Chapter 11: Public health emergencies

SUMMARY POINTS

- Disaster management is a core function of public health law. National laws and emergency plans must take account of international obligations for the management of public health emergencies, including the International Health Regulations (2005) (IHR). The purpose of the IHR is to prevent and manage the public health risks arising from the international spread of disease, while avoiding “unnecessary interference with international traffic and trade”.

- Important obligations that arise under the revised IHR include the following:
  - Each country is required to establish a National IHR Focal Point accessible at all times for communications with WHO.
  - Each country must develop and maintain the capacity to assess health risks within its territory and to notify WHO of all events that may constitute a public health emergency of international concern. The IHR contain a decision instrument to assist countries to identify events requiring notification.
  - The IHR impose a legal requirement on countries to strengthen and maintain their surveillance and response capabilities at local, intermediate and national levels, and at designated airports, ports and ground crossings. At national level, countries are expected to develop the capacity to assess all reports of urgent events within 24 hours.
  - Following a determination by WHO that a public health emergency of international concern is occurring, the Director-General may issue temporary recommendations, after receiving advice from the Emergency Committee. These recommendations may include the requirement to carry out medical examinations and vaccinations, to place suspect persons under public health observation, to quarantine, isolate or require the contact tracing of contacts of affected persons, to carry out exit screening, and to refuse entry to suspect or affected persons.
  - The IHR require countries to exercise their health powers in a transparent and non-discriminatory manner, with full respect for the dignity, human rights and fundamental freedoms of persons. When issuing temporary recommendations, the Director-General shall consider health measures that are neither more restrictive of international traffic and trade nor more intrusive to persons than reasonable and appropriate alternative measures. The IHR contain a number of more specific human rights protections that apply to the exercise of specific powers.
  - In addition to the IHR, the Pandemic Influenza Preparedness (PIP) Framework provides guidance in relation to the sharing of influenza viruses with human pandemic potential through the WHO-coordinated Global Influenza Surveillance and Response System. The framework includes a benefit-sharing system that gives commercial entities access to PIP biological materials in exchange for providing assistance to developing countries.
  - National authorities should develop a national emergency plan that sets out a clear chain of command and takes account of all relevant levels of government. The legal authority and roles of key officials during an emergency should be defined in legislation. These powers may include the authority to take such actions as are reasonably required to deal with a serious risk to public health. Public health laws should establish clear triggers for the application of emergency powers, with clear time limits. Disaster management laws should enable individuals to seek an
independent review of decisions that restrict their fundamental rights.

- In order to ensure an adequate health workforce during an emergency, public health laws may grant temporary practice licenses to health professionals who are inactive, retired or licensed in other jurisdictions.

- National emergency plans should establish a national stockpile of essential medicines, vaccines and medical supplies to meet emergency needs.

- In some circumstances, public health laws authorize government authorities to take control of premises, facilities and supplies, including health facilities and medical supplies, provided that reasonable compensation is paid.

- Public health laws should authorize public health officials to take such actions as reasonably necessary to investigate the causes, sources and means of transmission of disease agents, to authorize diagnostic testing, compulsory medical treatment, and to make orders for isolation and/or quarantine. These powers should not be exercised in an arbitrary or discriminatory way, and should be exercised in accordance with the principle of proportionality.

Disaster management is a core function of public health law. Public health emergencies can arise from a wide range of causes, including outbreaks of contagious, life-threatening disease, natural disasters, as well as chemical contamination of the environment and the release of radiation. In emergencies, large numbers of people may require medical attention, health care systems may be over-stretched, and public order may be threatened. This chapter identifies some of the legal issues that may arise for national authorities in the course of responding to a public health emergency.

11.1 International management of public health emergencies

(a) The International Health Regulations (2005)

The revised International Health Regulations (2005) (IHR), adopted by the World Health Assembly in 2005, are binding on all WHO Member States and provide a regulatory framework for international management of public health emergencies.¹ The purpose of the IHR is to prevent and manage the public health risks arising from the international spread of disease, while avoiding “unnecessary interference with international traffic and trade”.² Critical features of the IHR include:

- the legal obligation imposed on each country to notify WHO of events that may constitute a “public health emergency of international concern within its territory”;³

- the obligation of countries to “develop, strengthen and maintain” their national capacities to detect, assess, report and respond effectively to public health risks and emergencies;⁴ and

- the ability of the WHO Director-General to make non-binding, temporary recommendations to countries in whose territory a public health emergency of international concern has arisen.⁵

Advancing the right to health: the vital role of law
This report does not provide a technical review of obligations owed by countries under the IHR.\(^6\) WHO has published a range of resources to assist countries to implement their obligations under the IHR through national legislation (Box 11.1).\(^7\)

**Box 11.1: Implementation of the International Health Regulations (2005): selected priority areas\(^8\)**

<table>
<thead>
<tr>
<th>Priority Areas</th>
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<tbody>
<tr>
<td>National International Health Regulations (2005) (IHR) Focal Points: designation and operation</td>
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<tr>
<td>Detection, reporting, verification and control of events, as well as related communications, domestically and internationally</td>
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<td>Communications and collaboration with WHO</td>
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<td>Implementation of IHR documents:</td>
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<tr>
<td>- Ship Sanitation Certificate (Annex 3)</td>
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<td>- International Certificate of Vaccination and Prophylaxis (Annex 6)</td>
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<td>- Maritime Declaration of Health (Annex 8)</td>
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<td>- Health Part of Aircraft General Declaration (Annex 9)</td>
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<tr>
<td>Designation of Points of Entry (ports, airports and ground crossings) for development of core public health capacities</td>
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<tr>
<td>Identification (and informing WHO) of ports authorized to issue Ship Sanitation Certificates and provide related services.</td>
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</table>

**National IHR Focal Points**

In order to facilitate global surveillance and response capabilities, the IHR require each country to establish a National IHR Focal Point. The Focal Point shall be accessible at all times for communications with corresponding WHO IHR Contact Points, established by WHO to assist communications with each country.\(^9\) The IHR envisage a number of important forms of communication between national focal points and WHO; in addition, the focal points are expected to function as coordinating centres for surveillance and reporting within their countries, and for communications between government departments.\(^10\) Countries must ensure that telecommunications systems enable the focal point to be contacted and to communicate with WHO at all times.

**Reporting obligations**

The IHR require each country to assess health risks within its territory and to notify WHO of all events that may constitute a public health emergency of international concern, together with the health measures it has taken in response to those events.\(^11\) Following notification, each country shall continue to provide timely, accurate and detailed information about the notified event, including (where possible), “case definitions, laboratory results, source and type of risk, number of cases and
deaths, conditions affecting the spread of the disease and the health measures employed”, and any
difficulties faced and support needed in order to respond effectively.12

The concept of a “public health emergency of international concern” is not limited to epidemic-
prone diseases, but extends to biological, chemical and nuclear hazards, including the chemical or
nuclear contamination of the environment, and contaminated food and pharmaceuticals.13 The IHR
contain a decision instrument to assist countries to identify events requiring notification (Box 11.2).
Countries are required to notify WHO within 24 hours (or immediately in the case of nuclear-related
events), through their National IHR Focal Point.14 Prior to this point, countries are encouraged to
consult with WHO about emerging health threats and the appropriate health response.15

Determining the existence of a public health emergency of international concern under the IHR is
the prerogative of the Director-General, who acts on the advice of Emergency Committees.16

**Box 11.2: Notification of events that may constitute a public health emergency of international
concern under the International Health Regulations (2005)**

Article 6 of the International Health Regulations (2005) (IHR) imposes an obligation on countries to
notify WHO, via the National IHR Focal Point, of “all events which may constitute a public health
emergency of international concern within its territory”.17 The IHR define a “public health
emergency of international concern” as an extraordinary event that is determined to “constitute a
public health risk to other States through the international spread of disease and to potentially
require a coordinated international response”.18 The algorithm in Annex 2 of the IHR identifies two
categories of reportable events.19 Under the first category, countries are required to assess domestic
public health events against the four criteria below and to notify WHO when at least two of the four
criteria are met:

- Is the public health impact of the event serious? (yes/no)
- Is the event unusual or unexpected? (yes/no)
- Is there any significant risk of international spread? (yes/no)
- Is there any significant risk of international travel or trade restrictions? (yes/no)

Under the second category, one or more cases of the following four specific diseases are considered
by definition to constitute a public health emergency of international concern:

- smallpox;
- severe acute respiratory syndrome (SARS);
- human influenza caused by a new subtype;
- poliomyelitis due to wild-type poliovirus.

WHO has published guidance to assist countries to identify events that are reportable under Annex 2
of the IHR.20
**Surveillance and response capabilities**

The IHR impose a legal requirement on countries to strengthen and maintain their surveillance and response capabilities at local, intermediate and national levels, and at designated airports, ports and ground crossings. At the local community level, this includes the capacity to identify outbreaks of disease or death above expected levels for the particular time and place and for all areas within that country. At national level, countries are expected to develop the capacity to assess all reports of urgent events within 24 hours. In addition, countries are required to inform WHO of public health risks identified outside their territory that may result in the international spread of disease, as manifested by human cases, vectors for infection or contaminated goods. Countries are expected to establish and maintain core capacities for responding to the risks presented by ill travellers who present at designated airports, ports and ground crossings. These include providing prompt medical assessment of those who are ill, transporting ill persons to appropriate medical facilities, and assessing and if necessary imposing quarantine restrictions on persons who may have been exposed to disease.

**Temporary recommendations**

Following a determination by WHO that a public health emergency of international concern is occurring, the Director-General may issue temporary recommendations, after receiving advice from an Emergency Committee. These recommendations may include health measures for implementation both by countries experiencing the public health emergency, and other countries. Depending on the circumstances, the recommendations may include the requirement to carry out medical examinations and vaccinations, to place suspect persons under public health observation, to quarantine, isolate or require the contact tracing of contacts of affected persons, to carry out exit screening and to refuse entry to suspect or affected persons.

**Human rights protections within the IHR**

Countries are required to implement the IHR with “full respect for the dignity, human rights and fundamental freedoms of persons”, and to exercise their health powers “in a transparent and non-discriminatory manner”. When issuing temporary recommendations, the Director-General shall consider health measures that are neither more restrictive of international traffic and trade, nor more intrusive of persons than “reasonably available alternatives that would achieve the appropriate level of health protection”. More specific human rights protections are summarized in Box 11.3.

**Box 11.3: Protecting human rights under the International Health Regulations (2005)**

- Countries may require travellers, on arrival or departure, to provide information about their destination and itinerary, and may conduct a “non-invasive medical examination which is the least intrusive examination that would achieve the public health objective”. On the basis of this assessment, countries may also require a suspect or affected traveller, on a case-by-case
basis, to undergo a medical examination, provided it is the “least intrusive and invasive medical examination that would achieve the public health objective of preventing the international spread of disease”.

- Countries may require travellers to undergo invasive medical examinations, vaccination or other prophylaxis and deny entry to a traveller who refuses to consent to such a measure. However, where there is evidence of an imminent public health risk, travellers may be compelled to undergo “the least invasive and intrusive medical examination that would achieve the public health objective”. In these circumstances, countries may also require vaccination or other prophylaxis, and impose additional health measures in order to control the spread of disease, including isolation, quarantine and public health observation.

- Countries shall treat all travellers with “respect for their dignity, human rights and fundamental freedoms”. In order to minimize discomfort or distress associated with public health measures (including medical examinations, quarantine, and isolation), countries shall:
  - take into consideration the “gender, sociocultural, ethnic or religious concerns” of travellers; and
  - provide adequate food and water, accommodation and clothing, protection for possessions, appropriate medical treatment and linguistic assistance.

(b) Pandemic Influenza Preparedness Framework

The Pandemic Influenza Preparedness Framework (“PIP Framework”) adopted by the World Health Assembly in 2011 provides important international guidance in relation to H5N1 and “other influenza viruses with human pandemic potential”. Negotiation of the PIP Framework was precipitated by the decision of Indonesia in January 2007 to withhold H5N1 influenza virus samples from WHO for surveillance or vaccine development purposes, following advice that samples were provided to pharmaceutical companies without its consent. Indonesia’s position was that efforts to develop patentable diagnostics, vaccines and therapeutic drugs derived from use of biological samples sourced from Indonesia, without its consent, reflected the inequity of global arrangements for virus sharing, which benefit richer countries that can afford to pay for patented products at the expense of those which cannot.

The PIP Framework encourages WHO Member States to share PIP biological materials from influenza viruses with human pandemic potential in a “rapid, systematic and timely manner” through the WHO-coordinated Global Influenza Surveillance and Response System (GISRS). In doing so, countries are taken to consent to the onward transfer and use of PIP biological materials to other institutions, organizations and entities, subject to the terms of two standard material transfer agreements. These agreements apply to transfers of viruses and PIP biological materials within the GISRS system, and outside the GISRS system, respectively.

The framework requires WHO to establish an electronic traceability system to enable the tracking in real time of all PIP biological materials. Under the first material transfer agreement, between providers and recipient laboratories within the GISRS, both parties are encouraged not to seek to obtain any intellectual property rights in the materials. The second material transfer agreement,
between WHO and recipients outside the GISRS, creates a benefit-sharing system that gives commercial entities access to PIP biological materials in exchange for assistance to developing countries (Box 11.4). Among other provisions, the PIP Framework commits the Director-General to work with multilateral agencies and donors to establish stockpiles of vaccines and antivirals, and asks countries to urge manufacturers to implement tiered pricing in order to increase the affordability of influenza vaccines and antivirals in developing countries. Manufacturers of influenza vaccines, as well as diagnostic and pharmaceutical manufacturers receiving samples through the GISRS system are also required to pay annual contributions equivalent to half the running costs of the GISRS network.

Box 11.4: Benefit-sharing provisions applicable to commercial entities receiving influenza viruses under the Pandemic Influenza Preparedness Framework

A. Benefit-sharing options for manufacturers of vaccines and/or antivirals. Manufacturers shall commit to at least two of the following:

- donate 10% or more of real-time pandemic vaccine production to WHO;
- reserve 10% or more of pandemic vaccine production for WHO at affordable prices;
- donate at least X [amount to be negotiated] courses of antiviral treatment for the pandemic to WHO;
- reserve at least X courses of antiviral treatment for the pandemic at affordable prices;
- grant licences to manufacturers in developing countries on fair and reasonable terms for products in which the recipient holds intellectual property rights (influenza vaccines, adjuvants, antivirals, and/or diagnostics);
- grant royalty-free licences to manufacturers in developing countries, or alternatively, royalty-free licences to WHO for production of pandemic influenza vaccines, adjuvants, antivirals and diagnostics;

B. Benefit-sharing options for manufacturers of products other than vaccines or antivirals. Manufacturers shall commit to at least one of the following:

- donate to WHO at least X [amount to be negotiated] diagnostic kits for use in a pandemic;
- reserve at least X diagnostic kits for use in a pandemic, at affordable prices;
- in coordination with WHO, support the strengthening of influenza specific laboratory and surveillance capacity in developing countries;
- in coordination with WHO, support the transfer of technology and know-how for pandemic influenza preparedness to developing countries.

C. In addition to the above commitments, recipients shall consider contributing to the following measures:

- donations of vaccines;
- donations of pre-pandemic vaccines;
- donations of antivirals;
- donations of medical devices;
• donations of diagnostic kits;
• affordable pricing;
• transfer of technology and processes;
• granting of sublicences to WHO;
• laboratory and surveillance capacity-building.

(c) Strengthening WHO’s emergency response capacity

The Ebola virus disease outbreak in 2014–2015, which resulted in the establishment and deployment of the United Nations Mission for Ebola Emergency Response (UNMEER), has been a catalyst for a number of developments in the global management of public health emergencies. These include the establishment of a global health emergency workforce, and a contingency fund to support WHO’s emergency response capacity.

National governments bear the primary responsibility for developing their domestic health systems and establishing an effective health emergency workforce. However, in order to support national efforts, WHO has committed to scaling up the global health emergency workforce, both by expanding partnerships with United Nations agencies, funds and programmes, and by improving the coordination of other international responders, including through its leadership of the Global Health Cluster of international humanitarian health organizations. The process of operationalizing the global health emergency workforce includes developing processes for pre-deployment (establishing rosters, quality assurance and training), deployment (including logistic planning and medical evacuation), and decommissioning of personnel, together with governance and finance arrangements. In order to support its role in coordinating the global response to public health emergencies, WHO has established a contingency fund with a target capitalization of US$ 100 million. Financed through voluntary contributions, this fund can support all aspects of WHO’s emergency response work, including the mobilization of the global health emergency workforce, and surveillance in high-risk areas.

11.2 National public health emergency plans

The following sections identify some of the legal issues that countries may face during the process of strengthening their national laws and operational plans for responding to public health emergencies. Countries should prepare and regularly review a national emergency plan that sets out a clear command structure for decision-making and for activating and coordinating resources. Emergency plans should specify the officials and agencies that will have operational control during the emergency, and identify relevant advisory bodies, such as national emergency councils and standing committees advising in specialist areas. The roles and powers of officials performing key operational or executive roles during an emergency, including the health minister, chief health officer, director of human biosecurity (and similar officials), should be defined in legislation.
Since overlapping authority, and gaps in authority may cause uncertainty and disputes during an emergency, national emergency plans should take account of all levels of government (national, state/regional/provincial, and local/city), ensuring that the response to localized emergencies can be scaled up as required. In order to ensure that countries meet their obligations under the IHR, national governments may need to formalize agreements about operational control and chains of command through memoranda of understanding. Similarly, the roles and responsibilities of different ministries, as well as statutory and executive bodies, should be considered and specified.

Public health laws contribute to effective disaster management by authorizing rapid and decisive government responses, and by temporarily suspending the operation of laws and processes that would otherwise disrupt an effective emergency response. Public health laws should establish clear triggers for the application of emergency powers, such as the scale or seriousness of the emergency, or a formal declaration of emergency as well as a specific time period for the application of these powers (e.g. 30 days, renewable if necessary). Since the emergency powers required for disaster management may require interferences with individual human rights, disaster management laws should include accountability mechanisms, such as the right to seek review of decisions that affect a person’s fundamental rights by an independent, external body, within a time frame that is reasonable in the circumstances.

Emergency powers may include the power to rapidly marshal the physical and human resources that are needed to provide health care and other services. As discussed in the following sections, public health laws may authorize public health officials to:

- expand the health care or disaster management workforce by co-opting personnel from other agencies and jurisdictions under a unified command structure;
- seize property in order to establish emergency response centres and to ensure the availability and rapid distribution of pharmaceuticals and supplies; or
- conduct surveillance and mandate vaccinations, treatment, isolation or quarantine of infected or potentially infected individuals.

11.3 Emergency health workforce

Health care workers may be in short supply following a natural disaster or event causing mass casualties. Public health laws may provide that health professionals must assist in the provision of emergency assistance, grant temporary practice licences to medical professionals and nurses who are inactive, retired, or licensed in other countries or jurisdictions, or allow health professionals to perform functions beyond their licensed scope of practice (Box 11.5). The United States Model State Public Health Act illustrates how emergency health care workers may be protected from civil lawsuits that arise from treatment provided during an emergency in a given jurisdiction, except in circumstances where their actions or omissions demonstrated a reckless disregard for the life and health of the patient.
Box 11.5: Maintaining the health care workforce during a public health emergency: an example from the United States

<table>
<thead>
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<th>Model State Public Health Act 45</th>
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<td><strong>Section 6-104. Protection of individuals.</strong></td>
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**(d) Licensing and appointment of health personnel.** During a state of public health emergency, the state or local public health agency is authorized:

1. **Health care providers.** To require in-state health care providers to assist in the performance of vaccination, treatment, examination, testing, decontamination, quarantine, or isolation of any individual as a condition of licensure, authorization, or the ability to continue to function as a health care provider in this state.

2. **Health care providers from other jurisdictions.** To appoint and prescribe the duties of out-of-state emergency health care providers (with proof of current licensure in their state) as may be reasonable and necessary to respond to the public health emergency.

   (i) The appointment of out-of-state emergency health care providers shall not exceed the termination of the declaration of a state of public health emergency. The state or local public health agency may terminate the out-of-state appointments at any time or for any reason provided that any such termination will not jeopardize the health, safety, and welfare of the people of this state.

   (ii) The state public health agency may waive any or all licensing requirements, permits, or fees required by state code and applicable orders, rules, or regulations for health care providers from other jurisdictions to practice in this state.

   (iii) Any out-of-state emergency health care provider appointed pursuant to this Section shall not be held liable for any civil damages as a result of medical care or treatment related to the response to the public health emergency unless such damages result from providing, or failing to provide, medical care or treatment in the event of gross negligence or willful misconduct.

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<tr>
<th>Colorado State Governor’s Expert Emergency Epidemic Response Committee Draft Executive Order 5.0, United States of America 46</th>
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<tr>
<td>Authorizes Colorado licensed physician assistants and emergency medical technicians to practice outside of their normal supervision but under the supervision of another physician to meet the emergency epidemic.</td>
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11.4 Control of premises, facilities and supplies

Natural disasters as well as emergencies resulting from human actions, may create dangerous or contaminated areas that present a risk to public health and must be immediately closed off to the public. Public health laws may authorize public health authorities to compel the evacuation and closure of any premises or public area, and include the power to enter premises and private property in order to dispose of infectious waste or contaminated material (Box 11.6).
A public health emergency may create an urgent need for vaccinations, treatments and emergency response sites. Emergency plans should provide for the stockpiling of essential pharmaceuticals and medical supplies, and should consider the logistics of distributing essential supplies to areas of greatest need following an emergency event. For example, in the United States, federal law requires the Centers for Disease Control and Prevention (CDC), in coordination with the Secretary of Homeland Security, to maintain a strategic national stockpile of essential medicines, vaccines, medical devices and other supplies “in such numbers, types and amounts” as the Secretary determines to be necessary. The contents of the stockpile are required to be kept within their shelf-life limits and made available, free of charge, to meet the needs of states and communities within 12 hours of determination of emergency need. The Secretary is required to review the contents of the stockpile and to make plans for the management of the stockpile in consultation with federal, state and local officials. In 2009, the stockpile was used to assist state health departments to respond to the H1N1 influenza outbreak (antiviral drugs such as oseltamivir and zanamivir were distributed to states to replenish supplies). Public health laws can support these plans by authorizing public health officials to purchase or acquire essential medicines, vaccines and other medical supplies from public or private sources, on reasonable terms. In addition to authorizing the specific actions set out in Box 11.6, public health laws may contain general authorizing provisions permitting government officials to exercise executive powers following the declaration of an emergency, and authorizing health departments to take such actions as are reasonably required to deal with the risk to human health.

Box 11.6: Laws authorizing the emergency use of facilities and pharmaceuticals: an example from the United States

**Model State Public Health Act**

Section 6-103. Management of property.

(a) Emergency Measures Concerning Facilities and Materials. During a state of public health emergency, the state or local public health agency is authorized:

1. **Close facilities.** To close, direct, and compel the evacuation of, or decontaminate or cause to be decontaminated any facility of which it has reasonable cause to believe that it may endanger the public’s health.

2. **Use of materials and facilities.** To procure, by condemnation or otherwise, construct, lease, transport, store, maintain, renovate, or distribute materials and facilities as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof. Such materials and facilities include communication devices, carriers, real estate, fuels, food, and clothing.

3. **Use of health care facilities.** To require a health care facility to provide services or the use of its facility if such services or use are reasonable and necessary to respond to the public health emergency as a condition of licensure, authorization or the ability to continue doing business in the state as a health care facility. The use of the health care facility may include transferring the management and supervision of the health care facility to the state or local public health agency for a limited period of time.
(4) **Destruction of materials.** To decontaminate or cause to be decontaminated, or destroy, any material of which it has reasonable cause to believe that it may endanger the public’s health.

(5) **Control of materials.** To inspect, control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation, or other means, the use, sale, dispensing, distribution, or transportation of food, fuel, clothing and other commodities, as may be reasonable and necessary to respond to the public health emergency.

(e) **Control of Health Care Supplies.**

(1) **Procurement.** During a state of public health emergency, the state or local public health agency may purchase and distribute anti-toxins, serums, vaccines, immunizing agents, antibiotics, antidotes, and other pharmaceutical agents, medical supplies, or personal protective equipment to prepare for or control a public health emergency.

(2) **Rationing.** Where a state of public health emergency results in a state-wide or regional shortage or threatened shortage of any product under subsection (1), whether or not such product has been purchased by the agency, the agency may control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation, or other means, the use, sale, dispensing, distribution, or transportation of the relevant product. In making rationing or other supply and distribution decisions, the agency may give preference to health care providers, disaster response personnel, and mortuary staff.

(3) **Distribution.** During a state of public health emergency, the agency may store or distribute any anti-toxins, serums, vaccines, immunizing agents, antibiotics, antidotes, and other pharmaceutical agents, personal protective equipment, or medical supplies located within the state as may be reasonable and necessary to respond to the public health emergency, with the right to take immediate possession thereof....

**Section 6-106. Compensation**

(a) **Just Compensation.** The State shall pay just compensation to the owner of any facilities or materials that are lawfully used or appropriated by a state or local public health agency for its temporary or permanent use during a state of public health emergency according to the procedures and standards set forth in this Article.

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### 11.5 Health care services during a public health emergency

In order to deal effectively with a public health emergency, emergency powers can include the power to authorize compulsory medical treatment, and to make orders for isolation and quarantine. However, laws that directly restrict the freedom of individuals during a disaster or public health emergency should comply with the human rights protections set out in the IHR (see Section 11.1(a)), with the United Nations’ Siracusa Principles (see Box 11.7), and with any domestically applicable fundamental rights protection regime.
Box 11.7: Requirements for laws directly restricting individual freedom during a public health emergency: the Siracusa Principles

Emergency laws that place limitations on individual freedoms must:

1. Respond to a pressing public or social need;
2. Pursue a legitimate aim;
3. Be proportionate to the legitimate aim; and
4. Be no more restrictive than required to achieve the purpose sought by restricting the right.\(^{53}\)

Laws that restrict rights should not be applied or implemented in an arbitrary or discriminatory manner.\(^{54}\) Furthermore, where limitations are placed upon fundamental rights, such as freedom of movement, they must be substantiated by scientific evidence and implemented in ways that take account of the values of participation, transparency and accountability.\(^{55}\)

In addition to authorizing medical treatment, emergency powers should authorize urgent investigations to determine the causes, sources and means of transmission of disease agents. Conducting swift and accurate surveillance during a public health emergency enables authorities to design and implement effective responses. Public health laws can authorize state or local health departments to enter premises, to collect specimens and perform diagnostic tests on living or deceased persons, and to access previously collected samples or test results as necessary in order to respond effectively.

Disasters may threaten public order and public health due to violence and crime. Reproductive health needs are often especially great in the aftermath of a disaster. Displaced women are often victims of rape and sexual violence, and may have an urgent need for emergency contraception and treatment for sexually transmissible infections. WHO’s Interagency Emergency Health Kit,\(^{56}\) which includes emergency contraception and midwifery supplies, and WHO’s Model List of Essential Medicines,\(^{57}\) can serve as a benchmark in operational planning for a public health emergency.

REFERENCES\(^{1}\)


\(^{1}\) All references were accessed on 1 May 2016.


Advancing the right to health: the vital role of law