Introduction

Developing countries face problems created by a lack of resources, capacity and poor infrastructure. In health, this can manifest itself in areas such as lack of a trained health workforce, little capital development or upkeep of sites to deliver health services, inadequate supply of essential drugs and medical equipment, and inadequate surveillance and data collection. Many developing countries also have inadequate public health laws.

Public health laws provide a legal and administrative structure under which public health programmes are run, health promotion is supported, communicable and chronic diseases are managed, data are collected, health emergencies are addressed, and the rights and responsibilities of individuals and communities are made clear. In the area of health, approaches to legislation in both developed and developing countries have shifted enormously in the last century. Developing countries that lack the capacity and resources to undertake regular update and review of legislation may find that their public health laws are extremely outdated, do not take account of emerging communicable diseases and social trends, and do not support a modern approach to public health governance.

Even where modern laws exist, the rights and responsibilities of citizens and public health officials are often not fully understood, or are implemented by understaffed and often overwhelmed health department personnel. Laws introduced by colonial powers are also often poorly understood and accepted by indigenous people, who may have a very different approach to social organization.

The implementation of rights and responsibilities created in laws requires an understanding of those responsibilities, and the human capacity and resources to implement, support and prosecute breaches of the laws. Countries also need the capacity to continue to update laws and subordinate instruments as the broader political, social, scientific and economic environment changes. These capacities and resources are often lacking in developing countries.

In 2008, the Australian Agency for International Development funded a project to develop a model public health law for the Pacific Island region. The project will examine existing Pacific public health laws and consult with nation states to ascertain how the current laws are working at present. The final result will be the creation of a model law in a modular format, capable of being adopted in whole or in part by individual nation states. In addition to the domestic governance of public health, the model law will also provide opportunities for regional approaches to public health management where consultation and research indicate that a regional approach would be useful. The project covers the 14 members of the Pacific Island Forum: the Cook Islands; Federated States of Micronesia; Fiji; Kiribati; Nauru; Niue; Palau; Papua New Guinea; Republic of Marshall Islands; Samoa; Solomon Islands; Tonga; Tuvalu; and Vanuatu. This article outlines the rationale, method and expected outcomes of the project, since the model that this project embodies may be useful to other, region-wide approaches to public health law reform outside the Pacific basin.
Rationale for a region-wide approach to public health law reform

Public health laws are an important part of the social and legal infrastructure supporting the health system of a nation state. These laws set out powers for management of public health risk from small nuisances through to outbreaks of communicable disease. They also enable a variety of activities to promote health and prevent disease. These may include data collection and disease surveillance, the regulation of immunization, and the authorization of local government activities for sanitation and environmental health. Public health laws may also set various types of standards, including those for accommodation, food hygiene and potable water.

Most Pacific public health laws are 30–50 years old and very out of date. Some of the laws were drafted on the basis of British public health legislation of the early 20th Century and remain in force today, such as the Public Health Act 1936 (Fiji), Public Health Ordinance 1926 (Kiribati), Notification of Infectious and Contagious Diseases Ordinance 1923 (Nauru), and the Public Health Ordinance 1926 (Tuvalu). Some of these public health laws contain references to matters completely irrelevant to Pacific communities, such as the regulation of fellmongery, arsenic recovery works and explosives manufacture [Public Health Act 1936 (Fiji) s90, schs 2]; and the regulation of raw opium, indian hemp and coca leaf [Dangerous Drugs Act 1941 (Solomon Islands)].

Laws in many island states are drafted in a style that emphasizes the rights of government or government agents to compel individuals with communicable diseases to undergo treatment or to be quarantined from the community. In line with the British public health acts, there is no requirement of proportionality in the state’s response, nor any staged approach to the exercise of coercive rights, nor any rights of appeal. This is inconsistent with the tendency of more modern public health laws in some developed countries, and with the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights. One example is the Public Health Act 1936 (Fiji), which gives extensive powers to the Permanent Secretary, subject to the approval of the Minister, to make arrangements to prevent the spread of an infectious disease. This includes taking possession of vehicles and premises, requisitioning goods, isolating and detaining people, and compulsorily treating them. No rights of appeal are given from these powers, nor are they required to be time limited or proportional to the risk presented by the threat of an outbreak of infectious disease. Similar powers are found in other Pacific public health acts. The Notification of Infectious and Contagious Diseases Ordinance 1923 (Nauru) requires persons suffering from venereal disease to submit themselves for appropriate treatment to a medical officer, and to be detained for treatment with detention to continue until the patient is certified by a medical practitioner as free from danger of infecting others, or until the patient leaves to embark on board ship for the purpose of leaving Nauru.

While Pacific public health laws have been amended from time to time to address specific issues [HIV/AIDS Management and Prevention Act 2003 (Papua New Guinea), Tobacco Control Act 1998 (Fiji), Tobacco Control Act 2000 (Tonga)], many have not been reviewed comprehensively. For example, reviews of public health legislation have been undertaken recently in Tonga, Cook Islands, Tuvalu and Niue due to the need to implement the International Health Regulations (IHR) (2005). The reviews have shown that the existing legal frameworks are outdated, and hence new public health legislation has been necessary in order to implement the IHR. These reviews have focused on the content of the IHR rather than subjecting the laws to a comprehensive process of reform. Of these countries, only Tonga has passed recent legislation.

It is highly unlikely that resources will become available to every Pacific country to undertake the necessary work to review its public health legislation within the next 10 years. This would be a high-cost, specialist task that would take many years, assuming the specialist expertise could be found and resources made available. A model law developed for the Pacific context, in modules with advice about the necessary preconditions and advice about what might be required for implementation, could be of genuine practical value to a region which lacks resources and capacity in this area.

Methods for the development of a model public health law for the Pacific

The project will be undertaken by two project investigators based at La Trobe University in Melbourne, Australia. Their work will be overseen and guided by an independent expert panel (IEP) that will provide technical feedback and advice on the draft research conclusions and the draft model law. Communication with the IEP will be via e-mail and telephone, and the IEP will also meet face to face in the Pacific on two occasions to discuss and review the work of the project investigators. The IEP consists of people with experience in public health law and/or public health, and most have worked in the Pacific Island region. All 14 countries in the Pacific Island Forum are included in the project. Of these countries, three lead countries will be consulted in greater detail and visited twice each by the project investigators during the life of the project. Papua New Guinea and Fiji have been selected as lead countries for their relative size and complexity, and to help test the applicability of the model. A third country – a small island state – will also be chosen as a lead country as the project progresses.

Stage 1

Stage 1 of the project involves several key steps.

Literature review

A literature review will map the existing public health laws of the 14 Pacific Island countries. It will review relevant international models of health legislation and seek to identify best practice approaches to the development of public health legislation, as well as recommendations for how these approaches can best inform the task of public health law reform in the Pacific. The literature review will encompass development literature on legislation reform and governance generally and in the Pacific region.

The literature review will attempt to answer the following questions:

1. How well do public health laws in the Pacific Islands address the public health challenges of the 21st century?
2. How well do they protect and promote health in the Pacific?
3. Do they provide a modern legal infrastructure to assist the management of communicable disease, the gathering of data and the protection of the rights of those affected by the legislation?
4. Are the existing rights and responsibilities they create adequately implemented?
5. Do they enable regional communication and cooperation in the management of public health risks or emergencies of regional significance?
6. Do they fit with the current work of the World Health Organization (WHO) to implement the recent amendments to the IHR?
7. What is best practice legislation development in health regionally and internationally, and has this been applied to the Pacific context coupled with a strong Pacific and development perspective?
Examination of existing public health laws

An examination will be undertaken of the present public health laws of the 14 nations in the project. As the 14 countries considered in the project are developing countries where capacity is growing slowly and laws are not always fully understood, respected or implemented, the review will seek to address the following questions:

a. How do people generally interact with laws in this country? Do they interact differently with the laws in different parts of the country?

b. What areas of public health do existing laws cover? Is it possible to identify ‘core public health’ areas in which all or most of the 14 countries legislate or intend to legislate? A tool to measure the breadth of present public health laws is the Turning Point Model State Public Health Act, developed in the USA by the Centers for Law and the Public Health, and this has been used as a baseline for areas which might be covered by a public health law.

c. How well are the current laws understood:
   o by those who have rights under them?
   o by those who have responsibilities under them?
   o by those who are responsible for implementation and administration?

d. Are information and tools on how to implement public health laws readily accessible by health workers? Are public health laws being implemented in a manner consistent with the law? Are inspections and prosecutions carried out regularly to address breaches?

e. Do local languages and customs create barriers to accessing the laws by community members?

f. How well do public health laws fit with other laws of the country such as the Constitution and other health laws?

g. If public health laws are not being implemented fully, what is the reason for this? Are there insufficient human and financial resources to support implementation? Is there adequate capacity to hear and respond to complaints? If not, is this because health workers do not understand the legal framework? Or is it because of a lack of awareness of rights by the community and problems of access to legal assistance? Does culture discourage the exercise of rights?

The answers to these questions will provide direction for the project investigators on the realities of implementation of public health laws in the 14 countries under review, and enable the development of a better adapted model law. It is important to ascertain the effectiveness of implementation of present rights before recommending stronger rights and powers. If there is a lack of will, awareness, capacity or resources to implement present rights, stronger rights are likely to meet with the same fate. Such action is also likely to weaken respect for the legal system as observers of the system note the passage of another new law which fails to make an impact.

The project acknowledges that implementation of laws in developing countries is difficult, and drafted laws should be as pared down and as simple as possible while still providing the necessary legislative support for the promotion and protection of population health.

Research options for regional communication and cooperation

The project will collaborate with the University of the South Pacific, and a research component of the project will be carried out by the University on legislative and non-legislative options for cross-jurisdictional communication and cooperation. This paper will identify legislative approaches and cross-jurisdictional options for a region-wide response to public health risks of regional significance.

The project recognizes that regional approaches are difficult to create, implement and sustain. Such approaches will be recommended only where there is clear evidence from consultations and the literature review that the benefits of such an approach would outweigh the difficulties of setting them up and sustaining them. Examples where regional approaches may be considered useful include:

- creation of a regional mechanism for cooperation in public health emergencies of regional concern;
- opportunities to share information when there is an identified public health risk:
  o of regional concern; and
  o of international concern;
- opportunities to cooperate by sending personnel or receiving personnel for assistance to supplement workforce capacity and/or in the event of an emergency (this may require amendments to health profession registration legislation to secure the right to practise medicine or nursing in an emergency situation);
- establishing regional focal points for the IHR (2005);
- achieving regional recognition of a common list of emergency medicines enabling regional distribution of medicines;
- authorizing the delegation of public health powers to officers from other recognized cooperating nations (these may include customs, environmental health officers or other identified classes of officers as necessary);
- establishing a regional coronial investigation jurisdiction that enables coroners from one participating country to carry out a coronial investigation into a regional disaster affecting a number of Pacific countries;
- establishing a regional public health committee with limited regional powers; and
- developing a regional approach to intellectual property issues for drug patents such as compulsory licensing and parallel imports.

Recommendations for a model public health law for the Pacific Islands

The end result of Stage 1 of the project will be a report with recommendations regarding what should be put into a model public health law for Pacific Island Forum countries. The model will identify areas considered to be ‘core public health’ and recommend modules in the model to address them. This report would also consider the recommendations from the research undertaken by the University of the South Pacific, and suggest legislative or non-legislative approaches to achieving a cross-jurisdictional, regional response to public health risk of regional significance.

Stage 2

The report prepared in Stage 1 including research, consultations and the direction of the IEP will inform decisions about what might be included in the model legislation drafted in Stage 2. The project investigators will be assisted during this stage by a senior legislative drafter from a large Pacific country, who will provide guidance and a Pacific perspective to the drafting.

Some areas that might be included in the model are as follows:

- a broad definition of public health risk: a public health risk will exist if a properly qualified officer is satisfied that it exists according to certain criteria set out in the model law;
a broad definition of a public health emergency: a public health emergency will exist if a properly qualified officer is satisfied that it exists according to certain criteria set out in the model law;

- an officer or class of officers will be qualified to identify public health risks:
  - of local concern;
  - of national concern; and
  - of regional concern;

- an officer or class of officer will be qualified to identify public health emergencies:
  - of local concern;
  - of national concern;
  - of regional concern; and
  - of international concern;

- identification of risk against certain criteria will trigger powers:
  - to issue notices; and
  - to take certain actions;

- the legislation could include human rights protections such as:
  - proportionality;
  - a staged response to public health risks; and
  - protection of confidentiality as required in the Siracusa Principles;

- the identification of an emergency in accordance with identified criteria will trigger powers:
  - to take specific actions;
  - these powers will be stronger and may be applied more quickly than in cases where there is no identified emergency; and
  - the powers will enable very short-term arrangements to address an immediate public health emergency; and

- the modules must fit with and complement IHR (2005) obligations.

Pandemic influenza provides an example of a public health risk within the terms of the model described above. Influenza is likely to fit into both the categories of 'risk' and 'emergency' depending on its features. For example, it may be a public health emergency if a new strain is identified in the region, there is a low level of immunity in regional communities to the strain, and the strain spreads very quickly. Pandemic influenza would be both a public health emergency of regional concern and of international concern, triggering a regional response and obligations to report under the IHR (2005). Regional powers of communication and cooperation could be most helpful in mobilizing rapid assistance and pooling resources to manage the additional burden of a regional health emergency.

On completion of the draft model law, a meeting of the IEP will be convened in the Pacific for Pacific-based members. At this meeting, the project investigators and a representative of the University of the South Pacific will seek advice and guidance on the draft model law.

The project investigators will then travel to Papua New Guinea, Fiji and a third Pacific country to consult and liaise with personnel from the Department/Ministry of Health and other stakeholders such as representatives from the Attorney General and Parliamentary Counsel's offices on what has been included in the draft model public health law. These consultations will be undertaken as briefings, meetings of officials and interviews with individuals. This will help to provide a 'reality check' with respect to the content of the draft model law and its perceived usefulness and applicability to the countries consulted.

At the conclusion of the consultation, a final version of the model law will be developed. Supporting materials will also be prepared. These will identify preconditions such as resources, capacities, skills and infrastructure necessary to support implementation of the model law.

Introduction and passage of certain modules will not be recommended unless preconditions can be met. It is anticipated that countries will be in different positions in relation to existing preconditions to support implementation of some modules. An example of a precondition may that be universal immunization of children cannot be mandated in a law until a country has the capacity and resources for its implementation. Another example might be some of the protections that can be guaranteed to people living with human immunodeficiency virus (HIV) in developing countries, such as pre- and post-test counselling, and rights not to be asked about HIV status. A precondition for such legislative guarantees is universal infection control and the presence of trained counsellors to undertake the counselling. In developing countries, there is often no cohort of trained counsellors available nationally, and many clinics and aid posts would not have either gloves or bleach. It may be that countries consider a staged approach to implementation of the model law, with modules being passed into law when the preconditions are able to be met. As a result, uniformity in Pacific public health laws is neither sought nor likely as an outcome of this project.

The model public health law for the Pacific Islands will be finalized together with a detailed implementation kit. The model public health law implementation kit will contain the following materials:

- model public health law for the Pacific Islands in modules;
- options for regional communication and cooperation;
- advice regarding the preconditions necessary for the implementation of each module; and
- supporting material necessary to get a law through the parliaments of the 14 countries, including model cabinet submissions, explanatory memoranda and a model second reading speech.

Expected outcomes

The progress of the first two stages of the project will have raised the issue of the development of modern public health law to support the promotion of health and prevention of disease in individual Pacific countries, and the possibility of regional approaches to the management of risk. The project will have been raised repeatedly in regional communications, conferences, meetings with government personnel and project communications. It is anticipated that discussion and collaboration will lead to interest in the final product, and its use as a starting point when review and reform of public health laws are undertaken in any of the 14 countries. It is also hoped that the options for regional communication and cooperation are taken up at a high level and considered in regional meetings by heads of state and health leaders. If there is sufficient interest from the Pacific Islands, a subsequent project to support the implementation of the model may be considered by donors.

Broader consultation and collaboration

Extensive consultations with Pacific stakeholders are crucial to the success of this project. This work has already begun but will continue with stakeholders such as the ministries and departments of health in the 14 countries, the Secretariat of the Pacific Community, the Pacific Island Forum Secretariat, at regional meetings of health ministers, legislative drafters, attorneys general, legal officers and academics at South Pacific universities. The
project will also collaborate internationally outside the Pacific with other similar projects or relevant initiatives. These include the European Public Health Law Flu Project\(^8\)^\(^{10}\), WHO work to implement the IHR\(^11\); the project to review public health laws in Kenya, Uganda and Tanzania\(^12\); and the project to enhance technical support for policy development of essential public health functions in China.\(^13\)

**Conclusion**

This project for the development of a model public health law for the Pacific Islands aims to provide both practical assistance for individual Pacific island states, and a regional approach to public health law reform. Sovereign nations in the Pacific do not always welcome solutions to local issues created in developed countries as a ‘one size fits all’ approach. This is clearly understood and respected. It should be emphasized that uniform legislation is not the proposed outcome.

A model will be drafted which allows for different responses to different issues based on the politics, infrastructure and preferences of each sovereign nation. In some areas, alternative modules can be chosen and slotted into the model as preferred by individual nations. It follows that variations may exist in the legislation that is ultimately enacted. Pacific Island states will be free to adopt the model law, or modules drawn from it, as they deem appropriate.

Guidance will be provided on preconditions necessary for the implementation of each module to assist Pacific nations to assess their readiness to implement any law reform. A staged approach to adoption and implementation of the model will be possible and this may be the most practical response for many of the 14 countries. Opportunities for regional communication and cooperation in the management of public health risks and emergencies of regional concern will also be provided.

Legislating in public health is not for the faint-hearted in jurisdictions where capacity exists to undertake the work and resources can be found to support it. This is an area where multiple stakeholders must be consulted, new diseases emerge regularly, and scholarly research and thinking shift constantly. Pacific countries face the same issues but must manage with less capacity and fewer resources. A model law could provide a tool which may be adapted in whole or in part by participating countries for domestic use. In a region where health indicators are generally low, and in some instances continuing to fall, easily adapted legal infrastructure to support modern public health policies may prove to be of genuine practical assistance.

**Ethical approval**

None declared.

**Funding**

Australian Agency for International Development (AusAID).

**Competing interests**

None declared.

**References**