Implementers training on the Public Health Act Chapter 15:09

TRAINING WORKSHOP REPORT

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

14-16 July 2014
Harare, Zimbabwe

With support from
Open Society Initiative of Southern Africa (OSISA)

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Acknowledgements
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1. Background

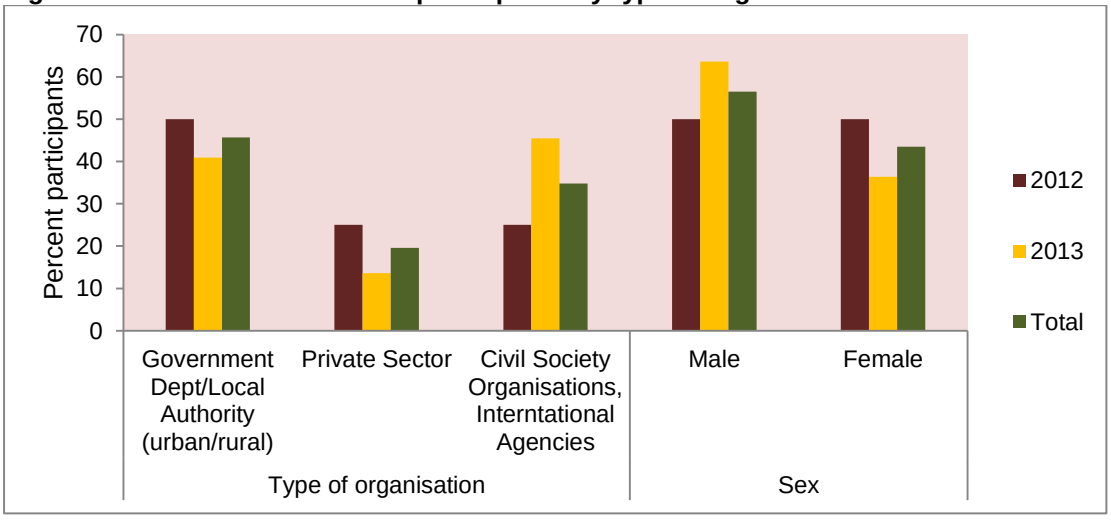
During the review of the Public Health Act Chapter 15:09 in Zimbabwe in 2011 it was evident that awareness of the contents of the Act was not high and that implementation of the Act would be improved by private and public sector stakeholders having improved knowledge of the contents and application of the law. During the stakeholder meetings and community level discussions few people had accessed the Act or were aware of its specific contents. While inspectorates in local government and Ministry of Health and Child Care (MoHCC) may be versed with the provisions of the PHAct, 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 Act to protect public health.

Proposals were thus made to hold follow up awareness raising and training on the Public Health Act. In 2012, a proposal was made to divide the training 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 a three day training for field level personnel from the same institutions who have a role in the implementation of the Public Health Act later. Both these two workshops were held in 2012. During the first top level workshop, participants noted that such training be designed to include representatives from government, local authorities, civil society organisations, private sector, law enforcement agents, professional bodies and other international agencies.This is the third time the implementers training course was held, the first and second one having been held in 2012 and 2013 respectively (see Table 1 and Figure 1 for details of participants trained to date)

Table 1: Distribution of participants trained by type of organisation and sex: 2012-2013

Description	Year 2012		Year 2013		Grand Total	
	Number	Percent	Number	Percent	Number	Percent
Total Trained	**24**	**100**	**22**	**100**	**46**	**100**
Type of Organisation						
Government department/Local Authority (urban/rural)	12	50	9	41	21	46
Private Sector	6	25	3	14	9	20
Civil Society Organisations, International Agencies	6	25	10	45	16	35
Sex						
Male	12	50	14	64	26	57
Female	12	50	8	36	20	43

Figure 1: Percent distribution of participants by type of organisation and sex: 2012-2013



The 2014 workshop was planned and convened jointly by Training and Research Support Centre (TARSC) and Ministry of Health and Child Care (MoHCC) in association with the Advisory Board of Public Health (PHAB). The resource persons were drawn from the MoHCC, TARSC, local government (City of Harare), Centre for Applied Legal Research and from UNICEF. This workshop was planned based on feedback and review obtained after the training in 2012 and 2013

The three day course thus aimed to familiarize field level personnel in government, private sector and non state organizations on the Public Health Act Ch15:09 in terms of

1. the understanding of public health and national policy
2. the key areas, rights and responsibilities, duties and obligations, functions of Ministry of Health, other ministries and other actors in the Act
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 participants 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. The training included discussion sessions and only a summary of the issues that emerged from these is captured in this report.

2. Opening and overview of the Public Health Act

Mr V Nyamandi (MoHCC) welcomed delegates to the training course. Delegates introduced themselves, noting the districts they were coming from and their roles in public health (see participants list in Appendix 2)

Mr Nyamandi noted that delegates were coming from diverse backgrounds and all had something to do with enforcement of public health. In this regard, he reiterated the importance of collaboration across different sectors in the implementation of the Act. Public health is diverse and calls for all citizens from all walks of life to work together to improve health and wellbeing. Public health is clearly reflected is our day to day lives for instance water, sanitation, life expectancy improvements and so on. Zimbabwe has suffered from diseases like cholera and typhoid in recent years; these are just some of the public health issues. Other areas of public health include such issues as child health (immunisations), non-communicable diseases and so on. He urged participants to reflect on these issues and on the areas covered during the training when they go back to their districts. He reminded the participants to be participatory and challenge the presenters on areas they are having difficulties within the districts and ensure that the information and knowledge obtained from the training is utilised and shared when they go back.

Participants introduced themselves noting their areas of work and districts of origin © TARSC 2014

Artwell Kadungure (TARSC) expressed his appreciation in respect of the financial support provided by the Open Society Initiative for Southern Africa (OSISA) towards the training course. He thanked the delegates and their organisations for the financial contributions and gave a background to the course as provided in the background section above. Public health law is diverse; a number of regulations provide for regulation of specific areas of public health. The training course would cover some of these regulations and the key areas in the Public Health Act. He 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 and implementation of public health law in Zimbabwe. Handouts and important background reading materials were provided on a CD given to the participants. He added that the course delivery includes presentations, discussions in groups and in plenary to enhance knowledge sharing, a pub quiz quiz and a formal evaluation at the end of the course. Participants would be given certificates of completion. Lastly, he acknowledged the diversity of the participants (geographical, areas of work); it was thus important for participants to share their experiences in relation to implementation of public health in their respective areas.

Participants' expectations were noted as follows;

Participants' Expectations

- To gain more knowledge on the Public Health Act Chapter 15:09 and its regulations x 19
- To network with other implementers of the Act from other sectors and departments x 2
- To gain an understanding on how implementation of the Act can be strengthened in my area of work eg workplace, food sector. To appreciate the gaps in the implementation of the law and how to address them x 16
- To understand the emerging issues on public health and how to deal with them x 3
- To appreciate the role of other sectors in the implementation of the Act, synergies required in the implementation of the law, role of ZRP, roles and rights of communities x 12
- Public health Act and the new constitution, issues being taken forward in the review of the Act, x 5

2.1 Public Health in Zimbabwe

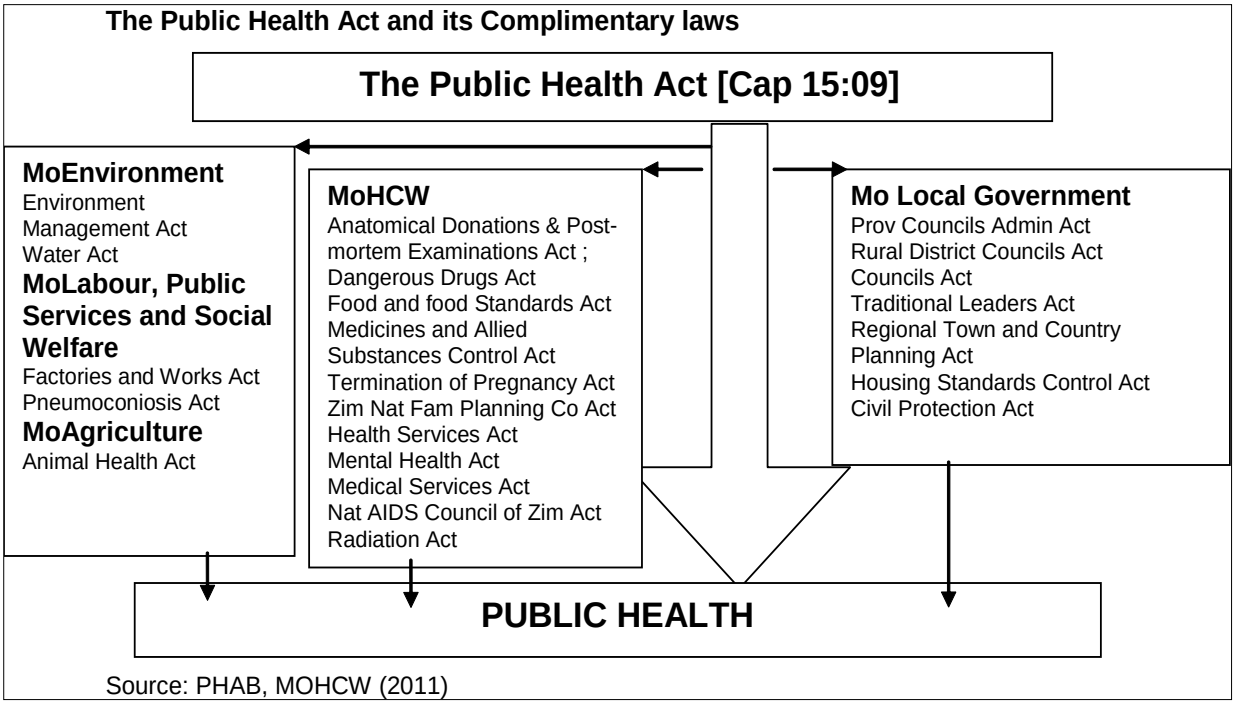
Mr A Chigumbu, UNICEF presented on public health trends and challenges Zimbabwe. Public health was defined as what we do to ensure the conditions for people to be healthy. It includes the actions taken to create conditions for and promote health, to prevent disease and prolong life, the actions by health 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. He noted the different levels of causes of health outcomes using the rainbow model on determinants of health pointing out that public health seeks to address not just immediate but also underlying causes of diseases and ill-health.

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)

Mr Chigumbu 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 water and sanitation, housing, social conditions, food, transport systems, and working conditions. For example trade liberalization has exposed households to poorly regulated products that may be harmful to health. There are also issues relating to tobacco smoking in young children, including in secondary schools. Mr Chigumbu 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 in any one time. Thus, there is need to 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**.**
On Zimbabwe's public health system, Mr Chigumbu 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. He noted the other key laws that compliments the Public Health Act (Figure 1)

Figure 1: The Public Health Act and laws that compliment it



Source: PHAB, MOHCW (2011)

2.2 Background on the Public Health Act

Mr V Nyamandi presented on the background to the Public Health Act and the Key provisions of the Act. He 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 for almost a century.

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

- Part II, Administration, (and the establishment of Advisory Board of Public Health, of District Health Management Committees, appointment of Chief Health Officer (Permanent Secretary), 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

In the discussion, participants noted that there appears to be lack of cohesion between the public and private sector in the implementation of the Act. Participants were worried that for instance, the public health system appeared to be side-lining the private health system in implementation of public health law yet these systems should be feeding into each other. Private sector has done some initiatives towards strengthening public health for instance Delta Corporation’s erection of waste collection centres (eg can cages) and there was a feeling that the public was not fully aware of these initiatives hence their utilisation could further be enhanced through awareness campaigns. The law allows for litigation of local authorities if they fail to implement the provisions of the Act; however delegates were concerned that the overall poor performance of the economy negatively impacts the provision of key public health elements eg water, sanitation, and housing and thus will stifle implementation of the Act. There is a greater need for government and other stakeholders to act on the economy to improve public health. Participants also noted that some of the challenges we have in public health relate to citizens’ mind-sets and thus a deliberate programme to change mind-sets need to be put in place to strengthen implementation of the Act.

“For me the major question is how we can adhere to the public health standards in light of an ailing economy…..some schools have not increased the number of toilets to match their increased enrolment”

Participant from rural district

Participants called for different sectors to work together to promote public health and the various legal instruments should work in harmony. For instance, while access to housing needs urgent attention (thus allowing people to settle on non-serviced stands) this should not be done in a way that threaten public health through non provision of key facilities like toilets and water. Community leaders need to b sensitised on the PHAct. Some participants cited political interference as hindering enforcement, particularly in illegal set ups like schools. Greater cooperation between the Environmental Management Authority (EMA) and the MoHCC is required and both institutions needed to have a goal of promoting public health (some delegates felt EMA seemed to be interested in collecting fines from companies that violate regulations rather than seeing fines as a means of enforcing the regulations on environment that have a bearing on health).

It was noted that the public health system lacks capacity to deal with some of the challenges and thus need to work in collaboration with the private sector. For instance, some private sector organisations have established infrastructure to examine food handlers and the MoHCC could collaborate with these players as well.

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

Artwell Kadungure, TARSC introduced the group work on

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

Participants noted that public health law is important in a number of areas including food hygiene, water, sanitation, housing and so on. While most of these areas are currently regulated (or partially regulated), there we gaps in terms of the enforcement of the regulations, roles of the various sectors are sometimes not clear and sometimes implementers appear to be working in silos. Addressing these gaps called for political will and commitment and more collaboration across the sectors with clear roles for each supported by awareness campaigns on the provisions of the Act- see Box 1

Box 1: Summary of responses on group work on the implementation of the Act

Areas where public health law is Important

Points of entry i.e Port Health- road, airport, particularly regarding disease surveillance, public premises eg recreational and religious areas, education facilities and so on for such issues like smoking control, water requirements, sanitation and food hygiene, manufactures and all sectors that handle food (for instance catering services) eg in relation to controlling non communicable diseases, food hygiene and so on. Planning and designing of factories as it relates to ways put in place to deal with toxic waste, pollution, sanitation and housing, mining areas as they relate to health of the environment and workers, employment facilities, slaughter houses, water treatment and supplies, importation of food items as well as clothes, waste management, transport sector in view of accidents, pollution from cars and so on, smoking control

Where are the gaps in the law and how can they be addressed?

Mostly the laws are in place but the enforcement is a challenge. It appears there is lack of co-ordination between parent ministries. Some roles appear to be overlapping for instance MoHCC and EMA. Personnel and statutory bodies who implement the act need to be resourced. There is lack of awareness on the act and corruption, lack of political will seem to be hindering enforcement. Rural urban migration has created challenges for local authorities. These gaps could be addressed through working with traditional leaders and those in authority to establish political will, training and capacity

building in implementers, harmonisation of statutory instruments (as well as make these regulations easily accessible within districts), public awareness of the Act and sharing of resources
Rural urban migration

What are the barriers faced in the implementation of the Act and how can they be addressed?
It appears the actors that are implementing public health are working silos; there is lack of clear coordination with specific roles and tasks. The government through the MoHCC should provide leadership for clear and meaningful collaboration of all actors including the private sector. Statutory bodies like the the PHAB need to include other sectors for instance the traditional health practitioners. Thus, a multisectoral approach is required with commitment by those responsible for implementation. Some regulations may need to be harmonised so that they are clear to follow and local authorities need to update outdated PHACt related bylaws. State enforcements agents like the ZRP need to be more active in the enforcement of such important acts like the PHAct. While political interference was also cited as a barrier, participants noted that implementers need to know the proper channels of dealing with such instances. In most cases, political interference arises from those who are in high office who are ignorant of the provisions of the regulations. The public health workforce need to be resourced and motivated and community level cadres like village health workers are very instrumental in the promotion of public health and thus need to be capacitated through provision of resources like for transport and communication. Knowledge and awareness of the Act is a barrier; training workshops like this one need to cascade to all regions. In some cases, fines and penalties are low and need to be reviewed upwards.

"One of the key barriers to the implementation of the Act is lack of social capital particularly in urban areas. We need to change the mind-sets of the population as regards to the importance of public health and ultimately how individuals behave to promote public health"
Participant

Where do our problems really lie in relation to implementation of the PHAct? Participants seem to be suggesting as they catty out their discussions © TARSC 2014

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

4.1 Roles, duties and functions, powers of the MoHCW

Mr A Chigumbu 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.

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 organisations, 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, participants noted that the multi sectoral concept in the implementation of the PHAct results in a number of questions, for instance "who will ultimately be accountable in the event of a public health disaster". This was raised in light of recent developments in Zimbabwe following the establishment of the Chigwizi holding camp for people affected by flooding during the rainy season. In the participants view, it was difficult for MoHCC to implement its mandate relating to public health given interests of other state departments and to some extent political interests. The establishment of a non-communicable disease division in the MoHCC was seen as a greater commitment towards dealing with the emerging challenges in public health in Zimbabwe for instance cancers, diabetes and hypertension.

4.2 Roles, duties and functions of local government

Mr John Kandwe, City of Harare, outlined the duties, functions and powers of the local government in public health. 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.

Mr Kandwe gave a practical example of the situation regarding water supply in Harare, noting that there are challenges regarding availability and accessibility of portable water with people resorting to use of unsafe sources. Harare City has a combined capacity to treat 600mgl per day yet the demand is 1200 mgl per day

Community alternatives to water supplies © J Kandwe 2014

City of Harare partners have attempted to assist in the following ways: donation of household water treatment chemicals, drilling of boreholes, repair of vandalized boreholes, community mobilisation, distribution of IEC materials and e –messages.

In the discussions, organisations representing communities noted that sometimes local authorities appear to be not cooperating with communities in relation to disease notification. It appears in some instances, local authorities try to portray a health picture yet in some cases outbreak of diseases would have long been identified. In response, Mr Kandwe noted that the community is empowered to notify local authorities about any diseases outbreaks and any delays in response and acknowledgements may relate to time required to

investigate these occurrences, identify if the occurrence is in line with trends or certain thresholds would not have been reached that warrant the outbreak to be declared as such. It was agreed that that communities need to know the avenues to follow should they feel their notifications are not being handled well. It was also noted that the private sector needed to collaborate more with the local authorities particularly in relation to notification of diseases and returns. Concerns were raised in relation to the role of the Standards Association of Zimbabwe regarding water inspections (use of SAZ seen as driven by commercial motives rather than for promotion of public health); it was noted that the MoHCC is the had the sole mandate to certify water as safe per the public health regulations. Participants noted that there is need for borehole water to be constantly tested given its susceptibility to contamination from fecal matter from septic tank systems in urban areas.

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) as well as non state actors (Faith Based Organizations and Communities). In his presentation, he pointed out the provisions in the new constitution relating to local governance and their bearing on implementation of public health including role of provincial councils.

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 discussions, it was noted that public health regulations needed to be aligned to the new constitution for their effective administration. The new constitution provides for devolution, at present it appears not very clear how the Ministry of Health will work with local authorities in the implementation of the Act. In the old constitution, the MoLG had delegated authority to implement the Act. Clearly local authorities will need more resources to cope with the increased public health responsibilities that come with devolution in the new constitution. Currently, it appears limited resources have resulted in the MoHCC allocating responsibilities to local authorities without the supporting resources.

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

Mr A Chigumbu presented on the rights, duties and roles of the private sector and of communities in the PHAct. He noted that members of the public have a right to live in healthy, disease-free environment, and therefore, the Public Health Act was promulgated to make provision for the public's health. It is the duty of the Ministry of Health and Child Care, 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 them 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, and Health Committees and Epidemic committees.

Participants noted that the public needed to be made aware of their rights and duties through awareness campaigns and training. A need was also felt for review of the composition of bodies that allow the public to participate for instance the PHAB. Health centre committees were also noted as instrumental in the participation of communities in public health and that such lower level committees needed to be supported and capacitated. Private sector health facilities need to be properly integrated in the National Health Information System, with a common reporting framework. Economic empowerment thrusts through indigenisation and ZImAsset should enhance and not harm public health; there is need for compliance with regulations by all actors.

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 Care 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. 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.

Participants noted that there was need for the Ministry of Health to make these regulations easily available. Some regulations needed to be harmonised and consolidated to avoid numerous pieces of regulations that appear to be regulating the same area. In respect of local authorities, a call was made for the review of bylaws that relate to public health. Meat inspection services need to be strengthened; there is growing concern for unregulated informal meat markets. Further, meat inspection fees charged by MoHCC and veterinary services need to be harmonised.

5. Participatory exercise on Implementation of the Act

Artwell presented on the key issues relating to implementations of public health regulations relating to:

i. Breast Milk Substitutes and Infant Nutrition (SI 46 of 1998) under the Food and Food Standards Act Ch 15:04 and the
ii. Food Labelling regulations (SI 265 of 2002) under the Public Health Act Ch 15:0

Artwell's presentation was informed by an assessment of compliance with the above regulations implemented by TARSC in 2013

The WHO Global Strategy on Diet states that consumers require accurate, standardized and comprehensible information on the content of food items in order to make healthy choices (WHO, 2004). The right to knowledge is also enshrined in the United Nations through the "Guidelines for Consumer Protection" adopted in 1985. Breast milk is uniquely suited to the human infant's nutritional needs and provides an unparalleled immunological and anti-inflammatory properties, it protects against a host of illnesses and diseases. There are health risks associated with formula feeding and early weaning from breastfeeding, including increases in common childhood infections, such as diarrhoea and ear infections. In 1981 World Health Assembly (WHA) of the World Health Organization (WHO) adopted the International Code of Marketing of Breastmilk Substitutes.

Artwell noted that the assessment aimed to determine compliance with the regulations in urban and rural areas. The design was a cross sectional survey of samples of food, breast milk substitutes and infant formula from both formal markets- and informal markets in high and low income sites of both rural and urban areas of Zimbabwe and 11 districts were covered. It was an observational study, and a total of 714 food labels were assessed. Artwell presented the summary of the findings as shown. Green indicates compliance of >90%, yellow 80%-90% compliance and red <80% compliance.

Table 2: Summary of the findings showing compliance for key areas of the law

Key provisions of the law	% labels complying	Colour code*
Food labels		
Label should accurately describe the contents	96	
Label should not create a false impression of the product	92	
Label should not suggest food to be similar to another food	89	
Label should have a common/usual name of the food	92	
Label should be in in English	98	
Label should be clear, indelible, prominent and legible	94	
Label should be in contrasting colour to the background	96	
Label font is should be at least size 6 font	89	
Label should be conspicuous on the package	90	
Label should show the name and business address of Manufacturer	97	
Label should show the site of production	93	
Label should show mass/measure/numerical count	95	
The mass should be written with at least size 12 font	75	
Label should show the expiry date	80	
Label should show the packaging number/ date of packaging	52	
Label should show the common name of each ingredient	62	
Breastmilk substitutes and infant nutrition		
The label should be in English	95	
Label should not be easily separated from container	71	
Label should show the conditions the food must be stored in	88	
Label should show the batch number	85	
Label should show the date before product must be consumed	94	
Label should show manufacturer's name and address present	99	
The label should state the exact ingredients used	100	
The label should have a message that "that the product is supplement to and not a replacement of breast milk "	69	
Label should show the age at which the product should be used/introduced	90	
The label should have the following words		
"Breast milk is the best food for your baby"	88	
"It protects against diarrhoea and other illness"	64	
The words above should be prominent and in bold	63	
Words should not be less than 10 point size font	57	
Words should be in black against a white background	59	
Label should have a warning that the food should not be the sole source of	69	

Key provisions of the law	% labels complying	Colour code*
nourishment		
The label should have the instructions for preparation of the food	97	
Label should have a message to continue breastfeeding a child as long as possible	79	
Label should have a statement on the superiority of breastfeeding	82	
Label should have a statement that the product should be used only after seeking advice from a health worker	78	
Label should have a warning concerning health and other hazards of improper preparation	77	
Above words should be in bold in not less than size 8 font	45	
The word " Important Notice" should be present	84	
The above word should be is greater than 10 point size font	45	

Source: TARSC, 2013

Figure 2 A NAN label in Portuguese, not English, Shona or Ndebele as required by the regulations , © TARSC 2013

Participants were asked to work in groups to come up with measures to strengthen implementation of these regulations. Having noted that stakeholder collaboration appeared to be the key issue, Artwell facilitated a participatory group exercise on the Implementation of the regulations. The exercise aimed to explore the roles and coordination of stakeholders in rural or urban district settings and Venn diagrams were used. Participants were divided into two groups, one representing a rural setting and the other an urban setting. For each setting, participants needed first to identify stakeholders in the implementation of the regulations (whether they had a positive or negative interest) in the implementation of the regulations. 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 regulations) represented the current level of involvement/interest of the stakeholder.

Implementation of the regulations was seen to be going beyond the law and involving culturing strategic alliances.


Participants discussing on measures to strenthen stakeholder coordination to improve implimentation of the PHAct regulations © TARSC 2014

In the discussions, certain key stakeholders were seen as having greater influence in the implementations of the regulations eg consumers (citizens/communities), MoHCC, CSOs, local authorities, political leaders. However, stakeholders were closer together in a rural setting than in an urban setting; communities were far away in urban areas than rural areas. Participants attributed this to the lack of social capital in urban areas. In rural areas, ZRP was seen as been more interested in the enforcement of the regulations compared to urban areas. Politicians were seen as having greater influence in both rural and urban areas but these were seen as not currently involved/interested in the enforcement of the regulations. Participants discussed the pattern of the stakeholders and interrogated the reasons for these patterns and suggested ways on how the stakeholder collaboration could be increased for instance using politicians to bring closer the communities. Generally, participants felt that with an ailing economy and increases in food imports, enforcement of the regulations is a challenge and community power will be important.

6. Water, sanitation, housing and infectious disease control

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

Mr D Rodrick, MoHCC, noted that the Public Health Act has sections that cover water and sanitation. 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 water sources. Water works have to be approved by the state before they 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. The Act defines what constitute a nuisance and how best they can be avoided, the role of the local authority where a nuisance is concerned and what procedures 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.

In the discussions, it was noted that the quality of water nationally is not satisfactory. Local authorities are not providing adequate water services. Concern was also raised regarding allocation of stands in areas that are not serviced.

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

Mr A Chigumbu highlighted that the Act provides for measures to deal with specifies 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 required 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 noted that the public health system should work for people to develop trust and use the system otherwise some people who may be suffering from the conditions stipulated in the regulations may be out of the health services. There is need for adequate communication from health officers eg explaining side effects of immunisations or drugs for people to trust the public health system. It was noted that the Act still empowers health authorities to quarantine people suffering from specific infectious diseases although in practice this was not being done due to lack of resources. While some participants felt that quarantining of these patients violates the human rights, most participants felt individual rights should not infringe rights of others. The public health workforce was noted to be overwhelmed with work in clinics and this has affected important public health outreach activities like school health programmes

7. Food safety and nutrition,

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

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

A food control system has three broad areas:

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

The primary legislation relating to food is the Food and Food Standards Act Chapter 15:04 and the Public Health Act and their regulations. The inspection powers and roles were discussed in earlier presentations. Food safety includes inspection and enforcement services, food laboratory, scientific information gathering and analysis, product tracing, crisis management systems, safety of imported and exported foods, novel foods and technologies and participation in international food safety management fora.
The role of the state is to:

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

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

He called for measures to improve laboratory diagnostics, mobility of the inspectorate, registration and pre-shipment inspections of foods and periodic review and upgrading of

laws and regulations. The agencies dealing with food safety should be strengthened to ensure a smooth execution of activities, national, regional and international networking should be strengthened and strengthen specialisation of food safety professionals to increase vigilance in food safety.

In the discussions, it was noted that the proposals on the fortification of food were welcome given the malnutrition challenges faced by people in Zimbabwe. There is need to review the definition of food in the PHAct as the current one excludes water. Problems with implementation of food regulations in urban areas were cited, for instance the local authorities appear to be just interested more in collecting fines from violators of the law (raising funds) instead of having the motive to protect the public. Levels of fines may need to be reviewed as in some cases they appear to be currently low. Participants called for action on unregulated products eg selling of milk by unregistered traders on roadsides and action on manufacturers that push products that are expiring. Mr Nyamandi noted that the MoHCC is working towards having port health services on all points of entry in Zimbabwe. Participants felt it is the state's responsibility to provide vaccinations at ports of exit say for yellow fever; and this should be provided at reasonable costs.

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$0 to US$5,000

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 which 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. Another issue was that premises of officers that are supposed to be implementing the Act do not sometimes comply with the provisions of the Act eg availability of water. This compromises implementations of the Act

8.2 Role of the Zimbabwe Republic Police in the implementation of the Act

Mr George Samson noted the legal framework establishing the ZRP as well as the technical and non technical departments of the police services. He outlined the functions of the ZRP in general and the other government security agencies the ZRP cooperates with in implementing law and order in Zimbabwe. He noted that in ZRP terms, the PHAct falls under “other Acts”. These are all other Acts of Parliament which are not the Criminal Law (Codification and Reforms) Act, Chapter 9:23, Act 23/2004. These have various institutions and departments which are empowered to enforce them other than the police. There is a direct link between the judiciary system and the institutions to enforce these Acts unlike in Criminal Law Codification Act. The ZRP enforces the PHAct directly and indirectly. Direct enforcement involves detecting, investigating, arresting and handover to the judiciary for prosecution. It also involves monitoring for further breaches of the law. Detection is either done directly by police officers, by institutions or by members of the public who make a report. In indirect enforcement, the ZRP will act upon court orders in any matter relating to violation of Public Health Act. These may arise as a result of matters that would have reached the judiciary directly without the involvement of police [section 87 of PHA].

Internally, the ZRP has also a medical services department which enforced implementation of the PHAct in police camps. Mr Samson noted that priority is given by ZRP to enforcement of Criminal Law (Codification and Reforms) Act, Chapter 9:23, Act 23/2004 over the “other” Acts under which the PHAct falls.

In the discussions, participants noted that there is need for close collaboration between the MoHCC inspectors and those in the Police force. A good working relationship needs to exist between the public health cadres in the police force and those in the MoHCC. The Environmental health services department in the police force is growing and and the ideal situation is to have an EHT at each police camp.

8.3 Review of the Act

Mr N Chishakwe 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 Care 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 Care in late 2011 for the legislative process. The Principles were reviewed internally by MoHCC and the Attorney's General Office started work on the Public Health Amendment Bill after a review by cabinet.

He 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

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 Care and with health laws under other Ministers. 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. New provisions also provided for health promotion and non communicable disease control. 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. 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, a formal evaluation was implemented. A total of 23 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. The full results of this formal evaluation are shown in Appendix 3.

Most of the expectations of the participants were met during the three days of training.

8.4 Closing

Artwell Kadungure thanked the MoHCC for partnering and cooperating with TARSC to implement the training course. He thanked Mr Chigumbu, the resource persons, TARSC

secretariat for the administrative support and the inputs provided by Dr Rene Loewenson (TARSC) and Mr Mangwadu (MoHCC) towards the course. Artwell also expressed his appreciation for the financial support from OSISA towards the training course. Artwell also thanked the participants and their organisations for contributions towards the training course and hoped that such organisations would continue to support the programme in future. 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. At the end of the training, participants were given certificates of completion to the marking the end of the training course.

One of the participants provided a vote of thanks and thanked the organisers for arranging such an important training workshop.

Appendix 1: Programme

COURSE BLOCK	COURSE TITLE	FACILITATOR
Time	**Session number, Content**	
Monday 14 July 2014		
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 MoHCC Artwell Kadungure, TARSC
0930-1045hrs	2. Background on the Public Health Act 3. Public Health in Zimbabwe Discussion	Mr G Mangwadu, MoHCC Mr A Chigumbu, Consultant, public health Law
1045-1115 hrs	**Tea Break**	
1115-1215hrs	4. Participatory exercise (Market place/Group work) on issues faced by participants in public health and implementing the law: i. Areas where public health law is important ii. Which areas are currently regulated and where are the gaps? How can these gaps be addressed? iii. What barriers are being faced in the implementation of the law at community, district, and national level? How can these barriers be addressed?	Mr A Kadungure TARSC, Mr A Chigumbu, Consultant public health law Mr G Mangwadu, MoHCC
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 Care set in the Public Health Act from national to local level and MoHCC personnel who implement the Act Discussion	Mr A Chigumbu, Consultant public health law
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. Case example of water and sanitation Discussion	Mr J Kandwe Environmental Health Manager, Harare City Health Department
Time	**Session number, Content**	
Tuesday 15 July 2014		
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 on the regulations on labelling of food and infant nutrition 1. Resources and implementers, 2. Gaps and reasons 3.Measures to strengthen implementation of the law	Mr A Kadungure 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 Discussion	Mr D Rodrick, Deputy Director Department of Environmental Health, MoHCC
1615-1630hrs	**Tea break**	
1630-1700hrs	12. Provisions, regulations and their implementation in relation	Mr A Chigumbu, Consultant public

COURSE BLOCK	COURSE TITLE	FACILITATOR
	to infectious diseases control Discussion	health law
Wednesday 16 July 2014		
0830-0930hrs	13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health Discussion	Mr V Nyamandi, Food Safety and Port Health, MoHCC
0930-1030hrs	14. Role of the ZRP in the enforcement of the Public Health Act Discussion	George Samson, Zimbabwe Republic Police
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 questions. The resource persons work through the answers after*	Mr A Chigumbu, Consultant public health law; Mr A Kadungure TARSC V Nyamandi, MoHCC
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	Mr Nyasha Chishakwe, Centre for Applied Legal Research
1630-1700	19. Course certificates and closing remarks	Artwell Kadungure TARSC Mr G Mangwadu, MoHCC
1700hrs	Closing	

Appendix 2: Participants' list

Item	Full Name, Title and Place of work, contact Details	Sex	District
1	Nare Mike, Veterinary Services Department, Ministry of Agriculture, Beitbridge, mcharlexy@operamail.com, 0775 974 106	Male	Beitbridge
2	Mr Dzirambi Norman, Ministry of Health and Child Care, Helath Promotions Officer, ndzirambi@gmail.com	Male	Mazowe
3	Mr. Jokoniah Mawopa, ZCTU, Harare, jtamawopa@gmail.com, 0774 170 442	Male	Harare
4	Chiunya Innocent, EHT MOHCC, Mudzi, vinniechiunya@gmail.com, 0772 363 654	Male	Mudzi
5	Flora Malandu, Hwange Colliery Company, fmalandu@hwangecolliery.co.zw, 0773 457 198	Female	Hwange
6	Dr. Vimiso P. Veterinary Public Health, Masvingo, pearvimiso@gmail.com 0777 810 835	Male	Masvingo
7	M. Maulana, PSMI, Harare, maulana@psmi.co.zw, 0772 749 976	Female	Harare
8	Ms Shupikai Bertha Manatsa, Delta Corporation, s.manatsa@delta.co.zw 0773 255 593	Female	Harare
9	Fisani Ngwenya, Delta Corporation, Bulawayo, fingwenya@delta.co.zw 0773 882 730	Female	Bulawayo
10	Phillina s. Mukon, Chiredzi Rural District council, phillinamukon@gmail.com 0773 490 083, 031 2465	Female	Chiredzi
11	Mrs Salizinah Makumbe, smakumbe@worlded.co.zw, 0772 303 192, 794620	Female	Harare
12	Leena Mbazima, Vertinary Services, mbazimaleena@yahoo.co.zw, 0773 238 352, 705 885 Ext 117	Female	Harare
13	Hildaberta Rwambiwa, Combined Harare Residents Association, hildachra@gmail.com 0773 874 484	Female	Harare
14	Lawrence Dinginya, Veterinary Public Helath, dinginyal@yahoo.com 0772 729 253	Male	Harare
15	Tapiwa Mukurunge, Gokwe Town Council, tapiwamukurunge@gmail.com 0734 050 255	Male	Gokwe
16	Samson Sekeranhamo, Gweru City Council, Samlinc07@gmail.com, 0772 361 589	Male	Gweru
17	Caiphas Chimhete, Communications Officer, Community Working Group on Health (CWGH), caiphas@cwgh.co.zw, 0772 275 871	Male	Harare
18	Vincent Itai Tanyanyiwa, Zimbabwe Open University, tanyanyiwavi@yahoo.com 0772 373 626	Male	Harare
19	Annastancia Chineka, Nutrition monitoring and Evaluation Coordinator, International Medical Corps, achineka@internationalmedicalcorps.org, 0772 336 423	Female	Bulawayo
20	Themba Maphosa, Nutritionist, MOHCC, Bulilima, Tmaphosa08@gmail.com 0773 722 640	Male	Bulilima
21	Raymond Kamhanda, Pharmacist, JG Pharmacy, raykamhanda@yahoo.com 0772 308 585	Male	Harare
22	Amos Mareverwa, Program Intern, CORDAID, Mareverwa05@gmail.com 0773 097 823	Male	Harare
23	Trish Mukunyadzi, Program Intern, CORDAID Zimbabwe, trishmukunyadzi@gmail.com, 0773 508 354	Female	Harare
24	Matthew Bangira, Claims Assessor, CORDAID Zimbabwe, matthew.bangira@cordaid.net	Male	Harare
25	Lovemore Makurirofa, Monitoring and Evaluation Officer, Cancer Association of Zimbabwe, makurirofal@gmail.com, 0774 161 346	Male	Harare
26	Christopher Munyau, EHT, Nyanga Rural District Council, cmunyau@yahoo.co.uk	Male	Nyanga
27	Simbarashe Pesanai, MD, Wantech Imaging Ltd, simbarashe@wantechimaging.co.zw	Male	Harare
28	Nixsem Mapesa, Operations Manager, PSMI, Harare, mmapesa@psmi.co.zw	Male	Harare
29	Patience Chikomba, Chinhoyi Hospital, Registered Nurse, pchikomba@gmail.com 0773 527 037	Female	Chinhoyi

Appendix 3 : Evaluation results

1. This skills training course is N=23

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

2. Overall, this training was (N=23)

Very useful	Useful	Party useful	Not useful
66%	30%	4%	0%

3. The trainers were (N=23)

Very good	Good	Poor	Very Poor
22%	78%	0%	0%

4. The materials were (N=23)

Very good	Good	Poor	Very Poor
48%	52%	0%	0%

5. The venue for the course was (N=23)

Very appropriate	Somewhat appropriate	Not appropriate
48%	48%	4%- reason given is food was cold

6. Communications from organisers was (N=23)

Very good	Good	Poor	Very Poor
70%	30%	0%	0%

7. Understanding of Sessions (Percent responses N=23)

Session	Under-stood all	Understood most of it	Did not understand
1. Welcome, Objectives of the training course, Delegate Expectations	78	22	0
2. Background on the Public Health Act, Public Health in Zimbabwe	61	39	0
4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	50	50	0
5. Roles, duties and functions, powers of the Ministry of Health and Child Care set in the Public Health Act from national to local level and MoHCC personnel who implement the Act	52	48	0
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	39	61	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	50	0
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	70	30	0
9. Participatory exercise – on the regulations on food labelling, breast milk substitutes and infant nutrition	48	52	0
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	43	57	0
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	45	55	0
12. Provisions, regulations and their implementation in relation to infections diseases control	55	45	0
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	48	52	0
15. Role of ZRP in the implementation of the Act	65	35	0
16. Compliance, penalties, incentives and enforcement of the Act	48	52	0
18. Proposals on and issues in the Review of the Public Health Act	48	52	0

8. Relevance and usefulness of sessions (N=23)	Relevant and useful	Partly relevant and useful	Not Relevant and useful
1. Welcome, Objectives of the training course, Delegate Expectations	95	5	0
2. Background on the Public Health Act, Public Health in Zimbabwe	95	5	0
4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	86	14	0

5. Roles, duties and functions, powers of the Ministry of Health and Child Care set in the Public Health Act from national to local level and MoHCC personnel who implement the Act	95	5	0
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	90	10	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	93	7	0
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	85	15	0
9. Participatory exercise – on the regulations on food labelling, breast milk substitutes and infant nutrition	90	10	0
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	71	29	0
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	80	20	0
12. Provisions, regulations and their implementation in relation to infections diseases control	76	24	0
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	84	16	0
15. Role of ZRP in the implementation of the Act	90	10	0
16. Compliance, penalties, incentives and enforcement of the Act	76	24	0
18. Proposals on and issues in the Review of the Public Health Act	80	20	0

6. Clarity and usefulness materials (N=23)	Clear and useful	Partly clear and useful	Not Clear and Useful
1. Welcome, Objectives of the training course, Delegate Expectations	95	5	0
2. Background on the Public Health Act, Public Health in Zimbabwe	86	14	0
4. Participatory exercise (Market place) on issues faced by participants in public health and implementing the law:	95	5	0
5. Roles, duties and functions, powers of the Ministry of Health and Child Care set in the Public Health Act from national to local level and MoHCC personnel who implement the Act	76	24	0
6. Roles, duties and functions of local government set in the Public Health Act and local government personnel who implement the Act	76	24	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	80	20	0
8. Rights, duties and roles of the private sector and of communities in the Public Health Act	80	20	0
9. Participatory exercise – on the regulations on food labelling, breast milk substitutes and infant nutrition	85	15	0
10. Overview of Regulations and by laws under the Public Health Act What are they? What do they cover?	90	10	0
11. Provisions of the Act , regulations and their implementation in relation to water, sanitation, housing and hazardous substances	95	5	0
12. Provisions, regulations and their implementation in relation to infections diseases control	76	24	0
13. Provisions, regulations and their implementation in relation to nutrition, food safety and port health	81	19	0
15. Role of ZRP in the implementation of the Act	90	5	5
16. Compliance, penalties, incentives and enforcement of the Act	81	14	5
18. Proposals on and issues in the Review of the Public Health Act	90	10	0

5. **What changes should be made to improve the course (content and delivery, administrative issues)**
   - Field visit to areas that are not implementing the Act/contravening the Act x 3
   - More time is needed for the course x 3
   - Improve on diversity of participants: Involve more people from different sectors, from private sector, different districts x 3
   - The course was good, perhaps organise an advanced course x 2
   - A practical exercise in the food markets or water supply systems would also assist with practical understanding of the issues, more practical exercises x 2

- Hotel services were very poor, food was cold x 2
- The course content and delivery and administration issues were satisfactory
- Act need to be updated and relevant to the current situation

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

- To increase my effectiveness in dealing with PH issues that are directly linked to employment and care of employees x 4
- A good course x 3
- Evaluation form too long x 2
- Improves my contact with the relevant stakeholders/other sectors in public health x 2
- An enlightening training on an important act. Should be extended to everyone x 2
- A course for EHT practitioners alone will also strengthen the implementation of the PHAct
- Consider spreading the training to other areas outside Harare
- Promoting good health seek behavior change within communities
- It will assist me in advocacy efforts for effective implementation of the PHAct
- There is need for practical field visits of places were nuisances are occurring