A Companion to Reviewers undertaking review and amendment of public health laws in the Pacific region. Covering policy making; development of legislation; communicable and non communicable disease, public health risk, role of local councils, use of customary approaches; protection of human rights, incorporation of treaty obligations; drafting the bill and Parliamentary processes; suggested legislative text in module format and flow charts designed to make legislation easier to understand and to use.
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The image on the front page and on the pages introducing Part 1 and Part 2 are taken from paintings by Andrew Kauage, a Papua New Guinean artist
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## Glossary of Terms

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<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>Assent</td>
<td>Some Acts come into operation on the date of assent, or royal assent if there is a monarch</td>
</tr>
<tr>
<td>Bill</td>
<td>A draft law which has not yet been passed by a Parliament</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the elimination of all forms of discrimination against women</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESR</td>
<td>International Covenant on Economic and Social Rights</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Covenant on the Rights of the Child</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations (2005)</td>
</tr>
<tr>
<td>Long title</td>
<td>The long title of an Act states a title which often includes the purposes of the Act</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health, sometimes also known as Department of Health</td>
</tr>
<tr>
<td>Negative licensing</td>
<td>A name given to a legislative approach to health practitioner registration which sits on a no regulation but less than full registration based on entry qualifications, and ongoing standards of practice. In negative licensing, practitioners are not regulated but must comply with a code of conduct. Those who do not comply are subject to prosecution and to restrictions in their ability to practice.</td>
</tr>
<tr>
<td>Objectives</td>
<td>Usually found at the front of the Act, a statement of the objectives of the law. Usually able to be used as an aid to interpretation</td>
</tr>
<tr>
<td>Paclii</td>
<td>Pacific Legal Information Institute see <a href="http://www.paclii.org">www.paclii.org</a></td>
</tr>
<tr>
<td>Purposes</td>
<td>Purposes are similar to objectives, setting out the purpose for which the law is made and usually able to be used in interpretation of the law</td>
</tr>
<tr>
<td>Penalty units</td>
<td>Penalty units are a mechanism for stating the amount payable for a fine for an offence in a law. The monetary value of each penalty until is usually set out in one law such as crimes act, crimes penalties Act or similar. Use of this mechanism helps countries</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>Proclamation</td>
<td>A way that an Act comes into operation. It is also possible for it to be done on date declared by the Minister in the government gazette.</td>
</tr>
<tr>
<td>Regulation</td>
<td>A form of delegated legislation which tends to contain details not found in principal Acts. Regulations might be made by the executive or the Minister, but are usually required to be subject to approval by Parliamentary Counsel and Cabinet.</td>
</tr>
<tr>
<td>Siracusa Principles</td>
<td>Siracusa Principles,¹ which set out where derogations for the <em>International Covenant on Civil and Political Rights</em> might be permitted. These might include a proportional response to an identified risk to the public health, use of the least restrictive option, protection of the confidentiality of sensitive health information, and access to reviews of administrative decisions and appeals and authorised by law.</td>
</tr>
<tr>
<td>STI's</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>Transitional provisions</td>
<td>These are usually found at the back of a law and provide for the transition from an old law to a new law. Transitional matters such as proceedings already begun under the old law and not finished or licenses created under an old law deemed to be licenses under a new law, what might happen when criteria for registration of health practitioners is changes giving rise to a period of grandparenting where those with qualifications under the old law are allowed to register under the new law for a limited period.</td>
</tr>
<tr>
<td>UNDHR</td>
<td>United Nations Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>

Introduction

Pacific Health ministries undertake the stewardship of their countries health systems. The vision for the health system and the planning and policy making for its realisation are the responsibility of the ministry. Implementation of health policies and plans requires cooperation across government ministries and often partnerships with churches, NGO’s civil society and community members.

The responsibility of stewardship means that the ministry must ensure the health sector is properly governed at national and sub national levels based on government policy and prevailing domestic and international values where these have been accepted or ratified.

Review and amendment of public health legislation is slow, complicated, resource intensive, potentially controversial and not for the faint-hearted. To complete a successful review, a ministry of health will consider and integrate government health policy, existing public health laws, other laws affecting health, constitutional provisions relevant to health and constitutionally guaranteed human rights.

In fulfilling its role as steward of the health system, it is desirable that the ministry regularly reviews the legislation administered by the health portfolio which supports implementation of the ministries vision, policy making and health planning. In the Pacific, this also means consideration of the operation of western style laws and customary laws in a pluralist system where customary methods of social organization remain strong.

Public Health Law in the Pacific - a Reviewers Companion is designed to sit on the desks of those who work with the legislation, regulation and enforcement of health policies. It is written as a resource into which officers may dip from time to time. It may be usefully read

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2 The department responsible for administration of health legislation and the health portfolio is usually called the ministry of health, but can also have other titles such as department of health, national department of health, department of health and child welfare etc. To simplify the document, the term “ministry of health” is used throughout, but the term does include other similar terms.
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in whole or in part depending on the size or complexity of the legislative issue under consideration.

In a review, important considerations include any other relevant law including interpretation Acts, case law and compliance with international treaty obligations. Current World Health Organization (WHO) and other literature on essential public health functions, the role of local customary approaches to social organisation and customary law, as well as implementation issues. Having worked through all these sometimes contradictory legal and policy influences, a clear policy approach to public health, or to the specific subject of the review, must emerge. It must be coherent, clear and easy to understand.

*Law in the Pacific context needs special consideration*

A recent study by scholars at the University of the South Pacific noted that existing statute law is also not always appropriate for its context. This may stem from a number of causes including: that laws, particularly those adopted from colonial powers, are archaic; a lack of resources required to make a law operationally effective; assumptions that existing legal systems are already functioning well, and comprehensively reach entire countries; and a lack of fit of a state promulgated law and the cultural environment in which it must operate. It should also be remembered that legal reforms that have not been specifically designed to fit the context in which they must operate have limited or even, possibly, negative value.

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3 Jowitt, Foukona and Tom’tavala, “Model Public Health Law for the Pacific Project—Customary Law and Public Health”, unpublished paper by Scholars from the University of the South Pacific for the Model Public Health Law for the Pacific Project. At the time of writing, there were plans to submit the paper for publication along with a series of papers on the project, to the *Journal of South Pacific Law* in 2011.
4 Ibid, 47
Reviewers Companion covers “core” elements of a public health law

Public health laws can encompass a broad range of laws; this Reviewers Companion does not cover them all. “Core elements” of public health laws are, however, covered. This is held to mean purposes, principles and administration, allocation and configuration of powers, notifiable diseases, non-communicable diseases, public health risks, emergency powers, constraints on the use of powers, and the use of customary law.

Any legislative review must also consider compliance with constitutional and international legal obligations in relation to health and this is covered. There is also some discussion of laws that might be exercised by government at the local level, possibly incorporating customary approaches to law and to social organisation.

A brief discussion of negative licensing for health practitioner registration is included. This term refers to the use of a legislative mechanism operating alongside existing registration of health practitioners but targets practitioners who breach a code of conduct. It is useful for cohorts of unregistered health practitioners such as traditional medicine practitioners and community health workers.

Suggested approaches to each of these elements are provided in module form, to enable them to be used separately, if that suits the needs of a country.

A series of legislative approaches in module form are offered. These can be used by countries in whole or in part. These modules address each of the elements of existing Pacific public health legislation and also address several new ones, which are described in detail. They have been developed from research into existing Pacific public health laws, relevant Pacific constitutional guarantees and principles, international treaty obligations entered into by Pacific countries, possible uses of customary law, and research into the experiences and observations of officers working every day with Pacific public health laws.

What is the idea behind the Reviewers Companion?

The Reviewers Companion came about because of a decade of experiences of the author and other professionals working in the area who shared some discussions with the author about similar experiences in the development of legislation policy and legislation in public health in a range of countries, most of which were developing countries and most in the Pacific. This gave rise to the author’s clear view that despite many differences, sufficient shared experiences in many of the countries of the region existed in history, geography and culture to provide a real opportunity to undertake some research to consider the following questions:

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Health Legislation in the Pacific – Process and Checklist

- what is in the current public health laws of the 14 Pacific Island Forum countries?
- What are the day to day experiences and opinions of the officers who work in Pacific ministries of health and use those laws every day?
- What is happening internationally in public health law that may be of interest and have application in the unique environment of the Pacific?
- Would the development of a model public health law for the Pacific be useful and what kinds of things might go into it?
- Are there any opportunities for some regional legislative approaches?

With funding from AusAID and some partnerships with regional ministries of health and regional institutions, work was done from 2008 to 2010 to answer those questions. The Reviewers Companion is not so much a model law, but a series of modules which correspond to existing elements of current public health laws in the Pacific and other regions and some altogether new elements designed specifically for the Pacific.

What were the legislative sources for legislative text in the Reviewers Companion?

Public health officers in Pacific countries made it clear that a coherent, relatively uncomplicated law was required that would give them the necessary powers, tempered by rights to enable them to carry out their jobs effectively. They did not advocate for great reform in the content of public health laws, but rather, for a better understood legislative structure with easier to use powers.

The most significant reform requested was the use of customary measures; other strong themes were about user-friendliness, language, and applicability in the Pacific context. The approach in the development of legislative text has therefore been to begin with an existing model of a well drafted, coherent and not overly complicated public health law, which can then be adapted for a Pacific environment.
Health Legislation in the Pacific – Process and Checklist

The South Australian Public Health Bill 2010 was used as a starting point for the legislative text. This is a modern public health law, which contains a coherent and not overly complicated legislative framework for administration, health planning, public health risk, non communicable diseases (NCD’s) communicable diseases and emergencies.

It is strongly emphasised that the bill was a starting point and has been significantly reworked and added to based on the research with Pacific public health officers, other research over the two years of the Model Public Health Law for the Pacific Project and consideration of a range of public health law passed in the last 5-6 years regionally and globally. In particular, there have been many additions which are not found in the original bill. These include modules to address options for customary law approaches, the use of village and island courts to address HIV stigma, powers and representation of customary chiefs on various decision making and advisory bodies, the specific recognition of some unique Pacific needs such as stringent requirements for donor partners to respect national planning in public health and specific guidelines for partners such as faith based organisations and NFO’s carrying out health service delivery. The final module creates a mechanism for the use of negative licensing for traditional medicine practitioners and community health workers to supplement the existing health practitioner regulatory mechanisms.

Most of these additions are created specifically for this project and are tailored for the unique Pacific environment.

The legislative text also draws on other recent public health laws. These include the Public Health and Wellbeing Act 2008 (Vic), the Public Health Act 1997 (ACT) and the Public Health Act 2002 (Quebec). The legislative text also draws on the draft laws prepared for the Custom, Women and Village Courts “Brukim Bush” project in PNG.

Additional resources for Pacific-based reviewers of public health legislation

There are many resources on which reviewers might call in undertaking their reviews. Some directly relevant to health legislation review in the Pacific include:

- www.pacllii.org, a website maintained by the University of the South Pacific—this is an excellent source of laws, regulations and other legal materials.
- WHO Western Pacific Regional Office (WPRO), Enforcement of Public Health Legislation 2006, see www.wpro.who.int/publications/PUB_9290612231.htm

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6 South Australian Public Health Bill 2010, see www.sahealth.sa.gov.au/wps/wcm/connect/ce05088044762ea0971e9fad53c49818/South+Australian+Public+Health+Bill+2010+rd+171GILF.pdf?MOD=AJPERES&CACHEID=ce05088044762ea0971e9fad53c49818. At the time of writing, the South Australian Public Health Bill 2010 had been introduced by the Minister for Health, Hon John Hill MP, but not yet passed.
7 Etheridge and Howse, Something People Outside Dreamed About and They Want us to Follow; Opinions and Experiences of Officers in Pacific Ministries of Health on Working with Public Health Laws A paper to be submitted for peer review to the Journal of South Pacific Law later in 2011.
8 Howse, G, Custom, Women and Village Courts “Brukim Bush” Project Report, phase two and draft laws, June 2010
Health Legislation in the Pacific – Process and Checklist

- Cooper, JE, *A Tool to Assist Implementation of the International Health Regulations Through Law*, see www.wpro.who.int/sites/hsd/documents/A+Tool+to+Assist+IHR+through+Law.htm
Part 1 - The process of review and amendment of health legislation in the Pacific

Introduction

The Pacific region faces considerable health challenges. Legislation is one possible intervention (among numerous multi-disciplinary and multi-sectoral policies, programs and actions) on which a Pacific government might draw, to manage the promotion of public health and the prevention of disease. In the context of the Pacific, and of developing countries, two important points are acknowledged:

1. The Pacific consists of countries with unique cultural, social, economic, political and geographical environments, which means that legislative approaches that may have been successful in other regions will not necessarily be successful in this region. Conversely, approaches may be found to be successful in the Pacific, but cannot be usefully applied in other regions.

Developing countries have limited resources and need to set priorities. Legislation must be able to be implemented to be effective, and the cost of implementation needs to be considered from the time legislation is put forward.

9 See WHO, *Health in Asia and the Pacific*, in particular chapter 13, key health challenges in the Asia Pacific Region, at www.wpro.who.int/publications/Health+in+Asia+and+the+Pacific.htm, accessed 14 July 2010

Phases of a legislation review

There are six main stages in a successful legislation review.

1. **Starting out** describes the kinds of matters a ministry of health would need to explore when it is considering undertaking a review. The ministry must decide whether a review is necessary, what resources might be required to undertake it and who will be responsible for each stage. It also needs to consider if the proposed review is consistent with existing health planning and with Constitutional and International treaty obligations. It must consider which groups might be affected by the current law, and what their views are on its efficacy. Completion of this step will result in a decision of whether or not to undertake a legislative review.

2. **Scoping the review** describes the matters that must be considered once a review is to be undertaken. This includes setting the parameters of the review, settling which materials will be considered, what consultation will be necessary and setting a timetable for the review. It is in this stage that the policy questions, which will be answered by the review, are considered and endorsed. Completion of this step will result in terms of reference and a timetable for the review.

3. **Policy development** goes through the steps needed to finalise the policy that will be supported by legislation. This step is crucial in exploring the questions to be considered; informing and consulting stakeholders, both within and outside government; and considering other materials, such as related state legislation and relevant customary law within and outside the health portfolio, and literature on relevant health and policy research. Any final policy must be considered for its consistency with current health planning and national planning. Completion of this step will result in a written policy that is accepted and endorsed by the Ministry.

4. **The drafting stage** turns the policy document into clear and detailed instructions to Parliamentary Counsel\(^{11}\) about the new regime, which enables Parliamentary Counsel to draft the new legislation. A close working relationship between the ministry and Parliamentary Counsel is crucial at this stage. Many matters will need to be checked and clarified, to ensure the new legislative regime successfully implements the policy, provides a smooth transition from the old legislative regime, and is consistent with the legislation already on the statute book. Completion of this step will result in a Bill to translate the policy into law.

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\(^{11}\) Most Pacific countries prefer bills to be drafted by Parliamentary Counsel, but often capacity and/or resources are often insufficient to enable this to occur with all bills. Health bills often struggle to achieve priority ahead of bills which might cover policing, taxation, mining etc. Therefore, although it is usually preferred that parliamentary Counsel drafts a bill, those working in the development of health laws in the Pacific will often find that the resources for the review need to include capacity for drafting law.
5. Cabinet approval process and introduction into Parliament entails preparing the necessary briefings to ensure Cabinet is fully informed on the legislative review process. This includes the terms of reference, a summary of the consultation process including submissions, stakeholder responses and the finalised policy. Cabinet must also be briefed on all the implications of the legislative change—whether they are financial, political, social or cultural. No proposed legislative change can be submitted to Parliament without Cabinet approval. This section also covers what to expect when the Bill is introduced into Parliament, the committee stage, the second reading speech and matters relating to regulations. Completion of this stage results in a law introduced into Parliament, and passed if that is the will of Parliament.

6. Implementation describes the formulation of an implementation strategy. Experience has shown that despite the considerable effort required to get a new law agreed, drafted and introduced into Parliament, implementation is the biggest challenge. Although this stage is the final one in the process, it must be under consideration from the beginning because policy cannot be developed and settled, nor legislation drafted, without constant consideration of how a new regime might be implemented. If there is not sufficient consideration of how implementation is to occur, and how it is to be resourced, the work of the legislation review may well be wasted. Completion of this stage results in the new law being understood and implemented by the Ministry, and by those other members of the community who are affected or regulated by it.
Checklist

This list is intended for quick reference. It attempts to list the possible steps that may need to be taken, to successfully undertake review or amendment of public health legislation—from the policy review through to implementation of a new legislative regime. Please note that the number of steps in this checklist, which actually need to be incorporated into any particular review, will vary greatly depending on the complexity of the review in contemplation. This checklist cannot be exhaustive as every review differs in character, in scope, in importance, in people affected and in the issues raised. These stages are then discussed in greater detail after the checklist.
Starting out

<table>
<thead>
<tr>
<th>Action</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Carefully examine the legislation being considered.</td>
<td>The new right, responsibility, mandated or sanctioned activity or power, which is the desired outcome of the proposed review, may in fact be possible or exist under the current legislation or regulations, or may be possible via an administrative solution rather than requiring legislation.</td>
</tr>
<tr>
<td>2 Consider any legislative review for consistency with existing health policy and planning.</td>
<td>Most countries have an existing national health plan, and any legislation review must use its direction as a starting point. Donors must comply with the Paris Declaration on Aid Effectiveness(2005), the ACCRA Agenda for Action (2008)12 and the recent Busan Partnership for Effective Development Cooperation (November 2011)13 in ensuring countries actually want any proposed reform, and that it is consistent with current country’s health planning.</td>
</tr>
<tr>
<td>3 Consider any legislative review for consistency with existing Constitutional obligations and treaty obligations.</td>
<td>The Constitutions of many countries guarantee certain rights and freedoms and some even make particular reference to health. Countries must use Constitutional rights and guarantees as a starting point. The same applies to treaties ratified by the country such as the WHO Framework Convention on Tobacco Control, or the International health Regulations. Other treaties include certain rights relevant to health such as CEDAW and the CESPR. These domestic and international legal obligations are part of the early consideration about whether a review is needed and its scope.</td>
</tr>
<tr>
<td>4 Examine non-legislative options.</td>
<td>Any review should always consider non-legislative options that could be an effective approach to the issues under consideration. Non-legislative options should continue to be considered at each stage of the review.</td>
</tr>
</tbody>
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12 Paris Declaration on Aid Effectiveness and the ACCRA Agenda for Action may found at [http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html](http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html) accessed 8 Feb 2012

<p>| 5 | Consider the broader legislative and legal environment. | It is very important to consider other legislation that may affect or be affected by the Act under review. It might also be important to consider the operation of customary law, where applicable. Most Pacific countries are also signatories to UN treaties and conventions. See <a href="http://www.pacli.org">www.pacli.org</a> for specific details of which country has signed which treaty or convention. Treaty obligations are legally binding and must be considered in any review. Compliance with treaty obligations is sometimes the purpose of the review. |
| 6 | Create a broad timetable of the review. (At this stage, it is an indicative timetable only) | This is speculative at this stage and almost certain to be amended later, but it will provide an important framework for communication within the ministry and to stakeholders. |
| 7 | Allocate a senior official to “champion” the legislation development process. | The process will always encounter blockages at various stages of the review process. A senior official, who is engaged with the process, can help a great deal. It may be the Director of Public Health or similar senior official. |
| 8 | Allocate a public “spokesperson” for media and public presentations. | This may only be needed for large reviews likely to attract media attention. It may be the senior official who is the “champion”, or another person, but for big reviews, this is important. |
| 9 | Allocate the ministry official responsible for managing the project. | This is the officer who will manage the project on a day-to-day basis. Donors may make technical assistance available, but it is important that a ministry officer manages that assistance and takes responsibility for the review for the ministry. |
| 10 | Seek nominated liaison officers in other departments. | These will vary according to the substance of the review. They will always include the Office of the Solicitor General/Attorney General’s Department and probably the office of local government. Other relevant portfolios may include Treasury, Customs, and Agriculture etc. |
| 11 | Plan for allocation of the necessary resources. | What staff are needed and for how long? What other resources may be needed? If technical assistance is needed, and donors are to be approached, the process may be quite protracted. It is important to begin the necessary work early. |</p>
<table>
<thead>
<tr>
<th>Step</th>
<th>Task Description</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Make any necessary budgeting arrangements to fund the review</td>
<td>Include all budgeting arrangements for the review, in the briefing material for senior executive signoff.</td>
</tr>
<tr>
<td>13</td>
<td>Set a timetable containing all the steps considered necessary for this particular review, building in extra time for unexpected events.</td>
<td>A draft timetable has already been considered. At this stage it must become firmer, building in all expected stages of the review. The terms of reference, review team etc will be settled, so a much firmer timetable will be possible.</td>
</tr>
<tr>
<td>14</td>
<td>Check the progress of the Parliamentary cycle and consider when the new legislation may be able to be passed.</td>
<td>This step facilitates working backwards to ascertain the time needed to complete all steps in the process. Allow for delays caused by unexpected changes to the Parliamentary program. The operations of parliaments are always subject to change. Note also that some countries require a planned review to be included in the Parliamentary program before initial work is permitted. It is prudent to check parliamentary process requirements. Some countries have guides to the process available. For example Fiji and PNG.</td>
</tr>
<tr>
<td>15</td>
<td>Consult the Secretary General to Parliament, or other person in charge of administering the process within Parliament itself.</td>
<td>The Secretary General to Parliament, or other relevant parliamentary official, can advise as to the current legislative program for Parliament.</td>
</tr>
<tr>
<td>16</td>
<td>Appoint a steering committee if necessary.</td>
<td>This is only necessary for quite broad ranging or particularly politically sensitive reviews.</td>
</tr>
<tr>
<td>17</td>
<td>Seek a nominated contact from important government stakeholders.</td>
<td>This is especially important on small reviews. On big reviews such stakeholders would be invited to join the steering committee.</td>
</tr>
<tr>
<td>18</td>
<td>Form a strategy for the inclusion of stakeholders outside government. Check whether the country has existing requirements for stakeholder consultation outside government, making arrangements consistent with such requirements if they do exist.</td>
<td>It is important to consult stakeholders outside government and seek their participation in the review. Consideration may be given to enabling oral responses, or collecting views via group discussions, where people who may have low literacy are part of the stakeholder group. Consumer groups or women’s groups may be also consulted, depending on the nature of the review. Women’s groups are particularly important in the Pacific given the problems with maternal mortality, and the obligations for all Pacific countries that have...</td>
</tr>
<tr>
<td></td>
<td>Consider whether some international instruments may be relevant.</td>
<td>For example, treaties, conventions, international regulations and other international instruments. See <a href="http://www.paclii.org">www.paclii.org</a> for information on treaties ratified by Pacific countries. There needs to be some sensitivity to the differences of view in different countries. In some countries, treaty obligations may be a useful catalyst for a review. In others, this approach may not be successful.</td>
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<tr>
<td>19</td>
<td>Consider whether other materials may be relevant.</td>
<td>For example, research, data and academic literature. WHO is often a good source of such materials but other scientific literature may be of interest and relevance.</td>
</tr>
<tr>
<td>20</td>
<td>Consider any guidance documents on Cabinet and parliamentary processes, such as the PNG NEC Guidelines.</td>
<td>Countries often produce guidance documentation on the preparation of Cabinet documents, or documents seeking approval of legislative reform proposals. Compliance with formal processes will be required, so it is important to ascertain what these might be, early in the process, to ensure the necessary documents are obtained or created. This will avoid delays caused by non-compliance.</td>
</tr>
<tr>
<td>21</td>
<td>Approval in Principle</td>
<td>In some countries Cabinet approval is required at this stage. Check the Cabinet process requirements in your country as lack of compliance may later cause delays and difficulties.</td>
</tr>
<tr>
<td>22</td>
<td>Settle the policy questions to be resolved in the review.</td>
<td>These are the issues that brought about the review.</td>
</tr>
<tr>
<td>23</td>
<td>Settle written terms of reference for a review of any size.</td>
<td>The terms of reference will be informed by the policy questions that brought about the review. It is important to set parameters around what the review will consider. This helps manage expectations both within and outside government.</td>
</tr>
</tbody>
</table>

14 See also the UN Global Strategy for Women’s and Children’s Health September 2010, at http://www.everywomaneverychild.org/images/content/files/global_strategy/full/20100914_gswch_en.pdf accessed 29 November 2011
| 24 | Obtain agreement from the ministry about the proposed review process including terms of reference, indicative budget, timetable, consultation strategy and parliamentary timetable. | It is crucial that the ministry signs off on all important stages of the review. The terms of reference, which will be the core of the review, must be approved by the ministry. This will probably mean endorsement at a senior executive meeting, and then the document is forwarded to the Minister for signoff, which enables the review to begin. |
### Policy development

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<tr>
<td>25</td>
<td>Consider whether a discussion paper raising the policy issues is necessary.</td>
<td>This is an important step in a large review, or a review that needs to consider a number of complex policy issues.</td>
</tr>
<tr>
<td>26</td>
<td>Develop a consultation strategy.</td>
<td>This will vary according to the size of review and the type of individuals or groups who need to be engaged.</td>
</tr>
<tr>
<td>27</td>
<td>Consider the need to seek public submissions on the policy questions under review.</td>
<td>Small reviews may be conducted entirely “in house” within the ministry, but most reviews will seek public input in some form. It would be expected that a report on the nature of consultation will be required when a Bill is submitted to parliament, if not before. Lack of consultation is a frequent reason for criticism of health reform Bills. Consultation will slow down the process but is likely to contribute to a better and more acceptable reform.</td>
</tr>
<tr>
<td>28</td>
<td>If it is a large review, there should be a strategy for release of the discussion paper.</td>
<td>It might be sent to all known stakeholders, and may be announced via a press release or advertisement in the national newspapers, or any other relevant publication or trade journal.</td>
</tr>
<tr>
<td>29</td>
<td>Develop a database of stakeholders.</td>
<td>This is very useful in a big review. It helps keep track of who has been sent a discussion paper, who has been briefed and who has made submissions etc.</td>
</tr>
<tr>
<td>30</td>
<td>At the completion of the consultation process, a report should be written.</td>
<td>This report details the consultation process, including who was consulted, and a summary of responses.</td>
</tr>
<tr>
<td>31</td>
<td>Draft a new policy document.</td>
<td>This would set out the preferred approach of the ministry to the policy questions raised in the review, and which arise from the consultations and review of relevant laws, treaty obligations and academic literature. It would also be consistent with any national health planning document.</td>
</tr>
<tr>
<td></td>
<td>The ministry may have guidelines related to policy making and have standards for policy development.</td>
<td>Any new policy must be consistent with any such guidelines.</td>
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<tr>
<td>33</td>
<td>“Reality check” the draft policy.</td>
<td>This may be done via internal and/or external stakeholders, and according to existing health planning, the constitution and other broader policies and obligations.</td>
</tr>
<tr>
<td>34</td>
<td>The new policy must have a properly resourced implementation plan.</td>
<td>This should be considered in detail at this stage of the process, and include the development of explanatory and training materials, and necessary travel, phasing in expenses etc.</td>
</tr>
<tr>
<td>35</td>
<td>Seek ministry signoff of the final policy, perhaps at the Cabinet level, for a significant review or one with political, cultural or financial implications.</td>
<td>This will be an important document, which may be needed to support the policy justification for drafting instructions, and other actions arising from the review.</td>
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### The drafting stage

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<tr>
<td>36</td>
<td>Drafting instructions must be developed. They must be specific and detailed, and they must reflect the policy that was signed off by the ministry. When they are submitted to Parliamentary Counsel, they should be accompanied by the policy document.</td>
</tr>
<tr>
<td>37</td>
<td>Liaise closely with the Office of the Solicitor General and First Parliamentary Counsel, or delegate. The closer the communication is at this stage, the more likely it is that the drafting instructions comply with the correct standards for the country, and are acceptable to Parliamentary Counsel when formal approval is sought.</td>
</tr>
<tr>
<td>38</td>
<td>The public service head of the ministry, whether Secretary, CEO or other title, or a senior officer authorised by the CEO, must issue and sign drafting instructions. Many countries have rules requiring very senior ministry officials to sign off drafting instructions, to ensure these are not lightly given to Parliamentary Counsel. Even without a formal requirement, senior level signoff is appropriate.</td>
</tr>
<tr>
<td>39</td>
<td>A meeting with the Office of the Solicitor General/Attorney General may be necessary, to clarify the drafting instructions. There may be a number of legal questions that arise about the proposed legislative scheme. These will be discussed and clarified with the Solicitor General/Attorney General’s Office.</td>
</tr>
<tr>
<td>40</td>
<td>Formally send drafting instructions to First Parliamentary Counsel for approval. These should be accompanied by a draft Cabinet Submission or approval in principle. Different countries have different names, but it is the draft Cabinet briefing that will seek approval for drafting the legislation to be commenced, and will include the drafting instructions signed off by the office of Parliamentary Counsel.</td>
</tr>
<tr>
<td>41</td>
<td>Necessary amendments are made to the instructions. Parliamentary Counsel may suggest or require changes. This occurs before the submission is lodged at Cabinet Office.</td>
</tr>
<tr>
<td>42</td>
<td>Formal Cabinet approval is sought. The Cabinet paper seeking approval of a legislative reform proposal, often referred to as the Approval in Principle, must comply with any Cabinet Office requirements in relation to the preparation of Cabinet papers. Most countries have a specific format for Cabinet briefings and this format must be followed. It is likely to require detail of stakeholder consultations and any financial, workforce, social and cultural implications of the proposed legislation.</td>
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### Health Legislation in the Pacific – Process and Checklist

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<tr>
<td><strong>43</strong></td>
<td><strong>Formal Cabinet approval is granted.</strong></td>
</tr>
<tr>
<td></td>
<td>Formal approval will be evidenced by minutes of the relevant Cabinet meeting, and a copy must be obtained and kept on the file. This formal approval is generally forwarded to the Office of Parliamentary Counsel so formal drafting may begin. In developing countries this is sometimes the consideration of a draft Bill, prepared by a consultant retained by the Ministry of Health.</td>
</tr>
<tr>
<td><strong>44</strong></td>
<td><strong>The ministry may choose to circulate drafts of the legislation to stakeholders.</strong></td>
</tr>
<tr>
<td></td>
<td>Release of an “Exposure Draft” of the Bill is a good method of consultation, but it certainly extends the timelines if changes are suggested and Parliamentary Counsel is requested to redraft to incorporate the changes.</td>
</tr>
<tr>
<td><strong>45</strong></td>
<td><strong>Undertake a detailed examination of the old legislation and regulations that are about to be amended or even repealed.</strong></td>
</tr>
<tr>
<td></td>
<td>Every section to be amended or repealed should be checked, and a decision made as to whether that particular part of the regulatory regime is to be included in the new regime.</td>
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</table>
## Cabinet approval processes and introduction into Parliament

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>46</strong></td>
<td>Obtain final draft of the Bill from the Office of Parliamentary Counsel.</td>
<td>Attach the Bill to the draft Cabinet briefing that seeks approval of the draft Bill for introduction and passage through Parliament.</td>
</tr>
<tr>
<td><strong>47</strong></td>
<td>The Ministry of Finance and the Public Service Commission must clear any financial or personnel resource implications.</td>
<td>If these stakeholders have been informed throughout the review, stakeholder attitude to this signoff should be reasonably predictable and the process straightforward.</td>
</tr>
<tr>
<td><strong>48</strong></td>
<td>Present the final draft Bill to the Minister, for approval.</td>
<td>The Minister must champion the Bill through Cabinet and argue its priority for introduction to Parliament. The Minister must be well briefed.</td>
</tr>
<tr>
<td><strong>49</strong></td>
<td>A final Cabinet briefing is prepared when the Office of First Parliamentary Counsel has drafted or settled the Bill. The briefing must contain an explanatory memorandum.</td>
<td>The explanatory memorandum is a clause by clause explanation of what is in the draft Bill.</td>
</tr>
<tr>
<td><strong>50</strong></td>
<td>The Cabinet approval is provided to the Office of the Solicitor General, for vetting.</td>
<td></td>
</tr>
<tr>
<td><strong>51</strong></td>
<td>If regulations have been drafted to accompany the Bill, they must also be sent to Parliamentary Counsel for comment.</td>
<td>This is unless they have been drafted by Parliamentary Counsel.</td>
</tr>
<tr>
<td><strong>52</strong></td>
<td>Although regulations are generally made by the Minister, the Minister must still present them to Cabinet.</td>
<td>A briefing explaining the regulations must be provided to Cabinet, and it would be useful to draft briefing notes for the Minister when he or she addresses Cabinet (seeking approval for the making of the regulations).</td>
</tr>
<tr>
<td><strong>53</strong></td>
<td>When final Cabinet approval is provided for the Bill, it must be transmitted to the Office of the Solicitor General for vetting.</td>
<td></td>
</tr>
<tr>
<td><strong>54</strong></td>
<td>The Minister will introduce the Bill into Parliament for a first and second reading.</td>
<td>A second reading speech must be prepared for the Minister, explaining the new legislative regime and its policy justification.</td>
</tr>
</tbody>
</table>
The ministry will follow the progress of the Bill in Parliament.

The ministry will also be required to attend the relevant Sector Standing Committee, if the Bill is referred to any such committee.

The Bill is passed.

If the Bill is passed, there are likely to be some administrative processes, such as signoff by the Speaker and gazettal, before it finally becomes law.
### Implementation

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<tr>
<td><strong>57</strong></td>
<td>The Secretary to Parliament and the Office of the Solicitor General are responsible for the publication of the Act in the Gazette.</td>
<td>This will settle its proclamation date.</td>
</tr>
<tr>
<td><strong>58</strong></td>
<td>Any administrative arrangements that need to be settled are addressed.</td>
<td>These may need to be published in the Government Gazette on the commencement of the Act or regulations. Note that it is common for a public health act to have a staged commencement. Regulations may include fees to be decided, committees to be appointed, officers to be authorised etc. These will need to be decided and formalized before commencement.</td>
</tr>
<tr>
<td><strong>59</strong></td>
<td>Communication strategies will need to be commenced.</td>
<td>These will have been developed at an earlier stage of the review but will now commence. The strategy is intended to ensure all those interested and affected have the opportunity to be fully informed about the upcoming changes to the law. An information brochure and/or a training package may be considered. It may be necessary, in the Pacific, to design information and training materials for people of low literacy.</td>
</tr>
<tr>
<td><strong>60</strong></td>
<td>In order to comply with new requirements and conditions, it may be part of the implementation strategy to introduce a period of time between passage of the legislation, and the date it comes into effect.</td>
<td>Staged implementation can assist acceptance and readiness of those affected by the new legislation.</td>
</tr>
<tr>
<td><strong>61</strong></td>
<td>There will be a period between the passage of the law and the proclamation date.</td>
<td>The strategy will need to address what should happen in this period.</td>
</tr>
<tr>
<td><strong>62</strong></td>
<td>Resources may be required to comply with any new standards, reporting requirements or administrative procedures introduced in a new regime.</td>
<td>Planning for legislation development and review must consider the resource implications of implementation of a proposed new regime.</td>
</tr>
</tbody>
</table>
**Starting out**

*Is legislation review and reform really necessary?*

It is sometimes the case that inaccurate ideas about what particular legislation does and cannot do may become normalised without challenge. It is worth examining the legislation being considered for amendment, and thoroughly exploring the extent of its powers, including regulation making powers. This exercise may establish that the new right, responsibility, activity or power, which is the desired outcome of the proposed review, is in fact possible or exists under the current legislation or regulations. If the necessary powers are found to exist, the time-consuming exercise of legislative review and reform will not be needed.

There may also be non-legislative options that could be an effective approach to the issues under consideration. Non-legislative options should be considered at all stages of the process. A decision should never be made to legislate or regulate before non-legislative options have been carefully examined and considered ineffective.

**Reformers sometimes also fall into the trap of believing that new laws can solve problems simply by virtue of the fact that the laws exist. Yet laws and regulations that are overly complex or that fail to take into account weaknesses in the agencies that will enforce them or the greater social context can create more problems than they solve.**

There may also be non-legislative options that could be an effective approach to the issues under consideration. Non-legislative options should be considered at all stages of the process. A decision should never be made to legislate or regulate before non-legislative options have been carefully examined and considered ineffective.

**Law reform does not “magically” eliminate injustice**

Reviewing reports on the health outcomes and health inequalities in the Pacific may engender a desire to advocate strong action to improve the situation. While it may be tempting to advocate for broad ranging reforms as soon as possible, premature action can ultimately result in frustration and failure. A UN Guide to Legislators on HIV/AIDS, Law and Human Rights sounds a cautionary note to reform enthusiasts: “Legislation would not be an effective means of practical implementation of human rights in some circumstances and countries, because of their lack of social or economic structures or resources that are a precondition to their fulfilment.”

Before legislation reform can be undertaken, consideration must be given to the current laws and the extent to which they are implemented. It may be that further resourcing and supporting the present legislative powers is an important first step toward reform. If present powers are not implemented

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properly, the same problem is likely to be faced with newer, better targeted powers unless proper resources\textsuperscript{16} are available.

**How big is the review?**

This document attempts to distinguish between small reviews, which may result in minor amendments to existing legislation, and big comprehensive reviews, which may result in entirely new Acts, and other reviews fitting somewhere between the two. The size of the review will make a great deal of difference to the steps required to complete the review, and the complexity of the work needed to complete each step. A small review may be quite simple, and only require the part-time attention of one officer, with advice provided by other officers from time to time. A large scale review, such as a complete review of a very large and complex Act, or series of Acts and regulations, will create a significant workload for several officers, over a number of months or even years.

A broad timetable for the review should be considered at this stage. As the parameters of the review have not yet been finalised, any timetable would have to be a somewhat speculative. However, in order to give some consideration to the necessary resources and to allocation of personnel, there has to be some thought given to the size and length of the review in contemplation.

**Finding a champion and spokesperson**

The ministry must allocate a senior official to “champion” the legislation development process. This senior officer would be likely to be the executive with line management responsibility for the section or area undertaking the review. This senior officer may need to provide regular briefings to the Cabinet or Executive Council on the process as it progresses, seeking assistance or direction where required. This senior officer will also need to contact other government departments, at senior officer level, to seek assistance or otherwise facilitate communication; be present at public consultations; and available to provide support to the legislation review officer, to help unblock the process, which inevitably happens from time to time.

The senior officer or “champion” may also take

\textsuperscript{16} Proper resources for a law reform may include a communication strategy; development of explanatory materials; training packages; new staff to undertake explanation and support of new rights and responsibilities; inspections and prosecutions; capacity of police to gather evidence and the Department of Public Prosecutions to prosecute and the Public Solicitor to defend; a new tribunal or an increased workload for a present tribunal; new registration of licensing regime may also need criteria and standards, processes, payment and appointment and removal powers.
responsibility, as spokesperson for the review, in any media interviews or enquiries about the review. If it is not this person, there must be a clear allocation of responsibility for the role of spokesperson. Some reviews may attract very little media attention, but others will cover controversial issues and may generate a great deal of attention and debate. The ministry must be prepared to respond.

Who is responsible?

Even the simplest review will usually require the input of a number of government officials from a number of departments. The process of legislative review can be protracted and unpredictable. It can certainly be expected to tax the patience and ingenuity of those involved. It is important, at the outset, to be quite clear about the responsibility of those involved. One government official from the ministry ought to be clearly responsible for managing the project. It is also helpful to seek nominated liaison officers in other departments, such as the Solicitor General's/Attorney General’s Office or the Office of Parliamentary Counsel.

What kind of expertise is required?

Irrespective of the size of the review, there would always need to be an officer who has the public health “content” knowledge. The knowledge required will vary depending on the legislation under review. Specialist content knowledge may be as diverse as food hygiene, drugs and poisons, mental health, nursing standards, avian influenza, HIV/AIDS, infectious disease surveillance, non-communicable disease management, and any other area covered in the health portfolio.

This public health officer would provide advice throughout the review, on matters relating to its subject content. For example, in a review about legislation covering infectious disease management, a public health officer with expertise in the management of infectious disease control would advise as to the current literature on the patterns of the spread of particular diseases, methods of diagnosis, the “at risk” population, methods of treatment, and any difficulties currently being experienced in the field in relation to the management of that particular disease. This officer would also advise on how the current regulatory regime is used in the field. For example, are certain rights and responsibilities adhered to, have any prosecutions taken place over the last five years, do the current laws in any way hamper the exercise of surveillance, contact tracing, treatment and education in relation to health promotion activities? This kind of advice is essential to the development of legislation and regulation that is highly sensitive and responsive to the current needs of the country.

It is also very helpful to have access to expertise in planning and budgeting, and in preparing proposals that align to the ministry budget cycle.

Personnel and resources

Depending on the nature of the review, a comprehensive multi-step process (involving a discussion paper, consultation with outside stakeholders and drafting a new policy) may be envisaged, or a
Health Legislation in the Pacific - Summary

simple and non-controversial amendment to one clause in an Act may be all that is contemplated. It should be noted that a planned amendment is so simple that no stakeholder consultation is necessary. For any review, consideration must be given to personnel and resources.

Some questions that need to be considered include the following: How many officers are needed to work on the review? How long will their duties include working on the review? Are there ministry or other resources available to fund the personnel? Is it possible to include some officers in review activities for capacity building in legislation review? Will any backfill be necessary to manage their current workload while they are diverted into the legislation review?

What other resources may be needed? Will workshops be run? Does the budget have to cover room hire and catering? What is the cost of printing and distribution of discussion papers? Will postage be required? What about travel, if workshops or information sessions need to be held outside the main cities? Will members of a steering committee have travel or other expenses? Will there be teleconference expenses?

Is the review internally funded by the ministry or perhaps funded by an outside donor or government? Is it jointly funded by more than one department? Is it being undertaken “in house” within the government department or ministry, or are contractors involved? This should be clear at the start of the process, and it would be good practice to have a document setting out the workload responsibilities of all involved, and the agreed timelines for the review, with this circulated to those who have agreed to the arrangement. A copy should also be placed on the file.

Scoping the review

Aim and scope of the review

A legislative review is never open ended. Specific terms of reference will determine matters being considered. It is important to make this clear to ensure the community and stakeholders have realistic expectations of the review. One commentator puts it this way:

At the commencement of the law review and reform process it will be useful to formulate a statement of the objectives or purposes of the new regulation. This statement would set the backdrop to the issues that need to be addressed through law reform. A narrow or incomplete statement will unduly circumscribe the law review and legal drafting exercise, while a broader statement, on the other hand, may be far too general and vague as to be of little practical value.

Legal context

Every piece of legislation is just one part of the many Acts of Parliament and Ordinances on the statute books in any country. Every Act will refer to other legislation and be affected by it. When conducting a review, it is an important step to identify the relevant legislation administered by your portfolio, briefly describe the purpose and effect of this legislation, and where the Act to be reviewed fits into the broader legislative scheme. This will give you a useful perspective for the
planned review. It is also important because it may be that one outcome of your review will be to recommend consequential amendments to other relevant Acts.

**Broader legislative environment**

What other Acts and regulations are relevant? As part of scoping the review, it will be necessary to consider the broader legislative environment and build some time into the review process to ensure that this is properly considered. Any legislative change will have implications for other legislation. Other legislation may contain powers, rights or responsibilities that are relevant to the review in contemplation. A small review or amendment may not be greatly affected by other legislation and this step will not take long under those circumstances. However, a bigger review may need to consider a number of other Acts and regulations. Under these circumstances, this step could be time consuming.

There are a number of Acts administered by the health portfolio. It will be necessary to look at some of these and assess how they may impact on the legislative review. It is quite likely that other Acts will also be relevant to the review. For example, the constitution and interpretation of legislation laws would be considered in any review. Other laws might include financial management laws, public service and public administration laws, fair trading laws, local government laws, customs and criminal laws etc. Some of these may be impacted by, or have some impact upon, the legislative review under consideration. Whether there are relevant jurisdictions available to hear allegations of breaches of new laws. This can be quite a long and onerous job as it will necessitate the reading and analysis of a number of different laws and subordinate legislation. Sometimes these will be quite difficult to assemble and assistance may need to be sought from the Solicitor General’s/Attorney General’s Office. The website www.pacii.org can be a very useful source of many of the laws of the Pacific, but it does not contain a complete electronic collection of Pacific laws and subordinate legislation. However, it is a most useful resource and highly recommended as a starting point.

It may also be necessary, as part of this step, to speak to officers in other government departments about the operation of relevant legislation. For example, it may be necessary to speak to Treasury, Customs, Police, Education or Agriculture about the day-to-day operation of various relevant Acts. It can sometimes also be difficult to obtain copies of relevant laws and some time might need to be set aside for searches in relevant departments, libraries and archives.

**What are the policy questions?**

The first step in scoping a legislation review is to settle the policy questions to be resolved. Examples may be to check health emergency powers to ensure readiness for the outbreak of an infectious disease, such as avian influenza. It may be that consideration needs to be given to legislation to support a response to HIV, or to implement a drug registration system or the regulation of a new health profession. All of these examples would raise a number of policy questions, which will need to be answered in some detail before amending legislation or drafting a completely new Act. The policy questions can then be shaped to form the terms of reference for the review.
**Terms of reference**

The smallest review ought to have set terms of reference. There must be clarity about what the review is to consider. What matters are “in” and what matters are “out”? Written terms of reference will assist both the ministry and stakeholders to have realistic expectations of what the review is about and can achieve. If crucial new policy issues are raised during the review process, it is always open to the ministry to review the terms of reference, if this is necessary. The terms of reference, which are the core of the review, must be signed off by the ministry.

When consultations begin, many matters will be raised—both internally within government and externally by other stakeholders. Some of these will be expected, some will not. Discussions may become robust, even heated. It is important to keep a tight rein on matters under consideration, and ensure that they are confined to matters specifically raised by the terms of reference.

Terms of reference (TOR) ensure that stakeholders have realistic expectations that are clear from the outset, and that the scope of work is predictable and contained.

**Setting a timetable**

Does the review seek to make minor amendments to an Act, substantial amendments, or perhaps even a brand new Act? This may not be fully known until some work has been done and some consultation undertaken. No matter what is being contemplated, there will be certain stages in the process that are the same for any kind of legislative development. Consider each part of the process, as it is set out in this Guide, and try to estimate how long it might take to complete that stage in the particular circumstances of the contemplated review. Create a timetable for the work. Although this may have to be revised many times as the work progresses, it provides a very useful perspective of the work involved in the project, right from the start.

The table below sets out some of the activities that would be likely to appear in a review timetable:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Estimated dates</th>
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<tbody>
<tr>
<td>Seek Cabinet approval or the Ministers approval to begin review if this step is required in the country</td>
<td></td>
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<tr>
<td>Convene Steering Committee</td>
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<tr>
<td>Release of discussion paper, which sets out TOR for review and asks specific policy questions</td>
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<tr>
<td>Consultation comprising meetings with stakeholders and public workshops</td>
<td></td>
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<tr>
<td>Responses to discussion paper received</td>
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<tr>
<td>Write consultation report, which notes the responses to each policy question asked</td>
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<tr>
<td>Development of a new policy</td>
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<tr>
<td>Internal legislative policy development process including consultation with other affected government departments, development of drafting</td>
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instructions and briefing materials for Cabinet and other government committees

Develop drafting instructions or draft legislation and regulations

Seek approval of Parliamentary Counsel

Briefing the Cabinet, the Minister and developing further Cabinet briefing material

Possible further brief consultation with stakeholders on contents of the Bill (this would not happen in a small review)

Passage through Parliament and proclamation

Development of implementation strategy

Implementation and communication strategy, possibly including a brochure describing the new legislative regime, and workshops for stakeholders

Legislation review is notorious for taking longer than expected. A timetable that is realistic in identifying the steps involved, and allocating timeframes, may help to avoid unexpected blowouts in the timetable. An event schedule planner, which would be suitable for preliminary planning and time allocation, is available free on the internet from Microsoft.17

Always build a little extra time into each stage to allow for unforeseen impediments in the process. For example, stakeholders may raise unexpected objections leading to a blowout in the consultation phase. A decision may be made to add to the matters under consideration. Public scrutiny may lead to further consultation. Intense lobbying from interest groups may require management and further consideration by the ministry. An election may be called. Parliamentary Counsel may have questions about aspects of the drafting instructions and further work is needed. Consequential amendments to other legislation may have been overlooked and must now be addressed.

**Parliamentary cycle**

At what stage is the parliamentary cycle? Consideration needs to be given to when the legislation might be passed by Parliament, having consulted the latest version of the parliamentary timetable, which is available from Parliament House and sets out the year’s sitting dates. To determine the available time to meet the deadline for introduction of a Bill into Parliament, work backwards to establish whether each stage can be completed in the available time. It is also important to be aware of the likely date for the next election. A sudden election announcement may derail plans to have a Bill ready for introduction and passage at a preferred date.

It would be helpful to consult the Secretary General to Parliament, or the parliamentary officer in charge of managing the list of Bills for introduction into Parliament, who can advise as to the current legislative program for Parliament, and when it might be possible for a new Bill to be fitted into the program.

Steering committee

A larger review, or a review with stakeholders across a number of industries and organisations, may benefit from a steering committee. It can also be useful if the matters being considered under the review are likely to raise some controversial issues and robust public debate is expected.

The steering committee will sign off on all important milestones in the legislation development process, and provide guidance about a range of matters the project team may need to consider. It should be made up of representatives from the relevant stakeholder organisations within government and outside government. A representative from the Solicitor General’s/Attorney General’s Office should always be invited. Depending on the nature of the review, a high profile chair of the steering committee can give the legislation development process a public profile, which may be desirable.

It is important to keep the steering committee a manageable size as too many members will make it very difficult to convene meetings, or provide useful guidance to the project team or legislation policy officer. If a number of people with different expertise are required, they may be co-opted to the steering committee as determined by the matters under consideration. This can help contain the size of the committee.

As with every step in the legislation development process described in this document, this step may not be needed if the review is small and uncomplicated.

Discussion paper

The size and complexity of this document, like all other steps in this process, will vary according to the size and complexity of the reforms being sought. For smaller reviews, a discussion paper will not be necessary at all. It will only be necessary to have brief terms of reference.

A discussion paper is most useful where a variety of issues are under consideration and there is a variety of stakeholders. It is used to clearly set out the background and reasons for the review, ask the relevant policy questions and seek submissions from stakeholders.

Some headings that may prove useful in the discussion paper might include: the aim and scope of the review, the background, legal context and submissions.

The discussion paper should make clear the process for making submissions, including a date and time of lodgement, and an officer to whom they may be addressed. It may also be a good idea to accept taped submissions, as a written submission may be difficult for some stakeholders. If written
submissions are sought, it is important to make clear that these will be considered to be public documents, and made available to be viewed by members of the public upon request, unless marked “private and confidential”. There is no freedom of information legislation in some Pacific nations as yet, but where it exists, stakeholders should be informed that submissions would be likely to be available if a freedom of information request was made seeking access to them.

To ensure clarity about the purpose and status of the discussion paper, it may be prudent to insert a note into the introductory section which reads “The opinions expressed in this paper are for discussion purposes only and do not represent the policy position of the Ministry of Health.”

Consultation

Whatever the size of the review, it remains important to involve stakeholders in the process from the very early stages. In a small review, it would still be useful to seek a nominated contact from important government stakeholders such as the Office of the Solicitor General, Treasury if there may be financial implications, and Customs if imports or exports are affected. If countries are also wishing to implement the International Health Regulations 2005, they will also need to include Ports and Airport Authorities and Immigration. Nominated representatives should then be contacted regularly and kept up to date on the progress of the review. Neglecting such stakeholders in the process can result in nasty surprises toward the end of the process, when stakeholders suddenly become aware of the legislative proposal, and may voice unexpected opposition, which can affect timelines and the credibility of the process.

Thought will also need to be given to the involvement of stakeholders outside government. It is important to keep them informed and involve them in the process as much as is possible and as much as resources allow. Sometimes this can be difficult as robust policy discussions may be needed, as part of the policy development process within government, before outside stakeholders are consulted. However, their importance in the process must be acknowledged. Consultation creates better policy when a wide range of views has been canvassed. Stakeholders are more likely to be supportive of a new legislative regime if they believe they have played a respected part in the process. The kinds of groups that must be consulted will vary depending on the subject matter of the review but are likely to include consumer groups, women’s organisations, church groups and those directly affected by the law under review or the proposed new law.

Consultation can be undertaken a number of ways. It would be planned having regard to the timelines of the review, the resources available, the number of stakeholders, and whether some of the policy issues under review are particularly sensitive or controversial.

Small meetings can be held with small stakeholder groups with quite specific issues. Large group consultations can take place with large stakeholders, such as the nursing profession, local government, or other large community groups that may have a stake in the policy development.

Written submissions can be sought. Some important stakeholders may not wish to make a written submission, but it is important that the review ascertain their views. Another approach is to convene a meeting and break up into groups to discuss and record responses to the policy questions under review. This can be quite a useful method of recording responses when a written submission cannot
be expected. In the Pacific, literacy rates can be quite low in some areas, so the convening of meetings to ascertain views is an important part of consultation.

Consider which central and other public service agencies need to be consulted. Depending on the nature of the legislation, these requirements would vary considerably, but Treasury would always be consulted if there are financial or taxation implications, and the Solicitor General’s/Attorney General’s Department would always be consulted to ensure the proposed legislation fits within the broader legislative styles and customs of the country. For example, is the review likely to recommend a broad power, for which a warrant would generally be required? Or is it likely to create an offence that may sit better in crimes legislation? Are the recommended penalties imposed for breaches of the proposed law consistent with penalties for similar offences in other legislation, particularly environmental laws, food safety laws and similar related laws? Are there matters to consider in the local interpretation of legislation laws?

The configuration of the health system

How is the health system configured? This is of great relevance to any legislative review or amendment. Some countries have systems that are federal in nature, where powers are divided between a central government and provincial governments such as the arrangement in PNG. In the Solomon Islands, provincial governments do have some concurrent responsibilities. In Fiji the public health law explicitly excludes application to traditional Fijian villages. The configuration of the health system is an important consideration when developing public health law in Fiji, as consideration must be given to the operation of the law inside Fijian villages. This might include the implications for customary law presently operating in those villages in relation to matters such as hygiene, rubbish collection and outbreaks of infectious disease, as well as other matters likely to be organised locally according to custom.

Some general comments on decentralisation

Although most countries in the Pacific region are geographically small, with small populations and a national public health law that covers the country, PNG is one exception. It has a population of around six million and has an active policy of decentralisation, with the creation of 20 provinces and the passage of the Organic Law on Provincial Governments and Local-level Governments, which was significantly amended in 1997 to support the implementation of decentralisation. Many other countries outside the region have policies of decentralisation which, like PNG, affect the planning, financing and delivery of health services. Examples include Yemen and the United Arab Emirates.

PNG has struggled with the effect of decentralisation on health service delivery, for both public and hospital care, and in 2007 passed the Provincial Health Authorities Act, intended to bring together public and hospital service delivery in PNG’s provinces. Its implementation is in the early stages. In any review or amendment of public health legislation, PNG would need to consider how it would be

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implemented in the provinces, as public health service delivery is undertaken by the provinces. This makes issues of delegation and the responsibility of local-level governments more significant in PNG.

In many countries, the introduction of decentralisation has not always been accompanied by plans for implementation, which include a phased introduction and comprehensive communication to all affected by the change, together with careful consideration of all intended and unintended consequences of the reforms. As a result, accounts of country experiences suggest there is a high level of dissatisfaction with decentralisation in a number of countries in which it has been introduced. It appears that the countries in which it has been most successful, are those in which it has been most carefully planned and implemented.

The issue is not whether or not to decentralise, but rather how to design and implement better policies to achieve national health policy objectives. Central and local elements are required in any health system; the issue is what balance should be struck, in which direction a particular country should move, and what means are at its disposal to alter the existing balance.

**Strong ministries of health**

A recent study emphasised the importance of enhancing the role and function of ministries of health. It pointed out that:

“There is a need to build awareness among politicians, policy makers, and the public, of the importance of stewardship and governance in strengthening health systems, and the critical role of ministers and ministries of health.”

**International legal obligations arising from ratification of treaties**

Pacific countries have ratified many international treaties. By ratifying the treaties, countries agree to further the objectives of the treaty in the specific ways set out in the treaty. For example, by

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19 [Organic Law on Provincial Governments and Local-level Governments (PNG)]


22 Ibid, page 4
ratifying CEDAW, PNG agreed to condemn discrimination against women in all its forms, and to pursue, by all appropriate means and without delay, a policy of eliminating discrimination against women. In relation to health, this means specific obligations in relation to access to reproductive health services and equality of access to health services for rural women.24

Implementation of multi-lateral treaties is an obligation at international law. Most applicable treaties, such as ICESCR and CEDAW, specify that the obligation is to pursue change using “all appropriate means” or by gradual means. Every ratifying country is different and “appropriate means” will be judged differently in every country. Pacific nations have unique cultural, political, economic and social environments and will need to seek to advance treaty objectives in ways that have resonance in their country, and in ways that may be sustainably implemented.

Opinions may also vary on what constitutes compliance. The articles in international treaties are often broadly drafted, particularly the human rights treaties. It is open to countries to implement policies in some areas that exceed the requirements of these treaties. In other areas, the use of “appropriate means” may be to recognise some progress toward implementation, but to also recognise that the policy and reform agenda in each country may take considerable time to reach a point where full compliance is politically, economically or culturally possible. Proposed reforms must also be practicable and sustainable.

The reform obligations in the text of many international treaties are broad and encompass areas of policy and law administered by a number of government departments. Ministries of Health will need to liaise with other departments, such as the Attorney General’s Department, Foreign Affairs and others, depending on the specific subject matter of the treaty.

This Guide is not intended simply as a guide to legislative compliance with human rights and other obligations arising from ratification of international treaties. It should be noted that excellent material, about how to meet human rights obligations in public health laws, was being produced at the time of writing and will be available in the near future.25

23 See www.paclii.org for details of which countries have ratified which treaties. For definitions of the various terms used in treaties or about treaties such as “ratification” see “Definition of Key Terms” section in UNICEF, Introduction to the Convention on the Rights of the Child at http://www.unicef.org/crc/files/Definitions.pdf accessed 30 November 2011
24 See http://.untreaty.org accessed 29 November 2011
25 A project to create a public health law manual was underway at the time of writing and a joint initiative of WHO, IDLO and the O’Neil Institute for Global Health Law (check accuracy of title)
In the context of the implementation of international treaties, discussions of the importance of culture, or the importance of preservation of traditional ways, which is a value enshrined in some Pacific constitutions, seem to uncover a tension between internationally agreed sets of values and their implementation in local situations. These tensions were not and could not have been contemplated by trans-national drafters of treaties.

This Guide acknowledges that tension. It aims to consider the implementation of treaties through a prism of the inherent value of indigenous customary ways. In this context, the wisdom of the Constitutional Planning Committee of PNG is acknowledged. This committee placed a high value on the preservation of Papua New Guinean ways. It also recognised that some of these ways do not serve the people, saying “our own institutions’ [place] constraints on our vision of freedom, liberation and fulfilment. These should be left buried if they cannot be reshaped for our betterment.”

Other materials

Other materials may be relevant such as research, data and academic materials—for instance, literature reviews on the area, and international approaches to similar issues in countries that have similar characteristics. The nature and size of the review would determine whether such materials may be relevant. For example, legislation that seeks to manage the spread of a communicable disease would have regard to the latest scientific information about the spread of the disease, the “at risk” populations, and reports about successful management programs in countries with similar characteristics.

Ministry of Health approvals

The discussion paper, terms of reference or any document describing the review process and the policy issues under consideration, is a Ministry of Health document. It must therefore have the necessary approval before it is publicly released. Depending on the size and scope of the review, it may be that the draft discussion paper and/or terms of reference are attached to the chief executive, and probably to a regular meeting of senior executive in the ministry, to brief them on the proposal and to seek approval.

It will be necessary to ascertain the date the Executive Council agenda (or any regular meeting which will consider the discussion paper and terms of reference) is finalised. This will ensure that the document, with a covering briefing, is submitted in sufficient time to be included in the agenda prior to its scheduled release. It would be useful to write a memorandum summarising the contents of the discussion paper and, in particular, any policy questions raised that may be politically sensitive.

26 For example see Constitution of the Independent State of Papua New Guinea, Goal 5, National Goals and Directive Principles
27 Constitutional Planning Committee Report, 1974
Release of the discussion paper

If it is a large review, the release of the discussion paper may be announced via a press release, or advertisement in the national newspapers or any other relevant publication or trade journal. In countries where literacy is low, use may also be made of radio spots to try to publicise the release as broadly as possible.

Compile a list of stakeholders, send or email the discussion paper to all, with a covering letter inviting participation in the review. It is important to keep a record of all stakeholders who have been sent a copy of the discussion paper.

Database

It would be a very useful exercise to develop a database of stakeholders. This is especially important if there is a large and diverse group of stakeholders with different interests. It may not be necessary for a small review.

A database can be a quite simple Microsoft Outlook or Excel-based document. It will help to ensure that all those with an interest in the review are contacted, and plans for the best way of engaging them can be made. Any contact made by stakeholders can be recorded in the database, which helps to keep track of who received the discussion paper, and any other communications and consultations.

Consultation report

At the completion of the consultation process, a report should be written that details how the process was made public, for example, by public advertisement, distribution of discussion paper or issues paper, public workshops and stakeholder meetings.

It also needs to record who was invited to participate in such meetings as well as recording those who attended. If stakeholders are advised of a consultation process and invited to participate, it is harder for them to later credibly complain that the new regulatory regime is in some manner unsatisfactory. It will assist in meeting this kind of criticism to have a record of who was invited to participate and to whom discussion papers were sent. The stakeholder database will be very useful for recording this information during a large review.

The consultation report is an important document when taking the next step in drafting a new policy. The new policy may not incorporate every suggestion made by stakeholders, but the ministry will certainly draw heavily from them in discussions on a way forward.

Depending on the nature of the issues raised, it may be necessary to brief the ministry executive, or the most senior public servant, on what is being said. This would be the case if particularly controversial matters were causing heated debate among stakeholders and within the community.
Health Legislation in the Pacific - Summary

This document evidences the consultation process and may be used later to brief the ministry, Parliamentary Counsel or outside stakeholders, on the breadth of the consultation process, the opportunities created for the participation of stakeholders, who participated and what was said.

New policy document

It is time to draft a new policy. It will clearly state:

- The policy questions under review and some description of the environment which gave rise to the issues.
- What is being done about them, i.e. the new approach adopted by the ministry. This will draw upon all the matters considered to this point. For example, it will refer to the pre-existing legislation, the matters raised in consultation and any other relevant matters, such as research, data and academic materials that may be relevant.
- The reasons for the approach, including scientific literature about matters such as the spread of infectious disease or how to contain it, the views of the stakeholders ascertained via consultation, and justifications from an evidence-based, risk management, human rights or public health approach. These need not be mutually exclusive; a number of approaches may be being used.
- The effect on other policies/legislation.
- The effect and timing of implementation, including what information and support will be offered to stakeholders and affected or interested community members.

The ministry may have guidelines related to policy making and have standards for policy development. Any new policy must be consistent with any such guidelines.

The draft policy should be “reality checked” with internal and some targeted external stakeholders. Depending on the nature of the review, some additional consultations may take place. Implementation of Constitutional provisions in relation to health and human rights would have been considered at the earlier stages of the review. At this point in the process, it would again be prudent to check the constitutionality of the proposal. Constitutions often have quite specific requirements about lawmaking and it would be advisable to ensure that the proposal will not purport to breach the constitution in any respect.

The new policy must have a properly resourced implementation plan. This should be considered in detail at this stage of the process.
The drafting stage

Drafting instructions

The new policy may now be used as the basis for the creation of drafting instructions to create any necessary enabling law.

Proposals for legislation by government departments are usually submitted to Parliamentary Counsel in the form of drafting instructions, although sometimes a draft Bill is submitted for consideration. Even if a draft Bill is prepared by external consultants, or within the Ministry of Health, it is very important to communicate closely with the Office of Parliamentary Counsel at all stages of the drafting. Drafting legislation is the function of Parliamentary Counsel, and that Office must always consider drafting instructions, or settle a draft Bill to satisfy itself that the Bill is constitutional, consistent with other legislation in the country, consistent with the in-house drafting styles and protocols, and is otherwise acceptable.

An officer within the Ministry of Health may be given the task of converting the policy proposal into instructions for the drafting of the amendments, or the drafting of new legislation. The length of time this takes will depend upon the complexity and completeness of the proposal. Sometimes, the ministry legal officer, or an external consultant, will also draft the Bill and any required regulations.

Drafting instructions must be specific and detailed. For example, is a board to be created? How many members? What are their powers and duties? Who will appoint the members? How will the Chair be appointed? How long will their terms be? How can they be dismissed? Will they be paid? These details must be provided to the legal officer who is drafting the legislation. If sufficient details are not provided, they will soon be requested by the legislative drafter. It will also be necessary to establish, in consultation with a legal officer, whether any consequential amendments will be necessary.

Some headings for the drafting instructions may include:

- overview of the policy approach of the ministry;
- reasons for legislation;
- problems;
- principal objectives;
- remedies;
- legal issues;
- other reports/advice;
- implementation;
- sanctions;
- deprivation of rights;
- binding Crown;
- amending Bill;
- commencement; and
- format.
Early consultation with the Office of Parliamentary Counsel

If the drafting is to be done within the Ministry of Health, it is necessary to liaise closely with the Office of the Solicitor General/Attorney General’s Department and Parliamentary Counsel. It is the role of Parliamentary Counsel to oversee the statute book, and to ensure that drafting styles in legislation are consistent and in line with local drafting conventions. Important advice may be given by Parliamentary Counsel about such matters, and early consultation with that Office is strongly advised. It may also be the case that advice may be required on penalties, appropriate appeal mechanisms and jurisdictions, audit provisions, financial years and some evidentiary provisions. Parliamentary Counsel can advise and assist with these matters, and should be consulted to make sure that the legislative approach is consistent with the approach to such matters in other legislation.

Senior officer to sign off drafting instructions

The Chief Executive, or an authorised senior officer, must issue and sign drafting instructions. The drafting instructions should state a timeline taking into account the government’s annual legislation program.

Once the Minister is satisfied with the Cabinet submission for Approval in Principle (see below for how to draft a Cabinet submission), and the drafting instructions or draft Bills, these may be formally submitted to Parliamentary Counsel for approval, before being submitted to Cabinet for approval.

Sending drafting instructions to Parliamentary Counsel

When the instructions or the draft Bill is finalised by the ministry, the documentation will be sent to the Parliamentary Counsel, together with a draft Cabinet submission, for approval prior to being sent to Cabinet. The comments from Parliamentary Counsel may indicate that the instructions are suitable for drafting, or that further work needs to be done, or that other issues not raised in the instructions need to be considered. When the instructions or draft Bill are submitted to Parliamentary Counsel, they should be accompanied by the policy document, which has been signed off by the ministry. Necessary amendments can be made to the instructions before the submission is lodged at Cabinet Office.
Drafting process

In many Pacific countries, there is insufficient capacity in the office of Parliamentary Counsel to draft every bill. In these circumstances the first draft will usually be produced by the Ministry and settled by the Office of Parliamentary Counsel. If the Office of Parliamentary Counsel has capacity to draft the bill, when drafting instructions are received, a preliminary meeting with the Office of the Solicitor General may be necessary to brief officers on the new policy, the policy development process including consultation, to clarify policy issues, and identify where the policy needs to be implemented by legislation.

The drafting process differs greatly depending on the size of the Act. For a small amending Act, some meetings are likely to be required. For a large Act, the drafting will take weeks or even months, and many meetings and phone calls are likely to be necessary to answer policy questions or clarify the ministry’s position on some relevant matters. These can include the number of people on a committee, what penalties may be required for particular offences, what powers may need to be given to authorised officers, whether some powers ought to be given to officers or to the Minister, whether a staged implementation is required, and whether some processes in the old legislation may need to be brought across to the new regime.

Please note that the drafting stage can raise a number of policy issues that have not been addressed before. It is important to build time into the review for the ministry to consider these and to develop a policy position. It can also be the case that when the first drafts of the legislation begin to appear, the ministry may decide it wants to change some policy decisions. Once again, this can take time and blow out the timelines if provision has not been made for this possibility.

If the ministry circulates drafts of the legislation to stakeholders, suggestions may be made by stakeholders to change the drafts in a number of ways. If these suggested changes are accepted, it will take time to redraft. The necessary time and complexity will depend on the nature of the proposed change. If stakeholders are to be consulted on the draft Bills, time will need to be built in to the process to allow for this.

Double checking the new legislative regime

Another important checking process, which should be carried out at this stage, is the detailed examination of the old legislation and regulations that are about to be amended, or even repealed. Every section to be amended or repealed should be checked, and a decision made as to whether that particular part of the regulatory regime is included in the new regime. Have any processes, rights, responsibilities or other things been inadvertently removed from the new legislative arrangements? Are they necessary and should Parliamentary Counsel be instructed to include them?

It is similarly important to check current bodies or committees, licenses, permits, and other bodies’ rights or responsibilities created by the old law, and whether they need to brought across to the new law. These can then be addressed in the transitional provisions.
Cabinet approval processes and introduction into Parliament

First Cabinet briefing—Approval in Principle

When drafting instructions are complete and approved by the Office of Parliamentary Counsel, they must be sent to Cabinet for approval. It should be noted that some countries require cabinet approval even before drafting instructions are sent to Parliamentary Counsel. It would also be necessary to brief Cabinet on the policy that is given effect in the legislation.

Cabinet ought to be briefed on the nature of policy development process, any key materials that influenced the policy decisions, the consultation process, including whether there was broad support for the policy proposals or whether there was opposition from some stakeholders. They ought also to be briefed on the nature of the proposed legislative changes, the policy reasons for the changes, and any expected consequences—whether political, financial, social or cultural. If the new Act or amendments have resource implications, this will need to be stated and the source of the funding to meet the resource requirements should be identified. It is usually a requirement to advise that Treasury has been consulted about any financial consequences. If other relevant ministries have been consulted, this could also be noted in the briefing.

It would also be useful to note that the constitutionality of the proposal has been checked and that there is no inconsistency with the rights entrenched in the constitution.

When Approval in Principle is provided, the formal drafting process may then begin. If the ministry has drafted the Bill in-house, the same process should be followed, but a draft Bill will be sent to Cabinet instead of drafting instructions. Once Cabinet approval is obtained, the Office of Parliamentary Counsel will check the Bill to ensure it complies with local drafting style, consistently implements the ministry policy, and is otherwise acceptable.

Ministerial approval of the final draft Bill

When the Office of Parliamentary Counsel has finished the final draft of the Bill, it must be submitted to the Minister for approval. The Office of the Solicitor General/Attorney General’s Department must be informed of the Minister’s approval. The information provided to the Solicitor General’s Office should contain the draft Cabinet paper for final approval by the Cabinet.

Final Cabinet briefing

A Cabinet briefing must be prepared, seeking approval of the final draft of the new Bill. The Cabinet paper must comply with any requirements of the Cabinet Office on preparation of Cabinet papers.

The Ministry of Finance and the Public Service Commission must first clear any financial or personnel resource implications.
Explanatory memorandum

The final Cabinet briefing must contain an explanatory memorandum or explanatory note. This document is a clause by clause explanation of what is in the draft Bill. If the Bill is large, this will be a time consuming task.

Are there any regulations?

If regulations have been drafted to accompany the Bill, they must also be sent to Parliamentary Counsel for comment, unless they have been drafted by Parliamentary Counsel. Although regulations are generally made by the Minister, the Minister must still present them to Cabinet. A briefing that explains the regulations must be provided to Cabinet, and it would be useful to draft briefing notes for the Minister, when he or she addresses Cabinet, seeking approval for the making of the regulations. Early attention to the drafting and promulgation of regulations is important. It is often a delay in the drafting of regulations which delays the commencement of new laws.

The timing of this process will depend on when it is planned for the regulations to be made. Sometimes regulations need to come into effect at the same time that a new Act is proclaimed; sometimes they will come into effect some months later.

Cabinet approval

When Cabinet approval is provided for the Bill, it must be transmitted to the Office of the Solicitor General for vetting.

The second reading speech

When the Minister introduces the Bill into Parliament for a second reading, he or she makes a speech explaining the new legislative regime and its policy justification. This is a very important speech as it may be used as an aid to interpretation of the Act. An officer within the ministry must prepare the second reading speech for the Minister, well prior to the planned date of the second reading.

Liaison with the Secretary General to Parliament, or other officer responsible for the list of Bills to be introduced, may assist in accurate planning about the likely dates for introduction of the Bill into Parliament, and when it might be expected to be second read.

Processing of the Bill in Parliament

The ministry will follow the progress of the Bill in Parliament and will be required to attend the relevant Standing Committee, if the Bill is referred to any such committee. The Standing Committee may make recommendations that are inconsistent with the policy approved by Cabinet. Any recommendation of a Standing Committee scrutinising a Bill that may materially affect the policy, as approved by Cabinet, should require the endorsement of Cabinet.
Implementation

Publication and commencement of the Act

The Secretary to Parliament and the Office of the Solicitor General are responsible for the publication of the Act in the Gazette.

An Act may have retrospective commencement, commence on the date it is published in the Gazette, or commence on a future date to be appointed by the Minister. It is also quite possible and even likely that there will be varied commencement dates for some parts of the new law. The Chief Executive of the ministry must ensure that any deferred commencement date is not delayed too long after the passing of the Act.

An implementation strategy must be developed. It will need to address the issue of resource allocation, and mechanisms for implementation, monitoring and evaluation. It will also need to consider the following:

Are there any administrative arrangements?

Are there any administrative arrangements that need to be settled, and perhaps published in the Government Gazette, on the commencement of the Act or regulations? For example, there may be fees to be decided upon, forms to be prescribed, committees nominated and appointed, officers appointed and other similar arrangements. Any requirements need to be considered well before the commencement date of the legislation or regulations, so that the new regime begins with all the administrative arrangements in place. This helps avoid unnecessary time delays, lost resources and frustration, which can result from a time lag in the undertaking of the necessary administrative procedures.

Communication

Communication strategies will need to be developed to ensure all those interested and affected have the opportunity to be fully informed about the upcoming changes to the law. These may include public meetings and workshops, the distribution of printed materials (for example, a frequently asked questions document) setting out the new regime, or advertisements in newspapers or relevant industry journals.

Depending on the complexity of the new regime, a useful strategy may be the development of a training program to help those affected by the new regime to understand their new rights and responsibilities.
**Health Legislation in the Pacific - Summary**

**A phasing in period**

In order to comply with new requirements and conditions, it may be part of the implementation strategy to introduce a period of time between passage of the legislation, and the date it comes into effect.

For example, a new Act may contain extra reporting requirements for some stakeholders, who may find the new requirements onerous or confusing. If the new requirements have a one year phasing in period, it may be much easier for those affected by the changes to develop an understanding and acceptance of what will be required of them.

By phasing in a law, by using different commencement dates for different parts of the law, it is easier to ensure that there is acceptance, and adequate resources and facilities for effective compliance with the law. Affected parties and organisations may need to be consulted about the time they may require to prepare for full compliance. Another option is different proclamation dates for different regions. For example, health infrastructure in rural and regional areas may be less developed and therefore more time is needed before new laws are implemented.

**Transitional arrangements**

There will be a period between passage of the law and the proclamation date. The strategy will need to address what should happen in this period.

**Resources**

Implementation of a new law can create extra work and extra costs for government officials and others. Resources are required to comply with new standards, new reporting requirements or new administrative procedures introduced in the new law. Planning for legislation development and review must consider the resource implications of implementation of a proposed new law. Before a decision is made to legislate, the ministry must be briefed on the resource implications of implementation and a decision made as to whether resources will be available to support the proposed new law. Treasury or Cabinet support will be needed to support a bid for resources, if the resource implications are significant. If the necessary resources will not be available, other options will need to be considered.

**Enforcement**

An excellent publication, entitled *Enforcement of Public Health Legislation*, is available for purchase from WHO Regional Office for the Western Pacific. It is available online at www.wpro.who.int/publications/PUB_9290612231.htm (ISBN 929061 223 1; the price is 10.00 US$, or 7.00 US$ for developing countries).

This publication is highly recommended as a guide to enforcement of public health legislation and no further material on enforcement is provided in this Reviewers’ Companion.
Part 2 - Legislative options in module form for use in reviewing or amending public health Acts in the Pacific region

Introduction

This part of the Reviewers’ Companion contains the legislative text and some accompanying explanatory material in module form.

What are modules?

The legislative text in this part of the Guide is set out in module form. A module is intended to be a block of legislative text covering a discrete area that might be expected to be addressed in a modern Pacific public health law. It is acknowledged that Pacific countries differ in their need for legislative reform in public health, and will also differ in their preferred approach to review. Modules are intended to offer a nation the opportunity to consider one or more modules, in whole or in part, as suits their legislative reform agenda. The development of modules is designed to offer maximum flexibility to nations in the use of the legislative text.

The modules are intended as a starting point to assist countries to visualise what a reformed law might look like. No Act is completely self-contained. All Acts rely to a greater or lesser degree on the general law, and other laws that create rules for the interpretation of legislation, or for other matters of general application to all Acts on the statute book. The modules cannot be created to fit into any Pacific jurisdiction without careful consideration of the application of the surrounding laws of that nation.

Each module will be accompanied by explanatory material. This is intended to explain the subject matter of that particular module, explain current Pacific approaches, and provide some context in relation to how Pacific officers currently find legislation covering the area. Each will also raise policy questions and advise about the preconditions necessary for implementation of the module, depending on its nature and the issues it raises. Each will have slightly different explanatory
Health Legislation in the Pacific – Modules with legislative text

material. This may entail general comments, summary of present approaches in Pacific public health laws, drafting notes and policy questions.

*Can the legislative text in a module be pasted into an existing Pacific public health law in its present form?*

It is very unlikely that the legislative text can be used to amend the law of any country without some alteration. Every public health law consists of PARTS, DIVISIONS and SCHEDULES, which contain concepts, powers and definitions that affect, and are affected by, other parts of the law. It is not advisable to simply repeal one part of an existing public health law and replace it with the legislative text in the module. The legislative text must first be carefully examined for its consistency with other parts of the existing law into which it will fit. It will influence, and be influenced by, other laws and this will have to be considered so that adjustments can be made to accommodate it into the broader body of law. Examples of relevant other laws may be laws affecting remuneration of board members, interpretation of legislation Acts, constitutions, laws covering the establishment of public hospitals and health service delivery, local government laws and laws about penalties.

**Acts, Bills and legislative text**

*What is an Act?*

An Act is an expression of Parliament’s legislative intention that states or alters the law in some respect. For example, a public health Act in the Vanuatu Parliament may establish powers for officers within the Ministry of Health and rights and responsibilities for Ni Vanuatu citizens; it may also impose responsibilities and sanctions. There are two sorts of Acts; principal Acts and amending Acts. A new principal Act would set up a new legislative scheme about the promotion of health and the prevention of disease. An amending Act amends existing laws. This Reviewers’ Companion is intended to be a useful starting point for both. It should also be noted that, over time Acts are amended and consolidated Acts contain all amendments until the date of consolidation.

*What is a Bill?*

In most Pacific countries, an Act is a piece of primary legislation that has been passed by a Parliament and has received assent. At any time before receiving royal assent, for example, when it is being drafted or is in Parliament, the draft legislation is known as a Bill. The material provided here is not an Act and not a Bill.
**What is legislative text?**

Legislative text is text written in a manner that would be found in a law and is drafted in modules that might roughly correspond to the parts and divisions in an Act. This makes it easy to see how the policy ideas raised in this Reviewers’ Companion may be translated into the kind of legislative text expected to be found within a law. Nations might find that some legislative text can be used as presently drafted, or that with some minor amendments it will be useful in a health Act review. Others nations may find the legislative text a useful starting point, but will make significant changes that reflect the policy direction and prevailing legislative environment, before using the legislative text.

The legislative text is not intended to be used without consideration of how it might fit into the current laws of the country. Every country is slightly or significantly different in its approach to laws and lawmaking. This is why legislative text is provided, together with substantial explanation and some guidance on the further considerations necessary before the text could be used to amend existing law, or to form part of a new principal Act.

**Numbering**

The legislative text is numbered in a manner that might be expected of a Bill during the drafting phase. Each piece of legislative text is numbered, beginning with the module number and then in the order it comes within the module. This can be changed, as appropriate, when the legislative text is used.
Penalties

Many Pacific officers told us that they were disappointed with present penalties and found that they contributed to a sapping of motivation to prosecute, because a successful prosecution resulting in a fine that is so low as to be meaningless, seemed a pointless exercise. As one said: “It isn’t worth the time and hours prosecuting the case when at the end of the day someone is just penalised with 5 dollars, which means nothing.” (PHD4)¹

As countries’ economies and economic circumstances and currencies differ, it was not thought useful to insert specific amounts into penalty sections. Instead the term “penalty units” has been used. It is suggested that countries nominate a figure that seems meaningful and then simply translate the penalty units into amounts in local currency (if the use of amounts is the usual drafting style). For example, in PNG, if the decision is that one penalty unit is worth K50, then a fine of 100 penalty units becomes K5,000. Some countries, such as the Solomon Islands use penalty unit.

The Solomon Islands Penalties Miscellaneous Amendments Act 2009 provides a good example of both penalties being increased (and converted to penalty units) with respect to existing Acts and the creation of a penalty unit system. The great benefit of a penalty unit system is that legislative change of value of penalty unit in one piece of legislation is effective to change total fines in all legislation with penalty units. This is significantly more convenient than constantly monitoring legislation across the statute book for penalties up to date with community expectations and the broad economic circumstances of the country.

Transitional provisions

Any amendment may create a need to address a period of changeover from the old arrangements to the new amended position. For example, registration of health practitioners may have changed to include new criteria. Currently registered practitioners will need time to meet new criteria, and special rules may continue to apply to them, for the duration of their practice, where experience may be “deemed” to meet newer criteria.
### Figure 2 – Elements of a public health law for the Pacific provided in the Reviewers Companion

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Module 1—Preliminary matters, objects and administration

What is in this module?

Preliminary

This module contains legislative text covering matters common to the preliminary sections of most legislation in the Pacific.

The legislative text appears in Times New Roman font and in a grey shaded textbox together with some explanatory notes and drafting suggestions within the legislative text.

Objects and principles

The objects and principles section contains material currently not found in Pacific public health laws. These are intended to serve as aids to implementation and interpretation of that law.

Part 1—Preliminary

The first page of an Act in most Pacific nations sets out the title of the Act. The date of assent is usually also found on that page, followed by the rest of the text of the Act and any schedules to it. It may look as follows:

A BILL FOR
An Act to promote and to provide for the protection of the health of the public of [insert country] and to reduce the incidence of preventable illness, injury and disability; to repeal the [insert name of current Act, if a full repeal is necessary]; and for other purposes.

The Parliament of [insert name of country] enacts as follows:

101—Short title
This Act may be cited as the [insert name of country] Public Health Act [insert year]

102—Commencement
This Act will come into operation on a day to be fixed by proclamation.

[Drafting note: there may be a range of mechanisms for bringing the Act into operation and each country will use the mechanism most appropriate for that country.]
Policy question about staged commencement

It may be worth considering whether the Act needs to commence in a staged manner, for example, if there is a lead time necessary to be ready to implement parts of the Act. In some countries it is difficult to get new legislation onto the Cabinet agenda and into Parliament. For that reason, it may be advantageous to pass a new law including reforms that may not be able to be implemented for a period of time. However, it is not advisable to leave implementation open-ended. It erodes confidence in the efficacy of the law, and of the legal system generally, if people have a perception that the government is not serious about implementation.

103—Interpretation

General comments

Definition sections are a standard inclusion in most laws. They are used to define words used in the text of the Act. In the principal Act, the definitions and other essential provisions that apply across the Act are usually placed together at the front of the Act. Sometimes a definition is used only for a limited part of the Act, and then it will be found close to the provisions to which it applies, rather than at the front of the Act.

Preconditions

Definitions also often cross-reference to terms already defined in other laws. It will be important, in using the legislative text in this module, to ensure that definitions used are consistent with other definitions in other laws of the country.

(1) In this Act, unless the contrary intention appears—
appointed member of NPHB means a member of the Board other than the Chief Public Health Officer;
authorised officer means a person appointed to be an authorised officer under [insert relevant section when confirmed];
building includes a structure;
Chief Executive means the Chief Executive of the Ministry and includes a person for the time being acting in that position;
Chief Public Health Officer includes a person for the time being acting in that position;

Drafting Note: Director of Public Health may be preferred for this role and the relevant policy issues will be canvassed in the section on creating the position of Chief Health Officer

communicable disease includes a human illness or condition due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or reservoir to a susceptible person, either directly or indirectly through an intermediate plant or animal host, vector or the inanimate environment;
controlled communicable condition means a disease or medical condition that is a controlled communicable condition, or taken to be a controlled communicable condition, under [insert relevant section when confirmed];
council means a council within the meaning of the [insert name of Act creating the existence of local councils or like local government bodies];
council subsidiary means a subsidiary [or other like relevant body, if existing in the country];
Court means [insert the name of any court or courts that will have jurisdiction arising from the operation of the Act];
the Department means the administrative unit of the Public Service that is, under the Minister, responsible for the administration of this Act;
emergency has the same meaning as in [insert the name of any Act that defines “emergency”, such as an Emergency Act];
emergency officer means a police officer or a person holding an appointment as an emergency officer under [insert relevant section when confirmed];
Legal practitioner means a person admitted and enrolled as a practitioner [insert relevant manner of enrolment for legal practitioners or change term if a different term is used in your jurisdiction];
LGA means the Local Government Association [or insert any relevant body representing local government, if such a body exists];
local authorised officer—see section [insert relevant section when confirmed];
local government area means the area of a council;
medical condition includes—
(a) a medical symptom or pattern of medical symptoms, including symptoms discerned from any signs or results of investigations, that indicate a disease (whether defined or yet to be determined); and
(b) a condition arising from a person being contaminated by 1 or more substances or biological pathogens;

medical practitioner means a person registered on the register [check relevant terminology for medical practitioner registration in your jurisdiction] under the Medical Practice Act [check correct name and year of the law registering medical practitioners];
National authorised officer—see section [insert relevant section when confirmed];
National Co-ordinator means the person holding or acting in the position of National Co-ordinator under the [insert name of relevant emergency Act if one exists];
notifiable condition means a disease or medical condition that is a notifiable condition under [insert relevant section when confirmed];
NPHB means the National Public Health Board established under [insert relevant section when confirmed];
pathology service means a service in which human tissue, human fluids or human body products are subjected to analysis for the purposes of the prevention, diagnosis or treatment of disease in human beings;
premises means—
(a) any land, building (including residential premises) or place (including a public place, or a movable building or structure); or
(b) a part of premises;

public authority means—
[Most jurisdictions will have an existing definition of public authority. Check the law creating the public service or covering public financing or administration requirements. The relevant definition should be repeated here, although consideration should also be given to additional inclusions such as:]
(a) a body, whether incorporated or unincorporated, established for a public purpose by [insert name of country], regardless of the way in which it is established; or
(b) a council or council subsidiary; or
(c) the Police Force [howsoever named]; or
(d) a member or officer of a body referred to in a preceding paragraph; or
(e) a person or body, or a person or body of a class, brought within the ambit of this definition by the regulations;

public health means the health of individuals in the context of the wider health of the community;
public health emergency(a definition may exist in other laws, so this is worth checking) —;
Public Health Emergency Management Plan means a plan (or a series of plans) prepared by the Chief Executive and approved by the Minister comprising strategies to be administered by the Department for the prevention of emergencies in [insert name of country] and for ensuring adequate preparation for emergencies in this State, including strategies for the containment of emergencies, response and recovery operations and the orderly and efficient deployment of resources and services in connection with response and recovery operations;
public health incident — see section 82;
public place includes a place to which the public ordinarily has access;
recovery operations has the same meaning as in the [insert name of relevant emergency Act, if one exists];
regional partnership agreement means an agreement entered into by a group of countries for the purposes of promoting the health of the population of the Pacific region;
response operations has the same meaning as in the [insert name of relevant emergency Act, if one exists];
vehicle includes an aircraft or vessel;
wastewater means—
(a) human waste either alone or in combination with water; or
(b) water that has been used in washing, laundering, bathing or showering; or
(c) water containing food or beverage waste; or
(d) water containing commercial or industrial waste; or
(e) water containing waste or other matter or substance that may detract from its safety, (or a combination of any of the above);

wastewater system means a system for collecting and managing wastewater (including through treatment, reuse and disposal), whether or not connected to the undertaking within the meaning of the [insert name of relevant law, such as a law regulating waste water].

(2) Without limiting the definition of public health in subsection (1), public health may involve a combination of policies, programs and safeguards designed—

(a) to protect, maintain or promote the health of the community at large, including where 1 or more persons may be the focus of any safeguards, action or response; or
(b) to prevent or reduce the incidence of disease, injury or disability within the community.
(c) to protect, maintain or promote the health of the region at large where a regional public health partnership agreement has been entered pursuant to the power in Section [insert relevant section when confirmed];

(3) For the purposes of this Act, harm includes physical or psychological harm, or potential harm, to individuals, whether of long term or immediate impact or effect.
(4) For the purposes of this Act, potential harm includes risk of harm and future harm.

(5) For the purposes of this Act, a person may cause something if he or she—

(a) contributes to something happening or proceeding, or allows or permits something to happen or proceed; or

(b) contributes to the continuation of a condition for which the person is responsible, or allows or permits a condition for which the person is responsible to continue.

Part 2—Overarching policy ideas, objects and principles

Long title

Many Pacific public health Acts have a long title. Long titles are drafted to make them wide enough to cover all the provisions of the Bill, but not so wide as to allow the proposal of amendments that are not properly included in the substance of the Bill. Some long titles also provide a description of the contents or the purposes of the Act. Different countries will have different “house styles” for legislative drafting. The local Office of Parliamentary Counsel can provide advice on house style.

Do existing Pacific public health laws have long titles?

The long titles of the Vanuatu and the PNG Acts are almost identical in their brief descriptions of “Acts to provide for public health”. PNG adds an additional component by also including “and to mental disorders, and for related purposes”. The Fiji Act has only the short title and in the Solomon Islands, the long title of the Environmental Health Act, in which public health laws appear as regulations, indicates that the Act makes provision for securing and maintaining environmental health. The policy reason for this unusual configuration of public health law within environmental health legislation is not clear from reading the Act. The terms “environment” and “environmental health” are not defined, leading to possible confusion about the legality of application of the Act to public health matters. While the terms do not need to be defined for the purposes of the Environmental Health Act as it applies to environmental matters, a definition which includes public health would assist in clearly bringing public health matters under the responsibility of the Minister responsible for environmental matters. In Samoa, the Ministry of Health Act 2006 has a long title stating that it is an Act “to establish and define the functions and powers of the Ministry of Health, the Minister and the Chief Executive Officer of the Ministry and for related purposes”.

Objects and purposes

Laws often contain statements known as “objects” or “purposes” in the first few sections. These set out the purposes of the Act and provide some guidance as to the kinds of things the law is intended to achieve. Objects and purposes may also be used in the interpretation of the law. For example,
this occurs in Federated States of Micronesia, Guam, Marshall Islands, New Caledonia and Australia.  

Public health laws, which often have broad policy objectives (such as legislative support for health planning, health promotion, protecting the public health, addressing health inequalities and balancing public good and private rights), are laws that can be made more understandable, to those who use them, by the use of specified objects, purposes or statements of principle.

There are no “objects” or “purposes” in the any of the Pacific public health Acts. Sometimes in Pacific countries, drafting styles include long titles of Acts used in a similar way to objects and purposes—to make some broader statement about the purpose of the law. This mechanism has not been used in any of the Pacific region public health laws examined for this paper.

Principles for operation and interpretation of a public health law

In addition to objects, some modern public health laws also establish principles by which the legislation should be operationalised, interpreted and administered. This is also a part of the Act that might refer to the role the legislation will play in the country achieving compliance with various international treaty obligations.

In this context, some relevant treaties include UDHR, ICPR (some articles of which are relevant to implementation of the IHR), ICRC and CEDAW.

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29 See Pearce and Geddes, *Statutory Interpretation in Australia*, Butterworths, 1988, page 64. This is an Australian text, but the Pacific countries and Australia share a common British legal history, so approaches to statutory interpretation are likely to be similar.


31 All Pacific countries are WHO members which obliges them to implement the International Health Regulations. Some are signatories to CEDAW, which has obligations in relation to women’s health, and some are signatories to the *Covenant on Civil and Political Rights*, which has an obligation in relation to the right to health.
Policy questions for consideration

This module provides a range of objects and principles for the consideration of Pacific countries reviewing and amending their public health legislation. It not suggested that all are adopted, rather that countries consider those put forward in this Guide, and select those that best reflect their approach and resonate with their people. Countries may also have other important principles they wish to include.

Principles are important statements of what the law hopes to achieve, and the principles by which it will be implemented and formally interpreted. This part gives countries an opportunity to decide the higher ideas on which their public health law will be based. It will be used as a guide in funding and planning. It may also assist when making a case to Treasury, for funding for various programs that implement one or more of the objectives.

Preconditions for implementation

It is important for countries to consider the objects and not select those unsuited to their country, or that are out of reach of achievement. If specifically seeking to implement treaty obligations (such as the right to health and some human rights obligations, or clauses 24 and 14 of CEDAW), it is important to be specific about what is intended to be implemented. Only include what it is possible for the country to implement, or acknowledge in drafting that the inclusion of the principle acknowledges that the principles will be progressively realised. It is unusual, though not impossible, for countries to be sued for a failure to carry out objects or purposes. If a country is concerned about this, it may add a clause such as the one in the PNG Constitution that makes it clear that the objects are not justiciable.
104—Objects of Act

(1) The objects of the Act are—

(a) to promote health and well being of individuals and communities and to prevent disease, medical conditions, injury and disability through a public health approach; and

(b) to protect individuals and communities from risks to public health and to ensure, so far as is reasonably practicable, a healthy environment for all [insert correct name for citizens such as ni Vanuatu, Papua New Guineans etc] and particularly those who live within disadvantaged communities; and

(c) to provide for the development of effective measures for the early detection, management and reduction of risks to public health; and

(d) to promote the provision of information to individuals and communities about risks to public health; and

(e) to encourage individuals and communities to plan for, create and maintain a healthy environment; and

(f) to provide for or support policies, strategies, programs and campaigns designed to improve the public health of communities and special or vulnerable groups within communities; and

(g) to provide for the prevention, or early detection, management and control, of diseases, medical conditions and injuries of public health significance; and

(h) to provide for the monitoring of any disease or medical condition of public health significance in order to provide for the prevention or early detection of any such disease or medical condition and for the protection of individuals and the community from the threat of any such disease or medical condition and from public health threats more generally; and

(i) to provide for the collection of information about incidence and prevalence of diseases and other risks to health in [insert name of country] for research or public health purposes; and

(j) to establish a scheme for the performance of functions relating to public health by national [insert provincial where relevant i.e. PNG] and local governments [use name of local government as it appears in domestic legislation—it is important to cross-reference any local government legislation].

(2) The Minister and other persons or bodies involved in the administration of this Act must have regard to, and seek to further, the objects of this Act.

105—Principles to be recognised under Act

In the administration of this Act and in seeking to further the objects of this Act, regard should be given to the principles set out in the following sections (insofar as may be relevant in the circumstances).
The principle of consistency with customary law and customary means of social organisation

Policy question for consideration

The constitution of a number of Pacific countries recognises customary law as part of the law of that country. Customary law has proved difficult to incorporate into the operations of the largely foreign, western legal system operating in many Pacific countries.  

The principle of recognition of the importance of traditional medicine

Policy question for consideration

For many villagers, traditional medicine is the only medicine to which they have access. National health plans often recognise this fact. WHO has recognised the importance of traditional medicine and developed a traditional medicine strategy.

Preconditions

The second part of the principle should not be included if there is no intention to develop national standards, technical guidelines or methodologies during the life of the Act. It would be possible to amend the Act to refer to such guidelines when there was capacity to develop them, or the principle could be modified to reflect the approach most suitable for each Pacific country. For example, it could include: “To promote the proper use of traditional medicine by developing and providing national standards, technical guidelines and methodologies and to facilitate integration of traditional medicine into the national health care system.”

The principle of women’s access to health care

Priority is given to women’s access to and satisfaction with health care services and information that allows them to maintain their health and wellbeing and that of their children.

Policy questions

Access to healthcare can be difficult for women, which may also affect the health of babies and young children. Institutional, economic, and educational barriers effect and lower their standard of living when compared to their male counterparts. Very high maternal mortality in some countries, such as PNG, takes a terrible toll in human tragedy. Inclusion of a principle to protect and support women’s access to healthcare is consistent with the CEDAW convention.

33 Forsyth Op Cit and Jowitt Op Cit
109—Precautionary principle
(1) If there is a perceived serious risk to public health, lack of full scientific certainty should not be used as a reason for postponing measures to prevent, control or abate that risk.

(2) In the application of this principle, decision-making and action should be proportionate to the degree of public health risk and should be guided by—
(a) a careful evaluation of what steps need to be taken to avoid, where practicable, serious harm to public health; and
(b) an assessment of the risk-weighted consequences of options; and
(c) an aim to ensure minimum disruption to an individual's activities, a community's functioning and commercial activity while ensuring any necessary protection from identified public health risks.

110—Appropriate regulation principle
Regulatory measures would take into account and, to the extent that is appropriate, minimise, adverse impacts on business and members of the community while ensuring consistency with requirements to protect the community and to promote public health.

111—Sustainability principle
Public health, social and economic factors should be considered in decision-making with the objective of maintaining and improving community well-being and the benefit to future generations.

112—Principle of prevention
Administrative decisions and actions should be taken after considering (insofar as is relevant) the means by which public health risks can be prevented and avoided.

113—Population focus principle
Administrative decisions and actions should focus on the health of populations and the actions necessary to protect and improve the health of the community and, in so doing, the protection and promotion of the health of individuals should be considered.

114—Participation principle
Individuals and communities should be encouraged to take responsibility for their own health and, to that end, to participate in decisions about how to protect and promote their own health and the health of their communities.

115—Partnership principle
(1) The protection and promotion of public health requires collaboration and, in many cases, joint action across various sectors and levels of government and the community.

(2) People acting in the administration of this Act should seek ways to develop and strengthen partnerships aimed at achieving identified public health goals consistent with the objects of this Act.
Organisations entering partnerships with the government for delivery of health services shall implement programs in compliance with the Paris Declaration on Aid Effectiveness.35

116—Equity principle

Decisions and actions should not, as far as is reasonably practicable, unduly or unfairly disadvantage individuals or communities and, as relevant, consideration should be given to health disparities between population groups and to strategies that can minimise or alleviate such disparities.

117—Guidelines

(1) The Minister may, from time to time, prepare or adopt guidelines that relate to the application of these principles.

(2) The Minister should take reasonable steps to consult with [insert name of board if the legislation has created a board] in the preparation of any guidelines, or before adopting any guidelines, under subsection (1).

(3) A person or body involved in the administration of this Act must have regard to any relevant guidelines under this section.

Policy question for consideration

Most Pacific countries are developing countries. In their legislative review, ministries of health must also attempt to consider the implications of a confusing array of funding streams, aid programs and partnerships in health service delivery, together with broader government policy, when arriving at legislative priorities for health policy, programs and spending.36

35 See http://www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html accessed 29 November 2011
These guidelines recognise that:

- The ministry of health has an overarching policy and planning role.
- All arrangements for partnerships between government and non-government entities for health service delivery must recognise this role, and comply with any government directions arising from it.
- All arrangements must be consistent with any national health plan.
- Any proposal for public private partnership for delivery of health services must be considered against the existing statutory responsibilities of government agencies, and existing health plans, and be fitted into those arrangements (i.e. arrangements should be made so there is no duplication of service and wastage of resources or “deskilling” of government provided health services).
- It is the role of the ministry of health to ensure equity of access, and equity of the quality of health service delivery across PNG. It must have regard to this important principle in deciding where and when to allow public private partnerships in health service delivery.
- The particular health needs of women and children must be considered in any public private partnership arrangement.
- Any public private partnerships must work with or strengthen the existing health system, as set out in current legislation and policy. The system must not be inadvertently weakened or undermined by allowing arrangements to bypass or circumvent it.

This general power enables the making of guidelines about the implementation of the principles. This is an opportunity for the government to flesh out some of the principles and to help clarify how compliance might be achieved. Guidelines are not binding, but can be a useful mechanism to show those affected how the government views implementation of the principles. A court would also be likely to have regard to them in its interpretation of their breadth and content.

Given the importance of compliance with the Paris Declaration on Aid Effectiveness (2005), the ACCRA Agenda for Action (2008) and the recent Busan Partnership for Effective Development Cooperation (November 2011), and the proliferation of partnerships for health service delivery in the Pacific region, some suggested content for guidelines in partnerships for the delivery of health services are proposed. 

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Suggested guidelines for partnerships in health service delivery

Faith-based organisations and various NGOs have a long history of contracting with government to deliver health services in the Pacific. Extractive industries, mining companies, agricultural ventures and other NGOs have more recently entered the field, in particular in Papua New Guinea, and the type and number of public private arrangements for health service delivery is expanding considerably. Ministries of health are recognising the need to take a coherent policy approach to partnering with non-government organisations, to deliver health services.

There are many benefits to the entry of non-government players into the field of health service delivery. In general, ministries of health wish to continue to encourage their participation, but to do so within a coherent policy framework.

The guidelines would set specific criteria for contracting (or entering any other arrangement with non-government health service providers). These would be likely to include:

- When a new health service is being considered, examine what other health services are provided in the area (especially of a similar nature), and whether creation of the proposed service is consistent with the policy objectives of access and equity.
- Incorporation or some administrative configuration, which satisfies the ministry of health that it is dealing with an entity that is sufficiently well-administered it can enter a formal agreement, or contract to deliver specified health services.
- Require compliance with the national health plan and national health standards.
- Set clear objectives for the delivery of the health service, including the standards of clinical care, numbers of people treated and criteria for admission (i.e. does the service treat anyone, or are there some requirements etc?)
- Ensure that the particular health needs of women and children can be met.
- Ensure that the entity has sufficient capacity to account for government monies and monitor standards.
- Ensure that the entity has sufficient capacity to set consistent standards for member organisations (if there are any, such as churches).
- Record key health information.
- Reach agreement on charging for services, and make any necessary administrative arrangements to charge for services that should be “affordable to the population served and sufficient to maintain services”.
- Ensure that the entity providing a government health service is consulted and involved fully in policy decisions reflecting the role played by them in health service delivery. This is particularly important for churches, which provide around 50% of rural health services.
- In deciding whether to fund an entity to provide health services, consider its past compliance with this criteria and any other relevant guidelines.
118—Interaction with other Acts

(1) Except as specifically provided by this Act, the provisions of this Act are in addition to, and do not limit, the provisions of any other law of [insert name of country].

Note

It should be noted that some new laws are stated to override other laws, with the exception of the Constitution and Organic Laws in the case of PNG. It is open to countries to consider using such provisions.

(2) Without limiting the generality of subsection (1), this Act is not intended to be construed so as to prevent any person from being prosecuted under any other enactment for an offence that is also punishable by this Act, or from being liable under any other law of the State to any penalty or punishment that is higher than a penalty or punishment provided by this Act.

(3) Nothing in this Act affects or limits a right or remedy that exists apart from this Act.
Module 2—Administration

What is in this module?

This module looks broadly at the health portfolio and covers allocation of broad policy making and planning responsibility. It also covers the more technical role of control of communicable and non-communicable disease, the high level power to decide when a risk to the public health has occurred, issuing orders to manage the risk, and other high level responsibilities. Such responsibilities might also include the power to set standards, draft and even promulgate regulations, issue guidelines, gather data, monitor the emergence of communicable diseases and other risks to the public health, appoint officers, delegate power and issue orders.

The module also recognises the possibility of regional cooperation and enables delegation to a regional class of persons.

Basis for administration of the health portfolio

In the Pacific, many nations are constitutional democracies. In a constitutional democracy, as part of its function in setting out sovereign power, the constitution establishes an “executive” that executes the will of government. Individual ministers take responsibility for parts of government function. These areas of specific responsibility are allocated to them by a determination of the Prime Minister, using a power in the constitution. In this way, the Minister for Health takes responsibility for executing the will of the government via carrying the functions and administering the laws in the health portfolio.

Nations generally share policy making and planning responsibilities among the ministers, possibly a national health board, the Chief Executive, and senior level public servants such as the Chief Public Health Officer, or Head of Disease Control. Sometimes powers for the Chief Executive, Chief Public Health Officer or Head of Disease Control are allocated in the Act, and sometimes the sharing of responsibility is achieved with a mix of statutory responsibilities and delegated powers. Policy questions will include the clarity provided by statutory roles versus the flexibility provided by delegated responsibilities. Some jurisdictions prefer to keep the Minister free of technical responsibility, focusing on the overarching policy role. In the Pacific, the ministers tend to have a broad range of administrative and even managerial responsibilities, in addition to the policy making and planning role.

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40 A form of government in which the sovereign power of the people is spelled out in a governing constitution.
41 For example, in the PNG Constitution, the power is found in section 148
How is responsibility for administration in public health laws currently allocated in the Pacific?

Allocation of responsibility for administration under public health laws is not uniform across jurisdictions in the region. In some countries this is done via a health board\(^{42}\) and in some power is granted directly to the Minister.\(^{43}\) Some jurisdictions share power between a combination of a health board, the Minister and the Chief Executive.

Policy setting and health planning

Among Pacific public health Acts, only PNG takes the opportunity to make the policy setting and health planning role of the Minister, and the National Department of Health, clear in its public health laws.\(^1\) However, this is not done in the Public Health Act, but rather the more modern National Health Administration Act 1997, which includes the objective of distributing power and responsibility for health planning and administration between the three levels of government in PNG.

For the Pacific countries other than PNG, the opportunity to enable some proactive communication of the broader role of both, is missed. All Pacific health ministries undertake policy development and health planning despite their absence from the administrative arrangements provisions in the legislation. Countries reviewing their law may want to consider the benefits of including a clear policy setting and planning role in the law. Besides the communication of the role, a legislative duty to produce a health plan may help elevate the status of such plans, and increase the likelihood of securing funding when advocating with Cabinet and Treasury for the allocation of scarce funds to support health expenditure.

Particular arrangements vary from one jurisdiction to another, but most begin with the allocation of overall power for the administration of the Act, and the making of orders and appointment of officers to whom power may be delegated.

Policy questions

The role of the Minister, the Chief Executive, the Chief Public Health Officer or Head of Disease Control, and other officers such as Environmental Health Officers and Medical Officers of Health, are always policy decisions to be considered while reviewing such laws. In the Pacific, the Minister’s role is sometimes quite managerial in style. As the Minister is the political head of the ministry, and does not necessarily have training in public health and disease control, it may be considered better policy to distance the Minister as much as possible from such day-to-day technical responsibilities. This also keeps the Minister out of administrative reviews of decisions or protests about mismanagement.

\(^{42}\) See National Health Administration Act 1997 (PNG) and Public Health Act 1973 (Fiji)

\(^{43}\) See Public Health Act (Vanuatu)
of specific cases. The Minister still has to take political responsibility, but can rightly say that his or her Ministry manages administrative and technical matters on a day-to-day basis.

This legislative text in this module gives the Minister a flexible role, granting an opportunity to shape the role somewhat, but to occupy a role that is broad and takes a policy making and planning approach, rather than a management approach. Note also that there is the opportunity to take national, regional or international action, consistent with the objects of the Act, thus enabling some regional approaches to public health law issues, where this may be desirable.

There is a small role for the Chief Executive. It is envisaged as being largely administrative and managerial, and is given little technical responsibility for public health orders and similar functions requiring public health training and experience. Instead, the role of Chief Public Health Officer is established, and may be appointed (but is not required to be appointed). This role is granted power to make the technical decisions, sign off on public health planning, and make the higher level public health orders. It is an approach consistent with other countries such as Australia and Canada.\footnote{Public Health and Wellbeing Act 2008 (Vic), Public Health Act 1997 (ACT) and Public Health Bill 2010 (SA), see www.austlii.gov.au, and Public Health Act 2002 (Quebec) for using public health directors rather than a Chief Public Health Officer see www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html, accessed 17 December 2010} Consideration could be given to broadening the role of the Chief Executive. Relevant policy considerations would include the size of the country, and therefore the Ministry of Health, the other portfolio responsibilities overseen by the Chief Executive, and policy decisions about the role of the Minister and the role of the Chief Public Health Officer.

If countries prefer not to create a Chief Public Health Officer position, those powers may be granted to the Chief Executive or to another senior officer, but the legislative text would have to be very clear about allocation of responsibility and about delegation. This would be necessary to enable a Chief Executive without a Chief Public Health Officer, to discharge his or her responsibility.
The statutory role of the Minister

What do Pacific public health laws currently say about the role of the Minister?

It is a feature of Pacific public health laws that the Minister is generally granted strong powers, which often include powers to administer and manage the day-to-day work of the Ministry. For example, in Vanuatu, a very comprehensive role for the Minister has been written into the public health law. The Minister is responsible for promoting the health and wellbeing of the people of Vanuatu; and the implementation, administration and enforcement of the Act. To achieve this, any power, explicit or not, may be used to carry out these responsibilities. The Minister is also given general powers of supervision and inspection over local authorities, for maintenance and promotion

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45 Public Health Act 1994, Section 2(1)
46 Public Health Act 1994, Section 2(2)
of public health. The Minister may also request any local authority to act as an agent for the government under the Act.  

In PNG and Fiji, presumably because of the existence of health boards, the direct responsibility given to both Ministers under the public health laws is narrower than in Vanuatu. There is no allocation of broad responsibility for the health of the people and the administration of the Act. In PNG, the Minister is granted all powers also conferred by the Act, on a local medical authority or on an inspector. In addition to powers shared with local medical authorities, the Minister still has sole powers in relation to gazettal of new infectious diseases, declaration of infected areas, and declaration of typhoid areas. In Fiji, the Minister has power to appoint six members of the seven member Central Board of Health, approve various actions of the Board and appoint medical officers of health.

In the Solomon Islands, the law to protect the public health is created in regulations under its Environmental Health Act. This greatly complicates understanding of the role of the Minister for Health. In the Act, the Minister is defined as the “Minister responsible for environmental health matters.” The Minister’s duties consist of responsibility for the administration of environmental health services. This creates a genuine question of law about how far the Minister’s duties extend to the management of risks to the public health using powers conferred on the Minister under the Environmental Health (Public Health Act) Regulations, made under the Environmental Health Act. No definition of the breadth of ministerial or administrative responsibility exists to assist in arriving at a sufficiently broad interpretation of “environmental health” and “environmental health matters” to include public health, and therefore powers to manage public health risks.

It is a feature of the Pacific public health laws that significant power for administration and the making of orders is granted to the Minister. A review might give consideration to a more strategic and policy oriented role for the Minister, with less day-to-day administration and less power to directly manage public health risks. This arrangement enables the Minister to take policy responsibility, but free from making decisions more suited to an officer with medical training or a management role.

It is worth noting PNG’s unique sharing of power between national, provincial and local-level governments. Their configuration of laws allocate responsibility in the health portfolio to all three levels of government—all of which have lawmaking powers relevant to health. In the Pacific, PNG is unique in having a decentralised system of health service delivery with provincial governments having significant responsibility for the delivery of public health services, and some streams of government funding are paid directly to provinces for the purpose of delivery of public health

47 Public Health Act 1994, Section 2(4)
48 Public Health Act 1973 (PNG), Sections 15 and 29(b)
49 Public Health Act 1973 (PNG), Section 35
50 Public Health Act 1973 (PNG), Section 39
51 Public Health Act (Fiji), Chapter 111 Section 4
52 Public Health Act (Fiji), Chapter 111 Sections 6, 11 and 13
53 Public Health Act (Fiji), Chapter 111 Section 7
54 Environmental Health Act (SI), Chapter 99, Section 2
55 Environmental Health Act (SI) Chapter 99, Section 3
The National Health Administration Act sets out the distribution of power and responsibility between the national, provincial and local-level governments. The Provincial Health Authorities Act 2007 enables provinces to choose to bring together hospital services and public health services under one entity called a provincial health authority.

201—Minister

(1) The Minister’s functions in connection with the administration of this Act include the following (to be performed to such extent as the Minister considers appropriate)—
(a) to further the objects of this Act by taking action to preserve, protect or promote public health within [insert name of country];
(b) to promote proper standards of public and environmental health within [insert name of country] by ensuring that adequate measures are taken to give effect to the provisions of this Act and to ensure compliance with this Act;
(c) to develop policies or codes of practice that are relevant to—
(i) the scope of the duty under Part 6; or
(ii) identifying risks to public health; or
(iii) setting standards in connection with any activity, material, substance or equipment relevant to public health;
(iv) providing for other matters relevant to the operation or administration of this Act, for matters that may be subject to regulations under this Act, or for such other matters as the Minister thinks fit;
(d) to the extent that may be necessary, practicable or desirable, to cooperate and coordinate with national, regional or international action consistent with the objects of this Act.

A relevant consideration here may be cooperation and coordination with the Pacific Public Health Surveillance Network (PPHSN). This network, established under a joint initiative of WHO and the Secretariat of the Pacific Community (SPC) in December 1996, has a goal to develop sustainable public health surveillance and response in the Pacific. The network has five broad strategies:

1. harmonisation of surveillance data and development of appropriate surveillance systems (with priority given to outbreak surveillance and response);
2. publication and/or dissemination of timely, accurate and relevant information in various forms;
3. training in applied epidemiology and public health surveillance, adapted to regional needs;
4. extension of the electronic communication network to new partners, new services and other public health networks; and
5. development of relevant and cost-effective computer applications.

Four services established under the network, namely, PacNet, LabNet, EpiNet and PICNet, have been playing an important role in strengthening the public health surveillance and response systems, in particular, the sharing of disease information and technical guidelines as well as building

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56 The Organic Law on Provincial Governments and Local Level Governments (PNG)
epidemiology and laboratory capacity for outbreak alert and response. As Pandemic (H1N1) 2009 developed, the PacNet list (together with PacNet restricted) played a crucial role in the dissemination of updates and guidance, and discussion of response options and priorities. The Pacific Public Health Surveillance Network continues to play an integral role in international collaboration and communication and thus strengthens the region’s International Health Regulations (IHR, 2005) capabilities.\textsuperscript{58}

\begin{quote}
(e) to be a primary source of advice to the Government about health preservation, protection or promotion;
(f) any other functions assigned to the Minister by this Act, or considered by the Minister to be relevant to the operation of this or any other relevant Act.
\end{quote}

\begin{quote}
(2) The Minister may develop or adopt procedures for the provision of advice to the Government—
(a) to ensure the promotion or implementation of policies or measures that are designed to enhance the health of individuals and communities; and
(b) to ensure that the Minister is consulted or involved in the development of policies or measures that may have a significant impact on the public health;
(c) to ensure the effectiveness of any aid provided to the Ministry of Health or affecting the operation of any program run by the Ministry of Health.
\end{quote}

\begin{quote}
(3) In addition, the Minister has the power to do anything necessary, expedient or incidental to—
(a) performing the functions of the Minister under this Act; or
(b) administering this Act; or
(c) furthering the objects of this Act.
\end{quote}

\textbf{202—Power to require reports}

This enables a proactive approach, rather than a consistently reactive one. It allows the Minister to immediately require an authority to report on a matter to enable the Minister to judge the next step based on the necessary information.

\begin{quote}
(1) In this section—
\textit{designated authority} means—
(a) the Chief Public Health Officer; or
(b) \{insert name of board if the Act creates a board, otherwise delete this subsection\}; or
(c) a government department or agency; or
(d) a council or council subsidiary \{ensure correct terminology for local government is used\}.
\end{quote}

\begin{quote}
(2) The Minister may require a designated authority to provide a report on any matter relevant to the administration or operation of this Act.
\end{quote}

\begin{quote}
(3) In a case involving a council, the Minister may require that the council provide a combined report with 1 or more other councils.
\end{quote}

\begin{quote}
(4) A requirement under this section may be (but need not necessarily be) that a report be provided—
\end{quote}

\textsuperscript{58} WHO and SPC, Op Cit
(a) on a periodic basis specified by the Minister; or
(b) on or in relation to the occurrence of an act or event specified by the Minister.

(5) A designated authority must provide the report in accordance with the requirements of the Minister.

(6) This section does not limit the operation of any other provision relating to the provision of reports.

203—Delegation by Minister

The delegation power is crucial. Depending on the size of the country, some tasks may be very large and it is a useful administrative tool to enable the Minister to choose whether or not to delegate. Note that the authority to delegate is enabled for an approved regional partnership initiative with an approved regional partner country.

In the Solomon Islands, all Ministers powers to delegate are found in the Constitution.

(1) The Minister may delegate a function or power conferred on the Minister under this Act—
(a) to a specified person or body; or
(b) to a person occupying or acting in a specified office or position; or
(c) to a person or class of persons in an authorised regional partner country (another section must set up the authorised regional country arrangements).

(2) A delegation—
(a) may be made subject to conditions or limitation specified in the instrument of delegation; and
(b) if the instrument of delegation so provides, may be further delegated by the Delegate except in the case of an authorised regional partner country; and
(c) is revocable at will and does not prevent the delegator from acting personally in a matter.

The role of the Chief Executive

The Chief Executive is the most senior public servant and the administrative head of the Ministry of Health. This position might be known by a number of names including Secretary and Permanent Head.
How do Pacific countries currently create a statutory role for the Chief Executive?

In Fiji, the Permanent Secretary is the Chair of the Central Board of Health. However, it is the Minister who has the power of appointment to the board, for officers of the board and for medical officers of health. Powers under the Act are granted to the board, the Minister, medical officers of health and local authorities, but the Permanent Secretary is largely left out. The Board does not have a power to delegate its responsibility, so it cannot delegate powers to the Permanent Secretary.

In Vanuatu, a specific power is given to the Minister, to delegate all powers granted to the Minister under the Act by order to the Director General, but this is a discretion, and the Minister may choose not to do so. The Director General also has some limited powers in relation to managing the outbreak of notifiable diseases. Aside from these powers, which are important in the outbreak of an infectious disease—but are not used as part of day-to-day business in the management of Vanuatu’s public health needs—the Director General has a somewhat limited area of responsibility under its Act.

These laws can leave the most senior public servant in the Ministry of Health with little legislative power, other than that delegated by the Minister on the occasions where this is possible.

Policy question for consideration

Most Chief Executives have somewhat limited areas of responsibility under current Pacific public health laws. The extent of statutory responsibility for the Chief Executive is a policy decision for the various governments; however, the Chief Executive is the most senior public servant in the Ministry of Health. It would usually be the case that this senior executive has a position description and contract of employment, which requires administration of the Ministry of Health and assisting the Minister to comply with the many obligations and responsibilities in the Act, and of others.
It may be that countries prefer the flexibility of the position description setting the role of the Chief Executive, and also recognise that this position has responsibility across the portfolio (not just under the public health law), which may make it an advantage to limit technical responsibility under the public health law.

The allocation of administrative responsibility under a public health law will vary from jurisdiction to jurisdiction, depending on the size of the country, the configuration of the health system and the broader administrative arrangements of the country. While the allocation of policy responsibility and the power to make orders is a policy decision for each Pacific country, and will no doubt continue to vary between jurisdictions, clarity about who has what power in what circumstances is crucial. When a risk to the public health occurs, it may manifest itself quickly and spread rapidly, leaving little time for enquiries as to who is able to make orders, conduct inspections etc. In the Solomon Islands and Vanuatu public health laws, the drafting is quite awkward in this area, and it is quite difficult to establish who is responsible for action in different circumstances where a risk to the public health arises. It is also important to understand how powers in the public health act interact with powers in quarantine, emergency powers and local government law. If the powers under the public health law are not clear, the interaction with other laws is potentially complicated.

**The Chief Public Health Officer**

*Policy question for consideration*

This is a position sometimes created in public health legislation. It gives responsibility to a position envisaged as a senior public servant who is also a public health physician. It is this person who develops health plans, oversees the data collection and surveillance, and makes the more serious orders under the public health law. If no Chief Public Health Officer position is created, the same role might be carried out by the Chief Executive or by delegation of powers under the Act. Other possibilities include a combination of the board, if one exists, the Chief Executive and other officers such as authorised officers.

The position of Chief Public Health Officer has proved useful in some jurisdictions. It is not presently used in the Pacific, although most have a Director of public health who may play a similar role. Smaller countries may prefer not to create an additional senior statutory role. However, it is put forward in the legislative text provided in this module as an approach for jurisdictions to consider, in light of the need for an officer to whom to delegate responsibility for being the focal point for collection of domestic data, for health planning and for the issuance of public health orders. In addition, the position could be useful as a focal point for international health regulations. If jurisdictions prefer not to use this role, these duties may be given to the Chief Executive, the board, the Minister or a combination of these.
Preconditions

A precondition would include a desire to create the position of Chief Public Health Officer, and the necessary arrangements with any public service department that signs off on management structure. It would also be necessary to include the “on costs” for the position in the recurrent salaries budget. However, it should be noted that the legislative text does not require the appointment of a Chief Public Health Officer, but simply allows it. This means that even if countries adopt this legislative text, they are still not obliged to appoint a Chief Public Health Officer unless and until they choose to do so.

204—Office of Chief Public Health Officer

(1) There may be a position of Chief Public Health Officer.

(2) The Governor in Council [or executive, such as Cabinet or the Minister, if preferred] may make an appointment to the position of Chief Public Health Officer.

(3) The terms on which a person is appointed to the position of Chief Public Health Officer shall be determined by the Governor in Council.

(4) The position of Chief Public Health Officer may be held by a member of the Public Service.

205—Functions of Chief Public Health Officer

(1) The Chief Public Health Officer's functions are as follows—
(a) to develop and implement strategies to protect or promote public health;
(b) to ensure that this Act, and any designated health legislation, are complied with;
(c) to advise the Minister and the Chief Executive of the Department about proposed legislative or administrative changes related to public health, and about other matters relevant to public health;
(d) to establish and maintain a network of health practitioners and agencies designed to foster collaboration and coordination to promote public health and the furtherance of the objects of this Act;
(e) at the request of Minister or on the Chief Public Health Officer's own initiative, to investigate and report on matters of public health significance;
(f) after advising the Minister and the Chief Executive of the Department, to make public statements on matters relevant to public health;
(g) any other functions assigned to the Chief Public Health Officer by this Act or any other Act or by the Minister.

(2) In subsection (1)—

*designated health legislation* means—
(a) any other Act committed to the administration of the Minister that is relevant to the objects or operation of this Act; and
(b) any other Act, or any part of any other Act, designated by the regulations for the purposes of this paragraph.
206—Risk of avoidable mortality or morbidity

(1) If—
(a) the Chief Public Health Officer becomes aware of the existence of, or potential for the occurrence of, a situation putting a section of the community or a group of individuals at an increased risk of avoidable mortality or morbidity; and
(b) the Chief Public Health Officer considers that effective solutions exist for the reduction or elimination of those risks, the Chief Public Health Officer may request the participation of any public authority whose intervention may be useful in identifying or producing a response to the circumstances being faced.

(2) A public authority that receives a request under subsection (1) must consider the request and then respond to the Chief Public Health Officer within a reasonable time.

(3) A response under subsection (2) must include details about—
(a) any steps already being taken by the public authority that may be relevant in the circumstances; and
(b) any plans that the public authority may have that may be relevant in the circumstances; and
(c) any steps that the public authority is willing to take in the circumstances; and
(d) any other matter relating to the public authority that appears to be relevant.

207—Biennial reporting by Chief Public Health Officer

(1) The Chief Public Health Officer is required to prepare a written report every 2 years about public health trends, activities and indicators in [insert name of country].

(2) Without limiting subsection (1), a report must also address any issue identified by the Minister for inclusion in the report.

(3) A report must be furnished to the Minister within 3 months after it is prepared.

(4) The Minister must, within 12 sitting days after receipt of a report under this section, cause a copy of the report to be laid before the Parliament.

208—Delegation

(1) The Chief Public Health Officer may delegate a function or power conferred on the Chief Public Health Officer under this or any other Act—
(a) to a specified person or body; or
(b) to a person occupying or acting in a specified office or position; or
(c) to a person specified for this purpose in a regional partnership agreement.

(2) A delegation—
(a) may be made subject to conditions or limitations specified in the instrument of delegation; and
(b) if the instrument of delegation so provides, may be further delegated by the delegate; and
(c) is revocable at will and does not prevent the delegator from acting personally in a matter.
Check to see whether the following is covered in public service legislation. If so, this section may not be needed.

### 209—Appointment of Acting Chief Public Health Officer

(1) If the Chief Public Health Officer is temporarily absent, or the Chief Public Health Officer’s position is temporarily vacant, the Chief Executive may assign a suitable person to act in the Chief Public Health Officer’s position during the temporary absence or vacancy.

(2) The terms on which a person is appointed will be determined by the Chief Executive after consultation with the Minister.

(3) A member of the Public Service may be appointed under this section.

(4) A person appointed to act in the Chief Public Health Officer’s position has, while so acting, all the functions and powers of the Chief Public Health Officer.

## Health boards

**What do current Pacific public health laws say about national health boards?**

A health board is established in both Fiji and PNG. The Fiji public health law constitutes an authority called the “Central Board of Health.” This board is fundamental to the operation of the Act, with broad powers to issue orders, enter premises, exercise powers of local authorities and make regulations. The Permanent Secretary is Chairman and the Board is a body corporate. It can make regulations as to its way of operating, and about the performance by its officers of their duties, and the powers vested in it by the Act.

In PNG, the National Health Board is not created under public health law, but under a separate law. Its role differs from that of the Fiji Board and is broader than the administration of public health legislation, although as in Fiji, the Secretary of the National Department of Health chairs the Board. The

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60 Public Health Act (Fiji), Chapter 111 Section 3
61 National Health Administration Act (PNG)
public hospitals. It may recommend approval of a National Health Plan to the National Executive Council.62

Preconditions

A pool of people properly qualified and willing to sit on the board. Resources to administer and house the board for its various meetings. Secretariat resources that will assist in getting out papers, organising meetings etc. Budget for sitting fees and other expenses.

<table>
<thead>
<tr>
<th>National Public Health Board</th>
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<tr>
<td><strong>210—Establishment of NPHB</strong></td>
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<td>The <em>National Public Health Board</em> (NPHB) is established.</td>
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**211—Composition of NPHB**

[Drafting note: this will vary depending on the jurisdiction, but here are some possibilities:]

(1) NPHB consists of—
(a) the Chief Public Health Officer *ex officio* (who will be the presiding member); and
(b) other members appointed by the Governor in Council on the nomination of the Minister, of whom—

(i) 2 must have experience in local government selected by the Minister from a panel of 5 nominated by [insert local government association or other appropriate body to nominate]; and
(ii) 1 must have qualifications in public health and experience in the administration of public health at the local government level selected by the Minister from a panel of 5 nominated by a body prescribed by the regulations for the purposes of this provision; and
(iii) 2 must be persons nominated by the Minister who have qualifications in public health; and
(iv) 1 must have experience in the administration of environment protection laws or strategies or in environmental management, selected by the Minister from a panel of 5 nominated by the Presiding Member of the Board of the [insert relevant body, such as the Environment Protection Authority]; and
(v) 1 must be a person nominated by the Minister who has experience in the field of health promotion; and
(vi) 1 must be a person nominated by the Minister who has experience in the prevention and control of communicable diseases; and
(vii) 1 must be a person nominated by the Minister who has experience in non-government community sector activities relevant to public health.
(viii) 1 must be a person with experience of customary approaches to the protection and promotion of public health selected by the Minister from a panel of 5 nominated by a body prescribed by the regulations for the purposes of this provision; and

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62 *National Health Administration Act 1997* (PNG), Section 4
(viii) 2 must have experience and expertise in women’s health and/or women’s reproductive health selected by the Minister from a panel of 5 nominated by a body prescribed by the regulations for the purposes of this provision.

(2) If the Minister, by notice in writing, requests a body to make nominations for the purposes of this section, and the body fails to make the nominations within the time allowed in the notice, a person may be appointed to NPHB on the Minister's nomination and that member will be taken to have been appointed on the nomination of the body in default.

(3) The Governor in Council may appoint a suitable person to be the deputy of a member of NPHB and the deputy may, in the absence of that member, act as a member of NPHB.

212—Conditions of membership appointed
(1) An appointed member of NPHB will hold office on conditions determined by the Governor for a term, not exceeding 3 years, specified in the instrument of appointment and will, at the expiration of a term of office, be eligible for reappointment.

(2) The Governor in Council may remove an appointed member of NPHB from office—
(a) for breach of, or non-compliance with, a condition of appointment; or
(b) for mental or physical incapacity to carry out duties of office satisfactorily; or
(c) for neglect of duty; or
(d) for dishonourable conduct.

(3) The office of an appointed member of NPHB becomes vacant if the member—
(a) dies; or
(b) completes a term of office and is not reappointed; or
(c) resigns by written notice addressed to the Minister; or
(d) is found guilty of an indictable offence; or
(e) becomes bankrupt or applies to take the benefit of a law for the relief of insolvent debtors; or
(f) is removed from office by the Governor in Council under subsection (2).

213—Allowances and expenses
An appointed member of NPHB is entitled to fees, allowances and expenses approved by the Governor in Council.

[Drafting note: some countries have specific laws about the conditions of members of public sector committees. Such laws need to be checked and any conditions for allowances, expenses etc would need to be determined under this law or at least be consistent with it. See PNG and Fiji. Some new financial management laws may also require that such provisions are subject to ministry of Finance approval]

214—Validity of acts
An act or proceeding of NPHB is not invalid by reason only of a vacancy in its membership or a defect in the appointment of a member.

215—Functions of NPHB
NPHB’s functions are as follows—
(a) to assist and advise the Chief Public Health Officer in relation to—
Health Legislation in the Pacific – Modules with legislative text

(i) the protection and promotion of public health; and
(ii) the development and maintenance of a system of strategic planning for public health at the local, regional and State-wide levels; and
(iii) the development of health plans under this Act; and
(iv) strategies to ensure that a sufficiently trained and skilled workforce is in place for the purposes of this Act; and
(v) programs to promote public health research in [insert name of country]; and
(vi) the preparation of the biennial report under [insert relevant division when this is confirmed]; and
(vii) the setting of standards and qualifications for authorised officers;

(b) any other functions assigned to NPHB by this or any other Act or by the Minister or the Chief Public Health Officer.

[Drafting note: this final subsection is intended to enable the use of partnerships in carrying out public health activities. It recognises that church groups and other organisations undertake a great deal of health service delivery in Pacific nations.]

(c) Subject to the partnership principles in [insert relevant section when this is confirmed] the NPHB may perform any of its functions in cooperation with—
   (i) a Provincial Government [where these exist], or a local level government or;
   (ii) any body established by that National Government, provincial government or local-level government for the purpose of encouraging the provision of health services in the province;
   (iii) a faith based organisation, church organisation, women’s organisation such as the national council of women or non-government organisation; or
   (iv) any other person or group which satisfies the NPHB that it can assist the NPHB to carry out its functions; or
   (v) the national council of chiefs [or like customary leadership group where one exists] or local level customary group.

216—Conduct of business

(1) The presiding member of NPHB will, if present at a meeting of NPHB, preside at the meeting and, in the absence of that member, the members present may elect 1 of their number to preside.

(2) 6 members constitute a quorum of NPHB.

(3) A decision carried by a majority of the votes cast by the members of NPHB present at a meeting of NPHB is a decision of NPHB.

(4) Each member present at a meeting of NPHB is entitled to 1 vote on a question arising for decision at the meeting and, in the event of an equality of votes, the person presiding is entitled to a second, or casting, vote.

(5) A conference by telephone or other electronic means between the members of NPHB will, for the purposes of this Act, be taken to be a meeting of NPHB at which the participating members are present if—
217 Committees and subcommittees

(1) NPHB may establish committees or subcommittees as NPHB thinks fit to advise NPHB on any aspect of its functions, or to assist NPHB in the performance of its functions.

(2) A committee or subcommittee established under subsection (1) may, but need not, consist of, or include, members of NPHB.

(3) The procedures to be observed in relation to the conduct of a business of a committee or subcommittee will be—
   (a) as determined by NPHB; or
   (b) insofar as a procedure is not determined by NPHB—as determined by the relevant committee or subcommittee.

218—Delegation by NPHB

(1) NPHB may delegate a function or power conferred on NPHB under this or any other Act—
   (a) to a specified person or body; or
   (b) to a person occupying or acting in a specified office or position; or
   (c) to a person specified for this purpose in a regional partnership agreement.

(2) A delegation—
   (a) may be made subject to conditions or limitations specified in the instrument of delegation; and
   (b) if the instrument of delegation so provides, may be further delegated by the delegate; and
   (c) is revocable at will and does not prevent the delegator from acting personally in a matter.

219—Annual report

(1) NPHB must, on or before [insert suitable date in line with ministry planning and reporting cycles] in each year, provide to the Minister a report on its activities for the financial year ending on the preceding [insert suitable date in line with ministry planning and reporting cycles].

(2) The Minister must, within 12 sitting days after receipt of a report under this section, cause a copy of the report to be laid before Parliament.

220—Use of facilities

NPHB may, by arrangement with the relevant body, make use of the services of the staff, equipment or facilities of a public authority.
Module 3A—Councils, authorised officers and emergency information

What is in this module?

Local authorities

In the Solomon Islands, all matters falling to be administered by the Ministry under the Act are delegated to the Honiara Town Council. Delegation is made possible to an enforcement authority. Both the Solomon Islands and Vanuatu laws make use of local authorities to undertake inspections, appoint officers and to take responsibility for more day-to-day management of minor public health risks, such as nuisances. In Vanuatu, a local authority may, with prior approval of the Minister, appoint such medical officers and Environmental Health Officers as may be necessary for carrying out duties under the Act. The Minister may also delegate any power or function to a local authority (municipal council).

How do existing Pacific Health Acts grant power to local governments?

The duties of local authorities are broad ranging and include taking all lawful, necessary and, under special circumstances, reasonably practicable measures for preventing the occurrence or dealing with any outbreak or prevalence of any infectious, communicable, or preventable disease, to safeguard and promote the public health, and to exercise the powers and perform the duties...
imposed on it in respect of the public health.\textsuperscript{63} At the time of writing, consideration was being given to a review of the \textit{Provincial Government Act} 1997, however no information was available on policy outcomes.

In Fiji, the \textit{Public Health Act} creates local authorities that may appoint sanitary inspectors, frame regulations for submission to the Board and carry out inspections; there are many other powers under the Act relating to management of low level risks to the public health. A local authority may also appoint such sanitary inspectors as may be necessary.\textsuperscript{64} The Act does not apply in Fiji villages,\textsuperscript{65} which makes it likely that villages will rely on customary forms of social organisation to manage minor public health risks, sanitation and general village neatness. At the time of writing this was under consideration but no information on outcomes is available.

In PNG, a Local Medical Authority\textsuperscript{66} is appointed in each province. That officer is given the main powers of inspection, entry and certification of buildings, and compulsory hospitalisation of infected persons. In addition to powers shared with Local Medical Authorities, the Minister still has sole powers in relation to gazettal of new infectious diseases,\textsuperscript{67} declaration of infected areas\textsuperscript{68} and declaration of typhoid areas.\textsuperscript{69}

The duties of local authorities are a very widely drawn area of responsibility, which is also quite vague in terms of specific responsibilities and specific powers. The consultation conducted in Vanuatu suggested that this power is not greatly used, although the relationship between policy makers at the national level, and those governing close to the people in towns, communities and villages, is crucial for the success of many public health programs.

\begin{quote}
\textit{We tend to use the Council by-laws a lot and side-step the Public Health Act. We are not sure of what has been delegated to us under the Public Health Act. Even though the public health legislation has more precise things, such as blocking up of drains and spillage, the by-laws have enough in them to do what we need to do.}\textsuperscript{1}
\end{quote}

\textbf{What do Pacific public health officers say about local government powers?}

\begin{itemize}
\item \textsuperscript{63} \textit{Public Health Act}, Section 6
\item \textsuperscript{64} \textit{Public Health Act (Fiji)}, Chapter 111 Section 11
\item \textsuperscript{65} \textit{Public Health Act 1973 (Fiji)}, Section ??
\item \textsuperscript{66} \textit{National Health Administration Act 1997 (PNG)}, Section 21, the Secretary may appoint an officer of the National Department in a province to act as its representative in the province and the person appointed under Subsection (1) is deemed to have been appointed as a Local Medical Authority in accordance with the \textit{Public Health Act 1973}
\item \textsuperscript{67} \textit{Public Health Act 1973 (PNG)}, Sections 15 and 29(b)
\item \textsuperscript{68} \textit{Public Health Act 1973 (PNG)}, Section 35
\item \textsuperscript{69} \textit{Public Health Act 1973 (PNG)}, Section 39
\end{itemize}
We found in some Pacific urban settings that municipal by-laws are being used by urban Environmental Health Officers, as opposed to their Public Health Act, as the officers were not certain of what had been delegated to them under the Act. As one noted:

This wariness on the part of Environmental Health Officers, again demonstrated their understanding of the law, as well as their awareness of the inherent weaknesses of their legislation.

In a case study into the use of customary approaches to public health in a village in the Trobriand Islands in PNG, it was reported that customary law is used in preference to other laws:

*We can use these different law customs, traditions and usages [to] dictate the positions and roles of the village leaders and officials [who] make public speeches in order to inform other villagers of undesirable conducts, request them to enjoin acceptable conduct, organise communal work activities and custom ceremonies ... Other villagers are elected as komiti*\(^70\) to oversee the proper functioning of various services and projects like the health clinic and school. It appears that in carrying out their tasks of village governance, both the formal and informal authorities do not normally use promulgated rules; where rules exist, these are unwritten. In other words, customs provide the mainstay of rules that are followed in village affairs.\(^71\)

\(^70\) A *komiti* is an individual representative, rather than a committee of several people

\(^71\) Jowitt, Foukona and Tomtavala, “Model Public Health Law for the Pacific Project—Customary Law and Public Health”, unpublished paper by scholars from the University of the South Pacific, for the Model Public Health Law for the Pacific Project. At the time of writing, there were plans to submit the paper for publication, along with a series of papers on the project, to the *Journal of South Pacific Law* in 2011
**Policy questions for consideration**

In deciding how to manage the power allocation to local councils, it is important to consider how the powers are being used now. Public health officers in Vanuatu report that local government laws are generally used in preference to public health laws. In the Trobriand Islands of PNG, customary law is used in preference to other forms of law. It is important to consider the use being made of customary approaches to the protection of public health and the promotion of health. How does it interface with the use of formal state laws? Are local government laws being used? How are public health laws used? Can the present mix of arrangements be expanded in scope, or formalised as part of public health law?

**Preconditions**

It would be important to align any allocated duties of authorised officers, which are set out in this Act, with position descriptions that are likely to have the force of law under relevant public service management legislation. This is to avoid a possible conflict of laws.

**301—Functions of councils**

*Drafting note: countries need to ascertain the current name of local councils in their legislation. For example, in PNG it is known as local-level government.*

The following functions are conferred on a council by this Act—

(a) to take action to preserve, protect and promote public health within its area;
(b) to cooperate with other authorities involved in the administration of this Act;
(c) to undertake the provision of immunisation programs for the protection of public health within its area, or to ensure that such programs are provided;
(d) to ensure that adequate sanitation measures are in place in its area;
(e) to ensure that businesses do not adversely affect public health within its area;
(f) to identify risks to public health within its area;
(g) as necessary, to ensure that remedial action is taken to reduce or eliminate adverse impacts or risks to public health;
(h) to assess activities and development, or proposed activities or development, within its area in order to determine and respond to public health impacts (or potential public health impacts);
(i) to provide, or support the provision of, educational information about public health and to provide or support activities within its area to preserve, protect or promote public health;
(j) such other functions assigned to the council by this Act.

**302—Cooperation between councils**

(1) A council may, in performing its functions or exercising its powers under this Act, act in conjunction or partnership with, or cooperate or coordinate with, 1 or more other councils.

(2) The Chief Public Health Officer may request a council to cooperate with 1 or more other councils if the Chief Public Health Officer considers that the councils share a common area of concern.
(3) If a council receives a request under subsection (2), the council must, within 28 days after receiving the request or such longer period as the Chief Public Health Officer may specify, furnish the Chief Public Health Officer with a written report on the action that the council intends to take in response to the request.

303—Power of Chief Public Health Officer to act

(1) If—
(a) the Chief Public Health Officer considers that a public health risk exists that has significance in relation to the areas of 2 or more councils; or
(b) the Chief Public Health Officer considers that action is warranted under this section in order to support or enhance the Minister’s functions to preserve, protect or promote public health within the State generally,
the Chief Public Health Officer may exercise any power conferred on a council under this Act (as if the Chief Public Health Officer were a council).

(2) Subject to subsection (3), before taking action under subsection (1) the Chief Public Health Officer must take reasonable steps to consult with the council or councils for the area or areas where the Chief Public Health Officer intends to act, and with PHC.

(3) If the Chief Public Health Officer considers that urgent action is required, the Chief Public Health Officer may, after informing the Minister of his or her proposed course of action, take action under subsection (1) without complying with subsection (2) (but the Chief Public Health Officer must then, within a reasonable time after taking the action, advise the relevant council or councils of the action that has been taken).

304—Council failing to perform a function under Act

(1) If, in the opinion of the Minister, a council has failed, in whole or in part, to perform a function conferred on the council under this Act, the Minister may consult with the council in relation to the matter.

(2) If, after consulting under subsection (1), the Minister considers that the council’s failure is significant, the Minister may, after consulting with NPHC, direct the council to perform a function under this Act.

(3) A direction under subsection (2)—
(a) must be in writing; and
(b) must set out the grounds on which the Minister is acting; and
(c) must set out the action that the Minister considers should be taken by the council.

(4) The Minister must cause a copy of the direction to be published in the Gazette within a reasonable time after it is furnished to the council.

(5) If a council fails to comply with a direction under this section, the Minister may, by notice served on the council, withdraw powers of the council and transfer them to the Chief Public Health Officer (and any such notice will have effect according to its terms).

(6) Before taking action under subsection (5)—
(a) the Minister must, by notice in writing—
(i) inform the council of the Minister's proposed course of action (setting out the grounds on which the action is proposed); and
(ii) invite the council to make written submissions to the Minister in relation to the matter within a period specified by the Minister; and

(b) if the council so requests in its written submissions to the Minister—the Minister must discuss the matter with a delegation representing the council; and
(c) the Minister must, at such time as the Minister thinks fit, consult with the Chief Public Health Officer and NPHC.

(7) The Minister must cause a copy of the notice under subsection (5) to be published in the Gazette within a reasonable time after it is served on the council.

(8) A member of the staff of the council must comply with any request or direction of the Chief Public Health Officer in or in connection with the exercise of a power transferred to the Chief Public Health Officer under this section.

(9) The Chief Public Health Officer, or a person acting under the authorisation of the Chief Public Health Officer, is entitled to make use of the equipment or facilities of the council, without any other authority, in connection with the exercise of a power transferred to the Chief Public Health Officer under this section.

(10) An act of the Chief Public Health Officer in the exercise of a power transferred to the Chief Public Health Officer will be taken to be an act of the council.

(11) The Chief Public Health Officer must, in acting under this section, have due regard to the role and responsibilities of the council to its community in other respects.

(12) The Minister may recover as a debt, costs and expenses reasonably incurred in the Chief Public Health Officer exercising powers under this section from the council.

(13) The Minister may, after consultation with the Chief Public Health Officer and NPHC, by notice served on the council, vary or revoke a notice under subsection (5).

(14) The Minister must cause a notice under subsection (13) to be published in the Gazette within a reasonable time after it is served on the council.

(15) In this section—

function includes a power or duty.

305—Transfer of function of council at request of council

(1) A council may request that a function of the council under this Act be performed by the Chief Public Health Officer.

(2) A request under subsection (1)—
(a) must be made to the Minister; and
(b) must be in writing; and
(c) must be accompanied or supported by such information that the Minister may require.
(3) The Minister must, after receiving a request, consult with the Chief Public Health Officer and NPHB.

(4) The Minister may then, if the Minister thinks fit, by notice in the Gazette, transfer a specified function of the council to the Chief Public Health Officer (and any such notice will have effect according to its terms).

(5) A member of the staff of the council must comply with any request or requirement of the Chief Public Health Officer in or in connection with the performance of a function transferred to the Chief Public Health Officer under this section.

(6) The Chief Public Health Officer, or a person acting under the authorisation of the Chief Public Health Officer, is entitled to make use of the equipment or facilities of the council, without any other authority, in connection with the performance of a function transferred to the Chief Public Health Officer under this section.

(7) An act of the Chief Public Health Officer in the performance of a function transferred to the Chief Public Health Officer will be taken to be an act of the council.

(8) The Minister may recover costs and expenses associated with the Chief Public Health Officer acting under this section under an agreement with the council.

(9) The Minister may, at the request of the council, or on the Minister's own initiative after consultation with the council, the Chief Public Health Officer and NPHC, vary or revoke a notice under subsection (4) by further notice in the Gazette.

(10) In this section—

function includes a power or duty.

**Division 5—Authorised officers**

**Policy question for consideration**

Decisions need to be made on terminology. In many parts of the Vanuatu *Public Health Act*, reference is made to powers of “Medical Officers” and “Environmental Health Officers”, rather than “authorised officers”. An “authorised officer” also includes those to whom the Minister has delegated powers. Inconsistent use of terminology throughout the Act gives rise to confusion about who can be granted powers and in what circumstances. This must be addressed in any review, so that the legislation can be practically used by the Ministry of Health. In the Solomon Islands *Environmental health (Public Health Act) Regulations*, several different terms are used. It is therefore quite difficult to understand who has power and under what circumstances it might be exercised.

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72 *Public Health Act*, Section 1
Preconditions

Ability to train and equip a cohort of officers of the kind referred to in the Act. Have they support for inspections, prosecutions and regular training? Thought also needs to be given to mundane but very necessary means of transportation, particularly in the Pacific where geography can be quite challenging and roads difficult. Necessary resources for travel may include transport and maintenance of any vehicles required, access to boats and safety equipment such as radios, GPS, torches etc and security if needed in countries like Papua New Guinea.

306—Authorised officers

(1) The Minister may appoint a suitably qualified person to be an authorised officer.

(2) An appointment under this section may be made subject to such conditions or limitations as the Minister thinks fit.

(3) Without limiting subsection (2), the powers conferred on an authorised officer under this or any other Act may be exercised in the whole of [insert name of country] or such part or parts as may be specified in the instrument of appointment.

[Drafting note: countries may wish for specific appointments to be province wide or district wide in larger countries, such as PNG.]

(4) An authorised officer is subject to direction by the Chief Public Health Officer.

(5) The Minister may vary or revoke an appointment at any time.

307—Local authorised officers

(1) A council may, by instrument in writing, appoint a suitably qualified person to be a local authorised officer.

(2) An appointment under this section may be made subject to such conditions or limitations as the council thinks fit.
(3) Without limiting subsection (2), the powers conferred on a local authorised officer under this or any other Act may be exercised within the area of the council.

(4) A local authorised officer is subject to direction by the council.

(5) A person may hold an appointment as a local authorised officer from more than 1 council.

(6) The council may vary or revoke an appointment at any time.

(7) A council must notify the Department if the council—
(a) makes an appointment under this section; or
(b) revokes an appointment under this section.

(8) A notification under subsection (7) must be accompanied by such information as the Chief Executive thinks fit and specifies for the purposes of this section from time to time.

(9) A council must, in determining the number of local authorised officers who should be appointed for its area, take into account any policy developed by the Chief Public Health Officer for the purposes of this section.

308—Qualifications
(1) Subject to subsection (2), a person is not eligible for appointment as an authorised officer unless the person holds qualifications approved by the Minister for the purposes of this Division (being qualifications or classes of qualifications that may vary according to factors determined by the Minister).

(2) The Minister may grant exemptions from the operation subsection (1).

(3) An exemption may be granted on conditions determined by the Minister.

309—Identity cards
(1) An authorised officer appointed under this Act must be issued with an identity card in a form approved by the Chief Public Health Officer—
(a) containing the person’s name and a photograph [check practicality of this before putting into the legislation. Perhaps check whether country already has this capacity for driver licences, student cards at a university etc] of the person; and
(b) stating that the person is an authorised officer for the purposes of this Act; and
(c) setting out the name or office of the issuing authority.

(2) The identity card must be issued as soon as is reasonably practicable after the appointment is made (but an authorised officer is not prevented from exercising powers under this Act just because an identity card is yet to be issued).

(3) An authorised officer must, at the request of a person in relation to whom the officer intends to exercise any powers under this Act, produce for the inspection of the person his or her identity card (unless the identity card is yet to be issued).

(4) An authorised officer appointed under this Act must, on ceasing to be an authorised officer for any reason, surrender his or her identity card to the Chief Executive (if a nationally authorised officer) or the council that made the appointment (if a local authorised officer).
Maximum penalty: 50 penalty units.

Drafting Note, these penalties are included to give some idea about where a penalty for a particular offence may be pitched while also ensuring that the amounts are consistent with other penalties in the Act. However, these are suggestions only and will always be subject to examination of penalties in the other laws of the country.

310—Powers of authorised officers

(1) An authorised officer may, for any purpose connected with the administration or operation of this Act or with the performance, exercise or discharge of a function, power or duty under this Act—
(a) at any reasonable time, enter or inspect any premises or vehicle; and
(b) during the course of the inspection of any premises or vehicle—
(i) ask questions of any person found in the premises or vehicle; and
(ii) inspect any article or substance found in the premises or vehicle; and
(iii) take and remove samples of any substance or other thing found in the premises or vehicle; and
(iv) require any person to produce any plans, specifications, books, papers or documents; and
(v) examine, copy and take extracts from any plans, specifications, books, papers or documents; and
(vi) take photographs, films or video recordings; and
(vii) take measurements, make notes and carry out tests; and
(viii) remove any article that may constitute evidence of the commission of an offence against this Act; and
(c) require any person to answer any question that may be relevant to—
(i) ascertaining whether the person is suffering from a notifiable condition; or
(ii) the administration or enforcement of this Act.
(d) convene a village meeting to discuss any matter which may be relevant to—
(i) customary measures in use in the village for the protection of public health; and
(ii) customary measures in use in the village for the promotion of health; and
(iii) any customary practice in use in the village which may adversely affect public health in the village. (need to link this with later powers to make joint order)

(2) In the exercise of powers under this Act, an authorised officer may be accompanied by such assistants as may be necessary or desirable in the circumstances.

(3) An authorised officer may use force to enter any premises or vehicle—
(a) on the authority of a warrant issued by a magistrate; or
(b) if the officer believes, on reasonable grounds, that the circumstances require immediate action to be taken.

(4) A magistrate must not issue a warrant under subsection (3) unless satisfied—
(a) that there are reasonable grounds to suspect that an offence against this Act has been, is being, or is about to be, committed; or
(b) that the warrant is reasonably required in the circumstances.
(5) If an authorised officer is inspecting premises or a vehicle under this section, the person in charge of the premises or vehicle must provide such assistance as the authorised officer reasonably requires to facilitate the inspection.

(6) A person who—
(a) hinders or obstructs an authorised officer, or a person assisting an authorised officer, in the exercise of a power under this section; or
(b) having been asked a question under this section, does not answer the question to the best of his or her knowledge, information and belief; or
(c) being the person in charge of premises or a vehicle subject to an inspection and having been required to provide reasonable assistance to facilitate the inspection, refuses or fails to provide such assistance, is guilty of an offence.

Maximum penalty: 200 penalty units.

Drafting Note: It is important to check the Crimes Act or similar relevant legislation in the country as such laws often contain a provision of this nature, obviating the need to include it here.

(7) A person who furnishes information under this section cannot, by virtue of doing so, be held to have breached any law or any principle of professional ethics.

(8) It is not an excuse for a person to refuse or fail to furnish information under this section on the ground that to do so might tend to incriminate the person or make the person liable to a penalty.

(9) However, if compliance with a requirement to furnish information might tend to incriminate a person or make a person liable to a penalty, then—
(a) in the case of a person who is required to produce, or provide a copy of, a document or information—the fact of production, or provision of, the document or the information (as distinct from the contents of the documents or the information); or
(b) in any other case—any answer given in compliance with the requirement, is not admissible in evidence against the person for an offence or for the imposition of a penalty (other than proceedings in respect of the provision of information that is false or misleading).

Division 6—Emergency officers

311—Emergency officers

(1) The Chief Executive may appoint, individually or by class, such persons to be emergency officers for the purposes of this Act as the Chief Executive thinks fit.

Drafting Note: This needs to be checked for consistency with any provisions in an Emergency Powers Act.

(2) An appointment under subsection (1) may be subject to conditions or limitations specified by the Chief Executive.

(3) An emergency officer, other than a police officer, must be issued with an identity card in a form approved by the Chief Executive—
(a) containing the person’s name and a photograph of (consider practicality) the person; and
(b) stating that the person is an emergency officer for the purposes of this Act.

(4) An emergency officer must, at the request of a person in relation to whom the officer intends to exercise any powers under this Act, produce for the inspection of the person—
(a) in the case of an emergency officer who is a police officer and is not in uniform—his or her certificate of authority; or
(b) in the case of an emergency officer who is not a police officer—his or her identity card.

(5) An emergency officer appointed under this Act must, on ceasing to be an emergency officer for any reason, surrender his or her identity card and any insignia or special apparel or equipment issued to the emergency officer for the purposes of this Act to the Chief Executive or a person nominated by the Chief Executive.

Maximum penalty: 50 penalty units.

Division 7—Specific power to require information

312—Specific power to require information

(1) The Minister, the Chief Public Health Officer or a council may require a person to provide such information relating to public health as may be reasonably required for the purposes of this Act.

(2) A person who fails to comply with a requirement under subsection (1) is guilty of an offence.

Maximum penalty: 200 penalty units.
Expiation fee: 10 penalty units.

(3) A person who provides information under this section cannot, by virtue of doing so, be held to have breached any law or any principle of professional ethics.

(4) It is not an excuse for a person to refuse or fail to provide information under this section on the ground that to do so might tend to incriminate the person or make the person liable to a penalty.

(5) However, if compliance with a requirement to provide information might tend to incriminate a person or make a person liable to a penalty, then—
(a) information—the fact of production, or provision of, the document or the information (as distinct from the contents of the documents or the information); or
(b) in any other case—any answer given in compliance with the requirement, is not admissible in evidence against the person for an offence or for the imposition of a penalty (other than proceedings in respect of the provision of information that is false or misleading).
Module 3B—Public health plan

What is in this module?

Countries have found it useful and strategic to include public health planning as a statutory requirement. Planning is an essential activity of ministries of health and most countries have an active health plan, which is updated on a cycle of around three years. There are many examples of modern public health Acts where health planning is mandated. It is also a policy consideration for developing countries, which often struggle to get sufficient allocation of funds to the health portfolio, to advise Treasury or Ministry of Finance and budget officials that planning and the achievement of the plan is a statutory requirement. Ministry of health staff have found statutory planning requirements a useful bargaining tool in health portfolios where funds allocated to public health are often consumed by a rapacious hospital budget, which generally enjoys a higher profile and thus greater attention from political masters. A statutory planning requirement can help to elevate the planning requirement, and even add some status to the matters included in the plan.

Some countries, such as PNG, already have a planning requirement under another law, in this case, the National Health Administration Act. PNG may wish to have a public health plan that is part of the national plan, or perhaps to make a policy decision that one statutory requirement for health planning is sufficient, and so exclude health planning from the public health law because it is dealt with in another law.

This module includes the option to create a public health partner authority, which enables, by agreement with the public health partner authority, it to take responsibility for undertaking any strategy, or for attaining any priority or goal, under the plan. A public health partner authority may be declared in the national Gazette for the purposes of the plan and may include a local village or community.

313—Public health plan

(1) The Minister must prepare and maintain a plan to be called the Public Health Plan.

(2) The Public Health Plan is to set out the principles and policies for achieving the objects of this Act and implementing the principles established under this Act throughout [insert name of country].

(3) In connection with the operation of subsection (2), the Public Health Plan should—

(a) —

(i) comprehensively assess the state of public health in [insert name of country]; and

(ii) identify existing and potential public health risks and develop strategies for addressing and eliminating or reducing those risks; and

73 Public Health and Wellbeing Act 2008 (Vic), Public Health Act 1997 (ACT), Public Health Bill (SA)
(b) identify opportunities and outline strategies for promoting public health in [insert name of country]; and
(c) include information about issues identified in regional public health plans established under this Part or any other plan or policy that the Minister considers to be appropriate; and
(d) include information about customary approaches to the protection of public health and the promotion of public health currently existing and identify how these might be included in health planning to maximise opportunities to advance the health of local communities.

(4) The Public Health Plan may also take into account any plan, policy or strategy determined to be appropriate by the Minister.

(5) The Minister must review the Public Health Plan at least once in every 4 [consider a suitable length of time for the plan—about 5 might be sufficient, but this is a question of policy for the Ministry] years.

(6) Subject to subsection (7), the Minister may amend the Public Health Plan at any time.

(7) The Minister must, in relation to any proposal to create or amend the Public Health Plan—
(a) prepare a draft of the proposal; and
(b) take reasonable steps to consult with (and take into account the views and comments of)—
(i) NPHB [if one has been established]; and
(ii) [any local government association, if such a body exists];
(iii) others such as customary representatives of some local communities from islands, highlands and coastal regions, national council of women, National Council of Chiefs; in relation to the proposal; and
(c) by public notice, give notice of the place or places at which copies of the draft are available for inspection (without charge) and purchase and invite interested persons to make written representations on the proposal within a period specified by the Minister.

(8) Subsection (7) does not apply in relation to an amendment that is being made—
(a) in order to ensure that the Public Health Plan is consistent with any plan, policy or strategy that—
(i) has been prepared, adopted or applied under another Act; and
(ii) falls within a class prescribed by the regulations for the purposes of this provision; or
(b) in order to remove or replace information in the Public Health Plan that has been superseded by information that the Minister considers to be more reliable or accurate; or
(c) in order to make a change of form (without altering the effect of an underlying policy reflected in the Public Health Plan); or
(d) in order to take action considered by the Minister to be—
(i) addressing or removing irrelevant material or a duplication or inconsistency (without altering the effect of an underlying policy reflected in the Public Health Plan); or
(ii) correcting an error; or
(e) in any circumstances prescribed by the regulations.

(9) The Public Health Plan, or an amendment to the Public Health Plan, has no force or effect until published by the Minister in accordance with the regulations.

(10) The Minister must ensure that copies of the Public Health Plan are reasonably available for inspection (without charge) and purchase by the public at a place or places determined by the Minister.

(11) The Public Health Plan is an expression of policy and does not in itself affect rights or liabilities (whether of a substantive, procedural or other nature).

(12) A failure of the Minister to comply with a requirement of this section cannot be taken to affect the validity of the Public Health Plan, or any other plan or instrument under this Act.

Part 5—Regional [provincial] public health plans

Preconditions and policy questions for consideration

Consider the practicality of localised planning according to the size of the country. Are regional or provincial public health plans necessary? What planning is presently undertaken by local government for public health? Does this need to be assisted by a more detailed public health plan? Policy issues to consider would be the need to plan at the local level and what planning, whether mandated by statute or otherwise, was presently being undertaken. It is also important to consider the availability of officers to liaise, discuss, educate, ensure consistency and to implement. However, the existence of consistent health plans at national and local level is invaluable for planning, and for ensuring a consistent approach to matters such as malaria eradication, HIV, maternal health and other issues, which might be best approached by a combination of national policy and local action roll out at various levels, and for liaison with community development officers, education officers etc.

314—Regional public health plans

(1) A council or, if the Minister so determines or approves, a group of councils, must prepare and maintain a plan for the purposes of the operations of the council or councils under this Act (a regional public health plan).

(2) A regional public health plan must be in a form determined or approved by the Minister.

(3) If a group of councils are to prepare and maintain a regional public health plan, a reference in this Part to a council is to be taken to be a reference to the group of councils.

(4) Notwithstanding that a group of councils are to prepare and maintain a regional public health plan, any council within the group may also prepare its own plan that relates to 1 or
more matters that are to apply specifically within its area (and then this Part will apply accordingly).

(5) A plan should be consistent with the National Public Health Plan.

(6) The Minister may, from time to time, prepare or adopt guidelines to assist councils in the preparation of regional public health plans.

(7) The Minister should take reasonable steps to consult with NPHB, [any local government association, any provincial council of women, customary leaders] in the preparation of any guidelines, or before adopting any guidelines, under subsection (6).

(8) A regional public health plan must—
(a) comprehensively assess the state of public health in the region; and
(b) identify existing and potential public health risks and develop strategies for addressing and eliminating or reducing those risks; and
(c) identify opportunities and outline strategies for promoting public health in the region; and
(d) address any public health issues specified by the Minister following consultations with NPHB, [any local government association, any provincial council of women, customary leaders]; and
(e) include information as to—
(i) the state and condition of public health within the relevant region, and related trends; and
(ii) environmental, social, economic, customary and practical considerations relating to public health within the relevant region; and
(iii) other prescribed matters; and
(f) include such other information or material contemplated by this Act or required by the regulations.

(9) In addition, a plan must—
(a) include information about issues identified in any plan, policy or strategy specified by the Minister or NPHB [if one has been established]; and
(b) address, and be consistent with, any intergovernmental agreement specified by the Minister.

(10) Subject to subsection (11), a council may amend a regional public health plan at any time.

(11) A council must, in relation to any proposal to create or amend a regional public health plan—
(a) prepare a draft of the proposal; and
(b) when the draft plan is completed, a council must—
(i) give a copy of it to—
(A) the Minister; and
(B) any incorporated hospital established under the [insert name of Act under which hospitals are created and incorporated, or provincial health authority in PNG] that operates a facility within the region; and
(C) any relevant public health partner authority under subsection (23); and
(D) any other body or group prescribed by the regulations; and

(ii) take steps to consult with the public.

(12) The Minister may require that a council consult with the Minister, or any other person or body specified by the Minister, before a council releases a draft plan under subsection (11).

(13) Before bringing a regional public health plan into operation, a council must submit the plan to the Chief Public Health Officer for consultation.

(14) The Chief Public Health Officer may refer the plan to NPHB or any other body determined by the Chief Public Health Officer for further consultation.

(15) A council must take into account any comments made by the Chief Public Health Officer, NPHB, and any other body within the ambit of a determination under subsection (14), at the conclusion of the consultation processes envisaged by subsections (13) and (14).

(16) A council may then adopt a plan or amend a plan with or without alteration.

(17) A council may undertake the processes set out in the preceding subsections in conjunction with the preparation and adoption of its strategic management plans under [insert any relevant sections of local level government legislation] (and may, if the council thinks fit, incorporate a regional public health plan into its strategic management plans under that Act).

(18) A regional public health plan may, by agreement with the public health partner authority, provide for a public health partner authority to take responsibility for undertaking any strategy, or for attaining any priority or goal, under the plan.

(19) A regional public health plan must be reviewed at least once in every 4 years [or insert different time period as necessary, or to fit into the cycles of other related or relevant plans].

(20) A council must, in preparing and reviewing its regional public health plan and insofar as is reasonably practicable, give due consideration to the plans of other councils insofar as this may be relevant to issues or activities under its plan.

(21) A council must, when performing functions or exercising powers under this or any other Act, insofar as may be relevant and reasonable, have regard to the National Public Health Plan, any regional public health plan that applies within the relevant area and any other requirement of the Minister, and in particular must give consideration to the question whether it should implement changes to the manner in which, or the means by which, it performs a function or exercises a power or undertakes any other activity that has been identified in the National Public Health Plan as requiring change.

(22) A public health partner authority must, when performing a function that is relevant to the National Public Health Plan or a regional public health plan, insofar as is relevant and reasonable, have regard to the provision of the plans.

(23) For the purposes of this section—
(a) the regulations may provide for an entity to be a public health partner authority for the purposes of this section; and
(b) the Minister may, after consultation with the relevant entity, by notice in the Gazette, declare an entity or local village or community to be a public health partner authority for the purposes of this section (and may, after consultation with the entity, revoke any such declaration by notice in the Gazette).

315—Reporting on regional public health plans
(1) A council responsible for a regional public health plan must, on a 2 yearly basis, prepare a report that contains a comprehensive assessment of the extent to which, during the reporting period, the council has succeeded in implementing its regional public health plan to the Chief Public Health Officer.

(2) In a year in which a report is required (a reporting year), the report must be provided to the Chief Public Health Officer on or before [insert appropriate date in line with Ministry planning cycle] in the reporting year.

(3) The report must relate to a reporting period of 2 years ending on [insert appropriate date in line with Ministry planning cycle] in the reporting year.

(4) The Chief Public Health Officer may, from time to time, issue guidelines to assist in the preparation of reports on regional public health plans by councils.

(5) The Chief Public Health Officer must provide a copy of each report provided under this section to the Minister by [insert appropriate date in line with Ministry planning cycle] in each reporting year.
Module 3C—HIV and powers for village courts and island courts

What is in this module?

The legislative text on communicable conditions is broadly drafted and includes HIV. HIV may also be included in a list of controlled communicable conditions, which may be prescribed by the regulations or by the Minister where urgent circumstances pertain. The module on communicable and non-communicable conditions covers testing, rights and responsibilities of people infected with a communicable disease, a responsibility not to knowingly infect, and principles respecting the rights of the individual by which the sections are interpreted and applied.

For a comprehensive discussion of a range of alternative approaches to the management of HIV in legislation, including stand-alone legislation, see the joint United Nations Development Programme (UNDP) and United Nations Programme on HIV/AIDS (UNAIDS) publication, *Enabling Effective Responses to HIV in the Pacific Island Countries: Options for Human Rights-Based Legislative Reform*. In addition to legislative options to address matters such as a national framework, testing, pre- and post-test counselling, and access to means of protection, it includes a range of other related laws affecting HIV and those infected or affected. These include anti-discrimination legislation, criminal laws, domestic violence legislation and others. It contains some very interesting discussion and legislative text for a model compulsory licensing provision, which may be of broad interest to countries for a range of essential drugs. It is beyond the scope of the Reviewers’ Companion to address the issues of patents, imports of drugs and the problems faced by the Pacific in an affordable effective drug supply.

However, the Reviewers’ Companion suggests that more consideration should be given to customary approaches, or approaches utilising customary courts, rather than remedies based on courts and state systems. Miranda Forsyth, in her work *A Bird that Flies with Two Wings—Kastom and Justice Systems in Vanuatu*, provides a useful summary of the problems with the operation of the state system in Vanuatu. The points set out below are drawn from Forsyth’s summary, and are consistent with the reports from public health officers on use of the public health laws across several Pacific countries. Some of the important problems relevant to the dependence of legislating stronger court-based remedies to HIV rights are set out as follows:

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74 UNDP Pacific Centre, Suva, Fiji, 2009
75 Etheridge and Howse, *Op Cit.*
Health Legislation in the Pacific – Modules with legislative text

This module proposes an approach to complement legislative text in the section on communicable diseases, by the extension of the jurisdiction of village courts or island courts to include a small discrimination and stigmatisation jurisdiction. This provides genuine access to remedies for problems of discrimination and stigmatisation, which are presently only available to those who are aware of legal remedies and can access a court, or in PNG, the Ombudsman Commission.

It is set out as Module 3C because it operates alongside local government laws and, if used, would become a legislative mechanism to advance public health within laws on village and island courts and local government laws, rather than laws within the public health law itself.

As PNG faces the most serious HIV threat in the Pacific, it is used as an example of a legislative approach to such a jurisdiction. This could be adapted for use in other countries should they see the need to do so. Countries wishing to adopt an approach to HIV, similar to that described in this module, would need to legislate to slightly expand the jurisdiction of village or island courts, and do so in a manner consistent with other legislation affecting the application of customary law and the operation of village or island courts.

The proposed approach is quite consistent with current jurisdiction of the PNG village courts, and would provide access to a remedy that PNG’s legal system is otherwise unable to make available to most Papua New Guineans. This proposed approach is drawn from a paper published in 2008, which seeks to make a case

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76 WHO Western Pacific Region, Reproductive Health—Global and Regional Situation, 2005 see www.wpro.who.int/sites/rph/overview.htm, accessed 30 December 2010
for the expanded village court’s jurisdiction in PNG.77

**Incorporating anti-discrimination and anti-stigmatisation jurisdiction into village courts and island courts**

Only two Pacific countries, Fiji and Papua New Guinea have a law to manage and prevent the spread of HIV; in Fiji it is called the HIV/AIDS Decree 2011, no 5 of 2011 which came into force 15 February 2011. In PNG it is called the *HIV AIDS Management and Prevention Act 2003*. It passed the Parliament of PNG in August 2003 and was gazetted in October 2004. It is colloquially known in Papua New Guinea as the “HAMP Act”.

The *HAMP Act* is intended to give effect to some of the rights and freedoms acknowledged in the preamble to the PNG Constitution, by providing for the prevention of the spread of HIV/AIDS, the protection of people affected from discrimination and the protection of public health.

The *HIV/AIDS Management and Prevention Act 2003* was drafted with reference to the specific constitutional and legal frameworks in PNG, and the political and social responses to HIV/AIDS that prevailed at the time.78 Within these limitations, it sought to reflect the legislative principles of HIV/AIDS management outlined in the *UN Handbook for Legislators on HIV/AIDS*.79, 80

How does the *HAMP Act* protect those infected or affected by HIV or AIDS? The Act makes it unlawful to discriminate against a person on the grounds that the person is infected or affected by HIV or AIDS.81 The discrimination must be to the detriment of that person, adding another limb to the offence.

The Act also sets out a number of areas in which discrimination might be found to be taking place. These include: in relation to employment and contract work; partnerships; industrial and professional organisations and clubs; education and training; persons in custody; the provision of accommodation; surveillance and access to goods, services and public facilities.82

The Act makes it unlawful to stigmatise a person on the ground that they are infected or affected by HIV/AIDS. The term “stigmatise” is defined and includes “to vilify or incite hatred, ridicule or contempt against a person or group on the grounds of an attribute.”83 Means of stigmatisation include publication and communication, which extends to gestures or actions.

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78 Howse, G, Op Cit
81 *HIV/AIDS Management and Prevention Act 2003*, Section 6
82 *HAMP Act*, Section 7(a),(b),(c),(d),(e), (f),(g) and (h)
83 *HAMP Act*, Section 2
The definition of a person infected or affected by HIV/AIDS is broad, encompassing people infected, but also those presumed to be, and those being tested, seeking to be tested or refusing to be tested. It also covers those related to or associated with people infected with HIV, and even includes those presumed to have such associations.  

This means that the right to the protections provided by the Act extend considerably beyond people known to be infected. The scope for complaints about unlawful acts of discrimination is very broad. Rights to complain are likely to be encountered in every day life in the villages and cities of PNG, by people infected with HIV, and also by their families, workmates and other community members.

The Act contains strong confidentiality protections for people infected or affected by HIV or AIDS and these include court proceedings. For example, measures are able to be taken to exclude persons from proceedings, or to prohibit publication of reports of proceedings, where information relating to the status of a person infected or affected by HIV is heard.

If a person infected or affected by HIV wishes to bring an action to protect his or her rights under the Act, some avenues are:

- complaints about alleged unlawful acts by government departments, or publicly funded organisations or their employees, to the Ombudsman Commission; and
- seeking a declaration in the District or National Court that an act is unlawful under the HAMP Act and then seeking relief such as compensation, apology or reinstatement.

Passing such a progressive Act is a forward step in the fight against the spread of HIV/AIDS in PNG. However, rights must be accessible and enforceable, if they are to provide the protections intended by Parliament passing the law.

**Jurisdiction of the Ombudsman Commission**

Jurisdiction under the HAMP Act is granted to the Ombudsman Commission. The Commission derives its jurisdiction via the discriminatory practices jurisdiction. This appears to be a jurisdiction
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additional to the overseeing of government administrative decision making, and is intended to extend to practices by private individuals. The constitution does not specifically state that this jurisdiction extends to consideration of the actions of private individuals, and a reading of the *Organic Law on the Ombudsman Commission* suggests that the only action open to the Commission in relation to complaints about private sector individuals and organisations, is to refer matters to the Public Prosecutor.

However, even for complaints about public sector individuals or agencies, the Commission’s discriminatory practices jurisdiction sits awkwardly in the *Organic Law on the Ombudsman Commission*, which otherwise appears entirely drafted to cover issues arising from the exercise of administrative functions of government, or the operation of public bodies.

The Organic Law does not provide easily understood and applicable remedies for complaints about discrimination and stigmatisation made against private bodies and individuals. 89 Remedies appear to be confined to procedural arrangements such as to:

(a) consider the matter further; or  
(b) take certain specific action; or  
(c) modify or cancel any administrative act; or  
(d) alter any regulation or ruling; or  
(e) explain more fully any administrative act; or  
(f) do any other thing. 90

This list of remedies concentrates on procedure. They are not likely to be the kinds of remedies sought by ordinary people in the villages of PNG who are encountering discrimination or stigmatisation.

The Ombudsman Commission cannot award compensation 91 and decisions cannot be reviewed. 92 While legal representation is not necessary, the resources and coverage of the Commission do not stretch throughout PNG; it has regional offices for Southern (Port Moresby), Momase (Lae), Highlands (Mt. Hagen) and Islands (Kokopo/Rabaul). PNG has twenty provinces, each of which is divided into one or more districts, which in turn are divided into one or more local-level governments. There are thousands of villages. Four offices throughout PNG makes the Ombudsman Commission virtually inaccessible for a large proportion of Papua New Guineans.

Since the *HAMP Act* was gazetted in 2004, the Ombudsman Commission has heard very few cases of discrimination on the grounds of HIV infection or because of having AIDS.

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88 *HAMP Act*, Section 27  
89 *Organic Law on the Ombudsman Commission*, Sections 13, 14, 17 and 22  
90 *Organic Law on the Ombudsman Commission*, Section 22  
91 *Organic Law on the Ombudsman Commission*, Section 22  
92 *Organic Law on the Ombudsman Commission*, Section 24
District and National Court jurisdiction

If relief is sought as compensation, or one of a number of orders, action can be taken in the National Court or a District Court. An action in the District or National Court is a formal legal process, which requires lodgement of appropriate court documents and would be better undertaken with the assistance of a lawyer. The accessibility of these courts to ordinary Papua New Guineans is questioned. Further, there are signs that the courts are struggling with increasing caseloads. “An expanding caseload has placed great pressure on the court system and led to lengthy delays in proceedings.”

The Magisterial Service administers, manages and sustains the operation of 70 District Court establishments, and 400 Court Circuit Court locations throughout the country. The District Courts provide a mechanism for the administration of justice and the resolution of disputes. Some relevant areas of District Court jurisdiction include: civil matters of up to K10,000; a summary criminal jurisdiction; village court appeals and administrative tribunals. A recent commentary on the law and justice system in PNG, noted in relation to the accessibility of District Courts, that: “There are currently 130 District Court Magistrates. This works out at only 1 magistrate per 36,000 people and less than 1.5 per administrative district. The deteriorating condition of court buildings and staff accommodation has also had an adverse impact in many areas.”

The civil jurisdiction of the National Court is for the trial of major matters involving an amount exceeding K10,000. Therefore, actions seeking sums over K10,000 in compensation would need to be taken in the National Court. While some cases seeking this level of relief would arise, most matters of discrimination and stigmatisation would be for lesser compensation figures than K10,000.

Literacy rates in PNG are low and English is the official language. However, over 715 indigenous languages are also spoken, and Melanesian pidgin remains the lingua franca, with Motu also widely spoken. The literacy rate remains between 58-71 percent.

Low literacy is also more heavily concentrated in rural areas and is greater for women. It would not be easy for a person who has low literacy to become aware that they had an actionable grievance under the HAMP Act, and then to take the necessary action to prosecute that action in the National or District Court.

Agriculture provides a subsistence livelihood for 85 percent of the population. It is estimated that approximately 37 percent of the population live below the poverty line. For many people in PNG, a journey to a regional centre to access the court registry, to file a complaint, would present considerable difficulty and expense. Access to legal assistance for poor people in civil matters is

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93 HAMP Act, Section 28. Includes declaration that an act is unlawful; an order not to repeat the act; an order for apology or retraction; damages and other orders of a restorative nature.
96 Dinnen S.  Op Cit
98 Ibid
99 Ibid
unlikely, and without it, it would be very difficult for an ordinary PNG villager to take a District or National Court action, to seek damages and other relief, for an actionable act of discrimination or stigmatisation.

Village courts

The village courts are a strong institution, well entrenched in PNG. It is undoubtedly the court most accessible to the ordinary people of PNG, who live mainly outside the cities.

Village courts provide an inexpensive, readily available means by which ordinary people can seek justice. It is estimated that 13,000 officials conduct 1,100 village courts, hearing about half a million cases every year. They operate under the Village Courts Act 1989 (passed in 1974) and the principal purpose is to maintain harmony within the community through mediation and application of customary law. Village courts existed in PNG well before the arrival of the British and their legal system.

“Village courts are ... used widely and constitute the most important hybrid institution established in the post-independence period. The effectiveness of informal processes is largely a consequence of the degree of social cohesion of rural communities.”

The village courts are the only court jurisdiction that truly reaches across PNG, and is accessible to most of the population. This is not to deny some significant problems in the operation of the village courts. Some reports have pointed to courts exceeding their jurisdiction, perpetuating violence against women, and showing little understanding of the broader legal framework in which they operate. Another report suggests that some of these negative accounts of the operations of village courts lack credibility, as they are based on anecdotes and not on representative research. The commentator puts forward his own research to suggest that village courts are, in fact, a useful resource for women and are successfully used by them.

Village courts are well entrenched in PNG, have an impressive reach, are known and understood by most of the population, are conducted in local language and do not require the lodging of complicated documents, onerous costs or legal representation. Small amounts of compensation can be awarded to K1,000. Orders can also be made to perform specified work, or work of a specified

100 See Department of Justice and Attorney General Village Courts website at www.justice.gov.pg/vc/, accessed 19 July 2007
102 Demian, M, “Custom in the Courtroom; Law in the Village; Legal Transformations in Papua New Guinea,” in The Journal of the Royal Anthropological Institute, Volume 9, Number 1, March 2003, pp. 97-115(19)
105 Village Courts Act 1989, Section 45
kind, for the benefit of an injured or aggrieved party. These could be quite useful remedies for small acts of discrimination or stigmatisation.

The Village Court Act 1989 sets out the jurisdiction of the village court. It has a general jurisdiction in relation to its geographical area if the dispute arose in its area, or all the parties are ordinarily resident in the area. It can also have jurisdiction if some of the parties are ordinarily resident and the rest consent to jurisdiction. The rules of evidence do not apply, but the Constitution imposes an obligation to apply the rules of natural justice. Parties may be represented by a person other than a lawyer.

The criminal jurisdiction applies in respect of prescribed offences. The offences are set out in the Village Court Regulation 1974, in Regulation 3.

The Act grants a number of jurisdictions to village courts, in addition to the general and criminal jurisdictions. These are civil, including matters related to some land disputes, bride price, custody or guardianship of children, customary marriage or illegitimate children.

106 Village Courts Act 1989, Section 44
107 See section 37(22) of the Constitution, which requires the powers and procedures of village courts to be exercised in accordance with the rules of natural justice; these rules are set out in Division 4 of the Constitution, sections 59 to 62
108 Section 41(a) of the Village Courts Act states that the village court has criminal jurisdiction in respect of prescribed offences for the purposes of this section. Regulation 3 of the Village Court Regulations purports to set out the prescribed offences but refers to them as being for the purposes of Section 22(a) of the Act. This appears to be an error. The correct section is section 44(a). The Regulations should be amended to correct the error.
109 The prescribed offences, for the purposes of the Village Courts Act are as follows:
   (a) taking or keeping, without the consent of the owner, the property of another to a value not exceeding K100.00;
   (b) striking another person without reasonable cause;
   (c) using insulting words or conduct;
   (d) using threatening words or conduct;
   (e) using offensive words or conduct;
   (f) intentional damage to trees, plants or crops belonging to another person;
   (g) intentional damage to trees, plants or crops belonging to the defendant and another person;
   (h) intentional damage to any other property belonging to another person;
   (i) making a false statement concerning another person that offends or upsets him;
   (j) spreading false reports that are liable to cause alarm, fear or discontent in the village community;
   (k) conduct that disturbs the peace, quiet and good order of the village, or of a resident of the village;
   (l) drunkenness in the village court area;
   (m) carrying weapons so as to cause alarm to others in the village court area;
   (n) failure to perform customary duties or to meet customary obligations after having been informed of them by a village magistrate;
   (o) failure to comply with the direction of a village magistrate with regard to hygiene or cleanliness within a village court area;
   (p) sorcery, including—
      (i) practising or pretending to practise sorcery; or
      (ii) threatening any person with sorcery practised by another; or
      (iii) procuring or attempting to procure a person to practise or pretend to practise, or to assist in, sorcery; or
      (iv) the possession of implements or charms used in practising sorcery; or
      (v) paying or offering to pay a person to perform acts of sorcery.

4. Records of settlement by mediation.
The court also has a preventive jurisdiction allowing it to act in order to prevent a dispute that may have caused a breach of the peace. The final jurisdiction granted in the Act is the mediatory jurisdiction, which states that the primary function of the court is to “ensure peace and harmony in the area for which it is established by mediating in, and endeavouring to obtain just and amicable settlements of disputes.”

The following areas of village court jurisdiction are examples that would fit well with complaints of discrimination or stigmatisation:

- using offensive words or conduct;
- making a false statement concerning another person that offends or upsets him;
- spreading false reports that are liable to cause alarm, fear or discontent in the village community; and
- conduct that disturbs the peace, quiet and good order of the village, or of a resident of the village.

The village courts apply custom. The Constitution establishes that custom is part of the underlying law of PNG. The Underlying Law Act 2000 sets out how custom is to be ascertained and applied. Ascertaining custom is to be done by having regard to submissions made by, or on behalf of, the parties concerning the customary law relevant to the proceedings. Village courts may also consider books and other relevant materials.

Custom may only be applied subject to the justiciable parts of the Constitution and, in particular, section 55 would be likely to be raised often in the context of village courts. It may only be applied subject to any applicable statute law. The question of the existence of a custom is a matter of law.

The village courts have no specific jurisdiction for the application of the HAMP Act, however, the legal infrastructure in which the village courts operate requires that they apply custom, subject to the Constitution and to other law. As they are bound to consider custom in this way, it would certainly be open to village court magistrates to consider the provisions of the HAMP Act in relation to discrimination and stigmatisation, when dealing with matters in the general jurisdiction, or in cases of insult or breach of the peace. They could also be applied in the preventive and the mediatory jurisdiction of the village courts. They may also have application in adultery, divorce and bride price cases.

To avoid confusion about the application of custom, and to ensure credibility and engagement with an initiative to introduce the application of HAMP Act principles into village courts, a law reform would be the simplest approach. A well publicised and implemented amendment to the HAMP Act was considered in 2005, in a project funded by the Australia Agency for International Development (AusAID), and is a large part of the Village Courts (VC) Project and training curricula will be developed to assist them to do so. This material will also need to briefly address the legal environment in which they presently operate, so as to assist them to fit some application of the HAMP Act into that legislative environment.

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110 See section 52
111 Underlying Law Act 2000, Section 6
112 Underlying Law Act 2000, Section 16
113 The options available to village court magistrates to apply the HAMP Act within their present jurisdiction was considered in 2005, in a project funded by the Australia Agency for International Development (AusAID), and is a large part of the Village Courts (VC) Project and training curricula will be developed to assist them to do so. This material will also need to briefly address the legal environment in which they presently operate, so as to assist them to fit some application of the HAMP Act into that legislative environment.
and the *Village Courts Act* would assist village courts administration, magistrates, peace officers and most importantly, the people who know and use the village courts in such large numbers throughout PNG, that the law has changed in relation to matters of stigmatisation and discrimination on the basis of HIV or AIDS.

While problems with village court jurisdiction have been acknowledged, they remain a highly accessible jurisdiction known and respected by ordinary Papua New Guineans. Proceedings are conducted in the local language, no complicated forms need be filled in, travel is generally not required, lawyers are not required and the process is not costly. As one commentator put it: “their strength lies in the provision of an accessible legal forum that is highly responsive to local expectations. Their location between the national court system and local dispute resolution makes them an important point for creative interaction between formal and informal justice sectors.”\(^\text{114}\)

Further, the suggested additional jurisdiction will fit very well with the existing criminal jurisdiction of the village courts.

Such a reform would also be an excellent example of the use of restorative justice. One commentator, who noted the damage done to societies by crime, also noted the importance of the use of restorative justice to rebuild and restore harmony. He states that “empowering communities to manage conflict in this way can thus become an important force for community development.” It is suggested that empowering village courts with a limited *HAMP Act* jurisdiction will empower local communities to use traditional methods of restorative justice, to address stigma and discrimination based on HIV status.

**Legislative amendment to give village courts limited jurisdiction under the HAMP Act**

It is suggested that the necessary amendment should be limited to matters of discrimination and stigmatisation, and should add to the criminal jurisdiction of the village courts. This is because the nature of village courts jurisdiction best lends itself to consideration of matters of discrimination and stigmatisation. Matters such as dismissal from employment, or improper conduct on the part of a health practitioner, are better managed under the other avenues of relief provided by the *HAMP Act*.

Other amendments would be necessary to make both Acts consistent and workable. Other parts of the criminal jurisdiction of village courts may also be expanded to encompass *HAMP Act* principles. For example, using insulting words or conduct, or using offensive words or conduct.\(^\text{115}\)

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\(^{114}\) Dinnen, Op Cit

\(^{115}\) See Regulation 3, *Village Courts Regulation 1974*
Amending legislation could also slightly expand jurisdiction in cases of insult or breach of the peace, and enable HAMP Act principles to be applied in the preventive and mediatory jurisdiction of the village courts. They may also have application in adultery, divorce and bride price cases.

The possible situations giving rise to discrimination, as set out in Section 7 of the HAMP Act, should be limited in the village courts jurisdiction to subsections (f) provision of accommodation, and (h) access to goods, services or public facilities. Other examples of discrimination included in Section 7 would not be suitable for application in a village court jurisdiction—these include employment, partnerships, industrial and professional organisations, education and training, and detainees and persons in custody.

The confidentiality provisions of the HAMP Act would apply to the operation of HAMP Act jurisdiction in village courts. Witnessing the very public nature of village court hearings and noting that, on many occasions, villagers attend to watch proceedings, it is acknowledged that protection of confidentiality in the village setting would be difficult given the nature of village courts and village life. It is suggested that this issue could be addressed in two ways. The first approach is the hearing, where the status of the person infected or affected by HIV or AIDS is already known, and a public direction as to their rights and the illegality of discriminatory acts and practices would be a benefit to that person. This may be a complaint about gossip or a public act of discrimination. In this scenario, a confidential hearing is unnecessary, even undesirable, and the usual arrangements would be appropriate. This would also be consistent with the parallel objective of “mainstreaming” HIV.

In a second scenario, where the person concerned wished to keep his or her status as a person affected or infected by HIV confidential, this confidentiality must be protected. Support should be sought from the village courts Secretariat, as part of the implementation strategy for the law reform to provide the necessary information, training, facilities and monitoring, and to ensure this is strictly applied. The effective convening of closed hearings would have to be routinely available in every village court.

In relation to remedies, it is suggested that current remedies available in village courts jurisdiction would be adequate. Small amounts of compensation can be awarded to K1,000. Orders can also be made to perform specified work, or work of a specified kind, for the benefit of an injured or aggrieved party. Orders could also address the right of a person infected or affected by HIV to leave peaceably in the village. These could be quite useful remedies for small acts of discrimination or stigmatisation.

\[116\] The options available to village court magistrates, to apply the HAMP Act within their present jurisdiction, was considered in a 2005 project funded by AusAID. Training curricula will be developed to assist them; this will also need to briefly address the legal environment in which they presently operate, to help them apply some of the HAMP Act into that legislative environment.

\[117\] Village Courts Act 1989, Section 45

\[118\] Village Courts Act 1989, Section 44
Module 4—General duty

What is in this module?

This module puts forward the policy proposal to replace traditional nuisance powers found in many Pacific public health Acts. The new proposed legislative text creates a general duty to prevent or minimise harm to public health. This approach does not exclude dealing with specific risks to public health if that is deemed desirable. If there is a breach of the general duty, compliance may be enforced by the issuance of a notice under [insert relevant section when confirmed].

The offences of significant risk to public health and serious risk to public health are also established. These create responsibilities for the public to observe the duty to minimise harm to the public health, and create offences and sanctions to address the times when that duty is breached and causes either significant or serious harm.

This module includes two flowcharts to assist with understanding and using the legislative text:

1. operation of the general duty to prevent or minimise harm to public health; and
2. operation of the general public health offences

How do public health Acts currently address public health risk?

The public health laws of Vanuatu, the Solomon Islands and Fiji use the legislative mechanism of “nuisance” to manage low level public health risks. PNG does not do so and appears, instead, to rely on the lawmaking powers of provinces and local-level governments to manage these low level public health risks. However, no provincial or local-level local public health law was able to be found when preparing this paper, so this available mechanism does not appear to be utilised.

The definition of nuisance is very similar between all three jurisdictions and has the following features:

1. “Nuisance” is broadly defined. Vanuatu, Fiji and the Solomon Islands have almost identical definitions. For example, in Vanuatu, a nuisance is anything which injures or is likely to injure health, and which is able to be fixed either:
   • by the individual who caused the nuisance;
   • by a person or body in charge of the area where the nuisance exists; or
   • the local authority (municipal council).

In addition to the definition in the definition section, at the front of the Act, a further detailed definition of nuisance is provided in the nuisance part of the Act.\(^\text{119}\) It broadly covers both the built and natural environment, rubbish, water collection, cemeteries, factories, septic tanks, keeping of

\(^{119}\) Public Health Act, Section 24
animals and many other things. It also refers to dwellings or premises that are of such a condition as to give rise to the spread of an infectious disease, not a “notifiable disease”. In Fiji, it is sufficient that the matter be simply “offensive”, such as the accumulation of material in workplaces. Offensive trades or businesses are included.

2. **The Acts establish a positive duty not to create a nuisance.**

3. **Duties and powers to issue notices are created for people such as medical officers, and for bodies such as local authorities, to respond to and manage a nuisance.** Generally, these are discretionary, which means that those with power to issue notices may choose whether to do so or not. This is important as the meaning of nuisance is broad and would capture many small matters that ought not to attract an administrative abatement order. For example, in Vanuatu, local authorities have a duty to remedy a nuisance or require it to be remedied if it is liable to be injurious or dangerous to health, or to give rise to the spread of any infectious disease (note, not a notifiable disease).

In Fiji for example, local authorities are given responsibility to abate a nuisance. If the local authority is satisfied that a nuisance exists, it may serve a notice on the person who is responsible for the nuisance, or the owner or occupier of the premises. The notice will require the person to abate the nuisance, or to carry out such action as required, or do works or such things as are required.

In the Solomon Islands, local authorities are given a positive duty to take all lawful, necessary and reasonably practicable measures to ensure the district is maintained in a clean and sanitary condition. They must also prevent the occurrence; remedy the cause, of any nuisance or condition liable to be dangerous to health or injurious; and take any proceedings at law against any person causing or responsible for the continuance of any such nuisance or condition. “No person shall cause a nuisance or shall suffer to exist on any land or premises owned or occupied by him or of which he is in charge any nuisance or other condition liable to be injurious or dangerous to health.”

The laws then usually provide a power to prosecute the creator of a nuisance in the event of a breach or non-compliance with an abatement order.

Features of the mechanism of nuisance include flexibility in the definition, an ability to seek abatement of the nuisance, and powers to seek a court order in the event of a failure to comply with an order. However, the term itself is problematic in that it is neither familiar nor resonant in a Pacific environment.

Respondents to the questionnaire at a workshop held on 20 February 2009, on the use of the *Vanuatu Public Health Act*, showed that public health officials had a good understanding of the nature of nuisance, as set up in the Act, but generally thought the term should change.

Many of the regional public health laws also use nuisance as the legislative mechanism to manage other public health risks. For example, in the Solomon Islands, nuisance is the basis of control of...
mosquitoes (together with the *Public Health (Malaria Eradication) Rules*) by making the breeding places nuisances.\(^\text{124}\) This part contains obligations re receptacles,\(^\text{125}\) water tanks,\(^\text{126}\) septic tanks\(^\text{127}\) and larvae.\(^\text{128}\)

Most of the regional public health laws also, in some measure, cover “offensive trades”. Pacific public health officers reported little or no use of these sections of the public health laws.\(^\text{129}\) This is not surprising as few Pacific countries have trades such as fellmongery, tripe boiling and arsenic works. There are some examples of industries in the pacific where use may be made of such provisions. Examples include pearl farming in the Cook Islands and pig farming and phosphate mining in Nauru.

The provisions creating the general duty not to create a nuisance, and the powers to require abatement, have been flexible but awkwardly drafted for the Pacific, and are redolent with the language of industry in Britain in the nineteenth century.

**What do Pacific public health officers say about nuisance?**

Amongst all groups (Environmental Health Officers, Directors and general health workers) there was a good understanding of the legal mechanism of nuisance and the concepts behind it. However, there was general concern, tempered with humour, at the inappropriateness of some parts of the definition. For example, the definition of nuisance in Vanuatu refers to chimneys, effluvia, privies, water closets and earth-closets.\(^\text{130}\) Reference to such provisions evoked outright laughter among some interviewees when asked about their applicability in the context of the modern Pacific. As one participant pointed out, quite matter-of-factly: “of course your nuisance provisions, it’s not really reflective of what the situation is and it would be fair to say we need to go through the language of the Act and see what is appropriate. I think it’s too specific, and it’s too restrictive in a way.”\(^\text{131}\)

Officers had already reported that they found the old style nuisance provisions too specific and too detailed. The response to a suggestion it be replaced by “public health risk” was strongly supported. “The term ‘public health risk’ is much better. It clearly defines the relation to health. I think the term nuisance is somewhat ambiguous. The term public health risk has more meaning and there is instant agreement on what it means.”

**Policy questions for consideration**

There is general agreement among officers working with public health laws in the Pacific, that the term “nuisance” is old and outdated. However, it is a big undertaking to reform the old term nuisance and to replace it with the new general duty to prevent or minimise harm to public health.

\(^{124}\) *Environmental Health (Public Health Act) Regulations*, Reg 34
\(^{125}\) *Environmental Health (Public Health Act) Regulations*, Reg 35
\(^{126}\) *Environmental Health (Public Health Act) Regulations*, Reg 35
\(^{127}\) *Environmental Health (Public Health Act) Regulations*, Reg 36
\(^{128}\) *Environmental Health (Public Health Act) Regulations*, Regs 37 and 38
\(^{129}\) Etheridge and Howse, Op Cit
\(^{130}\) *Public Health Act* 1994 (Vanuatu), Section 24
\(^{131}\) Etheridge and Howse, Op Cit
Preconditions

Are resources available for a broad-ranging communication strategy aimed at training officers in government, and local-level government officers, and key people within regional areas such as people in health clinics, women’s groups and village elders?

Part 1—General duty to prevent or minimise harm to public health

401—General duty

(1) A person must take all reasonable steps to prevent or minimise any harm to public health caused by, or likely to be caused by, anything done or omitted to be done by the person.

(2) In determining what is reasonable for the purposes of subsection (1), regard must be had, amongst other things, to the objects of this Act, and to—

(a) the potential impact of a failure to comply with the duty; and
(b) any environmental, social, customary, economic or practicable implications; and
(c) any degrees of risk that may be involved; and
(d) the nature, extent and duration of any harm; and
(e) any relevant code of practice under Part 8;
(f) any matter prescribed by the regulations.

(3) A person shall be taken not to be in breach of subsection (1) if the person is acting—

(a) in a manner or in circumstances that accord with generally accepted practices taking into account community expectations and prevailing environmental, customary, social and economic practices and standards; or
(b) in accordance with a policy or code of practice published by the Minister in connection with the operation of this Part; or
(c) in circumstances prescribed by the regulations.

(4) Subject to subsections (5) and (6), a person who breaches subsection (1) is not, on account of the breach alone, liable to any civil or criminal action.

(5) If a person breaches subsection (1), compliance with the subsection may be enforced by the issuing of a notice under Part 12.

(6) Subsection (4) does not limit or derogate from any other provision of this Act.

Flow Chart for operation of general duty

In order to make it easier for officers to indentify when a the general duty arises, the flow chart below is intended to show the operation of the duty and may be used as a tool to assist environmental health officers in the application of the law.
Health Legislation in the Pacific – Modules with legislative text

Module 4
General Duty
Flow Chart

act or omission

Does it breach the general duty?

General Duty
to prevent or minimise harm to the public health
A person must take all reasonable steps to prevent or minimise any harm to public health caused by; or likely to be caused by anything done or omitted to be done by the person

Were reasonable steps taken to prevent or minimise harm?

Who???

Any restrictions on use of powers?

A determination on whether reasonable steps were taken can be made after having regard to:

- Objects of the Act
- Potential impact of a failure to comply with the duty
- Environmental, social, customary, economic or practicable implications
- Any degrees of risk which may be involved
- The nature, extent and duration of any harm
- Any relevant code of practice under Part 8
- Any matter prescribed by the regulations

Was the person acting in a manner or in circumstances that accord with generally accepted practices taking into account community expectations and prevailing environmental, customary, social and economic policies and standards?

Act to enforce court decision

No

Is decision made to enforce compliance?

Breach of general duty has occurred

No

Is the person acting in accordance with a policy or code of practice published by the Minister in connection with the operation of this part of the Act?

Issue notice under part 12

No

Risk abated?

Court prosecution

No

Risk abated?

Risk abated?

Perhaps follow up with information, education, training or counselling.

No further action under the law

Yes

No

Yes

Breach of general duty

Was the person acting in a manner or in circumstances that accord with generally accepted practices taking into account community expectations and prevailing environmental, customary, social and economic policies and standards?

Yes

Act to enforce court decision

No

Court prosecution

No

Risk abated?

Issue notice under part 12

Yes

Is decision made to enforce compliance?

No

No

Yes

Any restrictions on use of powers?
Part 2—General public health offences

402—Significant risk to public health
(1) A person who—
(a) intentionally or recklessly causes a significant risk to public health; and
(b) does so in the knowledge that harm to public health will result or is likely to result
is guilty of an offence.

Maximum penalty: 2,500 penalty units or imprisonment for 5 years or both.

(2) A person who—
(a) causes a significant risk to public health; and
(b) does so in circumstances where a person should reasonably be expected to know that
harm to public health will result or is likely to result
is guilty of an offence.

Maximum penalty: 1,200 penalty units or imprisonment for 2 years or both.

(3) A person who causes a significant risk to public health is guilty of an offence.

Maximum penalty: 500 penalty units.

(4) For the purposes of this section, a significant risk to public health occurs when an act or
omission by a person or persons harms or might reasonably be expected to harm the health of
one or more persons, but does not include a case where the harm, or risk of harm, is trivial or
minor.

403—Serious risk to public health
(1) A person who
(a) intentionally or recklessly causes a serious risk to public health; and
(b) does so in the knowledge that harm to public health will result or is likely to result
is guilty of an offence.

Maximum penalty: 10,000 penalty units or imprisonment for 10 years or both.

(2) A person who—
(a) causes a serious risk to public health; and
(b) does so in circumstances where a person should reasonably be expected to know that
harm to public health will result or is likely to result
is guilty of an offence.

Maximum penalty: 5,000 penalty units or imprisonment for 7 years or both.

(3) A person who causes a serious risk to public health is guilty of an offence.

Maximum penalty: 1,200 penalty units.
(4) For the purposes of this section, a serious risk to public health occurs when an act or omission by a person or persons harms or might reasonably be expected to cause serious harm to the health of one or more persons.

(5) Without limiting subsection (4), in making a determination about whether a serious risk to the public health under subsection (4) has occurred or is likely to occur, the following matters might be taken into account—
(a) the nature, scale and effects of the harm, and any associated illness, injury or disability, that may arise; and
(b) the location, immediacy and seriousness of the threat to human health; and
(c) the total number of persons affected or likely to be affected; and
(d) the availability and effectiveness of any precaution, safeguard, treatment or other measure that may be used to eliminate or reduce the harm.

404—Defence of due diligence

(1) In any proceedings against a person for an offence under this Part, it is a defence to prove that the person took all reasonable precautions and exercised all due diligence to prevent the commission of the offence.

(2) Without limiting subsection (1), it is not proved that a person took all reasonable precautions and exercised all due diligence to prevent the commission of the offence under this Part unless it is proved that the person—
(a) had taken reasonable steps to prevent or avoid the circumstances that gave rise to the risk to public health, including by putting in place any systems or safeguards that might reasonably be expected to be provided; and
(b) complied with the requirements of any notice or order under this Act that related to the risk to public health; and
(c) as soon as becoming aware of the circumstances that gave rise to the risk to public health—
   (i) reported those circumstances to the Chief Public Health Officer, the Department or a council; and
   (ii) took all reasonable steps necessary to prevent or reduce the risk to public health.

405—Alternative finding

If in proceedings for an offence against this Part the court is not satisfied that the defendant is guilty of the offence charged, but is satisfied that the defendant is guilty of an offence against this Part that carries a lower maximum penalty (determined according to relative maximum monetary penalties), the court may find the defendant guilty of the latter offence.
Module 5—Communicable conditions, non-communicable conditions and notifiable diseases

What is in this module?

This module presents a suggested approach to communicable and non-communicable diseases and conditions and notifiable diseases.

Non-communicable diseases and conditions

In the Pacific, there is an increasing burden of non-communicable diseases (NCDs), with the risk factors of tobacco use, physical inactivity, and unhealthy diets and obesity contributing to that burden. The burden of NCDs was once felt disproportionately in highly industrialised countries. However, chronic diseases are now the major cause of death and disability worldwide and increasingly affect people from resource-poor countries. The latest available data (from 2001) show that chronic diseases contributed to 59 percent of the 56.5 million total reported deaths in the world and 46 percent of the global burden of disease. If the trend continues, by 2020, NCDs will account for 80 percent of the global burden of disease, causing seven out of every ten deaths in developing countries. 132, 133, 134

Pacific island countries and areas have taken action in response to the recommendations of the Vanuatu Commitment, through various NCD prevention and control programs. There is a need to expand, sustain and synergise the various interventions with evaluations. 135

For non-communicable diseases and conditions this module proposes a neat mechanism, which will enable the declaration of a non-communicable condition, leading to a power to create guidelines. This is flexible. Countries may have different approaches to non-communicable diseases and may wish to address them at different times in different ways. This mechanism means that when ready, the law will enable codes of practice with some legislative force.

Customary measures were identified by Pacific public health officers as potentially providing useful and broadly acceptable support to the promotion of health and the prevention of disease. The power to create codes of practice includes codes in relation to a customary practice in a specified area. This can only occur after receipt of advice from the local health advisor in consultation with the affected community.

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133 PNG National Health Plan


135 WHO and SPC, Eighth meeting of Pacific Health Ministers, Op Cit
Communicable diseases and conditions

Communicable diseases continue to burden the population of the Pacific. In particular, HIV/AIDS remains a risk to be controlled. Emerging communicable diseases also continue to cause concern. Globalisation and the International Health Regulations (2005) mean that countries have to consider domestic approaches to communicable disease, and then be ready to take their part in the management and reporting of public health emergencies, of regional and international concern.

Outbreaks of communicable disease are well known public health risks. Threats, from the plague and Spanish flu to H1N1, have historically and more recently caused widespread suffering for people in all parts of the globe. More are expected in the future.

It is worth noting that countries in the Pacific responded quickly to the pandemic threat of H1N1 ("swine flu"). WHO declared a public health event of international concern on 25 April 2010. The virus spread rapidly to other countries. WHO raised the level of pandemic alert to phase 4 on 27 April, phase 5 on 29 April, and phase 6 (the highest level—pandemic phase) on 11 June. As of 7 July, 136 countries and areas had officially reported 95,207 confirmed cases of influenza A(H1N1) infection, including 430 deaths. More than half of the Pacific island countries and areas have reported cases of the pandemic influenza. It is thought that the virus will eventually reach all countries of the world. The aim of control measures is to slow down the transmission, in order to preserve the health care system and other essential services, while also gaining more time to wait for an effective vaccine to become available, which may take several months.

Outbreaks often happen quickly and countries must have the capacity to take actions, such as collecting data, monitoring and conducting surveillance, undertaking laboratory testing where possible or necessary, and affecting a response based on all information received, to contain the spread in the event of an outbreak. It is therefore crucial that countries have laws enabling an adequate response. Strengthened laws addressing the protection of public health and prevention of disease sub-nationally make a significant contribution to addressing outbreaks at an early, more manageable stage. This addresses domestic disease management and control, and contributes to more effective compliance with the IHR for a modern, flexible public health law in Pacific countries. Laws also have to be sufficiently flexible to envisage different kinds of responses to contain an outbreak of a communicable disease, as the mode of spread of the disease can differ. The country also needs to have core competencies to take any health measures required by WHO.

This module offers a process to manage occurrences of controlled communicable diseases, in individuals posing a threat to the public health. The powers are appropriately strong, and enable testing, treatment, counselling and ultimately detention of individuals who may have contracted a communicable disease, and who are behaving in a manner that may place others at risk of infection. The powers are compliant with human rights principles. Derogations from these principles are in

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conformity with the Siracusa Principles, which provide guidance on where such derogation is appropriate and justified.\footnote{Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, provide a template for State action in a public health emergency. See \url{http://graduateinstitute.ch/faculty/clapham/hrdoc/docs/siracusa.html} accessed 12 January 2012}

The module also offers a mechanism for the recognition of regional medical orders, to enable public health orders to be effective across the region, for countries wishing to participate in a regional cooperation in relation to the sharing of information and public health orders. Other matters may also be useful subjects for a cooperative regional approach, and more detail may be found in a paper prepared as part of the work on this Reviewers’ Companion.\footnote{See Public Health Act, Chapter 111 (Fiji) and Public Health Act 1994 (Vanuatu).}

How do Pacific public health laws presently address the management and control of communicable diseases?

Generally, in the Pacific and elsewhere, legislative systems for management of communicable disease set up a process with several steps:

1. A category of diseases called “notifiable diseases” is created in the law. The term is usually found in the definition section of an Act and defined to mean a disease included on a list in a schedule to the Act.\footnote{Environmental Health (Public Health Act) Regulations, Reg 32(2)} This is a very important legislative mechanism, which identifies the diseases that may be the subject of statutory control measures.

2. The list of notifiable diseases needs to be included somewhere in the law and this is usually done by a schedule or regulations. Regulations and schedules are easier to amend than a principal Act, and the list may need to be updated urgently, from time to time, if a new disease emerges whose management may require use of public health Act powers. Examples from recent years include avian influenza, SARS and H1N1.

3. In Vanuatu, notifiable diseases are listed in Schedule 1 of the Act and in the Solomon Islands it is Schedule 2 of the Regulations. In most regional laws, the Minister is able amend the schedule of notifiable diseases via a notice\footnote{Public Health Act 1994, Section 21} in the Government Gazette. In Vanuatu, the Minister also has power to make exemptions from the provisions of this part in relation to any specified notifiable disease.

4. The law usually requires certain qualified people to notify the ministry when it appears that a person has a notifiable disease, or has died from one, although this can be problematic in some Pacific countries due to the scarcity of post mortem examinations. This responsibility is intended to ensure that important data on emerging health risks or disease patterns makes its way quickly to a central point, where the progress of outbreaks or clusters of disease may be monitored. This will assist with decision making, or the use of powers to abate any risk to the public health. This data is also needed to comply with obligations under the \textit{International Health Regulations}.  

\footnote{Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, provide a template for State action in a public health emergency. See \url{http://graduateinstitute.ch/faculty/clapham/hrdoc/docs/siracusa.html} accessed 12 January 2012}
5. Responsibility is given to an individual to decide whether there is a risk to public health from a possible spread of the disease. In Pacific public health laws, this is often the Minister, although powers are also given to local authorities, and various authorised officers.

6. Once a potential outbreak of a notifiable disease giving rise to a public health risk is identified, all Pacific public health laws trigger powers for ministers, authorised officers, and others to take a range of actions to contain the spread of disease.

Many modern public health laws contain measures to protect the rights of those affected by the exercise of powers under public health Acts. These measures are consistent with the Siracusa Principles,\(^{142}\) which set out where derogations for the *International Covenant on Civil and Political Rights* might be permitted. These might include a proportional response to an identified risk to the public health, use of the least restrictive option, protection of the confidentiality of sensitive health information, and access to reviews of administrative decisions and appeals and authorised by law. However, the age of most public health laws precludes the application of the Siracusa Principles, which were published in 1984. As the constitutions of Pacific countries are often more recent and more progressive than their public health laws, many of the constitutions do include rights derived from the *International Covenant on Civil and Political Rights* and the *Universal Declaration on Human Rights*. This could raise the legal question of the constitutionality of many of the strong powers within present Pacific public health laws, which are inconsistent with rights guaranteed in their constitutions. Some countries’ constitutions contain a public interest exemption from the operation of some constitutional rights, including the protection of public health, so the operation of the public health powers would need some careful consideration to establish their validity.

The present Pacific approach to communicable disease is heavy in its use of command and control mechanisms,\(^{143}\) without the use of provisions limiting the breadth of such powers, and protecting the rights of those affected by the laws. For example, in Vanuatu and the Solomon Islands, onus is placed on the heads of households to report on a family member contracting a communicable disease. Many have sections on compulsory treatment. In Vanuatu, if a person knows he is suffering from a notifiable disease and wilfully exposes himself, without proper precaution against spreading the disease in any street, public place, shop or public conveyance, without informing the driver, he shall be guilty of an offence and liable on conviction to a fine not exceeding VT300,000 or three years imprisonment.\(^{144}\) Fiji, Cook Islands and the Solomon Islands have similar provisions. It may be that modes of transmission are considered in finalising legislative policy on management of communicable disease.

In a very dated approach to communicable disease management, both the Vanuatu and Solomon Islands public health laws place an almost identical responsibility on the head of the family when “he becomes aware or has reason to suspect” a person is suffering from a notifiable disease. The head of the family must consult specified officers, which differ slightly in each jurisdiction.\(^{145}\) It is difficult to imagine a modern public health law placing such an onerous requirement on a person who is not

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143 Gostin, L.O, *Public Health Law, Duty, Power, Restraint*

144 *Public Health Act*, Section 13(1)

145 *Public Health Act* 1994, Section 8
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medically trained, in an age when diagnosis of many notifiable diseases requires pathology tests. It also illustrates lawmaking from another era, when the head of the household might have taken responsibility for the medical treatment of all family members.

Both countries also place responsibility on “any medical practitioner or nurse attending on the patient who becomes aware or has reason to suspect” a patient is suffering from a notifiable disease, or food poisoning, to notify the area medical officer.

In Vanuatu, if a medical practitioner or nurse “becomes aware or has reason to suspect” any person has died of a notifiable disease, he or she must give a written certificate to the area medical officer. There is no requirement in this section for notification to a central point. However, these medical officers have no further obligation to notify the Director General or a central head of disease control. These provisions re notification of notifiable diseases are rather confusing and do not guarantee that all data reaches a central point.

In a more recent law, PNG has taken a human rights approach to HIV in its HIV/AIDS Management and Prevention Act 2003. The implementation of this Act has not been free of difficulty,146 and countries need to consider the preconditions necessary for implementation when they are drafting a new law. Modes of transmission remain a relevant consideration. In the event of a review of Pacific public health laws, this area would be highly recommended for reform.

A feature of the powers to manage notifiable diseases in regional public health laws is their awkward drafting, which leads to a difficulty in establishing who has power to act, and what powers are available in a given set of circumstances. For example, in Vanuatu, there is no obligation to report notifiable diseases to the Director General or to a central head of disease control.

A further problem in the Vanuatu law is that slightly different systems seem to operate for “notifiable diseases” and for “diseases”. “Disease” would seem to be a broader term that encompasses notifiable diseases, but this is not entirely clear. The term “disease” is also not defined. Any review should address this issue and clarify the delegation of powers, making it clear who has powers and under what circumstances.

Further, there is considerable confusion about who appoints “authorised officers”, and what they can do and in what circumstances. This part of the Act, relating the powers to prevent and manage an outbreak, needs immediate review and reform. If Vanuatu was to rely on these powers to

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146 See Howse G, insert HIV paper reference
empower a cohort of officers to act to address a public health risk, from the outbreak of a notifiable disease, these awkwardly drafted powers potentially give rise to a great deal of confusion and possibly officers acting inadvertently without power.

In addition, the laws are almost uniformly confusing in the allocation of responsibility to act in the event of an outbreak of a public health risk or a public health emergency.

What do Pacific public health officers say about the operation of current legislative provisions on notifiable diseases and communicable disease management?

Public health officers are well aware of the advancing risk of non-communicable diseases. As one said:

_In a very short time it has been developed you find many people are suddenly exposed to things that the world has gone through and they feel that is not good for their health. So they think they can eat these things like lamb flaps. It is easy to eat and it is cheap. So that is like an individual choice. But if government can have legislation to prevent the import of things that could easily be used by people who are a bit illiterate it would be good._ (PHD4)

In all countries where we conducted interviews, the outdated lists of notifiable diseases were being disregarded as largely irrelevant. Many officers reported that the current legislation fails to provide the basis for disease reporting and surveillance, and there is extremely limited alignment between actual public health surveillance data collection systems and the diseases currently set out in Pacific notifiable disease schedules. Moreover, due to general capacity weakness in surveillance methodology and systems, there was limited awareness of how the surveillance system should link with legislation.

Senior health officials, such as Directors, tended to have a good sense of the processes for amendment of the notifiable diseases list. One Director spoke of having their notifiable list updated for the Influenza A virus during the 2009 H1N1 outbreak, so that public health powers could be triggered accordingly. It was certainly observed that such amendments to the list of notifiable diseases tended to be reactionary, rather than undertaken in a systematic fashion.

In line with their roles and functions within the ministry and the legislations, Environmental Health Officers and the wider cohort of health workers had a limited awareness of what would trigger new diseases being added the list of notifiable diseases. Answers ranged from “don’t know” through to “needs to be addressed”.

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147 Etheridge and Howse, Op Cit
Non-communicable diseases and conditions

Part 1—Management and control of non-communicable diseases and conditions

501—Declaration of non-communicable conditions
(1) The Minister may, by notice in the Gazette, declare a disease or medical condition (such as cancer, cardio-vascular disease or diabetes) to be a non-communicable condition if the Minister considers that the disease or medical condition is of significance to public health.

(2) The Minister may, by further notice in the Gazette, revoke a declaration under subsection (1).

502—Minister may issue code of practice
(1) The Minister may issue a code of practice in relation to preventing or reducing the incidence of a non-communicable condition.

(2) A code of practice may relate to—
(a) an industry or sector;
(b) a section or part of the community;
(c) an activity, undertaking or circumstance;
(d) after receiving advice from the local health advisor in consultation with the affected local community, a customary practice in a specified area.

(3) Without limiting subsection (1) or (2), a code of practice may relate to the manner in which, for the purposes of public health—
(a) specified goods, substances or services are advertised, sponsored, promoted or marketed (including through the provision of certain information to consumers of certain goods, substances, or services);
(b) specified goods or substances are manufactured, distributed, supplied or sold (including the composition, contents, additives and design of specified goods or substances);
(c) buildings, infrastructure or other works are designed, constructed or maintained;
(d) the public, or certain sections of the public, are able to access specified goods, substances or services;
(e) a customary practice is carried out.

(4) The Minister must, before issuing or amending a code of practice, insofar as is reasonably practicable, consult with any person or organisation that the Minister considers to be representative of any industry or sector affected by the proposed code or amendment.

(5) The Minister may publish a report on the performance of an industry, sector, local community or person in relation to a code.

(6) The Minister must, before publishing a report under subsection (5) that would reasonably be expected to have an adverse impact on a person specifically identified in the report, provide a copy of the report to the person and then allow the person at least 14 days to make representations in relation to the contents of the report.
(7) No action lies against the Minister in respect of the contents of a report published under this section.

Part 2—Management and control of communicable diseases, micro-organisms and medical conditions

Division 1—Preliminary

503 Principles applying to the management of controlled communicable diseases
The following principles apply to the management and control of controlled communicable diseases—
(a) the spread of a controlled communicable disease should be prevented or minimised with the minimum restriction on the rights of any person;
(b) a person at risk of contracting a controlled communicable disease should take all reasonable precautions to avoid contracting the controlled communicable disease;
(c) a person who has, or suspects that they may have, a controlled communicable disease should—
   (i) ascertain whether he or she has a controlled communicable disease and what precautions he or she should take to prevent any other person from contracting the controlled communicable disease; and
   (ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the controlled communicable disease;
(d) a person who is at risk of contracting, has or suspects he or she may have, a controlled communicable disease is entitled—
   (i) to receive information about the controlled communicable disease and any appropriate available treatment;
   (ii) to have access to any appropriate available treatment.
(e) discrimination, in all its forms and subtleties, against individuals with a communicable disease, or persons perceived or believed as having a communicable disease shall be considered inimical to individual and state interest.

504—Least restrictive option to be chosen
If in giving effect to this Division alternative measures are available which are equally effective in minimising the risk that a person poses to public health, the measure which is the least restrictive of the rights of the person should be chosen.

505—Declaration of controlled communicable diseases
(1) The regulations may declare a disease or medical condition to be a controlled communicable disease.

Note: A controlled communicable disease is one which is considered to present a higher risk to the public health than other communicable diseases and is therefore subject to greater legal controls.
(2) The Minister may, if he or she considers it to be necessary in the interests of public health because of urgent circumstances, by notice in the Gazette, declare a disease or medical condition to be a controlled communicable disease.

(3) A regulation or declaration under subsection (1) or (2) may be varied from time to time, or may be revoked, but a declaration of the Minister under subsection (2) will, unless revoked sooner, expire 6 months after publication in the Gazette.

(4) The revocation or expiry of a declaration of the Minister—
(a) does not prevent the disease or medical condition the subject of the declaration being declared to be a controlled communicable disease by the regulations; and
(b) does not prevent the disease or medical condition being the subject of a further declaration of the Minister if the Minister considers that urgent circumstances again warrant the declaration of the disease or medical condition to be a controlled communicable disease.

506—Chief Public Health Officer to be able to act in other serious cases

(1) In this section—
serious disease, in relation to a particular person, means a disease—
(a) which is, or may be, infectious; and
(b) which the Chief Public Health Officer reasonably believes to present a serious risk to public health.

(2) This section applies to a person if—
(a) the Chief Public Health Officer has reason to believe that the person (the relevant person) has, or has been exposed to, a serious disease; and
(b) the disease is not a controlled communicable disease; and
(c) the Chief Public Health Officer determines that it is appropriate for action to be taken under this section; and
(d) the Chief Public Health Officer serves notice of the determination on the relevant person.

(3) In a case where this section applies—
(a) the serious disease will, in relation to the relevant person, be taken to be a controlled communicable disease; and
(b) the Chief Public Health Officer may take action under this Part in relation to the relevant person as if the person had a controlled communicable disease.

(4) This section will cease to apply to a relevant person—
(a) if the Chief Public Health Officer revokes his or her determination under subsection (2)(c); or
(b) at the expiration of 28 days from service of the notice under subsection (2)(d); or
(c) if the serious disease is declared to be a controlled communicable disease under this Part, whichever first occurs.

(5) The fact that this section ceases to apply to a person—
(a) does not effect any order, requirement or direction that applies in relation to the person immediately before the time that this section ceases to apply if the serious disease that gave rise to the application of this section has been declared to be a controlled communicable disease under section 66 (and is a controlled communicable disease at the time that the section ceases to apply); and
(b) does not prevent the section applying to the person again if the Chief Public Health Officer has a reason to believe that the person is again suffering from, or has been exposed to, another serious disease (and the other requirements of subsection (2) are satisfied).

507—Children

(1) If a requirement is imposed under this Part in relation to a child—
   (a) a parent or guardian of the child who is aware of the requirement must take such steps as are reasonably necessary and available to achieve compliance with the requirement; and
   (b) any requirement to serve any notice or other document will be satisfied if service is effected on a parent or guardian of the child.

(2) The regulations may make other modifications to the operation of this Part in relation to its application to children (and those modifications will have effect accordingly to their terms).

(3) A person who fails to comply with subsection (1)(a) is guilty of an offence.

Drafting Note: A number of Pacific countries have obligations under the ICRC and should consider these obligations in relation to this section and the public health law generally.

Maximum penalty: 200 penalty units.

(4) In this section—
   child means a person under 16 years of age;
   parent includes a person in loco parentis.

Drafting note: “In loco parentis” means in place of parents. Different countries may express this meaning in the laws in different ways.

Division 2—Controls

508—Power to require a person to undergo an examination or test

(1) The Chief Public Health Officer may impose a requirement under this section if subsection (2) or subsection (3) applies.

(2) This subsection applies if the Chief Public Health Officer has reasonable grounds to believe—
   (a) that a person has a controlled communicable disease and the person presents, has presented, or is likely to present, a risk to health through the transmission of that disease; or
   (b) that an incident has occurred or a circumstance has arisen in which a person could have been exposed to, or could have contracted, a controlled communicable condition.

(3) This subsection applies if—
   (a) an incident has occurred or a circumstance has arisen, while a caregiver or custodian is acting in that capacity, in which, if any of those involved were infected by a disease
constituting a controlled communicable condition, the disease could be transmitted to the caregiver or custodian; and
(b) the Chief Public Health Officer has reasonable grounds to believe that the imposition of a requirement under this section is necessary in the interests of a rapid diagnosis or clinical management and, if appropriate, treatment of any person involved in the incident or connected with the circumstance (whether or not as a caregiver or custodian).

(4) However, the Chief Public Health Officer should not act under this section unless the Chief Public Health Officer considers—
(a) that the person has been given a reasonable opportunity to undertake an examination or testing of the kind that will be subject to a requirement under this section but has failed to do so; or
(b) that the imposition of a requirement under this section is reasonably necessary for the purposes of a rapid diagnosis or clinical management and, if appropriate, treatment of the relevant person.

(5) A requirement that may be imposed on a person under this section is that the person—
(a) present himself or herself at such place and time as may be specified in the notice in order to undergo a clinical examination or to undertake (or be the subject of) tests, or both; and
(b) comply with any requirement imposed by a person who may conduct the examination or carry out the tests.

(6) Subsection (4)(a) does not apply if the person is unconscious or the Chief Public Health Officer considers that the person does not have the capacity to consent to an examination or testing of the relevant kind.

(7) If the person is unconscious, subsection (5) is modified so as to allow the Chief Public Health Officer to arrange a clinical examination or tests (or both) for the person.

(8) A requirement will be imposed by service of an order on the person (unless the person is unconscious).

(9) The testing that may be undertaken under this section may include the provision or taking of a sample of blood, urine or other biological specimen.

(10) If—
(a) a person is examined or subject to any test under this section; and
(b) the examination and any test disclose that the person does not have a controlled communicable condition, the person is entitled to reasonable compensation from the Department for costs and expenses directly incurred by the person in attending for the examination and any test.

(11) Compensation payable under subsection (10) may be recovered as a debt.

(12) The Chief Public Health Officer is entitled to be provided with a report on the outcome of any examination or test conducted under this section (and a person who conducted the examination or test must, at the request of the Chief Public Health Officer, furnish the Chief Public Health Officer with such a report).

(13) In this section—
care giver or custodian means—
(a) a person who is employed by, or performs work at, a health service; or
(b) a person who provides, or who is associated with the provision of, any medical service or other form of service designed to benefit human health;
(c) a person who is employed by, or performs work at, a pathology service; or
(d) a person who—
(i) removes human tissue from a person, whether alive or dead; or
(ii) handles human tissue, under the [insert name of relevant Act if one exists to control use of human tissue]; or
(e) a police officer; or
(f) a legal custodian of a person who is in legal or protective custody and any person who is employed or engaged by a legal custodian in the cause of keeping that person in legal or protective custody; or
(g) a person who is within a class prescribed by the regulations for the purposes of this definition.

health service means a health service within the meaning of the [insert name of relevant Act defining health services, if such an Act exists].

509—Power to require counselling
(1) If the Chief Public Health Officer has reasonable grounds to believe that a person has, or has been exposed to, a controlled communicable condition, the Chief Public Health Officer may impose a requirement on the person under this section.

(2) However, the Chief Public Health Officer should not act under this section unless satisfied that the person has been given a reasonable opportunity to participate in the relevant counselling or activity but has failed to do so.

(3) A requirement will be imposed by service of an order on the person.

(4) A requirement that may be imposed on a person under this section is that the person participate in 1 or more of the following—
(a) counselling;
(b) education;
(c) other activities relevant to understanding the controlled communicable condition or the impact or implications of the controlled communicable condition.

(5) Without limiting subsection (4), the order may specify the type, nature or extent of any counselling, and the type or details of any information that must be provided to the person.

510—Power to give directions
(1) If—
(a) the Chief Public Health Officer has reasonable grounds to believe that a person has, or has been exposed to, a controlled communicable condition; and
(b) the Chief Public Health Officer considers that an order under this section is reasonably necessary in the interests of public health, then the Chief Public Health Officer may give directions to the person under this section.
(2) However, the Chief Public Health Officer should not act under this section unless satisfied—
(a) that the person has undertaken counselling that is appropriate in the circumstances, or has refused or failed to undertake counselling that has been made reasonably available to the person; or
(b) that counselling is not appropriate or necessary in the circumstances of the particular case; or
(c) that urgent action is required in the circumstances of the particular case and that counselling can be provided after action is taken under this section.

(3) Any direction will be imposed by service of an order on the person.

(4) The directions that may be imposed by an order under this section include—
(a) a direction that the person reside at a specified place and, if considered to be appropriate by the Chief Public Health Officer, that the person remain isolated;
(b) a direction that the person refrain from carrying out specified activities (for example, without limitation, employment, use of public transport or participation in certain events), either absolutely or unless specified conditions are satisfied;
(c) a direction that the person refrain from visiting specified place or place within specified classes, either absolutely or unless specified conditions are satisfied;
(d) a direction that the person refrain from associating with specified persons or specified classes of persons;
(e) a direction that the person take specified action to prevent or minimise any health risk that may be posed by the person;
(f) a direction that the person attend meetings and provide such information as may be reasonably required in the circumstances;
(g) a direction that the person place himself or herself under the supervision of a member of the staff of the Department or a medical practitioner or other health professional nominated by the Chief Public Health Officer and obey the reasonable directions of that person;
(h) a direction that the person submit himself or herself to examination by a medical practitioner nominated by the Chief Public Health Officer at such intervals as the Chief Public Health Officer may require;

(i) a direction that the person undergo specified medical treatment, including at a specified place and time (or times);
(j) such other direction as to the person's conduct or supervision that the Chief Public Health Officer considers to be appropriate in the circumstances.

(5) The Chief Public Health Officer—
(a) cannot impose a direction under paragraph (h) or (i) of subsection (4) if the Chief Public Health Officer is satisfied that the person has a conscientious objection to the relevant examination or treatment (as the case may be) due to a religious, cultural or other similar ground; and
(b) cannot impose a direction under paragraph (i) of subsection (4) if the treatment would impose a serious threat to the person's health.

(6) However, if a direction under paragraph (h) or (i) of subsection (4) would relate to a child, the Chief Public Health Officer may make a direction under either (or both) paragraphs despite a conscientious objection of a parent or guardian of the child if the Chief Public
Health Officer considers that the relevant examination or treatment (as the case may be) is in the best interests of the child (and reasonably necessary in the interests of public health).

511—Power to require detention

(1) If—
   (a) the Chief Public Health Officer has reasonable grounds to believe that a person has, or has been exposed to, a controlled communicable condition; and
   (b) the person has been the subject of 1 or more directions under section 71 and contravened or failed to comply with a direction, or the Chief Public Health Officer has reasonable grounds to believe that there is a material risk the person would not comply with 1 or more directions under that section if they were to be imposed; and
   (c) the Chief Public Health Officer considers—
      (i) that the person presents, or is likely to present, a risk to public health; and
      (ii) that action under this section is justified.

(2) However, the Chief Public Health Officer should not act under this section unless satisfied—
   (a) that the person has undertaken counselling that is appropriate in the circumstances, or has refused or failed to undertake counselling that has been made reasonably available to the person; or
   (b) that counselling is not appropriate in the circumstances of the particular case; or
   (c) that urgent action is required in the circumstances of the particular case and that counselling can be provided after action is taken under this section.

(3) An order under this section must be served on the person.

(4) An order under this section will be that the person submit to being detained at a specified place while the order is in force.

(5) An order under this section may contain other requirements relating to the person’s conduct or supervision that the Chief Public Health Officer considers to be appropriate in the circumstances.

(6) An order under this section—
   (a) will be for an initial period not exceeding 30 days; and
   (b) will be able to be renewed from time to time by the Chief Public Health Officer for periods not exceeding 90 days.

(7) The Chief Public Health Officer must facilitate any reasonable request for communication made by a person detained under this section.

512—General provisions relating to orders, requirements and directions

(1) An order, requirement or direction under this Division may be given or imposed on a person on 1 or more occasions.

(2) Any combination of orders, requirements or directions under this Division may be given or imposed on a person at any time.

(3) The Chief Public Health Officer may at any time, by notice served on a person, vary or rescind an order, requirement or direction under this Division.
(4) If the Chief Public Health Officer serves an order or notice on a person under this Division, the order or notice must be accompanied by a notice in a form determined by the Chief Public Health Officer that—
(a) sets out the grounds on which the order or notice is made; and
(b) contains a statement of the person's rights under this Act (including a person's right to apply for a review under this Division); and
(c) contains any other information determined by the Chief Public Health Officer to be relevant or appropriate.

Drafting Note: It is important to consider whether a provision of this nature may be subject to constitutional protections.

513—Duty to comply
A person who is the subject of an order, requirement or direction under this Division must not, without reasonable excuse, contravene or fail to comply with the order, requirement or direction.

Maximum penalty: 200 penalty units.
Expiation fee: 10 penalty units.

514—Warrants
(1) If the Chief Public Health Officer considers it necessary to do so, the Chief Public Health Officer may apply to a magistrate—
(a) for the issue of a warrant for the apprehension of a person who has failed to comply with an order, requirement or direction under this Division;
(b) for the person to whom the warrant relates—
(i) to be subject to any examination, test or other action required by the order, requirement or direction to which the warrant relates; or
(ii) to be brought before a magistrate.

(2) If or when a person is brought before a magistrate, the magistrate may take such action as the magistrate thinks appropriate to achieve compliance with the relevant order, requirement or direction, including—
(a) by making such orders as the magistrate thinks fit;
(b) by issuing a warrant for the detention of the relevant person until the person is willing to comply with the order, requirement or direction.

(3) Without limiting subsection (2), a warrant under that subsection may provide that the person be held in a place of quarantine or isolation—
(a) for a period determined by the [insert relevant judicial officer who hears warrant applications in the country], or from time to time subject to periodic reviews by a magistrate; or
(b) until otherwise determined by [insert relevant judicial officer who hears warrant applications in the country].

(4) An authorised person is authorised to take any action contemplated by a warrant under this section (including to take a person to any place and to restrain a person while any
examination or testing is undertaken (including testing involving the taking of a blood, urine or other biological sample)).

(5) Without limiting subsection (4), reasonable force may be used in the execution of a warrant under this section.

(6) A right of appeal exists to the [insert relevant court, such as the national court in PNG] or (constituted of a single judge) against a decision of [insert relevant judicial officer who hears warrant applications in the country] under this section.

(7) On an appeal, the [insert relevant court, such as the national court in PNG] may—
(a) confirm, vary or quash the magistrate's decision;
(b) make any order that the justice of the case may require.

(8) Subject to an appeal, an order of [insert relevant judicial officer who hears warrant applications in the country] under this section will be taken to be an order of the [insert name of court or tribunal where relevant judicial officer sits].

(9) In this section—
authorized person means—
(a) a police officer; or
(b) a person authorised by the Chief Public Health Officer to act as an authorised person under this section.

515—Review of orders etc

(1) A person who is the subject of an order, requirement or direction of the Chief Public Health Officer under this Division may apply to the [insert relevant court, such as the district court in PNG] for a review of the order, requirement or direction.

Drafting Note, once again, it needs to be checked as to whether the Constitution contains provisions which will affect the operation of this provision.

(2) An application under this section may be instituted at any time during the currency of the order, requirement or direction (and, subject to subsection (3), more than 1 application may be made while the order, requirement or direction is in force).

(3) If a second or subsequent application is made with respect to the same order, requirement or direction, the District Court must first consider whether there has been a significant change in the material circumstances of the case and should, unless the District Court in its discretion determines otherwise, decline to proceed with the application (if it appears that the proceedings would simply result in a rehearing of the matter without such a change in circumstances).

(4) Subject to complying with subsection (3), the District Court may, on hearing an application under this section—
(a) confirm, vary or revoke any order, requirement or direction, or substitute any order, requirement or direction;
(b) remit the subject matter to the Chief Public Health Officer for further consideration;
(c) dismiss the matter;
(d) make any consequential or ancillary order or direction, or impose any conditions, that it considers appropriate.

(5) The District Court is to hear and determine an application under this section as soon as is practicable.

(6) An application for a review under this section will be taken to be the making of an appeal for the purposes of the application of [insert relevant law about operation of the Act governing court applications, such as the PNG District Court Administration Act].

**Division 3—Related matters**

Countries should consider whether these sections are practical, but they are included to give broad options to countries.

**516—Tests on deceased persons**

(1) If the Chief Public Health Officer has reasonable grounds to believe that a deceased person has had a controlled communicable condition, the Chief Public Health Officer may, by instrument in writing, authorise the carrying out of any test or procedure specified in the instrument on the body of the deceased person.

(2) If the Chief Public Health Officer has authorised the carrying out of a test or procedure under this section, an authorised officer, accompanied by such assistants as the authorised officer thinks necessary, may—

(a) enter premises (using such force as is necessary) in which the authorised officer reasonably believes the body of the deceased person is located; and

(b) search the premises for the body, and, on finding the body, the authorised tests or procedure may be carried out in accordance with this section.

(3) However, an authorised officer must not exercise a power to enter premises under subsection (2) unless—

(a) the authorised officer has made a reasonable attempt to contact the occupier of the premises and advise the occupier of the intention to exercise such powers; and

(b) if force is required to enter premises—the authorised officer is accompanied by a police officer.

(4) A test or procedure authorised under this section must be carried out by—

(a) a medical practitioner; or

(b) a person who is qualified as required by the regulations to carry out tests or procedures of the relevant type.

(5) A person carrying out a test or procedure under this section may be assisted by any other person.

(6) Nothing in this section authorises the exhumation of a body.
517—Regional orders
(1) In this section—
corresponding law means a law of another Regional nation declared by the regulations to be a corresponding law;
order includes a notice, requirement or direction;
Regional nation means a nation of the Pacific region declared by the Regulations to be a Regional nation for the purposes of this section.

(2) If—
(a) a person is subject to an order under a corresponding law; and
(b) the terms of an order provide for matters that could be the subject (wholly or substantially) of an order under this Part; and
(c) the person enters [insert name of country],
then, subject to subsections (3) and (4), the order will have effect in [insert name of country] as if the order had been made under this Part.

(3) An order that has effect in [insert name of country] under subsection (2)—
(a) may, by notice served on the relevant person, be varied by the Chief Public Health Officer, as it applies in [insert name of country], in such manner as the Chief Public Health Officer thinks fit; and
(b) will cease to have effect in [insert name of country] if—
(i) the order expires or is revoked under the corresponding law; or
(ii) the order is revoked by the Chief Public Health Officer acting under this provision.

(4) The cessation of the operation of an order under this section does not prevent an order subsequently being made under this Part in relation to the same person.

518—Protection of information
A document that relates to a particular person held or produced by the Chief Public Health Officer, or any other person acting in the course of official duties, for the purposes of this Part is not subject to access under the [insert name of freedom of information law, if any such law exists].

Division 1—Notifiable conditions

519—Declaration of notifiable conditions
(1) The regulations may declare a disease or medical condition to be a notifiable condition.

(2) The Minister may, if the Minister considers it to be necessary in the interests of public health because of urgent circumstances, by notice in the Gazette, declare a disease or medical condition to be a notifiable condition.

(3) A regulation or declaration under subsection (1) or (2)—
(a) may be varied from time to time, or may be revoked; and
(b) a declaration of the Minister under subsection (2) will, unless revoked sooner, expire 6 months after publication in the Gazette.
(4) The revocation or expiry of a declaration of the Minister—
(a) does not prevent the disease or medical condition the subject of the declaration being declared to be a notifiable condition by the regulations; and
(b) does not prevent the disease or medical condition being the subject of a further declaration of the Minister if the Minister considers that urgent circumstances again warrant the declaration of the disease or medical condition to be a notifiable condition.

520—Notification

(1) If—
(a) a medical practitioner; or
(b) a pathology service; or
(c) a person of a class prescribed by regulation, suspects that a person has, or has died from, a notifiable condition, the responsible person must as soon as practicable and, in any event, within 3 days of that suspicion being formed, report the case to the Chief Public Health Officer.

Maximum penalty: 100 penalty units.

(2) A report under subsection (1) must be—
(a) made in a manner and form determined by the Chief Public Health Officer; and
(b) accompanied by the information required by the Chief Public Health Officer to be furnished in connection with the provision of the report.

(3) On the receipt of a report under subsection (1) that relates to a person in a local government area, the Chief Public Health Officer must, if there is an immediate threat to public health in the area, immediately communicate the contents of the report to the council for the area.

(4) A medical practitioner who suspects that a person is suffering from a notifiable condition is not required to make a report under subsection (1) with respect to that case if the practitioner knows or reasonably believes that a report has already been made to the Chief Public Health Officer by another medical practitioner who is, or has been, responsible for the treatment of the person.

(5) Following receipt of a report made under this section, the Chief Public Health Officer may from time to time require additional information about the person or the person's condition from—
(a) the person who provided the report; and
(b) any other person who the Chief Public Health Officer reasonably believes could furnish the Chief Public Health Officer with information relevant to preventing, monitoring or controlling the notifiable condition.

(6) A person must not, without reasonable excuse, fail to comply with a requirement imposed on the person under subsection (5).

Maximum penalty: 100 penalty units.
(7) No civil liability arises from a statement made honestly and without malice in, or in connection with, a report under this section.

(8) A person who furnishes information under this section cannot, by virtue of doing so, be held to have breached any law or any principle of professional ethics.

(9) A document that relates to a particular person held or produced by the Chief Public Health Officer for the purposes of this section is not subject to access under the Freedom of Information Act 1991.

(10) In this section—

responsible person means—
(a) in relation to a medical practitioner—the medical practitioner;
(b) in relation to a pathology service—the pathologist responsible for the day-to-day operation of the pathology laboratory;
(c) in the case of a person of a class prescribed by regulation—a person identified under the regulations.

521—Report to councils

The Department—
(a) must, on a monthly basis [Drafting note: monthly reporting would be effective from a public health point of view but countries need to consider whether monthly reports are possible, and therefore enter bi-monthly, quarterly or other reporting schedule as best suits their conditions], provide each council with a report on the occurrence or incidence of notifiable conditions in its area and any problems or issues caused by or arising on account of such diseases or medical conditions that may exist in its area; and
(b) must inform a council of the occurrence or incidence of any notifiable condition in its area that constitutes, or may constitute, a threat to public health.

522—Action to prevent the spread of infection

(1) If there is danger to public health from the possible spread of a disease constituting a notifiable condition, the Chief Public Health Officer or an authorised officer authorised by the Chief Public Health Officer for the purposes of this section may give such directions and take such action as may be appropriate to avert that danger.

(2) Without limiting the generality of subsection (1), the Chief Public Health Officer or authorised officer may—
(a) direct that any premises, vehicle or article be cleansed or disinfected;
(b) direct the destruction of any article, substance, food or other thing;
(c) seize any vehicle, article, substance, food or other thing;
(d) impose areas of quarantine or close premises;
(e) restrict movement into and out of any place or premises;
(f) take such other action as may be prescribed.

(3) A person who is given a direction under subsection (1) or (2) must not, without reasonable excuse, contravene or fail to comply with the direction.

Maximum penalty: 200 penalty units.
Expiation fee: 10 penalty units.
(4) For the purpose of exercising a power under subsection (1) or (2), an authorised officer
may be helped by such assistants as may be necessary or desirable in the circumstances.

(5) If a person fails to take action in accordance with a direction, the Chief Public Health
Officer or an authorised officer may take that action or cause it to be taken.

(6) The Crown (or other usual term if a republic) may recover as a debt costs
and expenses reasonably incurred in exercising powers under subsection (5) from the person
who failed to take the required action.

(7) For the purpose of exercising a power under this section, a person authorised to do so by
the Chief Public Health Officer—
(a) may enter premises or any vehicle at any reasonable time; and
(b) may break into premises or any vehicle if authorised by a warrant issued by a magistrate.

(8) A magistrate must not issue a warrant under subsection (7) unless satisfied that the
warrant is reasonably required in the circumstances.

(9) If the Chief Public Health Officer informs a council of the occurrence of a disease
constituting a notifiable condition, the council must take such action as is reasonably open to
the council to assist in preventing the spread of the disease.

Division 2—Notifiable micro-organisms

Countries will need to check any relevant food safety law to avoid duplication or
inconsistency

523—Declaration of notifiable micro-organisms
(1) The regulations may declare a micro-organism to be a notifiable micro-organism.

(2) The Minister may, if the Minister considers it to be necessary in the interests of public
health because of urgent circumstances, by notice in the Gazette, declare a micro-organism to
be a notifiable micro-organism.

(3) A regulation or declaration under subsection (1) or (2) may be varied from time to time,
or may be revoked, but a declaration of the Minister under subsection (2) will, unless revoked
sooner, expire 6 months after publication in the Gazette.

(4) The revocation or expiry of a declaration of the Minister—
(a) does not prevent the micro-organism the subject of the declaration being declared to be a
notifiable micro-organism by the regulations; and
(b) does not prevent the micro-organism being the subject of a further declaration of the
Minister if the Minister considers that urgent circumstances again warrant the declaration of
the micro-organism to be a notifiable micro-organism.

524—Notification of a notifiable micro-organism in food
(1) If—
(a) a laboratory service; or
(b) a person of a class prescribed by the regulations,
detects or isolates within or from food, or within or from samples taken from food, a
notifiable micro-organism, the responsible person must as soon as practicable report the
detection or isolation to the Chief Public Health Officer.

Maximum penalty: 100 penalty units.

(2) Subsection (1) does not apply—
(a) if the notifiable micro-organism is detected or isolated in the course of a test carried out
only for—
(i) educational purposes; or
(ii) the purpose of academic research; or

(b) in any circumstance prescribed by regulation.

(3) If the proprietor of any food business or a food vending machine in [insert name of
country] is
informed at any time by a responsible person for a laboratory service (including a laboratory
service outside the country) that—
(a) a sample of food handled by that proprietor has been tested by that laboratory; and
(b) the test conducted by the laboratory has detected or isolated a notifiable micro-organism,
the proprietor must as soon as practicable report the detection or isolation to the Chief Public
Health Officer.

Maximum penalty: 100 penalty units.

(4) A report under subsection (1) or (3) must be—
(a) made in a manner and form determined by the Chief Public Health Officer; and
(b) accompanied by the information required by the Chief Public Health Officer to be
furnished in connection with the provision of the report.

(5) Following receipt of a report made under this section, the Chief Public Health Officer
may from time to time require additional information from—
(a) the person who provided the report; and
(b) any other person who the Chief Public Health Officer reasonably believes could furnish
the Chief Public Health Officer with information relevant to monitoring or controlling the
notifiable micro-organism in food.

(6) A person must not, without reasonable excuse, fail to comply with a requirement imposed
on the person under subsection (5).

Maximum penalty: 100 penalty units.

(7) No civil liability arises from a statement made honestly and without malice in, or in
connection with, a report under this section.

(8) A person who furnishes information under this section cannot, by virtue of doing so, be
held to have breached any law or any principle of professional ethics.
(9) In this section—

food includes—
(a) any substance or thing of a kind used for, or represented as being for the use of, human consumption, whether it is raw, prepared or partly prepared;
(b) any substance or thing of a kind used, or represented as being for use, as an ingredient or additive in a substance or thing referred to in paragraph (a);
(c) any substance used in preparing a substance or thing referred to in paragraph (a), other than a substance used in preparing a living thing, if it comes into direct contact with the substance or thing referred to in that paragraph, such as a processing aid;
(d) chewing gum or an ingredient or additive in chewing gum, or any substance used in preparing chewing gum;
(e) any substance or thing declared to be a food under [insert the name of any relevant law or legislative instrument].

food business has the same meaning as in section 4 of the [insert the name of any relevant law or legislative instrument];
handled has the same meaning as under the [insert the name of any relevant law or legislative instrument];
laboratory service means a service which performs tests or analyses on food or samples of food for the purpose of isolating or detecting micro-organisms in the food or a sample of food;
responsible person means—
(a) in relation to a laboratory service—the person responsible for the day-to-day operation of the laboratory service;
(b) in the case of a person of a class prescribed by the regulations—a person identified under the regulations.

Flow Chart for controlled communicable diseases

In order to make it easier for officers to use the powers for management of controlled communicable diseases, the flow chart below is intended to show the operation of the powers and may be used as a tool to assist Chief health officers, environmental health officers and others in the application of the provisions.
Health Legislation in the Pacific – Modules with legislative text

Module 5-Part 2
Controlled communicable diseases

Principles from Module 5 apply to this Division
Includes using least restrictive option

Order that person submit to detention at a specified place
Order lasts 30 days and may be renewed for periods up to 30 days

CPHO has reasonable grounds for believing that the person would not comply with directions if imposed

Person has a right to appeal any order, requirement or direction under this Division

Order served on person which may include directions
(a) a direction that the person reside at a specified place and, if considered to be appropriate by the Chief Public Health Officer, that the person remain isolated;
(b) a direction that the person refrain from carrying out specified activities (for example, without limitation, employment, use of public transport or participation in certain events), either absolutely or unless specified conditions are satisfied;
(c) a direction that the person refrain from visiting specified place or place within specified classes, either absolutely or unless specified conditions are satisfied;
(d) a direction that the person refrain from associating with specified persons or specified classes of persons;
(e) a direction that the person take specified action to prevent or minimise any health risk that may be posed by the person;

More possible directions to be included in an order are set out in section 508.

Person has complied with directions in order?

Yes

No

CPHO has reasonable grounds to believe that the person
• presents
• has presented
• or is likely to present a risk to health
through transmission of that disease

Any reasonable request for communication by the detained person must be facilitated

Has CPHO reasonable grounds to believe that the person
• presents
• has presented
• or is likely to present a risk to health
through transmission of that disease

Person must not fail to comply with the order without reasonable excuse

CPHO may apply for warrant to enforce order

Person has been given a reasonable opportunity to get tested voluntarily?

Yes

No

Is testing or treatment reasonably necessary for a rapid diagnosis or clinical management or treatment?

Requirement that person present for clinical examination or to be tested or both and comply with any requirements of the person examining and testing which may include taking of blood, urine or other biological specimen

Yes

No

Has the person been given a reasonable opportunity to get tested voluntarily?

Yes

No

Does the person have a CCD?

Yes

No

Has the person been given a reasonable opportunity to participate in counselling or other relevant activity?

Yes

No

Requirement that person participate in one or more of
- Counselling
- Education
- Other activities relevant to understanding the CCD or its impact

Compensation payable for expenses directly incurred in attending for testing

Report provided to CPHO on the outcome of examination and/or test

CPHO may request such report from person who conducted examination and/or test

Could someone have contracted the CCD?

Yes

No

Could a caregiver or custodian have been exposed to the CCD?

Yes

No

Could someone have been exposed to the CCD?

Yes

No

Incident occurs

Yes

No

Has the person been given a reasonable opportunity to participate in counselling or other relevant activity?
Module 6—Management of significant emergencies

What is in this module?

This module makes provision for the management of emergencies. It also attempts to link with other emergency management legislation presently operating in the country. As this type of legislation and the preferred policy approach will differ between countries, consideration will need to be given to this module in conjunction with consideration of existing emergency legislation and emergency planning. Often a Constitution contains provisions affecting who may declare an emergency. This must be checked.

This module also establishes a public health review panel, to hear appeals against decisions to issue notices to manage breaches of the general duty to minimise risks to the public health. This is a useful mechanism in a developing country, as it is a relatively low cost approach to the review of smaller administrative decisions by authorised officers, about risks to the public health. It enables a panel, which has relevant public health experience, to hear such complaints.

Policy questions for consideration

What tribunals and courts already exist to hear small administrative decision reviews? The public health review panel is an interesting approach for reviewing relatively minor decisions, and can use the skills of the National Public Health Board (NPHB).
601—Principles
The principles set out in [insert relevant section when confirmed, but refers to principles for application of Communicable Disease powers] have application to this Part.

602—Public health incidents
(1) If it appears to the Chief Executive that the nature or scale of an emergency that has occurred, is occurring or is about to occur, is such that it should be declared to be a public health incident, the Chief Executive may, with the approval of the Minister, declare the emergency to be a public health incident.

(2) A declaration under this section—
(a) may be made orally (but if made orally must, as soon as is reasonably practicable, be reduced to writing and a copy provided to the Minister); and
(b) subject to this section, remains in force while response operations are being carried out in relation to the emergency (but not for a period exceeding 12 hours).

(3) The Chief Executive may, at any time, revoke a declaration under this section.

603—Public health emergencies
(1) If it appears to the Chief Executive that an emergency has occurred, is occurring or is about to occur, the Chief Executive may, with the approval of the Minister, declare the emergency to be a public health emergency (whether or not the emergency has previously been declared to be a public health incident under section 82).

(2) A declaration under this section—
(a) must be in writing and published in a manner and form determined by the Minister; and
(b) remains in force for a period specified in the declaration (which must not exceed 14 days) and for such further periods (which may be of any length) as may be approved by the Governor in Council.

(3) The Chief Executive may, at any time, revoke a declaration under this section.

604—Making and revocation of declarations
(1) The Public Health Emergency Management Plan may contain guidelines setting out circumstances in which an emergency should be declared to be a public health incident or to be a public health emergency.

(2) Before making a declaration under this Part, the Chief Executive must consult with—
(a) the Chief Public Health Officer; and
(b) [insert the position of any person under other legislation, such as an emergency Act, with responsibility for coordinating public emergencies].

(3) The Chief Executive must revoke a declaration under this Part at the request of the [insert the position of any person under other legislation, such as an emergency Act, with responsibility for coordinating public emergencies].
605—Powers and functions of Chief Executive
(1) On the declaration of a public health incident or public health emergency, and while that declaration remains in force, the Chief Executive must take any necessary action to implement the Public Health Emergency Management Plan and cause such response and recovery operations to be carried out as he or she thinks appropriate.

(2) The Chief Executive must provide information relating to a public health incident or public health emergency to the [insert the position of any person under other legislation, such as an emergency Act, with responsibility for coordinating public emergencies] in accordance with any requirements of the [insert the position of any person under other legislation, such as an emergency Act, with responsibility for coordinating public emergencies].

606—Application of relevant emergency legislation, such as an Emergency Management Act
(1) On the declaration of a public health incident or public health emergency, the following provisions of the [insert relevant provisions of emergency legislation, such as an emergency management Act] apply in relation to the emergency as if those provisions formed part of this Act but subject to the modifications specified in subsection (2) and any other prescribed modifications:
These may include powers that may be exercised in relation to declared emergencies, recovery operations, offences, some miscellaneous provisions and some definitions.

(2) The provisions of the [insert name of emergency legislation, such as an emergency management Act] applied under subsection (1) are modified as follows:
(a) a reference to the Minister is to be read as a reference to the Minister responsible for the administration of this Act;
(b) a reference to the State Coordinator is to be read as a reference to the Chief Executive;
(c) a reference to an authorised officer is to be read as a reference to an emergency officer;
(d) a reference to the State Emergency Management Plan is to be read as a reference to the Public Health Emergency Management Plan;
(e) a reference to an identified major incident is to be read as a reference to a public health incident;
(f) a reference to a major emergency is to be read as a reference to a public health emergency;
(g) a reference to a declaration is to be read as a reference to a declaration under this Part;
(h) a reference to this Act (meaning the [insert name of emergency legislation]) is to be read as a reference to this Part;
(i) a reference to section 25(1) of the [insert name of emergency legislation] is to be read as a reference to section 85(1) of this Act;
(j) section 25(2)(m) is to be read as if it did not include the words in brackets.

Part 12—Notices and emergency situations

Division 1—Interpretation

607—Interpretation
In this Part—
relevant authority means—
(a) the Chief Public Health Officer; or
(b) a council.

Division 2—Notices and emergencies

608—Notices

(1) A relevant authority may issue a notice under this section for the purpose of—
(a) securing compliance with a requirement imposed by or under this Act (including the
general duty under [insert relevant section when confirmed]; or a requirement imposed under
a regulation or a code of practice under this Act); or
(b) averting, eliminating or minimising a risk, or a perceiving risk, to public health.

(2) Before issuing a notice to secure compliance with the general duty under [insert relevant
section when confirmed], a relevant authority must have regard to—
(a) the number of people affected, or potentially affected, by the breach of the duty;
(b) the degree of harm, or potential degree of harm, to public health on account of the breach
of the duty;
(c) any steps that a person in breach of the duty has taken, or proposed to take, to avoid or
address the impact of the breach of the duty, and may have regard to such other matters as the
relevant authority thinks fit.

(3) A notice under this section—
(a) subject to subsection (4), must be in the form of a written notice served on the person to
whom it is issued; and
(b) must specify the person to whom it is issued (whether by name or by a description
sufficient to identify the person); and
(c) must state the purpose for which the notice is issued and give notice of the requirement or
the risk to which it relates; and
(d) may impose any requirement reasonably required for the purpose for which the notice is
issued including 1 or more of the following:
(i) a requirement that the person discontinue, or not commence, a specified activity
indefinitely or for a specified period or until further notice from a relevant authority;
(ii) a requirement that the person not carry on a specified activity except at specified times or
subject to specified conditions;
(iii) a requirement that the person take specified action in a specified way, and within a
specified period or at specified times or in specified circumstances;
(iv) a requirement that the person take action to prevent, eliminate, minimise or control any
specified risk to public health, or to control any specified activity;
(v) a requirement that the person comply with any specified code or standard prepared or
published by a body or authority referred to in the notice;
(vi) a requirement that the person undertake specified tests or monitoring;
(vii) a requirement that the person furnish to a relevant authority specified results or reports;
(viii) a requirement that the person prepare, in accordance with specified requirements and to
the satisfaction of the relevant authority, a plan of action to secure compliance with a relevant
requirement or to prevent, eliminate, minimise or control any specified risk to public health;
and
(e) must state that the person may, within 14 days, appeal to the [insert name of relevant
court, such as the District Court in PNG] against the notice.
(4) An authorised officer may, if of the opinion that urgent action is required, issue an emergency notice imposing a requirement of a kind referred to in subsection (3)(d) as reasonably required in the circumstances.

(5) An emergency notice may be issued orally but, in that event, the person to whom the notice is issued must be advised forthwith of the person's right to appeal to the [insert name of relevant court, such as the District Court in PNG] against the order.

(6) If an emergency notice is issued by an authorised officer, the notice will cease to have effect on the expiration of 72 hours from the time of issuing unless confirmed by a notice issued by a relevant authority and served on the relevant person.

(7) A relevant authority may, by written notice served on a person to whom a notice under this section has been issued by the relevant authority, vary or revoke the notice.

(8) A person to whom a notice is issued under this section must not, without reasonable excuse, fail to comply with the notice.

Maximum penalty: 100 penalty units.

(9) A person must not hinder or obstruct a person complying with a notice under this section.

Maximum penalty: 100 penalty units.

(10) The Minister may, as the Minister thinks fit, determine various protocols that should be taken into account by a relevant authority under this section.

(11) A protocol may include guidance as to which relevant authority should act under this section in various classes of cases.

(12) The Minister should not adopt or vary a protocol under this section except after consultation with—
(a) the Chief Public Health Officer; and
(b) [insert the name of any organisation representing local governments, if such an organisation exists].

609—Action or non-compliance with a notice
(1) If the requirements of a notice under this Part are not complied with, a relevant authority may take any action required by the notice.

(2) Action to be taken by a relevant authority under subsection (1) may be taken on the relevant authority's behalf by an authorised officer, a member of the Department, or another person authorised by the relevant authority for the purpose.

(3) A person taking action under this section may enter any relevant land at any reasonable time.
(4) The reasonable costs and expenses incurred by a relevant authority in taking action under this section may be recovered by the relevant authority as a debt from the person who failed to comply with the requirements of the notice.

(5) If an amount is recoverable from a person by a relevant authority under this section, the relevant authority may, by notice in writing to the person, fix a period, being not less than 28 days from the date of the notice, within which the amount must be paid by the person, and, if the amount is not paid by the person within that period, the person is liable to pay interest charged at the prescribed rate per annum on the amount unpaid.

610—Action in emergency situations

(1) If an authorised officer believes, on reasonable grounds—
(a) that a situation is creating, or likely to create, a risk to public health; and
(b) that immediate action is required,
the authorised officer may, after giving such notice (if any) as may be reasonable in the circumstances, take action or cause action to be taken as necessary to avert, eliminate, control or eliminate the risk.

(2) In the exercise of powers under this section, an authorised officer has, in addition to any other powers of an authorised officer under this Act, power to—
(a) enter and take possession of any premises or vehicle (taking such action as is reasonably necessary for the purpose); and
(b) seize, retain, move or destroy or otherwise dispose of any substance or thing.

(3) The action taken under subsection (2) may include the use of force to enter any premises or vehicle without a warrant if the authorised officer believes, on reasonable grounds, that the circumstances requires such a step to be taken.

(4) Action may be taken under this section whether or not a notice has been given to a person in relation to the risk under a preceding section.

(5) The reasonable costs and expenses incurred by an authorised officer in taking action under this section may be recovered by—
(a) in the case of action taken by a State authorised officer—the Crown; or
(b) in the case of action taken by a local authorised officer—the relevant council, from any person who caused the risk to which the action relates, as a debt.

Division 3—Reviews and appeals

611—Reviews—notices relating to general duty

(1) This section applies if a person has been issued with a notice under this Part to secure compliance with the general duty under Part 6.

(2) A person to whom a notice has been issued may apply for a review of the notice under this section.

(3) The review will be to the Public Health Review Panel (the Review Panel) constituted under this section.
(4) The application must be made within 14 days after the notice is served on the person unless the Review Panel, in its discretion, allows an extension of time.

(5) Subject to a determination of the Review Panel to the contrary in relation to a particular matter, the operation of a notice subject to a review is not suspended pending the outcome of the proceedings.

(6) A review under this section is to be conducted as a full review of the matter to which the review relates.

(7) For the purposes of this section, the Review Panel will from time to time, in relation to a particular review, be constituted by—
(a) the Chief Public Health Officer (who will be the presiding member); and
(b) 2 members of NPHB selected by the Chief Public Health Officer for the purposes of the particular review; and
(c) any other person or persons selected by the Chief Public Health Officer in order to provide additional expertise on the panel.

(8) If the review relates to a notice issued by the Chief Public Health Officer, a delegate of the Chief Public Health Officer must act in place of the Chief Public Health Officer under subsection (7).

(9) A reference to a member of NPHC under subsection (7)(b) extends to a deputy of a member of NPHC.

(10) 3 members of the Review Panel constitute a quorum of the Review Panel.

(11) A decision carried by a majority of the votes cast by the members of the Review Panel present at any proceedings of the Review Panel is a decision of the Review Panel.

(12) Each member present at a meeting of the Review Panel is entitled to vote on a question arising for decision and, in the event of an equality of votes, the person presiding has a second, or casting, vote.

(13) A party is entitled to appear personally or, with leave of the Review Panel, by representative, in proceedings before the Review Panel.

(14) The Review Panel may proceed to determine a matter in the absence of a party if the party has had notice of the time and place of the proceedings and fails to appear.

(15) In any proceedings, the Review Panel is not bound by the rules of evidence but may inform itself about any matter relating to the proceedings in such manner as it thinks fit.

(16) The Review Panel may, on hearing any proceedings under this section—
(a) confirm, vary or revoke any requirement to which the review relates and, if appropriate, discharge the relevant notice;
(b) substitute any requirement or notice that could have been made or given in the first instance;
(c) remit the subject matter to the relevant authority for further consideration;
(d) dismiss the matter;
(e) make an order for costs;
(f) make any consequential or ancillary order or direction, or impose any conditions, that it considers appropriate.

(17) The Review Panel is to hear and determine an application under this section as soon as is practicable.

612—Appeals

(1) A person who has been issued with a notice under this Part (including a notice to secure compliance with the general duty under [insert relevant section when confirmed]) may appeal to the [insert name of relevant court, such as the District Court and National Court in PNG]—

(a) against the notice; or
(b) if review proceedings have been determined under this Division—against the outcome of the review (including any order or other matter made or imposed at the conclusion of the proceedings on the review).

(2) To avoid doubt, a person who has been issued with a notice to secure compliance with the general duty may institute an appeal under this section without the need to have already applied for a review of the notice under this Division.

(3) An appeal must be instituted within 14 days after—
(a) in the case of an appeal under subsection (1)(a)—the notice is served on the person;
(b) in the case of an appeal under subsection (1)(b)—the review proceedings are concluded.

(4) A relevant authority is entitled to be a party to any proceedings under this section.
Module 7—Declarations of local custom for village health

The work to identify opportunities in the use of customary laws makes extensive use of work commissioned from scholars in the University of the South Pacific as part of a series of papers developed for the Model Public Health Law for the Pacific Project. It also makes extensive use of a paper by Radha Etheridge and Genevieve Howse which was undertaken as part of the background research on the Model Public health law for the Pacific Project. Reference is made throughout the Module to those papers.

What is in this module?

The legislative text in this module creates a decision making process for creating declarations of local village custom for health, utilising customary village community decision making and a community based approach to public health. The mechanism proposed blends two very different traditions of lawmaking and problem solving. It is a hybrid of custom and state law, which is used to create a mechanism to address the protection and promotion of health, and the prevention of disease, at village level.

This is a new approach to legislating in public health, and has been developed for the unique Pacific environment where traditional methods of communication and decision making are largely oral. It attempts to blend this oral medium of village decision making with the formal written medium of the state law. These

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148 Jowitt, Foukona and Tom’tavala, Model Public Health Law for the Pacific Project – Customary Law and Public Health, Unpublished Paper by Scholars from the University of the South Pacific for the Model Public Health Law for the Pacific Project. At the time of writing, there were plans to submit the paper for publication along with a series of papers on the project, to the Journal of South Pacific Law in 2011.

149 Etheridge and Howse, Something Someone Else Dreamed About and Want us to Follow: Opinions and Experiences of Officers in Pacific Ministries of Health on Working with Public Health Laws, a paper which has been prepared for publication as part of the background research on the Model public health Law for the Pacific Project.
two approaches to decision making and problem solving do not easily come together: “In a print based courtroom, where law books, briefs, citations and other written materials define and organise the method of finding the truth—the oral tradition has lost much of its resonance.”

The language of custom is different from the language of law. It is oral, and the way of talking and the process of discussion, are often crucial to the validity of the decision. Villages may have ways of summoning community members for important discussions. There may be protocols about who may speak and the way discussion is conducted. For example, in some villages on Manus Island in PNG the speaker holds a branch of betel nut during community discussions. If a fruit falls while the speaker is talking, it bodes ill for the success of the enterprise under discussion. If no fruit falls, the omen is good.

Customary decision making stresses mutual benefit, status in speaking during decision making, the roles of villagers and groups within villages, traditions, mutual exchange of skills, benefits and goods, the coming together of families, and the mutual obligation brought into existence by participating and belonging in village life. People in villages discussing custom, speak of families and the whole community coming together to support each other in meeting accepted obligations. It is observance of these obligations that binds people and brings them together.

The language of statute and case law is very different. It is primarily in written form and decision making is also undertaken largely in written form—by reference to documents as a basis for decision making or as evidence. Legal language seeks precision. Consider the following advice given to students of legislative drafting: “The word or phrase which most exactly conveys the intended meaning in the intended context must be diligently sought and found. The habit of using dictionaries and good usage guides in the search must be developed. The demon sloppiness must be conquered.”

Legal language relies on precise definitions, clear unemotional language and sanctions for breaches. Modern public health laws protect the rights of

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152 Howse, G, *Custom, Women and Village Courts*, Op Cit

the individual and do not have a language to acknowledge the bonds of community, or the dignity in long respected tradition. They do not try to do this and cannot do this. For this reason, in attempting to use customary approaches to decision making and problem solving in public health at village level, an oral decision making process is proposed. The details of the decisions may later be recorded to give the decision status, both in the village and as part of the processes of the written state law. Declarations of local custom for village health are intended to speak the language of custom, and refer to principles rather than purport to be codification of custom. Supporting local laws may contain specific rules and enable enforcement.

The mechanism developed is not a “one size fits all” mechanism. It is a process that will consider different issues and reach a different result in every village in which it is used.

Customary approaches have been emphasised in the Reviewers’ Companion because case studies of rural Pacific villages show that decisions about matters of hygiene, water quality, cleanliness and some matters affecting disease control, are currently being managed using customary means. Customary measures can be found in other modules, as requirements to seek the opinion of customary leaders or include them in decision making.

This module creates a process based on a hybrid of customary decision making, in an oral tradition, with written state law. The process brings together a declaration made using customary means with complementary local laws to set any necessary rules and assist with enforcement. Enforcement was consistently identified as a weakness of customary approaches to the protection and promotion of health at village level. The process is voluntary and villages may decide to use it, should they wish to do so. It is interesting to note that a similar process, piloted in Manus Province in Papua New Guinea in 2009-2010, was enthusiastically taken up in every village in which it was offered.

It requires a consultative decision making process, which seeks the views of important local groups, such as women’s groups and church groups. It also requires consultation with a public health outreach worker (or similar local government public health officer), who may advise village groups on the options that might best address the current issues of village health under consideration. The declarations of custom are complemented by local laws, where legal rules are needed to support the declaration and to enable enforcement.

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154 Jowitt, Foukona and Tom’Tavala, “Model Public Health Law for the Pacific Project—Customary Law and Public Health”, unpublished paper by scholars from the University of the South Pacific, for the Model Public Health Law for the Pacific Project. At the time of writing, there were plans to submit the paper for publication, along with a series of papers on the project, to the Journal of South Pacific Law in 2011

155 Etheridge and Howse, Op Cit

156 Etheridge and Howse, Op Cit and Jowitt et al Op Cit

157 Howse, G, Custom, Women and Village Courts, Op Cit
What do Pacific countries’ constitutions say about customary law?

Although Pacific, regional, public health laws are largely imported from British laws of the early twentieth century, strong internal influences of custom or “kastom” have created unique legislative and constitutional arrangements—some of these have some relevance to the interpretation of public health laws. It is also relevant that some countries in the region have taken steps, in their laws, to preserve their own ways of social organisation and these principles are often enshrined in constitutions.

In Vanuatu, the National Council of Chiefs is recognised in the Constitution, and has a general competence to discuss all matters relating to custom and tradition, and may make recommendations for the preservation and promotion of ni Vanuatu culture and languages.\textsuperscript{158} The Council may be consulted on any question, particularly any question relating to tradition and custom, in connection with any Bill before Parliament.\textsuperscript{159} Anecdotal evidence gathered during informal discussions with ni Vanuatu suggest that the constitutional powers granted to the National Council of Chiefs are not greatly used.

In the Fiji Islands Constitution Amendment Act 1997, the Bose Levu Vakaturaga (otherwise known as the Great Council of Chiefs), established under the Fijian Affairs Act, continues in existence. Its membership, functions, operations and procedures are as prescribed from time to time, by or under that Act, and as conferred on it under the Constitution. Further, the Parliament must make provision for the application of customary laws and for dispute resolution, in accordance with traditional Fijian processes. In doing so, the Parliament must have regard to the customs, traditions, usages, values and aspirations of the Fijian and Rotuman people.\textsuperscript{160} It should be noted that the Fiji Constitution is presently abrogated by President Josepha Iloilo (from 10 April 2009).\textsuperscript{161, 162} No new Constitution has yet been drafted to replace it.

In the Solomon Islands, a new draft Constitution Bill is currently under consideration. It includes considerable efforts to utilise both customary law approaches and human rights protections. In describing its content and the content of its predecessor, one scholar commented that: “The vast divide between the introduced system of law and governance on the one hand and traditional authority and practices on the other was finally acknowledged.”\textsuperscript{163}

\textsuperscript{158} Constitution, Section 30(1)
\textsuperscript{159} Constitution, Section 30(2)
\textsuperscript{160} The Fiji Islands Constitution Amendment Act 1997, Section 186 (1) and (2)
\textsuperscript{162} In April 2009 the “interim government” of Fiji abrogated the Constitution, dismissed the judiciary, and commenced ruling by decree. A constitutional exercise is to begin in September 2012 on the basis of recommendations adopted in the 2008 charter of the National Council for Building a Better Fiji. Although the authorities have set out a road map for general elections in September 2014, following abolition of race-based constituencies and establishment of a common roll, there is no widespread confidence about the certainty of the timeframe. See Hassall, Op Cit, page 13
While the Constitution is the supreme law of Vanuatu, customary laws have effect as part of the law of Vanuatu. This is similar to PNG and the Solomon Islands. The Constitution makes provision for the continuation of operation of the British and French laws in force, or applied in Vanuatu, immediately before the day of Independence. They apply to the extent that they are not expressly revoked or incompatible with the independent status of Vanuatu, and wherever possible take due account of custom. The Constitution expressly states that customary law continues to have effect as part of the law of the Republic of Vanuatu. In Tonga, the Constitution does not mention customary law or grant it any particular status. The Government Act makes provision for any district officer to make regulations for the governing of his village plantations, and other necessary matters relating to the people of his village.

In Papua New Guinea, the National Goals and Directive Principles specifically mention the importance of “Papua New Guinean ways”. They include a call for “Traditional villages and communities to remain as viable units on Papua New Guinean society, and for active steps to be taken to improve their cultural, social, economic and ethical quality.” The Constitution also specifically states that the laws of PNG include the underlying law. The Constitution enables Parliament to declare the underlying law of PNG and provide for its development. This has been done via the Customs Recognition Act 2000.

“Custom” is defined in the Constitution as meaning: “the customs and usages of the indigenous inhabitants of the country existing in relation to the matter in question at the time when and the place in relation to which the matter arises, regardless of whether or not the custom or usage has existed from time immemorial.” This effectively says that custom is the local custom in relation to

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164 Constitution, Section 2
165 Constitution, Section 95(1)
166 Constitution, Section 95(3)
167 Government Act (Tonga) Section 26, village regulations
168 Constitution of the Independent State of Papua New Guinea, national goals and directive principles
169 Constitution of the Independent State of Papua New Guinea, Section 9
the matter under consideration, irrespective of whether the custom may be relatively new or very old.\(^{170}\)

In Papua New Guinea, one Village “Lapun” or elder in Pere Village on Manus Island said: “We know about the Constitution, but we just put it under the table and use our traditional ways.”\(^{171}\)

These inclusions of customary law in Pacific Island constitutions shows the desire of Pacific parliaments to promote customary law as well as human rights.\(^{172}\)

**Recent studies into the use of customary approaches to public health protection and promotion**

In research undertaken by scholars at the University of the South Pacific (USP), on the Model Public Health Law for the Pacific Project—Customary Law and Public Health,\(^{173}\) the interface between customary law and public health law was examined. Models of existing customary approaches in Pacific laws were examined, as were cases studies of customary approaches to protection and promotion of village health in three countries—Vanuatu, PNG and the Solomon Islands.

Jowitt et al reported that: “Despite the general lack of use of customary law within the State legal system, custom continues to regulate lives of people, particularly in the rural areas where the State has limited presence. The rural population makes up about 85% of Solomon Islands population.”\(^{174}\)

One of three case studies conducted as part of the USP research into customary law and public health, focused on two villages on North East Guadalcanal, namely, Komuvatha and Dadave. It provides an snapshot of how village custom addresses matters of village health.

Generally, people have a limited understanding of public health. Some of the people thought that public health meant a good and clean environment. Others understood public health as having a clean village and quality way of life. However, people had no knowledge or idea about what public health law covers. For some, when asked “what do you think public health law covers?” they said it was the first time they had heard about such law.

The main public health issues identified by the people, who participated in the interviews in the two villages were: there is no proper place to dispose of rubbish; animals such as dogs and pigs roam around freely; and not everyone in the village has proper toilets. It was highlighted by some of the interviewees that flies are also an issue in the two villages. The common sorts of sicknesses highlighted by the people were diarrhoea, malaria and flu.

Some of the health problems in the two villages are partly because of how people live. Chiefs and elders tell people to tidy their houses, build proper toilets, dig holes for rubbish, and on every Wednesday clean the village. However, not everyone follows or listens to what the chiefs and elders

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170 Constitution of the Independent State of Papua New Guinea, Schedule 1
173 Jowitt, et al, Op Cit
174 Jowitt et al, Op Cit
say. While the chiefs and elders have the role to meet and agree on rules, then to let the people know of the rules and frequently remind them of the rules, they do not have any punitive power to penalise people if they fail to follow these, and therefore lack the capacity to ensure people follow the rules.

The water supply in Komuvatha village is from taps pumped from an underground water source. The water pump was supplied and installed by the COC Bible College. There are five main taps for thirty households. For Dadave village, water supply is pumped from a well. The whole village has access to the one pump, which was installed by a private company, Fielders Co. In both villages the water supply is used mainly for cooking and drinking, while for swimming and washing, people use the Mbalasuna River.

The chiefs and elders in both villages have made rules about the water supply. For example, people in Komuvatha village are allowed to turn on the five main taps only in the mornings and evenings, to conserve fuel. The people make contributions for the fuel for the pump, and the chief is responsible for holding onto this money. For Dadave village, the chiefs and elders are responsible for maintaining the water supply. They also ensure that the area where the water source is located is kept clean.

With regard to toilets in the two villages, they are mainly slabs over pits. In Komuvatha village only four houses use flush toilets, although without septic tanks. The toilets in Komuvatha village are located behind the houses, and far away from the taps, while the toilets in Dadave village are located closer to the river. It is common practice for people to use the bush or river.

Jowitt et al also located a number of useful examples where state public health and custom can interact on a formal level. This provides models for consideration for inclusion in a model public health law for the Pacific. These examples are: Vanuatu’s Water Management Act 2002 and Health Committees Act [Cap 296]; Samoa’s Fisheries Act 1988 and Village Fono Act 1990; and the PNG Local-level Governments Administration Act 1997 and the 2010 Custom and Women in Village Courts Project.

The legislative text in this module has been developed by considering a blend of suggested approaches, from laws and mechanisms identified by the USP scholars and the PNG Custom, Women and Village Courts pilot project, in Manus Island in PNG. It is also informed by the comments of Pacific public health officers on their current use of existing Pacific public health laws.


176 Village Courts Secretariat, Custom, Women and Village Courts, Pilot Project Manus Island, phases one and two, unpublished report, 2009
What do public health officers say about the use of customary approaches in Pacific public health laws?

The public health officers interviewed were aware that there is little reference to customary law and community mechanisms, for public health, in existing public health laws. Yet, across the expanse of the Pacific—in Melanesia, Micronesia and Polynesia—respondents reiterated the central role of the village and village leadership in daily life. Every health department we consulted, to some degree, drew upon village and tribal structures in order to achieve public health outcomes in communities.

We asked health workers whether their laws should reflect the direction of modern Pacific public health policy and practice, and provide a role for village structures. Should public health laws also provide low level public health powers to village chiefs or village councils? Some ideas we put to interviewees included options for villages to make environmental health plans, and to have a low level of powers to enforce these.

There was strong recognition of the social changes that have influenced village leadership structures over recent decades, and with this came reservations about providing powers to solely village chiefs.

*There is this sort of thing that our legislations should have some of the authority vested upon the village chiefs. But I think the traditional way of chiefly system has changed a lot. People are no longer [getting] the respect that they have [had], say 10 years ago. Chiefs are not respected in many places and there are many places now, that begin to have 3, 4, 5 chiefs. Who is the right chief, that sort of thing. It can be very complicated if you want to put the chiefs under the Act.* (MOH2)

Interviewees preferred that powers should be given to village councils or village committees, as opposed to the chief, because:

*What I [am] saying [is] that now you find in some of the villages disputes over who is chief and that sort of thing. So it would be better to have a collective council to oversee the affairs of the village really. Because you don’t want to find that at the end of the day one chief is saying one thing, and one other party is saying he isn’t the chief you shouldn’t listen to them.*

However, others were more cautious about the ability of village communities to effectively undertake public health work: “maybe to help to develop information, to assist environmental health officers … but I don’t think as inspectors, because most of them don’t have skills.” (EHO3) Another said: “I’d say people’s knowledge of environmental health matters are still coming from a low basis. Definitely in the villages. You find in the urban areas it’s now coming along.” (EHO4).

Examples of customary approaches in existing Pacific laws

*Joint development of by-laws, by customary and state authority, in Samoa*

This approach is taken from Samoa’s *Fisheries Act* 1988. Under this Act one of the duties of the Chief Executive Officer (CEO) is to “consult with fishermen, industry and village representatives, concerning conservation, management and development measures for fisheries” (s 3(2)(c)). Under
s 3(3)(d) the powers of the CEO include to: “In consultation with fishermen, industry and village representatives, prepare and promulgate by-laws not inconsistent with this Act for the conservation and management of fisheries, including limiting or banning the use of particular methods of fishing.”

There is no express power for the CEO to make by-laws without consultation, although the Head of State retains this power (s 25). Section 3(4) says that such by-laws shall: be signed by the Chief Executive Officer for the Ministry of Agriculture; be published in the Gazette and in a newspaper circulating in Samoa; and come into force on a day fixed in the by-law, which must be at least 7 clear days after the date of publication in the Gazette. Laws affecting lagoon fishing must be issued to the Pulenuu (mayor) of adjacent villages at least 7 clear days before it shall come into force.

Declaration of custom about health matters made together with enforcing local level laws

In the Custom, Women and Village Courts Pilot Project in Manus Island, PNG, customary law is used in partnership with local municipal laws. The principles of custom are made clear in a declaration of custom, and local laws are passed to make some detailed rules to give effect to the principles of custom. The declaration and the local law may only be settled after extensive consultation with local people. The Provincial Governor and the head of a local-level government may jointly make a declaration of local customary law—if they are both satisfied that a consultation process has established that a desire exists in the people, of the affected local-level government, for the making of a declaration of local customary law.

For example, a draft declaration has been drawn up for the limitation of bride price in several villages on Manus. The declaration sets out the purpose and meaning of the bride price ceremony, and its underlying meaning for the village and family involved. A complementary local law, made under the Local-level Government Administration Act, creates a cap on bride price, to give effect to the declaration of custom. The enforcement of the cap occurs by operation of the Local-level Government Administration Act.

Appointment of public health outreach workers to act as liaisons and informally promote public health

There are laws that recognise the authority of custom authorities to make public health by-laws for their localities. The Local-level Government Administration Act 1997 divides the country into local-level government areas. This third level of government is separate from the national and provincial governments. These local areas are then further divided into wards, or clusters of villages. Each ward has an elected Ward Councillor, Ward Recorder and Ward Komiti. The former represents the ward at the local-level government meetings and is the main government official at the village. The Act also envisages a multi-person Ward Development Committee. The local-level governments can make laws (under s 59), although the Act is silent on the subject matters for such laws.

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177 Village Courts Secretariat, Custom, Women and Village Courts, Pilot Project Manus Island, phases one and two, unpublished report, 2009
The PNG case study in the USP Customary Law paper indicates that, in that particular ward, the Ward Councillor saw it as his role to promote and regulate public health matters.\textsuperscript{178}

The other country case studies also support such an approach. In Vanuatu, for instance, most villages are close to an aid post, a dispensary or a health centre. The aid post worker in Mangaliliu was central to the development of an awareness of public health. However, her position was not remunerated or legally mandated.

\textit{Laws that recognise the authority of custom authorities to make public health by-laws for their localities}

This approach is drawn from Samoa’s \textit{Village Fono Act} 1990. Under this Act the village fono, or council, is empowered to make rules for the village, including rules for “the maintenance of hygiene in the village” (s 5(2)(a)). This is commonly done, especially in the rural villages. Such rules are not required to be written but, if written, do not need to go through another process of scrutiny and approval. This makes it easier for particular villages to make changes to their rules when they see fit.

\textit{Declarations of local village custom for health made together with complementary local laws}

This module proposes legislative text that combines some of the above approaches. It enables declarations of custom to be made about health matters affecting the village. This may happen after consultation with the public health outreach worker (or similar village health worker), and can be enforced under local law. The declarations may be made jointly by a Ward President (or similar local-level government role), together with the Governor, when both are satisfied that a consultation has taken place with the affected village, and with the public health outreach worker or similar local government public health officer.

Complementary local laws would then be made to make any necessary legal rules, and enable enforcement under local government legislation. Local laws may be specific rules about matters of local hygiene, the location and use of shared toileting facilities, shared drinking water and so on. They may give effect to the broader declaration of custom, which covers the importance of the village as a meeting place, sharing of food, mutual caring and respect etc. Local laws may be made together with a declaration of custom, or without one if deemed appropriate. When a declaration of custom is made, it may be enforced in local village/island courts. Local laws are enforceable under the relevant local government law.

This is intended to be a hybrid approach that acknowledges the importance of a customary village based approach, is a model of inclusive governance at village level, and draws upon local customary enforcement measures (where these exist in village courts or similar arrangements). Declarations of custom are intended to use the language of custom, and to reflect the ideas and stories of the people, about how they have addressed custom for village health (in the past and in the present), and their declaration of custom for the future which draws on these traditions, stories and ideas. It

\textsuperscript{178} USP Customary Law Paper, Op Cit
also uses local government laws to make formal rules to complement stories, customs and ideas of caring, mutual help and mutual benefit; and it supplements enforcement, as the lack of enforcement measures and sanctions was cited by many villagers in the two studies undertaken for this project.  

Part 1—Declaration of local custom for village health

Preconditions

It is necessary to consider how the countries’ present laws incorporate customary law. Many Pacific countries do adopt customary law as part of the underlying law, and some specifically refer to declarations of custom as a way of recognising what is a custom for purposes of state law. Before the legislative text may be used, reference will need to be made to powers in the constitution, or other laws that enable recognition of customary law.

It is necessary to have resources to train officers to advise villages about this approach to village health. The process to explain and consult is resource intensive initially. It requires resources to support several visits to villages to explain, consult, and discuss possible declarations of custom, and to return to the village with a draft declaration. Time is also needed to brief provincial leaders and administrators, and obtain support to pass a local law. Briefing materials are likely to be necessary for support to make declarations, and for local government bodies that will make the enforcing local laws.

801—Principles applying to the use and interpretation of a declaration of local custom for village health

The following principles apply to the use and interpretation of a declaration of local custom for village health—

the home grown wisdom existing in a village or local-level community is best placed to understand and address problems arising in that village or local level community; and

(a) villages and local-level communities manage their communal lives through traditional and customary ways which are vibrant and alive and which change and shift over time; and

(b) lawmaking and problem solving in villages and local-level communities is largely oral in nature and such oral customary laws, subject to the Constitution, form part of the underlying law of [insert name of country]; and

(c) written declarations of village custom do not codify custom, but rather record principles of custom.

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179 Jowitt et al, Op Cit
180 Etheridge and Howse, Op Cit
181 Underlying Law Act 2000 (PNG), Customs Recognition Act 2000 (SI), section 5 which enables reference to statements by provincial governments or chiefs (whether published or not), as to the existence of a custom.
802—Power to make a declaration of local custom for village health

(1) The Provincial Governor [insert other political head of the area as suitable for the country context] and the head [insert correct term, president, mayor, etc] of a Local-level Government may jointly make a declaration of local custom for village health if the Governor and the head of the affected Local-level Government are satisfied that a consultation process has established that a desire exists in the people of the affected Local-level Government for the making of a declaration of local customary law for village health.

(2) The Provincial Governor and the head of a Local-level Government, in deciding whether a consultation process has established that a desire exists in the people of the Local-level Government for a declaration of local custom for village health, must consider a report in writing prepared by the deputy head of the affected Local-level Government which contains:

(a) a report of oral consultations with the affected village on the custom under consideration which may cover but is not limited to—

(i) a description of the custom and how it operates now; and
(ii) how the custom affects the village and groups within the village; and
(iii) how the custom operated in the past; and
(iv) conclusions on how the village would prefer the custom to operate within the affected Local-level Government area including local villages which may be affected by the proposed declaration of local custom for village health; and

(b) a description of oral statements by chiefs of affected villages if such statements have been made; and
(c) any written statements by chiefs of affected villages if such statements have been made; and
(d) a description of oral statements made by community groups including but not limited to women’s groups; Church groups; youth groups and other community groups if such statements have been made; and
(e) any written statements made by community groups including but not limited to women’s groups, Church groups, youth groups and other community groups if such statements have been made; and
(f) any other oral or written material considered relevant by the provincial governor or the head of the affected Local-level Government.

(3) A declaration of local custom for village health may contain principles of custom and ideas about health and the importance of community and the role of the village community in the protection and promotion health and the prevention of disease.

(4) The declaration of local custom for village health comes into effect from the date it is jointly signed by the Provincial Governor and the head of the Local-level Government.

(5) The Provincial Governor must cause a copy of the declaration of local custom for village health to be delivered to:

the Provincial Administrator; and
the District Chief Magistrate; and
(a) any community group which provided a statement considered by the Provincial Governor and the head of a Local-level Government pursuant to Section 3(2)(d).
(6) A declaration of local custom for village health shall:
(a) come into effect from the date it is signed by both the Governor and the head of the Local level Government; and
(b) remain in effect for the period stated in the declaration but the period must not exceed five years.

(7) To accommodate different customs in villages within a Local-level Government area, a declaration of local custom for village health may be limited in its effect to a village or group of villages within the Local-level Government area covered by the declaration of local customary law.

An example of a declaration of local custom for village health and a complementary local law is included in Schedule 1.
Module 9—Miscellaneous

901—Delegation by Chief Executive
(1) The Chief Executive may delegate a function or power conferred on the Chief Executive under this Act—
(a) to a specified person or body; or
(b) to a person occupying or acting in a specified office or position.

(2) A delegation—
(a) may be made subject to conditions or limitation specified in the instrument of delegation; and
(b) if the instrument of delegation so provides, may be further delegated by the delegate; and
(c) is revocable at will and does not prevent the delegator from acting personally in a matter.

902—Confidentiality
(1) If a person, in the course of official duties, obtains—
(a) medical information relating to another; or
(b) information the disclosure of which would involve the disclosure of information relating to the personal affairs of another, the person must not intentionally disclose that information except to the extent that the person is authorised to do so under subsection (2).

Maximum penalty: 100 penalty units.

(2) A person is authorised to disclose information if the person is—
(a) disclosing information in the course of official duties, or for any other purpose connected with the administration of this Act or another law in [insert name of country]; or
(b) disclosing information as required by law; or
(c) without limiting paragraph (b), disclosing information as required by a court or tribunal constituted by law; or
(d) disclosing information at the request, or with the consent, of the person to whom the information relates or a guardian or medical agent of the person; or
(e) disclosing information to a relative, carer or friend of the person to whom the information relates if—
(i) the disclosure is reasonably required for the treatment, care or recovery of the person; and
(ii) there is no reason to believe that the disclosure would be contrary to the person’s best interests; or
(f) subject to the regulations (if any)—
(i) disclosing information to a health or other service provider if the disclosure is reasonably required for the treatment, care or recovery of the person to whom the information relates; or
(ii) disclosing information by entering the information into an electronic records system established for the purpose of enabling the recording or sharing of information between persons or bodies involved in the provision of health services; or
(iii) disclosing information to such extent as is reasonably required in connection with the management or administration of a hospital or ambulance service; or
(g) without limiting a preceding paragraph, disclosing information to the extent to which it is reasonably necessary—
(i) to provide treatment to the person; or
(ii) to prevent the transmission of any disease constituting a controlled notifiable condition; or

(h) without limiting a preceding paragraph, disclosing information if the disclosure is reasonably required to lessen or prevent a serious threat to the life, health or safety of a person, or a serious threat to public health; or
(i) disclosing information for medical, research or statistical purposes if—
   (i) there is no reason to believe that the disclosure would be contrary to the person’s best interests; and
   (ii) the disclosure is of a kind approved by the Chief Public Health Officer for the purposes of this paragraph; or

(j) disclosing information in accordance with the regulations.

(3) Subsection (2)(e) does not authorise the disclosure of information in contravention of a direction given by the person to whom the information relates.

(4) In this section—
relative—a person is a relative of another if the person is a spouse or parent of the other of or over 18 years of age or a brother, sister, son or daughter of the other.

903—Provision of certain information

(1) This section applies to a person employed or engaged by [insert name of country] for the purpose of—
   (a) monitoring public health in [insert name of country]; or
   (b) investigating public health problems within [insert name of country]; or
   (c) assessing and improving the quality of public health in [insert name of country].

(2) The Minister may, by instrument in writing, authorise a person to whom this section applies to have access to confidential information relating to the performance of any function referred to in subsection (1).

(3) Confidential information may be disclosed to a person authorised under subsection (2), and to any person providing technical, administrative or secretarial assistance to that person, without breach of any law or any principle of professional ethics.

(4) A person must not disclose confidential information obtained directly or indirectly pursuant to this section unless—
   (a) the disclosure is made in the course of official duties; or
   (b) the disclosure is made with the consent of the person to whom the information relates; or
   (c) the disclosure is required by a court or tribunal constituted by law; or
   (d) the disclosure is authorised under the regulations.

Maximum penalty: 100 penalty units.

(5) In this section—
confidential information means—
   (a) medical information; or
   (b) information relating to a person's personal affairs.
904—Service of notices or other documents

(1) Subject to this section, if this Act requires or authorises a notice, order or other document to be served on, or given to, a person, the notice, order or document may—
(a) be served on, or given to, the person or an agent of the person; or
(b) be left for the person at his or her place of residence or business with someone apparently over the age of 16 years; or
(c) be sent by post to the person or an agent of the person at his or her last known address; or
(d) if the notice, order or document is to be served on the owner of land, the land is unoccupied, and the person seeking to serve the notice, order or document has taken reasonable steps to effect service under the other paragraphs of this subsection but has been unsuccessful—be served by fixing it to some conspicuous part of the land; or
(e) if the notice, order or document is to be served on the occupier of land—be sent by post to the occupier at the address of the land; or
(f) be served on the person by fixing it to, or leaving it on, a vessel that the person is apparently in charge of, or expected to board at some stage, if the person giving or serving the notice, order or document has reasonable grounds to believe that service in this manner will bring the notice, order or document to the attention of the person to be served; or
(g) be sent to the person by facsimile transmission; or
(h) be served or given in some other manner prescribed by the regulations.

(2) Without limiting subsection (1), a notice, order or document to be served on or given to a company or registered body within the meaning of the [insert name of relevant corporations law] may be served or given in accordance with that Act.

(3) Subject to the regulations, a notice, order or document required or authorised to be given to an owner of land may, if it is to be served personally, be served on the owner, one of any joint owners, or the agent of the owner.

(4) An order under Part 10 must be served personally on the relevant person.

905—Immunity

(1) No personal liability attaches to—
(a) the Chief Public Health Officer or Chief Executive; or
(b) a member of a body constituted under this Act; or
(c) an authorised officer or any other person engaged in the administration of this Act, for an honest act or omission in the performance, exercise or discharge, or purported performance, exercise or discharge, of a function, power or duty under this Act.

(2) Subject to subsection (3), a liability that would, but for subsection (1), lie against a person lies instead against the Crown.

(3) A liability that would, but for subsection (1), lie against an officer, employee, agent or contractor of a council lies instead against the council.

(4) In addition, no action lies against a person (or an employer or contracting party with respect to a person) who in good faith and with reasonable care—
(a) takes a sample of blood, urine or other material in accordance with this Act; or
(b) conducts a test for the purposes of this Act; or
(c) provides a report about any test results under this Act.
906—False or misleading information
A person must not, in connection with a requirement or direction imposed by or under this Act, provide any information or produce or furnish any document that is false or misleading in a material particular.

Maximum penalty: 200 penalty units.

907—Offences
(1) Proceedings for an offence against this Act may only be commenced by—
(a) the Minister; or
(b) the Director of Public Prosecutions; or
(c) the Chief Public Health Officer; or
(d) an authorised officer; or
(e) a member of the staff of the Department; or
(f) the chief executive officer of a council; or
(g) a member of the police force; or
(h) a person acting on the written authority of the Minister.

(2) An apparently genuine document purporting to be under the hand of the Minister and to authorise the commencement of proceedings under this Act must be accepted in legal proceedings, in the absence of proof to the contrary, as proof of an authorisation under subsection (1)(h).

908—Offences by bodies corporate
If a body corporate is guilty of an offence against this Act, each director of the body corporate is guilty of an offence and liable to the same penalty as is prescribed for the principal offence unless it is proved that the director could not by the exercise of reasonable diligence have prevented the commission of the offence by the body corporate.

909—Continuing offences
(1) If an offence against a provision of this Act is committed by a person by reason of a continuing act or omission—
(a) the person is liable, in addition to the penalty otherwise applicable to the offence, to a penalty for each day during which the act or omission continues of not more than an amount equal to one fifth of the maximum penalty prescribed for that offence; and
(b) if the act or omission continues after the person is convicted of the offence, the person is guilty of a further offence against that provision and liable, in addition to the penalty otherwise applicable to the further offence, to a penalty for each day during which the act or omission continues after that conviction of not more than an amount equal to one fifth of the maximum penalty prescribed for that offence.

(2) For the purposes of this section, an obligation to do something is to be regarded as continuing until the act is done notwithstanding that any period within which, or time before which, the act is required to be done has expired or passed.

910—Regulations
(1) The Governor in Council may make such regulations as are contemplated by this Act or as are necessary or expedient for the purposes of this Act.
(2) Without limiting the generality of subsection (1), those regulations may—
(a) require the provision of reports, returns, documents or other forms of information relevant to public health to the Chief Public Health Officer or other prescribed person or body;
(b) require the keeping of records, statistics and other forms of information by any person or body that performs a function under or pursuant to this Act (and the provision of reports based on that information);
(c) prohibit, restrict or regulate the manufacture, possession, transport, storage, use or disposal of any substance, material or equipment that may create a risk to public health;
(d) provide for the removal or destruction of any material, substance or equipment that creates a risk to public health;
(e) set standards or procedures that must be observed to protect public health and provide for public health planning;
(f) prohibit, restrict or regulate any activity, or the use or sale of any substance, equipment or material, that is a risk to public health;
(g) prescribe information that must be provided to persons in relation to any activity, or the use of any substance, equipment or material, that is a risk to public health;
(h) authorise or require the taking of specified measures to prevent the occurrence or spread of any notifiable condition;
(i) provide for the analysis or testing of samples taken under or for the purposes of this Act, including—

(i) the persons who may analyse or test those samples; and
(ii) the places where those samples may be analysed or tested; and
(iii) the reporting of the results of the analysis or testing of those samples;
(j) provide for such matters as are necessary in consequence of conditions directly or indirectly caused by an emergency declared to be a public health incident or public health emergency under this Act;
(k) without limiting a preceding paragraph, regulate the construction, installation, maintenance and operation, and provide for the inspection, of any facility, infrastructure or structure designed for human use;
(l) without limiting a preceding paragraph, regulate wastewater systems, including by—

(i) regulating the manufacture, construction, sale, installation, alteration, commissioning, decommissioning, operation, maintenance and servicing of wastewater systems; and
(ii) regulating the collection, treatment, reuse and disposal of wastewater or waste from wastewater systems; and
(iii) providing for the referral of applications for approvals in relation to wastewater systems or proposed wastewater systems to specified persons or bodies; and
(iv) requiring the provision of certifications, technical reports or other forms of information in relation to wastewater systems or proposed wastewater systems; and
(v) in connection with the implementation or operation by the authority of a scheme for a wastewater system for a town, regional area or other community—

(A) requiring public notification of the scheme; and
(B) requiring, or empowering the authority to require installation, alteration or connection of wastewater systems for the purposes of the scheme; and
(C) requiring, or empowering the authority to require, the owner or occupier of land to make an application to the authority for any approval required by the regulations for the installation, alteration or connection; and
(D) empowering the authority to carry out necessary work if the owner or occupier fails to comply with the regulations and providing for the recovery of costs or expenses reasonably incurred in doing so from the owner or occupier; and

(vi) regulating the connection or disconnection of wastewater systems from the undertaking within the meaning of the [insert name of sewerage Act or like law regulating the area]; and

(vii) providing for the inspection and testing of wastewater systems and for the giving of orders or the undertaking of work (and recovery of costs incurred) for compliance purposes;

(m) on the recommendation of the Chief Public Health Officer, prescribe guidelines to assist in the administration of this Act;

(n) prescribe fees and expenses in connection with any matter arising under this Act, which may be of varying amounts according to factors prescribed in the regulations or determined by the Minister from time to time and published in the Gazette;

(o) provide for the payment and recovery of prescribed fees and expenses;

(p) empower or require the Minister or a council to refund, reduce or remit any fee payable under this Act;

(q) prescribe forms for the purposes of this Act;

(r) exempt, either absolutely or subject to prescribed conditions or limitations—

(i) persons or classes of persons;

(ii) areas of the State, from this Act or specified provisions of this Act;

(s) prescribe penalties, not exceeding 100 penalty units, for breach of any regulation;

(t) prescribe details of the process to create a declaration of local custom for village health and related matters.

(3) The regulations may adopt, wholly or partially and with or without modification—

(a) a code or standard relating to matters in respect of which regulations may be made under this Act; or

(b) an amendment to such a code or standard; or

(c) a regional partnership agreement between participating regional countries; or

(d) an amendment to a regional partnership agreement between participating regional countries.

(4) Any regulations adopting a code or standard, or an amendment to a code or standard, or a regional partnership agreement or an amendment to a regional partnership agreement may contain such incidental, supplementary and transitional provisions as appear to the Governor to be necessary.

(5) The regulations or a code or standard or regional partnership agreement adopted by the regulations may—

(a) refer to or incorporate, wholly or partially and with or without modification, a standard or other document prepared or published by a prescribed body or person, either as in force at the time the regulations are made or as in force from time to time; and

(b) be of general or limited application; and

(c) make different provision according to the persons, things or circumstances to which they are expressed to apply; and
(d) provide that any matter or thing is to be determined, dispensed with, regulated or prohibited according to the discretion of the Minister, the Chief Public Health Officer, the Chief Executive or a council.

(6) If—
(a) a code or standard or regional partnership agreement is adopted by the regulations; or
(b) the regulations, or a code or standard or regional partnership agreement adopted by the regulations, refers to a standard or other document prepared or published by a prescribed body, then—
(c) a copy of the code, standard, regional partnership agreement or other document must be kept available for inspection by members of the public, without charge and during normal office hours, at an office or offices specified in the regulations; and
(d) in any legal proceedings, evidence of the contents of the code, standard, regional partnership agreement or other document may be given by production of a document purporting to be certified by or on behalf of the Minister as a true copy of the code, standard or other document; and
(e) the code, standard, regional partnership agreement or other document has effect as if it were a regulation made under this Act.
Module 10—Negative licensing, as an option for regulating unregistered health practitioners

What is in this module?

Introduction

Sound stewardship, good governance and effective health workforce management. Together, these constitute one of the three key result areas in the WHO Regional Strategy on Human Resources for Health 2006-2015. Within this document are the following two suggested strategies to address this key result area:

- develop regulatory systems and processes for the accreditation, licensing and certification or credentialing of all categories of the health workforce, including professional codes of practice and cross-border recognition of health worker competencies; and
- promote professional and regulatory body responsibility for self-regulation and continuous quality improvement.

Statutory regulation of health professions is a mechanism to protect the public by setting minimum standards of education, experience, clinical and ethical competence for entry into a profession. Formal registration usually enables suitably qualified applicants to become registered in a certain profession, and to use a title protected under statute, such as “Doctor”, “Nurse” and “Dentist”. Some legislative approaches also protect professional practice, restricting certain specific practices to registered practitioners. These types of approaches are generally not found in the Pacific.

Summary of regulation of health professions in the Pacific

Most Pacific countries have a level of regulatory control of the health professions, concentrating mainly on medical practitioners, dentists, pharmacists and nurses. These laws tend to be old and

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183 For example, see Solomon Islands’ Medical and Dental Practitioners Act 1996, Nursing Council Act 1996 and Pharmacy and Poisons Act (Chapter 105); PNG’s Dental Charges Act 1969 and Medical Registration Act 1980; Vatuatu’s Control of Pharmacists Act, Health Practitioners Act 2006 and Nurses Act (Chapter 262); Fiji’s Medical and Dental Practitioners Act (Chapter 255), Medical Assistants Act (Chapter 255A), Nurses and Midwives Act (Chapter 256), Pharmacy and Poisons Act (Chapter 115), Medical and Dental Practitioner Decree 2010, Medical Imaging Technologists Decree 2010 and Radiation Health Decree 2009; Samoa’s Dental Practitioners Act 2007, Medical Practitioners Act 2007, Healthcare Professions, Registration and Standards Act 2007, Nursing and Midwifery Act 2007 and Pharmacy Act 2007; Tonga’s Health Practitioners Registration Act 2001, Health Services Act 1991, Pharmacy Act 2001, Health Practitioners Review Act 2001, Medical and Dental Practice Act 2001 and Nurses Act 2001; Nauru’s Health Practitioners’ Act 1999; Kiribati’s Nurses and Midwives Ordinance (Chapter 64), Medical and Dental Practitioners Act 1981 and Medical Services Act 1996; and the Cook Islands’ Medical and Dental Practices Act 1986 and Nurses Act 1986. In Niue, the Niue Act 1966 (NZ) where Niue constitution is schedule to the Act. Art 21 of Constitution deals with persons authorised to practice medicine or surgery. Art 23 provides that all hospitals and other institutions under control of Director of Health. The Government
do not regulate the broader range of health practitioners that might be found practising in the Pacific.

**Trend toward registration of appeals body covering all registered professions**

Alongside the older health practitioner registration laws, which are confined to a small coterie of professions, there is a more recent trend in the region toward laws creating a registration body or appeals body to cover all currently registered professions, and to include new ones in some instances. Anecdotal evidence and some government reports\(^\text{184}\) suggest that investigations into professional conduct and prosecutions for breaches of health practitioner registration laws are not routinely pursued, and breaches of the regimes are common.

There is currently work being undertaken in the UK to devolve some of the rules of professional regulation to the professions themselves and to move to a form of registration for alterative health practitioners.\(^\text{185}\)

**Public servants are also subject to a parallel disciplinary regime under public service management laws**

These health practitioner registration laws apply equally to health practitioners (whether in public employment or private practice), as they apply to “use of title”, which is used in both public and private branches of the profession. Public health practitioners who are also public servants are also subject to disciplinary regimes applicable to public servants, although these are not well tailored for health professionals as the codes of conduct on which they are usually based, envisage a more desk-based working environment.

Those charged with responsibility to investigate and make determinations, and apply sanctions in public service disciplinary regimes, are not necessarily trained or experienced in hearing matters relating to the professional conduct of health practitioners. Public service disciplinary regimes are generic for application to all public servants and do not set standards of education, training and professional conduct relevant to health professionals, although some of these may be contained in position descriptions forming the basis of a public servant’s contract of employment. While it is important to note the existence of this parallel regime for health practitioners who are public servants, public service disciplinary measures applied to health practitioners in the public service will

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\(^{184}\) Howse, G, *The Creation and Implementation of a Drug Registration System for the Fiji Islands*, Ministry of Health Fiji, 2005

not be pursued further here. The focus of this module is on regulatory regimes specifically for the registration of all health professions.

**Summary of countries with an overarching health professions registration law**

The health professions in the Pacific that are most commonly regulated by statute, are medical practitioners, nurses, dentists and pharmacists. PNG regulates these four professions, as does Fiji and the Solomon Islands. The Cook Islands regulates three of the four. Nauru, Samoa, the Solomon Islands, Vanuatu and Tonga are part of the more recent trend to add a health practitioners Act to the mix of regulatory approaches in regulating health practitioners. These five countries all have such a law, although it is hard to generalise about the operation and effect of these laws as they function differently in each jurisdiction.

In Vanuatu, the *Health Practitioners Act* operates to register the professions, sets up a Disciplinary Committee and a disciplinary process. Traditional medicine is specifically excluded from the regime.\(^{186}\) It covers all practitioners, whether in private practice or employment under a contract of service for government or another authority.\(^{187}\) The term “health profession” includes medicine and dentistry, but does not include either nursing or pharmacy.\(^{188}\) Ancillary medical professions are also covered and include physiotherapy, osteopathy, radiography and medical laboratory technicians. There is a mechanism for the Minister to prescribe further ancillary professions but not further health professions.

The Nauru *Health Practitioners Act* is an overarching registration regime applying to all health professions in Nauru. It covers medical practitioners, nurses, dentists and any class of health practitioner declared by the Minister in the Gazette. No detail was able to be found on what professions may have been added by declaration in the Gazette. The Act establishes the Health Practitioners Registration Board, granting it powers to consider applications for registration, grant registration and inquire into complaints against registered health practitioners.\(^{189}\)

In Samoa, health practitioners are also separately registered under individual Acts. The *Healthcare Professions Registration and Standards Act 2007* sets up a Disciplinary Committee and a registrar. The Committee ensures standards approved by the registration boards for the professions are acceptable, reflect government policy and comply with international standards. The registrar holds the registers of all registered professionals. The Disciplinary Committee conducts hearings into complaints alleging serious breaches of professional standards, for all registered health professions. The registrar prepares a written record of all complaints and then refers the written record to the relevant council for initial consideration. The council makes a determination. Complaints of serious breaches cause the registrar to convene a hearing of the Disciplinary Committee.

In Tonga, health practitioners are separately registered under individual registration Acts for each profession, including medical practitioners, dentists, pharmacists and nurses. The *Health Practitioners Review Act* sets up the Health Practitioners Review Council. This Council acts to review,

\(^{186}\) *Health Practitioners Act 2006 (Vanuatu)*, Section 17  
\(^{187}\) *Health Practitioners Act 2006 (Vanuatu)*, Section 20  
\(^{188}\) *Health Practitioners Act 2006 (Vanuatu)*, Section 1  
\(^{189}\) *Health Practitioners Act 1999 (Nauru)*, Section 3
upon application, orders made by the Medical and Dental Practice Board, the Nurses Board and the Pharmacy Board.

The Solomon Islands Health Workers Act is different from the others as it defines a health worker as “a person entitled under the provisions of the Act to practise a particular category or categories of health work and perform such functions as may be described”. The desktop review could not locate regulations that might further elucidate the functions of health workers, but the Solomon Islands separately registers medical and dental practitioners, nurses and pharmacists. Each of those laws creates a separate council with duties to undertake investigations into complaints about professional conduct. The Health Workers Board does not appear to have any jurisdiction over the other registered professions, and seems to operate only to regulate this separate cohort of health practitioners.

Community health workers

The registration of community workers in an effort to create standards of practice and education, and to provide for protection of the public, is generally not done by way of a health practitioner registration Act in the Pacific, other than in the Solomon Islands. However, as most community workers are public servants, they would be subject to the disciplinary regime for public servants, although, as described previously, this is not well targeted to the needs of health professionals.

Unregistered practitioners including those practising traditional medicine

The regulatory regimes in Pacific countries are generally confined to a small coterie of professions with some opportunity, in some jurisdictions, to add to those professions by regulation or administrative order. In the preparation of these materials, no data was available on numbers and classifications of registered and unregistered practitioners in Pacific countries, although some national health plans specifically refer to the importance of the practice of traditional medicine in the mix of available health services. A WHO report indicates that in Fiji, 60-

180 Health Practitioners Review Act 2001 (Tonga), Section 3
191 National Department of Health PNG, National Health Plan 2001-2010. In 1979, the Government of the Solomon Islands officially recognised and accepted the use of traditional medicine, as a supplement to
80 percent of the population use traditional medicine. In PNG, it is widely accepted and practised in rural areas where the majority of the population lives. The use of traditional plants for curing common ailments and afflictions in village communities is encouraged by private and non-governmental organisations on the grounds that it is a sensible option in the face of the rising costs of allopathic medicine, transport difficulties, and the poor facilities at aid posts and rural health centres. Similarly, traditional medical practitioners in Samoa have used medicinal plants and other forms of non-drug treatment for centuries. This knowledge is typically passed down within families. There is very little documentation on traditional medicine in the Solomon Islands. Traditional medicine practitioners regard the medicines they use as their personal property and conduct their practices under very strict confidence. Tonga did consider regulation of traditional medicine practitioners but ultimately did not do so.

In Pacific countries, as in many developed and developing countries in other regions, unregistered practitioners are not subject to regulation other than via laws on prescribing and dispensing of drugs and controlled substances, competition and consumer law where these exist, or the criminal law. In Fiji, the lawful practice of acupuncture is subject to registration by the Permanent Secretary for Health. Applicants for registration must establish that they are licensed or otherwise satisfactorily qualified or experience as acupuncturists. The Medical and Dental Practitioners (Amended) Act 1981 (Kiribati) authorises some aspects of traditional medicine in Section 37, which states:

*Nothing in the Medical and Dental Practitioners Ordinance shall affect the right of anyone of Kiribati to practise in a responsible manner Kiribati traditional healing by means of herbal therapy, bone-setting and massage, and to demand and recover reasonable charges in respect of such practice.*

**Do unregistered health practitioners present a risk to the public?**

Protections provided to protect the public from risks presented by unregistered health practitioners in the Pacific, are patchy at best and unlikely to be sufficient. As with registered health practitioners, the overwhelming majority of unregistered practitioners are honest, competent and caring. However, there will always be a limited number of members who present a risk to the public because of a lack of competence, impairment or dishonesty. Adverse events arising from consumption of herbal medicines may be due to any one of a number of factors.

*These include the use of the wrong species of plant by mistake, adulteration of herbal products with other, undeclared medicines, contamination with toxic or hazardous*
substances, overdose, misuse of herbal medicines by either healthcare providers or consumers and use of herbal medicines concomitantly with other medicines.\textsuperscript{193}

Evidence in reports from many countries note the risk to the public from unscrupulous health workers making unsubstantiated claims, the difficulty of members of the public identifying skilled and qualified health practitioners, and the fact that people mix therapies from conventional and traditional medicine leading to unwanted side effects and complications.\textsuperscript{194} Anecdotal evidence notes the proliferation of vendors in markets, in many Pacific countries, selling potions said to cure HIV or cancer.

Unregistered health practitioners may pose a serious risk to the public. It is not suggested that developing countries in the Pacific immediately add several more classes of health practitioner to those already registered, although this may be a matter for longer term policy consideration. The WHO National Policy on Traditional Medicine and Regulation of Herbal Medicines is an excellent resource for countries undertaking policy consideration for regulation of traditional medicine. The usual model of health practitioner registration legislation would be unlikely to be suitable for traditional practitioners. Training for traditional medicine practitioners is via a largely oral tradition, although some training is done through primary health care. This makes the setting of minimum standards of education and training difficult. Further difficulties in relation to the use of herbal medicines include the lack of research data, lack of appropriate control mechanisms, lack of education and training, and lack of expertise.\textsuperscript{195}

**Negative licensing as a regulatory model to facilitate regulation of unregistered health practitioners**

Negative licensing is a regulatory model that, on a regulatory continuum, sits somewhere between self-regulation and statutory registration. It is a more targeted and less restrictive form of regulation than statutory registration, and it provides the regulatory tools to deal directly with those who behave illegally or unethically and, if necessary, prohibits them from practising, while leaving the vast majority of ethical and competent members of an unregulated health profession to self-regulate. It can provide an additional level of public protection with respect to unregistered practitioners, at minimal additional cost to the community.

Using negative licensing of unregistered practitioners is intended to complement existing health practitioner registration laws with a relatively simple legislative mechanism, to enable prosecution of practitioners falling short of a code of conduct for clinical standards. It enables the development of a code of conduct for unregistered health practitioners. “Unregistered health practitioner” refers to any person who provides a health service and is not registered under existing health practitioner

\textsuperscript{194} Lin, V, Bensoussan, A, Myers, S, McCabe, P, Cohen, M, Hill, S, Howse, G, and Dean S, The Practice and Regulatory Requirements for Naturopathy and Western Herbal Medicine, 2005, Melbourne, Victorian Government Department of Human Services
registration laws. The code of conduct also applies to registered health practitioners who provide health care treatment that is unrelated to their profession. Practitioners who breach the code may be dealt with by an appropriate court or tribunal, and where the practitioner represents a substantial risk to the health of members of the public, the practitioner can either be banned from practice, or have conditions placed on his or her practice. It is suggested in the five Pacific countries where a health practitioners board or council or health workers board has been established, that this would be the natural home for such a responsibility, and could be added to the existing responsibilities of such boards without significant additional burden.

How does negative licensing work?

A code of conduct provides the basis for the effective enforcement of standards of conduct and practice by unregistered health practitioners. It provides a court or tribunal with a set of standards against which to objectively assess the conduct of practitioners, and communicates these standards to practitioners.

It means that registration, which can be administratively burdensome and expensive, is simplified by a legislative mechanism that creates a code of conduct setting minimal, rather than optimal, standards to which all practitioners are obliged to adhere. It also enables limitations or removal of rights to practise on those practitioners whose conduct is found to fall short of the standards imposed by the code of conduct. The code is placed in public health law, and amendments would be made to existing health practitioner registration laws, and to any overarching health practitioner registration law where one exists. It is a relatively simple legislative approach.

It is suggested that this mechanism is best placed in a schedule to the public health regulations. Alternatively, it could be placed in a schedule to the regulations of health practitioners Acts.

Policy considerations

In each jurisdiction, consideration should be given to existing health practitioner registration law. What boards currently exist, and is there presently an overarching body that registers, conducts investigations into serious professional misconduct, or hears appeals from determinations of single profession registration boards? The mechanism of negative licensing does not replace but complements existing law. It is currently in use in jurisdictions that have substantial health practitioner registration laws. What broad policy approach do countries wish to take in this area in the short to long term? What issues presently exist in relation to potential public harm from unregistered practitioners, who fail to meet acceptable standards of training, behaviour or clinical practice? The most important consideration is protection of the public. Is the public at risk under the current regime, which leaves many health practitioners unregistered?

Further policy considerations might be an identified need to address specific cohorts of workers currently working in the health profession, but who are almost entirely unregulated. In the Pacific, this may include community health workers and traditional medicine practitioners. It would be

196 Health Legislation Amendment (Unregistered Health Practitioners) Act 2006 (NSW)
possible to develop separate codes of conduct for such workers, if the kinds of matters to be included in such a code of conduct could not be properly addressed in a generic code.

**Preconditions for implementation of negative licensing**

The most essential precondition is a tribunal to hear the complaints. This model generally uses a health complaints commissioner, but health complaints laws and health complaints commissioners are not found in the Pacific. An alternative might be to give the role to a panel convened by the Chief Executive. Appeals would then lie to the most appropriate court, for example the National Court in PNG. However, the simplest mechanism, and that which is proposed in the legislative text, is the use of an existing overarching body which registers, conducts investigations into serious professional misconduct, or hears appeals from determinations of single profession registration boards.

It is suggested that the hearing of complaints into breaches of a code of conduct by unregistered practitioners would not add greatly to the existing administrative burden of such councils. Some consideration would also need to be given to the accessibility of such a regulatory regime, particularly in geographically diverse and difficult countries such as PNG. Consideration might need to be given to a council going on circuit and perhaps a system of referrals, via a delegation by the registrar, to a nominated officer in a provincial health authority.

**Conclusion**

Negative licensing has the virtue of helping to address some obvious gaps in the system of registration and regulation of health professions. It might be particularly useful for professions not well regulated but practising in large numbers, such as community health workers and traditional medicine practitioners. If there is an existing body that is suitable to hear complaints, the mechanism can be activated without adding greatly to the existing administrative burden of professional registration (by using an existing overarching body with a registration and investigation role or a role to review decisions of single discipline registration boards). The mechanism targets those who breach a code of conduct, rather than setting standards and monitoring all practitioners. The mechanism is worthy of a place in the mix of regulatory strategies in the developing countries of the Pacific region.

The legislative text is set out in three parts to create a negative licensing regime.

- **Part 1** is legislative text to be included in an existing overarching health professions registration law where one exists, for example, in Tonga, Samoa and Nauru.
- **Part 2** is legislative text to be included in regulations under the public health law or, if preferred, in regulations under the overarching health professions registration Act, which contains the code of conduct to which all unregistered practitioners must adhere. It also applies to registered practitioners where they are conducting treatments outside their area of professional registration.
- **Part 3** is legislative text to be included in all single profession health practitioner registration laws, such as a medical practice Act, dentists Act or nurses Act.
Part 1

Part one is legislative text to be included in an existing overarching health professions registration law where one exists, for example, in Tonga, Samoa and Nauru. An alternative, where such an overarching law does not exist, would be to create a separate division in a public health law to establish a panel or body to conduct the investigations. However, such an approach requiring creation of a new body to conduct investigations and hear complaints, would impose a much greater burden than using an existing body.

If preferred, the legislative text included here could be easily adapted for such a purpose.

This legislative text is not complete as it would need additions to fit it into the existing legislative regime, but as these are quite different across the Pacific, this legislative text is intended to provide a good idea of how such a regime might look. Additional work would need to be done in each jurisdiction to complete the amending Bill, to make any necessary changes to existing powers to accommodate this additional responsibility, and to savings and transitional provisions etc.

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**Action against unregistered health practitioners**

1001—Interim prohibition orders

(1) The [insert name of health professions review board or council] may, during any investigation of a complaint against an unregistered health practitioner, make an order (an interim prohibition order) in respect of the unregistered health practitioner.

(2) The [insert name of health professions review board or council] may make an interim prohibition order only if:

   (a) it has a reasonable belief that the health practitioner has breached a code of conduct for unregistered health practitioners; and
   (b) it is of the opinion that:

      (i) the health practitioner poses a serious risk to the health or safety of members of the public; and
      (ii) the making of an interim prohibition order is necessary to protect the health or safety of members of the public.

(3) An interim prohibition order may do one or both of the following:

   (a) prohibit the health practitioner from providing health services or specified health services;
   (b) place such conditions as the Commission thinks appropriate on the provision of health services or specified health services by the health practitioner.

(4) An interim prohibition order remains in force for a period of 8 weeks or such shorter period as may be specified in the order.

(5) The Commission must notify the health practitioner of its decision to make an interim prohibition order and provide the health practitioner with a written statement of the decision that sets out the grounds on which the decision was made as soon as practicable after the decision is made.

(6) In this section, code of conduct for unregistered health practitioners means a code of conduct prescribed by regulations under section [insert relevant section of public health law].

1002—Prohibition orders and public statements

(1) The [insert name of health professions review board or council] may take action under this section if:
(a) it has complied with [insert any relevant sections about the triggering of an investigation under the relevant health professions registration or review Act] with respect to an investigation of a complaint against a health practitioner; and
(b) it finds that the health practitioner has breached a code of conduct for unregistered health practitioners or has been convicted of a relevant offence; and
(c) it is of the opinion that the health practitioner poses a risk to the health or safety of members of the public.

(2) The action that the [insert name of health professions review board or council] may take under this section is either or both of the following:
(a) make an order (a prohibition order) that does any one or more of the following:
(i) prohibits the health practitioner from providing health services or specified health services for the period specified in the order or permanently;
(ii) places such conditions as the [insert name of health professions review board or council] thinks appropriate on the provision of health services or specified health services by the health practitioner for the period specified in the order or permanently;

Note: [insert relevant section of the public health Act] provides that it is an offence for a person to provide a health service in contravention of a prohibition order.

(b) cause a public statement to be issued in a manner determined by the [insert name of health professions review board or council] identifying and giving warnings or information about the health practitioner and health services provided by the health practitioner.

(3) If the [insert name of health professions review board or council] is aware that a person in respect of whom it is proposing to make a prohibition order is registered under the health practitioner registration law, the [insert name of health professions review board or council] is, before making the prohibition order, to notify the relevant professional council of the proposed order and give that council an opportunity to make a submission.

(4) The Commission may revoke or revise a statement under subsection (2) (b).

(5) In this section:
\textit{code of conduct for unregistered health practitioners} means a code of conduct prescribed by regulations under [insert relevant section of the public health law].
\textit{relevant offence} means:
(a) an offence under [insert relevant section of the public health law]; or
(b) an offence under the [insert sections in any relevant fair trading or trade practices legislation] that relates to the provision of health services.

\textbf{1003—[insert name of health professions review board or council] to provide details of its decision to make prohibition order}

(1) If the [insert name of health professions review board or council] makes any of the following decisions in respect of a health practitioner under section 1002, it must provide the health practitioner with a written statement of the decision as soon as practicable after the decision is made:
(a) a decision that the health practitioner has breached a code of conduct for unregistered health practitioners;
(b) a decision to make a prohibition order in respect of the health practitioner;
(c) a decision to issue, revoke or revise a public statement about the health practitioner under section 1001.

(2) The statement of a decision must:
(a) set out any findings on material questions of fact; and
(b) refer to any evidence or other material on which the findings were based; and
(c) give the reasons for the decision.

(3) The [insert name of health professions review board or council], subject to subsections (4) and (5):
(a) must provide a statement of the decision to the complainant; and
(b) must provide a statement of the decision to any professional body or association that the
Commission considers to be relevant to the health practitioner or to the area of practice to which the
complaint relates; and
(c) may make a statement of the decision publicly available.

(4) The [insert name of health professions review board or council] may remove from a statement of
a decision that is provided to a person or body, or made publicly available, under subsection (3), any
material that it considers to be confidential information.

(5) When confidential material is not included in the statement of a decision the statement should
indicate that such material has been removed.

(6) This section does not affect the power of a court to make an order for the discovery of documents
or to require the giving of evidence or the production of documents to a court.

(7) In this section:
confidential information means information that:
(a) has not previously been published or made available to the public when a written statement of a
decision to which it is or may be relevant is being prepared; and
(b) relates to the personal or business affairs of a person, other than the person to whom the [insert
name of health professions review board or council] is required to provide the written statement of the
decision; and
(c) is information:
(i) that was supplied in confidence; or
(ii) the publication of which would reveal a trade secret; or
(iii) that was provided in compliance with a duty imposed by or under an Act; or
(iv) the provision of which by the Commission would be in breach of an Act or law.

1004—Appeals to [insert appropriate review body, such as a national court]

(1) A health practitioner may apply to the [insert appropriate court] for a review of the following
decisions under section [insert relevant section when confirmed];
(a) a decision that the health practitioner has breached a code of conduct for unregistered health
practitioners;
(b) a decision to make an interim prohibition order or a prohibition order in respect of the health
practitioner;
(c) a decision to issue, revoke or revise a public statement about the health practitioner.

(2) An application under this section is to be made within 28 days after the day on which the health
practitioner is provided with the statement of the decision.

1005—[insert name of health professions review board or council] to provide registration
authorities and professional councils with details of interim prohibition orders and prohibition
orders

If the [insert name of health professions review board or council] makes an interim prohibition order
under section 1001 or a prohibition order under section 1002 in respect of a health practitioner, it is to
provide a copy of the statement of the decision in respect of that order to each registration authority
and professional council.
Part 2

This is the proposed legislative text to be included in the public health law. It creates a code of conduct for unregistered health practitioners and creates an offence of breaching that code of conduct. Once again, it would need to be carefully considered for its “fit” into the existing regulatory regime. The “mix” of laws creating regulatory regimes for health practitioners differs greatly across the Pacific, so careful consideration would need to be given to the regime in its entirety, and would be likely to result in alterations and additions to the legislative text.

1006—Definitions in this Part:

health practitioner, health registration Act, health service and registration authority have the same meanings as in the [insert name of relevant law if these terms are defined in other laws, such as existing health practitioner registration laws or health complaints laws].

[Drafting note: suggested definitions for the terms if none presently exist in other laws are as follows:] health practitioner means a natural person who provides a health service (whether or not the person is registered under a health registration Act).

health registration Act means any of the following Acts: [insert names of existing health practitioner registration laws, such as dental practice Act, medical practice Act, nurses and midwives Act etc]

health service includes the following services, whether provided as public or private services:

[Drafting note: check for definition of “health service” in other laws to avoid possible inconsistency. Also note that this is a comprehensive list taken from regulations in a developed country. Many of these professions would be likely to be removed where they do not exist, however, the complete list has been left in for the purpose of enabling a comprehensive consideration of which health practitioners may be operating and require inclusion in the regime. Traditional medicine practitioners are specifically included.]

(a) medical, hospital and nursing services;
(b) dental services;
(c) mental health services;
(d) pharmaceutical services;
(e) ambulance services;
(f) community health services;
(g) health education services;
(h) welfare services necessary to implement any services referred to in paragraphs (a) to (g);
(i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, psychologists and optical dispensers;
(j) services provided by persons practising traditional medicine;
(k) services provided by dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers;
(l) services provided in other alternative health care fields;
(m) forensic pathology services;
(n) a service prescribed by the regulations as a health service for the purposes of this Act.

registration authority means the person who has the function, under a health registration Act, of determining an application for registration under the Act

medical student has the same meaning as in the [insert name of medical practice Act, or any other law where this term is defined]

registered midwife and registered nurse have the same meanings as in the [insert name of nurses and midwives Act, or any other law where this term is defined]

restricted health services are health services prescribed in Schedule 2.
1007—Proceedings for offences under this Part

(1) Proceedings for an offence under this Part may be instituted by the Chief Executive, a registration authority, the [insert name of any authority charged with responsibility to hear complaints into health service delivery, e.g., health professions registration council or similar] or by any other person.

(2) Proceedings for an offence under this Part may be commenced at any time within, but not later than, 2 years after the date on which the offence is alleged to have been committed.

Division 2—Health practitioners who are de-registered or subject to prohibition orders

1008—Definitions

(1) In this Division:

de-registered health practitioner means a health practitioner whose registration as a health practitioner under a health registration Act is cancelled or suspended as a result of disciplinary proceedings.

prohibition order means a prohibition order made under a health registration Act or under [insert relevant section of a health professions registration Act, which enables a prohibition order to be made against an unregistered practitioner for breach of the code of conduct. Draft legislative text for such legislation is set out above.]

(2) For the purposes of this Division, a person’s registration as a health practitioner under a health registration Act is cancelled if any of the following happen as a result of an action, decision, determination or order of a registration board, tribunal or court under that Act or legislation:

(i) the person’s registration is cancelled;
(ii) the person is de-registered;
(iii) the person’s name is removed from, or struck off, a register or a roll; or
(iv) the person’s practising certificate is cancelled.

(3) For the purposes of this Division, a health practitioner is subject to a prohibition order if the order subjects the health practitioner to whom it applies to conditions when providing health services or prohibits the practitioner from providing some or all health services.

1009—Provision of health services by persons who are de-registered or subject to prohibition orders

(1) A person must not provide a health service in contravention of a prohibition order.

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(2) A de-registered health practitioner must, before providing a health service to a person, ensure that the following persons are notified, in accordance with the regulations, that the health practitioner was registered under a particular health registration Act and that the health practitioner’s registration under that Act or legislation has been cancelled or suspended:

(a) the person to whom the health practitioner intends to provide the health service or, if that person is under 16 years of age or under guardianship, a parent or guardian of the person;
(b) if the health service is to be provided by the health practitioner as an employee, the health practitioner’s employer.

Maximum penalty: 50 penalty units.

(3) A health practitioner who is subject to a prohibition order must, before providing a health service to a person, ensure that the following persons are notified, in accordance with the regulations, that the health practitioner is subject to the order:

(a) the person to whom the health practitioner intends to provide the health service or, if that person is under 16 years of age or under guardianship, a parent or guardian of the person;
(b) if the health service is to be provided by the health practitioner as an employee, the health practitioner’s employer.

Maximum penalty: 50 penalty units.

1010—Advertising of health services if a person is de-registered or subject to a prohibition order

(1) A person must not advertise a health service that is to be provided by a de-registered health practitioner unless the advertisement specifies that the health practitioner was registered under a particular health registration Act and that the health practitioner’s registration under that Act or legislation is cancelled or suspended.

Maximum penalty: 50 penalty units.

(2) A person must not advertise a health service that is to be provided by a health practitioner who is subject to a prohibition order unless the advertisement specifies that the health practitioner is subject to the order.

Maximum penalty: 50 penalty units.

(3) A person is not guilty of an offence under this section if he or she did not know, and could not reasonably have known, that the health practitioner was de-registered or subject to a prohibition order.

Division 4—Miscellaneous

1011—Codes of conduct for unregistered health practitioners

(1) The regulations may prescribe codes of conduct for the provision of health services by:
(a) health practitioners who are not required to be registered under a health registration Act (including de-registered health practitioners); and
(b) health practitioners who are registered under a health registration Act who provide health services that are unrelated to their registration.

(2) Before a code of practice is prescribed under subsection (1), the Minister is to:
(a) give public notice of the code in a form and manner determined by the Minister, specifying where the code can be inspected and the time and manner in which submissions may be made; and
(b) place the draft code and an impact assessment statement for the code on public exhibition for not less than 21 days; and
(c) consider any submission received within 21 days (or such longer period as the Minister may determine) after the end of that exhibition period.

Note: the Legislative text provided above permits [insert name of health professions review board or council] to make a prohibition order in respect of a health practitioner if the [insert name of health professions review board or council] finds that the health practitioner has breached the code of conduct and poses a substantial risk to the health of members of the public. The [insert name of health professions review board or council] is also able to cause a public statement to be issued in such circumstances identifying and giving warnings about the health practitioner.

1012—Advertisement or promotion of health services

A person must not advertise or otherwise promote the provision of a health service in a manner that:
(a) is false, misleading or deceptive; or
(b) is likely to mislead or deceive; or
(c) creates, or is likely to create, an unjustified expectation of beneficial treatment.
Maximum penalty:
(a) for a first offence 100 penalty units; or
(b) for a second or subsequent offence 200 penalty units.

1013—Warnings about unsafe treatments or services
(1) If following an investigation, the [insert name of health professions review board or council] is of the view that a particular treatment or health service poses a risk to public health or safety, the [insert name of health professions review board or council] may cause a public statement to be issued in a manner determined by the [insert name of health professions review board or council] identifying and giving warnings or information about the treatment or health service.

(2) The [insert name of health professions review board or council] may revoke or revise a statement under subsection (1).

1014—Board decisions and names of de-registered practitioners to be publicly available
(1) The [insert name of health professions review board or council]:
(a) must make publicly available a statement of a decision of the Board if the statement is provided to it under a health registration Act and is in respect of a complaint that has been proved or admitted in whole or in part; and
(b) must make publicly available the statement of a decision of the following bodies if the statement is provided to it under a health registration Act [insert names and relevant sections of health practitioner registration laws, such as the medical practice Act, nurses Act etc];
(c) may disseminate any other statement of a decision provided to it under a health registration Act as the [insert name of health professions review board or council] thinks fit, unless the relevant tribunal or board has ordered otherwise.

(2) The [insert name of health professions review board or council] is to make publicly available information required to be provided to it under a health registration Act about a person whose registration as a health practitioner under a health registration Act is cancelled or suspended as a result of disciplinary proceedings.

(3) For the purposes of this section, a person’s registration as a health practitioner under a health registration Act is cancelled if any of the following happen as a result of an action, decision, determination or order of a registration board, tribunal or court under that Act:
   (i) the person’s registration is cancelled;
   (ii) the person is de-registered;
   (iii) the person’s name is removed from, or struck off, a register or a roll; or
   (iv) the person’s practising certificate is cancelled.

1015—Protection from liability for certain publications
(1) A publication in good faith under section [insert numbers of relevant sections above enabling publication of information] does not subject a protected person to any liability (including liability in defamation).

(2) In this section:

protected person means:
(a) [insert name of health professions review board or council]; or
(b) a board or tribunal established under a health registration Act or a member of any such board or tribunal; or
(c) the proprietor, editor or publisher of a newspaper; or
(d) the proprietor or broadcaster of a radio or television station or the producer of a radio or television show; or
(e) an internet service provider or internet content host; or
(f) a member of staff of or a person acting at the direction of any person or entity referred to in this definition; or
(g) any person, or person belonging to a class of persons, prescribed by the regulations for the purposes of this section.

SCHEDULE 1—Code of conduct

1 Definitions
In this code of conduct:
health practitioner means a natural person who provides a health service (whether or not the person is registered under a health registration Act).
health registration Act means any of the following Acts: [insert names of existing health practitioner registration Acts, such as those regulating medical practitioners, dentists, nurses and pharmacists]
health service includes the following services, whether provided as public or private services:
(a) medical, hospital and nursing services;
(b) dental services;
(c) mental health services;
(d) pharmaceutical services;
(e) ambulance services;
(f) community health services;
(g) health education services;
(h) welfare services necessary to implement any services referred to in paragraphs (a)-(g);
(i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, psychologists and optical dispensers;
(j) services provided by persons using traditional medicine;
(k) services provided by dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers;
(l) services provided in other alternative health care fields;
(m) forensic pathology services;
(n) a service prescribed by the regulations as a health service for the purposes of this Act.

2 Application of code of conduct
This code of conduct applies to the provision of health services by:
(a) health practitioners who are not required to be registered under a health registration Act (including de-registered health practitioners); and
(b) health practitioners who are registered under a health registration Act who provide health services that are unrelated to their registration.

3 Health practitioners to provide services in safe and ethical manner
(1) A health practitioner must provide health services in a safe and ethical manner.

(2) Without limiting subclause (1), health practitioners must comply with the following principles:
(a) a health practitioner must maintain the necessary competence in his or her field of practice;
(b) a health practitioner must not provide health care of a type that is outside his or her experience or training;
(c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client;
(d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances;
(e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate;
(f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable;
(g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving;
(h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving;
(i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation;
(j) a health practitioner must use their best efforts to obtain appropriate available emergency assistance in the event of any serious misadventure during a client consultation.

4 Health practitioners diagnosed with an infectious medical condition
(1) A health practitioner who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.

(2) Without limiting subclause (1), a health practitioner who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

5 Health practitioners not to make claims to cure certain serious illnesses
(1) A health practitioner must not hold himself or herself out as qualified, able or willing to cure cancer and other terminal illnesses.

(2) A health practitioner may make a claim as to his or her ability or willingness to treat or alleviate the symptoms of those illnesses if that claim can be substantiated.

6 Health practitioners to adopt standard precautions for infection control
(1) A health practitioner must adopt standard precautions for the control of infection in his or her practice.

(2) The meaning of “standard precautions” in subsection (1) when applied to persons practising traditional medicine must take into account the village and bush settings in which such services take place.

7 Appropriate conduct in relation to treatment advice
(1) A health practitioner must not attempt to dissuade clients from seeking or continuing with treatment by a registered medical practitioner.

(2) A health practitioner must accept the right of his or her clients to make informed choices in relation to their health care.

(3) A health practitioner should communicate and cooperate with colleagues and other health care practitioners and agencies in the best interests of their clients.

(4) A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner must refer the matter to the [insert name of health professions review board or council].

8 Health practitioners not to practise under influence of alcohol or drugs
(1) A health practitioner must not practise under the influence of alcohol or unlawful drugs.

(2) A health practitioner who is taking prescribed medication must obtain advice from the prescribing health practitioner on the impact of the medication on his or her ability to practice and must refrain from treating clients in circumstances where his or her ability is or may be impaired.
9 Health practitioners not to practise with certain physical or mental conditions
A health practitioner must not practise while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that detrimentally affects, or is likely to detrimentally affect, his or her ability to practise or that places clients at risk of harm.

10 Health practitioners not to financially exploit clients
(1) A health practitioner must not accept financial inducements or gifts for referring clients to other health practitioners or to the suppliers of medications or therapeutic goods or devices.

(2) A health practitioner must not offer financial inducements or gifts in return for client referrals from other health practitioners.

(3) A health practitioner must not provide services and treatments to clients unless they are designed to maintain or improve the clients’ health or wellbeing.

11 Health practitioners required to have clinical basis for treatments
(1) A health practitioner must not diagnose or treat an illness or condition without an adequate clinical basis.

(2) The meaning of “adequate clinical basis” when applied to persons practising traditional medicine must take into account the oral and customary nature of the training process.

12 Health practitioners not to misinform their clients
(1) A health practitioner must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or as to his or her qualifications, training or professional affiliations.

(2) A health practitioner must provide truthful information as to his or her qualifications, training or professional affiliations if asked by a client.

(3) A health practitioner must not make claims, either directly or in advertising or promotional material, about the efficacy of treatment or services provided if those claims cannot be substantiated.

13 Health practitioners not to engage in sexual or improper personal relationship with client
(1) A health practitioner must not engage in a sexual or other close personal relationship with a client.

(2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of their therapeutic relationship.

14 Health practitioners to comply with relevant privacy laws
A health practitioner must comply with the relevant legislation of the State or the Commonwealth relating to his or her clients’ personal information.

15 Health practitioners to keep appropriate records
(1) A health practitioner must maintain accurate, legible and contemporaneous clinical records for each client consultation.

(2) Subsection (1) does not apply to persons practicing traditional medicine.

16 Health practitioners to keep appropriate insurance
(1) A health practitioner should ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.
(2) Subsection (1) does not apply to persons practising traditional medicine.

17 Certain health practitioners to display code and other information
(1) A health practitioner must display a copy of each of the following documents at all premises where the health practitioner carries on his or her practice:
(a) this code of conduct;
(b) a document that gives information about the way in which clients may make a complaint to the [insert name of health professions review board or council], being a document in a form approved by the Chief Executive of the Department of Health.

(2) Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.

(3) This clause does not apply to any of the following premises:
(a) the premises of any body within the public health system;
(b) the premises or place of consultation of a person practising traditional medicine.

Part 3

[Drafting note: this part of the legislative text is intended to be used in all existing health practitioner registration Acts. Insert in alphabetical order in definition section:]

[insert name of health professions review board or council] means the Board constituted under the [insert name of relevant health care professions standards Act]

Health Registration Act includes [insert names of relevant health practitioner registration Acts]

Health service has the same meaning as in the [insert name of relevant law]

Prohibition order has the same meaning as in [insert name of relevant law].

1016—Consequences of misconduct etc
(1) If the Board makes an order under [insert relevant section] in respect of a person and it is satisfied that the person poses a substantial risk to the health of members of the public, it may by order (a "prohibition order") do any one or more of the following:
(a) prohibit the person from providing health services or specified health services for the period specified in the order or permanently;
(b) place such conditions as the Board thinks appropriate on the provision of health services or specified health services by the person for the period specified in the order or permanently.

Note: [insert relevant section and name of the public health Act] provides that it is an offence for a person to provide a health service in contravention of a prohibition order.

(2) If the Board is aware that a person in respect of whom it is proposing to make a prohibition order is registered under a health registration Act other than this Act, the Board is, before making the prohibition order, to notify the board constituted under that other Act of the proposed order and give that board an opportunity to make a submission.

1017—Written statements of decisions
The Board:
(a) must make publicly available a statement of a decision if the decision is in respect of a complaint that has been proved or admitted in whole or in part and ensure that any such statement is provided to the [insert name of health professions review board or council]; and
(b) may disseminate any other statement of a decision as the Board thinks fit.
### 1018—Cancelled registrations to be publicly available

(1) The Board is to make publicly available:
(a) the name of each person who is subject to an order of the Board or the [insert correct name of Court] that the person’s name be removed from the register; and
(b) such other information about the person as may be prescribed by the regulations.

(2) The Board is to ensure that the information required to be made publicly available under subsection (1) is provided to the [insert name of health professions review board or council].

(3) The Board is not required to make publicly available information about a person:
(a) who is deceased; or
(b) who belongs to a class of persons prescribed by the regulations for the purposes of this section.

### 1019—Protection from liability for certain publications

(1) A publication in good faith under section 1017 or 1018 does not subject a protected person to any liability (including liability in defamation).

(2) In this section:
protected person means:
(a) the Board or a member of the Board; or
(b) the proprietor, editor or publisher of a newspaper; or
(c) the proprietor or broadcaster of a radio or television station or the producer of a radio or television show; or
(d) an internet service provider or internet content host; or
(e) a member of staff of or a person acting at the direction of any person or entity referred to in this definition; or
(f) any person, or person belonging to a class of persons, prescribed by the regulations for the purposes of this section.

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### Schedule 1—Example of a declaration of local custom for village health and a complementary local law

This example was developed under Papua New Guinea law, and uses the example of a law developed for a local-level government area in Manus province. It refers to a number of relevant affected PNG laws. It could easily be adapted for other countries, but was drafted showing how such a law might be fitted into other relevant existing laws. To adapt it for use in other countries, work would need to be done to explore how the constitution incorporates customary law and which present laws provide for the use of customary law. These would then need to be fitted into the operation of the declaration and the complementary local law, as shown in this example. It would also be necessary to explore local government laws to establish how local laws were made, and to ensure the complementary local law is consistent with such existing law.
Schedule 1 – Declaration of Local Custom for Village Health

Public Health Act 2011

Declaration of Local Custom for Village Health in relation to food exchanged in bride price ceremonies

Declaration No 2 of [insert name of village or Local-level Government area/ward etc]

This joint declaration of local customary law is hereby made by us, [insert name of Governor], Governor of [insert name of province or relevant region], together with [insert name of Head of Local-level Government and relevant area/village etc], in accordance with the Public Health Act 2010 empowering the Governor jointly with a Head of a Local-level Government to make a declaration of local custom for village health.

We, [insert name of Governor] Governor [insert name of province or relevant region] and [insert name of Head of Local-level Government and area], declare as follows:

1. Our local customs provide structure, dignity and purpose in our way of life. In a global environment where people are suffering from the loss of a sense of shared humanity, our communities are strong and our family kinship is close. We are proud of the strength of our shared customs and we wholeheartedly embrace the fifth goal of the National Goals and Directive Principles called for by the people of Papua New Guinea in our Constitution:

“We declare our fifth goal to be to achieve development primarily through the use of Papua New Guinean forms of social, political and economic organisation.”

2. We believe in the importance of our customary ways which bind the people of the villages and communities of [insert name of province or region] and bring them together; and

3. Our customary ways are the expression of love of home, family, community and way of life, care for others and a commitment to sharing resources; and

4. Our customary ways have cared for the health of generations of our parents and the parents of our parents and we yearn for the strength to retain customary ways to protect the health of our children and grandchildren;

5. We are confident of the wisdom of the men and women of [insert name of village], whether passed down by our elders or currently possessed in our villages; and after broad public consultation with the men and women of [insert name of village], we assert the following principles:
PRINCIPLES OF CUSTOM IN RELATION TO FOOD EXchanged IN BRIDE PRICE CEREMONIES

1. Customary rituals and celebrations which are part of the process of formalisation of customary marriage are intended to create a new family within the community which is recognised, welcomed and supported by the families of both the bride and the groom and by the whole community in which they will take their place as husband and wife and later into which their children will be welcomed and raised.

2. [insert name of village] wishes to nurture respect between men and women in customary marriage.

3. We reject as grotesque the idea that a price can ever be put on a man, woman or child and it is not the purpose of bride price ceremonies to put a price on a woman or a man but rather to form part of the marriage obligation exchange to mark the coming together of two families and signal the mutual obligation brought into existence by the marriage.

4. This declaration does not codify the full ritual of customary marriage in [insert name of village] which lives in the traditions and memories of our people and is a rich and complex practice consisting of many steps.

5. We recognise that bride price ceremonies have changed over time and our elders remember when it was performed with local food and dogs teeth but now it is usually performed with cash and food bought from a store.

6. Some of our people are poor and struggle to pay increasing amounts of cash and purchase expensive store foods to meet their obligations for bride price ceremonies.

7. We recognise that more of our people are contracting diabetes and that part of the cause is the move away from our traditional diet of local food to higher consumption of store food.

8. Consultations with the people have shown a desire to reduce the burden of bride price ceremonies payment and to reduce the burden of the disease of diabetes on ourselves and our children but to retain the rich tradition of customary marriage with all its meaning and significance and to continue to recognise, celebrate and welcome the formalisation of customary marriage in [insert name of village].

DECLARATION COMPLEMENTED BY A LOCAL LAW

This Declaration of Local Custom for Village Health is complemented by a local law passed by [insert name of village] Local-level Government, the purpose of which is to create some legal rules about limitations on the exchange of store food as part of bride price ceremonies payment which enables [insert name of village] Local-level Government, to take some specific actions to support the application of the principles in this Declaration.
LAW CANNOT GIVE EFFECT TO THE ASPIRATIONS, EMOTIONS AND OPINIONS OF THE PEOPLE

The nature of a law is narrow and its technical structure cannot express the underlying aspirations, emotions and opinions of the people of [insert name of village] Local-level Government. The purpose of this Declaration of Local Custom for Village Health is to make clear the rich customary and cultural context in which the local law is made and to which the local law on its own is incapable of giving expression.

This Declaration of Local Custom for Village Health is:

1. binding on village courts by operation of [insert section and name of the relevant Act that governs village courts]; and
2. may be referred to by a court in the determination of a question about the existence of the local customary law referred to in this declaration by operation of [insert section and name of the relevant underlying Act].

We hereby make this declaration of local customary law applicable within [insert name of village] Local-level Government.

This Declaration is made on Date: [insert date] and will have effect until [insert date of sunset, which must not exceed 5 years]

By:

Governor [insert name of Province or other region]  Local-Level Government President [insert name of village] Local-level Government

Name of Witness  Name of Witness
[INSERT NAME OF LOCAL-LEVEL GOVERNMENT]

No. of 2011.

A BILL

for

A Local Law of [insert name Local-level Government].

No. of 2011.
A BILL

for

A Local Law of [insert name of Local-level Government]

entitled

[insert name of LOCAL-LEVEL GOVERNMENT (BRIDE PRICE CEREMONIAL FOOD GIFT LIMITATION) LAW 2011].
[INSERT NAME OF LOCAL-LEVEL GOVERNMENT]

No. of 2011.


ARRANGEMENT OF CLAUSES

1. Name of law
2. Interpretation
3. Application
4. Limitation on type of food exchanged for the purpose of a bride price ceremonial exchange payment
5. Bride price ceremonial exchange payment payable on customary marriage between parties from [insert name of village/Local-level Government area] and outside the Local-level Government area
6. Law does not create an obligation to make a bride price ceremonial exchange payment
7. Offence
[INSERT NAME OF LOCAL-LEVEL GOVERNMENT]

No. of 2011.

A BILL

for

A Local Law

entitled


BEING a law of [insert name] Local-level Government to—

(a) give effect to [insert relevant laws where these exist, possibly the Constitution, organic laws, or local government laws]; and
(b) give effect to the [insert relevant public health Act]; and
(c) give effect to the Declaration of Local Custom for Village Health made on [insert date of Declaration of Local Custom for Village Health]; and
(d) to limit the type of food exchanged as part of bride price ceremonial exchange payment in [insert name of Local-level Government]; and
(e) to provide for other related matters.
MADE by the [insert name of Local-level Government] to come into effect—
(a) upon the approval of the Minister; or
(b) upon the deemed approval of the Minister if he has not made a decision whether or not to approve the law after 60 days from the date the law was served on him;
in accordance with Section 141 of the Organic Law on Provincial Governments and Local-level Governments.

1. NAME OF LAW
This Law is to be cited as the [insert name of Local-level Government] (Bride Price Ceremonial Food Exchange) Limitation Law 2011.

2. INTERPRETATION
In this Act unless the contrary intention appears—
Administration means the [insert the name of the province or region] Provincial Administration.
Bride means a woman taking part in the rituals which formalise a customary marriage between a woman and a man.
Bride price ceremonial exchange means quantum of payment in cash or in goods or in a combination of both made by—
(a) the family of the bride to the family of the groom; and
(b) the family of the groom to the family of the bride
to formalise and recognise the marriage of a man and a woman under local custom in [insert name of Local-level Government] and includes bride price ceremonial exchange payment.
Constitution means the Constitution of [insert name of the country]
Customary marriage means a marriage formalised in accordance with the custom prevailing in the village or community to which the parties to the marriage or either of them belong or belongs.
Declaration of Local Custom for Village Health means a statement or declaration of local custom or local customary law made by local, provincial and other authorities in accordance with the [insert name of the relevant public health Act].
Groom means a man taking part in the rituals which formalise a customary marriage between a man and a woman.
Head of a Local-level Government means a head of a Local-level Government elected pursuant to Section 12 of the [insert name of local-level government administration Act].
Minister means the Minister responsible for provincial government and local-level government matters.
Provincial Administrator means the person appointed under Section 73(2)(a) and (b) of the Organic Law on Provincial Governments and Local-level Governments for the [insert name of Province].
Village Court means a village court established under [insert section and name of relevant village courts Act] and includes a joint sitting of Village Courts under [insert section of Act].

3. APPLICATION
This Law does not affect the validity of payment or promise of payment of bride price ceremonial exchange in respect of a customary marriage that took place before the commencement date.

4. LIMITATION ON THE TYPE OF FOOD EXCHANGED AS PART OF BRIDE PRICE CEREMONIAL EXCHANGE PAYMENT
Food exchanged as part of bride price ceremonial exchange payment must not include food purchased from a store or market which is not gathered, grown or caught within [insert name of village/province].
5. BRIDE PRICE CEREMONIAL EXCHANGE PAYMENT PAYABLE ON CUSTOMARY MARRIAGE BETWEEN PARTIES FROM [INSERT NAME OF VILLAGE/LOCAL-LEVEL GOVERNMENT] AND OUTSIDE THE LOCAL-LEVEL GOVERNMENT

If a man and a woman from [insert name of village/Local-level Government] and another Local-level Government which has not made a local law about limitation on the type of food exchanged as part of bride price ceremonial exchange payment;

(a) wish to enter into a customary marriage; and

(b) the local law of [insert name of village/Local-level Government] and the local law of Local-level Government in which the other party to the proposed customary marriage is currently resident is different in relation to bride price ceremonial exchange payment; and

(c) the marriage takes place in [insert name of village/Local-level Government].

this law applies to the food which may be offered by or accepted by the bride or groom or family of the bride or groom ordinarily resident in [insert name of village/Local-level Government].

6. LAW DOES NOT CREATE AN OBLIGATION TO MAKE A BRIDE PRICE CEREMONIAL EXCHANGE PAYMENT

This law does not create an obligation to make a bride price ceremonial exchange payment.

7. OFFENCE

1. A person or persons who give food purchased from a store or market which is not gathered, grown or caught within [insert name of village/province] as part of bride price ceremonial exchange payment, are guilty of an offence.

Penalty: A fine not exceeding K200.

2. A person or persons who receive food purchased from a store or market which is not gathered, grown or caught within [insert name of village/province] as part of bride price ceremonial exchange payment, are guilty of an offence.

Penalty: A fine not exceeding K200.
Certificate of Chairman of Local-level Government (LLG)

I, [insert name of Chairman of the LLG], Chairman of the [insert name of Local-level Government] Local-level Government, hereby certify that the [insert name of LLG] Local-level Government (Bride Price Ceremonial Food Exchange Limitation) Law 2011. (No. of 2011) was made by the [insert name of Local-level Government] Local-level Government on …………….. 2011.

I provide this certification in compliance with Section 59(1)(b)(ii) of the Local-level Governments Administration Act 1997.

[insert name of Chairman of the LLG]

Chairman

[insert name of Local-level Government] Local-level Government

Certificate of Executive Officer

I, [insert name of Executive Officer of the LLG], Executive Officer of the [insert name of Local-level Government] Local-level Government, hereby certify that the [Insert name of LLG] Local-level Government (Bride Price Ceremonial Food Exchange) Limitation Law 2011. (No. of 2011) is a true copy of the law made by the [insert name of Local-level Government] Local-level Government on …………….. 2011.

I provide this certification in compliance with Section 59(1)(b)(i) of the Local-level Governments Administration Act 1997.

[insert name of Executive Officer]

Executive Officer