Community views on Public health law and Practice in Zimbabwe

Training and Research Support Centre
Working with
community based researchers from

Community Working Group on Health

Civic Forum on Housing

Zimbabwe Congress of Trade Unions

August 2011
Harare, Zimbabwe

With support from the Technical Working Group for review of the Public Health Act and the Open Society Foundation

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Acknowledgements:
We acknowledge with thanks the review input on the research protocol from the Ministry of Health and Child Welfare and the Technical Working Group (TWG) for the review of the Public Health Act, and to B Bhala, I Rusike, E Mutasa, S Chaikosa, N Banda for support.

Cite as: TARSC, CWGH, CFH, ZCTU (2011) Community views on public health law and practice in Zimbabwe TARSC Harare

Executive Summary

In April 2010, the Minister of Health and Child Welfare (MoHCW) requested the newly constituted Advisory Board of Public Health (PHAB) to review the Public Health Act. The review was implemented within the context of Zimbabwe's health policy, most recently articulated in the National Health Strategy (NHS)(2009-2013), of the existing laws relating to public health, issues raised in prior reviews of the Act in 1993 and 2008 and issues identified by stakeholders as important for the current review. In May 2011 a White Paper was circulated to draw submissions from the public and from stakeholders on key areas relevant to the Public Health Act, in relation to the context, policy framework and vision for public health; the rights, responsibilities, duties and powers in public health; the Public Health System; Public Health Functions and the implementation and enforcement of the law.

This assessment sought to determine views of communities, local leaders and public sector and non government organization workers at community level on discussion questions raised in the White Paper. It was implemented by the Training and Research Support Centre working with community researchers from Community Working Group on Health, Civic Forum on Housing and Zimbabwe Congress of Trade Union. A cross sectional survey design was implemented in May 2011 covering 33 focus group discussions and 991 likert scale questionnaires in eleven rural and urban districts of Zimbabwe(Arcturus, Chikwaka, Chitungwiza, Gweru, Kariba, Mangwe, Masvingo, Tsholotsho, Bindura Epworth and Mutare). The initial evidence was compiled and submitted to the Review of the Act in early June 2011 before submissions closed.

The assessment found a majority view that the Public Health Act is poorly implemented and the public health system somewhat ineffective, with frustration over the lack of priority given to public health and over new risks that are not being managed. It was perceived that the Public Health Act and its penalties are not well known.

This contrasted with the strong support for public health, for a strong legal framework to protect public health and for communities and frontline workers across all sectors to play an active role in promoting public health. There was relatively support for public health to be given higher priority in relation to other socio-economic goals than at present.

The key recommendation thus emerging from this assessment is that government as a whole should be giving higher priority to public health, to make known and implement current law, even while it undertakes the review to update it.

Communities want to see specific visible actions addressing public health concerns and want to be involved in these actions, backed by resources and public information.

It was perceived that a new Public Health Act should continue to apply to the state.

The most highly prioritized issues related to environments for health and it was expected that the Act will provide basic standards and entitlements in these areas. It was also felt that public health measures at border areas needed strengthening, to protect against risks coming from outside Zimbabwe like cosmetics, medicines, strong alcohol, GMO foods and new diseases such as H1N1. The Act should provide general standards and give flexibility for local powers to identify and address specific local health problems.

The community level respondents supported a broad approach to public health, controlling risks *and* creating the conditions to be healthy. This calls for a wider focus in the Act, covering social determinants, health promotion, better systems to respond to public health emergencies and co-operation across sectors, different actors including private sector and communities.

There was strong consensus for the rights to health to be included in the Act and for a rights based approach, and a call for inclusion of responsibilities for health, including duties on individuals not to compromise rights of others. The rights that people expected to see in law included rights to social determinants like water, food and housing; to health services and medicines, and to public information.

Respondents supported state intervention to ensure that the rights of vulnerable groups are protected, even if that means limiting the rights of others, particularly in relation to compulsory vaccination of children; control of infectious diseases; and compulsory testing for new epidemics if merited.

While there was some diversity of views, the majority view was for a decentralized system, with inter-sectoral involvement in public health. This places high demand on MoHCW to co-ordinate different sector actions. While health workers thought current co-ordination was effective, community members and workers from other sectors did not agree. Community level members and personnel also called for a broader perspective of the definition of "public health workforce" to include the range of community and frontline workers in the health sector and in other sectors to do with public health.

There was a shared view that private producers of harmful products or waste should pay towards the costs of public health and that new investments should be assessed for their public health impacts. The Act should provide for ethical business to promote public health, prevent practices that harm health and regulate specific practices or products that may be harmful to health. The role of not for profit non state actors like churches, community based and non governmental organisations should also be recognized.

The implementation of the law was seen to require resources (financial, human, equipment, knowledge), and the Public Health Act should contain provisions on financing. New options for financing public health were raised, including increased funds from the national budget, taxes on activities that harm public health, external funding, private sector contributions, penalties, fines, and fees for licenses and inspections.

Implementation was also seen to call for stronger penalties to be swiftly applied.

However responses also indicated that greater attention needs to be given to the role of the community in implementation. This calls for education and training in public health, including in the school curriculum, wider community consultations, legal recognition for community level structures like Health Centre Committees and Development Committees, and resources to support community roles.

Communities can play a more direct role in public health, such as in promotion of safe and healthy living and working environments and health lifestyles. Examples were given of management of solid waste, using environmentally friendly fuels, education on good hygiene. This is more likely to happen when it is linked to economic empowerment activities that also improve health.

1. Background

1.1 Public Health

Drawing from definitions by the World Health Organisation, public health is the science and art of disease prevention, prolonging life and promoting health and wellbeing through the organised efforts and informed choices of society, state and non state organizations, communities and individuals for the sanitation of the environment, the control of communicable infections and non communicable diseases, the organisation of health services for the early diagnosis, prevention and management of disease, the education of individuals in personal health and the development of the social machinery to ensure everyone the living conditions adequate for the maintenance or improvement of health. Public health measures range from vaccinating children to controlling advertising or trade in products harmful to health, like cigarettes or alcohol.

The factors that affect health are (a) socio-economic factors such as income, poverty, adult literacy, housing, food availability and working conditions; (b) environmental factors such as promotion of safe water, appropriate and adequate sanitation, food and personal hygiene and; (c) health promotion such as healthy lifestyles and behaviour (See the Rainbow diagram below).

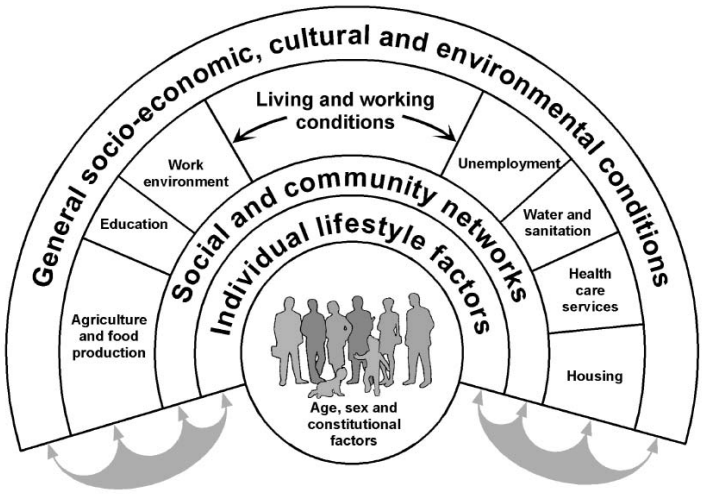


Figure 1: Rainbow diagram by Dahlgren and Whitehead, 2007

Zimbabwe's National Health Strategy 2009-2014 proposes that health is promoted by

- improving the socio-economic status and living conditions of the population;
- strengthening inter-sectoral coordination and collaboration towards improving health and quality of life of the population;
- increasing awareness on and advocacy for action by relevant ministries and other stakeholders on the major determinants of health such as water, sanitation, food, hygiene, education and gender amongst other.
- Increasing access to safe water and sanitation;
- Increasing national awareness and understanding on the impact of environmental conditions on the health and quality of life of the population;

- Promoting rural and urban development and housing within an environment where pollution from various types of waste is reduced to an acceptable minimum; reducing air, water and terrestrial pollution by strengthening regulation to control and minimize contamination of the environment; and
- Ensuring food for sale to the public meets standards and is sold and prepared in a manner and in premises that comply with public health regulations (MoHCW 2009).

Surveys in Zimbabwe show that people suffer from preventable diseases, including nutritional deficiencies, communicable diseases, and health problems related to pregnancy, childbirth and of new born children, as shown in the box below.

- Adult HIV prevalence has fallen but is still at an unacceptably high level of 13.7% with only 180,000 of an estimated 400,000 people in need of treatment actually receiving antiretroviral therapy (ART) by mid 2009;
- High levels of communicable diseases from poor living and working conditions, including tuberculosis, cholera epidemics, malaria, and even rabies and anthrax;
- High levels of child mortality due to communicable diseases, and nutritional problems, with stunting (chronic malnutrition) at a third of children under 5 years of age.
- Very high levels of maternal mortality (725 deaths per 100,000 births) due to maternal health and inadequate access or uptake of services for antenatal care or assisted delivery;
- Increasing levels of chronic non-communicable conditions such as diabetes and hypertension;
- Gaps in adequate health personnel, medicines, transport, communications needed for a functional health delivery system, especially at primary care levels, although with some improvement in personnel due to training of Primary Care Nurses;
- Inadequate public health personnel, including environmental health officers, village health workers and resources for their functioning;
- High levels of literacy and civil society engagement in health, but limited resources for social roles in health;
- Under-funding of the public health sector although health prioritised in the national budget.

Source: MOHCW 2009

1.2 Review of the Public Health Act in Zimbabwe

The Public Health Act [Cap 15:09] of 1924 is the principal law regulating public health matters in Zimbabwe. (The full Act can be found at www.chr.up.ac.za/undp/domestic/docs/legislation_56.pdf). It is administered by the MoHCW. The Public Health Act has played an important role in protecting public health in Zimbabwe over 87 years. While the age of the Act is itself not a basis for review, the lack of a holistic review in 87 years has led to a number of shortfalls, identified in more detail in the White Paper. These relate to the manner in which the Act

- Addresses current public health challenges, including non communicable diseases, maternal health, cross border risks; new epidemics;
- Reflects new methods and approaches, particularly for promoting public health;
- Incorporates norms and constitutional provisions for individual and social rights,

- Reflects post independence health policy, including on primary health care and the involvement of non state actors and communities in health;
- Uses outdated terminologies; and
- Is affected by the fragmentation of public health law that has emerged over time, limiting synergies and co-ordination between the Act and newer laws relating to public health both within the MoHCW and with laws in other Ministries (MoHCW PHAB 2011).

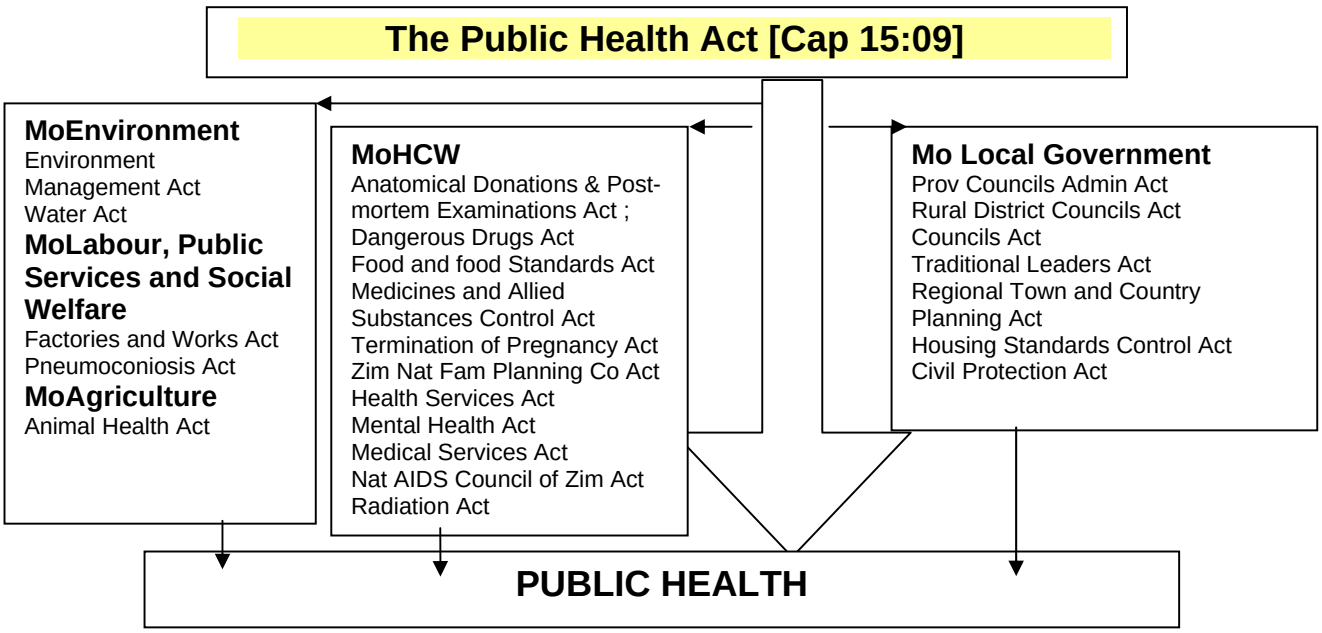
The sections of the current Public Health Act are shown in Box 2 below

Box 2: Sections of the Public Health Act

PART I PRELIMINARY
PART II ADMINISTRATION
PART III NOTIFICATION AND PREVENTION OF INFECTIOUS DISEASES
PART III SPECIAL PROVISIONS FOR FORMIDABLE EPIDEMIC DISEASES
PART IV VENEREAL DISEASES
PART V INTERNATIONAL SANITARY REGULATIONS
PART VI WATER AND FOOD SUPPLIES
PART VII INFANT NUTRITION
PART VIII SLAUGHTER HOUSES
PART IX SANITATION AND HOUSING
PART X GENERAL

The Public Health Act is complemented by other laws (Figure 2)

Figure 2: Laws complementing the Public Health Act



Source: PHAB, MOHCW (2011)

The Minister is empowered under the Act to promulgate Regulations to implement certain aspects of the law, and has the following regulations under the Act.

- Carrier of Infectious diseases regulations SI507 1943;
- Declaration of formidable epidemic diseases SI1051/1976;
- Declaration of Infectious diseases: Infectious Hepatitis SI958/ 1973;
- Declaration of Infectious diseases: Malaria SI 6/ 1959;
- Declaration of Infectious diseases: Smallpox SI461/ 1948;
- Public Health Advisory Board regulations 1966;
- Public Health (Bilharzia) Control and Prevention Regulations SI 587/1971;
- Public Health (Control of Cholera) Restriction of Public Gatherings Regs SI371 1974;
- Public Health (Port Health) Regulations SI200/ 1995;
- Public Health (Breast Milk substitutes and infant nutrition regulations) SI 163/ 1998; and
- Public Health (Control of Tobacco) Regulations SI 264 1997 (rev 2002).

In April 2010, the Minister of Health and Child Welfare (MoHCW) requested the newly constituted Advisory Board of Public Health (PHAB) to review the Public Health Act. The review was implemented within the context of Zimbabwe's health policy, most recently articulated in the National Health Strategy (NHS)(2009-2013), of the existing laws relating to public health, issues raised in prior reviews of the Act in 1993 and 2008 and issues identified by stakeholders as important for the current review. The PHAB working with MoHCW and national stakeholders instituted a review process that included technical and legal review, relatively wide stakeholder consultation and international advice. The members of the PHAB and a Technical Working Group (TWG) guided the process, which involved a high level of stakeholder consultation. In May 2011 a White Paper was circulated to draw submissions from the public and from stakeholders on key areas relevant to the Public Health Act, in relation to the context, policy framework and vision for public health; the rights, responsibilities, duties and powers in public health; the Public Health System; Public Health Functions and the implementation and enforcement of the law. The submissions closed on June 10, were compiled and reviewed by the TWG, and proposals were tabled with a national stakeholder meeting on July 6th 2011.

This assessment was one contribution to the submissions for review of the Act called for in the White paper. It sought to determine views of communities, local leaders, public sector and non government organization workers at community level on discussion questions raised in the White Paper. It was implemented through the Community Based Research and Training Programme at Training and Research Support Centre and sought to strengthen and widen the consultation process, particularly at community level.

2. Aims and objectives

The assessment was implemented to organize input from communities, local leaders and public sector workers at community level as submissions on the Public Health Act review in response to a White paper on the Act.

Specifically, the assessment sought to determine community, local leaders and frontline workers views on key areas relevant to the review of public health law, in particular on;

i. priority public health issues the law should address and approaches to dealing with those issues;
ii. knowledge of, and strengths and weaknesses in the current experience of the operations of the law

iii. perceived role, duties and powers of the State, situations where state powers may or may not limit individual rights for public health, and rights and responsibilities of individuals and society in ensuring public health.
iv. options for enhancing community participation
v. measures for protection of vulnerable groups
vi. options for strengthening the public health system, including relationships within government and partnerships with other stakeholders
vii. the role of the private and traditional health sectors in public health
viii. sanctions, incentives and resources for public health

The work also aimed to build capacities in existing community based researchers to use focus group and likert scale methods for collection of evidence. Twenty five community based researchers were drawn from three membership based civil society organizations, the Community Working Group on Health (CWGH), Civic Forum on Housing (CFH) and the Zimbabwe Congress of Trade Union (ZCTU) - (eight from CWGH, four from ZCTU and five from CFH) - identified on the basis of their skills to implement this assessment. The researchers were also trained by TARSC in research methods, skills and data collection before implementing the assessment under field supervision of TARSC and ZCTU (TARSC 2011).

3. Methods

A cross sectional survey design was used for focus group discussions and a likert scale questionnaire that was implemented in May 2011 in eleven rural and urban districts of Zimbabwe. The evidence gathered was based on the questions for discussion raised in the White Paper and the initial evidence was compiled and submitted to the Review process in early June 2011 before submissions closed.

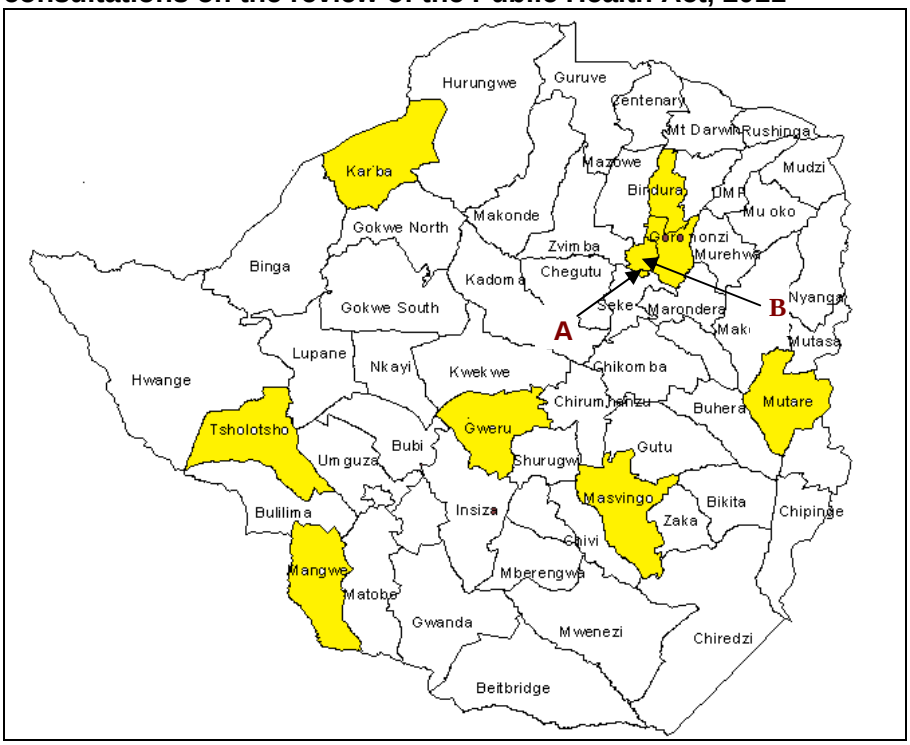
The target respondents were community members, community leaders and community level workers with roles in public health. The assessment obtained views from these categories as they have a key role in public health, while limited financial resources and time meant that other relevant groups at community level such as traditional health workers were not included. These groups also have umbrella organizations that were directly involved in the review. Table 1 shows the three categories of respondents.

Table 1: Target groups of the assessment

Target group	Composition
Community members	Adult household members, community organisations, community based civil society, youths, womens organizations, producer organizations, community club members, residents associations, people living with HIV and AIDS; people with disabilities; members of faiths (including Apostolic) and traditional healers
Community leaders	Traditional leaders: chiefs, headman, kraal head, Government: councilors, Faith based: church leaders, traditional religious leaders; Health: Health Centre committee members; Village / Ward assembly leaders, Residents association leaders;
Community level workers	Teachers, Agriculture extension workers, health workers (nurses, EHTs, VHW, Community Home based Care Givers), Police officers, Local council EHTs, Public health inspectors, EMA community based inspectors, District development fund workers), Veterinary inspectors

The 11 districts included are shown in Figure 2. The districts with the participating sites (Arcturus, Chikwaka, Chitungwiza, Gweru, Kariba, Mangwe, Masvingo, Tsholotsho, Bindura Epworth and Mutare) were purposively selected as areas were previous health assessments had been done, areas with rural and urban households and districts with the researchers with skills that could be used to implement this work. The districts were sampled to include rural and urban areas, across all provinces. Within the districts stratified convenience sampling was used to select the sample for both focus group discussions and likert scale questionnaires, taking logistic constraints and the need for a gender balance. The number was limited to 30 people per each focus group with three focus groups and 90 likert scale questionnaires per district (one focus group with respondents from each of community members, community leaders and community level workers and 30 likert scale questionnaires with each category).

Figure 2: Districts with participating sites in the community consultations on the review of the Public Health Act, 2011



A; Chitungwiza and B; Harare and Epworth

Data collection was implemented through;

1. Focus group discussions, one each with i. community members, ii. community leaders and iii. community level services workers using a standardized guide covering perceptions of major public health problems; duties and powers of the state (local and central government) in public health; rights, duties and responsibilities in health; protection of vulnerable groups; areas where rights of individuals may need to be limited for public health; meaningful community participation; traditional health services and customary law; strengthening prevention and management of public health emergencies, barriers to the implementation of the current public health law and how to overcome them. Appendix 1 shows the guide to the focus group discussions.

2. A self administered likert scale questionnaire rating views on key areas and debates for the review of the Act. The Likert scale questionnaire was administered to respondents before the focus group discussions and to other respondents within the specific category within the district but in a neighboring ward immediately after the focus group discussion. Appendix 2 shows the likert scale questionnaire.

The tools were piloted and the tools and design were reviewed by the Ministry of Health and Child Welfare and the Technical Working Group. Prior to the fieldwork, the researchers introduced the aims and process of the assessment to obtain authority from local traditional leadership, district administrators and police to implement the work. Individual respondents to the likert scale questionnaire were introduced to the assessment, individual confidentiality noted and verbal consent obtained before proceeding. The field work was supported through visits and telephone and data was checked and followed up to clean data before and during analysis.

The characteristics and details of the respondents included are shown in Table 2 and Figure 3 below and further detailed in Appendix 3.

Figure 3: Focus Group Discussions participants (N=620)

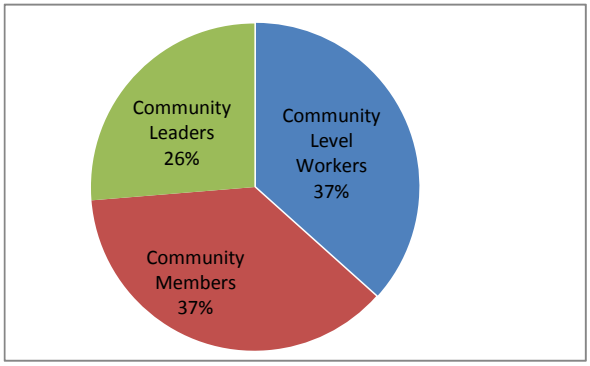


Table 3: Respondents to the likert scale questionnaire per district by category

District	Number of respondents that are				
	Community members	Community Leaders	Health Worker	Other(*)	Total
Arcturus	27	23	12	16	78
Chikwaka	27	27	10	27	91
Chitungwiza	28	30	28	2	88
Gweru	30	29	28	2	89
Kariba	49	13	17	11	90
Mangwe	30	30	22	8	90
Masvingo	45	24	17	5	91
Tsholotsho	30	31	1	28	90
Bindura	31	30	28	1	90
Epworth	70	14	13	3	100
Mutare	36	26	32	0	94
Total	**403**	**277**	**208**	**103**	**991**
Percent	**41**	**28**	**21**	**10**	**100**

(*) Includes District Development Fund Workers, Veterinary workers; Local business people; Youths (including students) and youth's leaders; Teachers; Police Officers; Agriculture extension workers; Environmental Management Authority Workers; Traditional Healers

The focus groups had a higher share of participants representing community members and community level workers than community leaders. The community level workers came from a diverse range of sectors; including health, veterinary, district development, agriculture, education, security and youth sectors. The respondents to the likert scale questionnaire had a higher share of community members (41%) than community leaders and health workers. Given the sample sizes and limited number of districts the findings cannot be generalised to the population as a whole but it does provide information on areas where there is high consistency of views across the eleven districts, given the measures to ensure reliability of evidence – ie training of researchers, supporting fieldwork, data cleaning in the field, data cleaning before and during data analysis.

4. Findings

The findings from the assessment are presented within the relevant sections of the White Paper from which the research questions were drawn, namely;

i. The public health context
ii. Rights, responsibilities, duties and powers in public health
iii. The public health system
iv. Public health functions
v. Implementation and enforcement

Appendix 4 provides the specific responses to the Likert scale.

4.1 The public health context

The focus groups raised a number of priority public health problems. The most highly prioritized issues related to environments for health, including safe water, solid waste, sanitation and hygiene (See Table 4). This suggests that there are high expectations that the Act will provide for the basic standards and entitlements in these areas. Also highly prioritized was food, both in terms of safety and availability. Table 4 summarises the issues raised in the focus group discussions (FGDs).

Table 4: Public health challenges raised in the FGDs (N=33)

Public Health problem	Number of FGDs Raising Problem	Percent of FGDs Raising Problem
Water Supply	26	79
Solid Waste management	24	73
Sanitation	22	67
Food availability and safety	19	58
Hygiene	15	45
Shelter related issues	13	39
Sexual and reproductive health	12	36
Communicable diseases	11	33
Non communicable diseases	9	27
Transport	9	27
Problems in health services	6	18

'Currently water shortages are forcing residents to use the bush and garbage bins are being used to store water rather than the garbage itself, hence waste is being dumped anywhere'.

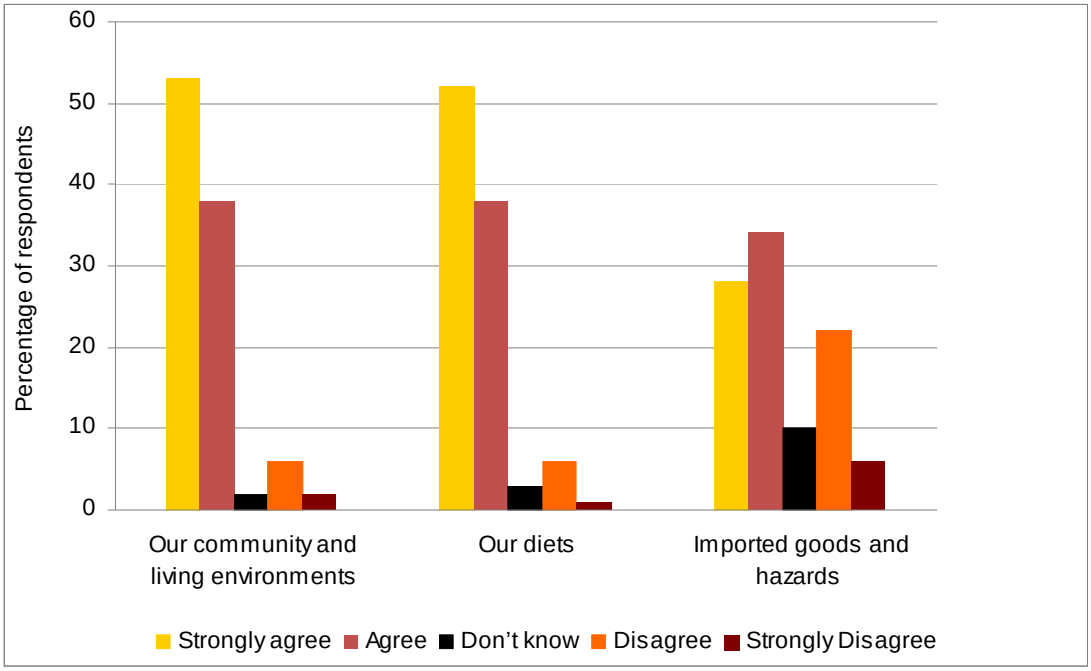
Community leader, Masvingo

Apart from these general issues, specific issues were raised in particular areas, including: Companies discharging toxic effluents in Masvingo;' Unsafe labour practices in Gweru; apostolic groups refusing children's medical treatment and immunisation in Bindura; the safety of genetically modified (GMO) foods in Chitungwiza, Bindura and Tsholotsho; poverty amongst college students leading to commercial sex in Masvingo; smelly fumes due to the roasting of crocodile meat using fish fat in Kariba and the lack of toilets for resettled farmers in Chikwaka. These indicate that while there are general concerns over environmental, food safety and sexual and reproductive health issues in many areas, there are also specific local concerns. The Public Health Act may provide general standards but should also give flexibility for local measures and powers to identify and address specific local health problems.

Community leaders, community members and community level workers all raised the interconnectedness of these major challenges. For instance overcrowding was noted to lead to the spread of communicable diseases in a third (33%) of FGDs. Respondents were concerned with food preparation and handling by unregistered vendors in about 80% of FGDs. Respondents also raised a number of public health problems coming from outside Zimbabwe, including skin lightening oils and other cosmetics, medicines, strong alcohol, GMO foods, new diseases such as H1N1, as well as cultural practices and mobile or migrating people who may raise the risks of unsafe sex, or dumping of rubbish. The effectiveness of public health measures at border areas was questioned.

The respondents to the likert scale were generally in agreement that their health was affected by their local community and living environments and diets (See Figure 4). Hazards from outside the area were seen to be a lesser public health risk.

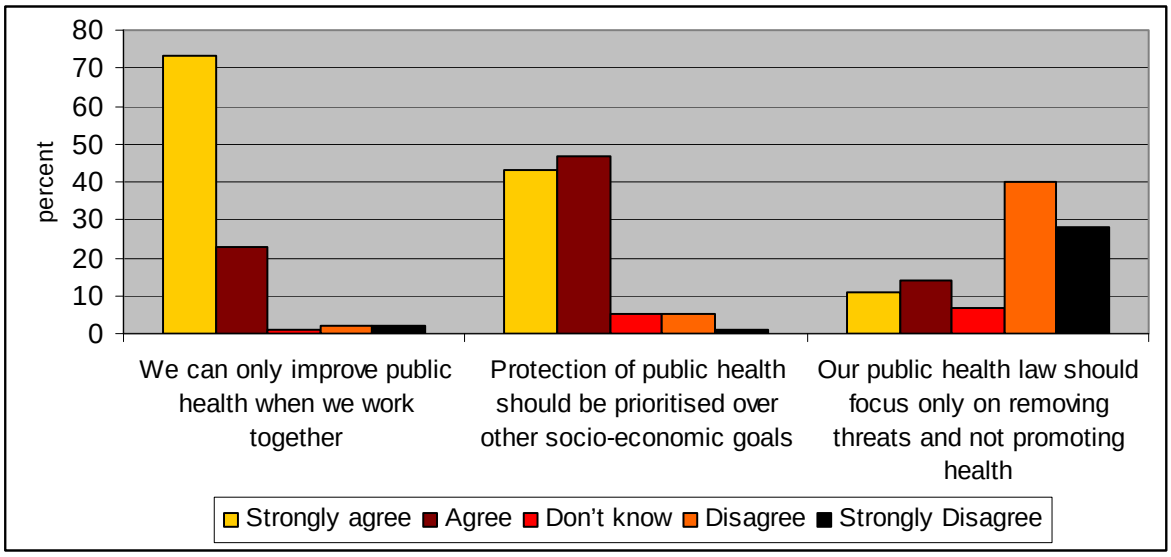
Figure 4: Likert scale responses on source of public health problems (N=991)



The White paper raised for discussion whether to adopt a narrower approach in law that focuses on reducing and eliminating threats to health, or a wider approach that seeks to promote the general health of society including action on the social determinants, or the social causes, of health. The National Health Strategy 2009-2013 identifies the need to promote health, including through action by sectors other than the health sector; to manage the diseases that have greatest burden on Zimbabweans, to strengthen the health system and to acknowledge and enable the actions of a wide range of stakeholders, including communities. The current Public Health Act in contrast takes the more narrow approach, emphasising the elimination and control of disease.

In the likert scale responses (Figure 5) people did not agree with a narrow approach to public health and saw it as demanding co-operation across sectors, different actors including private sector and communities. There was less agreement that public health should be given priority over other socio-economic goals, but still with relatively high agreement to this, for all groups (see Appendix 4). Health promotion was strongly supported as a means to improving public health in the FGDs, and ensuring community knowledge and information seen to be critical for this. Towards this the FGDs raised the wider public duties to promote public health, and the obligations of the state to support and ensure this.

Figure 5: Likert scale responses on approach to public health (N=991)



'It should be the duty of every person to promote health and it's the responsibility of the government to see that this happens every where'.

Community level worker, Tsholotsho

4.2 Rights, responsibilities, duties and powers in public health

The White paper sought views on the roles, duties and powers of the state, Ministry of Health and other Ministries, and the rights and responsibilities of individuals including corporate individuals and society in ensuring public health.

In more than three quarters of the focus groups (76%) participants raised that the right to health should be included in the new public health law. Specific rights were indicated, particularly to social determinants like water, food and housing; to health services and medicines, and to public information (See Table 5).

"Communities should have a right to education on public health, free immunisation for all children under 5 years and free maternal and child health services. We also need a right to safe water and sanitation"

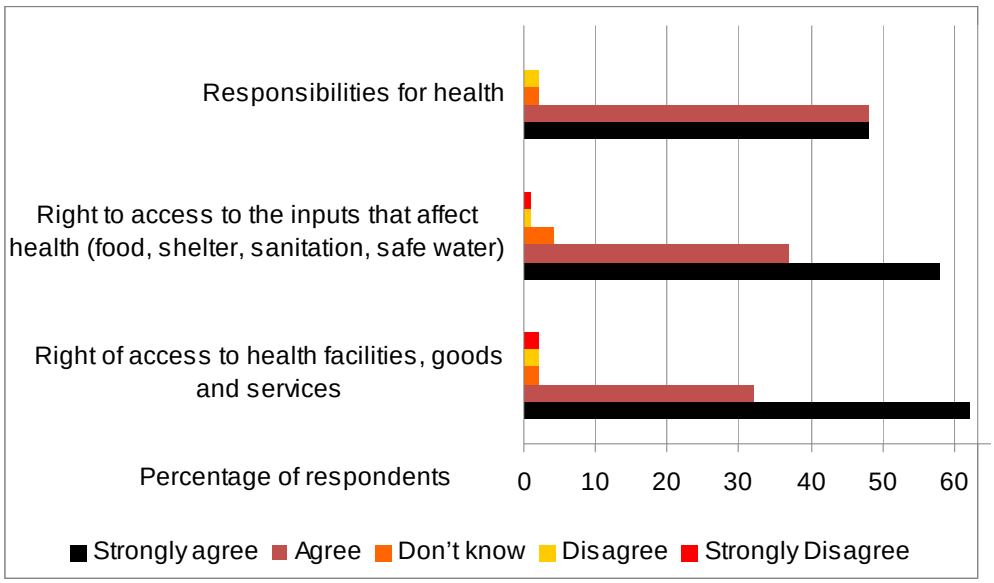
Community level worker, Chikwaka

Table 5: FGD views on rights to be included in the public health law (N=33)

Proposed Right to….	FGDs raising the right	
	Number	Percent
Access to goods and services relating to the social determinants of health (food, shelter, water, sanitation)	12	36
Access to health facilities and services	10	30
Access to free medication and free maternity services	10	30
Emergency treatment	10	30
Health services that provide confidentiality and privacy	9	27
Public information and education	7	21
Non discrimination when accessing services	7	21
Participate in social services	4	12
Live in dignity and achieve the highest standard of health reasonably possible	4	12

Responses to the likert scale indicated a high degree of agreement with inclusion of rights of access to inputs that affect health and to health services, but also to inclusion of responsibilities for health. There is thus a view that a rights based approach should be used in public health law, together with duties on individuals not to compromise rights of others. (See Figure 6).

Figure 6: Likert scale responses on rights that should be in law (N=991)



In the FGD's, community members raised specific expression of the rights, such as to health education; to immunization; to be treated anywhere without referral letters or cards; to free treatment for expecting mothers; or to compensation in the event of a mishap due to negligence by health care providers. One FGD noted that adopting a rights based approach may result in the state committing to responsibilities it may not be able to fulfill so that the rights should be subject to the resources available.

To enforce these rights, the FGDs (number shown in brackets) raised the need for

i. Government to provide funds to protect vulnerable groups, including people living with HIV (PLWHIV), chronically ill patients, expecting mothers, children (8 FGs)
ii. Communities to take a proactive role in educating communities to know and uphold the rights (6 FGs)
iii. Stiffer penalties be applied on those that violate health rights (5 FGs)
iv. Strengthening of health systems, health workers and regulation of private health providers to ensure compliance (4 FGs)
v. Review of laws and regulations relating to these rights (2 FGs)
vi. MoHCW to take a leading and co-ordinating role in their enforcement (2 FGs)
vii. Implementation and enforcement of the rights by local authorities (2 FGs).

All FGDs agreed that vulnerable groups should be protected, including PLWHIV, children, pregnant women, people with disability, chronically ill patients and elderly people. These groups were seen to need exemption from charges for services, laws to prohibit discrimination (5 FGDs), state financial support (8 FGs), information and education (4 FGs) and economic activities that will support their incomes (2 FGs).

The FGDs generally observed that the state, and particularly MoHCW has particular obligations in public health (shown in Table 7). Many of these are proactive roles, to finance, promote, administer, provide facilities for public health and implement the law.

Table 7: FGD views on duties of the state in relation to public health (N=33)

Proposed duty of the state	FGDs raising the proposal	
	Number	Percent
Financing public health	15	46
Promote safe environments and conditions for good health	6	18
Set public health policy and system and administer the law	4	12
Planning, Advocacy and Implementation of the Public Health Act	4	12
Ensuring provision of facilities for early diagnosis and treatment of diseases and advice on matters relating to public health	3	9
To protect and preserve health by enforcing public health law	3	9
Protect health rights	2	6

'Government should establish some community health officers. Garbage collection monitors to be established by the government, it should also ensure that the community is getting good supply of goods and services like a supply of water'.

Chitungwiza community member

'Local authorities need to be semi autonomous and independent in making decisions regarding health issues as currently there are a number of bottle necks which hamper their operations. Local authorities should consult widely during budget formulations with their residents'.

Community leader, Masvingo

'Ministry of transport should ensure accessibility of the road network to health centres'
Community worker, Mangwe

The FGDs mostly referred to MoHCW, but also to ministries of local government, labour, agriculture, home affairs, transport, environment, tourism, housing, and public works.

Community level personnel were also asked about situations where individual rights may have to be limited or state powers constrained. Examples included compulsory immunization, notifying partners of health conditions, or testing individuals without consent.

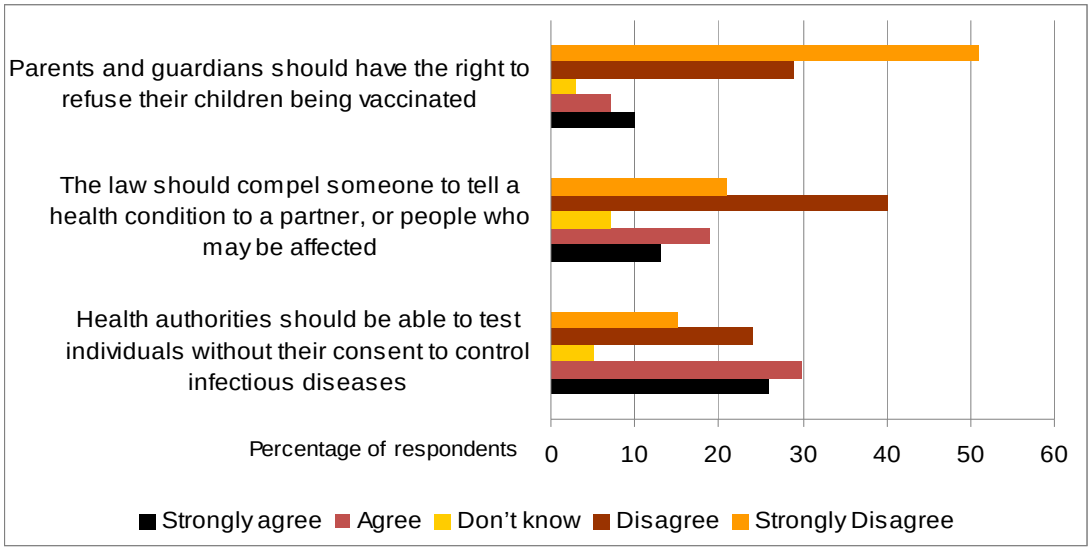
In the FGDs, respondents noted that the state should intervene to ensure that the rights of vulnerable groups are protected, even if that means limiting the rights of others, including to

i. compel compulsory immunisation (17 FGDs)
ii. access premises and persons when controlling infectious diseases like cholera (15 FGDs)
iii. compel compulsory testing when dealing with new epidemics from outside Zimbabwe like H1N1 (13 FGDs)
iv. criminalise the spread of infectious diseases in children, and in old, vulnerable or disabled people (12 FGDs).

Some FGDs had strong views, such as to quarantine and restrict movement of infected people in certain cases such as for H1N1.

The views on this from the likert scale responses are shown in Figure 7.

Figure 7: Likert scale responses on state powers in specific situations (N=991)



'Immunisation of children should be compulsory regardless of beliefs, religion'.
Community Members, Kariba

Community members, leaders and community level workers feel that parents should not have the right to refuse their children being vaccinated, supporting compulsory vaccination.

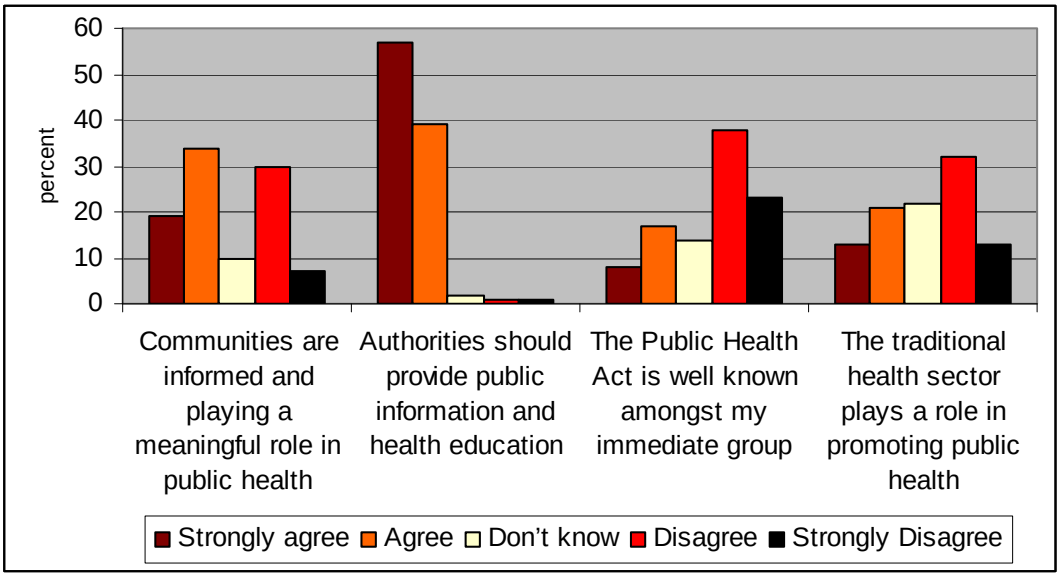
There was less consensus on disclosing health conditions to a partner or other person affected. This was also found in the FGDs where eleven FGDs stated that disclosure of a health condition to a partner or others affected should be done, while seven disagreed, four noting the need for legal protection against discrimination and loss of jobs and three that disclosure should not be included in the law. In the likert scale, health workers were more opposed to disclosure than others (See Appendix 4).

'Disclosure should be forced because it helps partners to make plans for the family/. People posing risk behaviours should be sued because some behaviours are killing people'.

Community members, Kariba

The FGDs raised that the law should ensure that roles and duties were implemented by the state and through partnerships as these were vital in enhancing public health, as already shown in Figure 5 on likert scale responses and the FGD responses on the role of other sectors of government and of the traditional health sector, and the private sector. In the likert scale responses, there was a relatively equal number agreeing and disagreeing that communities are informed and playing a meaningful role in public health (See Figure 8). Communities had a more positive view of their role than health workers. While there was general agreement that authorities should provide public information and health education, it was also perceived that the public health Act is not well known, making it difficult for communities to play a role in implementing the Act.

Figure 8: Likert scale responses on community roles in public health (N=991)



'Education on diseases is common, but we want to know about the Public Health Act as well'

Community leader, Mangwe

'Communities should be educated on public health law and rights through health literacy seminars and workshops'

Community member, Bindura

In the FGDs community members raised that they need education and training in public health, including in the school curriculum. They also called for wider community consultations for meaningful community participation. In seven FGDs participants specifically advocated for legal recognition of community level structures like Health Centre Committees and Development Committees, while two other FGDs called for resources to support communities if they are to participate in public health. Roles raised by communities in the FGDs included:

- giving information to MoHCW on health hazards/ problems, such as through Health Centre Committees. (12 FGDs)
- participating in promotion of safe and healthy living and working environments including health lifestyles such as through management of solid waste, using environmentally friendly fuels, education on good hygiene. (7 FGDs)
- economic empowerment to improve health. Managing resources for public health such as boreholes and mobilizing resources for public health. (5 FGDs)

'Communities should set up health committees at local health centres to ensure their effective participation in public health.'

Community level worker, Gweru

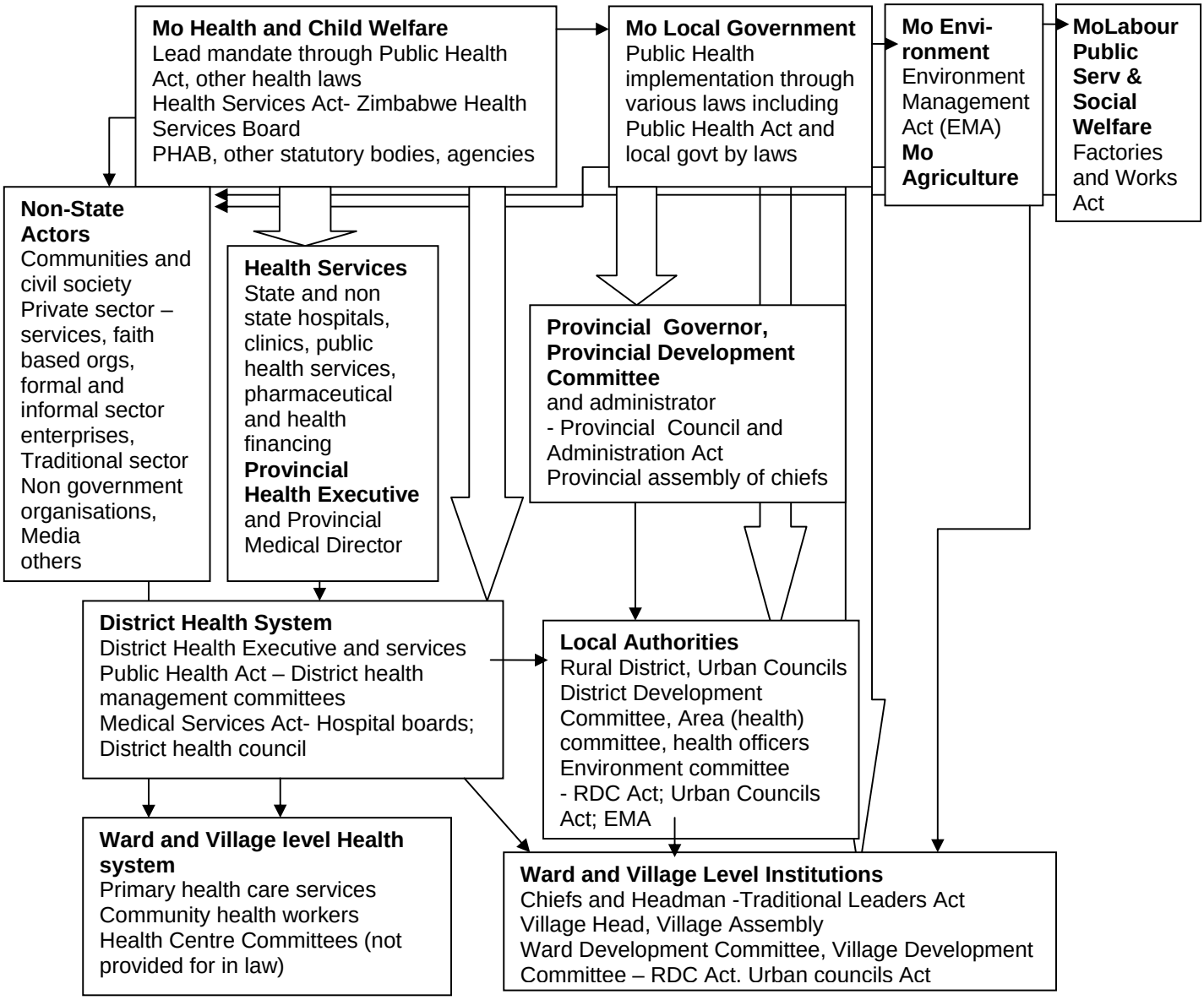
4.3 The Public Health System

The diagram overleaf outlines the public health system in Zimbabwe as set in law. Public health matters are implemented at community (ward and village), primary, district, provincial and national level institutions of the MoHCW, of Ministry of Local Government (MoLG), and for some areas of public health through other Ministries and authorities. The Minister of Health and Child Welfare has overall responsibility for implementing the Public Health Act and other health related Acts.

The PHAct refers to implementation through District medical officers (DMO) (rural) and medical officers of health (urban) under local government. In the 1980s, the MoHCW set up the District Health Executives (DHE) under the chairmanship of the DMO to run and manage services at district level. In urban areas, the DHE and DMO is under the urban council, but in rural areas, the DHE was not a structure under local government, but one under the central MoHCW. At provincial level the MoHCW works through the Provincial Health Executive under the chairmanship of the Provincial Medical Director. While not the principal administrator of the Public Health Act, the Ministry of Local Government (MoLG) is tasked with the implementation of the Act at the district level, assisted by medical officers of health, health inspectors, and health committees. The Traditional Leaders Act [Cap 29:17], provides for the role of Chiefs and headmen in health matters, including notifying of outbreaks of epidemics, promoting good standards of health and enforcing environmental conservation and planning laws.

The White paper asked for views on the effectiveness of the institutions, mechanisms and workforce responsible for public health and the partnerships and interactions with other sectors of government, non state actors (private, traditional, civil society) in public health. The White paper asked about the strengths, gaps or weaknesses that need to be addressed and how the system can be better organized to strengthen its effectiveness.

Figure 9: The public health system in Zimbabwe



Source: MoHCW PHAB 2011

Focus group respondents showed different views on the level of effectiveness of the implementation of the current Public Health Act in controlling public health risks, and various reasons were cited to support their views (Table 8). The majority view was that the system is somewhat ineffective, and a similar number thought it to be ineffective as effective. The reasons cited in Table 8 suggest that at community level there is frustration over the lack of priority given to public health, over the new situations that have created risks that are not being managed, and over lack of accountability of officials. In contrast, effectiveness was associated with specific visible actions to address public health concerns. Community members, leaders and local workers thus generate positive cycles when actions are resourced and taken to improve conditions.

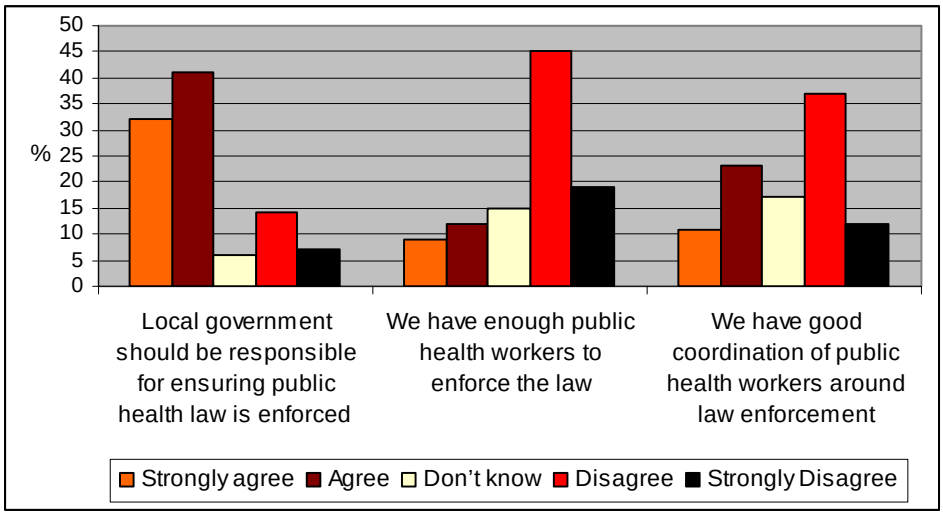
Table 8: FGD views on the effectiveness of the implementation of the current Public Health Act

Perceived level of effectiveness	Number of FGDs (*)	Major reasons for the choice of perceptions/ Barriers to effective implementation
Very Effective	1	We have managed to control specific diseases like cholera and HIV/AIDs successfully.
Effective	6	Promotion of health environments eg safe water is being done. Awareness campaigns on safe water and healthy environments are being done. Treatment and control of infectious diseases and preventive measures (eg immunizations) is being implemented. We did not have the right to heath in the law. Implementation is weak in some cases. Political context is affecting administration of the Act. Ministry of Health should have overlapping power to control anything that can affect public health.
Somewhat Ineffective	11	Corruption is hindering implementation of the Act and laws. Shortage of resources is also affecting implementation; we have fewer workforces, we are importing most of our food and skilled labour migrated. There is less education on this going on. Most people are not aware; there are few people who know about the regulations. We have neglected infrastructure. Priority is being given to job creation than looking at the work environment as well.
Not effective at all	5	Shops and butcheries are not being monitored. There is lack of information and education. Corruption is high. Central government does not have public health as a priority due to the economy. Poverty is affecting public health. People have been moved to areas with no safe water. Human rights are not being respected in this country. Enforcement is weak.

(*) the remainder of FGDs had mixed views

The likert scale response showed that there was high agreement that local government should be responsible for implementation of the law. However there was equally high agreement that there are not enough health workers to carry out this role, and some divergence of views as to whether public health workers from different authorities were adequately co-ordinated (Figure 9). While health workers thought there was reasonable co-ordination, community members and workers from other sectors did not agree (See Appendix 4).

Figure 9: Likert scale responses on public health system (N=991)



Eleven focus groups discussed about the public health workforce in their areas. In all, a broader perspective of the definition of "public health workforce" was cited. All the focus groups noted their public health workforce as including community level workers working directly in health (for instance nurses, environmental health technicians (EHTs), Home Based Care Givers, Counselors, community condom distributors and so on) and workers in other ministries and sectors to do with public health, such as from the Environmental Management Authority, District development fund and Agritex). For all workers, inadequate pay and resources was noted as a barrier to effective performance.

'Public health actions can be implemented and effective only if those working to implement them can be better paid in salaries'.

Community leaders, Tsholotsho

'Sub district structures and other committees should be given resources. Provide bicycles to community based public health workforce'

Community members, Chikwaka

Participants of the FGDs raised a number of ways other ministries act in the public health system:

Table 9: FGD views on public health roles of other ministries

Ministry	Role and linkage to MoHCW	Number of FGDs
Ministry of Local Government	Enforcement and implementation of law with oversight from MoHCW. Bylaws should conform to MoHCW guidelines and regulations. Promote health and safe living environments, provide health services, Ensure decentralization of activities	15
Ministry of Finance	Resourcing Public Health through the budget	8
Ministry of Environment	Mandated to promote safe and healthy environments. Should consult the MoHCW on public health matters	7
Ministry of Water Resources	Consult MoHCW on safe water standards and ensure safe water in emergency outbreaks like cholera	6
Ministry of Education, Sport and Culture	Promote public health for children in schools in line with MoHCW regulations and standards	5
Ministry of Home Affairs	Enforce regulations relating to import of substances including food items,	5
Ministry of Transport	Ensure roads for easier access to health facilities. Should provide and service ambulances and other services	5
Ministry of Agriculture, Veterinary services	Work with MoHCW on promotion of healthy diets, growing nutritious crops, food preservation to ensure adequacy	4
Ministry of Industry and Commerce	Collaborate with MoHCW on companies that cause pollution, manufacture of foods that promote health and promotion of healthy work environments. Registration of companies should consult with MoHCW on possible effects of the products and services on the health of the public.	4
Ministry of labour and Social Services	Work with the MoHCW in creating safe and healthy working environments. Social Service department to work with MoHCW on exemption policies on vulnerable groups	3
Ministry of Public Works	Infrastructure development to promote healthy living environments eg housing in consultation with MoHCW on standards	2

Ministry of Local Government, of Finance, of Environment and of Water Resources were identified most frequently for their roles in health, although other Ministries were also identified. In two FGDs, a proposal was made for greater autonomy in local authorities to enforce public health and to improve efficiency in the delivery of services. At the same time another FGD argued that the MoHCW should enforce all the laws and regulations that have a bearing on public health directly, to avoid confusion on responsibilities. Hence while there was some diversity of views, the majority view was for a decentralized system, with inter-sectoral involvement in public health. This places high demand on MoHCW to co-ordinate different sector actions.

'There should be coordination between ministry of health and other ministries so that the act can be implemented effectively'

Community leader, Tsholotsho

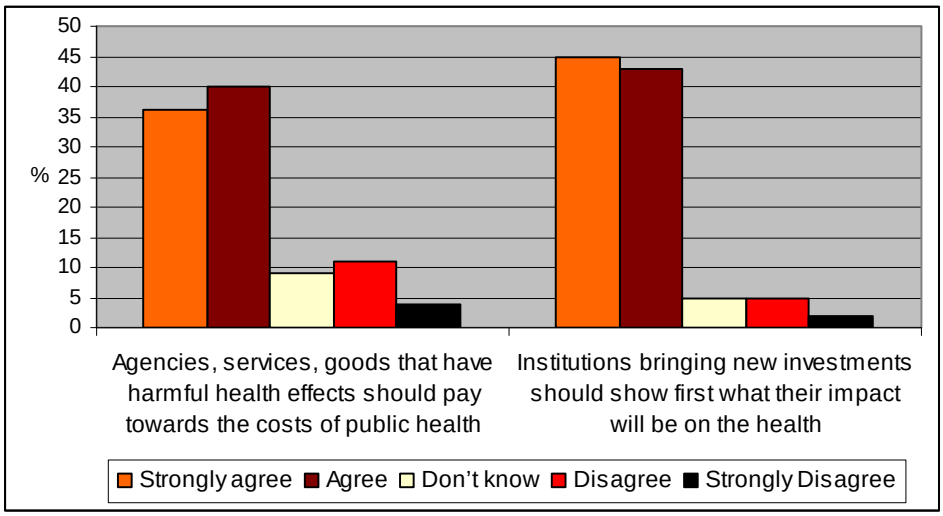
MoHCW should play a leading role in public health, Public Health Act should supersede all other Acts, roles in public health need to be clearly clarified, eg MoHCW and EMA and there should be more coordination among partners in public health

Likert scale Community respondents, all areas

The private sector was seen having an important role in public health in 25 FGDs, with roles including:

i. providing incentives for health promotion, corporate responsibility to promote public health and ensuring safe working environments (18 FGDs)
ii. disposing waste in an environmentally friendly manner (6 FGDs)
iii. ethical business in compliance with public health laws and regulations including not selling unauthorized foods, expired foods and complying with regulations, such as on tobacco smoking control, alcohol sale, medicines sale (11 FGDs)
iv. paying levies and taxes to support resources for public health (2 FGDs)

Figure 10: Likert scale responses on private sector roles in public health (N=991)



'Business that harm our public health should be made to pay. Penalize people who sell hazardous goods'

Community level leader, Mangwe

The likert scale responses indicated a view that private producers of harmful products or waste should pay towards the costs of public health and that new investments should be assessed for their public health impacts. This raises new areas not covered in the current Public Health Act (See Figure 10).

Not for profit non state actors like churches, community based organisations and non governmental organisations were also identified in the FGDs as being key institutions in public health systems, especially for health promotion. Their role should be recognized in the Act.

The National Health Strategy 2009-2014 recognises that traditional health practice is an important part of Zimbabwe's health system. Respondents to the likert scale did not perceive traditional practice to play an important role in public health, as shown in Figure 8 earlier. Communities were seen to have a stronger role. In two FGDs, participants said traditional health had no role in public health issues, and the issues raised in FGDs related to the need to register and train traditional practitioners, improve the sanitation and hygiene of their services and strengthen their co-ordination with public sector services. One focus group observed that customary law has an important role to play in public health, positively but also negatively through bad practices, such as forced marriages (kuzvarira).

The traditional health sector and customary law should be covered (in the law) because traditional health practice is an important part of our health system. They should be licenced and registered by the MoHCW and also be mandated with reporting of disease outbreaks

Community member, Acturus

4.4 Public Health Functions

The White paper outlined the legal provisions for key functions in public health, ie . preventing ill health and promoting good health, through action on the social determinants, or the social causes, of health; preventing and managing the diseases that have greatest burden on Zimbabweans, through the organised actions of the health system, of other sectors and non state actors and involving communities.

Respondents in both the FGDs and likert scale questionnaire recognized the importance of social determinants in public health, particularly related to living and working conditions. More than two thirds (68%) of respondents from the likert scale questionnaire agreed that public health law should not focus only on removing threats to health but also promoting the general health of the society (as shown in Figure 5). The FGDs (14) raised various health promotion activities. Health promotion was cited as being used in disease prevention programmes, in immunisation, maternal and child health services, HIV/AIDS services, water and sanitation, management of tuberculosis and non communicable diseases. In two FGDs, concern was raised on the lack of health promotion content in the Public Health Act and called for its inclusion.

'No information is being given to the society on nutritional values for example fast food production'

Community level worker, Kariba

'Those who advertise their products do not show or tell the truth. Products such as white sugar, white bread and refined mealie meal should not be encouraged'

Community Member, Epworth

Focus group respondents also proposed that better systems be put in place to respond to public health emergencies, including

i. Educating communities, strengthening communication systems and forming public health emergency response teams (11 FGDs)
ii. Ensuring the personnel and resources for public health emergencies (9 FGDs)
iii. Improving collaboration with other stakeholders on emergencies (5 FGDs), and
iv. For the Minister of Health to have the power to declare public heath emergencies (3 FGDs).

'We should form responses committees supported with resources and an ambulance at health center level. We should form response groups eg disaster management committees at village level'

Chikwaka community members

4.5 Implementation of the law

In the FGDs, barriers were raised in the implementation of the current public health law, including

i. inadequate motivated qualified personnel (17 FGDs);
ii. Inadequate funds for implementation (15 FGDs);
iii. Poor coordination across ministries, other sectors and communities (8 FGDs);
iv. Corruption, politics (7 FGDs) and
v. Poorly defined roles in the law, and legal gaps (4 FGDs).

Resource constraints are often raised as a reason for why the law is not enforced. The implementation of the law requires resources (financial, human, equipment, knowledge), but the current Public Health Act does not contain any provisions on financing. In the FGDs, the participants proposed that;

i. More funds be allocated to public health from the national budget (15 FGDs)
ii. Taxes be collected from activities that raise public health burdens eg tobacco, alcohol (6 FGDs). More than three quarters (76%) of respondents in the likert scale also agreed with this suggestion;
iii. Collaboration be established with external funders and the private sector to build a public health fund (6 FGDs)
iv. Funds be raised from penalties and fines (5 FGDs) and from fees for licenses, inspections (4 FGDs)

If funds are collected from specific items eg tobacco the funds should also be used to control diseases or conditions which might occur due to tobacco productions usage etc. if EMA is charging a levy from tobacco why not for public health since tobacco is already a hazard to health. MOH should be empowered to charge spot fine to offenders and funds channeled to public health issues.

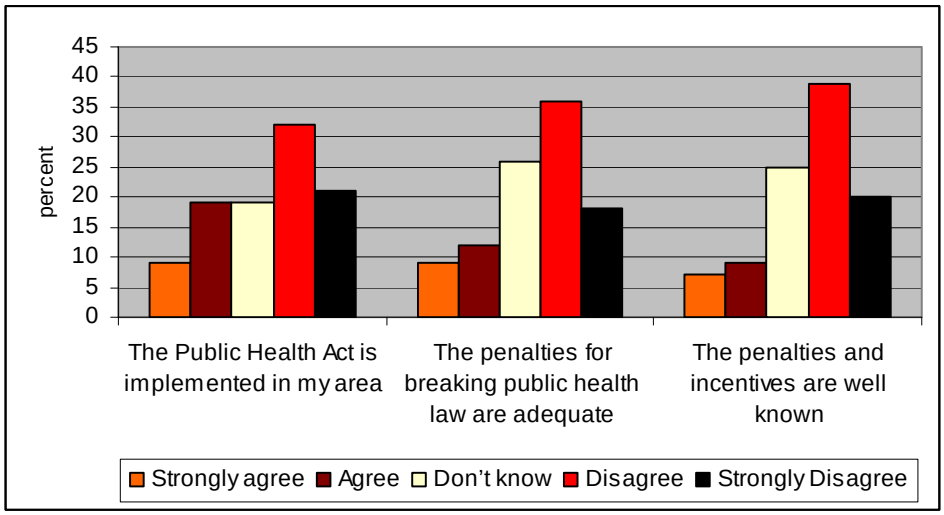
Community level worker, Kariba

Cut budgets for other ministries and prioritize health. Public service should prioritise health remuneration and also levies set aside from organizations to go to public health.

Community worker, Mutare

In the FGDs it was raised that the Act is poorly implemented. This was also the perception raised in the likert scale questionnaire, where most disagreed that the Act was implemented in their area, and that the penalties were adequate or even known (See Figure 11).

Figure 9: Likert scale responses on enforcement of the Public Health Act (N=991)



'The Act should provide for a section dealing with public health offences with progressive sanctions for causing significant and serious risks to public health with sanctions including fines and prison terms'

Community member, Acturus

Most FGDs (21) stated that the Public Health Act should apply to the state.

5. Discussion and recommendations

This report presents evidence from the community level of the health system, from community members, community leaders and local health and other workers. It thus presents perspectives from those most critical for the Primary Health Care approach that is at the core of national health policy since 1980 and thus a key influence in review of public health law.

There was a majority view that the Public Health Act is poorly implemented and that the public health system is somewhat ineffective, with frustration over the lack of priority given to public health, over the new situations that have created risks that are not being managed, and over lack of accountability of officials. It was perceived that the Public Health Act and its penalties are not well known, making it difficult for communities to play a role in implementing it.

This contrasted with the strong support for public health, for a strong legal framework to protect public health and for communities and frontline workers across all sectors to play an active role in promoting public health. There was relatively wide support for public health to be given higher priority in relation to other socio-economic goals than at present.

The key recommendation thus emerging from this assessment is that government as a whole should be giving higher priority to public health, to make known and implement current law, even while it undertakes the review to update it.

Communities want to see specific visible actions addressing public health concerns and want to be involved in these actions, backed by resources, public information and health education.

It was perceived that a new Public Health Act should continue to apply to the state.

The most highly prioritized issues related to environments for health, including safe water, solid waste, sanitation and hygiene, and sexual and reproductive health. There were expectations that the Act will provide for the basic standards and entitlements in these areas.

The effectiveness of public health measures at border areas was an area identified for strengthening, with new public health risks coming from outside Zimbabwe, including skin lightening oils and other cosmetics, medicines, strong alcohol, GMO foods, new diseases such as H1N1.

The range of specific local concerns indicate that the Public Health Act should provide general standards and give flexibility for local measures and powers to identify and address specific local health problems.

The community level respondents supported a broad approach to public health, controlling risks *and* creating the conditions to be healthy. This calls for a wider focus than in the current Public Health Act, covering a range of social determinants and health promotion, and calling for co-operation across sectors, different actors including private sector and communities.

It was felt that better systems need to be put in place to respond to public health emergencies, including organising and educating communities to respond, ensuring the personnel, resources and collaboration for responses to public health emergencies and a quick process for high level declaration of public heath emergencies.

There was support for the Act to include health promotion and particularly access to the community knowledge and information seen to be critical for this. Further the assessment indicated the need to include wider public duties to promote public health, and the obligations of the state to support and ensure this.

Hence while there was strong consensus for the rights to health to be included in the Act and for a rights based approach, there was also a call for inclusion of responsibilities for health, including duties on individuals not to compromise rights of others. The rights that people expected to see in law included rights to social determinants like water, food and

housing; to health services and medicines, and to public information.

Taking a rights based approach was seen to create a duty on the state and individuals to protect vulnerable groups, including PLWHIV, children, pregnant women, people with disability, chronically ill patients and elderly people. While this was seen to call for stronger health systems and more active public health workers, it was also seen to call for action from other sectors, including ministries of local government, labour, agriculture, home affairs, transport, environment, tourism, housing, and public works.

Further, respondents supported state intervention to ensure that the rights of vulnerable groups are protected, even if that means limiting the rights of others, particularly in

- compelling compulsory immunisation for children;
- accessing premises and persons to control infectious diseases like cholera
- compulsory testing for new epidemics if merited
- stopping the spread of infectious diseases in children, and in old, vulnerable or disabled people

Community members, leaders and community level workers feel that parents should not have the right to refuse their children being vaccinated, and support compulsory vaccination.

While there was some diversity of views, the majority view was for a decentralized system, with inter-sectoral involvement in public health. This places high demand on MoHCW to co-ordinate different sector actions. While health workers thought current co-ordination was effective, community members and workers from other sectors did not agree.

Community level members and personnel also called for a broader perspective of the definition of “public health workforce” to include community level workers working directly in health (for instance nurses, environmental health technicians (EHTs), home based care givers, counselors, village health workers, community condom distributors and so on) and workers in other ministries and sectors to do with public health, such as from the Environmental Management Authority, District development fund and Agritex). For all workers, inadequate pay and resources was noted as a barrier to their effective performance.

Greater attention was called for in relation to private sector roles in public health. There was a shared view that private producers of harmful products or waste should pay towards the costs of public health and that new investments should be assessed for their public health impacts. This is not covered in the current Public Health Act. Further, the Act should provide for corporate responsibility and ethical business practices to promote public health and prevent practices that harm health. Regulation should address specific areas, such as sale of unauthorized, expired foods, tobacco smoking, and sale of medicines, cosmetics and alcohol.

The role of not for profit non state actors like churches, community based and non governmental organisations should also be recognized in the Act.

The implementation of the law was seen to require resources (financial, human, equipment, knowledge), and the Public Health Act should contain provisions on financing. New options for financing public health were raised, including increased funds from the national budget, taxes on activities that public health burdens eg tobacco,

alcohol, external funding, private sector contributions, penalties, fines, and fees for licenses and inspections.

Implementation was also seen to call for stronger penalties that would be swiftly applied.

However responses also indicated that greater attention needs to be given to the role of the community in implementation. This calls for education and training in public health, including in the school curriculum, wider community consultations, legal recognition for community level structures like Health Centre Committees and Development Committees, and resources to support community roles.

Communities can play a more direct role in public health, such as in promotion of safe and healthy living and working environments and health lifestyles. Examples were given of management of solid waste, using environmentally friendly fuels, education on good hygiene. This is more likely to happen when it is linked to economic empowerment activities that also improve health.

6. References

1. Advisory Board of Public Health, Ministry of Health and Child Welfare (MoHCW) (2011) Report of the First National Stakeholder Consultation on the Review of the Public Health Act, March 2 2011, Harare
2. Advisory Board of Public Health, MoHCW (2011) White paper for the Review of the Public Health Act, Mimeo Harare
3. Government of Zimbabwe Ministry of Health and Child Welfare(2010), Health Sector Investment Case, MoHCW, Harare
4. MoHCW (2009) The National Health Strategy for Zimbabwe (2009-2013), Equity and Quality in Health A People's Right, Government of Zimbabwe, Harare
5. PHAB, MoHCW (2011) White paper for the review of the Public Health Act, Mimeo Harare
6. Training and Research Support Centre (TARSC) (2011) Training Workshop Report on research design and data collection on community consultation on the review of the Public Health Act May 2011: TARSC CBRT Harare
7. WHO CSDH (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva, Switzerland, World Health Organisation

7. Acronyms

ART	Anti Retroviral Therapy
CBO	Community Based Organisation
CFH	Civic Forum on Housing
CWGH	Community Working Group on Health
DDF	District Development Fund
EHT	Environmental Health Technician
EMA	Environmental Management Agency
FGD	Focus Group Discussion
HBCG	Home Based Care Giver
HCC	Health Centre Committee
MoHCW	Ministry of Health and Child Welfare
MoLG	Ministry of Local Government
NCD	Non Communicable Diseases
NGO	Non Governmental Organisation
NHS	National Health Strategy
PHAB	Advisory Board of Public Health
PHAct	Public Health Act
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS
SI	Statutory Instrument
TARSC	Training and Research Support Centre
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WHO	World Health Organisation
ZCTU	Zimbabwe Congress of Trade Unions
ZDHS	Zimbabwe Demographic and Health Survey

Appendix 1: Focus Group Discussion Guide

Researchers will;

1. *Obtain permissions from authorities and individuals to proceed*
2. *Introduce the background, scope of public health and purpose of the exercise*
3. *Guarantee confidentiality of views gathered.*
4. *Ensure that each FGD has the right composition of people and is unbiased.*
5. *Record views clearly and visibly using the prescribed format*

Important: **BEFORE** the FGP, participants are required to complete the Likert Scale questionnaire.

Questions for the FGD

1. What are the major public health problems in your area? Which come from within your area and which from outside your area? Outside Zimbabwe?

2. The current Public Health Act sets strong duties and powers of the state to stop public health risks (like unsafe food, unsafe water, diseases spread between people and so on) from harming people. How effective has it been? Why? What barriers have there been to effectively controlling these risks or nuisances?

3. How much do we currently use health promotion and promotion of healthy behaviours, products (eg healthy diets, primary Health Care) in public health? For what? Should the law include rights, duties and responsibilities for promoting health?

4. Should the PHA provide for a right to health? What rights? How would they be enforced? How would vulnerable groups be protected?
5. What duties do you think the following should have if we are to ensure the health of the public in your area?

- o Central government
- o Local government (explore further whether there need to be any changes in the roles of the MoHCW and MoLG at central and local level to strengthen effectiveness)
- o Health Ministry
- o Other ministries (which? explore further whether there need to be any changes in the roles of different ministries at central or local level to strengthen effectiveness)
- o Communities
- o Traditional health sector
- o Private sector and businesses

6. When do you think the state should have the power to limit the rights of individuals for public health? First open ended and then asked in relation to

- o Investigating and controlling infectious diseases, like cholera?
- o Dealing with new epidemics from outside Zimbabwe, like H1N1?
- o Compelling notification or disclosure of a health condition to a partner, an employer or others?
- o Compelling a public health intervention, like immunisation?
- o Criminalising behaviours related to the spread of infectious diseases?

In each case ask for the reasons why.

7. What should the law provide for to promote meaningful community participation in

public health? Through what roles and mechanisms?

8. How should the public health law cover the role and duties of traditional health services and customary law in public health?

9. What needs to be done to strengthen the prevention and management of public health emergencies, emergency health services, outbreak and disaster management?

10. What do you think are the main barriers to implementation of the current public health law? Just ask open ended and then probe further on:

- Who would you regard as the 'public health workforce' in your area? What are the gaps? What changes are needed in the public health workforce to be able to better promote and enforce the law?
- The funds for public health? How can they be increased?
- The sanctions for non compliance – the level and enforcement of penalties?
- The incentives to encourage public health actions?
- Should the Public Heath Act apply to the state?

At the end of the FGD, try to summarise issues discussed and remember to THANK the participants.

Appendix 2: The Likert Scale

RESPONDENT CATEGORY (circle the correct option):
I am a: Community member / Community leader / Health Worker / Other personnel……..

AREA/ DISTRICT: ……

Tick the box that best reflects the way you feel about the question. Please tick only ONE box for each question
For example

Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
Newborn babies should be breastfed	✓				

Statement IN OUR AREA:	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1. Our health is mainly affected by our local community and living environments					
2. Our health is mainly affected by our diets and lifestyles					
3. Our health is mainly affected by goods and hazards imported from outside the area					
4. We can only improve public health if we work together as individuals, communities, organizations and the government					
5. The protection of public health should be prioritised over other economic and social goals					
6.The Ministry of Health should encourage collaboration among public, private sector partners and communities in public health					
7. The Ministry of Health should be able to enforce laws and regulations that protect public health and safety on everyone, including other ministries					
8.Communities are being informed and playing a meaningful role in public health in my area					
9.The traditional health sector plays a role in promoting public health in my area					
10. Our public health law should focus only on/ emphasize only on removing the threats to health, and not worry about promoting the general health of society.					
11. Public health law should include the right of access to health facilities, goods and services					
12. Public health law should include the right access to the inputs that affect health, (food, basic shelter, housing and sanitation, and adequate safe water)					
13. Public health law should include responsibilities for health					
14. Authorities should provide information and health education when implementing public health actions					
15. Health authorities should be allowed to test individuals without their consent when investigating and controlling infectious diseases					

Statement IN OUR AREA:	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
16. The law should not compel someone to tell a health condition to a partner, or others, even if they may be affected by that condition					
17. Parents or guardians should have the right to refuse their children to be immunised					
18. Local government should be the main agency responsible for ensuring public health law is enforced in an area					
19. We have enough public health workers in our area to enforce the law					
20. We have good co-ordination between the public health workers in our area around law enforcement					
21. Agencies, services and goods that have harmful health effects (sweets, alcohol, road traffic, cigarettes, pollution) should pay directly towards the costs of public health					
22. Institutions bringing new investments to our area should show first what their impact will be on the heath of the people in the area					
23. The penalties for breaking public health laws are adequate					
24. The penalties and incentives in public health law are well known					
25. The Public Health Act is well known amongst my immediate group					
26. The Public Health Act is implemented and enforced in my area					

Do you have any other comment on improving public health in your area?

Appendix 3: Characteristics of respondents to the focus group discussions

District	Number of respondents			Total	Percent
	Community level workers	Community members	Community Leaders		
Arcturus	12	24	6	42	7
Bindura	17	13	14	44	7
Chikwaka	18	20	17	55	9
Chitungwiza	13	6	15	34	5
Epworth*	42	31	17	90	15
Gweru	18	12	6	36	6
Kariba	19	8	17	44	7
Mangwe	14	17	28	59	10
Masvingo	10	20	12	42	7
Mutare	36	45	16	97	16
Tsholotsho	28	34	15	77	12
Total	***227***	***230***	***163***	***620***	***100***
Average/Mean per group	***21***	***21***	***15***	***56***	

Distribution of community leaders by category of person		
Category	**Number**	**Percent**
Church leaders	18	11
Councilors	23	14
Health Centre Committee	22	13
Lawyers	1	1
Residents Associations	14	9
Traditional	17	10
Village Health Workers	1	1
Village Heads/Chiefs/Kraal Heads	25	15
Youth Leaders	12	7
Other	30	18
Total	***163***	***100***

Distribution of Community members by category of persons		
Category	**Number**	**Percent**
Adult household members	121	53
Church	12	5
Disabled and PLWHIV	18	8
Traditional Sector	18	8
Youths	37	16
Other	24	10
Total	***230***	***100***

Distribution of community level workers by occupation type		
Profession	**Number**	**Percent**
Agritex	10	4
Civil Society Organisations	10	4
District Development Fund	7	3
Environmental Management Authority	6	3
Home Based Care Givers	26	11
Local Authority EHTs	11	5
Labour representatives	36	16
MoH EHTs	10	4
Nurses	22	10
Police	21	9
Teachers	31	14
Transport sector	1	0
Veterinary	4	2
Other	32	14
Total	***227***	***100***

Appendix 4: Likert scale responses

Question		Rating by all combined (%) N=991				
		Strongly agree	Agree	Don't know	Dis-agree	Strongly disagree
1	Our health is mainly affected by our local community and living environments	53	38	2	6	2
2	Our health is mainly affected by our diets & lifestyles	52	38	3	6	1
3	Our health is mainly affected by goods and hazards imported from outside the area	28	34	10	22	6
4	We can only improve public health if we work together as individuals, communities, organisations and the government	73	23	1	2	2
5	The protection of public health should be prioritized over other economic and social goals	43	47	5	5	1
6	The MoHCW should encourage collaboration among public, private sector partners and communities in public health	56	37	4	2	1
7	The MoHCW should be able to enforce laws and regulations that protect public health and safety on everyone, including other ministries	62	32	2	2	2
8	Communities are being informed and playing a meaningful role in public health in my area	19	34	10	30	7
9	The traditional health sector plays a role in promoting public health in my area	13	21	22	32	13
10	Our public health law should focus only on removing the threats to health, and not worry about promoting the general health of society	11	14	7	40	28
11	Public health law should include the right of access to health facilities, goods and services	62	32	2	2	2
12	Public health law should include the right to access to the inputs that affect health, (food, basic shelter, housing,sanitation,an adequate supply of safe water)	58	37	4	1	1
13	Public health law should include the responsibilities for health	48	48	2	2	0
14	Authorities should provide public information and health education when implementing health actions	57	39	2	1	1
15	Health authorities should be allowed to test individuals without their consent when investigating and controlling infectious diseases	26	30	5	24	15
16	The law should not compel someone to tell a health condition to a partner, or others, even if they may be affected by that condition	13	19	7	40	21
17	Parents and guardians should have the right to refuse their children to be immunized	10	7	3	29	51
18	Local government should be the main agency responsible for ensuring public health law is enforced in an area	32	41	6	14	7
19	We have enough public health workers in our area to enforce the law	9	12	15	45	19
20	We have good coordination between the public health workers in our area around law enforcement	11	23	17	37	12

Question		Rating by all combined (%) N=991				
		Strongly agree	Agree	Don't know	Dis-agree	Strongly disagree
21	Agencies, services and goods that have harmful health effects (sweets, alcohol, road traffic, cigarettes, pollution) should pay directly towards the costs of public health	36	40	9	11	4
22	Institutions bringing new investments to our area should show first what their impact will be on the health of the people in the area	45	43	5	5	2
23	The penalties for breaking public health law are adequate	9	12	26	36	18
24	The penalties and incentives in public health law are well known	7	9	25	39	20
25	The Public Health Act is well known amongst my immediate group	8	17	14	38	23
26	The Public health Act is implemented and enforced in my area	9	19	19	32	21

Distribution of different types of respondents on selected questions

Respondent type	Number of respondents	Rating (%)				
		Strongly agree	Agree	Don't know	Dis-agree	Strongly disagree
The protection of public health should be prioritized over other economic and social goals						
Community members	403	43	44	6	6	1
Community leaders	277	45	49	2	4	1
Health workers	208	38	52	6	3	1
Other workers	103	43	48	2	6	2
Total	991	43	47	5	5	1
Communities are being informed and playing a meaningful role in public health in my area						
Community members	403	23	32	12	26	7
Community leaders	277	19	32	8	33	8
Health workers	208	17	37	10	32	4
Other workers	103	14	39	7	31	10
Total	991	**19**	**34**	**10**	**30**	**7**
Public health law should include the responsibilities for health						
Community members	403	49	46	4	1	0
Community leaders	277	50	46	2	2	0
Health workers	208	43	56	1	1	0
Other workers	103	49	46	0	4	2
Total	991	**48**	**48**	**2**	**2**	**0**
Health authorities should be allowed to test individuals without their consent when investigating and controlling infectious diseases						
Community members	403	22	30	7	26	15
Community leaders	277	31	31	3	23	13
Health workers	208	28	30	5	24	13
Other workers	103	26	28	2	20	23
Total	991	**26**	**30**	**5**	**24**	**15**

Respondent type	Number of respondents	Rating (%)				
		Strongly agree	Agree	Don't know	Dis-agree	Strongly disagree
We have good coordination between the public health workers in our area around law enforcement						
Community members	403	10	22	17	36	15
Community leaders	277	14	21	16	39	11
Health workers	208	9	31	20	34	7
Other workers	103	10	18	17	39	17
Total	991	**11**	**23**	**17**	**37**	**12**
Local government should be the main agency responsible for ensuring public health law is enforced in an area						
Community members	403	31	38	7	16	8
Community leaders	277	37	42	4	13	4
Health workers	208	27	46	6	12	8
Other workers	103	35	37	8	13	8
Total	991	**32**	**41**	**6**	**14**	**7**
The law should not compel someone to tell a health condition to a partner, or others, even if they may be affected by that condition						
Community members	403	15	21	8	38	19
Community leaders	277	14	18	4	45	20
Health workers	208	9	21	7	42	23
Other workers	103	17	16	7	36	25
Total	991	**13**	**19**	**7**	**40**	**21**
The penalties for breaking public health law are adequate						
Community members	403	10	12	27	32	19
Community leaders	277	10	10	26	38	16
Health workers	208	6	12	28	39	15
Other workers	103	11	11	14	38	27
Total	991	**9**	**12**	**26**	**36**	**18**