; or
 - relevant experts or expert bodies such as national scientific or medical advisory committees?

Time limits

13. Does the law impose a time limit so that a state of exception will terminate automatically after a specified period unless it is extended?
14. Does the law impose a limit on the total period that a state of exception may remain in force?

Publication

15. Does the law require the following to be published:
- any declaration of a state of exception;
 - any emergency decrees or regulations; and
 - the details of emergency measures introduced?
16. Does the law require the information identified in question 15 above to be published through a variety of communication channels?

Check laws and policies related to:

- Constitutional laws
- States of emergency or disaster
- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection



Further information and guidance

[PHE Report](#) Chapter 5

[DPR Report](#) Chapter 5

[DPR Checklist](#) Question 5

6 / Do your country's laws provide legal facilities to humanitarian actors for PHE preparedness and response?

Humanitarian actors, including National Societies and the IFRC, play a key role in the response to disasters and emergencies of all kinds, including PHEs. To respond efficiently and effectively, humanitarian actors require **legal facilities**. The term legal facilities refers to special legal rights that are provided to a specific organisation (or a category of organisations) to enable it (or them) to conduct operations efficiently and effectively. Legal facilities often take the form of exemptions from a law or legal requirement that would otherwise apply, or access to simplified and expedited regulatory processes.

Since its inception in 2001, IFRC Disaster Law has had a strong focus on promoting legal facilities for DRM. The [DPR Checklist](#) identifies the legal facilities that domestic humanitarian actors require for disaster preparedness and response, while the [IDRL Guidelines](#) provide recommendations for minimum legal facilities that should be provided to assisting states and humanitarian organisations for international disaster response. The DPR Checklist and IDRL Guidelines 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.³⁵

A key principle underpinning these two guidance documents is that legal facilities should be conditional on compliance with minimum quality standards and the humanitarian principles of humanity, neutrality, and impartiality. Moreover, it is the prerogative of the government of an affected state to determine which actors satisfy these requirements and should be *eligible* to receive legal facilities. These actors are, consequently, referred to as 'eligible actors'.

Many of the legal facilities identified in the DPR Checklist and the IDRL Guidelines are just as relevant to PHEs as to other types of disaster. In addition, the COVID-19 Pandemic has illustrated that restrictions introduced to curb the spread of a novel infectious disease – such as restrictions on freedom of movement and assembly and border closures – can unintentionally impede the response activities of humanitarian actors, unless targeted exemptions are granted.³⁶ The legal facilities required by eligible humanitarian actors during PHEs may include (but are not limited to):

- exemption from restrictions on freedom of movement and assembly (e.g. lockdowns, shelter-in-place orders or curfews);
- exemption from any restrictions on the import or export of goods and equipment (e.g. on personal protective equipment or medical supplies);
- exemption from border closures and, subject to health safeguards or criteria, exemption from requirements to quarantine or self-isolate upon arrival;
- waiver of the requirement for, or expedited provision of, visas and work permits for humanitarian personnel;
- automatic or expedited recognition of foreign (and, for federal states, interstate) qualifications and licences (e.g. for doctors, nurses); and
- exemption from taxes and fees directly associated with PHE preparedness and response activities, including customs duties and taxes.

These legal facilities may be required not only for preparedness and response to PHEs, but also for other disasters and emergencies that occur during a PHE. It may be necessary for the exemptions identified above to be subject to health safeguards, rather than provided automatically, to prevent the spread of a biological agent. However, health safeguards should only be imposed when, and for as long as, necessary. Further, they should be proportionate and tailored to the relevant health risk and not be framed to, in effect, render the exemptions unusable or unworkable.

Guiding sub-questions

1. Do your country's laws establish the legal facilities identified in the DPR Checklist and the IDRL Guidelines?
2. Do the laws that enable restrictions on freedom of movement and assembly to be imposed during a PHE or other disaster provide for humanitarian actors to be exempted?
3. Do the laws that enable import or export restrictions to be introduced during a PHE or other disaster provide for humanitarian actors to be exempted to enable them to freely import and export relief goods and equipment?
4. Do the laws that enable border closures or restrictions to be introduced during a PHE or other disaster provide for humanitarian personnel to be exempted?
5. Do laws waive requirements for, or significantly expedite, visas and work permits for humanitarian personnel during a PHE or other disaster?
6. Do laws provide for automatic or expedited recognition of foreign (and, for federal states, interstate) professional qualifications and licences during a PHE or other disaster?
7. Do laws and/or policies exempt humanitarian actors from taxes and fees incurred in preparing for and responding to PHEs and other types of disaster?
8. Where legal facilities are subject to health safeguards, are those health safeguards:
 - a. only applicable when, and for as long as, necessary;
 - b. tailored and proportionate to the relevant health hazard; and
 - c. workable, in the sense of permitting humanitarian actors to conduct their activities?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection
- States of emergency or disaster
- Charitable/not-for-profit/humanitarian organisations
- Red Cross or Red Crescent Law
- Immigration
- Employment
- Professional licensing
- Taxation
- Export and import controls



Further information and guidance

[PHE Report Chapter 9](#)

[IDRL Guidelines Part V](#)

[IDRL Checklist Question 5](#)

[IDRL Model Act Chapter VI](#)

[DPR Report Chapter 6](#)

[DPR Checklist Question 6](#)

Greece 2020 On 8 September, a devastating fire ripped through the Reception and Identification Centre in Moria, on the island of Lesbos, as migrants and refugees remained in COVID-19 lockdown. The camp was at more than four times its capacity and the fire all but destroyed it, prompting close to 13,000 refugees who had been living there to flee.

© IFRC



7 / Do your country's laws and policies minimise forced immobility and its negative impacts during PHEs?

All types of disaster can have an impact on human mobility. Like other types of disaster, a PHE may prompt physical flight; fear of contagion or a desire to avoid restrictions may drive internal and international movement. PHEs can, however, affect human mobility in quite different ways than other types of disaster. As the COVID-19 Pandemic has shown, restrictions imposed to prevent the spread of disease can create the opposite of forced displacement: **forced immobility**.³⁷

Border and travel restrictions introduced during the COVID-19 Pandemic have had a negative impact on many migrants and foreign citizens wishing to be repatriated, some of whom became stranded. During the COVID-19 Pandemic, citizens or permanent residents have generally been exempted from *inbound* border and travel restrictions. However, in some cases, restrictions on *outbound* travel and practical impediments (e.g. a lack of flights) have impeded repatriation. The forced immobility created by border and travel restrictions has been especially serious for migrants experiencing loss of livelihood, irregular or uncertain migration status, or illness or disease without access to healthcare.

Border and travel restrictions may have very severe – potentially even life-threatening consequences – for refugees, asylum seekers and others fleeing irreparable harm. At least at the outset of the COVID-19 Pandemic, a significant number of countries that fully or partially closed their borders did not make exceptions for asylum seekers. In some countries, there were also delays in the processing of applications for asylum due to the disruption caused by the Pandemic. Inbound and outbound border and travel restrictions also had negative impacts on people needing to travel for urgent personal reasons, such as to access life-saving medical care that is not available in their usual place of residence.

Border and travel restrictions potentially impinge on the right under article 12 of the International Covenant on Civil and Political Rights (ICCPR) to be free to leave any country including one's own, and not to be arbitrarily deprived of the right to enter one's own country.³⁸ As has occurred during the COVID-19 Pandemic, border and travel restrictions may also be inconsistent with temporary recommendations issued under the IHR.³⁹ Moreover, where border and travel restrictions result in the return of refugees and asylum seekers to the countries where they risk persecution or irreparable harm, this may breach international refugee and human rights law.⁴⁰

While border and travel restrictions may play a role in preventing the international spread of a biological agent, they should be consistent with states' international legal obligations and include clear exceptions for: migrants and foreign citizens wishing to be repatriated; refugees, asylum seekers and others fleeing irreparable harm; and persons needing to travel for urgent personal reasons. Due to the high likelihood that border and travel restrictions will be introduced during future PHEs, they should be addressed in standing laws, policies and plans relating to PHEs. These instruments should: specify the criteria for border and travel restrictions; identify how such measures will be implemented; provide for the exceptions identified above; and address the practical needs of individuals who may be detrimentally impacted by forced immobility, including repatriation assistance, financial assistance, visa extensions, and access to healthcare.

Guiding sub-questions

1. Do your country's laws, policies and plans relating to PHEs address the potential need to introduce border and travel restrictions in response to the international spread of a biological agent?
2. Do those laws, policies and plans:
 - a. clearly specify the criteria for border and travel restrictions;
 - b. outline how restrictions will be practically implemented;
 - c. include clear exceptions for migrants and foreign citizens that wish to be repatriated;
 - d. include clear exceptions for refugees and asylum seekers;
 - e. include clear exceptions for people needing to travel for urgent personal reasons;
 - f. outline measures to assist migrants and foreign citizens to be repatriated; and
 - g. outline measures to assist migrants and foreign citizens who are stranded including visa extensions, financial assistance and/or access to healthcare?
3. Are laws and policies relating to border and travel restrictions during a PHE consistent with international refugee law and international human rights law?
4. Do laws, policies and plans relating to PHEs establish contingency arrangements to ensure that the reception of asylum seekers and the processing of asylum claims continues during PHEs?

Check laws and policies related to:

- Immigration/refugees and asylum seekers/complementary protection
- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection



Further information and guidance

[PHE Report](#) Chapter 6

8 / Do your country's laws and policies ensure the protection of vulnerable groups during PHEs?

Disasters have a propensity to disproportionately impact certain groups within society including women and girls, children, older people, people with a disability or chronic illness, migrants, indigenous groups, racial and ethnic minorities, and sexual and gender minorities.⁴¹ This Guidance collectively refers to these groups as 'vulnerable groups' notwithstanding the shortcomings of this term.⁴² Some of the factors that contribute to vulnerable groups experiencing disproportionate disaster impacts include direct discrimination, assistance that is not adapted to their specific needs, and vulnerable housing or livelihoods. Vulnerable groups may also be at increased risk of falling victim to the various forms of violent, abusive and exploitative behaviours that generally increase during and following a disaster, such as sexual and gender-based violence and child abuse.

The groups identified above are potentially just as vulnerable during a PHE as in other types of disaster. As the COVID-19 Pandemic has illustrated, transmission of, and serious illness from, a new disease may be much higher among vulnerable groups, such as racial and ethnic minorities, indigenous groups, migrants, and people with lower socio-economic status due to increased exposure, decreased access to (appropriate and adapted) public health measures and/or pre-existing health inequalities. Importantly, the COVID-19 Pandemic has illustrated that vulnerable groups may not only be at heightened risk of primary impacts but may also experience especially severe secondary impacts during a PHE. Major secondary impacts experienced by vulnerable groups during the COVID-19 Pandemic have included: loss of livelihoods; increased incidents of sexual and gender-based violence; educational disruption due to protracted school closures; difficulties accessing general health and social care; and forced immobility (see Question 7).⁴³

In a PHE there may be one major additional vulnerable group: those who are especially vulnerable to the relevant health hazard. History illustrates that this may vary from one PHE to another —young adults were especially vulnerable to the H1N1 virus that caused the 1918 influenza pandemic, pregnant people and their unborn children are especially vulnerable to the Zika virus, while older people and people with certain underlying health conditions are especially vulnerable to COVID-19. Thus, while laws, policies and plans should identify measures that will be implemented to protect those who are most vulnerable to the relevant health hazard, they should also be flexible and not assume that any specific group will *always* be vulnerable. Measures to protect those who are especially vulnerable to the relevant health hazard — such as shielding or mandatory treatment — may be warranted. However, any limitation or derogation from human rights should be consistent with international human rights law and applicable regional human rights treaties.

There are many legal and policy measures that can be enacted to promote the protection of vulnerable groups in disasters and emergencies, including in PHEs. DRM and PHE instruments may include a legal prohibition on direct and indirect discrimination. (Although, this may not be strictly necessary if already provided by anti-discrimination or human rights legislation.) Further, DRM and PHE instruments can provide for representatives of vulnerable groups to be included in coordination and decision-making bodies and create legal requirements for vulnerable groups to be consulted in relation to the design and implementation of PHE preparedness and response activities.

Many of the primary and secondary impacts experienced by vulnerable groups during PHEs are foreseeable and can be mitigated through the following specific legal and policy measures:

- mandating the main actors that are responsible for PHE preparedness and response (usually health and DRM actors) to outline in their contingency plans:
 - how public health measures will be adapted to meet the specific needs of different vulnerable groups; and
 - the measures that may be implemented to protect those most vulnerable to the relevant health hazard;
- mandating relevant sectoral government departments to conduct contingency planning for continuity of essential services during a PHE (or other disaster) including for continuity of:
 - health and social care for older people;
 - health and social care for people with a disability or chronic illness;
 - prevention and response services for sexual and gender-based violence;
 - education for school aged children;
- providing exemptions to restrictions on freedom of movement to enable people to:
 - escape violence and access protection services; and
 - access or provide essential health and social care;
- developing financial assistance programs to be used in the event of a PHE (or other disaster) to assist those who are financially impacted;
- enacting legal protections against eviction or foreclosure that apply during a PHE (or other disaster) to protect people who may otherwise lose their housing due to inability to meet rental or mortgage payments; and
- providing for migrants (including irregular migrants) to have full access to health services and government assistance programs in the event of a PHE (or other disaster).

With respect to the first point above, there are numerous ways in which public health measures may need to be adapted to meet the needs of vulnerable groups. This may include measures such as: disseminating information in a variety of languages, formats, and media; developing culturally appropriate health messages and services; making access to services free of charge or anonymous; and providing services at home and in the community.



Peru 2021 Supporting the national vaccination campaign against COVID-19 of the Health Ministry of Peru for indigenous communities, in 2021 the Peruvian Red Cross together with the IFRC and the ICRC is implementing the project "Facilitation of community dialogue and logistic support to the COVID-19 vaccination for hard-to-reach communities". © Sebastián Castañeda / Reuters / CICR

Guiding sub-questions

1. Does the law prohibit governmental and non-governmental actors from engaging in discrimination in their PHE preparedness and response activities?
2. Do laws, policies and plans relating to PHEs provide for representatives of vulnerable groups to be included in relevant coordination and decision-making bodies?
3. Do laws, policies and plans relating to PHEs require consultation with vulnerable groups in relation to the design and implementation of preparedness and response activities?
4. Are laws, policies and plans relating to PHEs sufficiently flexible to accommodate the fact that different groups may be particularly vulnerable to the relevant health hazard from one PHE to another?
5. Do laws mandate the main actors that are responsible for PHE preparedness and response (i.e. usually health and DRM actors) to include in their contingency plans:
 - a. how public health measures will be adapted to the specific needs of different vulnerable groups; and
 - b. the measures that may be implemented during a PHE to protect those who are most vulnerable to the relevant health hazard?
6. Do laws require that any protective measures for vulnerable groups are consistent with international human rights law and applicable regional human rights treaties?

7. Do laws mandate relevant sectoral government departments to conduct contingency planning for continuity of essential services during a PHE including:
 - a. health and social care for older people;
 - b. health and social care for people with a disability or chronic illness;
 - c. prevention and response services for sexual and gender-based violence; and
 - d. education for school age children?
8. Do laws, policies and plans establish and reflect the principle that school closure should be a measure of last resort during a PHE (or other disaster)?
9. Do contingency plans for educational continuity in a PHE (or other disaster) address:
 - a. alternative means of providing teaching if schools physically close;
 - b. the needs of children who may have difficulty accessing alternative learning; and
 - c. practical measures to enable schools to remain open or to re-open during a PHE?
10. Do the laws that enable restrictions on freedom of movement to be imposed during a PHE (or other disaster) provide exceptions for people to escape violence and access protection services? Are there also exceptions for seeking or providing essential health and social care?
11. Do laws, policies and plans establish financial assistance programs to be used in the event of a PHE (or other disaster) to assist those who are financially impacted?
12. Are there legal protections against eviction or foreclosure that apply during a PHE (or other disaster) to protect people who may otherwise lose their housing due to inability to meet rental or mortgage payments?
13. Do laws and policies provide for migrants (including irregular migrants) to have full access to health care and other government assistance programs during a PHE (or other disaster)?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection
- Immigration/refugees and asylum seekers/complementary protection
- Prevention of sexual violence/domestic violence/family violence/violence against women
- Child protection/child abuse
- Human rights/anti-discrimination
- Education



Further information and guidance

[PHE Report](#) Chapters 7 and 8

[DPR Report](#) Chapter 9

[DPR Checklist](#) Question 9



Netherlands 2020 Netherlands Red Cross volunteers who are health care professionals (i.e. doctors or nurses) in their day to day lives are supporting general practitioners in testing people for COVID 19.

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9 / Do your country's laws ensure that instruments relating to PHEs are regularly reviewed and updated?

The COVID-19 Pandemic has underlined the importance of legal preparedness for PHEs. Concerningly, one of the main findings of the PHE Report is that a significant number of the states surveyed have relatively old PHE laws. The fact that a law is old does not *necessarily* make it ineffective. However, the PHE Report finds that older laws tend not to reflect the contemporary approach to disaster and PHE risk management, which emphasises the importance of all aspects of DRM, from risk reduction through to preparedness, response and recovery. Moreover, older laws tend not to take an 'all health risks' approach that addresses all current and emerging health hazards, instead applying only to a prescribed list of diseases. The prevalence of older legislation with these features highlights the need for states to undertake reviews of their laws, policies and plans relating to PHEs and, where appropriate, bring forward new or amending legislation as a matter of urgency.

Reviews should take place on a periodic basis (e.g. every 5 years) and, additionally, after the occurrence of a PHE, to permit the identification and implementation of lessons learned. A review should encompass the key issues identified in this Guidance and an assessment of how existing laws, policies and plans performed in any recent PHE. It is critical to implement the recommendations identified in reviews by promptly updating laws, policies and plans. One way to ensure that reviews are undertaken, and their findings are implemented, is to impose legal duties on appropriate actors to conduct this task, and to provide for the results of reviews to be summarised in an assessment report that is presented to, or tabled in, parliament. For instruments that can be updated by the executive branch of government without the involvement of parliament, the law should clearly designate who is responsible for regularly reviewing and updating those instruments.

Simulation exercises designed to test operational preparedness for a PHE can also provide a valuable opportunity to identify strengths and weaknesses in existing PHE laws, policies and plans. Indeed, simulation exercises can, and should, incorporate elements designed to test legal preparedness for PHEs. Learnings from simulation exercises should be recorded and, where appropriate, implemented through amendments to applicable laws, policies and plans.



Somalia 2021 Amram Ismail, a 24-year-old pregnant mother of 5, washes her hands as part of the COVID-19 protocols, prior to receiving antenatal care at the Allaybaday Clinic. © IFRC Africa

Guiding sub-questions

1. Has your country recently undertaken a review of its laws, policies and plans relating to PHEs to ensure that they are fit for purpose and address all health hazards that could cause a PHE?
2. Is there a legal requirement to review laws, policies and plans relating to PHEs: (a) on a periodic basis (e.g. every five years); and (b) after the occurrence of a PHE?
3. Does the law clearly identify who is responsible for regularly reviewing laws, policies and plans relating to PHEs?
4. Does the law require the preparation of an assessment report following a review and the presentation or tabling of that report in parliament?
5. For instruments that can be updated by the executive branch of government without the involvement of parliament, does the law clearly designate who is responsible for regularly updating those instruments?

Check laws and policies related to:

- Public health/health hazards/public health emergencies
- Disaster risk management/emergency management/civil protection



Further information and guidance

[PHE Report](#) Section 4.7

ENDNOTES

- 1 Report of the open-ended intergovernmental expert working group on indicators and terminology relating to disaster risk reduction, A/71/644 (1 December 2016) 13 (OIEWG Report). The terminology recommended in this report was endorsed by the United Nations General Assembly on 13 February 2017: Report of the open-ended intergovernmental expert working group on indicators and terminology relating to disaster risk reduction, GA Res 71/276, UN Doc A/RES/71/276 (adopted 13 February 2017).
- 2 Ibid 14.
- 3 This Guidance uses the definition of disaster risk management adopted by the IFRC: International Federation of Red Cross and Red Crescent Societies, Disaster Risk Management Policy (2020) 3 <<https://www.ifrc.org/media/48902>>.
- 4 OIEWG Report (n1) 16.
- 5 Miquel Porta, A Dictionary of Epidemiology (Oxford University Press, 6th ed, 2014) definition of 'epidemic'.
- 6 See World Health Organization, One Health (21 September 2017) <<https://www.who.int/news-room/questions-and-answers/item/one-health>>; Centers for Disease Control and Prevention, One Health Basics <<https://www.cdc.gov/onehealth/basics/index.html>>.
- 7 Miquel Porta (n5) definition of 'pandemic'.
- 8 In the WHO's definition the word "facilities" is used. It is, however, believed that the definition should instead refer to "fatalities". World Health Organization, Definitions: Emergencies <<https://www.who.int/hac/about/definitions/en/>>.
- 9 International Health Regulations (2005), 2509 UNTS 79 (entered into force 15 June 2007) art 1 (IHR (2005)).
- 10 See International Federation of Red Cross and Red Crescent Societies, Global Study - Effective Law and Policy on Gender Equality and Protection from Sexual and Gender-Based Violence in Disasters (2017) <<https://disasterlaw.ifrc.org/media/1788>> 7; International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies, Sexual and Gender-Based Violence: Joint Action on Prevention and Response (Background Report for the 32nd International Conference of the Red Cross and Red Crescent, Geneva, 8–10 December 2015) <https://rcrcconference.org/app/uploads/2015/04/32IC-Background-report-on-Sexual-and-gender-based-violence_EN.pdf> 1–2.
- 11 OIEWG Report (n1) 24.
- 12 International Federation of Red Cross and Red Crescent Societies, The Checklist on Law and Disaster Preparedness and Response (2019) <<https://disasterlaw.ifrc.org/media/1287>> (DPR Checklist).
- 13 International Federation of Red Cross and Red Crescent Societies, Law and Disaster Preparedness and Response Multi-Country Synthesis Report (2019) <<https://disasterlaw.ifrc.org/media/1302>> (DPR Report).
- 14 International Federation of Red Cross and Red Crescent Societies, Law and Public Health Emergency Preparedness and Response: Lessons from the COVID-19 Pandemic (2021) <<https://disasterlaw.ifrc.org/media/3010>> (PHE Report).
- 15 World Health Organization, International Health Regulations (2005) - A Brief Introduction to Implementation in National Legislation (January 2009) <<https://www.paho.org/en/documents/international-health-regulations-2005-brief-introduction-implementation-national>>.
- 16 World Health Organization, International Health Regulations (2005) - Toolkit for Implementation in National Legislation: The National IHR Focal Point (January 2009) <[https://www.who.int/publications/m/item/international-health-regulations-\(2005\)-toolkit-for-implementation-in-national-legislation](https://www.who.int/publications/m/item/international-health-regulations-(2005)-toolkit-for-implementation-in-national-legislation)>.
- 17 World Health Organization, International Health Regulations (2005) - Toolkit for Implementation in National Legislation: Questions and Answers, Legislative Reference and Assessment Tool and Examples of National Legislation (January 2009) <<https://www.paho.org/en/documents/international-health-regulations-2005-toolkit-implementation-national-legislation>>.
- 18 The RCCE approach is closely related to the Community Engagement and Accountability (CEA) approach, which additionally emphasises the importance of accountability to communities. For an introduction to the CEA approach see: International Federation of Red Cross and Red Crescent Societies, A Red Cross Red Crescent Guide to Community Engagement and Accountability (2021) <https://www.ifrc.org/sites/default/files/2021-11/20211020_CEAGuidelines_NEW1.pdf>.
- 19 Statutes of the International Red Cross and Red Crescent Movement, adopted by the 25th International Conference of the Red Cross and Red Crescent (Geneva, October 1986) article 4(3).
- 20 30th International Conference of the Red Cross and Red Crescent Movement, Resolution 2: Specific Nature of the International Red Cross and Red Crescent Movement in Action and Partnerships and the Role of National Societies as Auxiliaries to the Public Authorities in the Humanitarian Field (Geneva, 26 to 30 November 2007) [3].
- 21 Ibid [1].
- 22 33rd International Conference of the Red Cross and Red Crescent Movement, Resolution 3: Time to Act: Tackling Epidemics and Pandemics Together (Geneva, 9 to 12 December 2019) [2].
- 23 Bangkok Principles for the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030, adopted by the International Conference on the Implementation of the Health Aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030 (Bangkok, 10–11 March 2016) <https://www.who.int/hac/events/2016/Bangkok_Principles.pdf?ua=1>.
- 24 IHR (2005) (n9) arts 1, 12.
- 25 Ibid arts 5(1), 13(1), Annex 1.
- 26 Ibid Annex 1, 6(g).
- 27 Ibid Part II – Information and Public Health Response, arts 5–14.
- 28 Ibid art 4(1).
- 29 Ibid art 6(1).
- 30 Ibid art 6(2).
- 31 For a discussion of this topic see: PHE Report (n14) Chapter 3.
- 32 OIEWG Report (n1) 21.
- 33 OIEWG Report (n1) 17.

- 34 For a discussion of this topic see: DPR Report (n13) Chapter 5.
- 35 Resolution 7 of the 33rd International Conference (2019) endorsed the DPR Checklist and invited States to use the Checklist to evaluate and improve the content and implementation of their laws, regulations and policies: 33rd International Conference of the Red Cross and Red Crescent Movement, Resolution 7: Disaster Laws and Policies that Leave No One Behind (Geneva, 9 to 12 December 2019) [3]-[4]. Resolution 4 of the 30th International Conference (2007) adopted the IDRL Guidelines and encouraged States to make use of the Guidelines to strengthen their national legal, policy and institutional frameworks: 30th International Conference of the Red Cross and Red Crescent Movement, Resolution 4: Adoption of the Guidelines for the Domestic Facilitation and Regulation of International Disaster Relief and Initial Recovery Assistance (Geneva, 26 to 30 November 2007) [1]-[2].
- 36 For a discussion of this issue see: PHE Report (n14) Chapter 9.
- 37 For a discussion of this issue see: PHE Report (n14) Chapter 6.
- 38 International Covenant on Civil and Political Rights, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 12.
- 39 World Health Organization, Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV) (30 January 2020) <[https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))>.
- 40 Specifically, this may breach the obligation of non-refoulement established by the 1951 Refugee Convention: Convention Relating to the Status of Refugees, opened for signature 28 July 1951, 189 UNTS 137 (entered into force 22 April 1954) art 33. An obligation of non-refoulement also exists under international human rights law: Office of the High Commissioner for Human Rights, The Principle of Non-Refoulement under International Human Rights Law <<https://www.ohchr.org/Documents/Issues/Migration/GlobalCompactMigration/ThePrincipleNon-RefoulementUnderInternationalHumanRightsLaw.pdf>>.
- 41 For a detailed discussion of this topic see: DPR Report (n13) Chapter 9.
- 42 The term 'vulnerable groups' has several shortcomings. It may be interpreted as implying that vulnerability is inherent to certain people or groups, rather than a product of external social and political factors. Moreover, it arguably homogenises the members of vulnerable groups, and obscures the intersectional nature of vulnerability. The term is nonetheless adopted in this Guidance to serve purely as a convenient shorthand.
- 43 Concerning the socioeconomic impacts of the COVID-19 Pandemic see: International Federation of Red Cross and Red Crescent Societies, 'Drowning Just Below the Surface: The Socioeconomic Consequences of the COVID-19 Pandemic' (2021) <<https://www.ifrc.org/document/drowning-just-below-surface-socioeconomic-consequences-covid-19-pandemic>>.



IFRC Disaster Law works with National Red Cross and Red Crescent Societies and governments to strengthen disaster risk governance, through the development and implementation of disaster and emergency-related legislation, policies and procedures. With 20 years of experience supporting the development and implementation of disaster law and policy around the world, we are the global leader in disaster law technical advice to governments.