Extract from uncorrected copy of National Assembly Debates for 16th May 2018

JOINT REPORT OF THE PORTFOLIO COMMITTEE ON HEALTH AND CHILD CARE AND THE THEMATIC COMMITTEE ON HIV/AIDS ON THE EVIDENCE GATHERED DURING THE PUBLIC HEARINGS ON THE PUBLIC HEALTH [BILL H. B. 7, 2017].

**1.0 INTRODUCTION**

1.1 Pursuant to Section 141 (b) of the Constitution which states that; “*Parliament must ensure that interested parties are consulted about Bills being considered by Parliament..”,* the Portfolio Committee on Health and Child Care together with the Thematic Committee HIV and AIDS conducted public hearings in each of the ten provinces of the country. Participants at these public hearings included: representatives from doctors and nurses associations, environmental health technicians, local authorities, persons with disabilities, students, lecturers, religious leaders, women, youths, the elderly amongst others. The following are some of the key findings from the public hearings.

**2.0 FINDINGS**

**2.1 Preamble**

The public noted that the preamble *omits the elaboration of the rights of persons with disabilities* provided for under section 83 (d) of the Constitution. Being vulnerable members of the society, the Constitution obliges all state and non-state agencies to take due consideration of the needs of persons with disabilities and take deliberate actions to accommodate them.

**2.2 Monopoly of the Medical Practitioners**

The public noted that the medical practitioners dominated the administration of the Public Health Bill and recommended that it be open to other interested and qualified, capable health practitioners outside the medical field. However, other opinions argued that the administration of the public health should be done by medical doctors as the training of a doctor requires one to know what the rest of the team members do, thereafter it is easier for doctors to supervise. It was further stated that other health professionals are not trained that way.

**2.3 Clause 2: Interpretation**

2.3.1 The public noted that the Bill does not provide for the definition of the term “health’ and recommended that the term “health” be defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” It was further recommended that this definition should also state that health includes sexual reproductive health as stated in Section 76 (1) of the Constitution.

2.3.2 It was also observed that the word “School” is defined twice, hence the need to delete the other definition.

2.3.4 It was noted that the term “public health practitioner” is not defined, hence it was suggested the following definition be included in this clause:-

“public health practitioner” means a practitioner registered by any of the councils established by the Health Professions Act (Chapter 27:19), and holds a degree, diploma or certificate in public health granted after examination and registrable in Zimbabwe as well as in the country where it was obtained”.

**2.3 Clause 3: Ministry Responsible for Public Health**

2.3.1 The Ministry should manage public health information through a National Health Management Information System beyond the production of reports and statistics.

2.3.2 Functions of the Ministry can be strengthened by making a reference to promote the right to health care including reproductive health care, a very powerful constitutional provision. The Ministry’s function should be to promote the right to health care and the protection of other constitutional rights in the provision of health care through policy and other measures.

2.3.4 Another important function that needs strengthening is the function of promoting equality and equity in the provision of quality health care.

**2.3.5 Sub Clause 3 (2) (j)**

The public was of the view that this clause should be talking of the adequacy of health staff and not be limited only to competency. Therefore, it was suggested that sub-Clause 3 (2) (j) be replaced by the following text:-“to provide for equitable numbers of a competent public health workforce; and…*”*

**2.4 Clause 4: Advisory Board of the Public Health**

2.4.1 Some members of the public noted that the board has a wider (from 13 to 24) inclusion of various stakeholder groups, including persons with disabilities and further recommended inclusion of a youth representative, rehabilitation representative and key populations representative. However, others felt that the board is too bloated and need to be trimmed.

2.4.2 It was further recommended that the Chairperson of the Advisory Board be elected by the board members drawn from various special interest groups as defined in the Bill. It was also noted that the frequency of meetings for the board needs to be stipulated in the Bill. The public demanded that the Bill makes it mandatory for the Advisory Board to publish an annual report for public scrutiny.

**2.4.3 Sub clause (2) (O)**

The Environmental Health Practitioners noted that the clause reads as follows: “one member to represent environmental health practitioners or other similar personnel working in the field of environmental health;” They suggested that it reads as follows:-“one member to represent environmental health practitioners.”

**2.4. 4 Sub clause (4)**

Health practitioners were of the view that the Minister’s discretion is too broad and must be fettered. They proposed that Clause 4 (4) should read as - “Minister must be required to allow associations to nominate their own representatives.”

**2.5 Clauses 7 (Chief Health Officer); 9 (Provincial Health Officer) and 13 (District Health Officer)**

2.5.1 In each of the Clauses 7 (2a), 9 (2a) and 13 (2a), other health practitioners suggest that the text reads as:-

“… is a practitioner registered by any of the councils established by the Health Professions Act [*Chapter 27:19*]*.”*

2.5.2 The Medical practitioners suggested that in Clauses 7, 8, 9 and 10, the term “Health Officer” be replaced with the term “Medical Officer.”

**2.6 Clause 10: Other officers at provincial level**

The Zimbabwe Physiotherapy Association noted that the structure of Provincial Health teams does not include rehabilitation personnel. They suggested that instead of leaving it to “any other”, the Bill should specify Provincial Therapist to be part of the officers. The same applies to Clauses 12 and 15 and other teams in the Bill. It was further stated that there is no mention of local authorities’ representation in both Clauses 10 and 11, and that this should be included.

**2.7 Clause 11: Provincial or Metropolitan Health Team**

The public was of the view that there is need to clarify (2) (e) and (f) on the number of nominees from teaching hospitals and religious bodies sponsoring hospitals—i.e. is it one representative per body? If there are three different mission hospitals, will they have three representatives? It was further suggested that on (2) (e), the term “teaching hospital’ be substituted with the terms ‘College of Health Sciences” or “Faculties of Medicine.”

**2.9 Clause 16: District Health Team**

2.9. The Environmental Health Technicians observed that sub- Clause 16 (1) (a) (iv) which refers to “all EHT's and nurses in charge of rural health centre;” seems to be the only section where the abbreviation “EHT” is found. They suggested that the abbreviation be written in full and the term, “Environmental Health Technician” be defined under Clause 2 as ''environmental health technician'' “means a person registered as an environmental health technician under any law relating to the registration of environmental health technicians.

**2. 10 Clause 17: Health Centre Committee**

The public were of the view that at the Health Centre Committee level, there is a notable absence of recognition of the Village Health Worker. This is a critical cadre that legislators have advocated for to be formalised and remunerated since they have been the backbone of Zimbabwe’s primary health care for decades.

**2.11 Clause 19: Appointment of Director Health Services**

The public was of the view that sub-clause (2) needs to be re-worded as follows to make public health qualifications mandatory for Directors of Health Services:-

“In making such appointment, consideration shall be made only of health practitioners holding degrees, diplomas or certificates in public health granted after examination and registrable in Zimbabwe as well as in the country where they were obtained.”

**2.12 Clause 21: Government medical officers to be Director Health services in rural districts**

It was suggested that the clause be reworded to read as:-“In any area where no Director Health Services has been appointed, a Government **public health practitioner** designated by the Chief Health Officer by statutory instrument shall be the Director Health Services for the area specified in such statutory instrument and shall carry out the duties imposed by section …”

**2.13 Clauses 28 and 29: Human Resources**

Health professionals were of the opinion that the Minister should not to be given authority to prescribe remuneration and retention scheme in order to avoid bias since he/she will belong to a profession which under current circumstances is a medical doctor leading to impartiality. This should be left to the Health Service Board. However, on the issue of the Health Service Board, the public was of the view that it be abolished and replaced by Health Service Commission.

**2.14 Clause 30: The obligation to report on implementation on rights in public health**

2.14.1 Health practitioners are of the view that the Bill should provide for enforcement mechanism to guard against delays by the Minister in reporting to Parliament.

2.14.2 The public noted that the Constitution guarantees the right to health care including reproductive health in section 76. Section 76 (2) provides that persons suffering from chronic illness have a right to access services for such illnesses. Contrary to this, the Public Health Bill does not have provisions specifically defining these chronic illnesses and how this provision will be implemented. This creates a gap in terms of full realisation of the right to health care as provided for under section 76 of the Constitution.

2.14.3 The public was also of the view that right to health is absolute and should not depend on resource availability. Therefore, the Ministry and other employers should commit to provide necessary resources needed.

**2.15 Clause 31: Principles of Public health and practice**

It was noted that the Bill still falls short in terms of the extent to which it protects the right to health of key populations. Therefore, it was recommended that Clause 31 should include the following as key principles: “dignity and inclusion” and “promote universal design and accessibility” to premises. It was further recommended that Clause 39 be expanded to read as “Privacy and Confidentiality.”

**2.16 Clause 33: Emergency Treatment:**

The public was of the view that institutions must be obliged to have clear policy allowing health care workers to provide free treatment for all emergencies in Government and private facilities to safeguard health care workers who may be put in a dilemma by prescribed facility policies putting payment first for any service. The clause should state that if the health worker deliberately fails to render emergency treatment he/she may be charged to allow for investigation of the case to determine the cause and this will actually compel the employer to be committed to provide enough resources needed. It was also proposed that the Bill should state that “detention of patients for non-payment of medical fees is prohibited in all circumstances” and that the Bill defines what emergency treatment is and who qualifies for it.

**2.17 Clause 34: User to have full knowledge of services available**

Clause 34 (2) of the Public Health Bill states that “where possible” a health practitioner should communicate with a patient in a language that the patient understands. This provision is important given that the Constitution in section 63 provides for one’s right to use the language he/she understands and section 6 obliges all state institutions and agencies to promote usage of all languages. The public, particularly those in Beitbridge expressed great concern on language as a barrier to access health care services as residents in this area use more than one language. It was suggested that the Ministry of Health and Child Care deploys health professionals who understand the languages spoken in Beitbridge or to recruit those who are qualified to do the job from the local area. Persons with disabilities also noted that the Bill does not explicitly provide for sign language in the provision of health services. It was stated that whilst it is acknowledged that it may be difficult in some cases to find health practitioners who can speak the same language as the patient or professional translators, the main health legislation should at least mandate that all efforts be made to ensure that a translator is made available.

**2.18 Clause 35: Consent of user**

It was proposed that Clause 35 (1) to read as follows: “For the purposes of this section, "free and informed consent" means consent given voluntarily, without coercion, undue influence or misrepresentation for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 34.”

Health care providers must recognise children’s right to be heard when expressing opinions on their own health care and to give consent to treatment in accordance with their evolving capacities, including by recognising their legal capacity to consent to health care goods and services according to their age and maturity and their ability to comprehend, retain, believe and weigh information provided in arriving at a decision.

**2.19 Clauses 36, 37, 38, and 39**

It was noted that on pages 28-29, there are inconsistencies in the document with regard to confidentiality and consent. Routine syphilis and HIV testing is now carried out in antenatal care on an opt-out basis, i.e. it is carried out unless the person specifically refuses. This is meant to be the case with all practitioner-initiated testing which is government policy. It is not clear how the current Bill allows for this under consent issues. Similarly, the previous Act allowed for consideration that the risk of transmission to partners outweighed the individual’s right to privacy which seems to have been lost in this revision, i.e. the obligation of the health provider to protect the life of others, e.g. in potential transmission of HIV or TB, or in mental health concerns. Thousands of people became infected with HIV as a result of this individual right to privacy and caution is needed that we do not go back to this state with lack of clarity in the revised Public Health Bill. This is the required role of this legislation, to create a reasonable balance between individual rights and public safety.

**2.20 Clause 39 Confidentiality**

Health professionals were of the view that this clause should consider the impact of first time offence stern punishment on the employee’s family. They suggested that a protocol be laid down to allow reprimanding employees for breaching the clause for the first time.

It was also felt that Clause 39 (1) (c) is broadly worded in that the Bill does not provide guidance on the criteria for determining the threshold of ‘a serious threat to public health’. It was recommended that the determination of a ‘serious threat to public health’ be defined within the Bill to which it provides clear guidance as to the threshold for the assessment of a serious threat to public health and training to health care workers in identifying such risks is ensured.

**2.21 Clause 40: Access to health records by health care provider**

The public was of the view that the Bill should provide for private practitioners to be compelled to submit their statistics to the Minister, failure to do so, their operational licences should be withdrawn by the Minister. The public was of the opinion that the Ministry has not been able to get accurate figures on disease burden with the numbers from private health care providers not forthcoming. This becomes problematic in coming up with appropriate national interventions especially to pandemics like HIV and AIDS.

**2.22 Clause 41: Laying of Complaints**

Section 41 of the Bill which speaks to the “Laying of complaints” gives aggrieved persons a right to complain and make use of a complaint procedure set out at every health institution. The provision does not speak to anonymous complaints or mandate health institutions to include an anonymous complaint mechanism in the complaints procedure they are to come up with. The presence of anonymous complaint mechanisms is important for vulnerable groups such as gays, lesbians, bisexual and transgender persons as well as sex workers and women.

**2.23 Clause 42: Compulsory Immunisation of Children and incapacitated persons**

It was noted that the clause needs careful wording specifying the process by which this will be done. It was stated that in some countries the minor is made a ward of court, for instance. The public was of the view that there should be mention of what happens to those who refuse immunisation of children.

**2.24 Clause 44: Participation in decisions**

2.24.1 It was suggested that Clause 44 (2) reads as follows: “If the informed consent of the user individual is given by a person other than the user individual, the health personnel must ensure consent is also given and such person must, if possible consult by the user individual before accepting giving the required consent.”

2.24.2 It was further suggested that Clause 44 (3) reads as follows: “If a user is authoritatively judged not to have legal capacity to participate in a decision affecting his or her personal health and treatment, due to a transitory physical or mental state such as consciousness, a health-care provider may resort only to a life-saving emergency procedure, and only with the safeguard of third party medical opinion and only in the absence of a clear prior or immediate indication of refusal. The individual must be informed after the provision of the health service in question.”

**2.25 Clause 45: Rights of Health Personnel**

It was stated that a safe working environment for health care workers which is devoid of hazards should be provided for in all facilities. It was further stated that clear immediate compensation for occupational health injuries should be provided for.

**2.26 Clause 48: Notification by medical practitioners**

Some health practitioners felt that notification of STIs should not be a preserve of medical doctors only since in practice majority of cases are seen and resolved by nurses.

**2.27 Clause 51: Inspection of infected premises and examination of persons suspected to be suffering from infectious disease**

It was suggested that the title of the clause be changed to read as “Inspection of premises where an infectious disease has occurred, and examination of persons suspected to be suffering from infectious disease”. It was further suggested that the inspection of the premises be left to Environmental Health Practitioners who are trained to carry out inspection of premises, while medical practitioners limit themselves to the examination of the sick persons. Therefore, it was suggested that Clause 51 reads as follows:

“(1) The Director Health Services of any urban or rural area or any Environmental Health Officer duly authorised thereto by the local authority may at any reasonable time enter and inspect any premises in which he or she has reason to believe that any person suffering or who has recently suffered from any infectious disease is or has recently been present, or any inmate of which has recently been exposed to the infection of any infectious disease.”

“(2) Any medical practitioner of any urban or rural area or any medical practitioner may medically examine any person in such premises for the purpose of ascertaining whether such person is suffering or has recently suffered from any such disease.”

**2.28 Clauses 57, 74 and 130**

It was noted that there is reference throughout the Bill to potential fines and/or custodial sentences as a means of enforcing certain provisions. For example, Clause 57 (c) of the Public Health Bill provides for punishment - by fine or incarceration - of individuals for the “willful or negligent’ exposure of others to infectious disease; Clause 74, provides for punishment - by fine or incarceration - of individuals who fail to comply with compulsory treatment orders for a notifiable sexually transmitted diseases issued by the District Health Officer. It was stated that these provisions are particularly problematic when read in conjunction with Section 130 of the Bill, which in civil and criminal proceedings relating to infectious or communicable diseases, conditions of public health importance, or public health risks, imposes the burden of proof of the knowledge of the diseases or public health risk on the defendant. The Minister’s powers to declare by statutory instrument “forms of tuberculosis and such other infectious or communicable diseases including sexually transmitted diseases” risk including HIV and TB within the scope of these provisions, resulting in the indirect criminalisation of HIV and other sexually transmitted infections. There was concern that these provisions risk undermining the right to health by creating barriers and restricting access to necessary health care; fostering stigma and perpetuating discrimination. Longstanding international legal principles that guide states in implementing their treaty obligations, urge States to avoid unwarranted and unnecessary criminalisation in relation to health services. These approaches have also been shown to deter people from accessing HIV and TB testing and treatment services.

**2.29 Clause 58: Conveyance of infected persons in public conveyance**

It was noted that there are punitive measures for the health personnel who know that there is an infected client but cannot isolate that person. Thus, government is responsible for giving resources that are needed, for instance isolation centres.

**2.30 Clause 63: Reciprocal notification and consultation between Ministry and Veterinary Department**

It was noted that there is omission on the subsections because it mainly concentrates on live animals, and not the carcasses.

**2.31 Clause 65: Notification of suspected cases of formidable epidemic diseases and conditions of public health importance**

It was noted that the clause mentions a number of people who are supposed to be notified including a medical practitioner, school heads, villagers and other people but it is silent on animal health practitioners. It is also important for animal health practitioners to notify the Ministry of Health.

**2.32 Clause 68: Regulations regarding formidable epidemic diseases and conditions or events of public health concern**

The public proposed that Clause 68 (1) (i) should be expanded to include protection of health professionals and community health workers who have given evidence in cases of confidential enquiries, maternal death reviews and verbal autopsies, that they will be protected from their evidence being used in a legal action, and being forced to give evidence in such cases.

**2.33 Clause 75: Examination by medical practitioner:**

It was noted that the sub-clause (2) states that in the case of a female who is 12 years plus, examination should be done by a lady or in the presence of a lady but no mention of examination of a man. Thus, it was suggested this sub clause be gender inclusive.

**2.34 PART IV**

**Infectious Diseases**

**Notifiable diseases**

It was suggested that notifiable diseases be classified in two categories as follows:

**Category 1**: notifiable conditions that require immediate reporting by the most rapid means available upon diagnosis followed by a written or electronic notification to the Ministry of Health within 24 hours of diagnosis by health care provider, private or public health laboratories.

Anthrax, Botulism, Brucellosis [instead of undulant or Malta fever), Cholera, Diptheria, Enteric fever (typhoid or paratyphoid fever), Food borne disease outbreak, Invasive group A streptococcal disease including during pregnancy [instead of scarlet fever , erysipelas, puerperal sepsis], Listeriosis, Malaria, Measles, Meningococcal septicaemia, Pertussis, Plague, Poliomyyelitis, Rabies, Severe acute respiratory syndrome (SARS), Typhus, Viral haemorrhagic fever (VHF) and Yellow fever.

**Category 2**: notifiable conditions to be notified through written or electronic notification to the Ministry of Health within 7 days of clinical or laboratory diagnosis by health care providers, private or public health laboratories.

Acute encephalitis, Acute infectious hepatitis, Acute meningitis [instead of spot fever], Acute poliomyelitis, Bilhazia (schistosomiasis), Brucellosis, Congenital syphilis, Leprosy, Smallpox, Tetanus, Trypanosomiasis [sleeping sickness] and Tuberculosis (all forms and types).

**2.35 PART V**

Sexually transmitted diseases or infections

2.28.1 Health practitioners were of the view that in keeping with the WHO terminology, it is best to use the term *sexually transmitted infections (STIs,)* rather than sexually transmitted diseases, the term STI covers situations in which there is no overt disease as such but an infection is present. Furthermore, it was suggested that candidiasis be removed from the list of STIs as this has not been internationally established as a sexually transmitted infection, even though it may on occasion be sexually transmissible

2.28.2 However, the public was of the view that the title be changed to read as “Sexual Reproductive Health” and cover all other aspects of SRH not just STIs. It should also articulate access to SRH information and services that include but not limited to comprehensive sexuality education, access to contraception and STI prevention methods, and youth friendly services.

**2.36 Clause 89: Powers to inspect water**

The public was of the view that the Ministry of Health should be mandated to test the water and should actually be responsible for the terminal provision of water from taps and wells.

**2.37 PART X**

Inspection of Meat

It was stated that the Bill does not address the current conflict between Veterinarians and Public Health Officials on who should license slaughter houses. It was also stated that there is need for a specific definition of a meat inspector and clarity in roles to avoid conflicts and duplication of duties. It was further stated that instead of appeals to the Minister following a local authority’s refusal to grant or renew a licence for a slaughter house (Clause 98), the Bill should provide for appeals or review by the Administrative Court.

**2.38 Clause 102: Inspection of meat and fees for inspection**

2.31 It was noted that there seems to be a contradiction in the provisions of sub clause (1), second paragraph, when it says that a local authority can charge meat inspection fees. In the public’s view, inspection fees should only be charged by the authority carrying out the inspection. If a particular local authority has provided a slaughter facility in its area, or it has licensed a private one, and the authority employs a registered meat inspector, then surely this authority would be entitled to receive the inspection fees. It is only when the local authority cannot do the inspection itself that whoever is providing the inspector, whether it be the Ministry of Health and Child Care, the Veterinary Services Department or another local authority would be entitled to collect the inspection fees. It was suggested that sub clause (1), second paragraph, be deleted to avoid confusion. Otherwise, the Bill would continue to rob local authorities of their entitlements.

**2.39 Clause 104: Nuisances prohibited**

The public was of the opinion that Clause 104 be merged with Clause 32 and the title to be changed from “nuisance” to “public health risk” or “environmental health risk”.

**2.40 Clause 106: Local authorities failing to deal with nuisances**

It was suggested that in sub-clause (2) the phrase “Director Health Services” be replaced by “the Town Clerk or Town Secretary”. Since these are the Chief Executive Officers of any local authority, they hold and control the resources that can be used by the local authority to deal with the persisting nuisance.

**2.41 Clause 110: Persons making complaint of nuisance**

It was suggested that the requirement that certificates of medical practitioners are to support the complaint be reviewed; the certificate should be issued by the District Health Officer who can be a medical practitioner. However, others argued that at times the medical practitioner might not be there to go and inspect the environment for a nuisance because he has patients to treat. They suggested that authority be given to Environmental Health Technicians to do the inspections and give notices of existence of a nuisance or anyone with a public health degree not necessarily medical practitioner.

**2.42 Clause 112: Prohibitions in respect of back-to-back dwellings and rooms without through ventilation**

The public was of the view that the title of this clause be reworded as follows to cater for cross ventilation:-“Prohibitions in respect of back-to-back dwellings and rooms without adequate ventilation.” It was further explained that through ventilation is achieved where a room has openable windows on opposite walls; while cross ventilation refers to a situation where a room has openable windows only on adjacent walls.

**2.43 Clause 113: Health care waste management**

It was noted that the term “health care waste” is not defined and it was suggested that it be defined as follows in Clause 2 :-“health care waste” includes the paper, plastics and other general waste generated in a health institution as well as bandages, dressings, vials, diseased body tissues and body parts, and other medical waste disposed of in the health institution.”

**2.44 Clause 114: Sanitation Technologies**

It was also noted that Clause 114 introduces the term “Sanitation Technologies”. Unfortunately, this term is not defined in the interpretation clause (Clause 2), neither is it defined in the relevant section. To this end, it was proposed that it be defined as follows:-“Sanitation Technologies include those technologies and equipment that can be employed in the transporting, treatment, handling and disposal of any wastes including solid wastes, liquid wastes and nuclear wastes.”It was further proposed that the definition include electronic waste as part of that definition because we are now living in the world of technologies where we have cellphones, laptops, computers, radios and televisions.

**2.45 PART XIII**

Public Health Funds

The public noted that this may appear a welcome part if one takes a simplistic domestic public health approach but taking a closer look and introspection into Section 117 (2), one will notice that the purpose of the fund is one which is in fact expected to be absorbed by a properly funded and functional health sector through the National Budget. In light of this, the public was of the view that:

a.     There is need to ring fence the public health funds to avoid abuse. The Bill also proposes in Clause 118, the formulation of several health funds to be administered by the Minister to fund certain matters. Any health levy amounts to a tax on the citizenry. The provisions of the Health Bill purports to authorise the Minister to levy taxes on citizens and spend such amount taxed without Parliamentary oversight as required in terms of section 299 of the Constitution.

b.    The Constitution in the Fifth Schedule clearly outlines the procedure with respect to raising money bills. The Bill does not envisage such a process and sets very dangerous precedence with respect to the administration of public finances. This position is difficult to justify. In any event, the Minister of Finance has already constitutionally raised a Health Fund in terms of the Finance Act of 2016, making these provisions unnecessary.

c.     Generally on levies, it should be noted that levies will constitute an increase in the industry’s expenditure base which is unsustainable. These costs have to be passed on to consumers and cause a burden on the already stretched consumers. Levies should not be imposed but rather be taken as component of already existing excise taxation and be channeled into the fund through those means.

d.    Furthermore, price increases are not effective in changing consumer behaviour, but instead trigger an increase in the demand for cheaper alternatives – ultimately “fueling” illicit trade.

**3.0 General Observations by the Public**

3.1 The Bill should include a clause which says that “the health definition in the Public Health Act supersedes all other definitions in all other Acts.”

3.2 Minister has excess power and it was suggested that the Minister should do consultations on critical issues relating to appointments of key positions/boards. Additionally, the Bill should provide general standards and give flexibility for local powers to identify and address specific local health problems. Concentration of decision making and regulatory powers in the hands of the Minister can be counterproductive in so far as responses to specific local health problems are concerned.

3.3 Most sections put the phrase Minister “MAY” instead of “SHALL”, thus leaving everything to the discretion of the Minister which can lead to abuse of authority.

3.4 The Bill is quick to penalise and slow to protect/compensate, hence the need to balance services with resources before talking of penalties.

3.5 No consistence of nomenclature, e.g. in some sections there is District Medical Officer and other sections it is District Health Officer. It should read as District Health Officer to allow other health care professionals to occupy the post.

3.6 The Bill has many typographical errors that need to be attended to.

3.7 Doctors based in public hospitals should not be allowed to have private surgeries as they tend to dedicate most of their time in their surgeries.

3.8 The Bill does not clearly specify the structure of the public health system as well as appointment of health practitioners. Appointments that are stipulated in the Bill are for office bearers only. There is need for a provision of a proper structure which includes offices, duties among other key issues.

3.9 The Bill is silent on operations of local authorities with the Ministry of Health. That lack of clarity causes confusion. For example on licensing of trading premises, for a person to be given a licence, there should be a health report or recommendation from the Ministry of Health. So, a person can just be licenced in the absence of that health report. So the Bill should specify that in such a case, it is a requirement.

3.10 The Bill seems to be silent on public toilets for clients at the shops. Shop owners should construct toilets for the public. It was added that the Bill should state that “no person shall gather for whatever purpose at a place where there are no sanitary facilities.”

3.11 The Bill does not speak to the issue of age of consent for medical treatment, thereby creating confusion on what the age of consent for medical treatment is. General Comment 4 of the Convention on the Rights of the Child (CRC) recommends that, “These minimum ages should be the same for boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity.”

In General Comment 20 and 12, the CRC Committee stresses that, ‘all children who are able to demonstrate sufficient understanding should give voluntary and informed consent for any medical treatment or procedure, whether or not the consent of a parent or guardian is required’. It also stresses that even when a legal age requirement is in place, Member States should ensure that “when a younger child can demonstrate capacity to express an informed view on her or his treatment, this view is given due weight”. Accordingly, it is recommended that the age of consent for medical treatment be lowered to an age between 12-14 years, depending on the maturity of the child and the relevant procedure. Health professionals must use their discretion in this regard. The guiding principle must be the best interests of the child under the circumstances bearing in mind the need to protect the children’s health.

**4.0 Other Additional Issues**

4.1 Minister of Health should not be a preserve of medical doctors only, other health practitioners should be included either as Minister or Deputy Minister.

4.2 User fees in hospitals is too much and unaffordable by an average citizen.

4.3 The Bill should provide for the regulation of imported building materials and ensure that Public Health Practitioners are stationed at border posts.

4.4 Termination of Pregnancy Act should be reviewed.

4.5 There is need to address mental health.

4.6 The Bill should provide for the regulation of establishment of pharmacies in the country to address mushrooming of the same.

4.7 The Bill should regulate on faith healing practice in order to protect the public.

4.8 The Bill is silent on medical research promotion (there is a separate act under another Minister) how about mentioning it under Minister’s duties.

4.9 The Bill must mention the period after which it shall be reviewed.

4.10 Vulnerable Groups must be listed.

4.11 Free Health services for all children below 18 years not restricting to 5 years and below.

4.12 There is need for provision of doctors after hours for emergency cases.

4.14 There is need for government funding on water and sanitation for border towns.

**5.0 Recommendations**

The Committees recommend the following:

4.1 Review of the Urban Councils Act in respect of appointment and firing of Director Health Services.

4.2 Young people who claim to be sexually active should be allowed to access health services.

4.3 Decriminalisation of willful transmission of HIV by repealing section 79 of the Criminal Law Codification Act.

4.4 Review of the Termination of Pregnancy Act

4.5 Advisory Board should be inclusive of all relevant stakeholders.

4.6 Recognition of the Village Health Workers and remunerate them.

4.7 State must take responsibility to pay for emergency treatment.

4.8 Any time there is an emergency of issue of national importance, the Minister must give Ministerial statement within 5 days in Parliament.