High level workshop on the Public Health Act

MEETING REPORT

April 19th 2012,
Harare, Zimbabwe

Training and Research Support Centre
Ministry of Health and Child Welfare
In association with the Advisory Board of Public Health

With support from Open Society Foundation

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Cite as: TARSC MoHCW (2012) High level workshop on the Public Health Act, Harare, April 19th 2012, Harare

Acknowledgement to all the speakers, chairpersons, rapporteurs.

1. Background

In the review of the Public Health Act in Zimbabwe in 2011 it was evident that awareness of the contents of the Act was not high and that implementation of the Act would be improved by private and public sector stakeholders having improved knowledge of the contents and application of the law. In stakeholder meetings and community level discussions few people had accessed the Act or were aware of its specific contents. Even while inspectorates ion local government and Ministry of Health and Child Welfare (MoHCW) may be versed with its provisions, lower levels of wider knowledge reduces the role of the many social and institutional actors that have a role to play in knowing and implementing the positive provisions of the Act to protect public health.

It was thus proposed to hold follow up awareness raising and training on the Act. The proposal was made to divide this into two parts, first a high level one day meeting for top management of different sectors of the state, civil society, parliament, private sector, traditional, church and other institutions, to obtain their support for a more sustained programme of training, and then three day training for field level personnel in the same institutions who have a role in the implementation of the Public Health Act later in 2012.

The training was planned and convened jointly by Training and Research Support Centre (TARSC) and MoHCW in association with the Public Health Advisory Board (PHAB). The resource persons for the first meeting were drawn from MoHCW, TARSC, local government and Centre for Applied Legal Research. It was intended that the two courses be a pilot, and be evaluated by TARSC to assess their relevance and usefulness for input to planning of future training on the Act, particularly within districts in 2013. The areas covered would include the current Public Health Act and the practical issues in its implementation and would introduce in relevant areas the proposals made by stakeholders for review, while noting that this process is ongoing.

The one day course thus aimed to expose senior and top management of relevant state, private, civil society and parliament institutions of the content and implementation of Zimbabwe's Public Health Act, Ch 15:09, in terms of

1. the understanding of public health and national policy
2. the key areas, rights and responsibilities, duties and obligations, functions of Ministry of Health, other ministries and other actors in the Act (with an outline but not detailed treatment of the regulations under the Act)
3. how these are implemented and enforced, including co-ordination with other laws and authorities
4. briefly, the main proposals for review of the Act

The meeting also informed senior delegates of the proposed three day course to get their interest in and input on it.

The programme is shown in Appendix 1 and the delegate list in Appendix 2.
The report has been prepared by TARSC. Delegates were provided with a CD Rom of the presentations and background materials for the meeting, including the Act and its regulations.

2. Opening and overview of the Public Health Act

The meeting was opened by Mr G Mangwadu, Director Environmental Health Services, on behalf of the permanent secretary MoHCW. He explained the background to the meeting and with Dr Loewenson, TARSC/PHAB chair outlined the background to and aims of the meeting.

Delegates then introduced themselves.

Mr Mangwadu noted that public health has been an issue for social regulation since biblical times, quoting Deuteronomy 23 Vs12 *"The toilet area must be outside the camp."* and Vs 13 *"Each man must have a spade as part of his equipment; after every bowel movement must dig a hole with the spade and cover the excrement." (NLT).*
In more modern times Public Health was given greater importance with the disease control efforts on the early 20th century, particularly given the growth of concentrated urban populations.

He noted that Zimbabwe's Public Health Act (Chapter) 15:09 was enacted in 1924 and the date of commencement was 1st January 1925. The Act was adopted as a transplant from the English Law on Public Health aiming at controlling public health challenges that were mainly defined as 'nuisances', or those conditions or premises that were harmful to health.The Administration of this Act was assigned to the Ministry of Health and Child Welfare. The Act has a number of Regulations providing for specific areas of Public Health interest. While the Act has been amended many times since 1924, it has played an important role in protecting public health in Zimbabwe for over 87 years.

Mr Mangwadu outlined the various sections of the Public Health Act, and elaborated in the provisions in each of the areas below:

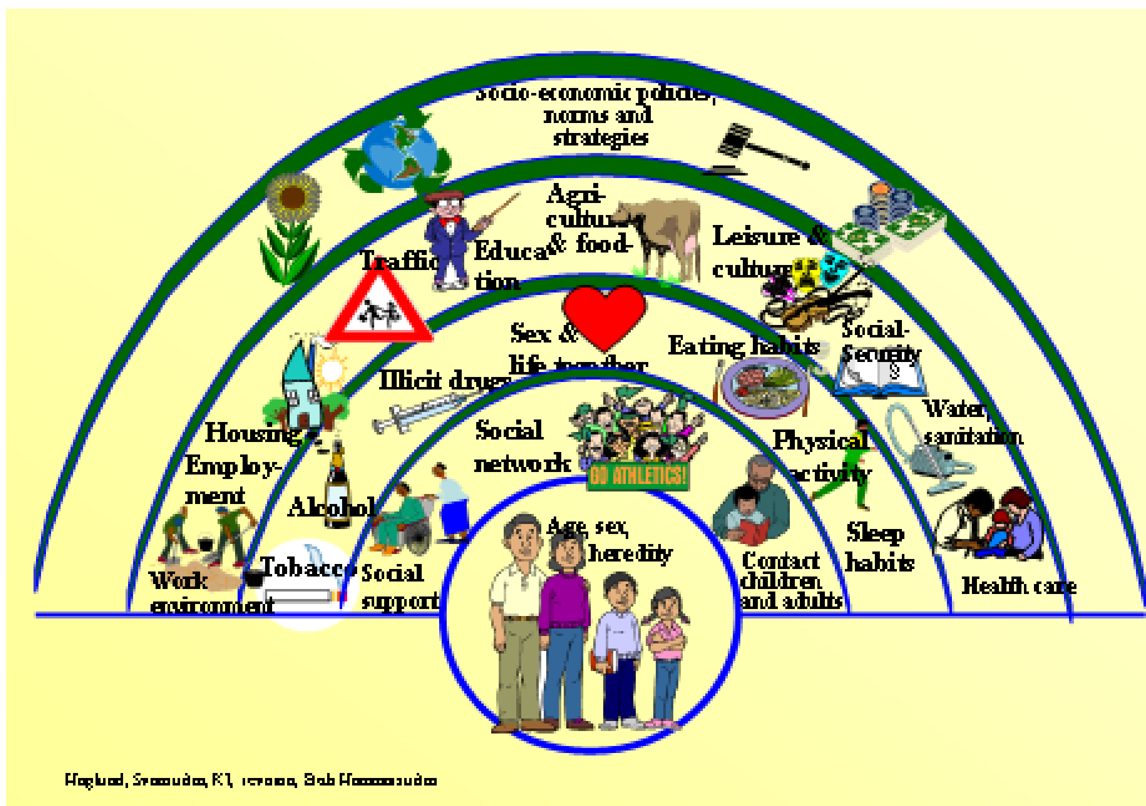
- Part II, Administration, (and the establishment of Advisory Board of Public Health, of District Health Management Committees, appointment of Chief Health Officer (P/S), Medical Officers, Health Inspectors and others); , removal and their duties as they are covered in the public health act. Notification of Infectious Diseases
- Part III covering notifiable and infectious diseases and the regulations governing the notification of the infectious diseases. He noted that the clauses include older provisions, like removal to cleansing stations, as well as clauses that are pertinent today dealing with exposure to public health risks and the management of infected persons or things, including the burial arrangements for those who die due to infectious diseases. The Act also has special provisions covering formidable epidemic diseases and their notification and the powers that the Minister of Health has in these areas.
- Part IV provides for infected person and medical practitioner duties in sexually transmitted diseases. These clauses have been discussed and updated provisions proposed in the Public Health Act review discussed later.
- The International Sanitary Regulations are covered in Part V of the Act, updated in 2005.
- Part VI covers Water and Food safety and the duties and powers to inspect water supplies, regulations regarding sale of milk and food articles and powers of the Minister of Health have make orders in these areas.
- Part VII covers provisions on infant nutrition

- Part VIII covers slaughter-houses, including licensing of slaughter houses and prohibition against sale of meat which has not been slaughtered in a slaughter house
- Part IX covers sanitation and housing and includes issues like ‘nuisances’ that are prohibited, penalties in relation to nuisances, demolition of unfit dwellings and prohibitions of back-to-back dwellings and rooms without through ventilation.
- Part X covers general issues, including the powers and duties of the Chief Health Officer and assistant health officers, protection of officers, powers of local authority outside its district and confirms the application of Act to the State.

3. Public health challenges in 2012 and the review of the Act

Dr Rene Loewenson, Director TARSC, chair PHAB presented on public health trends, challenges in 2012 and the role and the areas proposed in the 2011 review of the Public Health Act. Public health was defined as what we do to ensure the conditions for people to be healthy. It includes the actions taken to create conditions for and promote health, to prevent disease and prolong life. the actions by health care institutions to prevent, diagnose and treat disease, or improve family and community health and the actions of other sectors of government, public and private organisations, communities and individuals, media, business, academia. She noted the different levels of causes of health outcomes in the chart below, pointing out that public health seeks to address not just immediate but also underlying causes.

The social determinants of health



She gave a number of examples of recent public challenges. For example trade liberalisation has exposed households to poorly regulated products that may be positive or harmful to health. Tobacco imports have for example increased and smoking was found to show increasing prevalence, including in secondary schools.

She gave an outline of the reasons why it was necessary to review the Act, including in terms of its piecemeal revisions and fragmentation , the need to apply the law to new hazards, to address gaps, including in the rights and principles, provisions for affirmative actions, to ensure coherence with other laws and comply with International obligations. Other reasons were to review the roles and powers needed to implement duties and functions and promote an affirmative, proactive, partnership approach beyond the reactive, 'nuisance', restraining approach.

In 2010 the Minister of Health and Child Welfare asked Public Health Advisory Board to review Act. In 2011 the PHAB through a technical working group held various stakeholder forums, circulated a White Paper, held focus groups in 10 districts; obtained 29 written submissions and consulted specific technical expertis nationally and internationally. The final proposals were reviewed by the Technical Working Group, national stakeholders and the Public Health Advisory Board. A principles document was submitted to the Minister of Health and Child Welfare in late 2011 for the legislative process and is now within the Ministry.

She noted that the amendment should not weaken, dilute or reduce the powers in the current Act, that the Act remains the umbrella Act in Public health and applies to the state. Definitions were updated and 20 proposals were made within five broad areas of

- Principles, Vision, objects,
- Rights, responsibilities, duties and powers,
- Public Health Functions,
- The Public Health System,
- Implementation and enforcement of the law

She detailed the proposals for review which are captured in full in the final stakeholder meeting report and background document from the PHAB that was circulated at the meeting.

The proposals provide for a preamble that states a broad vision for public health and objects that clarify the mission of the state and other actors in public health, cross referencing for promotion of beneficial links and effective co-ordination across health laws within Ministry of Health Child Welfare and with health laws under other Ministers. She noted that the review would strengthen the framing of rights in the Act, and the general duty to prevent harm to health, The review provided for new measures, such as health impact assessments, for powers for the state to restrict individual freedoms in specific circumstances to protect public health in line with human rights and restraints set in the Siracusa Principles, duties on individuals (including corporate individuals) to prevent wilful and intentional harm to health; eg deliberate transmission of HIV, exposure to harmful substances and strengthened the framing of intersectoral mechanisms and co-ordination on the social determinants of health. New provisions also provided for health promotion and non communicable disease control.

She noted that the Act retained a decentralised approach, in line with capacities, with greater attention to roles and mechanisms to involve communities and stakeholders in decisions and actions on health. There was need to widen / update membership of the Public Health Advisory Board for stakeholder participation and update the provisions for the public health workforce. The proposals also included powers for the Minister to

mobilise resources from a range of specified sources and for stronger, graded penalties and incentives for good practice and provision of public information to support implementation .

3.1 Discussion

In the discussion on the two presentations participants raised that information sharing was critical for public health and that all public health practitioners and the public need to know and understand the implications of the Public Health Act. It was noted that the International Sanitary Regulations 2005 only become binding when included in the provisions of the Act and that they are included in the proposed review. Equally the policy approach of primary health care is given more profile in the proposals on the review.

Delegates felt that traditional health roles and practices needed more specific attention, including licensing of practitioners in dialogue with leaders of the religious and traditional sectors. The Traditional Medical Council Act provides for this but should not compromise the role of other practitioners to inspect and ensure public health issues. The issue of waste management should also be covered in the Public Health Act.

Delegates felt that harmonising the various Public health legal instruments (cross referencing) would be in the best interests of public health. There is need to come up with a Public Health Communication Strategy to ensure that everyone is abreast with the current provisions that are covered in Act and makes use of these provisions to promote public health.

Concern was raised that the polluters pays principle (polluters are allowed to pay fine and continue polluting with hazardous substances) is endangering lives as fines are collected but not being used to rehabilitate or take action to correct the situation.

4. Functions, rights, duties and powers in the Public Health Act

Mr Itai Rusike Community Working Group on Health chaired the session.

4.1 Roles, duties, functions and powers of MoHCW

Director of Environmental Health, Mr G Mangwadu MoHCW presented on the roles, duties, functions and powers of the Ministry of Health and Child Welfare. The Public Health Act has helped to keep relatively high standards but there has been a decline in recent years as behaviours and practices have declined.

He outlined the functions of the MoHCW as outlined in the Act as:

a) to prevent and guard against the introduction of disease from outside;
b) to promote the public health, and the prevention, limitation or suppression of infectious and contagious diseases within Zimbabwe
c) to advise and assist local authorities in regard to matters affecting public health;
d) to promote or carry out researches and investigations in connection with the prevention or treatment of human diseases;
e) to prepare and publish reports and statistics or other information relative to the public health;
f) generally to administer the provisions of this Act.

He outlined the provisions in the Act for the PHAB and its membership, and noted that every local authority shall, when required by the Minister, establish a District Health Management Committee in rural areas to manage and co-ordinate Health Services. The Minister may, after consulting the Local Authority or Local Authorities concerned make regulations which provide for:

a) the membership of a District Health Management Committee, including the number of members to be appointed and the method of appointment of members by the local authority concerned;
b) the power of a District Health Management Committee to co-opt persons with special knowledge or skill to serve on the committee;
c) the method of financing the operations of a District Health Management Committee; and
d) the powers of a District Health Management Committee.

He noted that the Secretary for Health is ex officio the Chief Health Officer and there is also provision for Government medical officers, assistant health officers, pathologists, medical inspectors, health inspectors and other officers as may be necessary for the purposes of the Act.

4.2 Roles, duties, functions and powers of local government

Mr John Kandwe, Local Government Health Forum, outlined the duties, functions and powers of the local government, Section 3 of the Public Health Act has provisions for delegated functions for

- preventing and guarding against introduction of diseases from outside Zimbabwe,
- promoting public health,
- prevention, limitation or suppression of infectious diseases
- promoting or carrying out research and investigations in connection with prevention or treatment of human diseases and
- generally administering the provisions of the Act.

Officials such as Medical Officers of Health are appointed by the Ministry of Health in consultation with the Local authority. The Act also provides for appointment of one or more competent health inspectors to carry out the functions of the Act. These Inspectors, or Environmental Health Practitioners, are responsible for food and water quality monitoring, investigation of infectious diseases, monitoring of environmental health hazards, enforcement of Council bylaws and inspections of business premises and other public buildings. The dismissal of Medical Officers and Health Inspectors requires the Minister's approval except in cases of retirement on account of age, ill health, but a local authority may suspend an official pending sanction by the Minister.

It is the duty of the local authority to take lawful precautions to prevent disease outbreaks, when dealing with infectious diseases and to exercise powers imposed or conferred by the Act as in section 14 of the Act. Local authorities may form Health Committees with the number of members, powers of the committee to co-opt people with special knowledge and skill set by the Minister in regulations.

Section 64 compels the owner of premises to connect to Municipal water, fixes minimum charges for such water, with the occupier obliged to pay for such service. The local authority may subcontract water provision and has the powers to inspect water supplies. The Chief Health Officer or Medical Officer of Health or authorised person may enter and inspect water works, take and test samples, and obstruction of an officer is an offense.

Local authorities have the powers to ensure that unwholesome, diseased or contaminated food is not sold, prepared, kept, or exposed for sale: to license slaughterhouses; to prevent occurrence of nuisances which are injurious or dangerous to health; to prohibit and demolish back to back dwellings that are not sufficiently lit or ventilated.

4.3 Rights, duties, roles and functions of other sectors, private sector and communities in the Public Health Act

Mr N Chishakwe, Director, Centre for Applied Legal research described the provisions of the Act in relation to the rights, roles, duties and functions of other state sectors Sectors (Ministries of Local Government, Water, Environment, Agriculture) and of non state actors.

Section 110 of the Act establishes its legal primacy over public health matters by providing that its provisions shall supersede other laws that are inconsistent or in conflict with it: 'Save as is specially provided in this Act, this Act shall be deemed to be in addition to and not in substitution for any provisions of any other law which are not in conflict or inconsistent with this Act. If any other law is in conflict or inconsistent with this Act, this Act shall prevail".

The Act sets the relationship between MoHCW and the Ministry of Local Government based on the principle of decentralization, where local level structures (i.e. provincial, district, ward, and village) that exist within the Ministry of local government are used as the institutional infrastructure for realizing the objectives of the law. The Act allows for the extension of executive powers of the Minister of HCW to the MLG for purposes of implementing and enforcing its provisions. In undertaking this mandate the Act bestows powers and responsibilities to the MLG. For example: Section 4 of the Act provides that every local authority shall, when required by the Minister of Health and Child Welfare after consultation with Minister of Local Government establish a District Health Management Committee to manage and coordinate the provision of health services within a rural district council area. In undertaking this mandate the act bestows powers and responsibilities to the Ministry of Local Government. This delegation also applies in respect of areas outlined in the earlier presentation in Section 4.2.

The Act establishes a relationship between MoHCW and other sectors. For example, with the Water Sector with regards water works and water quality standards, where the Minister has powers to approve (or not) water works schemes on ground of public health; inspect water supplies; and take such sample of water as deemed fit.

There appear to be challenges in the implementation of this model, including lack of institutional capacity to address responsibilities that come with decentralization.

The role of Non-State Actors is to complement the State in protecting public health, monitor and hold the state accountable; inform, mobilize and participate in public health matters, do no harm; support programmes and strategies; and a general duty to protect public health In the current Act these provisions are not extensive or comprehensive and are better covered in the proposals for review.
as such, the role of Non-State Actors in public health is not well-entrenched in the existing legal framework.

He also noted that stronger institutional coordination is required to ensure the efficient implementation of laws affecting the public health sector.

4.4 Discussion

In the discussion some of the constraints to implementing these roles were noted, eg

- there is no office for the Health Officers at the Harare International Airport, or incinerators for burning undesirable substances and vaccination clinic as provided for in the Public Health Act, a responsibility of the Provincial Medical Director for this Province;
- Section 101 blocks legal proceedings against Health Officers for doing their duty but both officers and communities need to know and take bolder action to enforce the law, such as on contaminated water.

Participants advocated for the inclusion of the Act in all health training curriculum for the school of law and public health cadres, as a requirement for passing these courses. There was need to for a simplified version of the Act to be produced so that the public will not have problems in interpreting it. It was also recommended that more public health specialists be included in the PHAB.

5. Water, sanitation, housing and infectious disease control-

Dr Lincoln Charimari, WHO chaired the session

5.1 Provisions, regulations and roles in relation to Water, sanitation, housing

Mr D. Rodrick A/Deputy Director Dept Environmental Health MoHCW noted that water, sanitation and housing are covered in the Public Health Act. Section 64 provides for the duties of the local authority to inspect and test water supplies as required by the Minister of Health to ensure provision of wholesome water for drinking and domestic purposes, and to maintain and secure of water sources. The water works has to be approved by the state for it to commence operations. The local authority has a duty to maintain existing water supplies in good order and to inspect water supplies.

The Act sets standards for safe water and housing. Sections of the Act deal what constitute a nuisance and how best they can be avoided, the role of the local authority where nuisance is concerned and what procurers are taken when dealing with nuisances. These sections cover issues on how penalties are applied, legal implications, examination of premises, demolition of unfit dwellings, and prohibitions in respect of back-to-back dwellings and rooms without through ventilation, as noted earlier.

5.2 Provisions, regulations and roles in relation to infectious disease control

Mr John Kandwe, Local Government Health Forum presented the provisions, regulations and roles in relation to infectious diseases control. Section 17 provides a list of notifiable diseases: ie Chicken pox; Diptheria; Erysipelas; Typhus fever; Pyaemia&septecaemia (f) Plague; Scarlet fever; Asiatic cholera; Typhoid or enteric fever; Leprosy; Undulant or Malta fever; Anthrax; Glanders ; Rabies; Sleeping sickness; Epidemic cerebrospinal meningitis; Acute poliomyelitis or infantile paralysis and all forms of TB.

The Minister of Health and Child Welfare may declare any infectious or communicable disease as notifiable. In institutions such as schools, orphanages, hotels and boarding houses the principal person in charge should notify of any infectious disease outbreak to the Ministry of Health in time and medical practitioners also have duties to report these diseases to the local Authority.

It is the mandate of the local Authority to distribute the prescribed forms on infectious diseases to health centres so that they can be filled in if there are any outbreaks; to provide isolation hospitals, ambulances and mortuaries ; disinfecting or cleansing stations and any other equipment, accommodation for dealing with outbreaks. Medical practitioners have a duty to ensure that a person is free from infectious disease before discharge and the local authority also has powers to prevent spread of infectious disease, including to authorize removal and burial of those who have died of a notifiable disease.

Mr Kandwe outlined the Formidable Epidemic Diseases noted in the overview by Mr Mangwende, including plague, Asiatic cholera and epidemic influenza, and the duty set in the Act for medical practitioners, principals of schools, and employers of labour to report to Local Authority cases of Formidable Epidemic Diseases, who should immediately report this to the chief health officer. The Minister of Health may constitute an epidemic committee for the purposes of coordinating outbreak control activities.

5.3 Discussion

In the discussion, delegates again called for information dissemination so that all stakeholders including the general public are aware of the contents and requirements of the Public Health Act. They noted the lack of implementation of provisions. The MoHCW should engage in cleanup campaigns in collaboration with the uniformed forces especially the Zimbabwe Republic Police, such as in the Mbare flats area.

It was proposed that Environmental Health Practitioners be included in the Public Health Advisory Board since they are the implementers on the ground. There should be environmental health impact assessments for Ministry to approve the commencement of water works and buildings. The Act should specify the minimum health requirements for buildings and business licenses.

One delegate called for greater involvement of private sector actors in the various mechanisms for enforcement of the Act.

6. Food safety, nutrition, smoking control

Dr Agnes Mahomva Zimbabwe College Public Health Physicians /PHAB chaired the session.

6.1 Provisions, regulations and roles in relation to food safety and nutrition

Mr Victor Nyamandi A/Deputy Director Food Safety and Port Health gave the definition of *food* as any substance or product, whether processed, partially processed or unprocessed, intended to be, or reasonably expected to be ingested by humans (SADC regional guidelines for the regulation of food safety). It includes drink, chewing gum and any substance, including water, intentionally incorporated into the food during its manufacture, preparation or treatment. It does not include medicines covered by the Drugs and Allied Substances Control Act [Chapter 15:03].

A food control system has three broad areas:

- the legal framework which covers acts, regulations and standards,
- enforcement covering inspection, sampling and analysis and
- administration including programme definition, monitoring and evaluation and data collection.

The primary legislation relating to food is the Food and Food Standards Act Chapter 15:04 and the Public Health Act and their regulations. The inspection powers and roles were discussed in earlier presentations.

Food safety includes inspection and enforcement services, food laboratory, scientific information gathering and analysis, product tracing, crisis management systems, safety of imported and exported foods, novel foods and technologies and participation in international food safety management fora.

In this the role of the state is to:
- Establish policies and standards governing the safety and nutritional quality of all food sold in Zimbabwe
- Carry out foodborne disease surveillance for early detection and warning.
- Enhance public health surveillance to provide immediate information on outbreaks of foodborne illnesses.
- Administer and enforce all national laws related to food inspection
- Inspect and regulate registered establishments, which are generally those that move products across provincial or national boundaries

He identified various challenges in dealing with improving food safety. Many countries do not have the capacity to monitor food-borne diseases and to implement food safety measures. Capacity building efforts in the region are often lacking or fragmented, and technical assistance interventions may not be well coordinated. Most ports of entries are not well equipped and often substandard foods get in the country. He noted that there is an increasing burden on the food supply in locations with high population density. Extreme weather conditions strain food control systems.

He suggested that the creation of parallel food safety and control bodies like the proposed Food Control Authority will distort food safety. He called rather for measures to improve laboratory diagnostics, mobility of the inspectorate, registration and pre-shipment inspections of foods and periodic review and upgrading of laws and regulations. The agencies dealing with food safety should be strengthened to ensure a smooth execution of activities, national, regional and international networking should be strengthened and strengthen specialisation of food safety professionals to increase vigilance in food safety.

6.2 Provisions, regulations and roles in relation to smoking control

Dr R Loewenson TARSC noted that noting that one in ten adult die globally due to smoking. There is no safe level of smoking, the risk rises with duration and frequency. Adolescents and females are more susceptible to smoking. Second-hand smoke harms all who are exposed.

Bandasson and Rusakaniko in 2010 in 6 secondary schools in Harare for that if the 650 children 29% had ever smoked - 18.5% female, 37,8% male. Smoking was associated with higher economic status, parents who smoked (2x), peers who smoked (8x) and alcohol consumption (16x more likely).

The Law is a public health measure in smoking. It can help the public and the state to control illicit trade; sales to and by minors**, r**educe demand and use through prices, taxes, product disclosures; regulate packaging, labelling, advertising**, and** reduce exposure to smoke. Entitlements can also be set on information, education, cessation services and treatment of dependence.

The WHO Framework Convention on Tobacco control (FCTC) approved by WHO member states in 2003 encompasses evidence-based demand and supply side measures to reduce availability, acceptability and use and assist people give up tobacco use. The interventions

included are price and tax measures, health warnings on packs; banning advertising, banning sales to minors, banning smoking in public places; containing illicit trade, service interventions: education, training and treatment of dependence. Many tobacco producers in Africa have ratified the FCTC, including DRC, South Africa, Tanzania, Zambia, Uganda and Kenya**,** and Zimbabwe is in the process.

She introduced the Public Health (Control of Tobacco) Regulations 2002, SI 264 2002 [CAP. 15:09], that controls smoking in public premises, on public transport, requires no smoking signs is public places, prohibits trading of tobacco to or by children and sets messages of certain size and wording on tobacco and product ingredients.

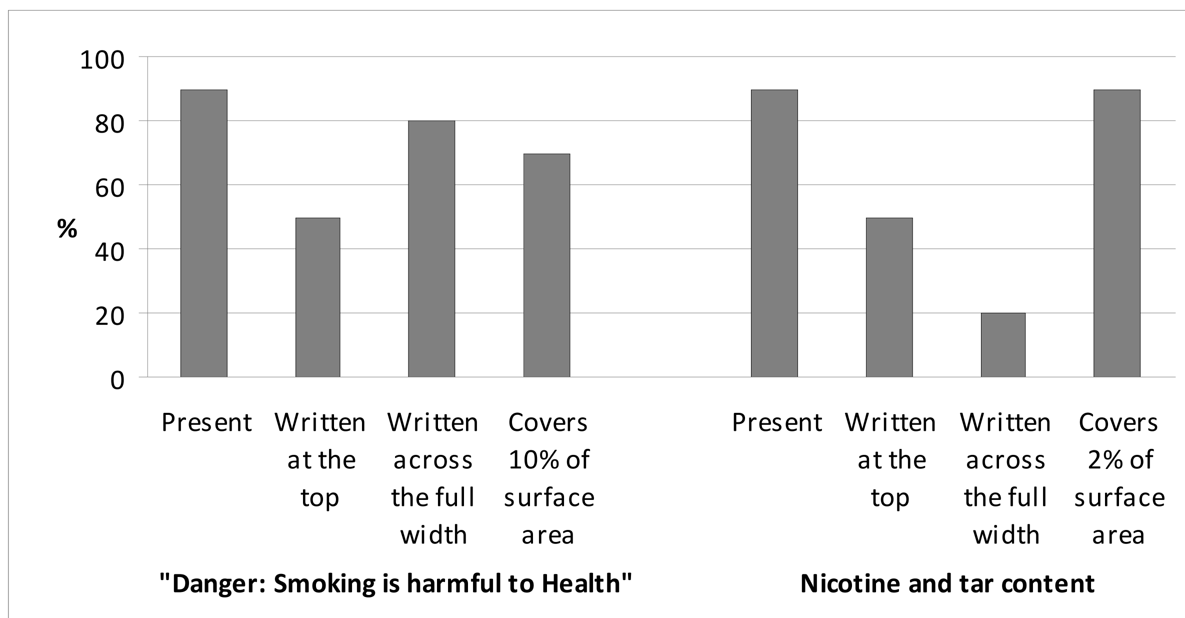
For example, the Public Health (Control of Tobacco) Regulations Statutory Instrument 264 of 2002 requires warning messages to state

- **Danger: Smoking is harmful to health** - Tobacco smoke contains many harmful chemicalssuch as carbon monoxide cyanide, nicotine and tar, which can cause disease and death. Non-smokers and ex-smokers, on average live longer and are healthier than smokers.
- **Tobacco is addictive** - Nicotine in tobacco is a drug which acts on the brain and nerves. Most smokers are dependent on nicotine that is why they feel uncomfortable and get cravings when they go without smoking for a while
- **Causes cancer** (special warning on snuff and chewing tobacco)
- For packages containing manufactured cigarettes mgs tar and mgs nicotine

The schedule specifies the size, % container and location of messages for packs, banners, film/video/TV and audio advertising.

However a TARSC cross sectional observational survey, November 2010 in low, medium, high density urban areas of Harare, Bulawayo, Mutare, Bindura covering 71 places designated as no smoking; 45 smoking permitted with no smoking zones; 16 trading places; 10 billboards; all packages of the 25 cigarette brands available on the formal market and print (7) and radio (5) adverts and billboards found poor enforcement of the law.

Compliance of billboards with non smoking regulations

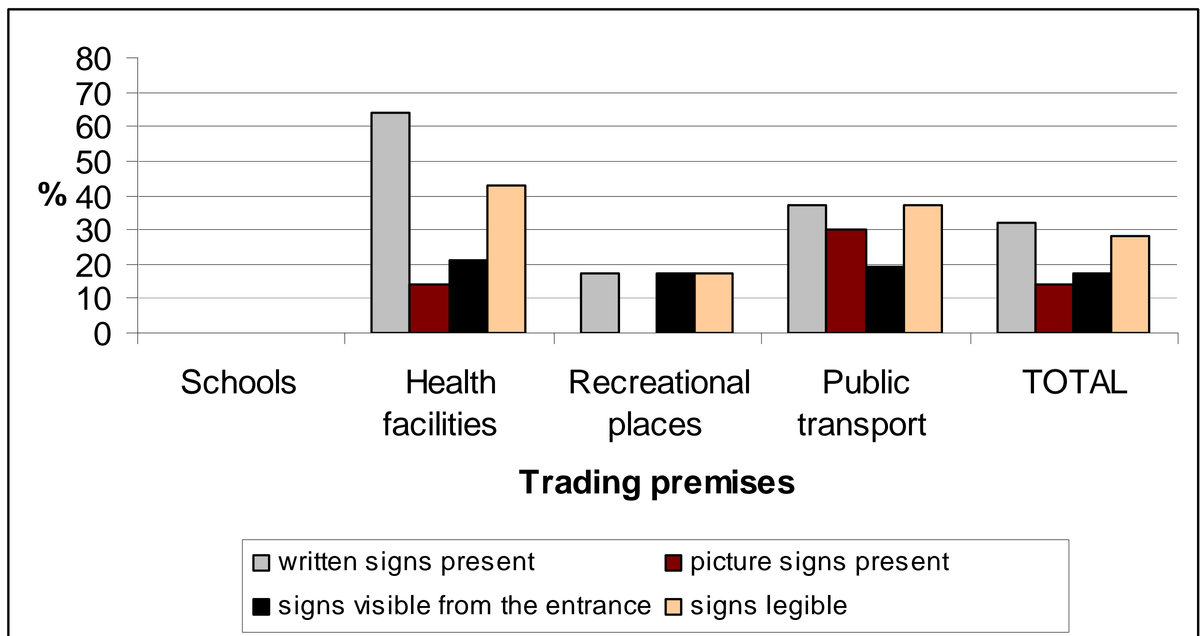


Source: TARSC 2010

Source: TARSC 2010

As the graph and photo show, there is poor compliance. Equally as shown below, compliance is low in public places, especially in schools and retail services.

Compliance with regulations on non smoking signs



Source TARSC 2010

It was found that some areas of the law are being implemented, for example

- Health warning messages are generally present
- Local tobacco brands are implementing legal requirements on health warnings
- Health facilities and airports are mostly compliant on no smoking signs
- Service station shops, some tuck shops had health warning messages and age restriction signs at the place where tobacco is sold

However many areas are not implemented:

- Health warning messages on billboards, print adverts are wrongly placed (bottom) wrong size (too small)
- Health warnings in radio adverts are not complete, (exclude tar/nicotine levels; not the end, in English; misleading message in one)
- 87% imported tobacco packages are not compliant, all packs have competing promotional messages
- There is non compliance with no smoking and signs in schools, recreation, retail, public transport facilities (smoking in 14%) or no smoking areas and signs in beer halls, restaurants and offices.
- There are no warning messages or age restriction signs in supermarkets; Cigarettes are displayed in the same place as sweets in some supermarkets.

She called for improved protection of public health by

- Improved awareness of the risks of smoking and of the current regulations.
- Promotion to ensure smoke free environments.
- Key stakeholders to have, know and enforce the regulations, eg Ministry of education, media editors, National Social Security Authority inspectorate, Zimbabwe Republic Police, local government, retailer associations
- Include SI264 provisions in local authority by laws; stronger local authority enforcement
- No smoking programmes in schools.
- Upward revision of penalty for breach of the law
- Prohibit all tobacco advertising; Extend smoking ban to offices and places used by the public
- Increased tax on cigarettes earmarked for public health measures, cessation programmes, and
- Ratifying the WHO FCTC.

6.3 Discussion

During the discussion participants raised that food vendors need regular medical examinations and that ports of entry need better monitoring because food is smuggled. It was thus questioned what capacity the MoHCW has for inspection. Pre-shipment inspections are being done but inspectors have no power to open containers at port of entry as they need to then be resealed.

Nutrition regulations presently cover only infants,.; Delegates felt that there were a number of areas that needed to be strengthened:

- provisions for controlling and labelling genetically modified foods;
- local authority roles in backyard food production;
- control of high fat, transfat, high sugar and high salt foods; and
- information to the public through mass media on the dangers of consuming fast foods.

On tobacco control delegates noted that adverts, especially billboards, should not be on school routes and no tobacco promotion should be taking place near youth. Participants agreed that awareness should be improved through no smoking programmes at schools. The Education Officer made it clear that the Ministry has a policy that prohibits smoking in schools, but the monitoring mechanism could be strengthened through production of a

Secretary's Circular reminding teachers and all staff in schools to desist from smoking and asking schools to introduce No Smoking Programmes. Ministry of Education, Sport, Arts and Culture through the Education Officer requested for support to introduce Non Smoking Programmes. Delegates also supported the banning of smoking in public places including offices as a measure to protect the public through passive smoking. It was recommended that information dissemination and training should cascade to the grassroots level, integrating already existing programmes and target Rural District Council associations and urban council associations in terms of training.

7. Implementation of the Act and conclusions

Mr G Mangwadu, MoHCW chaired the final session.

7.1 Compliance, penalties, incentives and enforcement of the Act

Mr. C. Mpofu. Principal Environmental Health officer Mata-beleland South, MoHCW presented the compliance, penalties', incentives and enforcement of the act. "Enforcement" applies to a situation when people are made to obey a law or rule. "Compliance" refers to a situation where someone obeys a rule, agreement or demand Compliance is usually voluntary but can be made mandatory.

Mr Mpofu said that it would be important for the MoHCW itself to be compliant itself as per requirements of Section 3, including in relation to the establishment of Advisory Board, of District Management Committees and Appointment of Chief Health Officer and others. The Local Authorities also need to take note of Sections 6, 7, 8, 10, 12, 14, etc. These mainly deal with the requirements in appointment of Medical Officers and Health Inspectors and combined appointments. Section 16 deals with how defaulting Local Authority situations are handled. A number of other sections described earlier in the day deal with public compliance.

Enforcement of the Act has been traditionally been done by Health Inspectors now known as Environmental Health Officers. It may start by serving of a notice followed by a request for prosecution to the court through the Public Prosecutor. Notices may be served to defaulting Local Authorities. The Chief Health Officer and Assistant Health Officers of the ministry may, with the authority and on behalf of the Chief Health Officer, may serve such notice and the Minister confirms and protects persons performing their duties where there are queried. The state and local authorities acting to implement the Act cannot be prosecuted in their personal capacity if they have acted in the course of their duties in good faith, and not for any damage to rights or property if they have used the best known or the only or most practicable and available methods. A certificate signed by the Chief Health Officer is used to make clear that they are using the best known, only or most practicable and available methods.

Section 103 Powers of Entry empowers the health officers or any district administrator or district officer, or any police officer of health or health inspector or other person generally or specially authorised by the local authority, at any reasonable hour, to enter any land or premises to make any inspection or to perform any work under the Act. Health officers must be given access and entry. He noted that the provisions of the Act are not fully complied with as health resources are not decentralised weakening enforcement capacities.

Local authority delegate representatives proposed that municipal courts were needed with the powers to sue the offender to fast track all the outstanding cases of vending offenders and other cases. The local authorities could draw from experience of South Africa and India who have such special courts. The Judiciary should be included in training on the Act

so that they know the areas covered and the legal implications. They also proposed inclusion of Environmental Health personnel in the PHAB.

7.2 Evaluation, introduction to the three day course

Dr Loewenson, TARSC, introduced the proposal to do follow up training on the Public Health Act for personnel at district level. The participants felt that the meeting was very relevant and useful information was covered in a short space of time. They felt that more time would be desirable for discussions and group work should be included to encourage interaction. Other relevant acts should be made available during the meetings for the purpose of cross referencing. It was commended that the meeting was well conducted and organized, and precise timely presentations. The standards should be maintained. The Public Health Act needs to be distributed widely and in advance.

A questionnaire was distributed to identify delegate views on the training and any follow up and twenty five (25) responses were obtained.

Of these 76% indicated that the workshop was relevant to their work or role, 72% found very useful or useful, and 52% and 24% rated the resource persons as very good and good respectively. A relatively consistent quarter of participants did not fund the training relevant to them. While 76% of the respondents noted that their organization have a direct role in enforcing / applying provisions of the Public Health Act, 26% said they have no direct role in enforcing or its application, which may explain the difference in views.
The rating of the different sessions is shown in the table below:

Responses on relevance and usefulness of different workshop sessions.

Session	Relevant and useful	Somewhat relevant and useful	Not relevant and useful	Not applicable/ did not attend this
PLENARY SESSIONS (ALL DELEGATES PARTICIPATED)				
Background to and overview of the objectives, scope and content of the Public Health Act	92	4	0	4
Public health trends, challenges in 2012 and the role and review of the Act	80	16	0	4
Roles, duties, functions and powers of Ministry of Health and Child Welfare	76	20	0	4
Roles, duties, functions and powers of local government	80	16	0	4
Rights, duties, roles and functions of other sectors, private sector and communities in the Public Health Act	64	28	0	8
Rights, duties, roles and functions of other sectors, private sector and communities in the Public Health Act	68	20	0	12
Compliance, penalties, incentives and enforcement of the Act	60	8	4	28
PARALLEL SESSIONS (DELEGATES DIVIDED)				
Provisions, regulations and roles in relation to water, sanitation, housing	68	12	4	16
Provisions, regulations and roles in relation to infectious disease control	68	12	4	16
Provisions, regulations and roles in relation to food safety and nutrition	60	16	8	16
Provisions, regulations and roles in relation to smoking control	60	16	8	16

The areas that delegates indicated wanting further information on were

- Intervention to promote non smoking programmes in schools and enforce existing policies and strengthen monitoring and evaluation on smoking in schools
- Content areas: Water and sanitation, Infectious diseases control, sexual violence, women and child health issues, port health
- The issues of port health authorities need further discussion
- Implementation issues: enforcement, financing, improving awareness of the Act,
- Health impact assessments; Public health requirements for registration and licensing of trade premises
- Roles: Involvement of private sector, role of environmental health officers in the PHAB
- Compliance: Prosecution procedures; what happens when both the state and the local authority fail to provide

Delegates supported reaching and engaging key decision makers at national, provincial, and district level to get support for the implementation of the Act.

More than half (52%) of participants said that they are not happy with their organization's current competencies in enforcing / applying provisions of the Public Health Act, while 32% said they are happy and 12% said that it is not applicable to their organization. Ninety two percent (92%) of the respondents indicated they would be interested in sending personnel from their organization to training on the Public Health Act, while 8% noted that it was not applicable to their organizations. Delegates suggested that training would be desirably organized for 3-5 days, although it was noted that the final timing depends on the content to be covered.

Delegates suggested that the training cascade to the provinces, districts, ward levels and the community. It was also proposed that for future training the courses include:

- *Government:* Ministry of Local Government, Ministry of Water, Parliament of Zimbabwe, Ministry of Justice – Prosecutors, Ministry of Home Affairs, Ministry of Agriculture Mechanization and Irrigation Veterinary, Environmental Management Authority, Zimbabwe National Water Authority, Environmental Management Agency, Scientific and Industrial Research and Development Centre
- *Local authorities*: associations of rural and urban councils, All Local Authorities; Rural District Council and District Administrators; Traditional leaders
- *Civil society and community*: health centre committees, residents association representatives, religious groups and non governmental organizations; Combined Harare Residents Association; Bulawayo United Residents Association; Harare Residents Trust; Zimbabwe Women's Trust; Vendors in urban and rural areas
- *Industry eg* CAMFED Trust, DELTA, CAINS Foods
- *Law enforcement agents*: Zimbabwe Republic Police, Zimbabwe Prison Service, Zimbabwe National Army, Judiciary, municipal police representatives.
- *Professional bodies:* Zimbabwe Medical Association; Health Professions Councils and Association for Health Workers; Health Professions Council
- *Other agencies:* UNFPA, UNESCO, UNICEF, Save the Children

It was recommended that training should be also cascaded to school level with training of school health masters and chairpersons of school health development association committees School Development Committees. It was recommended to include the Health Centre Committees representatives for community level training with information on the Act circulated in advance.

Within their own organisation the people they felt would benefit from the training and the areas to cover included:

People who would benefit	Areas of to be covered
education directors and education officers, provincial education directors, district education officers, school health in general	adolescent and reproductive health preventive services, communicable and non communicable diseases, drug abuse, HIV and AIDS, life skills
Public-public or public -private partnership	public health and financing
Management, implementers	Interpretation of the Act, responsibilities and roles, basic procedures and prevention measures, basic hygiene, waste management, pollution, contamination issues
environmental health officers, environmental health technicians and district medical officers, Health inspectors, public relations officers, provincial environmental health officers, district environmental health officers community health nurses	Prosecution procedures and nuisances notice saving procedures, law enforcement processes, overview of the public health act link between EMA and Public health act public health administration, public health enforcement, water and sanitation issues and advisory board appointment to include EHOs, notification of infected diseases, water and sanitation and food security
health officers, organisers directors, policy officer and intersectoral programme officer	Penalties for defaulters, court procedures, implementation issues, food safety and standards and infant nutrition
Women Alliance of Business Associations in Zimbabwe, SMES Officer, public relations officer, trade and information officer, gender HIV/AIDS focal persons/coordinator, human resources, publicity and information on	Awareness of the act in rural areas, women's health, water and food supplies and international sanitary regulations food safety, nutrition and smoking, provision regulations to food safety and nutrition, exposure to the act, implementation strategies
public relations officer, quality control officer, infection control officer legal and administration, membership . safety and health officers from member mines	Implementation issues, awareness campaigns and water and sanitation
youth programme officer, monitoring and evaluation officer and health literacy officer	structures for community participation, interpretation and awareness of the act and enforcement provisions
All law enforcement officers, committee clerks and researchers and members of parliament	diseases prevention and control, health promotions and EPII; What is the public health act, its provisions, use and advantages and enforcement; Provisions of the public health act and related statutes, gaps in terms of statutory provisions that are health related

Generally delegates called for multimedia dissemination strategies to spread information on the Act, with simplified or abridged versions of the Act highlighting key areas of public health concern. Public Health Act training should be integrated in all health curricula and Modules on the Act could be integrated within a range of training activities.

7.3 Closing

Mr Mangwadu, MoHCW thanked participants for their participation and their concern for public health. He noted that the Public Health Advisory Board would also be assisting on this process and other partners to chart the way forward. He urged those present to implement the information gained and review the materials distributed to deepen their understanding of information outlined in the meeting.
He wished delegates safe journeys home and closed the meeting.

APPENDIX 1: Programme

Time	Session	By
Session 1: Overview of the Public Health Act - Chair Mr G Mangwadu, Director Environmental Health Ministry of Health and Child Welfare (MoHCW)		
08:30 – 0930 09.30- -10:00 10.00-10.30	Welcome, Introductions Overview of the objectives, scope and content of the Public Health Act Public health trends, challenges in 2012 and the role and review of the Act Discussion	Mr G Mangwadu, MoHCW Dr R Loewenson, Director TARSC; Chair Advisory Board of Public Health (PHAB)
10:30-11:00	Tea/ coffee	
Session 2: Functions, rights, duties and powers in the Public Health Act - Chair Mr I Rusike, Deputy Chair, PHAB		
11:00 – 11:30 11.30-12.00 12.00-12.30 12.30-13.00	Roles, duties, functions and powers of Ministry of Health and Child Welfare Roles, duties, functions and powers of local government Rights, duties, roles and functions of other sectors, private sector and communities in the Public Health Act Discussion	Director of Environmental Health, Mr G Mangwadu MoHCW Dr S Mungofa, Chair, Local Government Health Forum Mr N Chishakwe, Director, Centre for Applied Legal research
13:00-14:00	Lunch	

Session 3: Parallel Sessions on specific areas of the Act		
1400-1530 1400-1430 1430-15.00 15.00-15.30	**Water, sanitation, housing and infectious disease control-** Chair Dr L Charimari WHO Provisions, regulations and roles in relation to Water, sanitation, housing Mr D. Rodrick A/Deputy Director Dept Environmental Health MoHCW Provisions, regulations and roles in relation to infectious disease control– Dr S Mungofa, Chair, Local Government Health Forum Discussion	**Food safety, nutrition, smoking control** Chair Dr A Mahomva Zimbabwe College Public Health Physicians Provisions, regulations and roles in relation to food safety and nutrition– Mr V. Nyamandi A/Deputy Director Food Safety and Port Health Provisions, regulations and roles in relation to smoking control–Dr R Loewenson PHAB Discussion

15:30-15:45	Tea/ coffee	
Session 4: Implementation of the Act and conclusions - Chair Dr G Mhlanga MoHCW		
15:45 – 16:30 16.30-16.45 16.45-17.00	Compliance, penalties, incentives and enforcement of the Act Discussion Evaluation, introduction to the three day course Closing	Mr. C. Mpofu. Principal Environmental Health officer Mata-beleland South, MoHCW Dr R Loewenson, TARSC, MOHCW

APPENDIX 2: Delegate list

	Institution	Name And Position
SPEAKERS		
	Ministry of Health and Child Welfare	• Mr Mangwadu Dep Director: Environmental Health Services • Mr D Rodrick Deputy Director Water Sanitation and Waste Management • Mr V Nyamandi: Deputy Director Food Safety and Port Health Environmental Health Officer • Mr C Mpofu Provincial Environmental Health Officer Matabeleland South
	Public Health Advisory Board – Training And Research Support Centre	Dr R Loewenson
	Local Authority Health Forum	Mr John Kandwe, Environmental Health Manager, Harare
	Centre For Applied Legal Research	Mr N Chishakwe Director
DELEGATES		
Government Institutions		
	Ministry of Health and Child Welfare	Dr Edward Makondo Deputy Director Nurse Education and Administration
		Dr Zizhou Provincial Medical Director Mashonaland East
		Mr Clide Jonga Environmental Health Practitioner Mashonaland West MoHCW
		Mr Robert Gwtima Provincial Environmental Health Officer MasvingoMoHCW
		MrsPeggy C Zvavamwe Chief Executive Officer Harare Hospital
		DrTonderayi Murimwa Programme Officer, AIDS and TB Unit
	National Social Security Authority	*Mrs Thembekile Dumbu Occupational Safety Health Principal Promotions Officer for Harare Region*
	Ministry of Water Development	MsTatenda Maokomatanda Acting Chief Engineer Water Resources Planning
	Ministry of Trade and industry	MrGerald Chinyemba Human Resources Officer
	Ministry of Education, Sports, Arts and Culture	Anatoria Ncube Education Officer
	Food and Nutrition Council	Mrs Jerida Nyatsanza Policy Officer
	Chitungiwsa Urban council	Dr Hebert Chirowodza Director Health Department
Parliament of Zimbabwe		
	Parliament Committee on Health	Ms Nkosinomsa Khumalo Committee Clerk Health Portfolio Principal Committee Clerk
Non state institutions and associations		
	Training & Research Support Centre	M Makandwa Information Officer
	University of Zimbabwe Department of Community Medicine	Dr L Takundwa Assistant Field MPH Coordinator
	Community Working Group on Health	Mr Itai Rusike Executive Director
	Zimbabwe Association of Church Hospitals (ZACH)	Mrs V Chitimbire Executive Director
	Zimbabwe Medical Association (ZIMA)	Dr Agness Mahomva President ZCPHP
	Urban Councils Association	Mr Munganasa Director of Health Services –EHO
	Consumer Council of Zimbabwe	Rosemary Mpofu Deputy Director
	Civic Forum on Housing	Mr S Chaikosa Director
	Informal Traders Association of	MrMasimba Ruzvidzo Secretary General

	Institution	Name And Position
	Zimbabwe	
	Centre for Diseases Control	DrPanganai Dhliwayo Deputy Director for Science-Public Health Specialist
Production sectors		
	Zimbabwe Farmers Union	Mrs L Kujeke-Goliati Programme Coordinator
	Zimbabwe National Chamber of Commerce	Nothokozo Muthombeni SMES Officer
	Chamber of Mines	Ms DumisaniMashingaidze Legal and Administration Manager
Legal organisations		
	Zimbabwe Republic Police	John Rutsito Dick Harare Provincial Nursing Officer
	Public Prosecutor	Mrs Fortunate Kachidza Principal Law Officer Public Prosecutor's Office Harare
International organisations		
	World Health Organisation	Dr L S Charmimari, Dr S M Midzi
Apologies		
	Environmental Management Authority	MrsPShoko Director
	Min Local Gvt civil protection Unit	MrNyoni Senior Principal Administration Officer
	Ministry of Agriculture	Mr Masoka Ngoni Permanent Secretary
	Ministry of National Housing and Social Amenities	MrParadza Deputy Director Design and Contracts
	Zimbabwe Congress of Trade Unions	Mr Nathan Banda Health and Safety Coordinator
	Rural district councils association	Mr R Mozhenty Chief Executive Officer
	Combined Harare Residents association	MfundoMlilo Director
	Employer's Confederations of Zimbabwe (EMCOZ)	Mr Jack Murehwa Vice President 0774825690
	Law Society	Mr E Mapara Executive Secretary
	United Nations Children's Fund (UNICEF)	Dr A Kampo

Administrative support from: Mr Z Mlambo, Mr J Chakupwaza, TARSC