Implementers Training on the Public Health Act

TRAINING WORKSHOP REPORT

15-17 October 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 Initiative for Southern Africa (OSISA)

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We acknowledge with thanks contributions made by all the presenters during the training workshop.

1. Background

During 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. During the stakeholder meetings and community level discussions, few people had accessed the Act or were aware of its specific contents. Even while inspectorates in 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.

Proposals were thus made 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 one day top management training workshop was held on 19 April 2012 in Harare, Zimbabwe

The implementers training course 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 this second training workshop were drawn from the MoHCW, TARSC, local government, Centre for Applied Legal Research and from a public health law consultant. It was intended that both the higher level and implementers training workshops be as pilots, and be evaluated by TARSC and MOHCW 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 introduced, where relevant, areas on the proposals made by stakeholders for review, while noting that this process is on-going. The three day course thus aimed to familiarize field level personnel in government, private sector and non state organizations on the Public Health Act Ch15 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
3. implementation and enforcement of the Act, and co-ordination with other laws and authorities
4. the proposals being taken forward for review of the Act.

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 T Mangwadu, Director Environmental Health Services, Ministry of Health and Child Welfare. He welcomed the delegates to the meeting and expressed his appreciation that the delegates represented the diverse geographical regions of Zimbabwe. He thanked the delegates for coming and recognised the presence of the MoHCW Provincial and District Environmental Health Officers among the delegates. Mr Mangwadu introduced and thanked Dr Rene Loewenson for her tremendous work in advancing public health in Zimbabwe and her continued support to the Ministry of Health and Child Welfare.

Delegates introduced themselves, noting the sectors they were coming from and their roles in public health.

Dr Rene Loewenson, Chair PHAB, Director TARSC expressed her appreciation in respect of the financial support provided by the Open Society Initiative for Southern Africa (OSISA) towards the training course. She also thanked the delegates for the financial contributions they made towards the course. Dr Rene gave a background to the course as provided in the background section above. She reiterated the need for the participants to give TARSC and the MoHCW an evaluation of the course to assist programming and design of similar future programmes. Public health law is diverse, with a number of regulations providing for specific areas of public health and the training course would touch on some of these regulations and key areas in the Public Health Act. She also noted that the training course would look at practical issues relating to implementation of the law, coordination with other sectors as well as proposals on the review of the Act. The aim of the course is to reach everyone who promotes public health. Dr Rene summarised the methods of delivery during the training course, noting that presentations and activities would be used to stimulate discussions, a CD rom with background documents including the PHAct and some of the key regulations would be provided to every participant, a group knowledge quiz and evaluation of the course would be implemented at the end and participants would receive certificates of attendance.

Mr G T Mangwadu facilitated a discussion on the participants' expectations. Table 1 below summarises the expectations noted by the participants

Table 1: Summary of expectations from the participants

Broad area of Expectation	Frequency raised
Understanding of Public Health and Public Health Law. Understand; o Areas provided for in the Public Health Act o Implementation of the Act o Other relevant laws and regulations relating to public health in Zimbabwe o Relevance of public health law to food safety o How the PHAct interfaces with other disciplines, for instance pharmacy.	22
Identify gaps in the PHAct, and the value that will be added to the existing legislation through the review of the Act, areas that are being reviewed	5
How to deal with challenges in the implementation of the Act	1
Roles and responsibilities in Public Health- Understanding roles of Environmental Health Officers, Rural District Authorities and non state actors	4
Disseminating the knowledge on the PHAct to others	1
Networking in the implementation of the Act	1
To receive a certificate of attendance	1

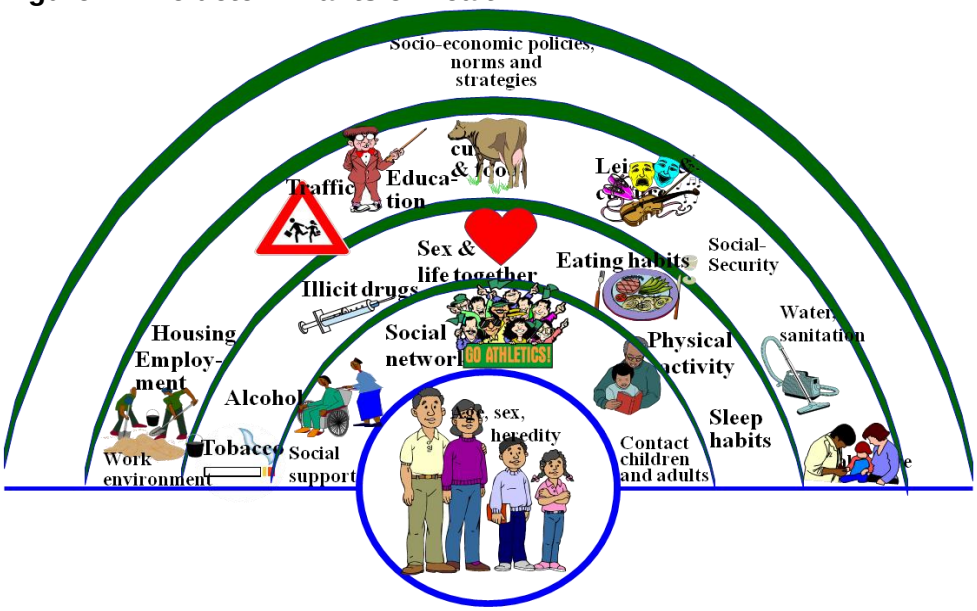
Note: Participants were allowed to list more than one expectation

Mr Mangwadu noted that at the end of training sessions, an evaluation would be done to determine the extent to which the expectations would have been met.

2.1 Public Health in Zimbabwe

Dr Rene Loewenson, Director TARSC, chair PHAB presented on public health trends and challenges in Zimbabwe. 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.

Figure 1: The determinants of Health



Source: Haglund, Svanström, KI, revision, Beth Hammarström

Dr Rene highlighted key challenges facing the Zimbabwe Health Sector as spelt out in the National Health Strategy (NHS) 2010-2013, noting that Zimbabwe's health challenges appear to be more influenced by challenges in the social environments for health, leading to communicable and non communicable diseases resulting from poor access to safe water and sanitation, housing, social conditions, food, transport systems, and working conditions. Rural and urban access to safe water fell during the period 2006-2009 and disparities in access between the rich and poor are wide with an 80% higher access to safe water in highest than lowest wealth groups. There are also wide rural-urban, provincial differences in access to safe water and sanitation. She gave a number of examples of recent public health challenges. For example trade liberalization has exposed households to poorly regulated products that may be harmful to health. Tobacco imports have, for example, increased and smoking was found to show increasing prevalence, including in secondary schools. Community monitoring suggests greater reliance for food on commercial supplies and less own produce.Dr Rene observed that everyone has a role to play in public health; public health depends on an informed public as implementers of the public health law cannot be at every place at any one time. Zimbabwe has

Zimbabwe Health context- NHS 2010-2013

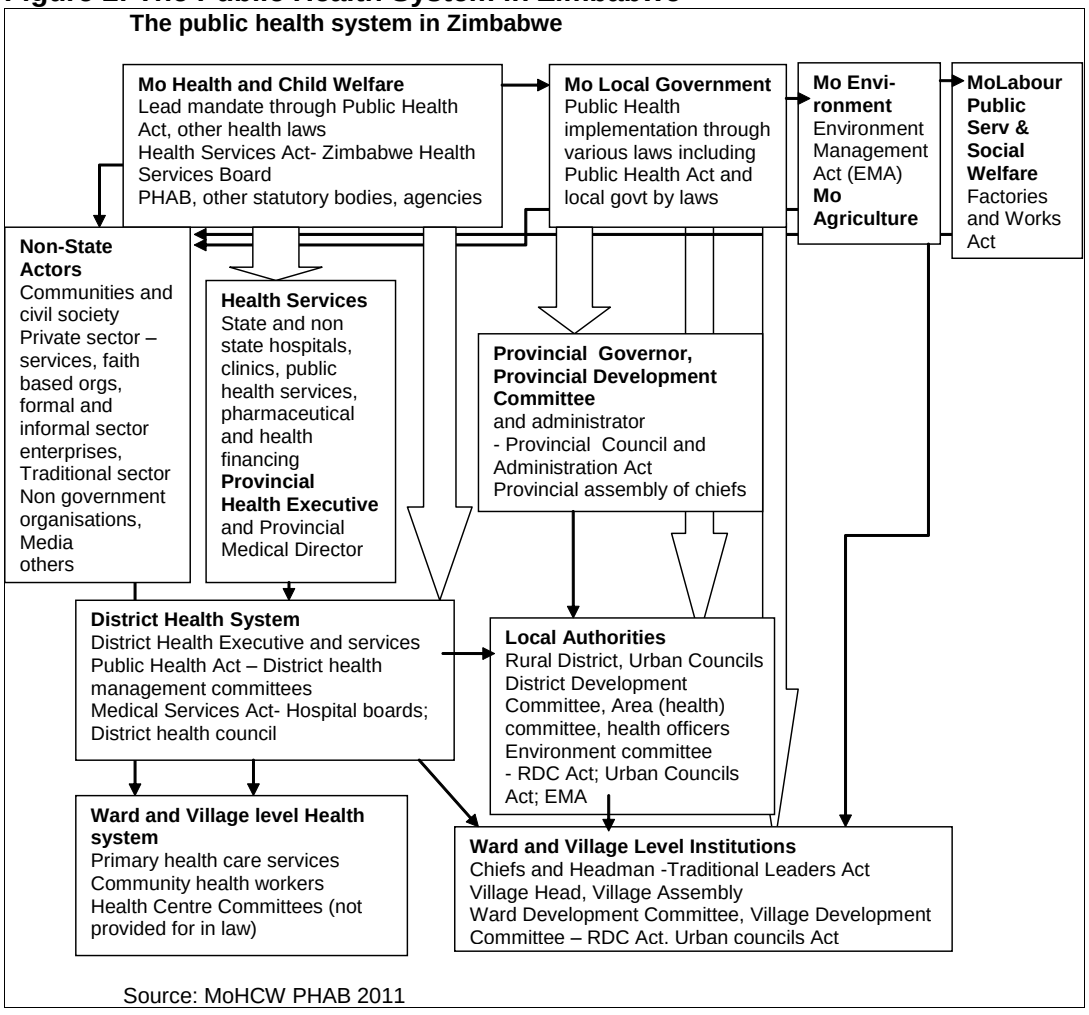
- Worsening child (86/1000) and maternal mortality (725/100 000)
- Mainly from preventable and treatable conditions: e.g. HIV and AIDS, TB, Diarrhea, ARI, (Cholera 4269 deaths 2009)
- Rising levels of mmalnutrition (35% stunting), NCDs, maternal health related complications
- Decline in health service coverage, access
- Medicine shortfalls in public health sector (V=64%, E=38%, N=54%) Feb 2010)

got some assets for public health in the form of an illiterate society, various civil society organisations, international agencies, government departments and so on. What is required is to harness the potential from these assets in a collective manner to transform the public health and health system. Public health law should thus move from reactive, restraining approach to public health nuisances and risks and individual curative care to promote affirmative, proactive, partnership approach to promotion of public health and client centred care**.**

An approach that puts more emphasis on detection and treatment of diseases is not an effective strategy. "*What good does it do to treat people's illnesses….then send them back to the conditions that made them sick*?" The National Health Strategy for Zimbabwe 2010-2013 identify the following as priorities: addressing the determinants of health; primary health care through priority health programmes aimed at major health burdens and building community participation; strengthening the health system through improved deployment, incomes and retention of health workers, ensuring medicines and other supplies to all levels, improving transport and communication for a reliable referral system, sustainable and predictable funding and; inclusive implementation through leadership, governance and participation and sound information base for decision making.

On Zimbabwe's public health system, Dr Rene noted the interconnectedness of the various stakeholders from national to local level including linkages with the MoHCW and other government departments and ministries as well as non state actors (see Figure 2).

Figure 2: The Public Health System in Zimbabwe



She noted that health systems that advance public health should reach everyone equitably with essential health services - based on public health need. They should

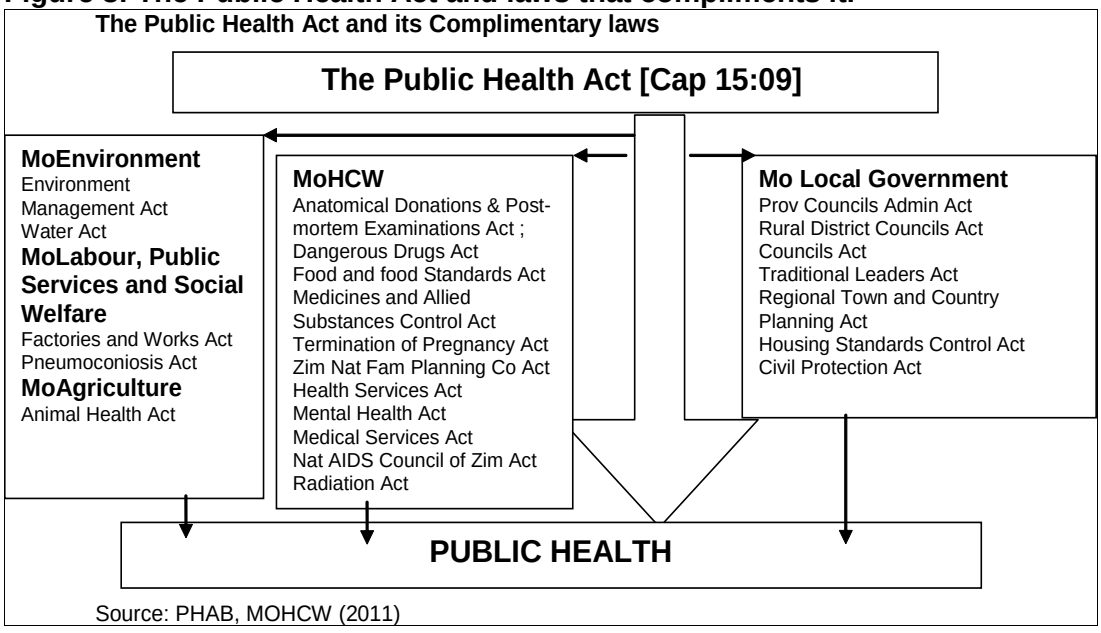
- Have a comprehensive PHC orientation- promote, prevent / protect, treat and rehabilitate, promoting multi-sect oral action on health
- Empower people - involve communities and stakeholders in decisions and actions on health.
- Directly influence other SDH including local employment and economies, are a good "corporate citizen".
- Act as champion and facilitator – to obtain support for and influence other sectors to act.

Public health law covers the legal powers and duties of the state, in collaboration with partners in the public health system to ensure the conditions for population health; and the limitations on the power of the state to constrain individual interests for common public health good. Public health law sets out

- affirmative rights, duties and powers to promote and assure the conditions for health
- constraining powers over the rights and actions of individuals in the interests of public health exercised consistently with constitutional and statutory constraints
- relationship between the state and the public, in terms of duties, powers and limits

She outlined the key laws that complement the Public Health Act (Figure 3)

Figure 3: The Public Health Act and laws that compliments it.



Source: PHAB, MOHCW (2011)

2.2 Background on the Public Health Act

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 of 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 of 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 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), aappointment of health inspectors by Local authorities, removal of medical officers and health inspector, local authority failing to appoint medical officer of health or health inspector, duties of local authorities, defaulting local authorities.
- 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

2.3 Discussion

In the discussion on the two presentations participants raised the need for such training to include all important sectors in public health. Dr Rene noted that the April top management workshop had diverse representation including people from parliament and such diversity was also shown during the review of the PHAct. The course would also be implemented in 2013, and participants were urged to spread the word on the course to various people within their districts who would benefit from such training to ensure various people from different ministries and departments and geographical areas receive the training.

Participants noted the need to strengthen community roles in public health. The current review of the Act is seeking to enhance this through recognition of community structures such as Health Centre Committees. The progress in HIV/AIDS for instance could be attributed to effective community level structures (AIDS committees).Participants noted the need to interrogate the roles of the District Health Management Team (DHMT) to ensure that such structures promote public health effectively.

A discussion ensued on the primacy of the Public Health Act, with participants noting that other Acts also seem to override others, for instance the Environmental Management Act. It was observed that the Public Health Act prevails over other Acts on areas and issues to do with public health. Further, City by-laws conform to provisions of the public health Act as the supreme public health law in Zimbabwe

3. Participatory exercise on issues faced in public health and implementing the law:

Artwell Kadungure, TARSC introduced a participatory market place exercise that aimed to identify and stimulate discussion on;

i. public health challenges faced within districts and in Zimbabwe
ii. areas where public health law is important
iii. barriers faced in implementation of the law

Participants were divided into three groups and three flipcharts with headings (i) to (iii) corresponding to the three issues covered above put on three different sides of the training room. Each group was asked to make inputs on each of the three charts and participants would debate on points raised by other group members or by the previous group(s).

Participants raised a number of issues relating to public health challenges within districts and Zimbabwe. These related to environments for health, particularly problems with access to safe water and sanitation, housing, waste management including e-waste, food imports and genetically modified foods, drug and alcohol abuse particularly illegal spirits and traditional brews, road traffic accidents, nutrition and food security issues and problems with communicable and non communicable diseases including cholera, tuberculosis, diabetes, hypertension, cancers and tobacco smoking related challenges.

Participants noted that public health law was important in all areas identified above, including on areas communities may regard as remote to public health risk eg radiation. Some of the major barriers cited in the implementation of the current public health law include limited knowledge on the Act by the implementers, lack of or limited cooperation by local authorities, fear of political retribution on the part of the implementers, limited financial resources and overlapping of areas with other laws, for instance the Environmental Management Act.

Table 2 below shows the key issues identified by the participants.

Table 2: Responses on public health challenges, areas where public health law is important and challenges in implementing the law

What are the public health challenges in Zimbabwe?
Poor waste management and water reticulation systems, Inadequate water and sanitation facilities Mixed disease burden (communicable and non communicable), limited IEC materials for the disabled Highly medical orient health delivery system, we want to cure, cure and cure, Infrastructure or facilities are limited, poor housing, and problems with e-waste, poverty, lack of awareness on the PHAct and its regulations, poor coordination amongst stakeholders and ministry of health, poor allocation of resources ie human resources, material, finance and lack of funding by central government and local authorities, political interference in the implementation of public health law, fragmentation of legislation , lack of confidence of enforcers, problems with lack of food, GMOs, tobacco smoking, alcohol and drug abuse, accidents caused by traffic on the roads,
In which areas is public law important?
Food safety – nutrition, agriculture, processing, distribution, water and sanitation, housing, hazardous waste, environmental waste management, communicable and non communicable diseases, trading and non-trading companies, premises eg handling food etc, port health, occupational health and safety, effects from mining, research, radiation radioactive and emissions hazardous waste, environmental pollution, radiation protection, health care waste management and infection control Institutions of learning and general communities- prisons, refugee camps, etc ,Infant and young child feeding, hazardous substances, meat hygiene, bilateral trade agreements.
What barriers do you face in implementing public health law?
Limited knowledge on the act (all stakeholders), local authorities not cooperating with MoHCW etc, fear of political retribution on part of the enforcers, limited resources (equipment, personnel, financial, etc), the Act is now difficult to apply in certain circumstances and situations eg HIV/AIDS, H1N1, corruption, outdated act eg fines, terms, conflicting legislation eg PHA and EMA,

3.1 Discussion

After the market place, Mr A Chigumbu, a public health law consultant, guided the discussion on points raised by the participants with input from Mr G Mangwadu (MoHCW) and Mr J Kandwe, Harare City Health Department.

It was noted that while political interference in the implementation of the law may be happening in some areas, implementers need to be confident when they implement the law and not to succumb to any pressure or interference. Participants questioned whether the law was being applied universally and consistently in view of what appears to be selective application of the law in mining companies, schools and other areas. It was noted that some discretion can be observed and implemented in respect of particular issues such as to temporarily allow people to occupy housing units with less than the normal and standard utilities if they would otherwise not be housed.

Participants had issues relating to overlapping of the PHAct and EMA Act and cited challenges in the enforcement of the Act in the mining areas. It was noted that sometimes overlapping is unavoidable but there is need for dialogue and collaboration across various ministries and departments to address these challenges. For instance, at local level, MoHCW environmental officers could get into the Environmental Management Committees for EMA and personnel from EMA could also be incorporated in the MoHCW committees to reduce problems associated with conflicts in the implementation of the laws, while at national level, the mandates of the different departments would need to be clearly delineated.

To strengthen implementation of public health laws, participants were against the “polluter pays” principle and felt that prevention strategies should be prioritised. They called on the Standards Association of Zimbabwe to regularly update standards for commodities that affect public health such as water. Fines and penalties as well as incentives would need to be introduced and updated to enhance compliance.

Participants noted gaps in regulation in respect of specific public health areas. For instance the Act is silent on non communicable diseases and some new issues have emerged for instance the disposal of baby pampers in households. Other areas that affect public health e.g. hazardous substances, air pollution are now being dealt with by EMA. Participants implored that they needed to be actively involved in exploring modern options of disposing waste, encourage waste segregation and encourage importation of goods with waste that the country can properly dispose or recycle through pre-shipment inspections.

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

4.1 Roles, duties and functions, powers of the MoHCW

Mr A Chigumbu, a public health law consultant presented on the roles, duties and functions of the MoHCW as set out in the PHAct. He noted that the Public Health Act defines the functions of the Ministry of Health and Child welfare as;

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

At national level the Permanent Secretary is the Chief Health Officer who has a team of officers at all levels who implement and administer the Act. The Ministry has established a Port Health

Service to ensure that the country prevents and guards against the introduction of diseases from outside. Within the country various departments and units were established and various structures set up to deal with specific issues concerning the promotion of public health and the prevention, limitation or suppression of infectious and contagious diseases.

The Ministry advises Local authorities and provides some of the critical services on behalf of smaller Local Authorities like Rural District Councils. The Act also provides for the appointment and composition of the Public Health Advisory Board whose function is to advise the Minister on all matters relating to Public Health in Zimbabwe. At the District Level the Act provides for the establishment of District Health Management Committees (DHMCs) to manage and coordinate the provision of health services in Rural District areas. Unfortunately, it seems that since the amendment to bring the provision on DHMCs on board was promulgated in 2002 Rural District Council Councils are yet to set up committees.

The appointment of various officers by the Ministry and by Local Authorities to administer the provisions of the Act is also provided for in the Act. The Act cites the Chief Health Officer (Permanent Secretary), medical officers (Provincial Medical Directors and Local Authority Health Directors), as well as health inspectors (environmental health officers). The Act also provides for the duties of Local Authorities and of those appointed officers regarding Public Health, and provides for how the Minister deals with Local Authorities that default in exercising their powers, or in performing their duties, and how any costs incurred by the Ministry are to be recovered from the defaulting Local Authority.

Mr Chigumbu noted that the district level is the main implementing and enforcing level for the Public Health Act. Through the District Health Management Committee and other related committees, the District ensures the proper management and coordination of the provision of district health services. Every profession in the district health services has an important role in ensuring the effective protection of public health. Rural District Councils which are also defined as “local authorities” in the Act are also key players who, together with the District Health Services, the District administrator and police officers perform specific functions under the Act. Various district officers are empowered to enforce relevant provisions of the Act with full authority to prosecute. Others play a supportive role in enforcement, in prevention, treatment and control of infectious diseases, in ensuring food and water safety, and in ensuring good sanitation in the district. The District Medical Officer and his/her team enforces the various sections of the Act pertaining to infectious diseases, eg immunisation of children, and reporting and management of disease outbreaks and cases of infectious diseases. They have powers to close down schools, crèches, churches and other institutions where an infectious disease occurs. They also have power to order local authorities and heads of mines and other industrial concerns to provide potable water and to maintain a healthy and sanitary environment.

Environmental Health Officers are specifically appointed “health inspectors” under the Act to perform various duties like, inspection of premises, inspection of articles of food and other items of public health importance, and dealing with public health nuisances occurring in their areas of jurisdiction. In such cases they are empowered to take appropriate action (including prosecution, closure or destruction) to protect public health. Other duties of the District Level include the provision of Port Health Services at ports of entry in line with the International Health Regulations, the supervision of the burial of bodies of people who die from diseases declared to be “formidable epidemic diseases”, medical examination and certification of food handlers and enforcing the regulations on breast milk substitutes (infant formulas). Generally the district level is charged with the responsibility of preventing, limiting or suppressing the occurrence of infectious diseases in its area of jurisdiction.

While the public health officials in the private sector play an important role in their organisation, they do not have a direct enforcement role. This is left to state and Local Authority officers. Their role can, among others, be summarised as follows:-

1. They provide direct advice to their principals/management on

    a. public health issues and on maintaining a healthy workforce and community, and on
    b. The public health obligations of their organisation
2. Invite State and Local Authority officials to the company's establishment regularly for on the spot advice and to ensure that their company public health programme is in keeping with national laws.
3. Alert the company on public health violations/ occurring in their area of jurisdiction and help to rectify identified problems
4. Educate the company staff and community on disease prevention, sanitation, hygiene and public health in general.
5. Be an active member of the public health team involved in the promotion of public health in the local authority area, district, province and nationally,. and represent his/her company on such teams.

In the discussions after the presentations, participants raised concern on the high number of districts that have not established the DHMC. Participants said there was need to ensure that the DHMC are effective and are resuscitated in areas where they are weak or non-existent. Concern was also raised on the chairing of the DHMC by District Medical Officers. To effectively ensure implementation of the law, participants said that EHTs should be empowered to prosecute those who violate provisions of the law. While most participants observed the importance of this, given that EHTs interact with the community more frequently, they noted that empowering them to prosecute should start with upgrading of their skills and there should be a system to continuously and periodically monitor their competencies. Lack of adequate material resources was also cited as a barrier to effective monitoring.

Concern was also raised on some unethical practices by private sector, for instance concealment of information relating to their activities that impact public health. Participants agreed that there is need to put in place a comprehensive package for food handlers covering not only their medical examinations but extend to cover increasing their knowledge and awareness on public health and their role in promoting public health within their food industry.

4.2 Roles, duties and functions of local government

Mr John Kandwe, Harare City Health Department, outlined the duties, functions and powers of the local government in public health. Firstly, Mr Kandwe gave a background to the PHAct, defined public health and gave a brief of the public health system. The Ministry of Local Government is responsible for both urban and rural local authorities. The Public Health Act provides for the decentralization and implementation of activities at the level where problems need to be acted upon eg provincial, district and ward level.

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.

Presenting on how these delegated functions are operationalized, Mr Kandwe noted that 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

During the discussion after the presentation, participants noted the need for medical doctors to embrace non medical staff in public health managerial roles and appointments. Some deficiencies with the current law were noted. The law refers to the appointment of Environmental Health Officers and not other environmental health practitioners and some degrees and qualifications are not registerable with the Environmental Health Practitioners Council.

A discussion was raised on religious sects that object to some of the public health interventions e.g immunization. It was suggested that local authorities should devise mechanisms to engagethese sects for instance through their leaders. Other Acts, for instance, the Childrens Act (Ch 5:06) could also be used in conjunction with the Public Health Act to protect the affected children. It was also raised that implementers need to be able to prepare the documents needed for court cases.

Participants noted the need for local authorities to prioritise the provision of safe potable water and sanitation and waste management to avert public health disasters like cholera and typhoid.

4.3 Rights, duties and roles and functions of other sectors of government

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 (Ministry of Local Government, Ministry of Water, Ministry of Environment, Ministry of Agriculture - Department of Veterinary Services) as well as non-state actors (Faith Based Organizations and Communities)

Section 110 of the PHA establishes legal primacy of the Act over public health matters by providing that its provisions shall supersede other laws that are inconsistent or in conflict with it. It states thus: '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 also establishes a direct relationship between MoHCW and the Ministry of Local Government based on the principle of decentralisation where local level structures (i.e. provincial, district, ward, and village) that exist within the MLG 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 Health and Child Welfare to the Ministry of Local Government for purposes of implementing and enforcing its provisions. In undertaking

this mandate the Act bestows powers and responsibilities to the MLG. For example section 4A of the Act provides that every local authority shall, when required by the Minister of Health and Child Welfare, after consultation with the Minister of Local Government, establish a District Health Management Committee to manage and co-ordinate the provision of health services within a rural district council area. The Act also bestows powers and responsibilities to the Ministry of Local Government, for instance; Section 14 states thus: “Every local authority shall take all lawful and necessary precautions for the prevention of the occurrence, or for dealing with the outbreak or prevalence, of any infectious or communicable or contagious diseases, and shall exercise the powers and perform the duties conferred or imposed on it by this Act or by any other enactment:

The Act establishes a relationship between MoHCW and other sectors. For instance, the Act establishes a relationship between the MoHCW and the Water Sector with regards to water works and water quality standards. The Minister of Health and Child Welfare has powers to approve (or not) water works schemes on grounds of public health; inspect water supplies; and take such sample of water as deemed fit. Mr Chishakwe also described how the Act establishes a relationship with the Department of Veterinary Services and the Environment sector. The Act empowers local authorities (municipal council or town council) to inspect any meat slaughtered at a licensed slaughter-house for meat that is intended for sale.

Mr Chishakwe noted that while the concept of primacy and decentralization is a noble one, there appear to be challenges in the implementation of this model. Some of these challenges include lack of institutional capacity to address responsibilities that come with decentralization, such as capacity of local government structures to equitably implement their various roles including public health roles (given the various tasks they have), and budgetary allocations for the decentralized activities etc.

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.

In the discussion, Mr Chishakwe made further clarification on the doctrine of primacy, the role of police in enforcement and highlighted that the review of the Act took cognisance of the possible inclusion of the right to health in the new constitution. Thus, the review of the PHAct took a rights based approach. The review of the act also attempted to make clearer the definition of public health. Participants questioned the effectiveness of the current Act given that some areas in urban areas are going for days without access to water. Participants appreciated the dynamics around implementation issues noting that sometimes enforcement issues can be political.

4.4 Rights, duties and roles of the private sector and of communities

Mr A Chigumbu, public health law expert, noted that members of the public have a right to live in healthy, disease-free environments, and therefore, the Public Health Act was promulgated to make provision for the public health. It is the duty of the Ministry of Health and Child Welfare, the respective local authorities and the authorities in the private sector and other sectors to ensure that they protect public health through the implementation and enforcement of the Act. Some of the rights of the public include living and working in a sanitary environment where land is not polluted by sewage and the atmosphere is clean and not polluted by smoke, dust, fumes, noise from industrial and other processes. They also

have a right to protection against infectious diseases through the elimination of breeding places for disease vectors, through access to wholesome and safe food and water and by ensuring that persons who suffer from infectious diseases do not pose a risk to the public. Therefore the provisions in the Act to do with prohibition of conveyance of persons suffering from infectious diseases in public transport, the removal of such people to isolation hospitals, the prevention and removal of nuisances, the enforcement of International health regulations, all ensure that the public enjoy good public health.

Section 30 protects members of the public from exposure to infected persons or things. The Act also provides for the protection of the public against claims (through advertisements) of cures for sexually transmitted diseases. Members of the public also have the right to professional education regarding infectious disease prevention. The right to privacy is also provided for in the Act. For example, where any order is made requiring the medical examination of any female over the age of twelve years and such female desires to be examined by a woman medical practitioner, such examination shall be made by a woman medical practitioner if one is reasonably available.

It is the duty of members of the public to present themselves for treatment once they suspect they might be suffering from an infectious disease or once the disease has been confirmed and the doctor has prescribed the appropriate medical treatment.

The Act also sets out roles and responsibilities of private sector. The private sector and local communities are key players in ensuring public health in Zimbabwe. Various community groups and civic organisations also participate in public health matters through the Advisory Board of Public Health and through various committees that the Act provides for. Community Health Clubs which have been piloted in some districts over the years and are known to produce a high level of hygiene and health behaviour change, are now becoming a country-wide phenomenon. The private sector and communities also help to finance the health sector through donations, through user fees, and in kind.

Specifically, Sections 4 and 4A of the Act establish two important bodies, the Advisory Board of Public Health and the District Health Management Committees. Section 15 and Section 44 provide for the appointment of health committees and epidemic committees respectively. All these bodies afford corporate organisations and community members a say in public health issues.

Mr Chigumbu outlined the composition and function of the PHAB, the District Health Management Committees, Health Committees and Epidemic committees.

In the discussion, participants raised concern on the increase in the cases of public adverts mainly in print media) with claims of cures of many diseases including STIs. These claims come from traditional practitioners as well as faith based healers and said the media should play a role in promoting public health by not promoting these adverts. Private sector and state actors have a collective responsibility in promoting public health. Private sector should play a role as they are the producers of the goods that threaten the health of the public.

4.5 Overview of Regulations and by laws under the Public Health Act

Mr A Chigumbu highlighted that a number of Regulations have been made by Ministers of Health and Child Welfare over the years under the Public Health Act. These are to do with infectious diseases, the sale of articles of food, infant nutrition, and sanitation and housing. He noted some of the regulations that have been promulgated and in brief, outlined the areas and issues they cover. Participants were provided with soft copies of some of the regulations prior to the training workshop. The regulations discussed are;

- Public Health (Carrier of Infectious diseases regulations) SI507 of 1943;
- Public Health (Declaration of formidable epidemic diseases) SI1051 of 1976;
- Public Health (Declaration of Infectious diseases: Infectious Hepatitis) SI958 of 1973;
- Public Health (Declaration of Infectious diseases: Malaria) SI 6 of 1959;
- Public Health (Declaration of Infectious diseases: Marburg and Lassa Fever) SI 1051 of 1976
- Public Health (Declaration of Infectious diseases: Smallpox) SI461 of 1948;
- Public Health (Abattoir, Animal and Bird Slaughter and Meat Hygiene) Regulations SI 50 of 1995
- Public Health Advisory Board regulations 1966;
- Public Health (Bilharzia) Control and Prevention Regulations SI 587 of 1971;
- Public Health (Breast Milk Substitutes and Infant Nutrition) Regulations) SI 163 of 1998;
- Public Health (Condemnation of Foodstuffs SI 235 of 1948
- Public Health (Contamination of Food SI 474 of 1973
- Public Health (Control of Cholera) Restriction of Public Gatherings Regulations SI371 1974;
- Public Health (Effluent) Regulations SI 638 of 1972
- Public Health (Medical Examination) (Food Handlers) Order SI 41 of 1994
- Public Health (Port Health) Regulations SI 200 of 1995;
- Public Health (Control of Tobacco) Regulations SI 264 of 1997 (rev 2002).
- The following are some of those that enforcement officers should be regularly enforcing.
- Public Health (Abattoir, Animal and Bird Slaughter and Meat Hygiene) Regulations SI 50 of 1995. These regulations control the slaughter of animals and birds for meat for public consumption. Under these regulations, slaughter facilities must be registered by the local authorities and all meat must be inspected by a meat inspector.
- Public Health (Breast Milk substitutes and infant nutrition regulations) SI 163 of 1998; these regulations control the sale and advertising of breast milk substitutes or infant formulas.
- Public Health (Condemnation of Foodstuffs) SI 235 of 1948. These are important old regulations which enforcers should use in dealing with foods that contravene the Act and food regulations. The regulations simplify the condemnation procedure. While in the Food and Food standards regulations food inspectors have to take 3 official samples of the suspected food for laboratory analysis to confirm their findings, these regulations allow the inspector to condemn the food using the results of his physical inspection.
- Public Health (Contamination of Food) SI 474 of 1973. The regulations lay down measures to be taken to prevent contamination of food intended for sale by pet food and rough offals.
- Public Health (Control of Cholera) Restriction of Public Gatherings Regulations) SI371 1974;
- Public Health (Effluent) Regulations) SI 638 of 1972
- Public Health (Medical Examination) (Food Handlers) Order SI 41 of 1994
- Public Health (Port Health) Regulations SI 200 of 1995;
- Public Health (Control of Tobacco) Regulations SI 264 of 1997 (rev 2002).

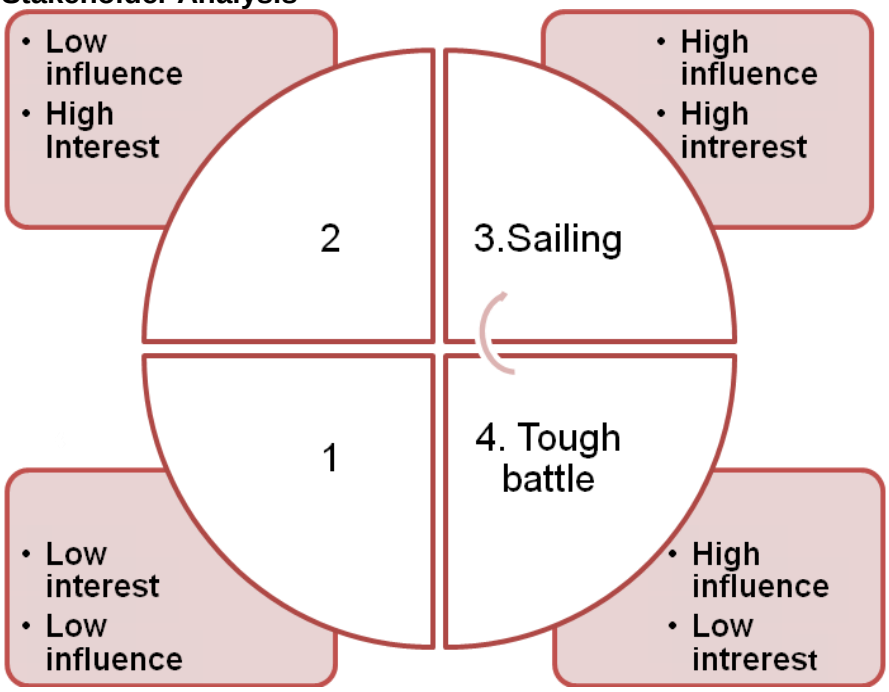
Public Health By-laws are specific to local authorities (mainly municipalities and Town Councils). Each local authority makes its own by-laws according to the public health problems in its area, and following the parameters set by the parent Act, the Public Health Act. In effect the by-laws bring together provisions in different government Acts and Regulations that have implications on public health. For example, in addition to public health regulations, the by-laws may cover areas regulated by the EMA, Food and Food Standards Act or Model Building By-laws.

In the discussion, participants said that these regulations should be readily accessible as some of them are not known by the implementers of the Act. Mr Chigumbu noted that it was easier to prosecute using Public Health regulations as opposed to regulations under the Food and Food Standards Act no samples are required unlike using the PHAct. Participants noted the need for a holistic approach in addressing problems relating to Port health, particularly given the porous nature of the Zimbabwean borders. An education and training programme for food handlers in non-commercial entities eg office orderlies in workplaces was noted to be important.

5. Participatory exercise on Implementation of the Act

Dr Loewenson facilitated a participatory exercise on the Implementation of the Act. The exercise was aimed at exploring the roles and coordination of stakeholders in rural or urban district settings. The exercise used Venn diagrams to depict the current situation relating to implementation of the law in rural and urban districts. Participants were divided into two groups, one representing a rural setting and the other an urban setting. She explained the Venn diagram tool, noting that participants needed first to identify stakeholders in the implementation of the Act and whether they had a positive or negative interest in the implementation of the Act. The teams would then assess the magnitude of the influence/impact of these stakeholders. The size (as measured by the diameter) of the circles used in the exercise represented the size of the influence/impact of the stakeholder while the distance of the stakeholder from the intended outcome (implementation of the PHAct) represented the current level of involvement of the stakeholder in the implementation of the Act. She noted implementation of the Act relies on the degree of cooperation of stakeholders. Through this stakeholder analysis, participants will be able to identify stakeholders with a greater influence within their districts and can strategically identify ways of bringing these on board, say through identification of other stakeholders who influence them or spending more time and resources in getting their buy in. Thus, implementation of the Act goes beyond the law and involves culturing strategic alliances.

Figure 4: Stakeholder Analysis



Stakeholders with high interest and high influence (quadrant 3) are desirable. Implementers of the Act need to strategically move stakeholders in quadrant 4 to 3 to ensure effective implementation.

Participants using Venn diagrams to do their stakeholder analysis, Harare © TARSC 2012

Venn maps for the rural setting © TARSC 2012

Venn maps for: the Urban setting © TARSC 2012

After the group work, Dr Rene facilitated a discussion on the results of the exercise. Participants concurred that the exercise was interesting and provoked them to think critically on stakeholders within their districts that would be useful in the implementation of the Act. Similarities and differences in the spread (distances of the stakeholders from the centre) and sizes of stakeholders between rural and urban settings were observed. In rural areas, stakeholders were closer to each other around the centre while those in urban areas were spread out. Dr Rene noted that participants should be able to interrogate such patterns and come up with strategies to ensure stakeholders are as close to the intended outcome as possible. Participants raised issues relating to the polarisation in urban areas as one of the reasons for the spreading out of stakeholders.

Some stakeholders were found to be common in both rural and urban areas. For instance EMA is found in both settings, increasing its influence. However, it was put by delegates in the Venn diagram distant from the intended outcome as well as from the MoHCW, depicting that coordination between EMA and MoHCW is still not very strong and needs to be strengthened.

During the discussions participants raised the importance of mechanisms for coordination at national, district and ward level, such as District Health Management Committees, Health Centre Committees, Ward Committees and other committees. Health Centre committees still need to be included in the Act.

Mechanisms to deal with gaps, overlapping of roles and linked responsibilities are important and should be implemented at all levels through multisectoral collaboration. The MoHCW and district level structures need to take the first step on this. Social Services cluster committees in Rural District Councils are welcome but the MoHCW still need to lead the process. Participants also proposed that coordination at national level be improved.

The MoHCW was found to be central in urban settings while in rural areas, the RDC administrative unit was central. Participants highlighted that councillors could have a big impact on the implementation of the Act. The community and business sector in both rural and urban areas has high potential impact but are often not involved in the implementation of the Act. The business sector has resources that can be tapped in the implementation of the Act. The current situation ideally leaves the government to implement the Act. Thus, strategies that could bring business (eg RDCs in rural areas, Local authorities in urban areas) are required, such as through mutually beneficial business models and using existing sympathetic businesses. In rural areas, traditional leaders, councillors, NGO's and so on are important in bringing the community on board. In urban areas, people are organised around civic society organisations and questions were raised whether the CSOs are representing the real people affected by these public health issues. Implementers should make a direct link with the public on the ground in urban areas. Media influence was noted to be significant in urban areas more than rural areas

Treasury was also noted to be having greater influence in the implementation of the Act, but it is currently at a distant. The review of the act has proposals for raising revenue towards the implementation of the Act as currently being done with EMA.

6. Water, sanitation, housing and infectious disease control

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

Mr D. Rodrick A/Deputy Director Dept of 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 define 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.

During the discussion after the presentation participants reiterated the need for an awareness programme on water standards and ensure that they are universally used. The standards should be harmonised (WHO, SAZ and so on). An awareness programme on regulations relating to water, sanitation and housing should be prioritised by local authorities. The public should be made aware of the legal provisions on nuisances should be empowered for them to interrogate local authorities when the regulations are not adhered to, for instance when being given stands near graveyards.

6.2 Provisions, regulations and their implementation in relation to infections diseases control

Mr A Chigumbu highlighted that the Act gives specific diseases classified as “Notifiable Infectious Diseases” and these include cholera, typhoid, TB, polio, rabies, leprosy, anthrax, chicken-pox and plague. It makes it a requirement that if any person suffers from any of the diseases, the Local Authority has to be informed (notified). It is the duty of every person who becomes aware of the occurrence of the disease to notify. This includes heads of schools, orphanages and other institutions, hotel managers, medical practitioners, and so on. Local Authorities in turn are to report the cases of notifiable infectious diseases occurring in their areas of jurisdiction, to the Permanent Secretary. The Act also provides for measures to be adopted by Local Authorities to prevent the spread of infectious diseases from an infected person to other people. It also provides for the manner in which the Local Authority is to deal with infected premises, and for the provision of isolation hospitals, mortuaries, disinfection stations and ambulances. The Act allows Local Authorities to issue removal orders. Exposure of infected persons or things to members of the public is not permitted in the Act. This includes conveyance of infected people in public transport. Removal and burial of bodies of persons who have died of infectious disease is also regulated by the Act.

On Formidable Epidemic Diseases (FEDs), Mr Chigumbu noted that the Act mandates the Minister when necessary to declare a disease to be a formidable epidemic disease. Currently Plague, Cholera and Epidemic Influenza are classified as formidable epidemic diseases. Measures for controlling epidemics of FEDs can include the enforcement of quarantine and the closure of schools, churches, and other places of public gathering. All local authorities are required to report FEDs urgently to the Permanent Secretary who in turn is to report to WHO immediately. The Act also has a section specifically providing for sexually transmitted infections (STIs). The provisions include duties of medical practitioners to educate patients and give them pamphlets on prevention, on avoiding getting married before cure, and on importance of treatment. The Act also provides for the rights of people suffering from STIs.

Mr Chigumbu highlighted the role of the International Sanitary Regulations in public health. The first International Sanitary Regulations were made in 1951 for the control of plague, cholera, yellow fever, smallpox, Typhus Fever and Relapsing Fever. These were renamed International Health Regulations (IHR) in 1969. The current IHR were adopted by the World

Health Assembly of WHO in 2005 following outbreaks of Ebola (1995) and SARS. They are legally binding regulations (forming international law) that aim to assist countries to work together to save lives and livelihood endangered by the spread of diseases and other health risks and to avoid unnecessary interference with international trade and travel. They form the basis of Zimbabwe's Port Health Regulations promulgated in 1995.

Mr Chigumbu noted some of the key regulations relating to infections disease control including the Public Health (Carrier of Infectious diseases) regulations SI507 of 1943;Public Health (Declaration of formidable epidemic diseases) SI1051 of 1976;Public Health (Declaration of Infectious diseases: Infectious Hepatitis) SI958 of 1973;Public Health (Declaration of Infectious diseases: Malaria) SI 6 of 1959; Public Health (Declaration of Infectious diseases: Marburg and Lassa Fever) SI 1051 of 1976;Public Health (Declaration of Infectious diseases: Smallpox) SI461 of 1948; Public Health (Bilharzia) Control and Prevention Regulations SI 587 of 1971; Public Health (Control of Cholera) Restriction of Public Gatherings Regulations SI371 1974.

The regulations on infectious diseases are enforced by the various public health officers discussed in sections above.

In the discussion, participants highlighted the need to incorporate the provisions of the International Health Regulations(2005) in the domestic public health laws to enhance enforcement.

7. Food safety, nutrition, smoking control

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

Mr Victor Nyamandi Deputy Director Food Safety and Port Health in the MoHCW 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 (Chapter 15:09) 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 Entry 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 (transport) 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.

In the discussions, participants raised concern in respect of increased Genetically Modified Foods from South Africa and that business need to conduct itself in an ethical manner when it imports food, including the need for proper labelling of such food items. The MOHCW should ensure that there are standards relating to the labelling of food items. All institutions dealing with food items need to be properly registered and monitored, although participants cited instances of corruption as barriers to effective monitoring of these entities. MoHCW needs to effectively implement pre-shipment inspections particularly for food items rather than relying on physical inspections at ports. Big local manufacturing companies have raised concern that local authorities (MoHCW, etc) were less visible to monitor them than international compliance regulators. Understandably, the MoHCW staff might be overstretched but participants suggested that local structures could be used for such monitoring. MoHCW emphasised the need for EHPs working in these companies to preserve the integrity of their professions by raising alarm to the MoHCW on any pertinent public health issues within their companies. The MoHCW could also increase the price for carrying out these inspections to generate revenue to sustain such activities.

7.2 Provisions, regulations and their implementation in relation to smoking control

Artwell Kadungure, TARSC, gave some statistics and trends in tobacco smoking in Zimbabwe using recent survey data. He noted that one in ten adults die globally due to smoking. There is no safe level of smoking and the risk rises with duration and frequency. Adolescents and females are more susceptible to smoking. Second-hand smoke harms all who are exposed.

In a survey done by Bandasson and Rusakaniko in 2010 covering 6 secondary schools in Harare and a sample of 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

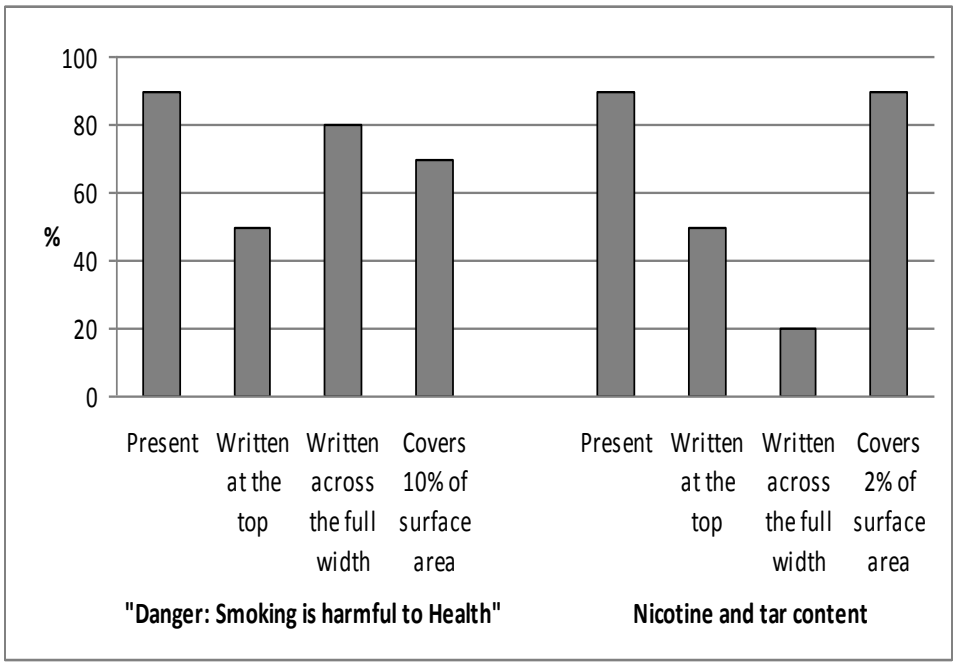
measures to reduce availability, acceptability and use and assist people give up tobacco use. The interventions included are price and tax measures, health warnings on packs; banning advertising, banning sales to minors, banning smoking in public places; containing illicit trade, service interventions: 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.

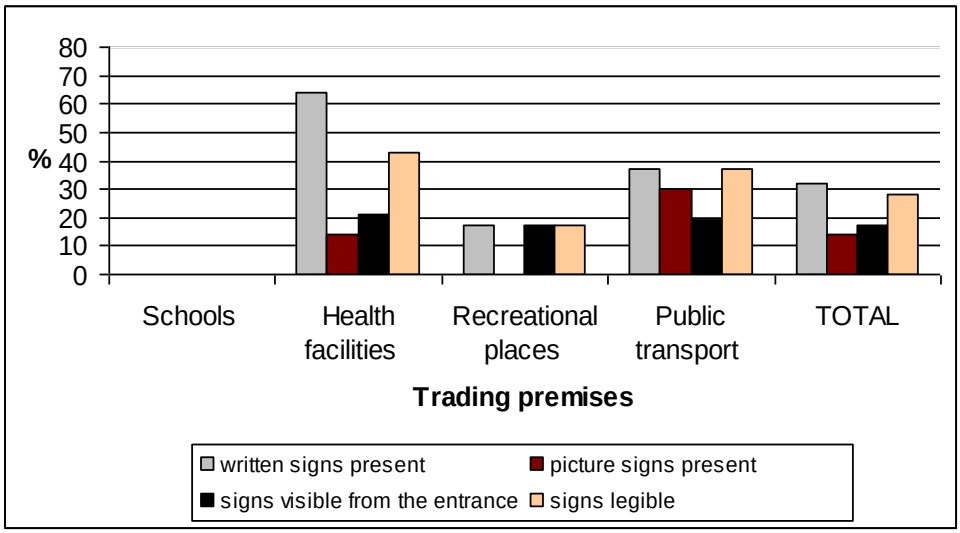
Artwell introduced the Public Health (Control of Tobacco) Regulations 2002, SI 264 2002 [CAP. 15:09], that controls smoking in public premises, on public transport, requires no smoking signs is public places, prohibits trading of tobacco to or by children and sets messages of certain size and wording 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 chemicals such 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 ravings 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 in the regulations specifies the size, percentage of 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 with tobacco control regulations





The two graphs and photo (below) show that there is poor compliance in terms of the tobacco regulations. Compliance is low in public places, especially in schools and retail services.

Figure 4: A non compliant billboard advertising cigarettes, Zimbabwe

Source: TARSC 2010

The assessment found that some areas of the law were being implemented, for instance; 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.
Artwell 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 to 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.

In the discussion, participants raised concern on the use of cigarettes as change in some of the shops in Zimbabwe, noting that this promotes smoking. The ages of people classified as minors need to be harmonised. In the PHAct, a minor is a person below the age of 16 years whilst the smoking regulations stipulate that a minor is a person below the age of 18 years. Participants raised interesting observations relating to the increase in tobacco manufacturing companies sponsoring research on the effects of smoking, noting that the results of these researches will need to be treated with caution given the likely conflict of interest between the interests of the companies and what the research findings will be communicating and the companies can easily influence the findings.

8. Implementation of the Act, Review of the Act and conclusions

8.1 Compliance, penalties, incentives and enforcement of the Act Compliance

Mr A Chigumbu highlighted that all sections of the community- government, local authorities, private companies, and individuals are expected to comply with the Act. Various penalties are stipulated for contravening sections of the Act. The fines are stated as levels 4-7 and range from US$50 to US$300 as provided in the Criminal Law (Codification and Reform) Act Chapter 9:23.

Mr Chigumbu gave examples of penalties provided in the Act for failing to comply with regulations relating to Infectious diseases control, Sexually Transmitted Infections, International Sanitary Regulations, water and food supplies, sanitation and housing Sections 45 and 46 stipulate the incentives that the Act affords local authorities that provide health facilities in their areas of jurisdiction. The Minister may authorize the making of advances, on such terms and conditions as he may fix, to any local authority or epidemic committee for the purpose of dealing with any out-break of any infectious disease, and in default of repayment any such.

Environmental Health practitioners are responsible for inspection of premises to check for public health violations. Inspections include plan examination and physical inspections. Prosecution, which is used as a last resort when education and persuasion has failed is applied to entities that violate the provisions of the Act. He gave examples of some of the offences that may call for prosecution. Persons who contravene the provisions of the Act are dealt with accordingly and may face prosecution. He gave a brief on how prosecutions are

done including; establishing that there is a contravention, filing a detailed recording of events and findings with dates, depending on the situation you may decide to write a notice to the owner manager informing him/her of the contravention and giving him a grace period to stop the contravention, ensuring that management of the premises or organisation is involved in the process, and is informed of decision to prosecute, ensuring that the requirements of the law have been fulfilled – samples, witnesses, proof of your authorisation under the Act or proof that an authorised officer has certified the contravention, writing a statement (requesting for prosecution) to the local police officer-in-charge, citing the Act being contravened, the contravention in question and the steps taken in establishing that there is a contravention , and preparing to testify as a state witness when called upon by the Public Prosecutor.

Enforcement of public health legislation has been progressively low over the years and a number of reasons can be cited. These include downplaying of the enforcement role vis-a-vis the public health educator role; inadequate hands on training on enforcement; fear of the unknown; non availability of public health legislation for reference and for training; attitude of prosecution and judicial officers towards public health cases brought to the courts and inadequate public health enforcement officers on the ground.

On some of the key provisions in the current Act, he noted that the State or Local Authorities cannot be sued for injuries to any person or damages to any property or for any rights detrimentally affected if its officers used the best known or the only or most practicable and available methods in the exercise of their power or performance of their duties. Officers performing their duty cannot be personally liable to prosecution for any report or action taken as long as they acted in good faith and without negligence. Persons generally or specially authorised by the Minister or by the Local Authority are free to enter any premises at any hour reasonable for the proper performance of their duties. It should however be noted that Local Authority staff are not permitted into military establishments. The Act does not confer powers or impose duties on Local Authorities in respect of any land or premises owned or occupied by the State for military purposes.

In the discussion, participants highlighted the need for increased knowledge on prosecution procedures in implementers. Mr A Chigumbu availed himself to assist any participants who had challenges. Some gaps were in other Acts, for instance dealing with foreign objects found in beer containers (eg condoms in scuds) is problematic if the Liquor Act does not make specific provisions relating to this area.

8.2 Review of the Act

Dr Rene Loewenson 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 expertise 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. The Principles were reviewed internally by MoHCW and are now being taken to cabinet, legislature.

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 given to the participants on the CD Rom. 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.

8.3 Evaluation

At the end of the training course, Artwell Kadungure obtained feedback from the participants through completion of a formal evaluation form and orally in plenary. A total of 22 participants completed the formal evaluation. The evaluation showed that all (100%) the participants felt that the training was relevant to their work or roles and was useful. Participants rated the quality of trainers and materials highly with all participants rating both as good. Participants understood most of the issues discussed during the training course and a very high share (86%) rated the resource materials as clear and useful. Participants felt that more time would be desirable for discussions and more group work should be included to encourage interaction. The PHAct and its regulations should be provided prior to the training day. It was commended that the meeting was well conducted and organized. The standards should be maintained. The full results of this formal evaluation are shown in Appendix 3.

During the oral evaluation, participants reiterated issues relating to allocation of more time for the course, provision of accommodation for participants and have a practical orientation to the course, perhaps a field visit during one of the days would help. The course should make references to provisions in other regional Acts regarded as best practice. More facilitators from local government should be invited, particularly in water and sanitation departments. Regulations should be made available on internet and be distributed widely and an Environmental Health Forum on Facebook for instance would help collaboration

across different practitioners. EHTs and EHOs needed identification cards. In future courses, people should be drawn from even more diverse sectors. Presenters should coordinate to reduce repetition of some areas.

Most of the expectations of the participants were met during the three days of training. Participants cited gaps they had in public health skills which included writing skills for reports and documentation, health financing, food safety and how to include community level cadres in implementation of the Act.

8.4 Closing

In her closing remarks, Dr Loewenson thanked the MoHCW for partnering and cooperating with TARSC to implement the training course. She thanked Mr Kadungure for the co-ordination and arrangements for the meeting, Mr Mangwadu for his inputs, TARSC secretariat for the administrative support and all the resource persons. She noted that being the first course of its kind, the participants' comments had been noted in an endeavour to improve future courses.

Mr Mangwadu, on behalf of the MoHCW and the Permanent Secretary thanked all the delegates for attending the training course. He hoped that the skills from the training would reflect in what the participants would do after the training in relation to the implementation of the Act. He advised the participants to share the knowledge from the training course with others.

During the last day of the training, participants had a pub quiz on areas covered during the training. Dr Rene and Mr Mangwadu presented prizes to the winning group and thereafter, Mr Mangwadu was assisted by Mr A Chigumbu in handing over certificates of completion to the participants.


Left: Reaping the fruits of hard work, a participant receives a certificate from Mr A Chigumbu. Right: A group member receives a prize for winning the pub quiz from Mr A Mangwadu, Harare, © TARSC 2012

APPENDIX 1: Programme

COURSE BLOCK	COURSE TITLE	FACILITATOR
Time	**Session number, Content**	
Monday 15 October 2012		
0815-0845 hrs	Registration and administration	Artwell Kadungure (TARSC)
Overview of the Public Health Act		
0845-0930 hrs	1. Welcome, Delegate Introductions Objectives of the training course Delegate Expectations	Mr G Mangwadu, Director Env Health MoHCW Dr R Loewenson Director TARSC, Chair Advisory Board of Public Health (PHAB)
0930-1000hrs	2. Public Health in Zimbabwe	Dr R Loewenson
1000-1030hrs	3. Background on the Public Health Act	Mr G Mangwadu
1030-1045hrs	Discussion on the two presentations	
1045-1115 hrs	**Tea Break**	
1115-1215hrs	4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law: 1. public health challenges faced 2. areas where public health law is important 3.barriers faced in implementation of the law	Mr A Kadungure TARSC, Mr A Chigumbu, Consultant public health law
1215-1300hrs	Discussion of the issues raised in the 'market place'	
1200-1300 hrs	**Lunch**	
Functions, rights, duties and powers in the Public Health Act		
1415-1530hrs	5. Roles, duties and functions, powers of the Ministry of Health and Child Welfare set in the Public Health Act from national to local level and MoHCW personnel who implement the Act Discussion	Mr A Chigumbu
1530-1545hrs	**Tea**	
1545hrs-1645hrs	6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act Discussion	Mr J Kandwe EHT Officer, Harare City Health Department
Time	**Session number, Content**	
Tuesday 16 October 2012		
0830-1000hrs	7. Rights, duties and roles and functions of other sectors of government in public health. How does the Public Health Act relate to other laws governing public health? What personnel in other sectors play a role in public health? Discussion	Mr N Chishakwe, Director, Centre of Applied Legal Research
1000-1100hrs	8. Rights, duties and roles of the private sector and of communities in the Public Health Act Discussion	Mr A Chigumbu, Consultant public health law
1100-1130hrs	**Tea Break**	
1130-1230hrs	9. Participatory exercise – Venn diagrams - on implementers of the Public Health Act and their roles in Urban and rural areas: 1. People and resources 2. Gaps faced 3.Co-ordination in implementation of the law	Dr R Loewenson TARSC
1230-1300hrs	Discussion of the issues raised in the 'market place'	
1300-1400hrs	**Lunch**	
Regulations to and Specific areas of the Public Health Act		
1400-1500hrs	10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover? Discussion	Mr A Chigumbu, Consultant public health law
1500-1615hrs	11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	Mr D Rodrick, Deputy Director Department of Environmental Health, MoHCW

COURSE BLOCK	COURSE TITLE	FACILITATOR
	Discussion	
1615-1630hrs	**Tea break**	
1630-1700hrs	12. Provisions, regulations and their implementation in relation to infections diseases control Discussion	Mr A Chigumbu, Consultant public health law
Wednesday 17 October 2012		
0830-0930hrs	13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health Discussion	Mr V Nyamandi, Acting Director Food Safety and Port Health
0930-1030hrs	14. Provisions, regulations and their implementation in relation to smoking control Discussion	Mr Artwell Kadungure TARSC
1030-1045hrs	**Tea break**	
1045-1130hrs	15. Participatory 'pub quiz' on materials covered in the course. *Delegates organised in groups as teams and answer a set of 15 questions. The winning team wins a prize. The resource persons work through the answers after*	Mr A Chigumbu, Consultant public health law; Mr A Kadungure TARSC
1130-1300hrs	16. Compliance, penalties, incentives and enforcement of the Act Discussion	Mr A Chigumbu, Public Health Law Expert
1300-1400hrs	**Lunch**	
Review of the Act and Concluding Sessions		
1415-1500hrs	17. Evaluation, Discussion	Artwell Kadungure, TARSC
1500-1515hrs	Tea break	
1515-1630hrs	18. Proposals on and issues in the Review of the Public Health Act Discussion	Dr R Loewenson Director TARSC, Chair Advisory Board of Public Health (PHAB)
1630-1700	19. Course certificates and closing remarks	DR R Loewenson TARSC, PHAB Mr A Mangwadu, MoHCW
1700hrs	Closing	

APPENDIX 2: Delegate list

Item	Full Name of Applicant , Organisation, Position and Full Contact Details	Gender	District
1	Punha Fusire , Environmental Health Officer Ministry Of Health And Child Welfare PMD Manicaland, 24 C' Avenue ,Mutare vashonga1984@Yahoo.Com , 0774 032 382/ 0733 855 096/ 020-63101/ 60624/ 60655	Female	Mutare
2	Emmanuel Mufambanhando, Provincial Environmental Health Officer Ministry Of Health And Child Welfare PMD Manicaland, 24 C' Avenue, Mutare mufamba@yahoo.com. 020-63101/ 60624/ 60655	Male	Mutare
3	Desire Pasipanodya Systems Auditor (Qms,Fsms,Haccp, Gmps) Standards Association Of Zimbabwe17 Coventry road, Workington, P.O.Box 2259, Harare dpasipanodya@saz.org.zw 0773 928 457/ 04- 783430/7	Male	Harare
4	Taremba Chirigo Lecturer/ EHO Higher & Tertiary Education/ Masvingo Polytechnic Box 800, Masvingo, Taremba.chirigo@gmail.com 0772316872	Male	Masvingo
5	Janet Tapiwa Jonga District Environmental Health Officer Ministry Of Health And Child Welfare St Alberts Mission Hospital, P/Bag 9047, Centenary tapiwajanetjonga@yahoo.com 0779983325	Female	Centenary
6	Simbarashe Crispen Kanyimo ,Project Officer Norwegian Refugee Council22 Ferreira Street , Chipinge simbarashe@zimbabwe.nrc.no, simbarashe.kanyimo337@gmail.com 0772851126	Male	Chipinge
7	Zanele Guvakuva SHEQ Systems Coordinator ZimPhos guavakuvaz@chemplex.co.zw 04 487803/6, 0773833969	Female	Harare
8	Noel Tawanda Siwela Behaviour Change Support Officer Family Aids Caring Trust, Mutare (FACT) 208 Phillips Avenue Low Density Chipinge/12 R.G Mugabe Way Mutare Box 790 Mutare noelsiwela@gmail.com , 0227 2821/020 61648	Male	Chipinge
9	Joliph Pedzisi District Environmental Health Officer Ministry of Health102 Kilwinning road Hatfield, Harare joepedzi@gmail.com 0772385673	Male	Bindura
10	Anesu Marume Ministry of Health and Child Welfare10 Odzi Street Dombotombo Marondera anemarume@gmail.com 0734 430 070	Male	Rushinga
11	Brenda Jura Environmental Health Officer Ministry of Health and Child Welfare Chimhanda District Hospital, Rushinga District, Brenda.jura@yahoo.com 0773068896	Female	Rushinga District
12	Caroline Rudzani Siphuma EHO Ministry Of Health & Child Welfare Box 3597 Bulawayo Siphumac@Gmail.com , 0773 585 642	Female	Mat South
13	Danai Nyoni Safety, Estates, Effluent, Sanitation And Rehabilitation Officer Zimbabwe Phosphate Industries Limited Box Ay 120 Amby, Msasa, Nyonid@Chemplex.Co.Zw (04) 487803/6 0772957111	Male	Harare
14	Stephen Marima Environmental Health Technician TARSC 3202 Unit D Seke Chitungwiza stephen.marima@gmail.com , 0772363824	Male	Harare
15	Yeukai Millicent Mupfurutsa Radiation Scientist Radiation Protection Authority of Zimbabwe Box A 1710 Avondale Harare, ym.mupfurutsa@gmail.com/ ymupfurutsa@rpaz.co.zw, 0774351907/ 0715009332	Female	Harare
16	Tafadzwa Carlington Chigariro Knowledge Manager Cancer Association of Zimbabwe 60 Livingstone Avenue, Cnr 6th Street, Harare, Zimbabwe education@cancer.co.zw +263-4-707444 / 705522 / +263 773255541	Male	Harare

Item	Full Name of Applicant , Organisation, Position and Full Contact Details	Gender	District
17	Faustino Zvenyika Environmental Health Officer Tongaat Hulett - Triangle Limited Environmental Health Department Bag 802 Triangle fzvenyika@triangle.co.zw 0772 946 607	Female	Chiredzi
18	Duncan Gwizo Environmental Health Officer City Of Kadoma Box 460 Kadoma dgwizo@ymail.com; Duncan@kadomacity.org.zw 0772562837 or 068-22044-6	Male	Kadoma
19	Sikhanyisiwe Moyo Environmental Health Officer Kadoma City Council Box 460 Kadoma smoyo@kadomacity.org.zw / skhaemoyo@gmail.com 068-22044/5/6	Female	Kadoma
20	Chiedza Chirisa Support Officer Family AIDS Caring Trust (FACT) 4163 Hobhouse 11 Mutare cchirisa@yahoo.com 0774319517	Female	Buhera
21	Bertha Mazango Registered General Nurse Population Services Zimbabwe5616 Unit J Seke, Chitungwiza, Bertha.mazango@pszim.com; bmazango@yahoo.com 0772645501	Female	Harare
22	Tendai Mudenge Provincial Pharmacy Manager Ministry Of Health And Child Welfare39 Chaplin Road, Khumalo, Bulawayo tendiemud@yahoo.co.uk 0772 143 598	Female	Bulawayo
23	Dzidzo Tapera, Chief Inspector of Factories, Standards Association of Zimbabwe, 17 Coventry Rd, Workington, P.O Box 2259, Harare, dtapera@saz.org.zw, 0773 928 457, 04 783 430/7	Female	Harare
24	Ranganai Mutonono, Quality Assurance Manager, SAZ, 17 Coventry Rd, Workington, P.O Box 2259, Harare, rmutonono@saz.org.zw, 0772 426 530, 04 783 430/7	Male	Harare

APPENDIX 3 : Evaluation results

1. This skills training course is

Relevant to my work or role	Not relevant to my work or role
100%	0%

2. Overall, this training was (N=22)

Very useful	Useful	Party useful	Not useful
80%	20%	0%	0%

3. The trainers were (N=22)

Very good	Very Good	Good	Poor	Very Poor
35%	65%	0%	0%	0%

4. The materials were (N=22)

Very good	Very Good	Good	Poor	Very Poor
70%	25%	5%	0%	0%

4. Understanding of sessions (N=22)	Under-stood all	Understood most of it	Did not understand
1. Welcome, Objectives of the training course, Delegate Expectations	68%	32%	0%
2. Public Health in Zimbabwe	64%	36%	0%
3. Background on the Public Health Act	68%	32%	0%
4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	68%	32%	0%
5. Roles, duties and functions, powers of the Ministry of Health and Child Welfare set in the Public Health Act from national to local level and MoHCW personnel who implement the Act	64%	36%	0%
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	48%	52%	0%
7. Rights, duties and roles and functions of other sectors of government in public health. How does the Public Health Act relate to other laws governing public health? What personnel in other sectors play a role in public health	50%	46%	4%
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	43%	52%	5%
9. Participatory exercise – Venn diagrams - on implementers of the Public Health Act and their roles in Urban and rural areas:	55%	41%	4%
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	41%	59%	0%
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	50%	50%	0%
12. Provisions, regulations and their implementation in relation to infections diseases control	46%	54%	0%
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	55%	45%	0%
14. Provisions, regulations and their implementation in relation to smoking control	46%	50%	4%
15. Participatory 'pub quiz' on materials covered in the course.	67%	33%	0%
16. Compliance, penalties, incentives and enforcement of the Act	50%	50%	0%
18. Proposals on and issues in the Review of the Public Health Act	50%	50%	0%
Overall	39%	61%	0%

5. Relevance and usefulness of sessions (N=22)	Relevant and useful	Partly relevant and useful	Not Relevant and useful
1. Welcome, Objectives of the training course, Delegate Expectations	91%	9%	0%
2. Public Health in Zimbabwe	96%	4%	0%
3. Background on the Public Health Act	96%	4%	0%

4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	96%	4%	0%
5. Roles, duties and functions, powers of the Ministry of Health and Child Welfare set in the Public Health Act from national to local level and MoHCW personnel who implement the Act	96%	4%	0%
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	91%	9%	0%
7. Rights, duties and roles and functions of other sectors of government in public health. How does the Public Health Act relate to other laws governing public health? What personnel in other sectors play a role in public health	96%	4%	0%
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	96%	4%	0%
9. Participatory exercise – Venn diagrams - on implementers of the Public Health Act and their roles in Urban and rural areas:	91%	9%	0%
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	96%	4%	0%
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	96%	4%	0%
12. Provisions, regulations and their implementation in relation to infections diseases control	91%	9%	0%
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	96%	4%	0%
14. Provisions, regulations and their implementation in relation to smoking control	96%	4%	0%
15. Participatory 'pub quiz' on materials covered in the course.	96%	4%	0%
16. Compliance, penalties, incentives and enforcement of the Act	96%	4%	0%
18. Proposals on and issues in the Review of the Public Health Act	95%	5%	0%
OVERALL RATING	95%	5%	0%

6. Clarity and usefulness materials (N=22)	Clear and useful	Partly clear and useful	Not Clear and Useful
1. Welcome, Objectives of the training course, Delegate Expectations	91%	9%	0%
2. Public Health in Zimbabwe	91%	9%	0%
3. Background on the Public Health Act	96%	4%	0%
4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	96%	4%	0%
5. Roles, duties and functions, powers of the Ministry of Health and Child Welfare set in the Public Health Act from national to local level and MoHCW personnel who implement the Act	77%	23%	0%
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	73%	27%	0%
7. Rights, duties and roles and functions of other sectors of government in public health. How does the Public Health Act relate to other laws governing public health? What personnel in other sectors play a role in public health	82%	18%	0%
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	77%	23%	0%
9. Participatory exercise – Venn diagrams - on implementers of the Public Health Act and their roles in Urban and rural areas:	73%	27%	0%
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	82%	18%	0%
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	73%	27%	0%
12. Provisions, regulations and their implementation in relation to infections diseases control	64%	36%	0%
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	73%	27%	0%
14. Provisions, regulations and their implementation in relation to smoking control	73%	27%	0%
15. Participatory 'pub quiz' on materials covered in the course.	77%	18%	5%
16. Compliance, penalties, incentives and enforcement of the Act	86%	14%	0%
18. Proposals on and issues in the Review of the Public Health Act	77%	23%	0%
OVERALL RATING	**86%**	**14%**	**0%**

5. **What changes should be made to improve the course (content and delivery, administrative issues)**

- Provide hard copies of the Acts and regulations preferably prior to the training dates x 5
- More time is required, 5 days are required x 5
- Use videos and other methods of delivery for variety 1
- More participatory exercises and group work x 5
- The course was good x 3
- Get presenters from the districts to improve on practical aspects of the course, hire policemen to explain their roles x 2
- Presenters should improve on delivery skills and not read from PowerPoint x 2
- Get participants from different sectors at district level x 2
- Increase number of facilitators to increase diversity of ideas x 1
- Include accommodation in the course package/costs x 1
- Tea breaks should come much earlier x 1

6. **Any other comments (please also indicate how you will use this training in your work)**

- I will share with my workmates and in other training workshops x 7
- The course will help me execute my duties x 7
- The course was an eye opener, it should cascade to districts x 2
- It will offer me skills in preparing prosecutions x 1
- Consider institutionalising the course x 1