REPORT

WORKSHOP ON PUBLIC HEALTH LAW
FOR PACIFIC ISLAND COUNTRIES

Auckland, New Zealand
12-15 February 2007

Manila, Philippines
March 2007
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Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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NOTE

The views expressed in this report are those of the participants in the Workshop on Public Health Law for Pacific Island Countries and do not necessarily reflect the policies of the World Health Organization.
This report was prepared by the World Health Organization Regional Office for the Western Pacific for governments of Members States in the Region and for the participants in the Workshop on Public Health Law for Pacific Island Countries held in Auckland, New Zealand from 12 to 15 February 2007.
The Workshop on Public Health Law for Pacific Island Countries was conducted in Auckland, New Zealand, from 12 to 15 February 2007 by the World Health Organization’s Regional Office for the Western Pacific.

The objectives of the meeting were to discuss:

(1) up-to-date frameworks and risk-based approaches for public health law, including requirements for implementing the International Health Regulations (2005) and for the control of communicable diseases and other public health risks;

(2) implications of international agreements on human rights for public health law; and

(3) the legislative interface between all laws that impact on public health, including those related to local government responsibility for public health.

Twenty one participants attended the Workshop from Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Micronesia, New Caledonia, Niue, Northern Marianas, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. Observers attended from Allen & Clarke Policy & Regulatory Specialists, Wellington, New Zealand, the Public Health Agency of Canada and the Secretariat of the Pacific Community (SPC). One WHO temporary adviser, one WHO consultant and seven WHO staff members serving as the secretariat, supported the Workshop.

The proceedings comprised presentations, discussions and small group activities acknowledging that public health law is a central component of every government's attempts to improve and promote health for its citizens, especially when facing the sudden emergence of
new health threats, such as SARS and avian influenza. At the same time, the challenges of long-standing communicable diseases such as tuberculosis continue. It is necessary for each Member State to have a range of effective options and mechanisms available, in order to deal with a variety of public health risks and situations. Legislation is a necessary part of a health protection framework that enables Member States to effectively detect, assess and appropriately respond to these health threats. The International Health Regulations (2005), which will enter into force in June 2007, are also part of this framework. These Regulations aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade and human rights. For these Regulations to be effective, it is important that a number of aspects are carefully integrated into individual national health protection frameworks including, where appropriate, through legislation.

Presentations addressed the scope of public health law and the need to ensure human rights principles in its operation, frameworks for legislation protecting and promoting public health, modern risk-based approaches to public health legislation and extensive consideration of the International Health Regulations (2005), including core capacity requirements that lead to the necessity to recognise legislative interfaces between Health and other Ministries/Departments that must be managed in the implementation of IHR (2005). Activities enabling planning for the legislative implementation of IHR (2005) in the Pacific were conducted and the meeting made recommendations concerning Public Health Law in general, these being:

- That Pacific Island Countries to include in their national budgets and WHO Program Budgets for 2008/2009 support for updating legislation that promotes and protects public health.
That Pacific Island Countries request WHO to continue work on providing guidelines and tools to check whether legislation promotes and protects public health, and relating specifically to the International Health Regulations as follows:

- That those Pacific Island Countries that have not officially designated the National IHR Focal Point (NFP) immediately designate their NFP and establish standard operating procedures for the NFP to communicate with other Ministries/sectors and WHO.

- That Pacific Island Countries put in place an inter-Ministerial task force and make administrative arrangements for implementation of IHR (2005) before 15 June 2007.

- That Pacific Island Countries should make efforts to make essential amendments to their Quarantine Act (or equivalent) or other relevant legislation to include Annex III (Ship Sanitation Control/Ship Sanitation Control Exemption Certificates) of the IHR (2005) by 15 December 2007 at the latest.

- That Pacific Island Countries should collaborate with ship operators to ensure awareness of IHR (2005) obligations.

- That WHO should continue close collaboration with the International Maritime Organization and any other relevant agencies to ensure that ship operators are aware of how IHR (2005) will affect them.

- That Pacific Island Countries and WHO should continue to advocate for consistency between IHR (2005) and new biosecurity requirements.
1. INTRODUCTION

1.1 Background Information

One of the cornerstones of public health is the ability of each Member State to efficiently implement a range of effective health protection measures to guard their citizens against potential or actual health hazards and risks. The sudden emergence of new health threats, such as SARS and avian influenza, together with the continuing challenges of long-standing communicable diseases such as tuberculosis, clearly demonstrate that it is necessary to update the options and mechanisms available to enforcement authorities for detecting, assessing and appropriately responding to a variety of public health risks and situations.

Legislation is a necessary part of the framework that enables Member States to effectively detect, assess and respond to public health threats, including those aspects necessary to fulfil commitments under the International Health Regulations (2005). These Regulations, which will enter into force in June 2007, aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

This workshop provided a forum for health policy advisers to discuss up-to-date approaches to public health law and an opportunity to discuss related aspects of human rights requirements, as well as legislative interfaces with other sectors. For the purposes of this workshop, public health law was considered to be all legislation associated with health protection, including not only any “Public Health Act” but also any relevant parts of laws related to areas such as customs, immigration, agriculture, local government, environment and privacy.
1.2 Objectives

By the end of the workshop, participants had discussed:

(1) up-to-date frameworks and risk-based approaches for public health law, including requirements for implementing the International Health Regulations (2005) and for the control of communicable diseases and other public health risks;

(2) implications of international agreements on human rights for public health law; and

(3) the legislative interface between all laws that impact on public health, including those related to local government responsibility for public health.

1.3 Participants

A list of participants, representatives/observers, temporary advisers and secretariat members is given in Annex 1. Twenty one participants attended the Workshop from Cook Islands, Fiji, French Polynesia, Guam, Kiribati, Micronesia, New Caledonia, Niue, Northern Marianas, Palau, Papua New Guinea, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu. Observers attended from Allen & Clarke Policy & Regulatory Specialists, Wellington, New Zealand, the Fiji School of Medicine, Public Health Agency of Canada and the Secretariat of the Pacific Community (SPC). One WHO temporary adviser, one WHO consultant and seven WHO staff members serving as the secretariat, supported the Workshop.

1.4 Organization

The workshop programme is given in Annex 2 and a list of documents distributed during the workshop in Annex 3. The documents include background papers and Power Point presentations by the temporary adviser, the consultant and WHO secretariat members relating to the three meeting objectives. Copies of these papers can be obtained upon request from the WHO Regional Office for the Western Pacific.

The officers of the workshop were elected as follows:

Chairperson: Mr Pascoe Kase, Papua New Guinea
Vice-Chairperson: Dr Nese Conway, Tuvalu
First Rapporteur Mrs. Ngapoko Short, Cook Islands
Second Rapporteur Dr Divi Oga Oga, Solomon Islands

For some discussions and exercises, participants were divided into three smaller groups, with countries sharing similar legal traditions being grouped together, these being:

Group 1: Participants from French Polynesia, Guam, Micronesia, New Caledonia, Northern Marianas and Palau.
Group 2: Participants from Cook Islands, Niue, Samoa, Tokelau and Tonga.
Group 3: Participants from Fiji, Kiribati, Papua New Guinea, Solomon Islands and Vanuatu.

The temporary adviser, consultant and members of the secretariat and observers were distributed among the three small groups, seeking to ensure that at least one lawyer was available in discussions of each group. For work utilizing the tool to help decide if domestic legislation was required to implement the International Health Regulations (2005), the participants sought to complete the tool for their own country, then came together for further discussion in the three smaller groups.

1.5 Opening remarks

Dr Dean Shuey, WHO Regional Adviser in Health Systems Development, welcomed all the participants representing 16 Pacific Island Countries. He introduced Professor Alastair Woodward and Dr Collin Kutuitonga of the School of Population Health, University of Auckland and expressed gratitude for the provision of the excellent venue for the Workshop. Professor Woodward welcomed all participants to the School of Population Health and expressed his pleasure that so many representatives of the Pacific Islands, including from the northern Pacific, were able to participate in the Workshop that included topics that were fundamental to public health activities, especially the provision of legal frameworks, regulations and policies.

Dr Chen Ken, WHO Representative in the South Pacific, welcomed participants on behalf of Dr Shigeru Omi, WHO Regional Director for the Western Pacific.
He recognized that public health is a central component of every government's attempts to improve and promote health for its citizens. He acknowledged that, recently, we have faced the sudden emergence of new health threats, such as SARS and avian influenza. At the same time, we are still struggling with the continuing challenges of long-standing communicable diseases such as tuberculosis. It is, therefore, clearly necessary for each Member State to have a range of effective options and mechanisms available, in order to deal with a variety of public health risks and situations.

Legislation is a necessary part of a health protection framework that enables Member States to effectively detect, assess and appropriately respond to these health threats. The International Health Regulations (2005), which will enter into force in June 2007, are also part of this framework. These Regulations aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic, trade and human rights. For these Regulations to be effective, it is important that a number of aspects are carefully integrated into individual national health protection frameworks including, where appropriate, through legislation.

He noted that the intention in holding the workshop is to provide a forum to discuss up-to-date approaches to public health law. The workshop provided the opportunity to participants to discuss related aspects of human rights requirements, legislative interfaces with other sectors, and in particular, to spend some time considering further the legislative implications and requirements for implementing the International Health Regulations 2005. Thanking the School of Population Health at the University of Auckland, Tamaki Campus, for use of their excellent facilities, and acknowledging the opportunity for discussion with the academic staff on campus, Dr Chen Ken officially opened the meeting and concluded his opening remarks by wishing all
participants well in their discussions, hoping that they had a stimulating and interesting time
during the workshop.

2. PROCEEDINGS

Dr Dean Shuey, WHO Regional Adviser in Health Systems Development, expressed the
key responsibility of all governments to protect their citizens against health risks, both real and
potential. He recognized that public health legislation is a key tool, necessary but not sufficient
in itself. He acknowledged that the revision of the International Health Regulations has created
new obligations and posed the question “Why the interest now?” Using examples of increased
risk created by SARS, avian influenza and drug resistant TB, he illustrated that the potential for
public health emergencies of international concern is increased by the impacts of globalization
on trade and travel. Acknowledging the economic impact of public health emergencies, he
considered that a balance between the rights of individuals and public health is necessary –
while decentralization of health systems has introduced even more challenges. Having
introduced the Objectives of the Workshop, Dr Shuey presented the workshop format
comprising presentations and discussions both in plenary and in smaller groups. He encouraged
free and open debate and discussion and welcomed the opportunities presented by the workshop
for individual interaction between participants, observers and facilitators. He introduced the
daily topics as being:

Day 1: Public health law, human rights and public health law, and public health
law frameworks.

Day 2: Risk-based approaches to public health law and introduction to the
International Health Regulations (2005)

Day 3: Legislation and deciding if legislative actions is needed; and

Day 4: Planning for legislative implementation of the International Health
Regulations (2005).
2.1 What is Public Health Law?

Ms Josephine Cooper, WHO Consultant, provided an overview to the question of ‘What is Public Health Law?’ referring to the background paper to Session 3. She referred to a number of definitions of Public Health Law, including that proposed by Gostin L that Public Health Law is ‘the legal powers and duties of the state to ensure conditions for people to be healthy … and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for protection or promotion of community health”. She recognized law to be a powerful tool to facilitate public health strategies, including those that protect and promote public health and those designed to prevent illness, injury of disability.

It was posed that, in any given nation, public health law comprises far more than just a particular Law known as a Public Health Act and extends beyond laws that Ministries of Health typically administer and enforce, concluding that, put simply, public health law can be said to be all law that concerns, acts upon or protects the public health. Drawing upon the work of Bidmeade and Reynolds, core areas of public health were recognized as being standards of sanitation and standards concerning food, drugs, poisons, therapeutic goods, tobacco and radiation. Other laws that have significant effect upon public health outcomes are part of an “outer” group of public health laws, such as those relating to product safety and traffic laws that address the public health aim of reduction of injury, of which wearing seatbelts and requirements for the use of child restraints in vehicles are examples. Taking this broader view, over 30 subjects can be identified that are often included in laws with the legislative intent to improve public health outcomes.

Consideration was given to the need to identify a country’s existing public health laws by building or acquiring a ‘legislative snap-shot’ of all primary and secondary laws that may affect the public health and the example of an Inventory of Laws of the Republic of the Fiji Islands...
was provided. The legislative picture is more complex in those nations that have federal systems where both Federal or Central Parliaments and State or other regional Parliaments may be lawmakers. The legislative interfaces of public health laws (where a range of Ministries or Departments might share operational responsibilities) will be revealed by expanding an Inventory of Law to include annotations describing the key matters and provisions contained in the text of Laws. The absence of consolidation of laws in some nations presents significant challenges to obtaining a complete picture of public health laws.

The ideal resource was considered to be the creation and maintenance of an electronic, web-based version of a nation’s laws. Such applications of information technology result in enormous gains in accessibility to, knowledge and understanding of, and compliance with, a nation’s laws.

2.2 Human Rights and Public Health Law

An address concerning Human Rights and Public Health Law was given by Mr Fernando Gonzales–Martin from the International Health Regulations Office in the Department of Epidemic and Pandemic Alert and Response, WHO Geneva, drawing upon background papers to Agenda Item 4 prepared by Mme Genevieve Pinet, Senior Health Lawyer, Global Programme on Evidence for Health Policy of WHO. Mr Gonzales-Martin made reference to the work of the Evidence for Health Policy Cluster, in collaboration with the Center for Law and the Public’s Health at Georgetown & John Hopkins Universities in the United States of America, with the objective of creating a framework of public health legal issues in order to produce model, universal provisions of public health law that advance the health related Millennium Development Goals (The Comprehensive Legislative Approach to Essential Elements of Public Health Action). The tool is intended to provide a framework of essential elements that a comprehensive Public Health Act should address for use by Member States in
revising public health laws. The Secretariat undertook to circulate updated information to participants regarding development of the tool.

2.3 **The Siracusa Principles**

The Siracusa Principles require that only as a last resort can human rights be interfered with to achieve a public health goal. Such interference can only be justified when all of the narrowly defined circumstances stated in the Siracusa Principles, are met, these being:

- The restriction is provided for and carried out in accordance with the law;
- The restriction is in the interest of a legitimate objective of general interest;
- The restriction is strictly necessary in a democratic society to achieve the objective;
- There are no less intrusive and restrictive means available to reach the same objective; and
- The restriction is not drafted or imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner.

Even then, such limitations should be of limited duration and subject to review.

Application of the international human rights principles, and options available to public health authorities, were considered in a small group setting, each group addressing a different scenario. Case 1 concerned a polio outbreak in an area where the disease had been declared eradicated and the human rights concerns associated with the public health authorities recommending administration of oral polio vaccine to all children under the age of 12. Case 2 involved a homeless person with drug resistant tuberculosis who had previously absconded from treatment. Case 3 addressed the case of a person who, upon seeking permanent residence to a country, is required to reveal HIV-status as a condition of entry.

2.4 **General frameworks for Public Health Acts**

General frameworks for Public Health Acts were presented by Ms Josephine Cooper, WHO Consultant, referring to the background documents to Agenda Item 5. Older approaches to public health led to Acts that to a large extent relied on ‘lists’ of diseases and recognized
A primary role of Public Health Acts is to establish processes for the exercise of regulatory powers in the event that they are needed, with relevant checks and balances, especially clear accountabilities for relevant authorized people to exercise such powers. The exercise of such powers is becoming increasingly important to a world that is unable to predict all diseases. Modern Public Health Acts have to enable a scaled response that is appropriate to the possible health risk that is faced and should ensure the provision of essential public health services and functions.

In some countries, specific public health issues and functions remain covered by the Public Health Act, even when they are perhaps not the responsibility of Health whereas, in others, some specific public health issues are the subject of separate legislation. It is argued that, even where specific public health issues are not normally directly regulated by Health, there should be reserve powers given to Health by the Public Health Act that permits action by Health should another agency be unable, or refuse, to act in response to a public health emergency. Some matters have to be included in a Public Health Act if they are not regulated in some other way. Environmental health risks are a good example as they can be dealt with separately if there is an Environmental Health agency or Ministry of Environment, but otherwise might remain placed within the jurisdiction of Health.

The meeting considered the content of the Public Health Acts listed below that had been recently adopted in different jurisdictions in order to ascertain whether common content could be discerned. The review involved:

Public Health Act 1991 of New South Wales, Australia;
Health Act 1996 of British Columbia, Canada
A table comparing Long Titles, Objects of Act and Terms Defined within the Act was presented to the workshop. Analysis of the different Laws revealed that, instead of being able to identify core or minimum matters that different jurisdictions have found necessary to include in their Public Health Acts, there were significant differences between them, apparently because they were drafted to be appropriate to their particular legislative setting. It was noted that the Law with the most terms defined was the Public Health Act 2005 of the State of Queensland, Australia. This was reflected in then length of the statute and in the breadth of subject matter regulated.

The Turning Point Model State Public Health Act, presented by the Public Health Statute Modernization National Excellence Collaborative, September 2003 and designed to serve as a tool for state, local and tribal governments in the United States to use to revise or update public health statutes and administrative regulations, was also compared, but there were no ascertainable common features.

2.5 **Risk-based approaches to public health law**

Ms Louise Delany, WHO Temporary Adviser explained risk-based approaches to Public Health Law based upon background materials for Agenda Item 6. A risk-based approach aims to consider the risks inherent in particular activities, products and behaviours (e.g. of a factory, business or person) in order to ascertain whether a risk is of sufficient significance to merit society exercising some control over the activity. ‘Risk’ has many different definitions but it is usually considered to be a combination of the degree of probability of something going wrong
coupled with a consideration of the gravity of the consequence in such an event. Risk involves a consideration of:

- What can go wrong?
- How likely is it?
- What are the consequences if it does go wrong?

Controls or ‘regulation’ might occur in an effort to prevent the occurrence of the undesirable consequence.

Risk-based regulation/laws were originally seen in environmental law and in the last 20 or 30 years the idea of risk-based regulation has been applied in many different contexts. Examples can now be seen across a broad range of subject matter, such as in banking and insurance law, professional regulation and many other aspects of the health sector e.g. drug regulation. Newer forms of law set out particular risk categories as being high risk, medium risk or low risk with sets of procedures and controls that change according to level of risk.

In public health, a fundamental aim of regulation is to prevent, reduce and manage public health risks. Risk regulation is both preventative and proactive and can be contrasted with traditional approaches to public health that tended to be purely reactive to the occurrence of a consequence. Risk regulation can also achieve other aims such as the reduction of inequalities and the enhancement of democratic values.

The concept of risk can guide a decision or response as to when to regulate. A fundamental consideration is whether the risks in a particular activity or behaviour mean that some governmental measure is appropriate? As different societies perceive risks differently in terms of the level of risk that is acceptable, the answer to this question will depend upon societal values. Ascertaining the acceptable level of risk in a society is dependent upon consultation. Decisions as to how, and whether, to regulate can also take account of cost considerations.
including which approach might be more costly for the government, for the business that is
being regulated, or for both.

Assessing level and nature of a risk is a scientific question. Hazards can be identified,
together with likelihood or probability of the occurrence of a given consequence. If there is a
degree of uncertainty regarding risk, the precautionary principle may be relevant where it is
accepted that it is better to regulate in order to prevent the occurrence of the undesired outcome.
In that instance, it may be accepted that it is “better to be safe than sorry”. A risk-based
approach includes that if the threat is of serious or irreversible damage, lack of scientific
certainty about the degree of risk is not a reason to do nothing. It may even be decided that even
though a particular activity does present risks, regulation will not help prevent the undesirable
outcome, or only partially, or might be at too high an economic cost. Conversely, as is the case
with tobacco control, activities might present risks that regulation will help.

If it is accepted that regulation must occur, there must be consideration of what kind of
law or regulation is going to be most appropriate. Regulation might be by law or by alternative
measures such as imposition of taxation, conduct of education, provision of resources etc. or by
a mix of such approaches. Principles employed in the risk-based approach include:

- Performance/outcomes versus prescriptive measures;
- Flexible versus inflexible responses;
- Self-regulatory controls versus more prescriptive responses;
- Development of bottom-up controls versus controls imposed from the top-down;
  and
- Participatory measures versus those that are imposed.

Some concepts used in laws are more risk-based than others. For example, a law might
focus on performance or outcomes, or specify the means by which objects are to be achieved.
Flexibility can be apparent in how much a regulated entity has choice in the manner in which a
stated objective is achieved, or whether the entity has certain behaviours or activities prescribed
in order to achieve the objective.
Enforcement of laws can also provide for flexible responses, the concept of responsive regulation often being included in modern laws to enable an appropriate response to breach that seeks to ensure compliance being achieved, rather than the automatic imposition of a particular penalty. It might involve incentives and disincentives to act in certain ways. Regulation might also be performance-based or even goal-based where a law sets a goal to be achieved but allows individuals or business to decide actions in order to meet the goal, rather than being told precisely what to do.

There can also be mixes of regulatory tools used in a law such as prescribing that a licence is required for a particular activity, but allowing those carrying out the activity to set their own standards that will achieve a stated goal of minimizing risk or where flexible tools to check compliance might be employed e.g. permitting a business to carry out self-assessment.

Three New Zealand examples of risk-based public health laws were then considered and analysed to show the employment of the risk-based approach, these being laws relating to:

(1) Drinking water;
(2) Communicable disease; and
(3) Emergency management.

The three small groups then utilized the checklist for ideas for public health laws prepared by Ms Delany to consider taking a risk-based approach in their own countries in order to regulate the practice of tattooing, the provision of sewerage disposal and measures to control obesity.

2.6 An introduction to the International Health Regulations (2005)

Dr Li Ailan, Medical Officer, Communicable Disease Surveillance and Response, Western Pacific Region of WHO introduced the IHR (2005) with the assistance of PowerPoint presentations produced as background papers to Agenda item 8.
The IHR (2005) were adopted by the World Health Assembly on 23 May 2005 by way of resolution WHA58.3. They will replace the existing International Health Regulations adopted in 1969 (IHR (1969)) when coming into force on 15 June 2007. IHR (1969) focused on just three diseases: cholera, plague and yellow fever. Those regulations cannot address the multiple and varied public health risks that are faced today, particularly from emerging and re-emerging infectious diseases and from non-infectious disease agents. Experience with both Severe Acute Respiratory Syndrome (SARS) and avian influenza highlighted the limitations of IHR (1969). In addition, some unwarranted and damaging travel and trade restrictions led to reluctance by some countries to promptly report disease outbreaks and other events.

The IHR (2005) establish a legal framework for the rapid gathering of information, for determining when an event constitutes a public health emergency of international concern, and for providing international assistance sought by countries. New reporting procedures are aimed at expediting the flow of timely and accurate information to the World Health Organization (WHO) about potential public health emergencies of international concern. WHO, as a neutral authority with an extensive communications network, can assess information, recommend actions and provide direct technical assistance when needed, tailored to events as they unfold, while minimizing interference with world travel and trade. The Purpose and Scope of IHR (2005) is contained in Article 2:

*To prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.*

The IHR (2005) will be legally binding on all Member States who did not reject the new regulations, make reservations against them or make a Declaration to the Director-General of WHO by 15 December 2006, as provided by Articles 21 and 22 of the Constitution of the World Health Organization. The IHR (2005) were subject to a further resolution of the World Health Assembly in 2006, this being resolution WHA59.2. In response to the risk posed by avian
influenza and pandemic influenza, the World Health Assembly requested the Director-General of WHO to undertake several activities to support immediate compliance, on a voluntary basis, with relevant provisions of the Regulations that would help the world to prevent, detect and respond to a potential pandemic of human influenza.

Dr Li emphasized that the key to implementation of IHR (2005) is the designation of a National Focal Point for each State Party. Some countries have seen this requirement as an opportunity to attract and mobilize resources accepting that the IHR (2005) comprise an agreement between Member States that was the subject of negotiation before adoption by the World Health Assembly. It provides opportunities for core capacity building and the strengthening of cooperation with global partners.

2.6.1 Core capacity requirements

Participants received knowledge of the details of the Core Capacity Requirements for Surveillance and Response contained within Annex 1A and for Designated Points of Entry contained within Annex IB that are to be developed, strengthened and maintained by State Parties as soon as possible but not later than 15 June 2012 (unless the Party obtains an extension of two further years for implementation or, in exceptional circumstances, a further two-year extension until 2016). Each State Party is required to assess, by 15 June 2009, the ability of existing national structures and resources to meet the minimum requirements both for surveillance and response and for designated points of entry. State Parties must develop plans of action to ensure that such core capacities are present and functioning.

2.6.2 Capacity for surveillance and response

Capacity is to be developed at three levels that may mean different things to different State Parties i.e. the local level/primary public health level, the intermediate response level and the national level.
At the local community level/primary public health level, there are three key elements for attaining capacity to be able to:

1. detect unusual events involving disease or death above the levels expected for the particular time and place;

2. report all available essential information to the intermediate level (including the reporting of epidemiological data, risk factors and, in some countries, preliminary laboratory data and information regarding what measures are being implemented); and

3. implement preliminary control measures immediately (such as avoiding close contact, using surgical masks etc. in cases of infectious disease).

At the intermediate public health response level (as defined by the State Party), the key capacity elements are to be able to:

1. confirm the status of reported events – e.g. number of people affected in 1 family in 1 village;
2. support additional control measures;
3. implement additional control measures;
4. assess reported events immediately and, if found urgent, report all essential information to central level;

At national level, the capacity to:

1. provide a direct operational link with senior officials;
2. provide direct liaison with other ministries;
3. provide links with hospitals, laboratories and points of entry;
4. establish, operate and maintain a national public health emergency response plan assessing all reports of urgent events within 48 hours (using Annex II of IHR - Decision Instrument for the assessment and notification of events that may constitute a public health emergency of international concern), notification to WHO within 24 hours of assessment of events which may constitute public health emergency of international concern (notification being by way of National IHR Focal Point);
5. provide above on a 24 hour basis (necessitating a duty officer system)

2.6.3 Capacity at Designated Points of Entry

At all times, there are standard core capacity requirements of:
access to an appropriate medical service including diagnostic facilities, with adequate trained staff, equipment and premises, who can manage sick travellers and have the capacity to do basic examinations. A basic medical service must be maintained at the point of entry (though the staff might need to be present only at times when international travellers are received). So long as preliminary treatment is available, travellers can be referred to a local hospital providing more extensive services.

access to equipment and personnel for the transport of ill travellers to an appropriate medical facility;

availability of trained personnel to inspect conveyances;

a safe environment for travellers using points of entry facilities (including potable water supplies, public washrooms, clean eating establishments, appropriate solid and liquid waste disposal services etc.)

For responding to events that may constitute a public health emergency of international concern, designated points of entry should have in place:

a public health emergency contingency plan (including the nomination of a coordinator and contact points for the relevant points of entry, public health and other agencies and services);

the capacity to assess and care for affected travellers or animals (including establishing arrangements with local medical and veterinary facilities for isolation, treatment and other support services that may be required);

the provision of appropriate space, separate from other travellers, to interview suspect or affected travellers;
(4) facilities for the assessment/potential quarantine of affected travellers (preferably in facilities away from points of entry);

(5) the means to apply recommended measures (e.g. to disinfect etc.) to baggage, cargo, containers, conveyances, goods or postal parcels;

(6) the ability to apply entry or exit controls for arriving and departing travellers; and

(7) access to specially designated equipment, and to trained personnel with appropriate personal protection, for the transfer of passengers who may carry infection or contamination.

When facilities cannot be located at the designated point of entry, systems need to be established to ensure their provision by local hospitals to which referrals can be made.

Mr Fernando Gonzales-Martin explained key concepts included in IHR (2005) and emphasized that State Parties should look at local structures that already exist in order to ascertain what strengthening is required.

2.7 The Four Diseases specified as Notifiable to WHO (in addition to Potential Public Health Emergencies of International Concern)

In addition to potential public health emergencies of international concern, the Decision Instrument (Annex II of IHR) requires Notification to WHO of cases of:

1. Smallpox,
2. Poliomyelitis due to wild-type poliovirus,
3. Human Influenza caused by a new subtype, and
4. Severe Acute Respiratory Syndrome (SARS).

Case definitions will be provided by WHO before 15 June 2007.

2.8 Legislative Interfaces with respect to IHR (2005)
Utilizing the background document to Agenda item 9, Ms Josephine Cooper, WHO Consultant, considered the legislative interfaces that exist between laws administered by Ministries of Health and laws administered by other Ministries/Departments or functions performed by staff of those others. The legislative interfaces are important in assuring that someone is responsible for carrying out particular IHR functions, the responsibilities being those of the State Party and not solely those of the Ministry of Health. Functions under IHR (2005) are ‘collegiate’. Certainly a single Ministry is unlikely to have the resources, personnel or expertise to do everything that is prescribed. If possible, existing areas of expertise and division of functions should be utilized in order to ensure a coherent and cohesive IHR system.

IHR (2005) includes both State Party functions and functions of a body termed the ‘Competent Authority’. It is sometimes apparent that the State Party and the Competent Authority are synonymous with a particular responsibility stated to be one of the State Party whereas the context makes it clear that it could be performed by the Competent Authority. To be competent, such an Authority must be empowered and able to perform the required tasks. The scope of tasks is large and it is apparent that a conglomerate of existing authorities filling certain roles can be declared to, together, be the Competent Authority of the State Party. The Competent Authority is defined to mean “an authority responsible for the implementation and application of health measures” under IHR (2005). General Obligations given in Article 19 require a State Party to identify the Competent Authorities at each designated point of entry in its territory. Thus it is likely that a Competent Authority will be required to have a presence at more than one location e.g. at least one international sea-port and one international air-port. This does not necessarily mean that a separate Competent Authority has to be declared for each designated point of entry, so long as the ‘umbrella’ Competent Authority has a presence at each location where the State Party considers that the Annex 1 capacities should be developed. The starting point for designating the Competent Authority should be to recognize the interface
between Health and other Authorities that carry out existing health-related functions at point of entry. These might include:

- Health
- Customs
- Agriculture
- Biosecurity Authority
- Environment
- Ports Authority
- Waste Management Authority
- Postal Authority
- Police
- Local Authority/Council
- State or Regional Authority

2.8.1 Is New or Amended Domestic Legislation needed to Implement IHR (2005)

Participants, initially in country groups, utilized the tool contained in the background paper to Agenda item 10 to consider this question. The tool mirrored the language of IHR (2005) and was intended to provide a comprehensive check-list of all responsibilities. It was acknowledged that many of the referenced matters clearly did not require legislation and participants suggested that these might be removed with any further development of the tool to include simplification of the language and grammar. Participants worked through the entire tool and became familiar with the scope of action required to implement IHR (2005).

2.9 Planning for Legislative Implementation of IHR (2005) in the Pacific

Ms Josephine Cooper, WHO Consultant, introduced a draft Generic Cabinet Paper that could be used, adapted as required, by Ministers of Health and other senior officials for briefing Cabinet and other colleagues regarding the responsibilities undertaken by State Parties under IHR (2005). The first part of the Paper gives a synopsis of IHR (2005) that could stand alone to serve as an Introduction to the International Health Regulations. It then groups together related responsibilities with full foot-noting back to the paragraphs, Articles and Annexes of IHR (2005), dividing them according to type as being requirements to:
1. Identify, designate or establish a position or entity;
2. Enable or empower activities to be undertaken;
3. Ensure prescribed activities are carried out in response to certain conditions; and
4. Prohibit certain behaviours or activities.

The detailed analysis could become the basis of drafting instructions for implementing legislation that could take the form of an International Health Regulation (Implementation) Act. A tenet of statutory interpretation, often expressed in Interpretation Acts, is that later enacted legislation prevails over an earlier adopted Law to the extent of any inconsistency between the earlier and later enactment. This consequence can also be expressly stated in a Law, thus lessening the need to amend all previously enacted inconsistent provisions.

Subsequent plenary discussion included reference to the need to ensure that the new model Ship Sanitation Control Certificates and Ship Sanitation Control Exemption Certificates contained in Annex III be adopted for use by State Parties by 15 December 2007 at the latest.

Recent developments in domestic Biosecurity legislation, frequently within the administrative control of a Ministry of Agriculture, may include provisions giving some responsibilities with respect to human health that are similar or identical to some requirements of IHR (2005). Participants appreciated that it is necessary to ensure consistency between Biosecurity Laws and any law enacted to give effect to the International Health Regulations.

3. RECOMMENDATIONS

The meeting acknowledged the timetable for implementation of IHR (2005) and recognized the opportunity they presented for review of laws impacting upon the public health, making two sets of recommendations.

The first set of recommendations relates to Public Health Law in general and actions that will enable member states to consider and maintain up-to-date approaches to public health law:
(1) That Pacific Island Countries to include in their national budgets and WHO Programme Budgets for 2008/2009 support for updating legislation that promotes and protects public health.

(2) That Pacific Island Countries request WHO to continue work on providing guidelines and tools to check whether legislation promotes and protects public health.

The second set of recommendations relate specifically to the International Health Regulations (IHR). These Regulations, which will enter into force in June 2007, aim to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade:

(3) That those Pacific Island Countries that have not officially designated the National IHR Focal Point (NFP) immediately designate their NFP and establish standard operating procedures for the NFP to communicate with other Ministries/sectors and WHO.

(4) That Pacific Island Countries put in place an inter-Ministerial task force and made administrative arrangements for implementation of IHR (2005) before 15 June 2007.

(5) That Pacific Island Countries should make efforts to make essential amendments to their Quarantine Act (or equivalent) or other relevant legislation to include Annex III (Ship Sanitation Control/Ship Sanitation Control Exemption Certificates) of the IHR (2005) by 15 December 2007 at the latest.

(6) That Pacific Island Countries should collaborate with ship operators to ensure awareness of IHR (2005) obligations.
(7) That WHO should continue close collaboration with the International Maritime Organization and any other relevant agencies to ensure that ship operators are aware of how IHR (2005) will affect them.

(8) That Pacific Island Countries and WHO should continue to advocate for consistency between IHR (2005) and new biosecurity requirements.
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