Law Commission Report No. 38

LAW COMMISSION

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE PUBLIC HEALTH ACT

July, 2023

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LAW COMMISSION REPORT NO. 38

CONSTITUTION OF MALAŴI

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE PUBLIC HEALTH ACT (Cap. 34:01)

The Report of the Law Commission on the Review of the Public Health Act (Cap. 34:01) is hereby published and shall be laid in Parliament under section 135 (*d*) of the Constitution.

Dated this 11th day of July, 2023.

TITUS EDWARD SONGISO MVALO
Minister of Justice

(FILE NO. LC/01/70)

REPORT OF THE LAW COMMISSION ON THE REVIEW OF THE PUBLIC HEALTH ACT

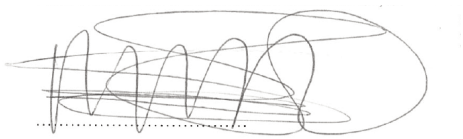
To: Honourable Titus Edward Songiso Mvalo, Minister of Justice

This is the Report on the Review of the Public Health Act (Cap. 34:01) by the special Law Commission appointed under section 133 of the Constitution to review the Public Health Act.

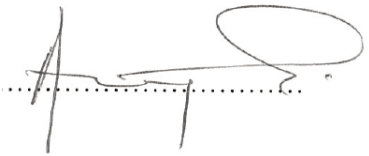
We, members of the Commission, submit this Report pursuant to section 135 (d) of the Constitution and commend the Report and its recommendations to the Government, Parliament and people of Malawi.

MEMBERS

Honourable Justice Dingiswayo Madise, ja — *Chairperson*
Supreme Court of Appeal
Malawi Judiciary



Dr. Ann Phoya — *Deputy Chairperson*
Ministry of Health



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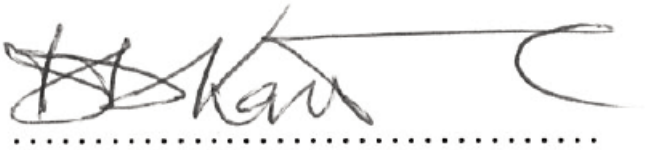

MR. VITTO MULULA — Lilongwe City Council

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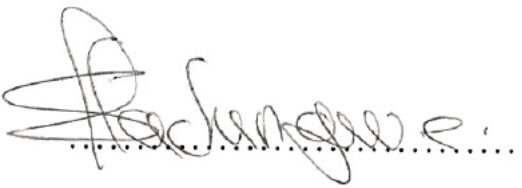
MS. SITINGAWAWO KACHINGWE — Community Health Consultant



Dated: 11th July, 2023

Changes in the Composition of the special Law Commission

In the course of the Programme, Commissioner Mrs. Fiona Kalemba, who was representing the Ministry of Justice on the special Law Commission, resigned following her appointment as Clerk of Parliament at the National Assembly in 2015. She was replaced by Ms. Kahaki Jere from the same Ministry.

In 2018, Mrs. Gertrude Lynn Hiwa, SC, who was Law Commissioner at the commencement of the Programme, completed her second term at the Law Commission. She was replaced by Ms. Rosemary Kumitsonyo Kanyuka.

Hon. Titus Mvalo who was representing the Malaŵi Law Society was appointed Minister of Justice in July, 2020 and resigned from the special Law Commission.

Programme Officers

The programme officers were Mr. Mike Chinoko, LLB (Hons) (MW), LLM (SA), LLM (USA) and PGDip in Legislative Drafting (UG); Mr. Chizaso Eric Nyirongo, LLB (Hons) (MW), LLM (NO) and PGDip in Legislative Drafting (UG); Ms. Rose Nayeja, LLB (Hons) (MW); and Ms. Chigomezgo Kamanga, LLB (Hons) (ZM).

Changes among Programme Officers

Dr. Chikosa M. Silungwe; Mr. Francis Mmame; and Mr. Wongani Mvula, who were the programme officers, left the Law Commission at the end of April, 2012, April, 2013 and October, 2020, respectively. Honourable Justice William Yakuwawa Msiska, was a programme officer until he was appointed a Judge of the High Court in October, 2020. Mrs. Siphiwe Phoya Mchenga was seconded to the Public-Private Partnership Commission in September, 2022; Honourable Justice Eddah Edayi Ngwira was a lead programme officer until she was appointed a Judge of the High Court in October, 2022.

Acknowledgements

The main sponsor of this programme was the Government of Malaŵi through the Ministry of Health. Other sponsors of the programme were the United Nations Children's Fund (UNICEF); the World Bank; the Centre for Disease Control (CDC, USA) through Management Sciences for Health (MSH) and the East, Central and Southern Africa Health Community (ECSA-HC) which funded some aspects of the programme.

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EXECUTIVE SUMMARY

Public health promotes and protects the health of people and communities. Over the years, there have been scientific advancements and new developments in law, policy, technology, the environment, and the economy, that have all affected public health, among many factors. The principal law on public health in Malaŵi, the Public Health Act (Cap 34:01) (the "Act"), was enacted in 1948 and predates the Constitution. This creates implementation challenges as some of the provisions of the Act are inconsistent with the Constitution. The Act has been overtaken by developments at legislative and policy levels, and changes and advancements in public health. A comprehensive review of the Act was thus necessary to modernise the law and ensure that it is consistent with the Constitution and international best practices. Following a submission from the Ministry of Health in 2010, highlighting the deficiencies in the Act, the Law Commission empaneled a special Law Commission (the "Commission") to carry out an extensive review of the Act.

The Commission identified several thematic areas to guide the review process. The areas identified are the scope of public health legislation; regulatory framework and issues; right to health; public health and ethics; control of the use of human tissue; disease prevention and notification; environment and waste; hospitality, public convenience, and public gatherings; substance abuse; enforcement and implementation; and public health emergencies. The Commission conducted thorough desk research, deliberated in plenary, went on comparative study visits, and also held extensive public consultations including focus group engagements on public health matters. The Commission has since completed its task, and based on its findings, it has made policy and legislative recommendations.

The Commission found that neither the Act nor any other law provides clarity on the hierarchy of public health administration and management in Malaŵi. The Commission observed that the Act does not provide for an authority to take the lead in matters of public health-related risks and response. The Commission observed that within the Southern African Development Community (SADC) region and beyond, national public health institutions have appeared to play a critical role in strengthening public health systems and accelerating and achieving implementation of the International Health Regulations (IHR 2005) of the World Health Organization (WHO). The Commission found that there is no independent public health institution in Malawi. The Public Health Institution of Malaŵi (the Institute) exists as part of the Ministry of Health operating at the Community Health Sciences Unit (CHSU), also under the Department of Preventive Health Services. An attempt to establish the Institute has been made administratively and it has no legal basis. The Institute has no legislative mandate to govern its operations. The Commission therefore recommends that the Institute should be established as a standalone public institution for the purposes of leading the implementation of public health legislation; and coordination of all public health-related responses among stakeholders among other functions.

The Commission found that the right to health is not provided for under the Constitution of Malawi and existing legislation. The Constitution only provides for health as one of the principles of national policy under section 13 (*c*), and for access to basic health services under the right to development in section 30. However, certain isolated pieces of legislation have provided for a narrower right of access to health services such as the Gender Equality Act[1], the Child Care, Protection, and Justice Act[2], and the HIV and AIDS (Prevention and Management) Act[3], among others, the Commission found that the general trend in comparative jurisdictions such as South Africa, Kenya and Mozambique was to provide for the right to medical and health care as well as emergency medical treatment. Considering that the right to health is crucial to the realization of other fundamental rights, the Commission resolved that the right to health should be expressly provided for under the legislation.

The Commission found that the health sector in Malawi is inadequately funded and yet Malawi is a signatory to the Abuja Declaration on Health Financing, 2001 which requires States Parties to allocate a minimum of 15% of National Budgets towards health services. This percentage can go up depending on the economic status of a State. The Commission recommends that the Government, as a matter of policy, should consider meeting the minimum 15% allocation in the National Budgets for health services so as to comply with its commitment under the Abuja Declaration.

Further, the Commission considered different methods of financing for health services in comparable jurisdictions. In particular, the Commission noted that in Namibia, 20% of the population contributes to health financing through medical aid schemes and 80% of the population is covered by public health financing. The public health system in Namibia is financed mainly through state resources, however, patients pay minimal fees for the health services. Considering that the health sector of Malawi is inadequately funded, the Commission recommends that all gainfully employed people should have health insurance, and non-employed people should pay a small nominal fee in accessing services in public health facilities. The Commission further recommended that the nominal fee should not be charged on public health services that are of national interest, such as, immunisation, family planning and antenatal services, including any emergency treatment such as treatment for victims of accidents. The Commission recommends that the minimum nominal fee to be charged on access to health services and the services that will not be charged should be prescribed in regulations. Additionally, the Commission recommends the establishment of a general Public Health Fund, to be administered and managed by the Institute.

The Commission noted that there was public concern about certain public places such as banks which sometimes hold clients in queues for a long period and do not provide toilets for their clientele. Further, the Commission was of the

[1] Section 19
[2] Sections 28 to 30
[3] Section 7

general view that there is inadequate provision of sanitation and convenience facilities in public places which is detrimental to public health. As such, the Commission recommends that local authorities should ensure there is the provision of adequate public sanitary convenience in any public place and buildings; cleaning and maintenance of sanitary convenience; and penalties for failure to do so.

The Commission also considered the issue of legislative regulation of food handlers under the law and recommends routine medical examinations of food handlers to prevent diseases. The mandatory medical examination should be done at regular intervals of six months.

The Commission further deliberated on other ethical issues which include consent to medical treatment, euthanasia, privacy and confidentiality, among others, and makes recommendations in accordance with the Constitution.

The Commission also deliberated on substance abuse, including the abuse of medical and legal substances; and it has made several recommendations including banning the smoking of tobacco in public places, and drug control measures.

Lastly, the Commission proposes consequential amendments to the Anatomy Act (Cap 34:03), Liquor Act (Cap 50:07), and the Pharmacy and Medicines Regulatory Authority Act No.9 of 2019.

1.0 INTRODUCTION

1.1 Background

In 2010, the Law Commission received a submission from the Ministry of Health requesting a review of the Act. The request was made against the following background:

(*a*) the law has lost pace with scientific developments regarding medicine and public health issues. For example, even though smallpox was declared as eradicated by the 33rd World Health Assembly in Geneva, Switzerland on 8 May, 1980, the Act still provides for vaccination against smallpox;

(*b*) the Act is old, having come into force on 29 July, 1948. While the fact that a law is old does not necessarily mean that it is a bad law, in the case of the Act, the content of the law has been overtaken by developments at legislative and policy levels and changes and advances in science. The Act also lags behind modern legal standards in regulation of public health;

(*c*) the Act fails in many ways to comply with the Constitution. The Act came into force in 1948, and it predates the Constitution. Some of the provisions of the Act are in conflict with the Constitution. This raises the issue of validity of those provisions and justifies the need for review of the Act in order to ensure that it is consistent with the Constitution;

(*d*) the Act does not clearly provide criteria for the exercise of the powers conferred on various authorities. This jeopardises the implementation and enforcement of public health law and policy. For example, powers of various authorities under the Act are important in testing, examination, immunisation, isolation and quarantining of individuals. The provisions on the exercise of powers under the Act are, in many instances, couched in very broad language. It is not clear whether the power is given to central government or to local government authorities. The lack of clarity compromises the effective implementation and enforcement of public health law and policy; and

(*e*) specific provisions on infectious diseases,[4] Sexually Transmitted Infections (STIs)[5] and disease–specific provisions[6] are broad and often overlapping. Further, the Act does not adequately provide for, among others, the imposition of minimum standards for solid and liquid waste management, including human excreta; hazardous and health care waste management; minimum legal standards for the operation of funeral parlours, shops, supermarkets, market places and businesses that supply or prepare food; and issues of food hygiene.

[4] From Parts 3 through 7.
[5] Part 8.
[6] Part 7.

In light of the foregoing, the Commission noted the need to review the Act and develop legislation that provides for mechanisms for implementation which ensure that the powers provided by legislation can actually be exercised.

1.2 Terms of Reference

The Commission adopted the following Terms of Reference to guide its work:

(*a*) to review the Public Health Act to be in line with the Constitution, applicable international law, comparable foreign law and international best practices;

(*b*) to review other existing legislation on health;

(*c*) to consult with stakeholders to elicit their views on the findings and recommendations of the Commission;

(*d*) to make recommendations on the law and policy on matters of health that will:

(i) put into effect the principles of policy on health, the Malaŵi Growth and Development Strategy including the Malaŵi 2063 Agenda;

(ii) articulate a health system based on principles of human rights, equity, equality, gender sensitivity, ethical considerations, efficiency, accountability, sustainable financing, community participation, evidence-based decision making, partnership and multi-sectoral collaboration; and

(iii) reflect corporate governance principles in the management of health services, in line with decentralization policies;

(*e*) to recommend any other matters relating to health; and

(*f*) to produce a report containing findings and recommendations accompanied by, if necessary, draft legislation based on such recommendations, to be submitted to the Minister of Justice, for consideration by Cabinet.

1.3 Work Methodology

The Law Commission adopted the following methodology in reviewing the Act:

(*a*) invited submissions from members of the general public;

(*b*) developed an Issues Paper and a Discussion Paper;

(*c*) conducted meetings of the Commission in plenary during which the Commission considered the Act and other relevant laws and policies according to thematic areas that were identified. In addition, the Commission examined several comparable statutes from various jurisdictions;

(*d*) undertook comparative study visits to Zambia, Namibia and Mozambique where Commissioners and programme officers had an opportunity to observe and experience first-hand public health service delivery at work;

(*e*) conducted focus group discussions in the districts of Karonga, Mzimba, Kasungu, Salima, Ntchisi, Mwanza and Blantyre;

(*f*) the Commission held targeted consultative meetings with various individuals and organizations;

(*g*) the Commission conducted three regional workshops to consult stakeholders on its findings and tentative recommendations;

(*h*) the Commission conducted a national consultative workshop to present its findings and recommendations and received feedback on the same; and

(*i*) the Commission produced this Report.

1.4 Structure of the Report

The first part of the Report is a narrative which contains the specific findings and recommendations made by the Commission. The recommendations for enactment made by the Commission are indicated in bold.

The second part of the Report contains proposed legislation which incorporates the recommendations of the Commission.

1.5 Overview of key legislation on public health

1.5.1 Public Health Act

The Act is the main statute which regulates public health matters in Malaŵi. It is divided into sixteen parts.

The Act commences with preliminary matters and Part I deals with interpretation of terms.

Part II deals mainly with matters of administration of the Act. The Minister has powers to direct inquiries in relation to any matters concerning public health in any place.[7] The Act further provides for general duties to local government authorities in handling issues of public health;[8] and how the Minister can proceed when hearing public health complaints against a local government authority.[9]

Part IIA provides for management of assisted hospitals and introduces the institutional arrangement of Boards of Governors in the management of assisted hospitals. The Minister has the power to establish a Board of Governors for such hospitals.

[7] Section 6.
[8] Section 7.
[9] Section 8.

Part III deals with notification of infectious diseases. It provides a list of infectious diseases which are notifiable.[10] In addition, the Part lays down in detail the duties of heads of dwellings like family houses,[11] schools[12] and medical practitioners,[13] with regard to the notification of a case of infectious disease which comes to their notice. The Part makes it an offence to fail to give notice or certificate of the occurrence of the infectious disease.[14] Further, the Part gives power to the Minister to make regulations for the notification of infectious diseases.[15]

Part IV deals with the prevention and suppression of infectious diseases. Medical officers have powers to enter and inspect premises where there is reasonable suspicion to believe that the premises have a person who is suffering or has recently suffered from an infectious disease.[16] Where the medical officer has certified that premises or a place are harbouring infectious diseases, and that the cleansing, disinfection or destruction of the premises would retain infection, a local government authority shall give notice to the occupier of the premises of the measures that the authority intends to implement.[17]

Further, the local government authority shall not compensate a person whose premises have been destroyed for the reason of preventing an infectious disease,[18] but shall provide means of disinfection[19] and conveyances for the carriage of persons suffering.[20] The local government authority has power to remove to a hospital or any place, a person suffering from an infectious disease where the person is a serious risk. These procedures shall be done at the expense of the local government authority.[21] It is an offence under this Part to expose persons or articles liable to convey infectious disease.[22] The Part, further, provides for penalties for failure to disinfect a vehicle which carried a patient[23] and letting infected houses.[24]

The Part places a duty on a person letting a house to give true information that the house had within six weeks previously, accommodated a person suffering from an infectious disease; failure of which one would be liable to a fine.[25] Occupiers of buildings are required to report to a local government authority of every death from an infectious disease.[26] It is an offence where an occupier keeps

[10] Section 11.
[11] Section 13 (1) (*a*).
[12] Section 13 (1) (*b*).
[13] Section 13 (1) (*c*), (*d*) and (*e*).
[14] Section 13 (2).
[15] Section 14.
[16] Section 16.
[17] Section 17.
[18] Section 19.
[19] Section 19.
[20] Section 20.
[21] Section 21.
[22] Section 22
[23] Section 23.
[24] Section 24.
[25] Section 25.
[26] Section 26 (1).

a dead body of a person who has died of an infectious disease in a room where food is kept, eaten or prepared; or keeps the body for more than twenty–four hours in a room other than a mortuary.[27]

Further, it is an offence to remove a dead body of a person who has died of an infectious disease to any place other than a mortuary or for purposes of immediate burial.[28] Local government authorities have a duty to remove and bury: (*a*) dead bodies of destitute persons; and (*b*) unclaimed dead bodies.[29] In addition, the Minister may make rules applicable to all infectious diseases as specified.[30]

Part V deals with certain formidable epidemic or endemic diseases, mainly smallpox, plague, cholera, yellow fever, cerebro-spinal meningitis, typhus, sleeping sickness or human trypanosomiasis and any other disease declared by the Minister.[31] Further, the Part gives power to the Minister to declare an infected area as such and make rules for prevention of the disease.[32] Local government authorities have powers to ensure the execution of all rules made.[33]

Part VI contains provisions relating to prevention of the introduction of infectious diseases by persons coming into Malaŵi. The Minister has power to enforce precautions at the borders of Malaŵi through regulating, restricting or prohibiting the entry into Malaŵi of people, animals, articles or things from a specified country.[34] Further, Part VI provides for powers of removal of infected persons arriving in Malaŵi by railway train or other vehicle;[35] and that infected persons are placed in isolation or under surveillance.[36] The Part empowers medical officers of health to board trains and other vehicles entering the territory to inspect passengers with a view to identifying cases of infectious disease, and if such cases are found, to take necessary steps.

Part VII deals with smallpox disease and vaccination against the disease, and it is a requirement for. It is a requirement under this Part for a child born in Malaŵi to be vaccinated after six months and within twelve months from birth.[37] However, if the child is not fit to be vaccinated, a certificate has to be provided.[38]

Part VIII deals with venereal diseases and gives power to the Minister to declare any other disease for the purposes of the Part.[39] A person with knowledge

[27] Section 26 (2).
[28] Section 26 (3).
[29] Section 28.
[30] Section 29.
[31] Section 30.
[32] Section 31.
[33] Sections 32 and 33.
[34] Section 38 (1).
[35] Section 39.
[36] Section 40.
[37] Section 43.
[38] Section 45 provides that persons who are not fit to be vaccinated have to be certified as such by a public vaccinator. The certificate shall be in force for six months only, but renewable for successive periods of six months until the public vaccinator shall deem the person fit for vaccination.
[39]

that he or she is suffering from a venereal disease commits an offence if he or she continues working in any capacity entailing the care of children or the handling of food intended for consumption or of food utensils.[40] Further, it is an offence to publish, exhibit or circulate an advertisement or a statement intended to promote the sale of any medicine, appliance or article for the alleviation or cure of a venereal disease or disease affecting the generative organs or functions, or of sexual impotence or of any complaint or infirmity arising from or relating to sexual intercourse.[41] This, however, excludes publications by or under the authority of the Secretary for Health, or by a local government authority, public hospital, public body, person or society in the discharge of its lawful duty for the advancement of medical science. It is an offence where a person wilfully or by culpable negligence infects another person with a venereal disease.[42]

Part IX provides for issues relating to sanitation and housing. It prohibits nuisance[43] and provides for duties of local government authorities to maintain cleanliness and prevent nuisances.[44] Local government authorities, further, have a duty to prevent or remedy danger to health arising from unsuitable dwellings by taking all lawful, necessary and reasonable practicable measures.[45] Thus, local government authorities can take persons who do not obey orders to court;[46] put on sale by public auction any matter or thing removed in abating a nuisance;[47] and demolish unfit buildings.[48] Further, the Minister has power to make rules regarding inspection of land, construction of buildings, keeping of animals and control of houses let in lodging.[49]

Part X provides that a local government authority may within its district and, subject to the prior approval of the Minister, outside the district, construct and maintain a public sewer and construct sewage disposal works.[50] Every owner and occupier of a premises or private sewer has a right to have his or her drains or private sewer connected to the public sewers,[51] so long as he or she has given notice to the local government authority.[52]

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40 Section 54 (1). It is also an offence if an employer continues employing a person suffering from a venereal disease in a communicable form, if the person is required or permitted to care for children or to handle food intended for consumption or food or household utensils, unless the employer proves that he did not know or suspect, and did not have reasonable means of knowing or suspecting that the person was suffering from the venereal disease (section 54 (2)).
41 Section 55 (1).
42 Section 57.
43 Section 59. Section 62 exhaustively provides for what constitutes a nuisance.
44 Section 60.
45 Section 61.
46 Section 66.
47 Section 69.
48 Section 71.
49 Section 75. See also section 76 for provision of standards regarding construction of buildings.
50 Section 79.
51 Section 83.
52 Section 86.

New buildings are required to make satisfactory provision for drainages[53] and latrines.[54] Local government authorities are required to ensure that plans for new buildings make satisfactory provision for drainages and latrines, if the facilities are not available.[55]

Part XI deals with preventive measures to reduce or eliminate mosquitoes, the causative agent of malaria. The Part declares breeding places of mosquitoes as nuisances.[56] In addition, the Part provides that all yards should be kept free from any item which may retain water and can breed mosquitoes, thus it is an offence to keep such items.[57] The Act requires households to ensure that overgrown bush and long grass is cleared;[58] and that wells are covered.[59] Further, the Act requires that cesspits should be screened to the satisfaction of a medical officer,[60] that mosquito larvae should be destroyed,[61] and provides that the mere presence of larvae on the premises of a person is an offence.[62]

Part XII provides that all buildings meant for the storage of foodstuffs for purposes of trade should be constructed in a manner that the foodstuffs are protected against rats, vermin and pollution.[63] Further, the Part makes it an offence where a person sleeps in a kitchen or room in which foodstuffs for sale are prepared or stored.[64]

Local government authorities have a duty, under this Part, to take all lawful, necessary and reasonably practicable measures for preventing any pollution dangerous to health of any supply of water which the public within its district has a right to use and does use for drinking or domestic purposes.[65] Further, the Act prohibits sale of food in tainted, adulterated, diseased or unwholesome state[66] and it provides that a health worker, local government authority or a person duly authorised may seize such food.[67] It is an offence to put on sale such unwholesome food.[68] Further, the Minister has power to make rules regarding inspection of dairy stock of animals intended for human consumption; taking and examination of milk, dairy produce, meat and the removal of animals suspected of being diseased or unwholesome for human consumption; and veterinary inspection of dairy stock, among others.[69]

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[53] Section 87.
[54] Section 88.
[55] Section 89.
[56] Section 96.
[57] Section 97.
[58] Section 98.
[59] Section 99.
[60] Section 100.
[61] Section 101.
[62] Section 102.
[63] Section 103.
[64] Section 104.
[65] Section 105.
[66] Section 106.
[67] Section 108.
[68] Section 109.
[69] Section 109.

Finally, the Minister has power to specify by order, standards of quality, composition and condition, and minimum standards, in respect of any foodstuffs, goods or other articles.[70]

Part XIV deals with cemeteries. The Minister has power to select, allocate, appoint and notify in the *Gazette*, sufficient and proper places to be used for burial of dead human bodies. The power applies to the designation of cemeteries both in urban and rural areas. It is mandatory, where such cemeteries or crematoria exist, to bury or cremate the dead in the cemeteries.[71]

Part XV deals with general provisions. The Part provides that it is illegal for a person to occupy a basement without permission.[72] The Act requires that lodging houses should be regulated and inspected;[73] as well as private hospitals, nursing homes and maternity homes.[74] The Minister has general powers for the inspection, sampling, examination of vaccines, vaccine lymphs, sera and similar substances imported into or manufactured in Malaŵi and intended to be used for the prevention or treatment of human diseases.[75]

Part XVI provides for miscellaneous provisions. These are provisions on court notices, summons and provisions regarding the legal capacity and general operational powers; It also provides for appeals against notices and the enforcement of notices requiring execution of works[76]; expenses recoverable from owners of premises as a charge on the premises[77]; Further, the Part provides for liability of the secretary or manager of a company; proceedings against several persons; prosecution of offences[78]; the exercise of power of a local government authority outside its district;[79] and the power of the Minister to make Rules for purposes of the Act.[80]

1.5.2 Other Related Legislation to Public Health

There are other pieces of legislation which provide for matters relating to public health. Although not exhaustive, the following are some of the pieces of legislation:

(a) *Anatomy Act (Cap. 34:03)*

The Anatomy Act[81] is an Act to make provision for the donation and use of bodies, or parts of bodies, of deceased persons for educational, scientific, research, therapeutic or diagnostic purposes.

70 Section 110.
71 Section 113 (1).
72 Section 120.
73 Section 121.
74 Section 122.
75 Section 126 (1).
76 Section 132
77 Section 134
78 Sections 139-141
79 Section 142.
80 Section 143.
81 It came into force on 1 April, 1991 repealing the Human Tissue Act.

(*b*) *Control and Diseases of Animals Act* (*Cap. 66:02*)

The Control and Diseases of Animals Act makes provision for the control of diseases of domestic animals. The Control and Diseases of Animals Act provides that all diseased animals should be separated and notification of the disease should be brought to the nearest inspector or police officer. Further, the Minister has power to make rules regarding the prevention and control of diseases of animals. Under Part XIII of the Act, the Minister has power to make rules regarding, among other things, the removal of animals suspected of being diseased or unwholesome for the purpose of human consumption. Similarly, under Part IX of the Act, the Minister has power to make rules regarding the keeping of animals.

(*c*) *Environment Management Act* (*Cap. 60:02*)

The Environment Management Act provides for the protection and management of the environment and the conservation and sustainable utilization of natural resources and other related matters.[82] It criminalises some of the acts which amount to public health hazards such as improper management of hazardous materials[83] and emission of pollutants into the environment.[84]

(*d*) *Liquor Act* (*Cap. 50:07*)

The Liquor Act provides for the law relating to the manufacture and sale of intoxicating liquor. Section 71 of the Liquor Act stipulates that only a holder of a manufacturer's licence can manufacture, for purposes of sale, any liquor, whether by brewing, distilling, fermenting or any other such process. Likewise, section 74 prohibits supply of liquor to young persons by any licensee under the sales licence. Similarly, section 75 prohibits employment of young persons to sell liquor. A young person is defined as any person who is, or who appears to be under the age of eighteen years.[85]

(*e*) *Local Government Act* (*Cap. 22:01*)

The Local Government Act provides for the law relating to local government and gives effect to decentralisation and devolution of certain powers, functions and services from central government to local government through the establishment of local authorities. Under section 103, a Council may make by-laws for the good rule and government of the whole or any part of the local government area or, as the case may be, for the prevention and suppression of nuisances in the local government area and for any other purpose. The Second Schedule to the Act provides for additional functions of the Councils established under the Local Government Act, most of which relate to public health.

82 See the long title to the Environment Management Act.
83 Section 66 (a) of the Environment Management Act.
84 Section 67 of the Environment Management Act.
85 Section 2 of the Liquor Act

(*f*) *Malawi Bureau of Standards Act* (*Cap. 51:02*)

The Malawi Bureau of Standards Act provides for standards to be followed by producers and standards of goods imported into Malawi. It establishes the Malawi Bureau of Standards which has the mandate to check that products are suitable for consumption and use.[86] On the issue of standards, Part XIII of the Act provides that the Minister may specify, by order, standards of quality, composition and condition, and minimum standards in respect of foodstuffs, goods or other articles.

(*g*) *Meat and Meat Products Act* (*Cap. 67:02*)

The Meat and Meat Products Act provides for the improvement and control of the production, processing, manufacturing, grading, sale, marketing and distribution of meat and meat products. It lists down diseases which, if found, will lead to:

(i) a rejection of specified parts of the carcass; and

(ii) a rejection of the entire carcass.

The rejection will be where the carcass is being offered for human consumption.

(*h*) *Medical Practitioners and Dentists Act* (*Cap. 36:01*)

The Medical Practitioners and Dentists Act provides for the establishment of the Medical Council of Malawi, the registration and disciplining of medical practitioners and dentists, the licensing of private practice of medical practitioners and dentists, the regulation of training within Malawi of medical personnel and generally for the control and regulation of the medical profession and dental practice.

(*i*) *Milk and Milk Products Act* (*Cap. 67:05*)

The Milk and Milk Products Act provides for the improvement and control of the production, processing and marketing of milk and milk products. It contains regulations which require among, others, that:

(i) dairy premises should at all times be in a clean and sanitary condition;

(ii) milk for human consumption which is on a dairy plant premises should be kept in a fluid state separate from all other milk and cream;

(iii) dairy plant equipment should at all times be thoroughly cleaned after use with hot water or suitable detergents;

(iv) premises for distribution of milk should at all times be kept in a clean and sanitary condition; and

[86] Section 4 provides for the objects of the Malawi Bureau of Standards.

(v) milk, cream and other dairy products should not be stored in a place where they may be exposed to a condition that may compromise their quality.

(*j*) *Noxious Weeds Act* (*Cap. 64:02*)

The Noxious Weeds Act provides for the eradication of noxious weeds. It defines a noxious weed as a plant which the Minister may by notice declare to be a noxious weed either throughout Malaŵi or in one or more districts or a portion of the district. Further, the Noxious Weeds Act provides for a duty to clear noxious weeds and prohibits throwing noxious weeds or its seed into a river or stream.

(*k*) *Nurses and Midwives Act* (*Cap. 36:02*)

The Nurses and Midwives Act provides for the establishment of the Nurses and Midwives Council of Malaŵi, the registration and disciplining of nurses, midwives and nursing midwifery technicians, the licensing of private practice, the regulation of education and training of nurses, midwives and nursing midwifery technicians and generally for the control and regulation of the nursing midwifery profession and practice.

(*l*) *Occupational Safety, Health and Welfare Act* (*Cap. 55:07*)

The Occupational Safety, Health and Welfare Act provides for the regulation of conditions in workplaces as regards the safety, health and welfare of persons employed in the workplaces.[87] It also provides for the inspection of plant and machinery, and the prevention and regulation of accidents occurring to persons employed or authorised to go into the workplaces.[88] The Act further requires an occupier of a workplace to report to the Director of Occupational Health, Safety and Welfare the occurrence of an industrial disease, or suspected case of an industrial disease, in the workplace. [89]

(*m*) P*harmacy and Medicines Regulatory Authority Act* (*No. 9 of 2019*)[90]

The Act among others, provides for the establishment of # the Pharmacy and Medicines Regulatory Authority, its powers and functions, and further provides for the registration and regulation of pharmacy practice premises; regulation and registration of medicines and allied substances; and regulation of clinical trials.

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87 See the long title to the Occupational Safety, Health and Welfare Act.
88 As above.
89 Section 68.
90 The Act repealed the Pharmacy, Medicines and Poisons Act (Cap. 35:01). The Pharmacy, Medicines and Poisons Act provided for the establishment of the Pharmacy, Medicines and Poisons Board, the registration and disciplining of pharmacists, pharmacy technologists and pharmacy assistants, the training within Malaŵi of pharmacists, pharmacy technologists and pharmacy assistants, the licensing of traders in medicines and poisons and generally for the control and regulation of the profession of pharmacy.

(*n*) *Physical Planning Act* (*No. 17 of 2016*)

The Physical Planning Act generally provides for physical planning and the orderly and progressive development of land in both urban and rural areas. It also provides for the grant of permission to develop land and other powers of control over the use of land. A local government authority is responsible for the preparation of a district physical development plan. Similarly, Part IX of the Act provides for the duty on local government authorities to prevent or remedy danger to public health arising from unsuitable accommodation, among others. Further, the Act provides that the Minister has power to make rules regarding the inspection of land, the construction of buildings, to control the letting of houses and the sanitary control of markets and market buildings, among others.

(*o*) *Prisons Act* (*Cap. 9:02*)

The Prisons Act provides for the establishment of prisons within Malaŵi, and for the management and control of prisons and prisoners. Regarding matters of public health, the Prisons Act provides for cleanliness of prisons; notification of illness; sick prisoners including their isolation where recommended by a medical officer; disposal of a dead body in the interest of public health; medical inspection of prisons, sanitation and cooking facilities; and vaccination.

(*p*) *Waterworks Act* (*Cap. 72:01*)

The Waterworks Act provides for, among others, the operation of water-borne sewerage sanitation.[91] The Waterworks Act provides that Water Boards have the overall responsibility to provide water. In contrast to the Waterworks Act, the Act places this duty on local government authorities. Part III of the Act provides that local government authorities should take all lawful, necessary and reasonably practicable measures for preventing pollution dangerous to the health of a supply of water which the public within its district has a right to use and does use for drinking or domestic purposes.[92]

(*q*) *Workers' Compensation Act* (*Cap. 55:03*)

The Workers' Compensation Act provides, among others, for compensation for injuries suffered or diseases contracted by workers in the course of their employment or for death resulting from the injuries or diseases.[93]

1.6 The National Policy Framework for Public Health

The Ministry of Health has over the years developed various policy instruments to address matters of public health. The following are some of the policies:

[91] See Part V of the Waterworks Act.
[92] Section 105 of the Public Health Act.
[93] See the long title to the Workers' Compensation Act.

(*a*) *Health Information System: National Policy and Strategy, 2003*

The Policy was developed with the aim of documenting the integral part and importance of health information in the national health system.

(*b*) *Infection Prevention and Control Policy, 2004*

The Policy outlines the broad principles of infection prevention and control for healthcare facilities. It was developed in accordance with international evidence-based information to protect patients, staff and the general public from infections acquired from a healthcare facility.

(*c*) *National Care of the Carer HIV and AIDS Workplace Policy, 2005*

The Policy was developed with the aim of preventing the transmission of HIV and other infectious diseases in the healthcare setting; providing support for healthcare workers caring for AIDS patients; providing care and support for health workers infected with HIV; and assisting informal health workers to prevent contracting HIV during home or hospital care of relatives suffering from AIDS related illnesses and delivery of HIV infected pregnant women in the home.

(*d*) *National Sexual and Reproductive Health Rights (NSRHR) Policy, 2009*

The Policy was developed with the aim of providing a framework for the provision of accessible, acceptable and affordable comprehensive sexual and reproductive health services to women, men, and young people in Malaŵi through informed choice to enable them to attain their reproductive rights and goals safely.

(*e*) *Quality Management Policy for the Health Sector, 2017*

The Quality Management Policy for the Health Sector[94] replaced the National Quality Assurance Policy, 2005. The purpose of this Policy is to provide a framework for integrating and coordinating quality assurance and quality improvement initiatives across departments and partners in the health sector.[95] This integration and coordination is expected to contribute to addressing the gaps in quality of care, thereby contributing towards achieving Universal Health Coverage (UHC).[96] The Quality Management Directorate acts as a secretariat to facilitate the coordination of implementation of the Policy.[97]

Further, this Policy is intended to guide all stakeholders in the health sector, including the Ministry of Health Headquarters, the Christian Health Association of Malaŵi (CHAM), central hospitals, district hospitals, and

94 Government of Malaŵi, Ministry of Health and Population, Quality Management Policy for the Health Sector (December, 2017).
95 Government of Malaŵi, Ministry of Health and Population, Quality Management Policy for the Health Sector (n 84) 5.
96 As above.
97 As above·

local public and private clinics.[98] Finally, with the advent of the decentralization of oversight powers from the Ministry of Health to local government authorities, this Policy outlines the shared strategies to be undertaken by the Ministry of Health and local government authorities to ensure provision of quality healthcare to all people living in Malaŵi.[99]

(*f*) *Health Sector Strategic Plan II, 2017- 2022*

The Health Sector Strategic Plan II (2017-2022) (HSSP II) provides the framework to guide efforts of the Ministry of Health and all stakeholders for a period of five years in contributing to the attainment of the highest possible level of health and quality of life and incorporation of the agenda of Sustainable Development Goals (SDG).[100] The approach taken by HSSP II was to use latest evidence and methods to revise the Essential Health Package (EHP) that is more realistic than its predecessor packages and help the public health sector to achieve higher total population health, increase financial risk protection and client satisfaction with health care.[101] Briefly, HSSP II covers situation analysis; introduction; vision, mission, goal, Sustainable Development Goals, national policy context, objectives and guiding principles; Basic Health Package (BHP) and Essential Health Package Plus (EHP+); strategies ; financing; and monitoring and evaluation.

1.7 The International Health Regulations

The International Health Regulations (the "IHR") are an international legal instrument adopted by the 58th World Health Assembly on 23 May, 2005 and entered into force on 15 June, 2007. The IHR are binding on 194 countries, including all member states of the World Health Organization (WHO). The aim of the IHR is disease prevention with an international cross-border public health risk while, at the same time, avoiding unnecessary interference with international trade and travel. The IHR incorporate a number of innovations—

(*a*) the scope of the Regulations is not limited to a specific disease or manner of transmission;

(*b*)States parties are obliged to develop minimum core public health capacity;

(*c*)States parties are obliged to inform the WHO of events that may constitute a public health emergency of international concern as defined under the IHR;

98 As above.

99 As above.

100 Government of the Republic of Malaŵi, Health Sector Strategic Plan II, p. 7. Available at http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/Malaŵi/health_sector_strategic_plan_ii_030417_smt_dps.pdf Accessed on 14 January, 2020.

101 As above.

(*d*) WHO can take into account unofficial reports of public health risks and verify the reports with a State party concerned;

(*e*) the IHR provide the procedure for the determination of a 'public health emergency of international concern' by the Director General of WHO;

(*f*) protection of the human rights of persons and travellers; and

(g) the establishment of focal points for urgent communication between WHO and States parties.

SPECIFIC FINDINGS AND RECOMMENDATIONS

2.0 PRELIMINARY AND INSTITUTIONAL MATTERS

2.1 Scope and Parameters of Public Health Legislation

The Commission noted that the discussion on the parameters of health and public health ought to be limited to law and policy. The Commission observed that despite the three programmatic interventions namely health population programmes, medicine-based health interventions, and public health-based programmes, public health law and policy is a sub-set of health law and policy generally. The delineation of the parameters of health and public health to law and policy is important for pragmatic reasons. Beyond the socio-economic, political and even cultural incentives of a healthy population, WHO defines 'health' as:

> *"the state of physical, mental and social well-being and not merely the absence of disease or infirmity".*[102]

This understanding of 'health' is broad, all-encompassing and dependent on the fullest co-operation of individuals and States.[103]

Even where the parameters are limited to law and policy, health law and policy covers issues of medicine, child health, women's health, men's health, health and safety in workplaces, abortion, mental health and public health issues, to mention a few. The general understanding of health law and policy is that it focuses on the relationships that exist generally, among providers in healthcare industry and its patients; and the delivery of healthcare services. In response to the question as to why a State should legislate for health, WHO points out that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures." [104]

In its specific consideration of public health law and policy, the Commission noted that public health is understood to mean:

"the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of the State and society".[105]

Public health, as an academic field, is highly varied and encompasses many academic disciplines. Some of these disciplines are:

(*a*) behavioural sciences;

(*b*) health education;

(*c*) biostatistics;

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[102] Constitution of the WHO, Basic Documents, Official Document No. 240 (Washington, 1991). The Constitution of WHO was adopted at the International Health Conference held in 1946 in New York, where it was signed by the representatives of sixty-one States (the "WHO Constitution").

[103] As above.

[104] World Health Organization, "Constitution". Available at https://www.who.int/about/who-we-are/constitution Accessed on 31 August 2020.

[105] Merriam Webster Dictionary, "public health" Available at http://www.merriam-webster.com/dictionary/public%20health Accessed on 6 May, 2011.

(*d*) emergency medical services;

(*e*) environmental health;

(*f*) epidemiology;

(*g*) global health law and policy;

(*h*) maternal and child health;

(*i*) nutrition;

(*j*) public health laboratory practice;

(*k*) public health policy and public health practice.[106]

Further, public health as a social and political concept aims at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.[107]

Public health mainly focuses on these core areas: promoting health; prevention of diseases; prolonging life, and organized community efforts against diseases.[108] These areas in the end seek to address:

(*a*) the sanitation of the environment;

(*b*) the control of communicable infections;

(*c*) the education of the individual in personal hygiene;

(*d*) the organization of medical, nursing and midwifery services for the early diagnosis and preventive treatment of disease; and

(*e*) the development of the social machinery to ensure every person a standard of living adequate for the maintenance of health.[109]

The key functions of public health agencies are assessing community health needs and marshalling the resources for responding to them, developing health policy in response to specific community and national health needs, and ensuring that conditions contributing to good health, including high quality medical services, safe water supplies, good nutrition, an unpolluted atmosphere and environment that offer opportunities for exercise and recreation are available to individuals.[110]

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106 As above.

107 Health Promotion Glossary, WHO/HPR/HEP/98.1. WHO, Geneva, 1998. Available at http://www.who.ch/hep Accessed on 6 May, 2011.

108 Linda Marks, David J. Hunter and Richard Alderslade, 'Strengthening Public Health Capacity and Services in Europe: A Concept Paper' (Durham University and WHO Europe, 2011) pp. 9. Available at http://www.euro.who.int/__data/assets/pdf_file/0007/152683/e95877.pdf Accessed on 18 September, 2017.

109 Nuffield Council on Bioethics, 'Public Health: Ethical Issues' (Cambridge Publishers, 2007).

110 As above.

Public health law provides the framework within which the State, civil society, communities and individuals operate in order to achieve a healthy community. The framework outlines the powers and duties of the State and its partners such as health care providers. These powers and duties are, however, subject to the rights of the individuals in the community.[111] There is, therefore, a constant balancing of the demands of the community on the one hand and those of the individual in health promotion and disease prevention on the other hand.

The prime objective of public health law and policy is to pursue the highest possible level of physical and mental health in the community. Public health law can be said to be ambulatory since it follows the emergence of diseases and scientific breakthroughs as they emerge. Gostin defines public health law and highlights several themes that emerge from the definition as follows:

(*a*) State power and duty;

(*b*) coercion and limits on State power;

(*c*) partners of the State in the "public health system";

(*d*) the focus on the community;

(*e*) health promotion; and

(*f*) the role of the State, civil society and the community in disease prevention.[112]

Public health law and policy, therefore, has the following characteristics:

(*a*) state responsibility: public health programmes are the primary responsibility of the State. Both central government and local government have a critical role in the enforcement and implementation of public health programmes;

(*b*) community: public health focuses on the community as opposed to the individual;

(*c*) services: public health deals with the provision of public health services and not personal medical services. It focuses more on community-wide assistance programmes like epidemiological investigations, surveillance activities such as reporting and partner notification services, and health inspections of food servers, lodging providers, etc. Thus, public health deals much with services geared toward the community good and not necessarily improvements in individual health; and

111 Gostin, L.O., 'A Theory and Definition of Public Health Law' Available at http://www.ucpress.edu/blog/178/a-theory-and-definition-of-public-health-law/ Accessed on 6 May, 2011.

112 Gostin, L.O., 'A Theory and Definition of Public Health Law' Available at http://www.ucpress.edu/blog/178/a-theory-and-definition-of-public-health-law/ Accessed on 6 May, 2011.

(*d*) coercion: public health possesses the power to coerce the individual for the protection of the community, and thus does not rely on the near individual ethic of voluntarism, for instance, when it comes to issues of vaccination and quarantine.

Health law and policy, and more specifically, public health law and policy involves the State, civil society, law and policy in order to achieve a common good, which in this case, is the attainment of a healthy population through health promotion and disease prevention. The quest for the common good is also balanced with the respect for autonomy, privacy and the liberty of the individual.

Consequently, the Commission considered whether the legislation to be developed should provide for public health-related risks or not; and the public health issues to be considered. The Commission noted that the Act does not adequately deal with responses to public health-related risks, for instance, climate change, which have direct impact on the health of the population.

The Commission was of the view that issues of climate change are part of public health and the legislation to be developed should take the issues into account. As regards the scope of public health, the Commission resolved that the legislation to be developed should provide for public health-related risks by outlining procedures to be followed in handling the risks when they occur, for example rapid urbanisation; emergency preparedness; and emerging diseases, for instance Ebola, H1N1 and COVID-19.

In view of the scope and parameters of public health considered, the Commission identified, discussed and agreed to come up with of thematic areas to guide the review process. Among others, the following were considered:

(*a*) Regulatory Framework and Issues;

(*b*) Right to Health;

(*c*) Public Health and Ethics;

(*d*) Control of Use of "Human Tissue";

(*e*) Disease Prevention and Notification;

(*f*) Environment and Waste;

(*g*) Drug and Substance Abuse;

(*h*) Enforcement and Implementation; and

(*i*) Public Health Emergency.

2.2 Institutional Framework and Regulation of Health Care Services

Health care services in Malaŵi are regulated by the Ministry responsible for health at three levels as follows:

(*a*) the tertiary level (referral, central or teaching hospitals);

(*b*) the secondary level (district hospitals, community hospitals and private hospitals); and

(*c*) the primary level (health centres, clinics or dispensaries).

There is no provision under the Act or any law for the hierarchy of public health administration and management in Malaŵi. The Act, for example, makes reference to a 'medical officer of health' who has been defined as Secretary for Health and has powers over some of the (public) health issues. The Ministry of Health has a Principal Secretary appointed under section 93 (2) of the Constitution.[113] There is neither a further statutory structure beyond the Constitution nor a cross reference to the Act. All other health officers are appointed subject to the provisions of the Public Service Act (Cap. 1:03); Medical Practitioners and Dentists Act (Cap. 36:01); Nurses and Midwives Act (Cap. 36:02); and Pharmacy and Medicines Regulatory Authority Act (No. 9 of 2019).[114]

Further, the Act has subsidiary legislation promulgated in 1973 on hospital advisory committees made by the Minister under section 143 of the Act. Initially, there were Hospital Advisory Committee Rules for Queen Elizabeth Central, Zomba General, Lilongwe General, Dowa, Kasungu, Rumphi, Salima and Chitipa District Hospitals. Under the said Advisory Committee Rules, there is provision for the office of Medical Superintendent of Health for each district. This office is equivalent to the position of Hospital Director. The law is not clear as to what ought to be done to hospitals that do not have advisory committees. However, the Commission noted that, in practice, all hospitals have advisory committees as a result of administrative policy.

Beyond the Hospital Advisory Committee Rules, the Act creates a complex public health regulatory system. The Act vests powers in the Ministers responsible for health, local government and land matters, respectively, depending on the issue at hand. It is not clear from the Act which authority takes the lead in cases of public health–related risks and the responses that ought to be in place to stem such risks although it may be presumed that since such a trio of Ministers are referred to under this Act, the Minister of Health shall take the lead.

The Act, for example, provides that local government authorities have a duty to take all lawful, necessary and under its special circumstances, reasonable and

113 Section 93 (2) of the Constitution provides as follows: "Every Government department shall be under the supervision of a Principal Secretary, whose office shall be a public office and who shall be under the direction of a Minister or Deputy Minister: …".

114 Repealed the Pharmacy, Medicines and Poisons Act (Cap. 35:01).

practicable measures for preventing any infectious disease.[115] Although the local government authorities have power to deal with an outbreak of a communicable disease, the lack of minimum guidelines leads to the absence of a coordinated response to such an outbreak. Further, as such outbreaks are not designated as emergency issues, there is no provision for the deployment of emergency health care workers.

The Occupational Safety, Health and Welfare Act creates a clearer hierarchy on the exercise of the powers under the Act. The Act establishes the office of the Director of Occupational Safety, Health and Welfare.[116] The Director deploys inspectors who are mandated by law to enter, inspect and examine at all reasonable times a place which is reasonably believed to be a workplace and in which there is reasonable cause to believe that explosives or inflammable materials are stored or used. The inspectors are subordinates of the Director and report to that office. The clear line of authority is important for efficiency.

The Commission observed that the law does not provide for an authority to take the lead in matters of public health-related risks. The Commission, further, observed that in the case of H1N1/bird flu, Ebola and other emerging or re-emerging diseases there are concerted efforts from various government departments, but the risk is that there is lack of ownership when the project comes to an end.

2.2.1 Public Health Institute

(*a*) Establishment of the Institute

A public health institute can be defined as a science-based governmental organization that serves as a focal point for a country's public health efforts including critical component of global disease prevention and response systems. Generally, public health institutes are non-profit organizations dedicated to advancing public health practice and make systematic improvements in population health that is to say they drive improvements which impact the health outcomes of groups as opposed to individuals.[117] Public Health Institutes also assist people in a country to access the conditions and resources they need to live healthy happy lives.[118]

115 Section 7 of the Public Health Act.

116 Section 72 of the Occupational Safety, Health and Welfare Act.

117 National Network of Public Health Institutes: 'About the National Network of Public Health Institutes', Available at: https://nnphi.org/about-nnphi/. Accessed 19 February, 2022.

118 As above.

The Commission noted that a typical national health institute provides focused, centralized leadership and coordination for public health in a country.[119] Some of the critical characteristics of an effective public health institute are that:

(*a*) they are generally quasi-government institutions, which are in most cases affiliated with national ministries of health;

(*b*) they have adequate human, financial, and infrastructure support;

(*c*) have good links with key organizations within the country and internationally;

(*d*) they are somewhat removed from politics and pressures of the ministry of health; and

(*e*) engender a high level of trust and in some cases, use of funds.[120]

The Commission observed that countries have tended to establish public health institutes in order to:

(*a*) deal with modern day challenges in the public health systems such as infectious and chronic disease as well as the need to improve environmental, mental, occupational health;

(*b*) strengthen systems for delivering public health services;

(*c*) reduce injuries; and

(*d*) prepare for unanticipated problems and emergencies for example, natural disasters and bioterrorism.[121]

The Commission observed that as countries face public health emergencies, building public health capacity to prevent, detect, and respond to threats has been a priority. It has also been observed that national public health institutes have appeared to play a critical role in strengthening public health systems and to accelerate and achieve implementation of the IHR. The Commission further observed that within the SADC region, for example, South Africa,[122] Zambia[123] and Mozambique[124] have vibrant public health institutes. The Commission during a comparative study visit to Namibia learnt that Namibia is in the process of establishing a public health institute in that the technical working group

[119] US National Library of Medicine, 'National Institute of Health: The role of national public health institute in health infrastructure development'. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2043446/. Accessed on 19 February, 2022.

[120] As above.

[121] As above.

[122] The National Public Health Institute of South Africa Act 1 of 2020 establishes the National Public Health Institute of South Africa in order to coordinate, and where appropriate to conduct, disease and injury surveillance; to provide for specialized public health services, public health interventions, training and research directed towards the major health challenges affecting the population among others.

[123] The Zambia National Public Health Institute Act of 2020 establishes the Institute in order to coordinate the public health security, among others.

[124] The Mozambique National Public Health Institute was established through a Ministerial Decree in 1991.

steering committee has developed a draft road map for submission to Cabinet but that the process stalled due to the Covid-19 pandemic.[125]

The Commission noted that in Malaŵi the process of establishing a public health institute started in November, 2011 when the Ministry of Health formed a Task Force to develop a Strategic Plan, Concept Paper and Road Map for the institute.[126] The Task Force was also responsible for advising and coordinating the consultations and development process towards the establishment of the institute.[127] The Commission also noted that the Task Force completed its work in August, 2021 and the Ministry of Health senior management approved establishment of the institute in November, 2012.[128] The Commission observed that the proposed institute exists as part of the Ministry of Health operating at Community Health and Services (CHSU) by administrative arrangement.

With respect to the issue of establishment of the institute, the Commission considered the legal character or nature of the institution to be developed, that is, whether it should be a stand-alone institute or should continue to operate within the Ministry of Health. The Commission noted that generally national public health institutes play a critical role in coordinating, developing, and strengthening public health capacities; helping countries achieve implementation of IHR, and improving population health. It is therefore important that the legislation to be developed should clearly define what the institute will do and how it will operate within the Government's structure. This approach would help clarify the institute's mission, governance, reporting structure, leadership and finance and would contribute to its success.

The Commission learnt that in Namibia establishment of the public health institute would cut short the bureaucracy with regard to responses to pandemics and that the institute would still be linked to the Ministry of Health but the vision was for it to be autonomous, to have a separate budget so that it could easily respond to emergencies.[129] The Commission also learnt that the Zambia National Public Health Institute was established as an autonomous body even though there exist a few overlaps between the Institute and the Ministry of Health.[130] The Commission further learnt that the Mozambique National Public Health Institute was established as a semi-autonomous institution in 1991 and later it was redefined as an autonomous public health institute in 2017 in that the institute's budget is negotiated directly with the Ministry of Finance.[131] The Commission

[125] The special Law Commission on the Review of the Public Health Act: 'A Report on a Comparative Study Visit to Namibia' conducted from 4th to 11th September, 2021, p.9

[126] Ministry of Health: Directorate of Preventive Health Services. Available at: https://www.health.gov.mw/index.php/directorates/preventive-health/public-health-institute. Accessed on 21 February 2022.

[127] As above.

[128] As above

[129] The special Law Commission on the Review of the Public Health Act: 'A Report on a Comparative Study Visit to Namibia' conducted from 4th to 11th September, 2021, pp.10.

[130] A special Law Commission on the Review of the Public Health Act: 'A Report on the Study Visit to the Republic of Zambia', pp.3.

[131] A special Law Commission on the Review of the Public Health Act: 'A Report on the Study Visit to the Mozambique' conducted from 29th November to 3rd December, 2021.

observed that most public health institutes are established as parastatal entities although the definition of parastatal and the implication for oversight and use of ministry systems differ across countries. As for Mozambique's National Public Health Institute, the Ministry of Health has guardianship of the NPHI and has the power to inspect the structure of NPHI, authorize and approve annual reports, programs bodies, and activity plans.[132]

Having considered the foregoing matters with respect to regulation of the public health sector in Malaŵi, the Commission resolved that a PHI should be established under the proposed legislation as a standalone authority for purposes of leading the coordination of all public health-related laws and stakeholders in the style of a public health institute. The separate status of the institute will enable it to raise funds for its projects and utilise the funds appropriately.

The Commission noted that NPHIs in most cases serve as focal points for efforts aimed at protecting, strengthening, and improving health catalysing responses to key public health challenges. Functions of NPHIs which have direct implications for health security include public health laboratory and surveillance systems, emergency preparedness and response, public health workforce development, and research in public health. Some NPHIs tend to lead in developing One Health approaches to surveillance, disease prevention, and emergency response as well as provide a bridge between clinical and public health systems in the country. For example, the Mozambique law stipulates core attributes and competencies of their institute in order to actualize functions and operations of the NPHI.[133] Likewise, the Ministry of Health of Zambia established the Zambia National Public Health Institute as a specialized agency to safeguard the public health security of the country in as far as disease control, surveillance and response is concerned.[134] The Commission found that functions provided for in most of the legislative instruments creating NPHI include administrative; laboratory; surveillance systems; disease prevention and health promotion; workforce development; and health research and development. The Commission recommends that the legislation to be developed should clearly stipulate functions and scope of duties for the proposed institute.

The Commission noted that legislative instruments establishing NPHIs stipulate leadership roles and provide for the position of a Director including legal requirements for appointment, removal, and tenure. For instance, in Mozambique, the Director General is appointed by the Prime Minister, on the proposal of the Minister overseeing the area of health.[135] In Liberia, the President is mandated to appoint the Director General upon recommendation of the Board of Directors.[136] Nigeria goes further requiring that the Director must be a health professional with

132 Articles 6 of the Mozambique Council of Ministers. Decree No. 57/2017.
133 Council of Ministers of Mozambique. Decree No.57/2017.
134 The special Law Commission on the Review of the Public Health Act: 'A Report on a Study Visit to the Republic of Zambia' conducted from 6th to 12th June, 2021. pp.3.
135 Articles 7 of the Mozambique Council of Ministers. Decree No. 57/2017.
136 National Assembly of Liberia. National Public Health Institute of Liberia Act. 2016. Available at http://ianphi.org/resources/toolkit/nphilegislation.html . Accessed on 21st February, 2022.

at least 15 years post graduate qualification experience in medicine or public health.[137] The Commission therefore found the need to make provision for a governing body for the proposed institute which is the Board. It therefore recommends accordingly.

(*b*) Response to Public Health Emergencies

The Commission considered the state of preparedness against public health emergencies in Malawi. The Commission found some gaps in the procedures, laws or identifiable action in place. The Commission was of the view that the Institute should support the response to disease outbreaks and public health emergencies in order to minimize the impact on health. The Commission was alert to the fact that the nature of what may be considered public health emergencies is fluid. Emergencies may include organized events or unplanned phenomena. To this end, the Commission noted that demonstrations, sporting, religious and political events, musical concerts, spontaneous traditional medicine events such as *"Mchape"* in Machinga,[138] industrial action and global epidemics are some of the events that can lead to public health emergencies if not well managed.

The Commission emphasized the need for laying down processes in this regard, to guide a Government to declare or announce the emergency, and the processes could be followed. The Commission observed that under the Constitution, the President has powers to declare a state of emergency.[139] However, the Commission considered that the state of emergency prescribed under the Constitution does not fit into the framework of public health emergencies envisaged in public health discourse. The Commission observed that while powers of the President to declare a state of emergency under the Constitution could remain intact, powers exercisable in public health emergencies under the legislation to be developed should be vested in the Minister.

The Commission, further, observed that there is need to synchronize efforts in light of the existence of the Department of Disaster Preparedness. The Commission was of the view that there is need to establish the mandate of this Department so that the process of harmonizing efforts is achieved. In light of this, the Commission observed that there is need for a body that shall be mandated to identify and forecast emergencies on a continuous basis.

The Commission observed that the proposals and recommendation made under these themes should embrace a human rights-based approach as a matter of necessity. The Commission observed that since the Act predates the Constitution,

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137 National Assembly of Nigeria. Nigeria Centre for Disease Control and Preventive (Establishment) Act. 2018. Available at:http://www.ianphi.org/_includes/documents/NCDC%20Odfficial%20Gazette.pdf Accessed on 21 February 2022.

138 Marissa C.M. Doran, "Reconstructing Mchape '95: AIDS, Billy Chisupe, and the Politics of Persuasion" Journal of Eastern African Studies Vol.1, No. 3, 397416, November 2007. Available at https://www.tandfonline.com/doi/epdf/10.1080/17531050701625573?needAccess=true&role=button. Accessed on 29th May, 2023.

139 Section 45(3).

there is need for suggested proposals to reflect the new constitutional order. The Commission suggested the need to draw up a list of factors that constitute a public health emergency.

Public health emergency refers to "an occurrence or imminent threat of widespread or severe damage, injury or loss of life or property resulting from a natural phenomenon or human act".[140] The responses to public health emergency include:

(*a*) declaration of the event that constitutes a public health emergency;

(*b*) nature of the public health emergency;

(*c*) length of the public health emergency; and

(*d*) public health emergency disaster preparedness and management.[141]

The Commission noted that a public health emergency has the potential to overwhelm routine community capabilities to respond to an event or occurrence. The Commission thus observed that a public health emergency preparedness require a wide range of prevention, mitigation and recovery activities in addition to those designed to enable responses to events.[142] The Commission also noted that preparing for a public health emergency requires both capacity in terms of infrastructure, personnel, plans, among others; and operational capabilities which is the ability to quickly execute prepared tasks.[143] At the same time there is need to always realise that a public health emergency is not a steady state. As such, there is also need for continuous improvements, formulation and execution of corrective action plans while not forgetting to also focus on improving the health and resilience of communities.[144] The Commission opined that the responsibility to prepare for a public health emergency does not only lie with government agencies but also with active, engaged and mobilised community residents, businesses and non-governmental organisations.[145] Considering that a large share of first aid, search and rescue and initial response activities are normally provided by on-site civilians prior to the arrival of response personnel.

The does not address the issue of public health emergency. However, the Disaster Preparedness and Relief Act[146] appears to partially address the issue. Broadly, the Disaster Preparedness and Relief Act provides a mechanism for the coordination and implementation of measures to alleviate effects of disasters. Disaster is defined as:

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140 Rebecca Haffajee, Wendy E. Parmet and Michelle M. Mello, "What Is a Public Health "Emergency"?" The New England Journal of Medicine 11 September, 2014. Available at http://nejm.org/doi/full/10.1056/NEJMP1406167 Accessed on 25 May, 2018.

141 Ibid.

142 Nelson, C and Others, 2007 " Conceptualizing and defining Public Health Emergency Preparedness" Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1854988/ accessed on 14 March, 2022.

143 As above.

144 As above.

145 As above.

146 Cap. 33:05 of the Laws of Malawi.

"an occurrence (whether natural, accidental or otherwise) on a large scale which has caused or is causing or is threatening to cause—

(a) death or destruction of persons, animals or plants;

(b) disruption, pollution or scarcity of essential supplies;

(c) disruption of essential services;

(d) influx of refugees into or out of Malawi; and

(e) plague or epidemic of disease that threatens the life or well-being of the community, and includes the likelihood of such occurrence."[147]

The Commission found that the Act does not expressly provide for public health emergency, although its aspects are manifested through the notifiable infections and the management of such infections. Further, the Commission found that the Disaster Preparedness and Relief Act deals with matters similar to what is covered under the concept of public health emergency.

The Commission noted that in Ethiopia, Liberia and Nigeria the national public health institute also authorise public health emergency response. For example, in Ethiopia the national public health institute is directed to design strategies, issue guidelines, develop preparedness and response plans, build capacity, establish and implement coordination and collaboration frameworks, conduct public health vulnerability assessment and risk analysis, and provide public health support to prevent and mitigate public health emergencies. This function also includes authorisation to conduct on site investigation when deemed necessary, verify outbreaks, issue alert, provide warning and disseminate information to the concerned organisations, mobilise or cause the mobilization of resources, and support the response activities carried out. Ethiopia also requires that there be a focal point for communication to implement international health regulations on grave public health emergencies having implication of international crisis. The Commission also noted that Nigeria has expressly dedicated their national public health institute as the IHR focal point. In Liberia the national public health institute is also authorised to recommend the declaration of public health emergency and disease outbreak based on available public health data.

The Commission after a lengthy discussion on the matter resolved that for public health emergencies it shall be the Ministry of Health that shall take the lead but it shall work with other ministries taking into account the extent of emergencies. The Commission also recommends that the Institute shall be the focal point for the implementation of IHR.

The Commission opined that since one of the responsibility of the Institute is to coordinate response to public health emergencies, there is need to create a fund where money can be made available to ensure speedy response to public

147 Section 2 of the Disaster Preparedness and Relief Act, Cap. 33:05 of the Laws of Malawi.

health emergencies similar to the Zambian national public health emergency fund.[148] The Commission thus recommends accordingly.

Therefore, the Commission recommends adoption of the following provisions:

PART… – PUBLIC HEALTH INSTITUTE

Division 1 – Public Health Institute

Establishment of the Institute

...—(1) There is hereby established an Institute to be known as the Public Health Institute (hereinafter referred to as the "Institute"), which shall be a body corporate with perpetual succession and a common seal.

(2) The Institute shall—

(*a*) be capable of—

(*i*) acquiring, holding and disposing of real and personal property;

(*ii*) suing and being sued in its own name;

(*iii*) doing or performing all acts and things as body corporate may, by law, do or perform; and

(*iv*) performing such functions and exercise such powers as conferred by this Act or by any other written law; and

(*b*) be composed of a Board (hereinafter referred to as the "Board") which shall be the governing body of the Institute, and a Secretariat.

Independence of the Institute

...—(1) The Institute shall perform the functions and exercise the powers provided for in this Act independent of the direction, undue influence or interference of—

(*a*) any public office;

(*b*) any organ of the Government;

(*c*) any person or organization or Authority or organization whatsoever:

(2) Notwithstanding subsection (1), solely for purposes of accountability, the Institute shall be and report bi-annually and directly to the Parliamentary Committee responsible for Public Health matters on the overall fulfilment of the functions and powers of the Institute.

[148] The Zambia National Public Health Institute Act, 2020.

Functions of the Institute

... The functions of the Institute shall be to–

(*a*) prevent, detect, monitor and control diseases of national and international public health concern, including emerging and re-emerging diseases;

(*b*) develop, maintain and coordinate surveillance systems to collect, analyse and interpret data on diseases of public health importance;

(*c*) detect public health threats, guide health interventions and set public health priorities;

(*c*) support the response to disease outbreaks and public health emergences in order to minimize the impact on health;

(*d*) develop and maintain a network of reference and specialized laboratories for pathogen detection, disease surveillance and outbreak response;

(*e*) conduct, collate, synthesize and disseminate public health research to inform policy and guidelines on a disease or diseases of public health importance, and put in place a national public health research agenda and database;

(*f*) support national health information systems to strengthen prevention and control measures of communicable diseases;

(*g*) provide information and awareness to the public on diseases and public health events;

(*h*) coordinate the operationalization of ongoing international health regulations, including trans-border disease surveillance and control activities;

(*i*) collaborate with health agencies within and outside Malaŵi;

(*j*) provide support and coordinate the control of national and trans-border responses to public health events of international concern, including mass casualties, flood, nuclear, biological or chemical terrorism, disease outbreaks and heavy metal poisoning;

(*k*) develop and maintain a communication network with all public health institutions, with roles in mitigating the impact of diseases;

(*l*) provide support to the Ministry responsible for public health for the development of evidence-based

guidelines and policies as well as the implementation of programmes relating to disease prevention and control, in accordance with international guidelines and recommendations;

(*m*) provide guidance, technical and logistical support for the planning, implementation and management of diseases of public health importance and on activities to reduce health risk and impact from public health events;

(*n*) provide technical support to communities, organizations and institutions on environmental health activities, as it relates to disease prevention, control and disaster emergency response;

(*o*) implement One Health Approach;

(*p*) contribute to the development of human resources, in particular, in the technical-professional and scientific areas specific to health;

(*q*) disseminate information of a technical-scientific nature, for the scientific community, health workers and the public in general;

(*r*) form partnerships with other national and international institutions for the execution of research, training, and public health activities; and

(*s*) carry out such activities as may be necessary or expedient for the performance of its functions under this Act.

Powers of the Institute

...The Institute shall in the discharge of its functions, have power to–

(*a*) request and obtain information, data, clinical samples and report on diseases of public health importance;

(*b*) support the control of public health emergencies;

(*c*) develop and enforce the use of standards, protocols and guidelines for disease prevention and control including diagnostic, disease detection and reporting in compliance with international best practice;

(*d*) enter through its designated officers any public place to inspect and enforce compliance with public health standards;

(*e*) manage, insure, lease, sell, dispose of, maintain, improve or in any way deal with any of its property;

(*f*) receive donation of funds, materials and technical assistance for the furtherance of its work; and

(*g*) do and perform all such things or acts as are necessary or expected for the execution of its functions and duties under this Act.

Composition of the Board

...—(1) The Board of the Institute shall consist of the following members appointed by the Minister—

(*a*) a representative from local research institution, nominated by the National Commission for Science and Technology;

(*b*) an epidemiologist, nominated by a school of public health at an accredited university;

(*c*) a representative of the Medical Council with expertise in public health, nominated by the Medical Council;

(*d*) a representative of the Nurses and Midwives Council with expertise in public health, nominated by the Nurses and Midwives Council;

(*e*) a member with expertise in veterinary medicine, nominated by a school of veterinary medicine at an accredited university; and

(*f*) the following ex-officio members

(*i*) Secretary responsible for Health;

(*ii*) Secretary responsible for Local Government;

(*iii*) Secretary responsible for Agriculture;

(*iv*) Secretary responsible for Water;

(*v*) Secretary responsible for Environmental Affairs; and

(*vi)* Commissioner responsible for disaster management.

(2) The Minister may designate any member of the Board, other than an *ex-officio* member under subsection (1) (*f*), as chairperson of the Board.

(3) A member of the Board, other than the *ex-officio* member shall not, by reason only of his appointment as a member of the Board, be deemed to be an employee in the public service.

(4) A person, other than an *ex-officio* member, shall not be qualified for appointment as a member of the Board, if he—

(*a*) does not possess—

(*i*) a minimum education of a master's degree or its equivalent obtained subsequent to a bachelor's degree, both qualifications obtained from a recognized or accredited higher education institution; and

(*ii*) expertise and experience in a field relevant to the functions and responsibilities of the Institute;

(*b*) holds a political office or is an active member of a political party;

(*c*) is adjudged or declared bankrupt; and

(*d*) would for any other reason be disqualified by law from serving as a director of a company or as a trustee.

(5) The Board may, where necessary taking into account the nature of the matter to be deliberated, invite any person to—

(*a*) attend a meeting of the Board or any of its committees and participate in the deliberations; or

(*b*) make a presentation or to be asked questions on any matter.

(6) A person invited to deliberations of the Board pursuant to subsection (5) shall not be entitled to vote.

Functions of the Board

—(1) The Board shall control, oversee and supervise—

(*a*) the performance of functions and duties; and

(*b*) the exercise of powers of the Institute to ensure efficiency and effectiveness in the implementation of the mandate of the Institute.

(2) Without prejudice to the generality of subsection (1), the Board shall—

(*a*) provide strategic guidance for the management of the Institute;

(*b*) approve annual plans and budgets of the Institute;

(*c*) monitor the implementation of the plans and programmes of the Institute;

(*d*) oversee the proper management of finances and assets of the Institute;

(*e*) review regularly the structure of the Institute, the staffing levels, emoluments and terms and conditions of the members of staff of the Institute;

(*f*) appoint senior management staff;

(*g*) monitory the performance of the Institute;

(*h*) consider and advise the Minister on matters relating to public health as the Board may, from time to time, consider appropriate or which may be referred to it by the Minister; and

(*i*) perform such functions as may be necessary for the achievement of the objectives of the Institute

Tenure of office

...—(1) A member of the Board, other than an *ex-officio* member, shall hold office for a period of three years and shall be eligible for re-appointment for one final term of three years.

(2) When making an appointment after expiry of three years, the Minister shall have regard to the need for continuity in the membership of the Board so that at least half of the appointed members shall be re-appointed for the next term of office.

Vacancy

...—(1) A vacancy in the office of a member of the Board shall occur, if the member—

(*a*) dies;

(*b*) is adjudged or declared bankrupt;

(*c*) is convicted of an offence and sentenced under any written law

for an offence to a term of imprisonment without the option of a fine;

(*d*) fails, without good and justifiable cause, to attend three consecutive meetings of the Board of which he has notice;

(*e*) is certified by a medical practitioner to be incapacitated by reason of physical or mental illness;

(*f*) is removed by the Minister, in accordance with subsection (3); or

(*g*) is in a situation that had it arisen before the person was appointed, it would have disqualified him from being appointed as a member of the Board.

(2) A member of the Board, other than an ex-officio member, may at any time resign his office by giving one month written notice to the Chairperson who shall then forward the resignation to the Minister.

(3) The Minister may remove any member of the Board or an entire Board, except an *ex-officio* member, on any of the following grounds—

(*a*) misconduct or misbehaviour that brings the office of the member into disrepute;

(*b*) incompetence in the execution of the function of his office as a member of the Board;

(*c*) in circumstances where the member is compromised to the extent that his ability to impartially and effectively exercise the duties of his office is seriously in question.

(4) Notwithstanding subsection (3), before a member is removed from office, he shall be given an opportunity to be heard.

(5) A vacancy in the membership of the Board shall be filled by the Minister within twenty-eight days.

(6) A person appointed to fill a vacancy shall serve for the remainder of the term but the period served by a person appointed under subsection (5) shall not be regarded as a term for the purposes of section 9.

(7) A vacancy in the membership of the Board shall not affect its decisions, the performance of its functions or the exercise of its powers under this Act or any other written law.

Honoraria etc

...—(1) Members of the Board and of its committees shall be paid such honoraria and other allowances as the Minister shall from time to time determine.

(2) The Board may make provisions for reimbursement of any reasonable expenses incurred by a member of the Board or a member of a committee or a person invited under section 7 (5) in connection with the business of the Institute.

Meetings

...—(1) The Board shall meet at least once every three months.

(2) The Chairperson shall convene ordinary meetings of the Board by giving members not less than fourteen days written notice and may, on his own motion, convene an extraordinary meeting of the Board at a place and time as he may determine.

(3) The Chairperson or in his absence, the Vice Chairperson shall at the written request of a simple majority of members call for an extraordinary meeting of the Board, at any place and time as determined.

(4) An extraordinary meeting of the Board shall be held within seven days of a request for the meting

(5) A quorum for a meeting of the Board shall be formed by five members

(6) The Chairperson or, in his absence, the Vice Chairperson shall preside at meetings of the Board.

(7) The members present and forming a quorum shall, in the absence of both the Chairperson and the Vice Chairperson, elect one of their number to preside over such meeting.

(8) The member so elected shall exercise all the powers and perform all the duties of the Chairperson.

(9) A decision of the Board shall, at any meeting of the Board, be that of the majority of the members present and voting.

(10) The person presiding over a meeting of the Board shall, in the event of an equality of votes, have a casting vote in addition to a deliberative vote.

(11) The Board or a committee shall, as the case may be, confirm the minutes at the subsequent meeting.

(12) The Board may, subject to the provisions of this Act, make rules to regulate the conduct of its proceedings and business or the proceedings and business of any of its committees.

Personal attendance of meeting

...—(1) A member of the Board or committee shall not attend a meeting of the Board or committee by proxy.

(2) Where a member of the Board or a committee is unable to attend a meeting, he may request that his apologies for failure to attend be recorded.

Committees

...—(1) The Board may, for the better carrying into effect of its functions, establish committees necessary to perform such functions and responsibilities as the Board may deem fit.

(2) A committee may consist of either members of the Board only or members of the Board and such other suitably qualified persons other than members of staff of the Institute as the Board may deem fit.

(3) The Chairperson of the Board shall appoint the chairperson and vice chairperson of each committee from among the members of the Board.

(4) The provisions of this Act relating to the meeting of members of the Board shall apply with necessary modifications to the meetings of its committee.

(5) Every committee shall act in accordance with any directions given to the committee in writing by the Board.

Disclosure of interest

...—(1) If a member of the Board or a committee is present at a meeting of the Board or a committee at which any matter which is the subject of consideration is a matter in which that member or his immediate family member or his professional or business partner is directly or indirectly interested, he shall, as soon as practicable, after the commencement of the meeting, disclose his interest.

(2) The member shall not take part in any consideration or discussion of, or vote on any question relating to the matter.

(3) A disclosure of interest by a member of the Board or a committee shall be recorded in the minutes of the meeting at which it is made.

Division 2 – Administration

Secretariat

... The secretariat of the Institute shall consist of the Director General and other employees of the Institute appointed under this Part.

Director General

...—(1) The Director General shall be appointed by the Board in an open and competitive process on terms and conditions as the Board may determine.

(2) The Director General shall, subject to the general supervision and control of the Board,—

(*a*) provide technical leadership in matters of public health in the implementation of this Part:

(*b*) ensure that the Institute has information, data, statistics documents and other materials pertinent to the efficient performance by the Institute of its functions and responsibilities under this Act or any other written law;

(*c*) have custody of the common seal of the Institute;

(*d*) be in charge of day to day operations of the Institute;

(*e*) be responsible for the management of funds, property and business of the Institute;

(*f*) ensure effective administration and implementation of the provisions of this Act; and

(*g*) provide secretarial functions to the Board.

(3) A person shall not be appointed as Director General unless he—

(*a*) is a health professional with at least ten years postgraduate qualification and experience in public health specialized in epidemiology obtained subsequent to a bachelor's degree obtained from a recognized educational institution;

(*b*) does not hold a political office or is not an active member of a political party.

(4) The Director General shall be appointed for a term of three years and be eligible for re-appointment for one final term of three years.

Removal of Director General

...—(1) The Board may remove the Director General from office on the following grounds-

(*a*) misbehaviour or misconduct that brings the office of the Director General or Institute into disrepute;

(*b*) incompetence in the execution of his functions as Director General;

(*c*) incapacity by reason of physical or mental illness as certified by a medical practitioner or medical board;

(*d*) if he is declared or adjudged bankrupt by a competent court; or

(*e*) if he is sentenced for an offence against any written law to any term of imprisonment without the option of a fine.

(2) The Director General shall not be removed from office unless he has been given an opportunity to be heard.

Other staff of the Institute

...—(1) There shall be employed in the service of the Institute, subordinate to the Director General other staff as the Institute shall consider necessary for the exercise of its powers and performance of its duties and functions.

(2) The staff of the Institute referred to under subsection (1) shall be appointed by the Board on terms and conditions as the Board shall determine in consultation with the department responsible for human resource management and development.

(3) The Board may, by directions in writing delegate to the Director General, the appointment of members of staff of the Institute in specified junior ranks.

(4) The Director General shall, pursuant to subsection (3), report to the Board every appointment made.

(5) The Director General may, with the approval of the Chairperson, delegate senior members of staff of the Institute to act as secretary to committees of the Institute.

(6) Where, in any meeting, the deliberations of the Board or of its committees concerns the Director General or any officer of the Institute designated to attend the meeting, the Board or the committee, as the case may be, may exclude the Director General or the officer from the meeting.

Division 3 - Finances

Funds of the Institute

...—(1) The funds of the Institute shall consist of –

(*a*) sums appropriated by Parliament for the purposes of the Institute;

(*b*) sums or assets that may accrue to or vest in the Institute whether in the course of the performance by the Institute of its functions or the exercise of its powers or otherwise;

(*c*) sums or assets that may accrue to or vest in the Institute by way of grants, subsidies, bequests, donations, gifts, from the Government or any other person; and

(*d*) fees and charges for services rendered by the Institute including fees for publication.

(2) Notwithstanding subsection (1) (*c*), sums or assets received pursuant to the subsection shall not jeopardize or compromise the independence of the institute.

(3) The funds and assets of the Institute shall—

(*a*) exclusively be under the control of the Institute; and

(*b*) be utilized solely for the purposes of this Act in accordance with the written directions of the Board and for no other purpose.

Cap. 37:01 Cap. 37:02 Act No. 27 of 2017

(4) The Institute shall at all times comply with the provisions of the Public Audit Act, the Public Finance Management Act and the Public Procurement and Disposal of Assets Act.

Establishment of Fund

...— (1) There is hereby established the National Public Health Emergency Fund for –

(*a*) the provision of public health emergency commodities;

(*b*) the operations of the epidemic preparedness, prevention, control and management committees, in the management of public health emergencies in their areas; and

(*c*) any other matter relating to the preparedness, prevention and mitigation of a public health emergency.

(2) The fund consists of monies that may: -

(*a*) be appropriated to the Institute by Parliament for the purposes of the Fund;

(*b*) be collected from levy that the Minister responsible for finance may prescribe, in consultation with the Minister;

(*c*) be paid to the Institute by way of fees, donations and grants from any source, with the approval of the Minister;

(*d*) vest in, or accrue to, the Fund; and

(*e*) by or under any written law, be payable to the Fund.

Administration and management of Fund

...— (1) The Institute shall administer and manage the funds for purposes specified under section 21.

(2) The Board shall ensure that prudent controls are established for the Fund relating to –

(*a*) fiscal controls and accounting procedures governing the Fund;

(*b*) reporting procedures for the matters relating to the Fund;

(*c*) investment of monies of the Fund.

(2) The Board shall cause to be kept proper books of accounts and other records relating to the Fund.

(3) the Fund shall be audited annually by the Auditor-General or an auditor appointed by the Auditor-General.

Accounting and audit

...— (1) The Institute shall cause to be kept proper books and other records of accounts in respect of receipts and audit expenditures of the Institute in accordance with acceptable principles of accounting.

(2) The accounts of the Institute shall be liable to audit annually by the Auditor General or by independent professional auditors appointed by the Board in consultation with the Auditor General, and the expenses of the audit shall be paid out of the funds of the Institute.

Financial year of the Institute

... The financial year of the Institute shall be the same as the financial year of the Government.

Oath of secrecy

... Every—

(*a*) member of the Board;

(*b*) member of a committee;

(*c*) member of staff or service provider of the Institute; or

(*d*) person invited under section 7 (5), shall, upon assumption of his office before attending a meeting, take an oath of secrecy in the form set out in the Schedule to this Part and the oath shall be administered by a commissioner for oaths.

Protection from liability

...— (1) No criminal or civil proceedings shall be brought personally against any member of the Board, a committee or staff of the Institute in respect of any act or omission done in good faith in the performance of the functions and duties under this Act.

(2) Where, in any proceedings, a question arises on whether or not an act or an omission was done in good faith in the course of carrying out the provisions of this Part, the burden of proving that the act or the omission was not done in good faith shall be on the person alleging that it was not so done.

3.0 THE RIGHT TO HEALTH

The Commission considered the nature of the right to health under international law and policy, as well as the nature of the right to health under the law in Malaŵi, with specific focus on the Constitution. Further, the Commission considered broader issues of rights and duties of health care providers, health professionals and health care 'consumers' respectively.

3.1 The Nature of the Right to Health under International Law and Policy

It is important that the discussion on the right to health is located within the debates on the universality, justiciability and practicality of economic, social and cultural rights. Economic, social and cultural rights are contested because they require positive obligations on the part of the state for their realization. On the other hand, what are described as civil and political rights require a negative obligation, that is, non-interference, on the part of the state. The arguments in support of the proposition that it is difficult to enforce economic, social and cultural rights are as follows: first, the rights are not universal as they cannot be enjoyed by everyone in a jurisdiction.[149] This reinforces the argument that these rights are not fully recognised. Secondly, a large body of scholarship has historically questioned whether economic, social and cultural rights are justiciable, that is, whether they can be enforced in a court of law.[150] Thirdly, the question of practicality of economic, social and cultural rights is raised because they are resource-dependent.[151]

As economic, social and cultural rights cannot be easily transposed to benefit a community, they are objectionable as incapable of being enforced as human rights. First, this objection is rooted in the thinking of philosophers such as Kant who lauded the importance of community[152] in what is known as the

[149] See Chirwa, D.M., Human Rights under the Malaŵian Constitution (Cape Town: Juta, 2011), pp. 257.
[150] As above, pp. 257-258.
[151] As above.
[152] See Justin Shaddock, Notre Dame Philosophical Reviews: An Electronic Journal. A review of Payne, C. and Thorpe, L. (eds.), Kant and the Concept of Community, University of Rochester Press, 2011 Available at http://ndpr.nd.edu/news/kant-and-the-concept-of-community/ Accessed on 19 September 2017.

cosmopolitan school of thought. The objection of economic, social and cultural rights for their apparent failure to benefit the community is a conceptual argument. Second, a more ideological argument is advanced by Sunstein and others. The argument states that economic, social and cultural rights should be rejected because they are an intrusion to the free market.[153] It is in the nature of the free market to champion competition thus the resource–dependency that is implicit under economic, social and cultural rights stifles the market and rewards free riding.

In the post-Cold War period, the general consensus is that there is no conceptual difference between civil and political rights and economic, social and cultural rights. It is argued that the divisibility of rights, their hierarchy and categorisation into generations is misplaced.[154] Indeed, a number of largely liberal democratic constitutions have emerged in the post-Cold War period that recognize economic, social and cultural rights.[155] Some constitutions recognize these rights as 'principles of state policy';[156] others as 'fully justiciable rights';[157] and yet others adopted a 'mixed model' of recognition, that is, state policies and fully justiciable rights.[158]

A healthy life is arguably the basic starting point of the enjoyment of every human right. The state of a healthy person is in itself universally acknowledged as a basic human right. This is the case because the enjoyment of the right to health is a necessary condition for the enjoyment of all other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.

The realisation of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments. [159] The right to the highest attainable standard of health is a human right recognised in international human rights law. Article 25 (1) of the Universal Declaration of Human Rights (UDHR) provides as follows:

"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."

The International Covenant on Economic, Social and Cultural Rights (ICESCR), in article 12 provides as follows:

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153 See Sunstein, C, 'Against Positive Rights' (1993) 2 (1) East European Constitutional Review 35 in D.M. Chirwa, pp. 25

154 See for example Baxi, U, The Future of Human Rights (Delhi: Oxford University Press, 2002).

155 See Chirwa, D.M. pp. 258.

156 Chirwa, D.M. pp. 258.

157 As above.

158 As above.

159 General Comment No 14 of 2000 by the Committee on Economic, Social and Cultural Rights ('CESCR') on "the right to the highest attainable standard of health" (article 12 of the International Covenant on Economic, Social and Cultural Rights).

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(*a*) the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;

(*b*) the improvement of all aspects of environmental and industrial hygiene;

(*c*) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(*d*) the creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Further, the ICESCR considers mothers under article 10 (2) and provides as follows:

"Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits."

The Committee on Economic, Social and Cultural Rights, in General Comment Number 14, laid out "underlying determinants of health" as being the component of the right to health. These include: safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education information; and gender equality. The Committee further notes that "[T]he notion of "the highest attainable standard of health" in article 12.1 [of the ICESCR] takes into account both the individual's biological and socio-economic preconditions and a State's available resources." [160]

Universal recognition of the right to health was further confirmed in the Declaration of Alma–Ata on Primary Health Care, 1978, in which States pledged to progressively develop comprehensive health care systems to ensure effective and equitable distribution of resources for maintaining health. They reiterated their responsibility to provide for the health of their populations, "which can be fulfilled only by the provision of adequate health and social measures."[161]

Additionally, the right to health is recognized, among others, in article 5 (*e*) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) of 1965; articles 11 (1) (*f*) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979; and in article 24 of the Convention on the Rights of the Child (CRC) of

[160] General Comment No 14 of 2000, para 9.
[161] WHO, Declaration of Alma–Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6 to 12 September, 1978.

1989. At the regional level, article 16 of the African Charter on Human and Peoples' Rights (ACHPR) of 1981 guarantees the right to health; so does article 14 of the Protocol to the ACHPR on the Rights of Women in Africa, and article 14 of the African Charter on the Rights and Welfare of the Child (ACRWC). Thus, some groups or individuals, such as children, women, persons with disabilities or persons infected with or affected by HIV and AIDS, should be given special attention in relation to their right to health. These groups of people face specific hurdles resulting from biological or socio-economic factors, discrimination and stigma. As such, states are encouraged to adopt positive measures to ensure that specific individuals and groups are not discriminated against.

States have the primary obligation to protect and promote human rights emanating from both international customary law and international human rights treaties. Through ratification of human rights treaties, state parties are required to give effect to human rights within their jurisdictions. Article 2 (1) of the ICESCR provides that states have the obligation to progressively achieve the full realization of the rights under the Covenant. This is an implicit recognition that states have resource constraints and that it takes time to implement the treaty provisions. States, at a minimum, must show that they are making every possible effort, within their available resources, to protect and promote all rights under the Covenant.

The Committee on Economic, Social and Cultural Rights set out the following as core minimum obligations towards the realization of the right to health—

(*a*) the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(*b*) access to the minimum essential food which is nutritionally adequate and safe;

(*c*) access to shelter, housing and sanitation and an adequate supply of safe drinking water;

(*d*) the provision of essential drugs; and

(*e*) equitable distribution of all health facilities, goods and services.

3.2 The Legislative Framework on the Right to Health in Malawi

The Commission found that the right to health is not expressly provided for under the Constitution and existing legislation. It was observed that the provision of health care is recognized under section 13(*c*) as a principle of national policy, and under the right to development in section 30. According to section 13, the State is required to actively promote the welfare and development of the people of Malaŵi by progressively adopting and implementing policies and legislation aimed at achieving, among other things, health as a key national goal. In that regard, the State is required to provide adequate health care, commensurate with the health needs of Malaŵian society and international standards of health care[162].

[162] Section 13 (*c*) of the Constitution.

However, the provision of health care as a principle of national policy is "directory in nature" [163] which raises the question of justiciability.

Under the right to development in section 30, the State is required to take all necessary measures for the realization of the right. Such measures include, amongst other things, equality of opportunity for all in their access to basic resources, education, health services, food, shelter, employment and infrastructure. The Commission, further, noted that the Constitution recognizes that access to health services, among other things, is a necessary measure for the realization of the right to development. The WHO and the Office of the Human Rights Commissioner adopted this development policy understanding of the right to health. The international bodies construe the right to health as an inclusive right which includes the right to:

(*a*) safe drinking water and sanitation;

(*b*) safe food;

(*c*) adequate housing and nutrition;

(*d*) safe working environment;

(*e*) health-related information and education; and

(*f*) gender equality. [164]

In addition, the international bodies construe the right to health as an entitlement to ethical medical practice and treatment, and functional public health and health care facilities. [165] Scholars, for instance Chirwa, note that in jurisdictions where the right to health is only recognized as a principle of state policy, it is useful to locate the right to health within the right to development. Chirwa argues that the "equality of opportunity" standard espoused in section 30 (2) of the Constitution is the benchmark for claims for the enforcement of economic, social and cultural rights such as the right to health. [166]

The construction of the right to health as the right to development is shared by one of the key technocrats during the making of the Constitution. [167] The Commission established that the National Consultative Council did not highlight the right to health (and indeed making provision of the right) under Chapter IV of the Constitution. The Commission noted that the view of the Council was that the provision of social services should not be a basis of a legal obligation on the part of the State. [168] Further, the Commission noted that if the matter was drawn to the attention of the Council, it may well be that an express provision on the right to health would have been provided for in Chapter IV of the Constitution.[169]

163 Section 14 of the Constitution.
164 See WHO and Office of the Human Rights Commissioner, Fact Sheet Number 31.
165 As above.
166 Chirwa D.M. pp. 265–268.
167 Consultations between the Law Commission and retired Justice of Appeal Elton M. Singini, SC on 19th January, 2012.
168 As above.
169 As above.

The Commission further considered whether the provisions of the Constitution so far discussed were adequately robust to make the state liable for violations or infringements relating to public health. The Commission noted that, from a comparative perspective, the Federal Constitution of India does not expressly provide for a right to health. Similar to the Constitution of the Republic of Malaŵi, health is provided as one of the directive principles of state policy.[170] The jurisprudence in India has developed an expansive interpretation of the right to life to include the right to health and the right to a clean environment. The Supreme Court of India has held that the right to live with human dignity, enshrined in article 21, derives from the directive principles of state policy and therefore includes protection of health. [171] Further, it has been held that the right to health is integral to the right to life and the Government of India has a constitutional obligation to provide health facilities. [172]

The Commission considered whether it is possible to construe the right to health within the right to life under the Constitution of the Republic of Malaŵi. Section 16 of the Constitution provides for the right to life as follows:

"Every person has the right to life and no person shall be arbitrarily deprived of his or her life:

Provided that the execution of the death sentence imposed by a competent court on a person in respect of a criminal offence under the laws of Malaŵi of which he or she has been convicted shall not be regarded as arbitrary deprivation of his or her right to life."

The proviso to section 16 of the Constitution only limits the right to life where a death sentence is pronounced on a person. However, there is a need to interpret the right to life more broadly. General Comment Number 6 of the Committee on Civil and Political Rights noted that "the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures."[173] The Committee considered that "it would be desirable for States parties to take all possible measures *to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics*."[174] In this respect, the right to life takes on a more unrestrained conception that goes beyond the instantaneous "ending of life".

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170 Article 47 of the Federal Constitution of India provides as follows: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health."

171 Bandhua Mukti Morcha v. Union of India 1984 AIR SC 802.

172 State of Punjab v. Mohinder Singh Chawla (1997) 2 SCC 83.

173 Para 5.

174 Emphasis added.

The Commission also noted that the right to health is narrowly provided under isolated Acts of Parliament. The Gender Equality Act[175] under Part VI provides for sexual and reproductive health rights, and the HIV and AIDS (Prevention and Management) Act[176] provides for the rights of persons living with or vulnerable to contracting HIV/AIDS, and the rights of persons affected with HIV under sections 7 and 8 respectively. Further, the Commission observed that the Environment Management Act[177] provides for the right to a decent environment.

The Commission considered the justiciability of economic, social and cultural rights if the right to health is to be expressly provided for under law, it observed that there is a lack of litigation on the rights. However, where these rights have been argued in courts for determination, the position is that where there is an express provision of a right, the State is bound by the right which is judicially enforceable. This is the position in *Gable Masangano v. Attorney General & Others*;[178] a case involving the conditions of prisons in Malaŵi. The applicants argued that the dire state of prisons and the services amounted to cruel, degrading and inhuman treatment in violation of the Constitution. It is not clear how courts in Malaŵi would consider an economic, social or cultural right that is only implicitly recognized under the Constitution.

Beyond recognition and the attendant issue of justiciability that arises, economic, social and cultural rights bring out challenges of enforcement. These relate to the availability of resources to ensure that persons fully enjoy their economic, social and cultural rights. Indeed, as a mirror image at the international level, economic, social and cultural rights, even in jurisdictions where they are fully recognized often have to contend with the minimum core principle. The minimum core principle in relation to economic, social and cultural rights entails that for a state to fail to meet minimum core obligations under international human rights law, it must demonstrate that all efforts were directed to using all of the available resources towards the realization of the right in question. The state cannot argue that resources are not available. It can only be argued that despite the provision of the resources available, a person has not fully enjoyed the right in question. Put another way, a state is exonerated if it shows that even though available resources were provided, the right could not be fully enforced.

In a South African case of the *Minister of Health and Others v. Treatment Action Campaign & Others*,[179] the Constitutional Court ordered, on the application of the applicants, that the state must provide Nevirapine, a drug that significantly reduces the incidence of mother-to-child transmission of HIV at birth, to all pregnant mothers in South Africa. Here, the Court placed more emphasis on the minimum core principle than on the purely administrative assessment of the availability of resources.

175 Cap 25:06.
176 No.9 of 2018.
178 Constitutional Case Number 15 of 2007 (unreported).
179 2002 (5) SA 703 (CC) (S.Afr.).

Beyond the minimum core principle, there is the requirement of "progressive realization" in international human rights law. General Comment Number 3 of the Committee on Economic, Social and Cultural Rights states that a state party to the ICESCR must move with speed, regardless of its national wealth, towards the realization of economic, social and cultural rights. At the African region level, the African Commission on Human and Peoples' Rights in *Purohit and Moore v. The Gambia*[180] held that:

"[M]illions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right. Therefore, having due regard to this depressing but real state of affairs, the African Commission would like to read into Article 16 the obligation on the part of States parties to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realized in all aspects without discrimination of any kind."

In *The Government of the Republic of South Africa & Others v. Grootboom & Others,* [181] the applicants, led by Irene Grootboom, were members of the Wallacedene informal settlement in Cape Town, South Africa. The applicants sued the state on the basis that it had failed to honour the right to housing that accrued to the applicants. The Constitutional Court held that "progressive realization" entails that "accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered over time".[182] Finally, the idea of reasonableness may be used as a measure of whether a state is meeting its obligations towards economic, social and cultural rights. A state party may have deliberate policies in place towards the attainment of economic, social and cultural rights but may still fall short if the policies are unreasonable. For instance, in *Grootboom*, even though the State had policies in place to address the lack of housing in poor communities, the Western Cape High Court found the policies unreasonable as they did not take into account short-term needs such as harsh weather conditions prevalent in the case. The Constitutional Court of South Africa has gone on to state that the reasonableness test must be balanced with the comprehensiveness test, that is, "policies must be well–coordinated and comprehensive so as not to exclude a significant section of the people or those in desperate circumstances, or to neglect a particular right."[183]

The Commission observed that in other jurisdictions, the right to health is expressly provided under their respective Constitutions and Public Health Laws. The South African Constitution probably has one of the strongest provisions on the right to health. The right to health is provided for under Article 27, together with the rights to food, water and social security as follows:

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[180] Purohit and Moore v. Gambia, African Commission on Human and People's Rights, Communication No. 241/2001, Sixteenth Activity Report 2002–2003, Annex VII.
[181] 2001 (1) SA 46 (CC) (S.Afr.).
[182] See para 45 of the judgment.a
[183] Chirwa, D.M. pp. 277.

"27. Health care, food, water and social security

1. Everyone has the right to have access to:

(a) health care services, including reproductive health care….;

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

3. No one may be refused emergency medical treatment."

To operationalize Article 27 of the Constitution, the National Health Act [184] of South Africa establishes a national health system which provides the population of the Republic with the best possible health services that available resources can afford and sets out the rights and duties of both health care providers and users, among others. The Act under section 4 provides in part that the Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.

Similarly, the constitutions of Mozambique and Kenya expressly provide for the right to health. According to section 89 of the Constitution of Mozambique, all citizens have the right to medical and health care, within the terms of the law, and have the duty to promote and protect public health. It also provides access to health facilities, goods and services on a non-discriminatory basis. [185] In Kenya, the right to health is provided for under Article 43 (1) (*a*) of the Kenyan Constitution which states that "every person has the right to the highest attainable standard of health which includes the right to health care services, including reproductive health care". The provision is however subject to Article 20 (5) which states that:

"... if the state claims that it does not have the resources to implement the right, a court, tribunal or other authority shall be guided by the following principle –

(a) it is the responsibility of the State to show that the resources are not available;

(b) in allocating resources, the State shall give propriety to ensure the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and

(*c*) *the court, tribunal or other authority may not interfere with a decision by a state organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion*."

184 No.62 of 2003.
185 Article 116.

In addition, section 7 of the Health Act of Kenya provides that every person has the right to emergency medical treatment. The Commission also noted that in select Asian jurisdictions such as Nepal, the right to health is also expressly provided for under the Constitution.[186]

Based on the foregoing discussion, the Commission considered whether to expressly provide for the right to health under the Constitution and the proposed legislation. The Commission observed that during regional consultative workshops, participants expressed two contrary views as one group advocated for the express provision of the right to health under the legislation to be developed while the other group stated that the Commission should have good reasons for making provision for the right to health taking into account the position under the Constitution which narrowly provides for the right to health.[187] However, during the National Validation Workshop, participants expressed a strong view that it is high time that Malaŵi should provide for the right to health under the proposed legislation.[188]

It was observed that the general trend in the comparative jurisdictions considered is to provide for the right to medical and health care as well as emergency medical treatment under the Constitution and Public Health law. The Commission noted that despite the Constitution providing for complementary rights such as the right to life and the right to development which are justiciable, the right to health is crucial to the realization of other rights, and, it is essential to expressly provide for the right to health under the Constitution and the proposed legislation. However, the Commission noted that Chapter IV[189] of the Constitution can only be amended through a referendum. Therefore, providing for the right to health under the Constitution would be a lengthy process, which might take a while to implement. Consequently, the Commission resolved to not make consequential amendments to the Constitution but to provide for the right to health under the proposed legislation. In that regard, the State will be required to take measures, within its available resources, to achieve the progressive realization of the right to health. In the event of an infringement of this right by the State, the burden will be on the State to show that the resources are not available.

The Commission thus recommends adoption of the following provisions relating to the right to health –

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186 Section 35 states as follows:
"35. Right relating to health:
(1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services.
(2) Every person shall have the right to get information about his or her medical treatment.
(3) Every citizen shall have equal access to health services.
(4) Every citizen shall have the right of access to clean drinking water and sanitation."

187 See The Report on Regional Consultative Workshops on the Review of the Public Health Act, November 2018, pp 8-9.

188 Ibid.

189 Human Rights

PART … — HEALTH AND HUMAN RIGHTS

Right to health

...—(1) Every person has the right to the highest attainable standard of health which includes –

(*a*) the right to basic health services from the State;

(*b*) progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services;

(*c*) right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act;

(*d*) right to get information about his medical treatment; and

(*e*) the right to have equal access to health services.

(2) Where the State claims that it does not have the resources to implement the right, a court shall be guided by the following principles—

(*a*) it is the responsibility of the State to show that the resources are not available;

(*b*) in allocating resources, the State shall give priority to ensure the widest possible enjoyment of the right having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and

(*c*) the court, may not interfere with a decision by a State organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion.

(3) For purposes of enforcing the right referred to in subsection (1), any person may bring an action in the High Court to—

(*a*) prevent or stop any act or omission which is deleterious or injurious to the health of any person;

(*b*) procure any public officer to take measures to prevent or stop any act or omission which is deleterious or injurious to the health of any person for which the public officer is responsible under any written law;

(*c*) require that any on-going project or other activity be subjected to a health audit in accordance with this Act.

Right to health

(4) Any person who has reason to believe that his or her right to health has been violated by any person may, instead of proceeding under subsection (3), file a written complaint to the Minister outlining the nature of his or her complaint and particulars, and the Minister shall, within thirty days from the date of the complaint, institute an investigation into the activity or matter complained about and shall give a written response to the complainant indicating what action the Minister has taken or shall take to restore the claimant's right to health, including instructing the Attorney General to take such legal action on behalf of the Government as the Attorney General may deem appropriate.

(5) Subsection (4) shall not be construed as limiting the right of the complainant to commence an action under subsection (3):

Provided that an action shall not be commenced before the Minister has responded in writing to the complainant or where the Attorney General has commenced an action in court against any person on the basis of a complaint made to the Minister.

Obligation of the employer

...—(1) every employer shall make provision for every person under his or under his or her employment to be a member of a medical scheme provided that such employees are not ten.

(2) The Minister in consultation with the Minister responsible for Minister for Labour, may by order published in the gazetted exempt any class or category of employers or employees for complying with the requirements of this part.

(3) An employer who contravenes this section commits an offence and shall on conviction be subject to –

(*a*) a written warning and order to remedy the effects of the contravention

(*b*) compensating persons who have suffered loss because of the contravention; and

(*c*) a fine of ten million (10,000,000.00) Kwacha

3.3. Access to Health Services

Access to health services is defined as a measure of the proportion of a population that reaches appropriate health services.[190] This concept is normally used to detect inequity in the use of services between different populations defined geographically, socially, or in terms of their clinical conditions.[191] Under this thematic area, the Commission considered the Essential Health Package and examines the dimensions of the right to health under international law as well as obligations which could be placed on Malaŵi if the right is provided under law.

3.4 Essential Health Package[192]

During the review, the Commission noted that funding to the health sector in Malaŵi is inadequate but yet Malaŵi is a signatory to the ABUJA declaration on Health Financing 1989 which requires governments to allocate 15% of National Budgets for health services. This percentage can go up depending on the state of the economy. Realizing that the 15% has never been realized since its adoption, it is imperative that beneficiaries contribute to the financing of health services either through health insurance or out of pocket payments. The Commission therefore recommends that all gainfully employed people should have a health insurance, and non-employed people should pay a small nominal fee in accessing services in public health facilities. However, the nominal fee should not be charged to primary health services as listed in the proposed legislation. The discussion on the right to health was prefaced with a discussion on the nature and content of the Essential Health Package (EHP) which the Commission noted was based on the appreciation of the state of the country's economy and its ability to successfully offer health services. The Commission, further, noted that the quality of health care provided in Malaŵi is compromised and challenges include sanitation, overcrowding and inadequacy of drugs and equipment. The EHP is based on the concept of Primary Health Care which is fully covered under the Ministry of Health (MoH) Strategic Plan. Government had decided to make EHP services available at various levels of health care and for free at the point of delivery. While the contents of the EHP are expected to be revised from time to time, the concept of EHP is expected to endure. The Commission noted that the package of EHP varies from one health facility to another, depending on the level of services offered. The EHP has generally met some considerable challenges in implementation, the main ones being inadequacy of personnel, problems relating to the attitude of personnel, lack of infrastructure and resources generally.

The Commission considered the question whether individuals can seek redress from the Government for non-delivery of the EHP in the absence of binding obligations. The Commission concluded that to make the EHP enforceable, although it is heavily resource dependent, some of its aspects as and under the right to health need to be entrenched.

190 The Free Online Palliative Care Dictionary, "Access to health services" Available at: http://pallipedia.org/access-to-health-services/. Accessed on 15 February, 2022.
191 As above.
192 In HSSP II, referred to as the Basic Healthcare Package (BHP) and Basic Healthcare Package Plus (BHP+).

The Commission having recommended for the provision on the right to health under the proposed legislation, examined the dimensions of the right to health under international law and obligations that could be placed on Malaŵi if the right was provided for under law. The Commission noted the following dimensions—

(a) Non-discrimination

The Commission noted that grounds and categories of victims of discrimination cannot be exhaustive. Discrimination evolves although there are commonly known victims. The Commission resolved to incorporate, if any, grounds listed under the non-discrimination clause of the Constitution.

(b) Accessibility (physical, economic and information)

The Commission was of the view that the state should not only bear the obligation to make facilities, goods and services available but should also make them accessible to the diversity of the population including persons with disability, the elderly and children. Economic accessibility requires that facilities, goods and services must be affordable. It is clear even from the Committee on Economic, Social and Cultural Rights that there is no obligation to make health facilities, services and goods free. The Commission noted that in practice, health facilities, goods and services are not free as people are required to make direct or indirect financial contribution towards delivery. The Commission, also, noted that in light of the cost of operating HSSP II, the strategic plan had considered estimates of the financial resources required and available in the health sector to guide implementation of the HSSP II. [193] The Commission observed that there is need to consider the issue of health insurance seriously to mitigate the burden of accessing goods and services for impecunious individuals.

The Commission noted that health insurance is one of the means for health financing hence the question was whether such interventions should be limited to health insurance or whether it should be the responsibility of government to identify other means of health financing. The Public Health Act does not provide for health insurance. Health insurance is an insurance that is taken out to cover the cost of medical care. It is a system for the financing of medical expenses through contributions or taxes paid into a common fund so as to pay for all or part of health services specified in an insurance policy or the law. [194] The main common features are that health insurance entails advance payment of premium or taxes, pooling of funds, and eligibility for benefits is based on contributions or employment. [195] The major purpose of health insurance is to ensure access to preventive and emergency treatment in view of increasing costs of medical care. The Commission considered making provision for health financing to permit local communities, where necessary, to contribute towards health programmes

[193] Government of the Republic of Malaŵi, Health Sector Strategic Plan II pp. 56.
[194] Encyclopedia Britannica, Health Insurance. Available at https://www.britannica.com/topic/health-insurance Accessed on 3 December, 2019.
[195] As above

meant for ensuring their own well-being. It observed that many people in rural areas access health care services through limited public health facilities or Christian Health Association of Malaŵi (CHAM) facilities at a fee. Thus, it is possible for them to pay for health services if they may be required under law to contribute an amount towards health financing. However, the Commission warned itself that the disadvantages of this approach include further alienation of particular groups of people in society, especially the poor, from accessing health services.

During a comparative study visit to Namibia, the Commission learnt that health financing of the health system in Namibia, twenty (20) percent of the population contribute through medical aid scheme CIMAS (Public Service Employee scheme) or five private medical aid schemes while eighty (80) percent of the population is covered by public health financing.[196] The public health system in Namibia is financed mainly through the state resources but patients pay only very minimal fees for the service ranging from N$4 for visits to small clinics, N$8 for visits to health centre, and N$14 for hospital.[197] However, Namibia's policy is that where a person shows up at a health facility must be assisted even where the person is unable to pay the stated fees but official at the hospital must encourage a person to make a contribution.[198]

Therefore, one of the considerations to be taken into account is that a person who cannot afford health insurance should be exempted from payment for health services. The Commission, therefore, resolved that the legislation to be developed should provide for health insurance styled as "health financing".

The Commission noted that information accessibility includes the right to seek, receive and impart information and ideas concerning health issues. It also noted that health personnel tend to have more information on health issues but such information is not shared with people. However, the Commission opined that accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Availability

The Commission considered the number of facilities available against the population and the acceptable distances for people to reach the nearest facility. The Ministry of Health plans that clients should not live more than approximately 8 kilometres from health facilities.[199] The Commission noted the important dimension of availability of facilities, goods and services which is dependent on training and remuneration for personnel in the sector. The Commission was aware of various interventions that have been put in place to address such challenges. The Commission, further, noted that the incompleteness of devolution of services

196 A Report on a Comparative Study visit to Namibia conducted from 4th to 11th September, 2022 by the special Law Commission on the Review of the Public Health Act, pp.5.
197 As above.
198 As above.
199 Government of the Republic of Malaŵi, Health Sector Strategic Plan II pp. 8.

to local government authorities creates loss of human resources to more lucrative sectors. The Commission, therefore, recommends that to attain the availability of facilities, there is need to ensure the retention of personnel, among others.

(d) Acceptability

The Commission noted that acceptability of facilities, goods and services has to be measured against human rights in general considering that sometimes competing rights pose some challenges. The Commission, further, noted that acceptability is already entrenched in the practice of sector personnel and may lead to termination of services if it is not observed. While the Committee on Economic, Social and Cultural Rights noted a number of grounds that would constitute acceptability, it was noted that public health interventions may not be acceptable to all based on religious grounds. In Malaŵi, freedom of religion is entrenched as non-derogable; non-limitable; and non-restrictable even in a state of emergency.[200] This constitutional protection would create problems in enforcing some public health coercive measures which include immunization and epidemic responses. However, the Commission consulted select faith leaders to understand reasons for refusal of administration of vaccines in children, blood transfusion and health services generally. The Commission noted that the reasons ranged from the understanding of scripture by the faith leaders, adherence to religious doctrines and perceived availability of alternative means of treatment, for instance artificial blood products instead of blood transfusion. The Commission, further, noted that this presented a potential conflict between religion and provisions of the Constitution. The Commission, therefore, observed that where a person refuses medical treatment, the considerations to be considered should be as follows—

(i) where a child is concerned, the best interests of the child;

(ii) in the case of an adult, the exercise of rights by the adult should not cause harm to others; and

(iii) the coercive nature of public health.

Finally, the Commission noted that there is need to entrench access to information within the sector and in delivery of services and goods. This implies the obligation to respect privacy within the bounds of protecting individuals whose rights may be infringed in the course of delivery of services and goods.

(*e*) *Quality*

The Commission reiterated the need for quality delivery of goods and services. The Commission noted that this is especially critical for drugs and service delivery. The Commission was aware that there are institutions which are expected to monitor the quality of provision of goods and services. These institutions include regulatory bodies which have a clear mandate to regulate quality, for instance the Nurses and Midwives Council; the Medical Council of

[200] Section 45 (2) (*h*) of the Constitution.

Malaŵi; and the Pharmacy and Medicines Regulatory Authority.[201] It was observed, however, that these institutions lack adequate personnel and the required facilities to carry out their mandate. The Commission recommends that as matter of policy, government should ensure strengthening capacities of the institutions to effectively deliver their mandate. The Commission noted that quality extends to underlying determinants of health and the need to regulate the various aspects of the determinants. These include safe and potable water, waste disposal and sanitation. As such, the Commission has made appropriate recommendations with regard to waste management in this Report. Further, the Commission noted that to realize the right to health, there is need for liaison between authorities responsible for various determinants to check whether the determinants contribute positively to the objectives of the legislation to be developed.

(*f*) *Limitations*

The Commission considered identification of areas and circumstances during which the right to health may be limited. Ultimately, the Commission resolved to adopt the grounds listed in the Constitution and apply them to the right to health and added that the limitations should be proportional and the least restrictive when implemented.

Therefore, the Commission recommends the adoption of the following provisions on health insurance and contribution to health services:

Contributions to health service

…—(1) A person accessing health services at a public health facility shall be required to pay a nominal fee as prescribed by the Minister from time to time

(2) Notwithstanding subsection (1), a person who has insufficient means to enable him to pay the nominal fee shall have access to health services at the expense of the State.

(3) The Minister may by order published in the gazette issue directives for the implementation of subsection (2).

3.5 Quality of Health Care

The health sector goals of the Government are as follows:

(*a*) to improve the health status of Malaŵians; and

(*b*) to ensure that the population is satisfied with the health services provided and does not suffer avoidable financial risks in the process of accessing healthcare.

In 2017, the country developed the Quality Management Policy for the Health Sector (QMP).

[201] Formerly the Pharmacy, Medicines and Poisons Board.
[202] Government of Malaŵi, Ministry of Health and Population, 'Quality Management Policy for the Health Sector' pp. 1.

The QMP identifies seven priority areas where all stakeholders in the health sector should focus their efforts and resources to address challenges affecting the quality of health services.[203] The priority areas are as follows:

(*a*) leadership, governance and accountability;

(*b*) human resources for health (HRH);

(*c*) clinical practice;

(*d*) client safety;

(*e*) people-centred care;

(*f*) support systems; and

(*g*) evidence-based decision making.[204]

Based on the priority areas, the QMP specifies the policy goal, expected policy outcomes, objectives, policy statements, and strategies to improve quality of care.[205] Further, the QMP provides a monitoring and evaluation framework with outputs and performance indicators for each priority area to guide stakeholders when designing, implementing, and evaluating quality initiatives. [206]

The Commission noted that health profession regulatory bodies are not fulfilling their mandate of ensuring delivery of quality care, as such it is recommended that these institutions be strengthened to carry out their inspectorate duties to promote the delivery of quality, dignified, and respectful care.

3.5.1 Levels of Care

HSSP II states that there are three levels of care, namely primary level, secondary level and tertiary level.[207] To ensure access to essential health services for all population groups in the country including those residing in rural hard to reach areas, health services are delivered at four levels in Malaŵi. Within each level there are referral system for patients and clients who require advanced level of care provided at a higher level.

The first level of care comprises of the community and health posts where HSAs and a wide range of volunteers provide promotive, preventive and minimal curative care through outreach family health clinics, IMCI/EPI village clinics, growth monitoring and nutrition counselling for under-five children, home visits, distribution of health commodities such as ITNS and promotion of WASH activities. The HSAs and volunteers are supported by other health care workers in the delivery of the community based services. A health surveillance assistant is responsible for about 1,000 people and there are about 11,000 HSAs.

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[203] As above, pp. 2.
[204] As above.
[205] As above.
[206] As above.
[207] Government of the Republic of Malaŵi, Health Sector Strategic Plan II pp. 15-16.

HSAs mainly provide "promotive and preventive health care through door-to-door visitations, village clinics and mobile clinics (Ministry of Health, 2011)."[208]

The second level of care comprises dispensaries, health centres, private maternity units and clinics. Health centres are an entry into the formal health care system and they provide all primary health services including basic emergency obstetric and neonatal health services. Health centres offer outpatient and maternity services and are designed to serve a population of 10,000.[209] Personnel providing the range of primary health services at health centre level include clinicians, nurses, midwives, and other allied health professionals. The Commission noted that health centres in hard to reach areas are mostly manned by the lowest cadre workers that are least trained to provide a comprehensive package of Essential Health Services. The Commission therefore makes a policy recommendation that health centres where most of the population receives their primary health centres should be managed by either registered nurse midwives or clinical officers supported by the relevant health professionals.

The third level of care comprise of district, CHAM and other private hospital who provide secondary level of care including surgical interventions. Services are provided by a team of health professionals. Hospitals also provide a package of primary health services for populations within their catchment areas. Secondary level health care facilities account for 9.5% of all health care facilities and provide referral services to health centres and community hospitals.[210] Further, secondary level health care facilities provide the surrounding populations with both outpatient and inpatient services.[211]

The fourth level of care is provided by teaching or central hospitals who provide a wide range of specialized medical services while providing referral services for secondary level facilities. The tertiary level ideally provide specialist health services at regional level and referral services to district hospitals within the region in which they are located.[212] In practice, however, around 70% of the services provided by tertiary level facilities "are either primary or secondary services due to lack of a gate-keeping system (Ministry of Health, 2011)."[213]

The Commission therefore recommends, that as a matter of policy, primary and tertiary level health services should be handled at the appropriate levels.

3.5.2 Emergency Care

The Commission identified the following issues for consideration:

(*a*) emergency care in cases of road accidents, ingestion of poison, contraction of bacteria and virus infections, among others; and

[208] As above.
[209] As above.
[210] As above.
[211] As above.
[212] As above.
[213] As above

(*b*) the institution responsible for responding to public health emergencies.

Emergency care refers to health care services provided in a freestanding emergency medical care facility to evaluate and stabilise a medical condition that has recently occurred and of severity, including severe pain, psychiatric disturbances or symptoms of substance abuse. Emergency care seeks to avert placing the person's health in serious jeopardy; impairment of bodily functions; dysfunction of a body organ or part; or in case of a pregnant woman, serious jeopardy to the health of the woman or foetus.

The Commission noted that the Public Health Act only provides for medical officer of health who has been defined as the Secretary for Health or any medical officer appointed by the Secretary for Health to act as such in an area.[214] The Secretary for Health is responsible for all health-related matters including public health. In addition, the Commission noted that there is no provision for an office equivalent or similar to that of Public Health General and Public Health Corps. The Commission, therefore, considered whether in addition to the "medical officer of health" or Secretary for Health, the legislation to be developed should provide for the establishment of a "Public Health General and Public Health Corps" responsible for emergency health issues including prevention, tracing and managing disease outbreaks as well as bioterrorism. The existing framework for dealing with disasters in Malaŵi includes the Disaster Preparedness and Relief Act;[215] policy guidance on clusters for Water, Sanitation and Hygiene (WASH) and general health in response to disasters;[216] and search and rescue clusters.

The Commission noted that, on the one hand, the Disaster Preparedness and Relief Act[217] makes provision for "the co-ordination and implementation of measures to alleviate effects to disasters, the establishment of the office of Commissioner for Disaster Preparedness and Relief, the establishment of a National Disaster Preparedness and Relief Committee of Malaŵi, and for matters incidental thereto or connected therewith".[218] However, the Act does not specifically address the provision of care during a public health emergency. Comparatively, article VI of the Model State Public Health Act (MSPHA) of the United States of America, provides for public health emergencies. This includes planning for a public health emergency;[219] declaring a state of public health emergency;[220] management of property;[221] protection of individuals;[222] and

214 Section 4.
215 Cap. 33:05 of the Laws of Malaŵi.
216 For instance, see Global WASH Cluster, "Water, Sanitation and Hygiene (WASH) Cluster Coordination Handbook"Available at https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/WASH%20Cluster%20Coordinator%20Handbook.pdf Accessed on 15 January, 2020.
217 Cap. 33:05 of the Laws of Malaŵi.
218 Long title to the Act.
219 Section 6-101.
220 Section 6-102.
221 Section 6-103.
222 Section 6-104.

compensation.[223] Section 6-102[c] of the MSPHA provides for the effect of the declaration of a state of public health emergency as follows:

"The declaration of a state of public health emergency shall activate the response and recovery aspects of the state, local, and inter-jurisdictional disaster emergency plans in the affected political subdivision(s) or geographic area(s). Such declaration authorizes the deployment and use of any forces to which the plans apply and the use or distribution of any supplies, equipment, and materials and facilities assembled, stockpiled, or available pursuant to this Article."

The Commission, further, noted that the United States of America provides a good example of a structure for emergency care styled the Commissioned Corps of the U.S. Public Health Service or USPHS Commissioned Corps.[224] The USPHS Commissioned Corps works on the front lines of public health and its "medical, health and engineering professionals fight disease, conduct research, and care for patients in underserved communities across the nation and throughout the world."[225] It is established under the Public Health Service which is a major agency of the United States Department of Health and Human Services. The Public Health Service Commissioned Corps is led by the Surgeon General and it has a wide range of specialities such as veterinarians, dentists, engineers, pharmacists, nurses, environmental health specialists, scientists, dietitians and other allied health professionals. The mission of the Public Health Service Commissioned Corps is to protect, promote and advance the health and safety of the nation. It is responsible for, among others:

(*a*) providing healthcare and related services to medically underserved populations;

(*b*) prevention and control of diseases, identifying health hazards in the environment and help in correcting them, and promote healthy lifestyles for the nation's citizens;

(*c*) ensuring that medical devices are safe and effective, food is safe and wholesome, cosmetics are harmless and that electronic products do not expose users to dangerous amounts of radiation; and

(*d*) conducting and supporting biomedical and health research, and communicating research results to health professionals and the public.

The Commissioned Corps achieves its mission through: rapid and effective response to public health needs; leadership and excellence in public health practices; and advancement of public health science. The Commissioned Corps emergency response teams are trained and equipped to respond to public health crises and national emergencies such as natural disasters, disease outbreaks, or terrorist attacks, both in the U.S. and overseas. Officers have responded to

223 Section
224 Commissioned Corps of the U.S. Public Health Service. Available at https://www.usphs.gov/ Accessed on 6 August 2020.
225 As above

emergencies such as the Ebola response in West Africa, Hurricane Katrina, the earthquake in Haiti, and the Deepwater Horizon oil spill."[226]

The Commission, further, considered public health emergencies and institutional infrastructure that can be established to declare and handle such issues. The Commission recalled that the IHR incorporate a number of innovations including obligations of states parties to develop minimum core public health capacity; and to inform the WHO of events that may constitute public health emergency of international concern as defined under the Regulations.[227] The Commission was, therefore, of the view that at the national level a similar structure may be established to coordinate all sectors and stakeholders working in the area of public health. During regional consultative workshops that the Commission conducted, stakeholders suggested that a separate office of the Public Health General should be established. The office should be responsible for public health emergencies as the existing set up may not be responsive, especially where the Secretary for Health is not a medical expert. The Commission resolved that the legislation to be developed should provide for the office of the Public Health General and Public Health Corps to be responsible for handling public health emergencies, among others. The Commission agreed that there is need for a public health corps whose duty is to do surveillance and response. It was suggested that the public health corps must be incorporated into the system. Further, the Commission reiterated its earlier recommendations and agreed that the corps should be under the PHIM. The Commission thus resolved that there is need to establish a directorate solely for public health. The Commission after a lengthy discussion on whether there was need to establish a directorate dedicated to public health resolved to retitle the Directorate of Preventive Health to the Directorate of Public Health and that the Director of Public Health shall head the directorate. The Commission thus recommends accordingly.

However, the Commission opined that the mandate to declare a public health emergency should be with the Minister responsible for health to elevate the status of public health in the general health system and ensure effective and efficient coordination. The Commission however, reiterated its earlier recommendation to establish a body styled "Public Health Institute of Malaŵi" which shall be served by a wide range of public health specialists, among others, public health officers at district level.

The Commission also considered scenarios where a road accident occurs and the only nearby health facility is a privately owned clinic that requires patients to pay before they can access the services and the person involved does not have the means to pay. Another scenario is where a woman is raped and needs to be assisted with emergency contraceptives to avoid pregnancy; and treatment to

226 Office of the Surgeon General, "U.S. Public Health Service Commissioned Corps". Available at https://www.hhs.gov/surgeongeneral/corps/index.html Accessed on 10 August, 2020.

227 World Health Organization, "What are the International Health Regulations and Emergency Committees?" Available at https://www.who.int/features/qa/39/en/index.html Accessed on 5 December, 2019.

avoid contracting HIV. The Commission was of the view that these instances warrant the person to receive treatment at a nearby health facility for free to avoid serious jeopardy to one's health. The Commission, therefore, recommends that all health facilities should provide emergency health care such as Covid-19 care for free to help save lives and mitigate the effects of delays in receiving treatment.

The Commission thus recommends adoption of the following provisions—

Declaration of public health emergency

...— (1) The Minister may declare a public health emergency by notice published in the *Gazette* where there is a situation that poses an immediate risk to health, life, property or the environment and may, in the same notice, prescribe preventive measures.

(2) To meet the criteria for a public health emergency, the incident should—

(*a*) immediately threaten life, health, property or the environment;

(*b*) have already caused loss of life, detriment to health, damage to property or the environment; or

(*c*) have a high probability of escalating to cause immediate danger to life, health, property and the environment.

Emergency powers in respect of public health matters

...— (1) The Minister may direct a public health official or other authorized officers to respond immediately to a public health emergency;

(2) The officers in subsection (1) shall have the power to enforce preventive measures prescribed under a notice in section …. or order an individual to be isolated or quarantined.

(3) A public health officer or authorized officer under subsection (1) may act outside his normal area of operation.

Emergency treatment

...— (1) A health care provider, public or private health worker or health establishment shall provide emergency treatment to any person requiring such service.

(2) For the purposes of this section, emergency treatment means medical treatment of sudden and life threatening bodily injuries and illnesses.

3.5.3 Rights and Duties of Health Care Providers, Health Care Workers and Health Consumers

The term "health care provider"[228] refers to the facility, for instance, a hospital; "health care worker"[229] means health professionals, medical, nursing, midwives and allied professionals; and "health care consumer"[230] refers to clients and patients seeking access to health care or accessing health care. While there are minimum standards which are expected in relation to each category, by and large, the rights and duties which apply to each category are influenced by domestic laws, the nature of health care that is provided, the field of expertise of the professional, and the nature of health care services.

The Commission noted that the Ministry of Health developed a Charter on Patients' and Health Service Providers' Rights and Responsibilities. The Charter provides for the following rights with respect to a patient:

(*a*) access to health care, which includes—

(i) treatment according to his or her need;

(ii) the right to be cared for by a competent health care worker;

(iii) the right to access medicines, vaccines and other pharmaceutical supplies of acceptable standards; and

(iv) the right to prompt emergency treatment from the nearest public or private health facility;

(*b*) choice and second opinion;

(*c*) adequate information and health education;

(*d*) informed consent or refusal of treatment;

(*e*) participation or representation;

(*f*) respect and dignity;

(*g*) access to a guardian;

(*h*) privacy and confidentiality;

(*i*) safe environment; and

(*j*) fair administrative remedy.

228 Also known as health care institution.
229 Also known as health worker.
230 Also known as user.

As regards the health care worker, the Charter provides for the following rights:

(*a*) access to equipment and supplies;

(*b*) continuing education;

(*c*) respect and dignity;

(*d*) working hours and rest;

(*e*) occupational health and protection;

(*f*) professional practice; and

(*g*) fair administrative remedy.

The highlighted rights carry responsibilities. For instance, a patient should ensure that he or she is conducting himself or herself in a manner that does not interfere with the rights or well-being of other patients and health professionals. Further, the patient has the responsibility to accept the consequences of his or her own informed decision; and to provide health professionals with relevant and accurate information for diagnostic treatment, rehabilitation or counselling purposes. The health care worker has responsibilities to conduct duties in the best interests of the patient; and to comply with ethical requirements, among others.

The Commission noted that the Ministry of Health has not developed corresponding provisions on the rights and duties of health care providers either in the Charter or any other document. In South Africa, the National Health Act[231] provides for rights and duties of users and health care personnel.[232] The rights and duties of users include:

(*a*) a mandatory duty to provide information to a user so that he or she has full knowledge about health status, range of diagnostic procedures and treatment options, their benefits, risks, costs and consequences and the user's right to refuse health service and explain the implications, risks, obligations of the refusal;

(*b*) information must be provided in a language that the user understands, taking into account the user's level of literacy;[233]

(*c*) obtaining informed consent from users;[234]

(*d*) providing users with a discharge report;[235]

(*e*) disseminating information;[236]

(*f*) obligation to keep record;[237]

231 National Health Act of the Republic of South Africa, 2003.
232 Chapter 2: Section 20 of the National Health Act of the Republic of South Africa, 2003.
233 Section 6 of the National Health Act of the Republic of South Africa, 2003.
234 Section 7 of the National Health Act of the Republic of South Africa, 2003.
235 Section 10 of the National Health Act of the Republic of South Africa, 2003.
236 Section 12 of the National Health Act of the Republic of South Africa, 2003.
237 Section 13 of the National Health Act of the Republic of South Africa, 2003.

(*g*) confidentiality;[238] and

(*h*) protection of health records[239].

The rights and duties of health care personnel include:

(*a*) not to be unfairly discriminated against on account of health status,[240] and that a health establishment must implement measures to minimize injury or damage to the person and property of health care personnel working at the establishment;

(*b*) to minimize disease transmission; and

(*c*) to recognize that a health care provider is entitled to refuse treatment to a user who is physically or verbally abusive or who sexually harasses him or her.[241]

In the case of Malaŵi, the Commission noted that the health sector implemented initiatives to identify health workers designated as "Hospital Ombudsman" as a mechanism for handling complaints in health facilities. The Commission, therefore, recommends making provision for a Charter containing rights and duties of health care providers similar to those covered under comparable legislation in South Africa to protect health care providers. Further, the Commission observed that the mechanism of Hospital Ombudsman was operational and that the Hospital Ombudsman reports to the District Health Officer. However, the Commission opined that there is need to source such an officer outside the hospital administration to ensure efficiency and independence in handling complaints. The Commission therefore recommends that every hospital should have a Hospital Ombudsman under the office of the Ombudsman in order to ensure independence of the office.

3.6 Health Services Infrastructure

In Malaŵi, "infrastructure" refers to physical structures required at a district hospital or other health facilities. The WHO defines public health infrastructures as "the formal and enduring structures that support public health" which comprise institutions and capacity; knowledge (of public and professional); and commodities (physical infrastructure).[242] Public health infrastructure exists inside and outside the government sector.[243] Elements of public health infrastructure that tend to be easiest to recognise and to describe include those concerned with communicable disease control (including the safety of food), the protection of the health of mothers and children and the control of environmental contamination.[244]

238 Section 14 of the National Health Act of the Republic of South Africa, 2003.
239 Section 17 of the National Health Act of the Republic of South Africa, 2003.
240 Section 20 (1) of the National Health Act of the Republic of South Africa, 2003.
241 Section 20 (3) and (4) of the National Health Act of the Republic of South Africa, 2003.
242 World Health Organization, "Public Health Infrastructure and Knowledge" Available at https://www.who.int/trade/distance_learning/gpgh/gpgh6/en/index1.html Accessed on 15 January, 2020.
243 As above.
244 As above.

However, in all these cases, effective improvements in public health require the following elements:

(*a*) institutions and capacity appropriate to respond to these problems and associated tasks (given the needs and circumstances of the country involved);

(*b*) knowledge, as assimilated and put to use both by the general population and by professional and administrative staff; and

(*c*) necessary commodities (resources or "tangible" infrastructure).[245]

In the United States of America, section 1-102(46) of MSPHA defines "public health infrastructure" as "the competencies and resources that enable public health agencies, in collaboration with other components of the public health system, to provide essential public health services and functions throughout the state."[246] Article III of thee MSPHA asserts the need to develop a strong infrastructure, which requires the coordinated efforts of state or local public health agencies and others within the public health system to:

(*a*) identify and provide leadership for the provision of essential public health services and functions;

(*b*) develop and support an information infrastructure that supports essential public health services and functions;

(*c*) develop and provide certification, credentialing, or effective training for members of the public health workforce;

(*d*) develop performance management standards for the public health system that are tied to improvements in public health outcomes or other measures;

(*e*) consider participation in voluntary accreditation programmes for state or local public health agencies;

(*f*) provide incentives for and evaluation of workforce development efforts, performance management, and accreditation standards; and

(g) comprehensively plan and set priorities for the accomplishment of essential public health services and functions. [247]

The Commission found that there is a gap in the availability of information on the status of health service infrastructure in Malaŵi. The Commission made a policy recommendation that the government should develop and support an information infrastructure aimed at supporting essential public health services and functions to ensure effective improvements in public health.

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245 World Health Organization, "Public Health Infrastructure and Knowledge".

246 The Turning Point Public Health Statute Modernization Collaborative, The Model State Public Health Act: A Tool for Reforming Public Health Laws (2003). Available at https://www.law.asu.edu/sites/default/files/multimedia/faculty-research/centers/phlp/turning-point-model-act.pdf Accessed on 18 September, 2017.

247 The Turning Point Public Health Statute Modernization Collaborative, 'The Model State Public Health Act: A Tool for Reforming Public Health Laws' (2003) pp. 12.

4.0 PUBLIC HEALTH AND ETHICS

4.1 General

The Commission considered the legal and ethical issues arising with respect to public health and including euthanasia, abortion and consent. It was observed that issues of consent in health are not as controversial as they seem. Medical practitioners are trained and advised to seek consent from patients whenever the medical procedure requires an invasion onto the body of the patient. Controversies normally arise in cases where the patients are children, unconscious or have mental health issues in which case consent is sought from an adult, next of kin or guardian. The Commission, further, observed the emphasis that medical practitioners are trained to save life and, therefore, they would do anything possible to save the lives of patients under their care. The practice followed is that patients or their next of kin sign a form consenting to the invasive procedure. The Commission noted that consent is not only sought for medical procedure, but also for research.

The Commission discussed the allegations that pregnant women are forced to test for HIV and AIDS whenever they have gone for antenatal care. It was noted that HIV and AIDS testing and counselling (HTC) under the UN Guidelines issued by UNAIDS [248] includes confidentiality, consent and counselling. The Commission noted that HTC for pregnant women is not necessarily the same as voluntary counselling and testing (VCT) as it is offered by the facility as a matter of routine when a woman falls pregnant and is due to deliver and entitled to receive antenatal care. Prior to the emergence of HIV and AIDS, pregnant women were being advised and encouraged to test for sexually transmitted infections (STIs). The Commission, therefore, concluded that women are not forced but advised to test for HIV.

The dominance of HIV and AIDS necessitated the inclusion of HIV testing in the antenatal package. As discussed under consent in the following paragraphs, the Commission emphasized that consent is required when administering curative medicine and there is an invasion of the body. However, the Commission observed that issues of HIV testing hinge on the right to privacy as well, thus pregnant women still have a right to opt out of any diagnostic test included in the antenatal care package. The Commission, further, observed that medical practitioners are encouraged to explain to pregnant women the advantages of HIV testing and counselling. The Commission was of the view that emphasis should not be placed on HIV and AIDS only as there are other highly infectious and fatal diseases which require attention. The Commission noted that section 18 of the HIV and AIDS (Prevention and Management) Act [249] prohibits compulsory HIV testing and recommends accordingly.

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248 See Ministry of Health, "Malaŵi HIV Testing Services Guidelines" (2016). Available at https://aidsfree.usaid.gov/sites/default/files/htc_Malaŵi_2016.pdf Accessed on 16 January, 2020.

249 No. 9 of 2018.

4.2 Consent

Consent to medical treatment may be defined as permission that a person gives before they receive any type of medical treatment, test or examination. Informed consent on the other hand, is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention.[250] The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention. Informed consent is both an ethical and legal obligation of medical practitioners and originates from the patient's right to direct what happens to their body. Implicit in providing informed consent is an assessment of the patient's understanding, rendering an actual recommendation, and documentation of the process. The required standard for informed consent is determined by the state. The three acceptable legal approaches to adequate informed consent are (1) Subjective standard: What would this patient need to know and understand to make an informed decision? (2) Reasonable patient standard: What would the average patient need to know to be an informed participant in the decision? (3) Reasonable physician standard: *What would a typical physician say about this procedure?*[251]

The Act does not provide for issues of consent. Consent is anchored in the right to personal liberty and security, and bodily integrity.[252] The Constitution guarantees the right of every person to personal liberty. [253] The right of personal liberty consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation.[254] Again, section 19 (5) of the Constitution prohibits the subjection of any person to medical or scientific experimentation without his or her consent. There is however no specific legislation criminalising acts of a medical nature conducted without consent. The Penal Code provides that a doctor who performs a surgery, in good faith and for the benefit of the patient is not criminally responsible.[255] Again, section 246 of the Penal Code criminalizes reckless negligent medical treatment. The Code of Ethics for the Medical Council of Malaŵi however urges all practitioners to ensure that as far as possible informed consent is obtained before any procedure is carried out on a patient.[256]

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250 Slim K, Bazin JE. 'From informed consent to shared decision-making in surgery'. J Visc Surg. 2019 Jun;156 (3): pp. 181-184. [PubMed].

251 Boskey ER, Johnson JA, Harrison C, Marron JM, Abecassis L, Scobie-Carroll A, Willard J, Diamond DA, Taghinia AH, Ganor O. 'Ethical Issues Considered When Establishing a Pediatrics Gender Surgery Center.' Pediatrics. 2019 Jun;143(6) [PubMed]

252 CESCR General Comment No. 14: 'The Right to the Highest Attainable Standard of Health (Art. 12)' Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4)

253 Section 18 of the Constitution.

254 Blackstone on the Absolute Rights of Individuals (1753), Philadelphia: J.B. Lippincott Co., 1893). Vol. 1 - Books I & II. Chapter I.: of the Absolute Rights of Individuals.

255 Section 243 of the penal Code.

256 Section 5 (6) of the Code of Ethics for the Medical Council of Malaŵi.

Comparable study conducted by the Commission showed that regionally, several states have legislative framework specifically addressing issues of consent in medical procedures. In South Africa, legal requirements for obtaining informed consent are codified in Section 7 of the National Health Act 2003 (NHA). Under the NHA, a doctor or other healthcare practitioner in South Africa must provide a patient with the following information before getting consent to a procedure:

(*a*) the patient's health status (unless, based on substantial evidence, this disclosure isn't in the patient's best interests)

(*b*) available diagnostic procedures and treatment options for addressing the patient's health issue(s)

(*c*) for each alternative, relevant benefits, risks and consequences

(*d*) the right of the patient to refuse treatment and relevant implications, risks and obligations.[257]

In South Australia, consent in medical procedures is governed by the Consent to Medical Treatment and Palliative Care Regulations 2014 under the Consent to Medical Treatment and Palliative Care Act 1995.

The Commission noted that a medical malpractice claim can be pursued if a medical procedure results in serious injury (or death) and the patient's informed consent was not properly obtained. At common law, lack of broad consent to the nature of treatment would lead to damages in tort for trespass to person.[258]

4.2.1 Consent in Children

Section 23 (6) of the Constitution defines a child as a person below the age of eighteen years. Section 4 of the Act provides that a child is "a person who is under or appears to be under eighteen years of age". The Commission noted, further, that section 13 (1) of the HIV and AIDS (Prevention and Management) Act provides that a child who is at least thirteen years old does not require consent from a parent or a legal guardian to access voluntary counselling and testing for HIV infection. Parents or guardians have the responsibility to provide consent to treatment on behalf of a child when the child is unable to provide valid consent for himself or herself, provided the treatment is in the best interests of the child.

Under section 5 (6) of the Code of Ethics for the Medical Council of Malaŵi, in the case of persons who may be unable to give informed consent including minors, the most senior practitioner in consultation with the parent or guardian may give consent for the procedure or treatment, and such consent should as far as possible be witnessed by a second practitioner. In the event of differing opinion between the parent or guardian and the practitioner, the practitioner's stand shall prevail in the best interest of the concerned person. The Commission, therefore, resolved that despite the various ages at which children may not need consent

257 Section 7 of the National Health Act of South Africa, 2003.
258 Airedale NHS Trust v Bland [1993] 1 All ER 821 (HL); McHale J, Fox M, Murphy J. Health Care Law: Text, cases and materials. 1st ed. London: Sweet and Maxwell; 1997:319.

according to medical practice or as specified by legislation, generally children below the age of eighteen years require consent.

The Commission considered the provisions of the Child Care, Protection, Justice Act[259] on the subject matter, and observed that the Act provides for matters of consent to medical treatment only in cases where a child is in distress or in conflict with the law[260]. According to the Act, if, in the opinion of the medical officer, a child who has been hospitalized is suffering from a minor illness, injury or condition, the treatment may be authorized by a social welfare officer, or where it is a serious illness, injury or condition requiring surgery or psychiatric examination or treatment, a social welfare officer or police officer is required to consult and get consent from parents or guardians. In the event where a parent or guardian of a child in need of medical or surgical treatment has unreasonably refused to give consent or cannot be found within a reasonable time or has ill-treated the child, a social welfare officer or police officer may give consent. The Commission was of the view that since both Constitution and the Child Care, Protection, Justice Act[261] have a gap on the subject matter, the proposed legislation should provide for consent in children generally.

During a comparative study visit to Namibia, the Commission learnt that before the enactment of the Child Care and Protection Act of Namibia the Ministry of Health used to face similar challenges as those in Malaŵi in order for a child to access treatment where a parent refuses to give consent to treatment on behalf of the child due to religious beliefs.[262] In such scenarios the Ministry of Health used to obtain a court order, in order to, for example, give the child blood through blood transfusion. However, the Child Care and Protection Act of Namibia now allows the child to get treatment and a parent in Namibia cannot interfere. The Commission also learnt that for an adult patient the Ministry of Health still goes to court to obtain a court order in cases where it is to save a person's life but treatment is being refused on the basis of religious belief.

The Commission noted that under the law, children are not compelled to receive treatment or to be subjected to scientific experiment. However, there are instances when parents withhold consent on behalf of a child to receive immunization. For example, two children died of measles in Chinsapo, Lilongwe in April, 2010 as elders of a church did not allow parents to take their children to hospital.[263] In addition, refusal of blood transfusions or cholera treatment by members of some religious groups pose challenges to government efforts to deal

259 Cap 26:03.
260 Sections 26 to 30.
261 Cap 26:03.
262 The special Law Commission on the Review of the Public Health Act: 'A report on a Comparative Study Visit to Namibia'.
263 Strohbehn, Ulf, 'The Zionist Churches in Malaŵi: History –Theology- Anthropology'. Available at: https://books.google.mw/books?id=ukwxDAAAQBAJ&pg=PA443&lpg=PA443&dq=Zionist+refusal+of+immunization+in+Malaŵi&source=bl&ots=XCs_6vJ0Ac&sig=ACfU3U2Ew8xlE2HQy6PhSO0KIojFcg6hvg&hl=en&sa=X&ved=2ahUKEwir2Pzb9J7mAhVz6uAKHS-QD58Q6AEwGHoECAoQAQ#v=onepage&q= Zionist%20refusal%20of%20immunization%20in%20 Malaŵi&f=false. Accessed on 5 December, 2019.

with these public health matters.[264] One view advanced by some religious institutions is that by refusing blood transfusion for example, a parent acts in the best interests of the child unless the state can demonstrate that the parent's health care choice does not meet the baseline standard of adequate or necessary medical treatment for the child considering that there are many non-blood management strategies that are available to treat children.[265] The Commission considered the extent to which a parent or guardian may refuse immunisation or treatment on behalf of a child on the basis of exercising religious freedoms enshrined under section 33 of the Constitution. The Commission acknowledged that the guiding principle in matters relating to children is that the best interests of the child is of paramount consideration. Thus, where children are concerned, the best interests of the child should prevail over the parental exercise of religious freedoms under the Constitution.

In the same vein, the Commission considered the concept of evolving capacities which has been defined as an enabling principle that addresses the process of maturation and learning through which children progressively acquire competencies, understanding and increasing levels of agency to take responsibility and exercise their right.[266] This transformation does not take place at a fixed point in a child's development but tends to steadily increase as the child is encouraged to contribute her or his views.[267] The Commission noted that the concept of evolving capacity positions the child's right rather than that of a parent at its core. For example, in other jurisdictions people aged sixteen or over are entitled to consent to their own treatment in that this can only be overruled in exceptional circumstances. The rationale being that like adults, young people who are aged sixteen or seventeen are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest to the contrary. While children under the age of sixteen can only consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment otherwise someone with parental responsibility can consent for them.

In view of the above discussion on consent relating to a child, the Commission found the need to make provision for consent to medical treatment or surgical operation under the proposed legislation bearing in mind that it is already a common practice that patients are required to give consent to any medical treatment that involves an invasion of the body. The rationale being to safeguard the best interest of a child. The Commission thus resolved to make

264 As above.

265 See para. (*b*) of the write up by the Association of Jehovah's Witnesses of Malaŵi dated 31st August, 2018 submitted to the Law Commission as a response to issues raised by the special Law Commission on the Review of the Public Health Act.

266 UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016, CRC/C/GC/20, available at: https://www.refworld.org/docid/589dad3d4.html [accessed 25 July 2022] para.18.

267 UN Committee on the Right of the Child (CRC), General comment No.12 (2009): The Right of the Child to be heard, 20 July 2009, CRC/C/GC/12, available at: https: //www.refworld.org/docid/4ae562c52.html [accessed 25 July 2022], para. 84

provision for the minimum age at which a child may give consent or be assisted to consent to a medical treatment or surgical operation.

The Commission recommends adoption of the following provisions relating to consent to medical treatment and surgical operations of a child–

Consent to medical treatment for child

...— (1) Where a medical officer determines that a child requires a medical procedure or treatment or surgical treatment, the following persons may grant consent for the medical procedure or treatment or surgical operation to be undertaken on the child –

(*a*) the parent or guardian of the child; or

(*b*) where the child is in an emergency or where a parent or guardian –

(i) is not present or cannot be readily traced or is deceased;

(ii) unreasonably refuses to give consent; or

(iii) for good and justifiable reasons, is incapable of doing so,

the hospital administrator or a person in charge of the hospital in the absence of the hospital administrator shall sign as a guardian ad litem.

(2) Where the hospital administrator gives or withholds consent for medical procedure or treatment or surgical operation to be undertaken on a child, the hospital administrator shall sign the consent certificate and explain the reasons thereof.

4.2.2 Consent in Adults

The Commission observed that consent in adults, where a medical procedure would involve an invasion of the body, is not as complicated as in minors. The adult client would easily understand the need to sign a consent form. However, controversy arises where an adult refuses to grant consent to a medical procedure due to his or her beliefs. The problem is aggravated where the medical procedure involves the community, where vaccination confers herd immunity, and an adult refuses, either on his or her own behalf or on behalf of a child under his or her care, to be vaccinated.

The Commission considered the principle of "common good" which describes a specific "good" that is shared and beneficial for all or most members of a given community as regards the right to freedom of conscience, religion, belief and thought under section 33 of the Constitution. It was noted that the

"common good" principle was partly enunciated in Jacobson v. *Commonwealth of Massachusetts*.[268] In Jacobson, Mr. Jacobson believed that the scientific basis for vaccination was unsound and that he would suffer if he was vaccinated. The Massachusetts Supreme Court found the statute consistent with the Massachusetts State Constitution, and Jacobson appealed to the United States Supreme Court. The Supreme Court considered whether involuntary vaccination violated Jacobson's "inherent right of every freeman to care for his own body and health in such way as to him seems best..."[269] The Court split the question, first considering the right of the State to invade Jacobson's person by forcing him to submit to vaccination as follows:

> "This court has more than once recognized it as a fundamental principle that "persons and property are subjected to all kinds of restraints and burdens, in order to secure the general comfort, health, and prosperity of the State; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be made, so far as natural persons are concerned."[270]

The Court stated that the basic bargain of civilization is that an individual must give up some personal freedom in exchange for the benefits of being in a civilized society. Jacobson sought to enjoy the benefit of his neighbours being vaccinated for smallpox without personally accepting the risks inherent in vaccination. The Court, therefore, rejected Jacobson's claim which it viewed as an attempt to be a free-rider on society.

The Court next considered Jacobson's right to contest the scientific basis of the Massachusetts vaccination requirement. Accepting that some reasonable people still questioned the efficacy of vaccination, the Court nonetheless found that it was within the legislature's prerogative to adopt one from many conflicting views on a scientific issue.

The Commission agreed that the *Jacobson* case illustrates that persons who refuse to be vaccinated can have their objection overridden on the basis of the "common good" principle and benefit to society. Similarly, HIV testing of pregnant women as part of their package of care offered at hospitals could be justified under the "common good" principle and benefit to society. The Commission, therefore, resolved that the main determining factor in issues of consent is the age of the patient in question, mental condition, and if the condition is a threat to the society if not treated then the legislation should prevail over any contrary views by particular groups. These considerations also apply to persons in prisons or held under captivity. As such, the Commission recommends that the proposed legislation should provide for the requirement to obtain consent from the adult user for purposes of medical treatment or surgical operations.

The Commission thus recommends adoption of the following provisions relating to consent in adults–

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[268] 197 U.S. 11 (1905).
[269] Page 26.
[270] As above.

Consent to medical treatment for child

...—(1) A health service may not be provided to a client without the informed consent of the client , unless–

(*a*) the client is unable to give informed consent and such consent is

given in writing by a person –

(i) mandated by the client in writing to grant consent on his behalf; or

(ii) authorized to give such consent in terms of any law or court order;

(*b*) the client is unable to give informed consent and no person is mandated or authorized to give such consent, in which case, such consent may be given by a spouse of the client or, in the absence of such spouse, a parent, grandparent, an adult child or a brother or sister of the client;

(*c*) the provision of a health service without informed consent is authorized under any law or a court order;

(*d*) failure to treat or provide a health service to the client, or group of people which include the client, will result in a serious risk to public health; or

(*e*) any delay in the provision of the health service to the client might result in his death or irreversible damage to his health and the client has not expressly, implicitly or by conduct refused that service.

(2) A health care provider shall take all reasonable steps to obtain the informed consent of the client.

4.3 Abortion

The Commission had set out to consider the issue of abortion under the legislation to be developed. However, the Commission noted that its sister special Law Commission on the Review of the Law on Abortion had done extensive work and made recommendations in this area.[271] The Commission considered the recommendations of its sister special Law Commission and adopted them accordingly.

4.4 Euthanasia

The Commission deliberated at length the ethical and legal dimensions of euthanasia. The discussion centred on whether people who are terminally ill should have the right to end their suffering with a quick, dignified, and

[271] A Report of the Law Commission on the Review of the Laws on Abortion published on 15 March, 2016.

compassionate death; and if accepted, whether Malaŵi should legislate for euthanasia. Euthanasia, comes from the Greek words, 'EU' meaning good, and 'THANATHOS' meaning death.[272] Euthanasia also known as "mercy killing", is an act, or practice of painlessly putting to death, people suffering from painful and incurable diseases, or incapacitating physical disorders such as being in a permanent vegetative state.

The discussion of euthanasia encompasses other important terminologies, and these include physician-assisted suicide; and withholding or withdrawing life sustaining treatment. Physician-assisted suicide means that the physician provides the means by which the patient can end his life.[273] Usually, the physician will prescribe a lethal drug which is administrated by the patient himself. Withholding or withdrawing life-sustaining treatment simply means that the physician forgoes the life sustaining treatment for a terminally ill patient taking into account the benefit of the patient, the wishes of the patient and family, and the futility of treatment.[274]

The Commission noted that the legal dimension of euthanasia revolves around the right to life; the right to dignity; and the legality of euthanasia in Malaŵi. Section 16 of the Constitution guarantees the right to life. The section prohibits deprivation of life, but only where that deprivation is arbitrary. Deprivation of life involves intentional or otherwise foreseeable and preventable life terminating harm or injury, caused by an act or omission.[275] Neither the Constitution, nor any other law specifically make reference to euthanasia. Under section 215 (*d*) of the Penal Code, a person is said to have caused the death of another if by any act or omission he hastened the death of a person suffering under any disease or injury which apart from such act or omission would have caused death. Again, aiding suicide is a felony under the Penal Code, punishable by life imprisonment.[276]

The Commission took cognizance that the other dimension of the right to life includes the right of every person to enjoy a life with dignity.[277] Section 19 (1) of the Constitution provides that the dignity of every person is inviolable. The argument is often made that, as people have the right to live with dignity, they also have the right to die with dignity. Some medical conditions are simply so painful and unnecessarily prolonged that the capability of the medical profession to alleviate suffering by means of palliative care is surpassed. Some advocates of

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272 Chao DV, Chan NY, Chan WY, 'Euthanasia revisited', available at https://pubmed.ncbi.nlm.nih.gov/11906976/.

273 Chao DV, Chan NY, Chan WY, 'Euthanasia revisited', available at https://pubmed.ncbi.nlm.nih.gov/11906976/.

274 5 The Medical Council of Hong Kong. Professional Code and Conduct. Issue No. 4. Section 26: care for the terminally ill. Hong Kong, May 2000.

275 ICCPR Human Rights Committee General comment No. 36 Article 6: right to life.

276 See section 228 of the Penal Code, Cap 7:01of the Laws of Malaŵi.

277 ICCPR Human Rights Committee General comment No. 36 Article 6: right to life.

euthanasia have argued that the primary task of the medical profession is not to prolong life or to promote health, but to relieve suffering.[278]

The Commission noted that regionally, South Africa is the only State to actively take steps towards legalising euthanasia. In 2016, the country's Supreme Court of Appeal overturned a ruling that granted a man the right to a medically assisted death. Legislation on assisted suicide had previously been developed and proposed. However, as of 2022, the legislation had not been promulgated, and currently, euthanasia is still unlawful in South Africa. Project 86 of the South African Law Commission issued a report in November 1998 titled 'Euthanasia and artificial preservation of life'. This draft bill of the South African Law Commission is a legislative proposal to regulate end-of-life decisions and related matters. The commission did not make any specific recommendations about voluntary active euthanasia but set out different options to get legal clarification on how to deal with this issue. This legislation has yet to be finalised despite tremendous legal and advocacy efforts. [279]

The Commission also noted that, globally, euthanasia has been the subject of much moral, religious, philosophical, legal and human rights debate. At the core of the debate is how to reconcile competing values: the desire of individuals to choose to die with dignity when suffering, and the need to uphold the inherent right to life of every person, as recognised by article 6 (1) of the International Covenant on Civil and Political Rights (ICCPR). Article 6 (1) of the ICCPR, states that every human being has the inherent right to life, which shall be protected by law. The duty to protect life implies that States should take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity. [280] In the context of public health, these general conditions may include degradation of the environment; the prevalence of life-threatening diseases, such as AIDS, tuberculosis and malaria; and extensive substance abuse.

Comparative study conducted by the Commission indicates that as of 2022, euthanasia is legal in Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Spain and all six states of Australia. In the Netherlands, the Euthanasia Act came into effect in 2002 to regulate the ending of life by a physician at the request of a patient who was suffering unbearably without hope of relief. In some parts of Australia, legislative attempts had been made to legalize euthanasia. For instance, the Northern Territory of Australia developed the Rights of the Terminally Ill Act 1995, which allowed for medically assisted voluntary euthanasia at the request of a terminally ill person. The Commission noted that

[278] The Conversation: We have a right to die with dignity. The medical profession has a duty to assist, Accessed at https://theconversation.com/we-have-a-right-to-die-with-dignity-the-medical-profession-has-a-duty-to-assist-67574.

[279] The South African Law Commission. Euthanasia and the artificial preservation of life. Pretoria: The South African Law Commission, 1998; p. 273.

some jurisdictions, such as Sweden, Denmark and Italy strictly prohibit euthanasia. In Switzerland, physician-assisted suicide, as opposed to euthanasia is allowed if it is done without any self-interest, for physicians and other citizens, while euthanasia is forbidden.

The Commission, further, considered the case of *Airedale NHS Trust v. Bland*,[281] widely known as the Hillsborough disaster, which deals with the issue of removal of life support from a patient in a persistent or permanent vegetative state. The case involved a Liverpool Football Club supporter who got injured during a football match. Bland suffered severe brain damage which left him in a vegetative state. As a result, the hospital with support from his parents, applied to the Family Division of the High Court for an order that he be allowed to die with dignity. Lord Keith in the House of Lords considered that such a decision to discontinue treatment could be taken by 'a large body of informed and responsible medical opinion to the effect that no benefit at all would be conferred by continuance' The Court granted the order allowing the hospital to withdraw the life-prolonging treatment from the patient, including food and water.

Some Commissioners opposed euthanasia and contended that doctors have a moral responsibility to keep their patients alive as reflected by the Hippocratic Oath, which states in part: 'to please no one will I prescribe a deadly drug, nor give advice, which may cause his death'. The obligation of the physician to preserve human life as contained in the International Code of Medical Ethics raises questions as to whether life must be preserved at all cost and at all times even against the expressed wish of the patient. Commissioners were of the view that allowing euthanasia would be the same as allowing a person who commits murder to be left unpunished. Other Commissioners were of the view that there is need to first of all determine the mischief which needs to be addressed if euthanasia is to be legalized in Malaŵi.

The Commissioners were of the further view that allowing euthanasia would result in killing some patients who would have lived. Furthermore, Commissioners who opposed euthanasia suggested that euthanasia is prone to abuse and difficult to safeguard against abuse. The Commission noted that the issue of euthanasia is controversial and that it is lawful in a small number of jurisdictions around the world. However, future generations may be in favour of euthanasia thus it was important to consider legalising it under the legislation to be developed. In addition, the Commission noted that there is a perception that health professionals deliberately tend to accelerate the death of some patients who are terminally ill, especially the elderly. The Commission was, therefore, of the view that making provision for euthanasia under the legislation to be developed would not assist in achieving public health ends as some people may end up shunning treatment on the basis that treatment is meant to kill them earlier than

[280] ICCPR Human Rights Committee General comment No. 36 Article 6: right to life.

[281] [1993] AC 789 HL; [1993] 1 All ER 821 HL.

expected. Based on the findings of the Commission on this subject matter including findings from a comparative study visit to Namibia, where the law completely outlaws euthanasia [282], the Commission resolved that euthanasia should not be legalised.

4.5 Confidentiality

The relationship of a health professional and a patient creates trust and confidence enforceable at law. Medical law and ethics has settled the principle that a health professional cannot reveal information about a patient obtained in the course of discharging his or her professional duty. The principle has developed in light of the right to privacy under human rights law. However, there are exceptions to the rule of medical confidentiality which have been developed due to the peculiar circumstances of each country. In Malaŵi, the Medical Practitioners and Dentists Act [283] and the Nurses and Midwives Act [284] do not provide for confidentiality as a matter of law. The Commission noted that medical confidentiality forms part of the ethics curricula during the training of health professionals in the country. However, it appears that the lower cadres of medical personnel may not have confidentiality as part of the curricula of their studies.

As regards exceptions to confidentiality, some jurisdictions including England, Wales and the United States have developed elaborate rules that allow disclosure of information on road traffic infractions; crime investigation, particularly gunshot and knife wounds; serious communicable diseases; or insurance, employment or similar purposes[285].

The Commission observed that personal privacy is protected by the Constitution[286] over and above the protection of privacy and confidentiality in the medical profession. However, the Commission noted that in some hospitals, case notes for a patient are placed by his or her bedside that the notes are easily accessible to anyone within the hospital ward. In contrast, the Commission noted that privacy is well provided for in medical research. The Commission was of the view that in the absence of proper training by different levels of health care workers and in light of the unlegislated provisions that form part of the training of medical and allied professionals, public health legislation should make clear provision for the protection of personal privacy and confidentiality of patients and clients within or outside medical facilities. In conclusion, the Commission recommends the following:

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282 A report on a co
283 Laws of Malaŵi, Cap. 36:01.
284 Laws of Malaŵi, Cap. 36:02.
285 See the list of ethical guidance of the General Medical Council of England. Available at http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp Accessed on 19 January, 2012; and the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (United States of America).
286 Section 21 of the Constitution

(*a*) the need to build partitions or provide curtains between beds within hospital wards;

(*b*) provision of adequate training on privacy and confidentiality for all health care workers or researchers;

(*c*) civic awareness of the public on the importance of privacy and confidentiality; and

(*d*) make provision for electronic storage space for medical records of patients in all hospitals.

The Commission, therefore, recommends adoption of the following provisions on confidentiality:

Confidentiality

...—(1) Information concerning a client including information relating to his health status, treatment or stay in a health establishment, is confidential.

(2) Subject to section.., a health service provider shall not disclose any information contemplated in subsection (1) unless—

(*a*) the client consents to that disclosure in writing;

(*b*) a court order or any law requires that disclosure;

(*c*) non-disclosure of the information represents a serious threat to public health; or

(*d*) the information is needed for research or clinical purposes.

Access to health records

...—(1) A health worker or a health service provider that has access to the health record of a client may disclose such personal information to any other person, health service provider or health establishment as is necessary for a legitimate purpose within the ordinary course and scope of his duties where such access or disclosure is in the interests of the client.

(2) For purposes of this section, "personal information" means factual or subjective information, whether recorded or not, about an identifiable individual.

4.6 Biomedical Research including Clinical Trials

Clinical trials are regulated under the Pharmacy and Medicines Regulatory Authority Act (PMRAA).[287] Section 2 of the PMRAA defines a "clinical trial" as

[287] No. 9 of 2019.

"the systematic study involving human participants or animal subjects that serves to answer the safety and efficacy of a medicine, biological products or method of prevention or treatment". Section 74 (1) of the PMRAA prohibits conducting a clinical trial involving any medicine or allied substance without a clinical trial certificate.

The PMRAA requires a person who intends to conduct a clinical trial to apply to the Pharmacy and Medicines Regulatory Authority (the Authority) for a clinical trial certificate in the prescribed manner following payment of the prescribed fee.[288] The Authority issues clinical trial certificates.[289]

However, defined broadly, the term "clinical trials" may not only cover inception of medicine. The Commission considered whether introducing a new surgical technique as a medical product would be subject to special regulation, or within the ambit of the Authority. The Commission noted that in England, before a clinical trial is undertaken, it is standard practice for the trial to be referred to a research ethics committee for approval.

The Commission observed that health research review in Malaŵi rests in the ambit of various research review committees for example, National Health Sciences Research Committee (NHSRC). This committee gets its mandate from the National Commission for Science and Technology (NCST) established under section 5 of the Science and Technology Act. [290] The Commission noted that under Part VIII of the Science and Technology Act, the NHSRC is responsible for issuing licenses and permits to conduct biomedical research. The Commission was aware that the College of Medicine Research Support Centre (COMREC) is more active in undertaking clinical trials and research generally, though not established by statute. Prior to the enactment of the PMRAA, the NHSRC, was responsible for issuing clinical trial licenses and overseeing clinical trials in Malawi.

Under the PMRAA, the Authority is mandated to register clinical trials; issue clinical trial licences; and monitor the conduct of clinical trials involving pharmaceutical and medicinal products.[291] The NCST-approved ethics committees, that is, the National Health Sciences Research Committee (NHSRC) and COMREC on the other hand are responsible for maintaining and protecting the dignity and rights of research participants and ensuring their safety throughout their participation in a clinical trial. [292] According to the 2012 revised edition of the Policy Measures and Requirements for the Improvement of Health Research Co-ordination in Malawi, before submitting a clinical trial application to the PMRA, the sponsor or principal investigator must obtain full ethical approval from either of the two Committees.

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288 Section 75 (1).
289 Section 76.
290 Cap. 30:10
291 See section 4 (h) of the Pharmacy and Medicines Regulatory Authority Act, No. 9 of 2019.
292 The Ministry of Health, (2012) Policy Measures and Requirements for the Improvement of Health Research Co-ordination in Malawi.

Having considered the regulation of clinical trials under the PMRAA, the Commission was of the view that the provisions were adequate to regulate the conduct of clinical trials in Malawi. Further, the Commission noted that there are draft regulations made under the PMRAA that are yet to be gazetted called the Pharmacy and Medicines Regulatory Authority (Control of Clinical Trials) Regulations 2023. These regulations, among others, provide for the protection of subjects participating in the clinical trials. Notwithstanding the conclusion, the Commission resolved that the proposed legislation should include a provision on ethical considerations in the regulation of clinical trials in the public health interest. The Commission therefore recommends adoption of the following provisions —

Ethics Approval of Biomedical Research Involving Human Subjects

…—(1) Any form of biomedical research protocols which involves human research participants to be conducted in Malaŵi shall conform to research ethics principles of Respect for persons, Beneficence and Justice

(2) Without prejudice to the generality of subsection (1), any form of biomedical research conducted in Malaŵi which involves the participation of humans shall,

(*a*) be relevant both to the overall health and developmental needs of the people of the Republic and the individual needs of those who suffer from the disease and or concerns of the study;

(*b*) have a valid scientific methodology and a high probability of providing answers for the specific research questions that are posed;

(*c*) be managed and conducted by a suitably qualified principal investigator and co-investigator in the field of biomedical research;

(*d*) ensure that research participants are well informed to make informed choices;

(*e*) ensure that participants' right to privacy and confidentiality are protected;

(*f*) ensure that selection, recruitment and inclusion or exclusion of research participants in research project are just and fair;

(*g*) be preceded by a risk-benefit analysis;

(*h*) undergo independent review and ethics clearance by a recognised and accredited research ethics committee.

(*i*) commence implementation of biomedical research protocol only after obtaining research ethics approval from a recognised and accredited research ethics committee.

Ethics approval of research involving animal Subjects

…Any form of research which involves animals to be conducted in Malaŵi shall conform to research ethic principles of Compassion for animals.

(*a*) the National Animal Research Ethics Committee shall approve research involving animals as subjects.

(*b*) ethical approval of research involving animals as subjects shall be granted by the animal research ethics committee.

5.0 CONTROL OF USE OF HUMAN TISSUE

5.1 General

Tissue is defined as any human tissue including any human flesh, organ, bone, body fluid or derivative of any human tissue. [293] The Commission understood the term "human tissue" to mean organs and parts of organs, cells and tissue, sub-cellular structures and cell products, blood, gametes (sperm and ova), embryos and foetal tissue. The Commission observed that the Anatomy Act is the principal legislation on human tissue and organs. However, the Anatomy Act does not define an "organ". Having noted these gaps, the Commission recommends the adoption of the following definition of a human organ under the Anatomy Act:

Interpretation

"human organ" means a group of tissues that perform a specific function or a group of functions, such as the heart, lungs, brain, eye, stomach and skin.

The Anatomy Act provides that removal of tissue from bodies of living persons may be only for educational, scientific research, therapeutic or diagnostic purposes under section 11. The provision states as follows:

"11. Removal of tissue from bodies of living persons

Any medical practitioner or any other authorized person may remove tissue from the body of a living person for educational, scientific, research, therapeutic or diagnostic purposes with the consent of—

(*a*) that person or his spouse or close relative;

(*b*) in the case of a minor or a mentally handicapped person, with the consent of a parent, guardian or close relative:

Provided that, in either case, the close relative is not himself a minor or a mentally handicapped person."

[293] Section 2 of the Anatomy Act.

At common law, the legal requirements necessary for a valid consent may vary between the two types of procedure: therapeutic and non-therapeutic. Regarding therapeutic procedures, there are two levels of consent. First, there must be express consent to the nature and purpose of a proposed intervention. Second, the degree of information concerning possible risks associated with the treatment, which the doctor must disclose, so as to make the consent informed and thus valid, is what a reasonable doctor would disclose. In some circumstances, for example where a patient is extremely anxious, a doctor may decide not to inform the patient about certain risks associated with a particular treatment. Where the procedure is non-therapeutic, the two levels of consent do not apply and there is no scope for medical discretion. In the latter instance, consent must be explicit and all relevant information must be provided. Thus, when removal of tissue takes place in a non-therapeutic context, for example from a volunteer in a research project, not only must the removal be for a purpose which the law permits, that is, in the public interest, but it must also be consented to expressly and on the basis of all appropriate information. [294]

A person who sells or buys a tissue removed from the body of a living person commits an offence. [295] Further, a person is not allowed, for gain or profit, to supply to any person for educational, scientific, research, therapeutic or diagnostic purposes, or any other purpose, tissue removed from the body of a living person. [296] The Trafficking in Persons Act also criminalizes the exploitation of a person by removing body parts or extracting, tissue or organs. [297]

The Commission observed that the transfer of tissue is not regulated by law. The Commission was of the view that the Anatomy Act should be amended to add provisions that regulate transportation and exportation of human tissues to the effect that the exporters should be allowed to apply for a "Material Transfer Certificate". In addition, when a person is applying to transfer tissue, he or she must state clearly how he or she intends to use further or destroy the tissue after the purpose for which the application was made has been fulfilled. In practice, the Ministry of Health grants Material Transfer Certificates to exporters of human tissue. The Material Transfer Agreement (MTA) Certificate form requires the use of tissue for five (5) years and to be destroyed. If there is need for the tissue to be used further, an applicant has to re-apply. The Commission thus recommends that the Anatomy Act should be amended to make provision for a clear mechanism and process for applying for a MTA Certificate under the Act. The mechanism suggested by the Commission reflects the existing practice, that an application for the use of tissue subsists for five (5) years after which the certificate expires and the tissue in question should be destroyed. If an applicant still has need for further use of the tissue, he or she should make a fresh application for the MTA Certificate.

294 Nuffield Council on Bioethics, "Human Tissue: Legal and Ethical Issues" (1995) 59.
295 Section 16 of the Anatomy Act.
296 As above.
297 Section 16 of the Trafficking in Persons Act.

The Commission observed that the Anatomy Act has fewer provisions relating to the choice by a person to donate his or her tissue while alive. In some jurisdictions, persons who express a will to donate their tissue carry donor cards. In case of emergency, tissue of the persons can be donated to patients in need on account of the donor cards. The Commission, therefore, recommends the adoption of the following provisions to the Anatomy Act –

"Removal of tissue from bodies of living

... — (1) A medical practitioner may remove tissue from the body of a living person for educational, scientific, research, therapeutic or diagnostic purposes—

(*a*) with the consent of the person, his spouse or close relative; or

(*b*) in the case of a child or a person with a mental disability, with the consent of a parent, guardian or close relative.

(2) Notwithstanding subsection (1), the close relative referred to in paragraphs (a) and (b) shall not himself be a child or a person with a mental disability.

(3) At least two (2) medical practitioners with relevant practical experience shall provide guidance concerning the removal of tissue from the body of a living person.".

In addition, the Commission recommends the following amendments to the Anatomy Act:

(*a*) making provision for donor cards;

(*b*) making provision for a prescribed manner of making donations, including the need for express consent; and

(*c*) requiring a donor to specify whether he or she is donating a tissue or an organ (for purposes of clarity).

Further, the Commission agreed that for purposes of advancing medical innovation and technology, the legislation to be developed should provide for measures to deal with emerging issues; and that the overall authority for the policy on the use and donation of human tissue should be the Minister responsible for health. The Commission observed that Part II of the Anatomy Act regulates cadavers. However, the Anatomy Act does not define the use and purposes of cadavers. The Commission agreed that the Anatomy Act should be amended to add the legal uses of cadavers and that anything outside the legal use should be criminalized. The Commission noted that a cadaver can be used for other purposes apart from anatomical examination. The Commission, therefore, recommends that Part II of the Anatomy Act which is styled "Authority for Anatomical Examination of the Body of a Deceased Person" should be renamed "Authority for Anatomical Use of the Body of a Deceased Person". In light of

these observations, the Commission recommends that there is need to conduct a thorough review of the Anatomy Act by a special Law Commission.

The Commission thus recommends adoption of the following provision on uses of cadavers—

"Use of cadavers

... – (1) A person may donate a human body, tissue, blood or blood products of deceased persons to any prescribed institution or person for the purposes of—

(*a*) training of students in health sciences;

(*b*) the advancement of health sciences;

(*c*) therapeutic purposes, including the use of tissue in any living person; or

(*d*) the production of therapeutic, diagnostic or prophylactic substance.

(2) A person shall, for purposes of subsection (1), be issued with a donor card.

(3) The donor card issued under subsection (2) shall, specify whether the person is donating a tissue or an organ.".

5.2 Confirmation of Human Death

Death is the clinical point of irreversible loss of the capacity for consciousness and the irreversible loss of the capacity to breathe. Death is determined by either neurological or circulatory criteria and must be made in accordance with accepted medical standards.[298] It is vital when confirming death, to ensure that death has indeed occurred. The medical profession has reached consensus as to the point of death, and the Commission did not belabour itself defining the same. However, the Commission observed that there may be instances where a person is declared dead by persons who do not have medical training. Such declaration of death arises where a person has died in the care of non-medical persons at home. Neither the Act, nor any other legislation places a requirement on medical practitioners to certify death. In other jurisdictions, when a patient dies, it is the statutory duty of the doctor who attended in the last illness to issue a Medical Certificate of Cause of Death (MCCD).[299]

During regional consultative workshops, participants suggested that the cadre of medical professionals who would certify death could be designated at different levels as follows:

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[298] World Health Organization. Clinical criteria for the determination of death, WHO technical expert consultation, WHO Headquarters, Geneva, Switzerland, 22 - 23 September 2014. Geneva: WHO; 2017. https://apps.who.int/iris/bitstream/handle/10665/254737/WHO-HIS-SDS-2017.5-eng.pdf;jsessionid=DBBFDE5645ED697AEA0D373772F54BDF?sequence=1 (accessed 22 February, 2023).

[299] Coronavirus Act 2020 of United Kingdom of Great Britain and Northern Ireland.

(*a*) medical assistants at health centre level;

(*b*) general doctors at district hospital level; and

(*c*) specialised doctors at central hospital level.

Health surveillance assistants should be precluded from the suggested list as they are not registered under any professional body. The Commission considered whether providing for a compulsory certification of death under the legislation to be developed is viable. This followed the realisation that there may be cases where people, especially in villages, end up burying persons without a certification of death by a medical personnel. The general consensus was that death should be certified. The authority to certify death should be exercised by various medical personnel including clinicians, [300] or medical assistants.. The Minister responsible for health should have powers to add and to remove certain medical personnel from the list.

In rural areas, the Commission noted that it is mainly chiefs who record deaths and that the Ministry of Health, which is the authority which certifies deaths that occur in rural areas, is based at the district headquarters. It thus seemed to the Commission that it was not practical for the Ministry of Health to certify all deaths that occur in rural areas. During regional consultative workshops, stakeholders suggested that certification of death could be done by laymen in local communities. The Commission was of the view that there is need to adequately provide for efficient certification of all deaths that occur in rural areas. The Commission resolved that certification of death by laymen in local communities should not be allowed. The Commission thus suggested the need for statistics and noted that the National Registration Bureau records vital statistics. The system for recording and certification of death under the National Registration Act [301] should be linked with the health management information system.

The Commission noted that the Death Report which hospitals issue in Malaŵi is deficient. The Death Report does not give full details as to the 'real' cause of death and last health professional who attended to the deceased. The Commission observed that the condition of HIV and AIDS is rarely revealed on a Death Report in instances where a person who dies was suffering from AIDS.

The Commission recommends the following provisions—

Confirmation of Death

...— (1) Every death shall be confirmed by a registered medical practitioner.

(2) A registered medical practitioner shall, where he is satisfied, that the death of any person has occurred complete a death report in the prescribed manner and state the cause death.

[300] The special Law Commission on the Review of the Public Health Act, a report on Consultation with Key Stakeholders: Ministry of Health and Specific Stakeholders conducted from the 14 to 15th December, 2021.

[301] Act. No. 13 of 2010.

(3) A death report shall be completed no more than twenty-four hours after death has occurred, or earlier where if reason of a religious belief, health reasons or any other reason, burial is required to take place earlier.

(4) Where death occurs in a place other than a health care facility, a registered medical practitioner shall visit such place as soon as possible, to examine the body and confirm death.

(5) Where a person is suspected to be dead on arrival at a health care facility, the person in charge of the health care facility shall immediately notify a registered medical practitioner as the case may be, for the confirmation of such death.

(6) In this section, a registered medical practitioner means a health assistant, a nurse, a midwife, a medical assistant, clinical assistant, clinical officer or doctor.

Unlawful confirmation and burial

...— (1) Any person who confirms death other than a person authorized under this section commits an offence, and shall upon conviction, be liable to a fine of two hundred thousand Kwacha (K200,000.00) and to imprisonment for six months.

(2) A person having charge of a place of burial, cremation or other means of disposal of human bodies who—

(*a*) buries;

(*b*) cremates;

(*c*) disposes of the body of a deceased person; or

(*d*) knowingly permits such burial, cremation or disposal,

without the confirmation specified under section… commits an offence, and shall, upon conviction, be liable to a fine of two hundred thousand Kwacha (K200,000.00) and to imprisonment for six (6) months.

(3) It shall be a defence to an offence under subsection (2) if the death occurred in a place other than a health care facility, and no registered medical practitioner was able to visit such place to examine the body and confirm death.

5.3 Post-mortem Examinations

A post-mortem examination is a detailed study of a body after death. It is also known as an autopsy. Post-mortem examinations are conducted by pathologists, who are medical professionals who specialize in, among other things, the diagnosis of disease after death and identifying the causes of death.[302] Post-mortem examinations are conducted for two main reasons:

(*a*) if the cause of a death is unknown, or when a death happens unexpectedly or suddenly, it is referred to a coroner who orders a post-mortem examination. By law, coroners' post–mortem examinations can take place without the consent of the family;[303] and

(*b*) the family of a deceased person may request a post-mortem examination to provide information about illness and cause of death. In this case, consent should be obtained from the family of the deceased person.

Under section 12 (1) of the Inquests Act, any Government medical officer or, in the absence of such officer, any other medical practitioner within his jurisdiction is required to make an examination of the body and to report thereon. Section 10 of the Anatomy Act also provides that any medical practitioner may carry out a post-mortem examination on the body of a deceased person. The Commission observed that pathology is a highly specialized field thus not everyone could be a pathologist or perform duties of a pathologist. Currently, there are only seven (7) pathologists in Malaŵi and they are based in Blantyre and Lilongwe. This illustrates that there are a few pathologists hence there is need to train more clinical officers and nurses to work as pathologists in order to respond to the demand for pathological services.

The Commission considered who else other than pathologists can be permitted to conduct post-mortem examinations. Participants at a consultative meeting with Ministry of Health and specific stakeholders submitted that the proposed legislation should not limit conduct of autopsies to pathologists only but should make provision to allow other cadres of health professional to perform autopsies so as to fill the existing personnel gap.[304] The Commission was of the view that other health personnel if properly trained may perform the function of pathologists under delegated authority. The Commission resolved that autopsies should only be conducted by pathologists. However, the Commission makes a policy recommendation to government that it should take measures to train more pathologists to address the acute shortage of pathologists.

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302 Human Tissue Authority, 'Post mortem' Available at http://www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem.cfm Accessed on 10 December, 2011.

303 Section 12 (1) of the Inquests Act (Cap. 4:02) of the Laws of Malaŵi.

304 The special Law Commission on the Review of the Public Health Act, a report on consultation with Ministry of Health and Specific Stakeholders conducted on 14th to 15th December, 2021, p.8.

The Commission was aware that due to cultural and religious considerations, it may not be possible to carry out a post-mortem examination in some cases. For instance, the Commission was aware that some faiths require that burial of a dead body should occur soon after death and within a specified period. The Commission took cognizance of other religious or faith groups which prohibit their members from seeking treatment or post-death processes offered by medical establishments. The Commission considered that there could be instances where the need for post-mortem examination may be a requirement to meet public health objectives, for instance, where there is a new and strange disease which might need anatomical examinations of dead bodies. The Commission concluded that the general rule should be that post-mortem examinations should not be compulsory, unless there is a court order and the condition requiring examination is suspicious or there is consent from the parties. The Commission was of the view that this is relevant as a person could be hiding a certain condition, for instance Ebola.

In that regard, religious or faith groups which prohibit post-mortem examination should be compelled to permit examination of dead bodies as one way of addressing the challenge. In England, the regulation of post-mortem examinations falls under the Human Tissue Authority which recognises the authority of a coroner in matters which require coordination between the Human Tissue Authority and the coroner. [305] The Commission thus recommends adoption of the following provision on post-mortem examination—

Post-mortem examination Cap. 4:02

Subject to the Inquests Act, a medical officer, an authorized health officer who suspects that a person has died of a communicable disease, whether in an infected area or not, shall—

(*a*) order that the body of the deceased person be conveyed to a specified place for an examination that the medical officer or authorized health officer considers necessary; and

(*b*) notify the directorate responsible for public health services in the area or a veterinary officer as the case may be, about the suspected case.

5.4 Disposal of Human Bodies

Where death has occurred, the disposal of the body gives rise to pertinent considerations in public health. First, is the location of the burial place for possible exhumation in the process of investigation where it is suspected that deceased died of unnatural causes. Second, is the public health concern regarding persons who die from a notifiable or other disease of public health significance. In other instances, the disposal of dead bodies raises socio-cultural and ethical issues.[306]

[305] See sections 11 and 13 of the Human Tissue Act 2004 (c. 30); and Human Tissue Authority, 'Post mortem'.
[306] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8573672/ accessed on 7th June 2023.

The public health interest in disposing dead bodies is to ensure that the body is properly disposed of. The Commission thus resolved that the proposed legislation should regulate the handling of dead bodies through a sequential process of notification, storage, and ultimately, the disposal, in order to address public health concerns.

5.4.1 Burial Reports or Certificates

The Commission considered the issue of Burial Reports or Certificates upon disposing of a dead body. The specific issues considered on the subject matter were:

(*a*) whether or not a burial report or certificate should be issued in respect of every disposal of a human body;

(*b*) who should be responsible for obtaining the burial report or certificate;

(*c*) who should be the issuing authority; and

(*d*) whether or not there should be penalties for failure to comply, and what they should be.

The Commission noted that the issue of making provision for a burial report or certificate in respect of every disposal of a human body was raised during stakeholder consultations on review of the National Registration Act. Stakeholders were of the view that it would be onerous on the part of communities to require a burial certificate or report in respect of every death. However, to aid post-mortem investigations where it is suspected that death is from unnatural causes, and to facilitate easy tracing of epidemics and ensure proper burial of bodies from such epidemics, provision ought to be made under the Public Health Act for a burial certificate to be issued only in respect of –

(*a*) a death suspected to have resulted from unnatural causes; and

(*b*) a death suspected to have occurred as a result of a known epidemic or other disease of public health significance.

The person responsible for collecting the body for burial should be the same person charged with the responsibility to obtain a burial certificate afterwards, and should be noted by a registered medical practitioner who confirms the death for the purpose. The burial certificate should be issued by the local authority of the area in which the body is disposed of, as they are responsible for human body disposal facilities within their locality. The burial certificate should be obtained within 21 days of burial. Where a person who has responsibility for the burial of a body to which any of the stated circumstances apply, the person should be liable to prescribed penalties, to ensure compliance in the public interest.

The Commission considered the recommendations and found that they are pertinent in addressing the public health implications that follow in disposing of dead bodies. the Commission thus recommends that the proposed legislation should provide for a burial report and certificate.

5.4.2 Cemeteries and Crematoria

The Commission noted that dead bodies are disposed of in various ways depending on a number of factors, such as cultural and religious beliefs or the cause of death in some cases. The common ways in which dead bodies are disposed of is through burial or cremation. The designation of sites for disposing of dead bodies is important to prevent any public health risks. The Commission considered the public health implications of the method and process of disposing of dead bodies. It was noted that poor disposal of bodies may cause public health risks such as water contamination or the spread of certain infectious diseases. The Commission observed that in the event of natural disasters, corpses do not pose a risk of the spread of an epidemic disease. [308] However, there is a substantial risk to health in cases where death was caused by an infectious disease. [309] These diseases include tuberculosis, blood-borne viruses i.e. hepatitis B and C and HIV, and gastrointestinal infections such as cholera, E. coli, hepatitis A, rotavirus diarrhoea, salmonellosis, shigellosis or typhoid/paratyphoid fevers·[310]

In relation to the location of burial sites, the Commission noted that were the burial ground is located where hydrogeological, geological and climatic conditions are not favourable to the process, contamination of soils and groundwater may occur, and decomposition may be inhibited, leading to social, economic and political problems. ·[311] The most critical parameters when assessing the pollution potential of a burial ground are burial depth, geological formation, depth of the water table, density of inhumations, soil type and climate.·[312] When these parameters are not taken into consideration, the negative impact on the environment and public health can be considerable.[313]

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[307] Jacqueline Lewis, 'On Death and Dying', available at https://ecampusontario.pressbooks.pub/deathanddying/chapter/4-1-traditional-disposal-methods-embalming-burial-and-cremation/ accessed on 8th December 2022.

[308] World Health Organisation (July 2013), 'Risks posed by dead bodies after disasters', available at https://www.who.int/publications/m/item/risks-posed-by-dead-bodies-after-disasters, accessed on 6th December 2022.

[309] Ibid.

[310] Ibid.

[311] Bruna R.F. Oliveira et al (1 March 2013)- Burial grounds' impact on groundwater and public health: an overview, Water and Environment Journal, Vol 7 at pages 99-106.

[312] Ibid.

[313] Ibid.

The Commission observed that under the Act, Part XIV provides for cemeteries. The Act gives power to the Minister to designate proper places to be the sites of, and to be used as, cemeteries or crematoria for townships and rural areas.[314] In such instances, it is obligatory for dead bodies to be disposed of in designated cemeteries or crematoria.[315] The Act prohibits exhumation without a permit being granted by the Minister.[316] It also gives power to the Minister to make an order for the exhumation of any cemetery for the purpose of public works, with six months prior notice.[317] Further, the Act gives power to the Minister to close any authorized crematorium or cemetery for a specified period of time.[318]

The Commission, held consultations with the ministry responsible for health regarding who should be responsible for designation of land for use as cemeteries between the Minister responsible for health and the Minister responsible for local government.

With regards to the issue, there was a consensus amongst the consultees that the designation of land for use as cemeteries should be the responsibility of the Local Government. The rationale was that Local Government has representation at district level, council level and all the way down to the chiefs. The Consultees opined that, at the district level, Ministry of Health is engulfed under Local Government. The consultees acknowledged that in some parts of the country, cultural practices would pose a challenge in as far as designating specific burial places is concerned. It was noted that in some districts such as Karonga, for example, there is no designated place for cemeteries. Rather every household or clan has a cemetery. The consultees found this to be unacceptable under public health practices because, for instance, some of these cemeteries are close to boreholes and there is a risk of soil pollution which contaminates the water.

Against this background, the Commission asked the consultees if the proposed legislation should provide that chiefs should designate land use for cemeteries rather than having cemeteries on every household. The consultees held different views on the issue. On the one hand, some consultants were of the view that there is a minimal risk of water pollution where cemeteries are close to the boreholes. The consultees opined that consideration should be had at how bodies are being preserved considering that others are simply covered in a cloth when being buried, whilst others are buried in a coffin. It was hence suggested that the Commission should conduct a research on how preservation of bodies contributes to soil contamination. Again, the consultees opined that it is a taboo to ask dwellers in these parts of the country to identify a designated area for cemeteries because this is a culture that has been there since before time memorial.

314 Section 113.
315 Ibid.
316 Section 115.
317 Section 116.
318 Section 118.

On the other hand, some consultees were of the view that this goes beyond legal minds and perhaps, the issue should be dealt with by Ministry responsible for Health or Ministry of Lands by liaising with Chiefs on how to go about it through civic education. The Commission reminded the consultees that the issue is not beyond the ambit of the law because every right has responsibilities and where one fails to meet those responsibilities; those rights have to be suspended. Nevertheless, the Commission observed that practicalities of the matter made the Ministry responsible for Local Government an appropriate authority for designation and regulation of cemeteries that notwithstanding, it was imperative that the Ministry responsible for Local Government should at all times liaise with the Ministry responsible for Health regarding location of cemeteries and crematoria in the public health interest. Therefore, the Commission makes a policy recommendation to that effect.

The Commission also considered the provisions on the notification of deaths and removal of bodies of persons dying of infectious diseases under section 26 of the Act. The Act places a duty on the occupier of a building in which death has occurred from infectious disease to immediately notify the local authority of the death, and on receipt of such notification, the local authority is required to inform the nearest medical officer of health and make the best arrangements practicable pending the removal of the body and the carrying out of thorough disinfection for preventing the spread of such disease. It is thus an offence to keep the dead body of any person who is known to have died of an infectious disease in any place except in a mortuary, other place set apart for the keeping of dead bodies, or for the purpose of immediate burial without first obtaining the sanction of the local authority or a medical officer of health. It is the duty of any person who removes the body to take it directly to the mortuary or the place of interment for burial. Any person who obstructs the execution of any order or direction given commits an offence.

The Commission observed that in places where no crematorium is provided, the Act makes it permissible for cremations to be carried out at such places and under such conditions as are laid down by the local authority with the concurrence of the medical officer of health.[319] In that regard, the Commission found that a local authority is conferred with functions in relation to the burial of dead bodies under the second schedule to the Local Government Act.[320] The provision states as follows:

"Subject to the provisions of section 28[321] of the Public Health Act, a Council—

(a) may establish, maintain and manage cemeteries and crematoria and mortuaries and provide funeral facilities;

319 Section 119.

320 Cap 22:01.

321 Section 28 provides that, "A local authority shall be responsible for the removal and burial of bodies of destitute persons and of unclaimed bodies within its own district."

(b) shall prohibit the disposal of human bodies otherwise than by interment in any cemetery or cremation at any crematorium established or permitted under the Public Health Act; and

(c) shall control the conveyance and disposal of any dead body within its area."

The Commission observed that the Act has substantive provisions on the disposal of dead bodies. In that regard, the Commission recommends the adoption of the provisions under the Act with the necessary modifications.

Therefore, the Commission recommends the adoption of the following provisions:

…Part—Burial of a Dead Body

Regulation of cemeteries and crematoria

...—(1) The Minister may in consultation with the Ministry responsible for Local Government make regulations for the designation and regulation of cemeteries and crematoria

(2) A local authority shall, subject to the regulations in subsection (1) be responsible for the designation and regulation of cemeteries and crematoria within its own jurisdiction;

(3) A local authority shall be responsible for the removal and burial of bodies of destitute persons and of unclaimed bodies within its area of jurisdiction.

Export of a corpse from Malawi

...—(1) A person who intends to export any corpse from Malaŵi, shall obtain the written permission of the Minister.

(2) A person who contravenes this section shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Permit to exhume

...—(1) Subject to this Act, a person shall not exhume a body or the remains of the body which may have been interred in any authorized cemetery or in any other cemetery, burial ground or other place without a permit.

(2) A permit under subsection (1) may be granted by the Minister on such terms and conditions as the Minister may prescribed to the legal personal representative or next of kin of the person buried, or to his or their duly authorized agent.

(3) any person who exhumes a body or the remains of a body in contravention of this Act, or who does not comply to with the terms and conditions of the permit commits an offence and shall upon conviction be liable to a fine of two

million Kwacha (K2,000,000.00) or imprisonment for two years.

Right of a coroner to order the exhumation of a body

...—Notwithstanding section … a coroner may order the exhumation of a body or the remains of a body for the purpose of holding an inquiry into the cause of death of any person.

Exhumation needed for execution of public work etc.

...—(1) The Minister, in consultation with the Minister responsible for local government, may by Order whenever he deems it expedient for the execution of any public work or any public purpose, direct the removal of a body or the remains of a body from any grave whether in an authorized cemetery or other place.

(2) The Minister shall not make an Order under sub-section (1) unless a prior notice of six months has been published in the *Gazette*.

(3) Copies of a notice issued under sub-section (2) shall be posted at or near such grave, and shall be served on the legal personal representative or next of kin of the person buried and on the local authority of the area in which the grave is situated.

(4) The Minister shall cause proper and fitting arrangements to be made for the re-interment of a body or remains of a body removed under this section, and for the removal and re-erection of any monument, and all charges in connexion therewith shall be borne by the State.

Record of permit for exhumation

...—(1) There shall be kept at the office of the District Commissioner or Chief Executive Officer a record of every permit granted under section … and of every order made under section … other than an order made by a court.

(2) The record shall—

(*a*) contain particulars, so far as the same can be ascertained, of the race, nationality, name, sex and age of the persons buried, date of burial and of the place of original burial and re-burial or removal; and

(*b*) be open for inspection by any person during office hours.

Closing of cemeteries by Minister

...—(1) The Minister in consultation with the Minister responsible for local government, may by Order published in the *Gazette* direct that any authorized crematorium or cemetery be closed for a period specified in such Order.

(2) A person who contravenes an Order issued under sub-section (1) shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Burial in places where cemetery or crematorium is not available

... In a place where a cemetery or crematorium is not available, the local authority may, in consultation with a health officer permit the burial of a body to be carried out at such place and under such conditions as the local authority may determine.

Offences relating to dead bodies

...— A person who—

(*a*) unlawfully hinders the burial of a dead body;

(*b*) without lawful authority disinters, dissects or mutilates a dead body; or

(*c*) being under a duty to cause a dead body to be buried, fails to discharge that duty,

commits an offence and shall, upon conviction, be liable to a fine of one hundred thousand Kwacha (K100,000.00) and to imprisonment for three (3) months.

5.5 Human Cloning

Human cloning is the creation of a genetically identical copy of a human being. Human cloning may be divided into two categories: reproductive cloning and therapeutic cloning. In reproductive cloning, the cloned embryo is implanted in the uterus of a woman, where it potentially results in pregnancy and the birth of a cloned human being.[322] Therapeutic cloning, on the other hand, allows scientists to create an abundant source of stem-cells for research purposes.[323]

The Commission noted the following observations on human cloning—

"In general, there is a consensus among legislators and scientists that reproductive cloning, which poses a large number of safety and ethical concerns, should be banned. Far less agreement, however, exists where therapeutic cloning is concerned. Proponents of therapeutic cloning contend that the process of extracting stem cells from cloned human embryos is essential for researching new therapies and developing cures for debilitating or life-threatening diseases like Alzheimer's and Parkinson's disease. Opponents, however, argue that creating cloned human embryos for research purposes unethically treats human life as a commodity and contend that destroying embryos in order to extract stem cells is tantamount to murder."[324]

322 Jody Feder, 'State Laws on Human Cloning' p. 2. Available at https://www.everycrsreport.com/files/20030514_RS21517_b70d9b70f2cb46b4d38d15b84b982b967db578cb.pdf Accessed on 10 August, 2020.

323 Ibid.

324 Jody Feder, 'State Laws on Human Cloning'. 2. Available at https://www.everycrsreport.com/files/20030514_RS21517_b70d9b70f2cb46b4d38d15b84b982b967db578cb.pdf Accessed on 10 August, 2020.

On 8 March 2005, the General Assembly of the United Nations adopted the United Nations Declaration on Human Cloning, by which member states were called on to adopt all measures necessary to prohibit all forms of human cloning in as much as they are incompatible with human dignity and the protection of human life.[325] The Commission noted that several jurisdictions have adopted legislation to completely ban human cloning, for instance, the United States through the enactment of the Human Cloning Prohibition Act of 2001; and South Australia through the enactment of the Prohibition of Human Cloning for Reproduction Act 2002. In South Australia, the Act makes it an offence punishable with fifteen (15) years imprisonment, for a person to intentionally place a human embryo clone in the body of a human or the body of an animal.

In view of the developments around human cloning elsewhere, there ought to be a legal and policy intervention in Malaŵi to deal with the scientific phenomenon. The Commission found it important to discuss emerging issues in human cloning as such issues contribute to the complexity of public health. The Commission was of the view that matters of human cloning require a thorough and holistic approach. For instance, apart from matters of reproduction of a double (reproductive cloning); further consideration could be given to other types including recombinant DNA technology or DNA cloning and therapeutic cloning.

The Commission observed that therapeutic cloning is defined as the production of human embryos for use in research and that it may be important in saving lives. Some Commissioners were of the view that there is need to have proper guidelines on the subject. Other Commissioners were of the view that there is a need for the law to provide for human cloning in Malaŵi as cloning science is ever-evolving hence the need to take into account the future of scientific advancements and research. The Commission noted that in the United Kingdom, cloning is accepted for purposes of research to treat diabetes, Alzheimer's and Parkinson's diseases.[326] The Commission, further, noted that the law in South Africa prohibits reproductive cloning of human beings except for therapeutic cloning.[327] Based on information from comparable jurisdictions and the need to encourage research in life saving treatment, the Commission concluded that reproductive human cloning should not be allowed. The Commission recommends that cloning should be allowed only for therapeutic purposes which covers the following—

(*a*) transplants;

(*b*) treatment of diseases which cannot be treated otherwise; and

(*c*) research.

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325 See United Nations, 'General Assembly Adopts United Nations Declaration on Human Cloning by Vote of 84-34-37' Available at https://www.un.org/press/en/2005/ga10333.doc.htm Accessed on 11 August, 2020.

326 See BBC News, 'Scientists given cloning go-ahead'. Available at http://news.bbc.co.uk/2/hi/health/3554474.stm Accessed on 25 June, 2019.

327 Section 57 of the National Health Act, 2003.

The Commission recommends adoption of the following provision on human cloning—

Prohibition of reproductive cloning of human beings

... — (1) A person who—

(*a*) manipulates any genetic material, including genetic material of human gametes, zygotes or embryos; or

(*b*) engages in any activity, including nuclear transfer or embryo splitting, for purposes of reproductive cloning of a human being,

commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha and to imprisonment for five years. In case of a legal person, a fine of two hundred million kwacha and revocation of their Material Transfer Certificate.

(2) The Minister may, under such conditions as may be prescribed permit—

(*a*) therapeutic cloning utilising adult or umbilical cord stem cells; or

(*b*) research on stem cells and zygotes which are not more than fourteen (14) days old on a written application and if—

(i) the applicant undertakes to document the research for record purposes; and

(ii) prior consent is obtained from the donor of such stem cells or zygotes.

(3) A person who imports or exports human zygotes or embryos without the prior written approval of the Minister commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000) and to imprisonment for five (5) years. In case of a legal person, a fine of K200,000,000, and revocation of their Material Transfer Certificate.

(4) For the purposes of this section—

(*a*) "reproductive cloning of a human being" means the manipulation of genetic material in order to achieve the reproduction of a human being and includes nuclear transfer or embryo splitting for such purpose; and

(*b*) "therapeutic cloning" means the manipulation of genetic material from either adult, zygotic or embryonic cells in order to alter, for therapeutic purposes, the function of cells or tissues.

6.0 SURVEILLANCE, PREVENTION, SUPPRESSION AND NOTIFICATION OF DISEASE

6.1 Surveillance and Response

Disease surveillance in respect of public health means the systematic and continuous collection, collation and analysis of data for public health purposes; and the timely dissemination of public health information for assessment and public health response as necessary. To combat the ever-present threat of infectious diseases, an efficient and robust health care system needs to have in place a sensitive epidemiological surveillance system to detect the occurrence of diseases and be able to take effective preventive and control measures rapidly.

The IHR require that each state party should assess events occurring within its territory. Further, each state party is required to notify the WHO, by the most efficient means of communication available, through the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the International Atomic Energy Agency (IAEA), WHO shall immediately notify IAEA. Following a notification, a state party is required to continue communicating to the WHO timely, accurate and sufficiently detailed public health information available to it on the notified event, where possible, including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary, the difficulties faced and support needed in responding to the potential public health emergency of international concern.

Rapid and appropriate response to emerging infectious diseases depends primarily on efficient surveillance systems at national, regional and global levels. Globally, the WHO coordinates surveillance systems. Public health systems are faced with challenges where outbreak information gets disseminated more rapidly by the media, NGOs and the private sector, while bypassing public health sources and increasing the pressure for rapid information from public health authorities at all levels. There is need, therefore, to learn how to address this new information-sharing environment for the only viable response would lie in the rapid verification of information and increased transparency for information-related outbreaks or even rumoured outbreaks.

Surveillance efforts therefore, require multiple skills including epidemiology, infectious diseases, public health, laboratory, field experience, telecommunication and information management. It requires multiple partnerships among the WHO, ministry responsible for health, private sector, NGOs and the media. This is termed "integrated surveillance". The WHO provides standards and norms for country systems to ensure regional and global consistency of surveillance data. It is important that the multi-purpose local human resources in an integrated surveillance system receive training in field epidemiology.

The first priority of a surveillance system at all levels is epidemic response capacity to ensure that surveillance information provided by the system can be effectively and rapidly used for action. Epidemic preparedness and response are primarily a matter of organisation rather than important resources. A core of experienced professionals in field epidemiology can rapidly conduct outbreak investigations provided with administrative arrangements.

The Commission noted that this thematic area is at the core of public health. The Commission observed that Malaŵi's epidemiological emergency response is inadequate. For instance, during the SARS outbreak the country did not have the capacity to combat the threat. There was lack of proper structures, either in the form of human resource or emergency health facilities to respond to the threat.

The Commission, further, noted that proper or legislative mechanisms for disease surveillance, especially for epidemics, were not available. The Commission found it important to address the challenge under the legislation to be developed. Although the Minister of Health has made regulations on the prevention of yellow fever under the Act, the Commission noted that there was minimal enforcement at entry points to Malaŵi. The Commission was of the view that either the Ministry of Health did not have enough personnel to handle disease surveillance or it did not have medicine and equipment in case of outbreaks.

The Integrated Disease Surveillance and Response (IDSR) recognizes the need for disease surveillance, which is the process of being watchful and vigilant for health problems and their determinants with the intention of taking measures that will control and prevent disease, and thus improve or maintain the health of the population. The IDSR provides that a single functional disease surveillance system integrated into each level and intervention programme of the health care system is essential for identifying problems and acting to resolve them. Further, incorporating epidemiological methods into the surveillance system enables health personnel to make evidence-based decisions for public health actions. Specific surveillance objectives guide policymakers towards selecting data that are the most useful to collect and use to set priorities, plan interventions, mobilize and allocate resources and predict or provide early detection of outbreaks – all strategies for disease control and prevention.

The IDSR aims to improve the capability of districts to detect and respond in a timely and appropriate way to diseases and conditions that cause high levels of death, illness and disability in the district's catchment area. Strengthening IDSR skills and resources can result into improved health and well-being for district communities. To that end, the IDSR seeks to:

(*a*) strengthen the capacity of health systems to conduct effective surveillance activities;

(*b*) integrate multiple surveillance systems so that tools, personnel and resources can be used more efficiently and effectively;

(*c*) improve the use of information for decision-making;

(*d*) improve the flow of surveillance information between and within levels of the health system;

(*e*) improve laboratory capacity and involvement in confirmation of pathogens and monitoring of drug sensitivity;

(*f*) strengthen the involvement of laboratory personnel in epidemiological surveillance;

(*g*) increase the involvement of clinicians in the surveillance system; and

(*h*) emphasize community participation in detection and response to public health problems.

The Commission observed that IDSR has gone beyond the scope of communicable diseases. The Ministry of Health still adopts a segregated health surveillance system. The Commission, further, noted that active and passive surveillance systems are available in Malaŵi but are not practised. The systems are in the following categories:

(*a*) Epidemic Prone Diseases which comprises cholera, typhoid fever, yellow fever, dengue fever, Ebola;

(*b*) Diseases Earmarked for Elimination comprised of leprosy, guinea worm, poliomyelitis and sleeping sickness;

(*c*) Diseases of Public Health Importance which comprises malaria, HIV and AIDS, STIs and tuberculosis; and

(*d*) emerging and re-emerging diseases for example, coronavirus diseases like Covid-19,

The Commission, having had recourse to the Guidelines on IDSR, recommends the adoption of the Guidelines on IDSR in Malaŵi which were developed by the Ministry of Health and its partners as the standard measures put in place to prevent public health threats. The Commission, further, recommends that Field Epidemiology and Laboratory Training Programme (FELTP) should be

introduced in local medical and nursing training institutions to equip students with skills on how to deal with public health emergencies.

According to Table 1 of the IDSR, diseases, conditions or events requiring immediate reporting of Malawi IDSR system include the following:

(*a*) Acute Flaccid Paralysis (AFP);

(*b*) Acute haemorrhagic fever syndrome (Ebola, Marburg, Lassa Fever, Rift Valley Fever (RVF), Crimean-Congo);

(*c*) Adverse effects following immunization (AEFI);

(*d*) Anthrax;

(*e*) Cholera;

(*f*) Cluster of SARI;

(*g*) Diarrhoea with blood (Shigella dysentery);

(*h*) Influenza due to new subtype;

(*i*) Maternal death;

(*j*) Measles;

(*k*) Meningococcal meningitis;

(*l*) Neonatal tetanus;

(*m*) Plague;

(*n*) Rabies (confirmed cases);

(*o*) Severe Acute Respiratory Syndrome (SARS);

(*p*) Smallpox;

(*q*) Typhoid fever;

(*r*) Yellow fever;

Any public health event of international concern (infectious, zoonotic, food borne, chemical, radio nuclear or due to an unknown condition)

The Commission resolved that disease surveillance and response will be undertaken by the Public Health Institute.

6.2 Disease Prevention Measures

The control of different infectious diseases involves an extensive range of interventions. These may depend on the nature of the disease, how easily it is transmitted, the mode of transmission, the infectious period, the incubation period (that is, the time from infection to the appearance of clinical disease), the population at risk, and the severity of its clinical manifestations. Many infections

are relatively mild and often self-limiting, and although they may cause significant minor morbidity and be a major burden to the health services, they are not a major threat to population health.[328]

Public health measures are needed when outbreaks and epidemics of new existing diseases occur. Such measures may involve controlling non-human sources of infection, such as birds, livestock, mosquitoes, or flooding, and reducing the risk of disease transmission by infected humans. In order for measures to be implemented effectively, strategies for infection control often incorporate disease surveillance, testing and monitoring. There are so many measures under the Act which are introduced to control infectious diseases. In order for measures to be implemented effectively, strategies for infection control often incorporate disease surveillance, testing and monitoring.

Methods for preventing infected people from transmitting an infectious disease and controlling the occurrence of infectious diseases vary. In some cases, people are required to comply with travel restrictions.[329] Under the Act, local government authorities have a duty to prevent or remedy danger to health arising from unsuitable dwellings by taking all lawful, necessary and reasonable practicable measures.[330] In addition, local government authorities have a duty to construct and maintain public sewers[331] which every owner and occupier of any premises or private sewer has a right to have his or her drains or private sewer connected to the public sewers,[332] provided that he or she has given notice to the local government authority.[333] Further, all new buildings are required to make satisfactory provision for drainages[334] and latrines.[335]

Under the Act, as a way of preventing the breeding of mosquitoes, all households are required to clear all overgrown bush and long grass.[336] The Act further requires that all cesspits should be screened to the satisfaction of a medical officer[337]; and that all mosquito larvae should be destroyed.[338] It is an offence for mosquito larvae to be found in the premises of any person.[339]

Disease prevention measures would normally target three areas that include the agent, the host, and the environment focusing on attacking the source, interruption of transmission route, and protection of the susceptible host. The Act provides for a few measures implemented in the prevention of diseases. Some of

328 Nuffield Council on Bioethics, 'Public Health', 70.
329 Section 38 of the Public Health Act empowers the Minister to regulate, restrict or prohibit the entry into Malaŵi of any person or of persons of any specified class or description or from any specified country, locality or area for the purpose of preventing the introduction of any infectious disease.
330 Section 61 of the Public Health Act.
331 Section 79 of the Public Health Act.
332 Section 83 of the Public Health Act.
333 Section 86 of the Public Health Act.
334 Section 87 of the Public Health Act.
335 Section 88 of the Public Health Act.
336 Section 98 of the Public Health Act. Section 99 of the Act requires that wells should be covered.
337 Section 100 of the Public Health Act.
338 Section 101 of the Public Health Act.
339 Section 102 of the Public Health Act.

the measures are in the form of criminal offences, thus making the implementation of the measures a difficult task. Malaria still remains one of the common causes of death and proper measures to prevent it should not be criminal as provided for under section 102 of the Act where failure to control breeding of mosquitoes is a criminal offence.

The following are some of the agents which cause infections and diseases: bacteria, viruses, mycoses (fungal), protozoa, helminthes and arthropods. Most agents have the ability to enter and multiply in a susceptible host and thus produce infection or diseases. Most of these agents can be eradicated if proper measures are taken. For instance, the use of dichlorodiphenyltrichloroethane (DDT) or its alternatives to kill mosquitoes.

6.2.1 Mosquito Control and Use of DDT in Malaŵi

The Commission observed that with respect to mosquito control, DDT is considered an effective chemical, especially if used in residual indoor spraying of households. The chemical is not easily degraded to other less toxic chemicals by physical agents such as heat and sunlight or by microorganisms. In the soil, its half-life has been found to have an average of 3 years while in human adipose tissue it is approximately 7 years.

The Commission was aware of the issues raised by the tobacco industry regarding the impact of using DDT to the tobacco market. The Commission observed that despite the threats and problems associated with the use of DDT, the chemical was used in large quantities in the agricultural sector in Malaŵi from early 1960s to 1985 when it was banned. Close to 3 million farming families, of which the majority are women and children, have been exposed to the chemical through daily inhalation, use of chemical containers for drawing water and storage of foodstuffs such as salt and various types of seeds. The chemical has also been used for crop storage. The Government of Malaŵi banned the importation and use of DDT in 1985 because of its persistence and cumulative effects in the environment and its accumulation in human and animal adipose tissues. Despite the ban, there is some evidence of use of DDT in the country, possibly from illegal cross-border trade. Following the ban in 1985, scientists conducted research in cotton, tea, coffee and tobacco industry to identify alternatives to DDT that can be used in the prevention and suppression of mosquito. This included the screening of organophosphates, carbamates, pyrethroids and bio-pesticides. The following pesticides have since replaced DDT and are being used in the country:

(*a*) for cotton insect pests, the alternative pesticides are Deltamethrin, Ripcord, Lambda cyhalothrin, Thiodicarb and Carbaryl;

(*b*) for tobacco soil pests, the alternatives are Carbofuran and Carbosulfan;

(*c*) for maize stem borers and army worms, the alternatives are Deltamethrin, Carbaryl, Fenitrothion and Sumicidin; and

(*d*) for household pests and protection against mosquitoes, the recommended chemicals are Deltamethrin, Permithrin, Lambda cyhalothrin, Alphacypermethrin, Cyfluthrin and Dichlorvos.

Malawi does not have a specific legal provision consolidating the banned or regulated use of DDT. The regulation of the use of DDT therefore falls under the Pesticides Act.[340] The Ministry of Agriculture (MOA) is responsible for the implementation of the Pesticides Act and its Regulations. The Act through the Pesticides Control Board provides for the importation, exportation, manufacture, distribution, storage, disposal, sales, repackaging and use of all pesticides in Malawi. It also restricts the import, manufacture or sell of a pesticide, which has not been registered under the Act.[341] Unregistered pesticide may be imported under an import permit issued for the purpose of analysis, registration or research[342], or under a pest emergency permit[343]; and manufactured for export in accordance with a license to manufacture. Only those pesticides that are registered under this Act can be imported or sold without a permit.

The Pesticides Act, however does not contain specific provisions to restrict production and use of DDT for public health Acts. Section 34 of the Act, which is in agreement with the Occupational, Safety, Health and Welfare Act, places the responsibility for the safety, health and welfare of their employees including providing and requiring the employees to use facilities, equipment and clothing conducive to the safe handling of pesticides (including POPs) under the employers.

The Malawi Bureau of Standards Act (1987)[344] also regulates the use of DDT. The Act is implemented by the Ministry responsible for Commerce and Industry through the Malawi Bureau of Standards, whose objectives include to provide for the testing of locally manufactured or imported commodities with a view to determining whether such commodities comply with the provisions of this Act, the Merchandise Marks Act or any other law relating to standards of quality. Thus, the Bureau inspects, tests and certifies imports and exports of all commodities including Persistent Organic Pollutants (POP) substances.

Other important regulatory frameworks relating to the use of DDT include (Environment Management Act,[345] implemented by the Ministry responsible for natural resources and environmental affairs which prohibits the aiding or abetting the illegal trafficking in chemicals, pesticides or hazardous processes; the Pharmacy, Medicines and Regulatory Authority Act[346] implemented by the

340 Cap. 35:03 of the Laws of Malawi.
341 Section 17 of the Pesticides Act.
342 Section 20 of the Pesticides Act.
343 Section 52 of the Pesticides Act.
344 Cap. 51:02 of the Laws of Malawi.
345 No. 19 of 2017.
346 No. 9 of 2019.

Ministry responsible for Health and Population which prescribes pesticides as drugs; the Plant Protection Act of 1957[347] implemented by the Ministry responsible Agriculture, Irrigation and Food Security in which fumigants are regulated; the Seeds Act of 1996 Act[348] which regulates seed treatment with pesticides; The Occupational Safety, Health and Welfare Act of 1997[349] under the Ministry responsible Labour and Vocational Training which deals with the safety and welfare of employees handling hazardous substances the Ministry responsible Commerce and Industry through the Department of Customs and Excise of the Ministry responsible Finance responsible for the clearing of imports and exports of all commodities including POPs substances.

Other important regulatory frameworks relating to the use of DDT include the Environment Management Act,[350] implemented by the Ministry responsible for natural resources and environmental affairs which prohibits the aiding or abetting the illegal trafficking in chemicals, pesticides or hazardous processes; the Pharmacy, Medicines and Regulatory Authority Act[351] implemented by the Ministry responsible for Health which describes pesticides as drugs; the Plant Protection Act of 1957[352] implemented by the Ministry responsible for Agriculture in which fumigants are regulated; the Seeds Act of 1996 Act[353] which regulates seed treatment with pesticides; The Occupational Safety, Health and Welfare Act of 1997[354] under the Ministry of Labour and Vocational Training which deals with the safety and welfare of employees handling hazardous substances the Ministry of Commerce and Industry through the Department of Customs and Excise of the Ministry of Finance responsible for the clearing of imports and exports of all commodities including POPs substance.

The Pesticides Control Board monitors and regulates pesticides imports into Malaŵi. However, since its establishment, the Pesticides Control Board has not processed any permits to import DDT despite the fact that a survey revealed the presence of DDT in the Central Region of Malaŵi. The source of the DDT was speculated to have originated from neighbouring countries. It can, therefore, be concluded that the country is still experiencing illegal trading of DDT.

At the international level, Article 3, Paragraph 1 (*a*) (ii) of the Stockholm Convention, to which Malaŵi is a party, having ratified it on 27th February, 2009, stipulates that each Party shall prohibit and or take the legal and administrative measures necessary to eliminate its import and export of POPs pesticides in accordance with the provisions of the Convention.

347 Cap. 64:01 of the Laws of Malaŵi.
348 Cap. 67:06 of the Laws of Malaŵi.
349 Cap. 55:07 of the Laws of Malaŵi.
350 No. 19 of 2017.
351 No. 9 of 2019.
352 Cap. 64:01 of the Laws of Malaŵi.
353 Cap. 67:06 of the Laws of Malaŵi.
354 Cap. 55:07 of the Laws of Malaŵi.

During a comparative study visit to Namibia, the Commission learnt that the country has reduced and is going towards eliminating malaria with the use of larviciding and indoor residual spray.[355] Namibia sprays mosquito bleeding areas with an insecticide called Temephos, which is approved by WHO, to control mosquitoes in mashes and swaps in malaria endemic areas like the Zambezi region and the northern part of Namibia.[356] The Commission also learnt that DDT is used as indoor residue spray and no side effects have been reported in Namibia. The Commission further learnt that the Ministry responsible for Health in Namibia obtains a clearance certificate from Ministry of Agriculture to procure DDT from India. The chemical is not readily available on the market to ensure that it is not used by the public. The Commission thus observed that DDT is used for control of mosquitoes by Namibia Ministry responsible for Health only.[357] The Commission noted that Namibia Ministry responsible for Health also works closely with Ministry responsible for Environment and Tourism in the control of malaria.

During a comparative study visit to Zambia, the Commission learnt that Zambia also banned the use of DDT in agriculture in light of the production of tobacco. The country however takes advantage of the Stockholm Convention which provides for an allowance of use of chemicals.[358] The Stockholm Convention is a global treaty that aims to protect human health and the environment from the effects of POPs. According to decision UNEP/POPS/COP.8/32 adopted by the eighth meeting of the Conference of the Parties to the Stockholm Convention, countries that rely on indoor residual spraying for disease vector control may need DDT for that purpose in specific settings where locally safe, effective and affordable alternatives are still lacking for a sustainable transition away from DDT. The Commission learnt that Zambia is one of the countries that has **"registered an acceptable purpose"** for DDT use for malaria control in line with Stockholm Convention. Where a member state to the Convention intends to use DDT, it is required to register for exemption for vector control in public health under the Convention.[359] Zambia Environmental Management Agency as a focal point for the Stockholm Convention applies for the exemption, and the Zambia Ministry of Health applies for registration of the product for malaria control.[360] The Commission was informed that the Ministry of Health uses DDT only when there is a special request upon ascertaining that there is an issue of malaria drug resistance due to mosquitos. The use of DDT in Zambia is therefore very restrictive.

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355 The special Law Commission on the Review of the Public Health Act, a report on a comparative study visit to Namibia conducted from 4th to 11th September, 2021, p.11
356 As above.
357 As above at pp. 33.
358 The special Law Commission on the Review of the Public Health Act, a report on a comparative study visit to Zambia conducted from 6th to 12th June, 2021, p.24.
359 As above.
360 As above.

The Commission considered the dangers of use of DDT in Malawi against the advantages that it brings in mosquito control. The Commission observed that DDT is a persistent biochemical pollutant which accumulates in the ecosystem. However, the Commission did not have proof that DDT is harmful to human beings. The Commission agreed on the need to ensure that the use of DDT is controlled and that access to DDT should be limited.

The Commission noted that during district focus group discussions and regional consultative workshops, stakeholders supported the reintroduction of DDT for the sole purpose of eradicating malaria[361] as the advantages appear to outweigh the disadvantages of using DDT. The Commission, further, noted that DDT has been used in other countries to eradicate malaria such as in Zambia and Namibia. Zambia has similar economic activities to Malawi, for instance, growing tobacco as a cash crop but that has not affected the tobacco market. The Commission, therefore, recommends the reintroduction of DDT to control malaria. Further, the Commission recommends that failure to control breeding of mosquitoes under section 102 of the Act should not be a criminal offence.

The Commission recommends adoption of the following provisions on vector control—

PART…— VECTOR CONTROL

Destruction of vectors including mosquitoes

...—(1) A local authority shall establish, whenever necessary, a vector control team for the purposes of the control of vectors of public health importance in the area of jurisdiction of the authority.

(2) A vector control team shall include—

(*a*) a medical officer;

(*b*) a veterinary officer;

(*c*) an environmental health officer or public health officer; and

(*d*) a person with knowledge and qualification in entomology

(3) A vector control team shall collaborate with the committee responsible for health in the area of jurisdiction of the authority.

(*4*) The team may—

(*a*) enter any premises between the hours of six o'clock in the morning and six o'clock in the evening for the purposes of vector control; and

361 See Special Law Commission on the Review of the Public Health Act, Report on Focus Group Discussions: Salima and Kasungu, July, 2015, pp. 26-27; and Special Law Commission on the Review of the Public Health Act, Report on Regional Consultative Workshop, November, 2018, p. 24.

(*b*) (i) take immediate steps or order the owner of the premises to take the necessary action to destroy vectors, including mosquitoes, found on the premises; and

(ii) render the habitat permanently unfit for the breeding of the vectors.

Protection of water receptacles

...— (1) An owner of premises or a person in occupation of premises shall not—

(*a*) allow on the premises the presence of a receptacle for water containing mosquito larvae, or water to be kept uncovered in a receptacle that has not been emptied and cleaned to the satisfaction of the local government authority; and

(*b*) allow on the premises a preventable condition which may be favourable to the breeding of mosquitoes and other vectors.

(2) Subsection (1) shall not apply where the receptacle is properly protected to the satisfaction of the local government authority from access to mosquitoes or other vectors.

Recovery of cost

...—(1) A local authority shall recover from the owner of premises the expenses incurred in carrying out measures in respect of premises under this Part.

(2) Where an owner of premises fails or refuses to pay expenses incurred by the local authority in carrying out a provision of this Part, the local authority shall recover the incurred expenses in a summary manner before a Court.

Penalty for refusal to comply with an order and obstruction

...— A person who—

(*a*) refuses to comply with an order made under this Part; or

(*b*) obstructs an officer empowered to carry out a provision of this Part or an act authorized by this Part,

commits an offence and shall, on conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for one (1) year and, in addition shall, for each day the offence continues, be liable to a fine of fifty thousand Kwacha (K50,000.00); or in the case of a legal person, a fine of five million Kwacha (K5,000,000.00), and in addition, shall, for each day the offence continues, be liable to a fine of one hundred thousand Kwacha (K100,000.00).

Payments to local authority Cap. 37:02

...— (1) Subject to the Public Finance Management Act the amounts of money recovered under this Part shall be paid to the local authority of the place where the offence was committed.

(2) The amounts of money recovered shall, in addition to other resources provided by the local authority, be used for public health management in the local authority.

Application of this part to vessels

...—This Part shall apply to vessels in the same manner as it applies to premises, with the modifications that are appropriate and necessary.

6.3 The Nature and Purpose of Notification of Infectious Diseases

An infectious disease has been defined as any disease which can be communicated directly or indirectly by a person suffering from it to another person.[362] Infectious diseases in human beings are transmitted by a wide range of disease agents including viruses, bacteria, fungi and protozoa (single-celled organisms including amoebae). Infectious diseases vary widely in their ability to be transmitted in human populations, and different infections are transmitted by different means. The means of spread include:

(*a*) airborne and aerosol, for example, measles, influenza and tuberculosis;

(*b*) food or water, for example, typhoid, cholera and hepatitis A;

(*c*) close contact, for example, scabies, impetigo and methicillin–resistant *Staphylococcus aureus* (MRSA);

(*d*) sexual intercourse, for example, gonorrhoea, syphilis, Chlamydia and HIV;

(*e*) blood, for example, hepatitis B, hepatitis C and HIV;

(*f*) insect vectors, for example, malaria and plague; and

(*g*) from an animal to a human being (zoonosis), for example, rabies and avian influenza and corona virus (Covid-19).

The Act provides that the following are notifiable infectious diseases: anthrax; blackwater fever; cerebro-spinal meningitis or cerebro-spinal fever; cholera; diphtheria or membranous croup; dysentery (bacillary); encephalitis lethargica; enteric or typhoid fever (including paratyphoid); erysipelas; hydrophobia or human rabies; influenza; measles; plague; acute primary pneumonia; acute anterior poliomyelitis; acute polioencephalitis; puerperal fever (including septicaemia, pyaemia, ceptic pelvic cellulitis or other serious septic condition occurring during the puerperal state); relapsing fever; scarlet fever or

[362] Section 4 of the Public Health Act.

scarlatina; sleeping sickness or human trypanosomiasis: smallpox or any disease resembling smallpox; all forms of tuberculosis which are clinically recognizable apart from reaction to the tuberculin test; typhus fever; whooping-cough and yellow fever. This list can be expanded to include emerging and re-emerging diseases as necessary.[363]

The Act places a duty on heads of dwellings like family houses,[364] schools[365] and medical practitioners,[366] to report to relevant authorities of the infectious notifiable disease discovered. The Act provides that a person who is required to give a notice or certificate of the occurrence of the infectious disease, but fails so to do, commits an offence.[367] The Minister has powers to make regulations for the notification of infectious diseases.[368]

Besides the Act, the Medical Practitioners and Dentists Act requires a licensee to report immediately upon treating a person for, or identifying a person as having any of the following notifiable infectious diseases at his private practice: cholera; typhoid fever; meningitis; tuberculosis; acute poliomyelitis; rabies; trypanosomiasis; measles; acute placid paralysis; viral haemorrhagic fever; plague (Bubonic or Pneumonic); and shigellosis.[369]

In England and Wales, the statutory requirement for notification of infectious diseases was first established in London in 1891 when cholera, diphtheria, smallpox and typhoid had to be reported by the head of the family or the landlord to the local authority.[370]

Notifiable disease schemes exist in many countries, and internationally, under the guidance of the WHO. The diseases included in each country are usually revised periodically. For example, there are around fifty notifiable diseases in New Zealand and around sixty notifiable diseases in the USA, with some variations between states in the USA. Under the IHR, a few diseases considered to have a "serious public health impact" (smallpox, poliomyelitis

[363] Section 12 of the Public Health Act gives power to the Minister to declare any other disease as the case may be, notifiable.
[364] Section 13 (1) (*a*) of the Public Health Act.
[365] Section 13 (1) (*b*) of the Public Health Act.
[366] Section 13 (1) (*c*), (*d*) and (*e*) of the Public Health Act.
[367] Section 13(2) of the Public Health Act.
[368] Section 14 of the Public Health Act.
[369] Regulation 20 of the Medical Practitioners and Dentists (Private Practice) Regulations.
[370] Doctors in England and Wales have a statutory duty to notify a 'Proper Officer' of the Local Authority or local Health Protection Unit (HPU) of suspected cases of certain infectious diseases. The attending Registered Medical Practitioner (RMP), should fill out a notification certificate immediately on diagnosis of a suspected notifiable disease and should not wait for laboratory confirmation of the suspected infection or contamination before notification. The certificate should be sent to the Proper Officer within three days or verbally within 24 hours if the case is considered urgent. All Proper Officers are required to pass on the entire notification to the HPA within three days of a case being notified, or within 24 hours for cases deemed urgent. HPUs are the primary recipient within the HPA of clinical notifications from Proper Officers. Notifications sent to the HPU must be made in a secure manner. This may be by telephone, letter, encrypted email or to a secure fax machine. GOV.UK, 'Notifications of infectious diseases (NOIDs)' Available at http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/NotificationsOfInfectiousDiseases/ Accessed on 20 January, 2013.

caused by wild–type poliovirus, human influenza caused by a new subtype, and SARS) must additionally be reported to the WHO. Similarly, other cases of infectious diseases deemed to constitute, under WHO definitions, a "public health emergency of international concern" need to be reported.[371]

The Act provides a list of notifiable infectious diseases and power of the Minister to declare any disease as a notifiable infectious disease. Out of the diseases which have been listed, only smallpox has special provisions in the Act. Smallpox, however, was declared defeated by the 33rd World Health Assembly in Geneva, Switzerland on 8 May, 1980. Malaria, although not listed as a notifiable infectious disease, has provisions under the Act on prevention and destruction of mosquitoes.[372]

The Act contains special provisions for certain formidable epidemic or endemic diseases in Part V. These diseases are smallpox, plague, cholera, yellow fever, cerebro-spinal meningitis, typhus, sleeping sickness or human trypanosomiasis and any other disease which the Minister may by notice declare to be a formidable epidemic or endemic disease.[373]

It has been argued that public health law should stop the separate classifications for communicable diseases. The argument is that having uniform standards, in public health legislation, based on the degree of risk, the cost of efficacy of the response, and the burdens on human rights, would lend clarity and coherence to public health interventions.[374]

It might be proper sometimes to make specific provisions addressing specific diseases for the sole reason that different diseases pose different risks of transmission. However, these specific provisions may be a source of problems. Firstly, rigid classifications can frustrate attempts to deal effectively with diseases that do not fit neatly into any category. Secondly, classification of diseases often determines whether those entrusted with the power to curb the threats are able to exercise compulsory public powers. Thirdly, disease classification reflects stereotypes associated with sexually transmitted infections or venereal diseases. Section 54 of the Act prohibits employing a person who is suffering from a venereal disease in a communicable form. The section further makes it an offence to employ such a person. However, the Commission doubted the legality of section 54 of the Act in light of section 20 of the Constitution which prohibits discrimination against any person on any ground.

The Commission noted that the main purposes of notification of infectious diseases are to encourage a rapid detection of outbreaks and epidemics; and timely implementation of measures to control such outbreaks by public health officials. The Commission, further, noted that the Act places a duty on the head

371 World Health Assembly (2005), "International Health Regulations". Available at http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf Accessed on 13 April, 2011.
372 Section 96 through 102 of the Public Health Act.
373 Section 30 of the Public Health Act.
374 Gostin L.O., et al., Improving state law to prevent and treat infectious disease. Available at http://www.milbank.org/010130improvinglaw.html Accessed on 13 April, 2011.

of human dwellings to report any suspicion or occurrence of infectious disease. The Act criminalizes failure to report. However, problems arise where the head of the family is a child. The Commission noted that Malaŵi has community health workers who can monitor the health status of community and households, these health workers include health surveillance assistants whose job and responsibility should be expanded to monitor the health status within their communities. The Commission, further, recommends that the penalty for the offence should only be a fine and not imprisonment.

The Commission was aware that some of the diseases on the list under section 11 of the Act are no longer treated as notifiable diseases. It was resolved that the list should be updated, and be placed as a schedule under the legislation to be developed to ease the process of updating the list. To that end, it was resolved that there should be two lists of infectious diseases: the first for surveillance purposes; and the second for infectious (formidable) diseases. The Commission reiterates its earlier recommendation, that first PHIM be the focal point for the implementation of public health issues in Malawi, and that at policy level, the Ministry of Health should take lead. Further, the Commission recommends that the Department of Preventive Health in the Ministry of Health to be retitled to "the Department of Public Health".

Finally, it was noted that there is a need to regulate time frames for notifications of diseases. For instance, the maximum period for reporting a cholera case should be 24 hours. Failure to report an occurrence of an infectious disease should be punishable by a fine depending on the gravity of the circumstances. The Commission observed that this could work best where the law provides for this duty to all DHOs. The Commission recalled that under the Medical Practitioners and Dentists Act, a private health practitioner is required to report immediately upon treating any person for, or identifying any person as having any of the following notifiable infectious diseases at his private practice: cholera; typhoid fever; meningitis; tuberculosis; acute poliomyelitis; rabies; trypanosomiasis; measles; acute placid paralysis; viral haemorrhagic fever; plague (Bubonic or Pneumonic); and shigellosis.[375]

6.4 Isolation and Quarantine

The IHR defines isolation, on the one hand, as separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in a manner which is to prevent the spread of infection or contamination. Quarantine, on the other hand, means the restriction of activities or separation from others of suspect persons who are not ill or of a suspect baggage, containers, conveyances or goods in a manner which is to prevent the possible spread of infection or contamination.

Under the Act, public health authorities are permitted to confine persons with active infectious diseases. The confinement can also be effected on persons who

[375] Regulation 20 of the Medical Practitioners and Dentists (Private Practice) Regulations.

are suspected to have had contact with a person suffering from an infectious disease. However, the quarantine provisions are not clearly stated and are rarely effected.

Generally, isolation has been said to be a necessary method in the prevention of tuberculosis. However, although medical interventions are important in the prevention or control of the spread of infectious diseases, they can interfere with civil liberties for instance bodily integrity and freedom of conscience. Public health law provides that the liberty of an individual can be restricted where decisions or actions of an individual potentially endanger the health of others. The Commission noted that there had been issues of infectious diseases attacking a large number of persons due to the complexity of the disease; or the disease being artificially introduced, for instance in cases of bio-terrorism.

The Commission was of the view that the focus of the Act on sanctions and quarantine of persons suspected of suffering from communicable and infectious diseases was a complete disregard for; and violation of human rights. Sections 18 and 19 of the Constitution provide for the inviolability of the right to personal liberty and dignity of all persons, respectively. Article 1 of the UDHR states that "all human beings are born free and equal in dignity and rights".[376] Further, article 3 of the UDHR provides that "everyone has the right to life, liberty and security of person".[377] Article 9 of the UDHR provides that "no one shall be subjected to arbitrary arrest or detention". Article 10 of the UDHR provides that "everyone has the right to freedom of movement and residence within the borders of each State". In Malawi, section 39 (1) of the Constitution provides that "every person shall have the right of freedom of movement and residence within the borders of Malawi".

Further, article 23 of the UDHR states that everyone has the right to work and to free choice of employment. The requirements for quarantine, the restriction of activity and the prohibition from work of specified persons, as provided in the Act do not conform to rights of liberty and dignity, for example, under the Constitution. However, the UDHR clearly indicates that rights and freedoms are not absolute and must be construed in a wider context. For example, article 29 provides as follows:

> "(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.
>
> (2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society."

[376] Article 1 of the Universal Declaration of Human Rights.
[377] Article 3 of the Universal Declaration of Human Rights.

The rights established under the ICCPR are similar to the UDHR and are modified by article 4 in times of public emergency:

"In a time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin."[378]

Further, individual provisions are qualified. For example, article 12 (1) of the UDHR provides that "everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence."[379] This is followed by the qualification in article 12 (3) that the right is subject to laws "necessary to protect national security, public order, public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant."

The requirements of public health allow the curtailment of individual liberty rights. There is, however, a liberal approach which was propounded by John Stuart Mill as one way to start thinking about resolving the tension between the promotion of public health and the protection of individual freedoms. This is in the famous 'harm principle' found in the essay 'On Liberty' and it states:

> "The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.
>
> He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for

[378] The limitation clause under Article 4 of the UDHR does not apply to the following rights under the Declaration: article 6 on inherent right to life, article 7 on torture or to cruel, inhuman or degrading treatment or punishment, article 8 (1) and 8 (2) on slavery and servitude, article on 11 imprisonment for debt, article 15 on retrospective penalties, article 16 on the right to recognition as a person under the law, and 18 the right to freedom of thought, conscience and religion. In Malaŵi, section 45 (3) (*c*) provides that rights can be derogated during a state of emergency in cases of war, threat of war, civil war or a widespread natural disaster, only strictly for the protection and relief of those people in the disaster area.

[379] Likewise, section 39 (1) of the Constitution of the Republic of Malaŵi provides that "[Every person shall have the right of freedom of movement and residence within the borders of Malaŵi."

compelling him, or visiting him with any evil, in case he [does] otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. Over himself, over his own body and mind, the individual is sovereign."[380]

The Nuffield Council on Bioethics Report on Public Health: Ethical Issues posits that Mill's principle is introduced in public health not to suggest that it provides a satisfactory answer to all the questions that arise in the context of public health. Further, it does not commit public health to the wider theoretical framework in which it was set out, or to claim that harm to third parties is always a sufficient legitimisation of coercion. Instead, it is used to illustrate that, even in an approach that seeks to ensure the greatest possible degree of individual liberty and the least possible degree of state interference, there is a core principle according to which coercive, liberty-infringing state intervention is acceptable: where the purpose is to prevent harm to others.[381]

The Commission noted that some formidable diseases can best be prevented using the prevention measures of isolation and quarantine. The Commission acknowledges that all provisions of the UDHR are entrenched under the Constitution. Further, the Commission acknowledges the existence of section 44 of the Constitution in light of public health emergencies and restrictions on movement. The Commission considered section 44 of the Constitution and concluded that the right to movement can be limited in public health emergencies.

The Commission recommends adoption of the following provisions on disease prevention and notification:

PART…—PREVENTION, SUPPRESSION AND NOTIFICATION OF DISEASE

Application of this Part

... — (1) The Minister may, by notice published in the *Gazette*, declare that a disease is communicable, infectious or contagious in nature.

(2) Where a notice is published in the *Gazette* declaring a disease as communicable, infectious or contagious in nature the provisions of this Part shall apply.

Declaration of infected area and subsequent orders

... — (1) The Minister—

(*a*) shall, by notice published in the *Gazette*, declare an area in which a disease that is communicable, infectious or contagious in nature has occurred as an infected area; and

380 Mills, J. S. (1859) 'On liberty', pp.13, cited by Nuffield Council on Bioethics (2007), 'Public Health: Ethical Issues'.

381 Nuffield Council on Bioethics (2007), 'Public Health: Ethical Issues', 16.

(*b*) may by the same or a subsequent notice published in the Gazette issue orders for the control, suppression or prevention of the diseases including restrictions on movements or the evacuation of the whole or a part of the infected area.

(2) A person shall not reside, enter or carry on business within an area to which an order under subsection (1) has been issued except under an order and on conditions specified by the Minister.

(3) A person who contravenes any order issued under this section commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for three (3) months.

Stopping of vehicles

... — (1) A medical officer, a veterinary officer, an environmental health officer, a police officer, or a person designated by the Minister, may for the purpose of medical examination and any other public health concern—

(*a*) stop a vehicle travelling in, or suspected to be travelling in or travelling to or from an infected area; and

(*b*) detain any of the persons travelling or being conveyed in or on the vehicle.

(2) A person suffering or suspected to be suffering from a communicable disease, or a corpse, or an article suspected to be capable of spreading infection may be removed from the vehicle and dealt with as prescribed.

(3) The driver of a vehicle who refuses or fails to stop when asked by any of the persons mentioned in subsection (1), commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Post-mortem examination Cap. 4:02

...Subject to the Inquests Act, a medical officer, an authorized health officer who suspects that a person has died of a communicable disease, whether in an infected area or not, shall—

(*a*) order that the body of the deceased person be conveyed to a specified place for an examination that the medical officer or authorized health officer considers necessary; and

(*b*) notify the directorate responsible for public health services in the area or a veterinary officer as the case may be, about the suspected case.

Marking

...—(1) A medical officer, authorized health officer or veterinary officer may place, or cause to be placed, on a house, structure or at an area where a case of a communicable disease has occurred, whether in an infected area or not, a marking denoting the occurrence of the disease as prescribed by Regulations.

(2) The mark referred to in subsection (1) shall be kept affixed for a period that the medical officer, authorized health officer or veterinary officer considers necessary.

(3) A person who unlawfully removes or obliterates the mark commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Disinfection

...—A medical officer, veterinary officer or an authorized health officer may order the disinfection of—

(*a*) a house, structure or an area in which a case or suspected case of a communicable disease has occurred, whether in an infected area or not;

(*b*) property belonging to a person residing or being in that house, structure or area; and

(*c*) order the disinfection of the vehicle and the person inside it.

Demolition of building

...—(1) A local government authority may, by order of the court, and subject to such compensation and ancillary order as the court may determine, cause the demolition of a house or structure whether in an infected area or not, where a case of a communicable disease has occurred and of anything in that house or building, or elsewhere which a medical officer, authorized health officer or veterinary officer considers necessary in the interest of public health.

Destruction of animals

...—(1) A veterinary officer or an authorized health officer may by order of the court, and subject to such compensation and ancillary order as the court may determine order the destruction of an animal whether or not the animal is in an infected area if the officer is satisfied that the animal is likely to be an agent in the transmission of a communicable disease.

(2) A veterinary officer shall dispose of the carcass of an animal destroyed pursuant to subsection (1) in the manner specified by the court.

Declaration of place as quarantine area

...The Minister may, by notice published in the *Gazette*—

(*a*) declare a place to be an area for purposes of quarantine; and

(*b*) provide for any matter necessary for the purposes of quarantine.

Appointment of officers

...The Minister may, by notice published in the *Gazette*, appoint persons to be officers to enforce and carry out the provisions of this Part.

Provision of sanitary stations, anchorages

...—(1) A local government authority shall provide appropriateequipment, houses, structures and sanitary stations for the purposes of this Part.

(2) The Minister may, by notice published in the *Gazette*, declare an area as a sanitary station or sanitary anchorage for the purposes of this Part.

Removal and isolation of infected persons

...—(1) A medical officer or an authorized health officer may—

(*a*) cause a person suffering or suspected to be suffering from a communicable disease, whether in an infected area or not, to be removed to a health facility or designated place; and

(*b*) detain the person until the medical officer or health officer determines that the person is safe to be discharged.

(2) The State shall bear the cost of the removal of a person contemplated in subsection (1) and of his or her maintenance at the hospital or place of isolation.

Quarantine of contacts or suspects

...—(1) A medical officer may order a person living in the same house or compound, or a person who has come into contact with another person suffering or suspected to be suffering from a communicable disease, whether in an infected area or not, to be quarantined in a designated place provided by the Government until the person is considered safe to be discharged.

(2) A person who refuses or fail without reasonable cause to comply with an order made under subsection (1)

commits an offence and shall upon conviction be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment to six (6) months.

Removal and bodies of persons who have died of an infectious disease

...—(1) A medical officer or an authorized health officer may, where he is satisfied or has reason to believe that the remains of a deceased person are likely to be an agent in the transmission of a communicable disease, whether or not the deceased person is in an infected area—

(*a*) determine the manner in which the remains of a person who hasdied of an infectious disease can be disposed of; or

(*b*) authorise the disposal of the remains of a deceased person in aspecified manner,

(2) A person who retains a dead body—

(*a*) in contravention of subsection (1); or

(*b*) in any premises in circumstances which, in the opinion of a health officer of health, are likely to cause nuisance or endanger health,

commits an offence and shall upon conviction be liable to a fine of five million Kwacha (K5,000,000.00) and to imprisonment for five (5) years.

Notification of deaths and removal of bodies of persons dying of infectious diseases

...— (1) An occupier of the building shall immediately notify the local authority of the death of a person who has died from an infectious disease.

(2) A local authority shall on receipt of a notice under sub-section (1) notify the nearest health officer and make the necessary arrangements pending the removal of the body and for the carrying out of thorough disinfection to prevent the spread of such disease.

(3) Any person who removes the body of a person who has died of an infectious disease or for the purpose of immediate burial commits an offence.

(4) Any person who keeps the dead body of person who has died of an infectious disease in any place other than a mortuary or other place set apart for the keeping of dead bodies, without first obtaining the permission of the local authority or a health officer commits an offence.

(5) An occupier of any premises who keeps a dead body in any room in which food is kept or prepared or eaten; or

keeps a dead body for more than twenty-four hours in any room in which any person lives commits an offence.

(6) Any person who contravenes this section shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Presumption of knowledge of disease

...—(1) A person in charge of, or attending to, or living with a person or animal suffering from a communicable disease and has reasonable cause to believe that the person or animal is suffering from a communicable disease shall report to any appropriate health authority in the area of the existence of the disease in the person or animal.

(2) A person who contravenes subsection (1) commits an offence shall,

upon conviction be liable to a fine of one hundred thousand Kwacha (K100,000.00) and to imprisonment for three (3) months.

(3) Subsection (2) shall not apply where it is proved to the satisfaction of the court that the person did not have that knowledge and could not with reasonable diligence have obtained that knowledge.

Obstruction, impeding, inciting, etc

...— A person who, without lawful authority or excuse—

(*a*) contravenes a provision of this Part for which a punishment is not provided, or does anything which, under this Part that person ought not to do; or

(*b*) obstructs, impedes, aids or incites a person to obstruct or impede a medical officer, veterinary officer, police officer, health officer, or a person lawfully acting in the execution of a provision of this Part,

commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

The Commission noted that proper guidelines on how to report the occurrence of any of the diseases on the list of notifiable infectious diseases under section 11 of the Act are not available. However, the Ministry of Health instituted the IDSR to monitor and report occurrence of diseases. The Commission further considered strengthening of the IDSR through domestication of the International Health Regulations (IHR) to help solve the problem and noted that some countries, for instance Botswana, have domesticated the IHR as part of the public health laws. The Commission learnt during its study visit to Namibia that the chief health officer after the commencement of the Public and Environmental Health

Act published in the *Gazette* the International Health Regulations 2005. As such, the Commission resolved to adopt the Namibia approach so as to ensure that subsequent amendment of the International Health Regulations to which Malaŵi is a party are merely published in the *Gazette* rather than having to initiate an amendment of the legislation.

The Commission therefore recommends adoption of the following provision:

Application of International Health Regulation

...International Health Regulations (2005) and as amended from time to time shall form part of the law on public health in Malawi and shall come into effect by order of the Minister published in the *Gazette*

The Commission, further, noted that the existing set-up where the Act gives powers to agents of local government authorities to report to DHOs within the set-up of the local government authorities had failed. The Commission suggested that the proper authority to receive reports on all matters should be the Ministry of Health under the Public Health Institute who shall report to the Minister responsible for health. Under this set-up, it would be easy to monitor all health practitioners with statutory duties to report of any disease.

The Commission, further, considered the authority to have powers to control outbreaks between a local government authority and the Ministry of Health. It was agreed that there should be a concurrent reporting system in which the Ministry of Health and local government authorities should work hand in hand to control outbreaks. The Commission noted that the existing set-up for notification of diseases in Malaŵi is affected by the following factors:

(*a*) lack of proper record keeping (in both the local government authorities and the Ministry of Health);

(*b*) lack of a dedicated public health institute;

(*c*) lack of electronic monitoring on surveillance data; and

(*d*) lack of experts to diagnose diseases.

The Commission reiterated its earlier recommendation that the legislation to be developed establish a Public Health Institute composed of experts and personnel dedicated to public health so as to ensure, among others, accurate and efficient surveillance mechanisms. The experts shall advise Government on all public health issues. The Commission, further, makes a policy recommendation, that at the district level should have Public Health Officers who should be frontline officers responsible for the collection of data from health centres on public health, instead of relying on the existing system where a District Medical Officer doubles as a District Health Officer.

6.5 Sexually Transmitted Infections

The Commission considered section 54 of the Act which provides for employment of persons infected with venereal diseases as follows:

> **"54. Employment of infected persons**
>
> (1) Any person who, while suffering from any venereal disease in a communicable form, accepts or continues in employment either as an employee or on his own account in or about any factory, shop, hotel, restaurant, dwelling-house, or any place in any capacity entailing the care of children or the handling of food intended for consumption or of food utensils for use by any other person shall be guilty of an offence, unless he proves that he did not know or suspect, and had no reasonable means of knowing or suspecting, that he was so suffering.
>
> (2) Every person shall be guilty of an offence who employs or continues to employ any person suffering from any venereal disease in a communicable form, if by reason of such employment such person is required or is permitted to have the care of children or to handle any food intended for consumption or food or household utensils, unless the employer proves that he did not know or suspect, and had no reasonable means of knowing or suspecting that the person so employed by him was suffering from such disease.
>
> (3) If an employee who is employed in any manner set out in the preceding subsections is shown by a certificate signed by a registered or licensed medical practitioner to be suffering from a venereal disease, or if any employer has reasonable cause to suspect that such employee is suffering from a venereal disease and the said employee refuses to submit himself to medical examination, it shall be lawful for the employer summarily to dismiss the employee with payment of wages up to the date of dismissal."

The Commission noted that, as a result of various scientific breakthroughs and developments in the field of public health, venereal diseases are referred to as Sexually Transmitted Infections (STIs) or Sexually Transmitted Diseases (STDs). These are diseases that are contracted and transmitted by sexual contact, caused by microorganisms that survive on the skin or mucus membranes, or that are transmitted through semen, vaginal secretions, or blood during sexual intercourse.[382] Section 54 of the Act provides that a person who accepts or continues in employment while knowing that he or she is suffering from a venereal disease in a communicable form commits an offence.[383] In addition, an employer covered under section 54 of the Act who employs a person with a venereal disease in a communicable form commits an offence.[384]

382 MedicineNet, 'Medical Definition of Venereal disease' Available at http://www.medterms.com/script/main/art.asp?articlekey=11545 Accessed on 26 April, 2011.
383 Section 54 (1) of the Public Health Act.
384 Section 54 (2) of the Public Health Act.

The Commission was of the view that the scheme of making it an offence to employ or continue employing a person who has a venereal disease in a communicable form or continuing to work within the setting provided under section 54 while having a venereal disease in a communicable form needs to be modified to apply to all infectious diseases. At the enactment of this Act the management of sexually transmitted infections had not advanced. As such, the Commission found the need to create a provision in the proposed legislation that will deal with equally infectious diseases like Covid-19, seasonal flues, Typhoid and sexually transmitted infections. It was agreed that a deliberate transmission of an infection should be an offence. The Commission, therefore, agreed that the legislation to be developed should require an employee who has an infectious disease in a communicable form to receive treatment during the period he or she is infected; and that the employer should ensure that an employee suffering from an infectious disease in a communicable form should not work. The Commission recalled the coercive nature of public health laws and recommended that an STI Workplace Policy should be established. The Policy should require persons employed in public places; and whose jobs entail provision of food and care to other people, for instance food handlers and nursery school teachers, to be regularly tested and screened for STIs.

The Commission agreed that section 54 of the Act should be modified to apply to all infectious diseases at the workplace. The Commission, therefore, recommends adoption of the following provision on sexually transmitted infections—

Transmission of infectious diseases

...— (1) A person commits an offence who, having knowledge that he is suffering from a disease in a communicable form, accepts or continues in employment either as an employee or on his own account—

(*a*) in or about a factory, shop, hotel, restaurant, dwelling-house;

(*b*) in other place in any capacity entailing the care of children;

(*c*) in handling of food intended for consumption; or

(*d*) engages in handling of food utensils for use by any other person.

(2) Notwithstanding subsection (1), it shall be a defence for the person if he satisfies the court that he did not know or suspect, and did not have reasonable means of knowing or suspecting, that he was so suffering.

(3) A person who—

(*a*) while caring for children;

(*b*) in the course of handling of food intended for consumption; or

(*c*) while handling household utensils,

wilfully transmits a disease of a communicable form commits an offence and shall, on conviction, be liable to imprisonment for five (5) years.

(4) An employer shall ensure that a person suffering from a disease in a communicable form who, by reason of his employment is required or permitted to–

(*a*) have the care of children;

(*b*) handle food intended for consumption; or

(*c*) handle household utensils,

does not report for work for the duration that the person has the infection.

(5) Notwithstanding subsection (4), it shall be a defence for the employer if he satisfies the court that he did not know or suspect, and did not have reasonable means of knowing or suspecting, that the person so employed by him was suffering from such disease.

(6) An employee employed in any manner set out in the preceding subsections shall communicate to the employer any certificate signed by a registered or licensed medical practitioner that serves to show that the employee is suffering from a disease in a communicable form

(7) An employer shall, upon receipt of communication under subsection (6), grant leave of absence from work to the employee for a reasonable period to allow the employee receive treatment.

(8) Where an employer has reasonable cause to suspect that an employee is suffering from a disease in a communicable form, and the employee refuses to submit himself to medical examination, it shall be lawful for the employer summarily to dismiss the employee with payment of wages up to the date of dismissal.

6.6 Vaccination

Generally, vaccination means the administration of antigenic material (a vaccine) to stimulate adaptive immunity to a disease. Vaccination is a type of control measure employed in the fight against some diseases. It has over the years

been considered as the most effective method of preventing infectious diseases. It involves treating a healthy person with an intervention derived from (or similar to) a particular infectious disease agent. The purpose is to induce an immune response in order to gain immunity to the disease in the future. The WHO estimates that vaccination programmes averted over two million deaths worldwide in 2002.[385] The incidences of diseases such as tetanus, measles, hepatitis B and poliomyelitis have been greatly reduced by vaccination programmes worldwide, and smallpox has been eradicated.[386]

Usually there are two main types of vaccination strategies. The first one is aimed at protecting vulnerable subgroups. Under this type, vaccines are given to members of selected population groups, for instance those who are at a high risk of infection or particularly vulnerable to serious consequences arising from the infection, for instance health personnel. The second type is the population-wide vaccination which is aimed at achieving 'herd immunity'. Under this type, vaccines are given to a large proportion of the population, usually during childhood. The 'herd effect' occurs when a sufficiently large proportion of a population is vaccinated, thus the chance of the disease being passed between unvaccinated people is reduced to a minimum.

Immunization against vaccine–preventable diseases was said to be essential to reaching Millennium Development Goal 4 on reducing under–five mortality by two thirds by 2015.[387] This is because millions of children die from diseases that can be prevented through vaccines.[388] There is normally the issue of consent which arises in children. Children are a vulnerable group and a decision whether to vaccinate them or not can have so many implications in their healthy life. In this scenario, it is important that concerned personnel focus on considerations of the best interests of the child and that decisions which are not in the best interests of the child can be overridden.

The Act provides for vaccination in the smallpox provisions under Part VII.[389] As noted above, smallpox was declared as a disease that had been eradicated in 1980. Under the Act, it is compulsory that every child born in Malaŵi should be vaccinated against smallpox after six months and within twelve months from birth unless the child is unfit.[390] The Minister has power under the Act to declare by a notice in the *Gazette* an area to be a compulsory vaccination area;[391] and every unprotected adult and the parent or guardian of every

385 World Health Organization (2005) 'Fact sheet No. 288: Immunization against diseases of public health importance'. Available at www.who.int/mediacentre/factsheets/fs288/en/index.html. Accessed on 9 June, 2011.
386 As above.
387 The Commission noted that in Malaŵi, this goal was attained. Further, the Commission noted that this is Sustainable Development Goal 3 under the Sustainable Development Goals which succeeded the Millennium Development Goals.
388 World Health Organization, 2011. '10 facts of immunization'. Available at http://www.who.int/features/factfiles/immunization/en/ Accessed on 9 June, 2011.
389 Section 42 of the Public Health Act defines vaccination as the introduction into the skin of smallpox vaccine virus contained in pure and tested vaccine lymph.
390 Section 43 of the Public Health Act.
391 Section 44 (1) of the Public Health Act.

unprotected child is required to ensure that he and the child in the compulsory vaccination area have been vaccinated within the period specified.[392] The Ministry of Health, following international health standards set by WHO, has introduced several vaccines on children. Children are routinely vaccinated for diphtheria, tetanus, whooping cough, poliomyelitis, tuberculosis, some types of meningitis, measles, mumps and rubella, among others.

In many cases, vaccination against an infectious disease is compulsory. Under the Act, the only instance where a person cannot be vaccinated against smallpox (although this ought to be general) is where he or she has been declared unfit and a certificate to that effect has been issued. The US Supreme Court handed down a 7-2 decision in the case of *Jacobson v. Massachusetts*[393] that upheld the right of states to enact compulsory vaccination laws. In asserting that there are "manifold restraints to which every person is necessarily subject for the common good"[394] the Court took a firm position on one of the most challenging constitutional dimensions of public health. It also set the terms for what would eventually emerge as a core question at the heart of public health ethics. The Commission thus recommends the adoption of the following provisions relating to vaccination—

PART …—VACCINATION

Public vaccinators

...—(1) For the purposes of this Part, a medical officer or licensed health professional in public service shall be a public vaccinator.

(2) The Minister may appoint a person having the necessary competence, skill and knowledge to be an assistant public vaccinator.

(3) An assistant public vaccinator shall perform the functions of a public vaccinator in accordance with the Regulations made under this Act.

Public vaccination

...— (1) A public vaccinator shall vaccinate a person who presents himself or is presented for the purpose, or a person who is or becomes liable to be vaccinated.

(2) Subsection (1) shall not apply where vaccination would be injurious to health, or where there is satisfactory evidence that a person is already successfully vaccinated or otherwise has natural immunity to the disease.

Exemption from vaccination

...— Subject to this Part, a public vaccinator shall not vaccinate a person who produces to the public vaccinator—

392 Section 44 (2) of the Public Health Act.
393 197 US 11 (1905).
394 Page 26.

(*a*) a certificate issued by a registered medical practitioner to the effect that the person named has within a prescribed period for the vaccine been successfully vaccinated; or

(*b*) a certificate issued within the prescribed period referred to in paragraph (*a*) to the effect that the person named in the certificate is medically unfit to undergo vaccination.

Compulsory vaccination

... (1) the Minister may, by notice published in the *Gazette*, generally or with reference to a particular district, area, or place or with respect to a particular class of persons, order the persons to whom the notice applies who do not produce satisfactory evidence of successful vaccination, to be vaccinated by a public vaccinator, unless in the opinion of the public vaccinator, the vaccination would be injurious to health.

(2) A notice under this section may be made subject to the appropriate qualifications and exceptions as the Minister may prescribe.

Vaccination of adults

... An adult to whom a notice made under section applies shall—

(*a*) attend for examination and if necessary, for vaccination, within the period and at the time and place appointed by the notice made under section …; and

(*b*) subsequently attend at the times and at the place that the public vaccinator may direct for the purpose of examination as to whether or not the vaccination has been successful, and if necessary, for re-vaccination.

Vaccination of children

... A parent of a child to whom a notice made under section … applies shall—

(*a*) within the stipulated period after the birth of the child and within the time appointed under section … bring the child to a public vaccinator at the time and place appointed for examination and, if necessary, for vaccination; and

(*b*) subsequently produce the child at the times and places that the public vaccinator shall direct, for the purposes of examination as to whether or not the vaccination has been successful and, if necessary, for re-vaccination.

Examination and vaccination at point of entry

... A public vaccinator or assistant public vaccinator may examine and vaccinate a person who arrives in the Republic who does not produce satisfactory evidence of successful vaccination.

Certificate of vaccination

... A public vaccinator who has vaccinated an adult or a child, and has ascertained that the vaccination has been successfully administered, shall record the vaccination in the appropriate form and issue a certificate in the Form set out in the *First Schedule* or in a form prescribed for the vaccination under notice published in the *Gazette*.

First Schedule

Prohibition of the practice of inoculation

...— (1) The practice of inoculation is prohibited, unless it is conducted under controlled research conditions.

(2) A person who engages in a practice of inoculation, or is present at the performance of an operation of inoculation, not being under controlled research conditions, commits an offence and shall, on conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for three years.

Deceiving, misleading, obstructing public, etc

...— A person who—

(*a*) deceives or misleads by a false statement or otherwise in respect of a provision of this Part; or obstructs a public vaccinator in the performance of his functions,

commits an offence and shall, on conviction, be liable to a fine of two million Kwacha (K2,000,000.00) and to imprisonment for three (3) years.

6.7 Prevention of Introduction of Infectious Disease at Points of Entry

Part VI of the Act deals with the prevention of the introduction of infectious diseases into Malawi. Among others, section 38 gives the Minister power to enforce precautions at the borders for the prevention of introduction of infectious diseases into Malaŵi. On the face of it, the scheme is in sync with section 4 (1) (*e*) of the Immigration Act, which is in the following terms:

(1) Subject to this Act, the following persons shall be prohibited immigrants and their entry into or presence within Malaŵi shall be unlawful—

(*e*) any person who is infected, afflicted with or suffering from a prescribed disease, unless he is in possession of a permit issued by the Minister, or any person authorized by the Minister, to enter and remain in Malaŵi issued upon prescribed conditions and complies with such conditions;

Nonetheless, in the case of *The State (on the application of Lin Xiaoxiao & Others) v. Attorney General*[395] the Court found the provisions under Part VI of the Act to be obsolete and ineffective as regards an attempt by officers of the Government of Malawi to apply them to prevent the introduction of covid-19 into Malawi.[396]

A sister special Law Commission on the Review of the Immigration Act found that it is necessary to prohibit entry of a person into Malaŵi on the basis of an infectious disease in order to protect the health of those in Malaŵi.[397] One of the challenges in the *Lin Xiaoxiao case* was that whereas the State sought to restrict entry into Malawi of persons deemed to be arriving from a covid-19 high risk country, covid-19 was not a prescribed disease both under the Public Health Act and the Immigration Act. Further, the subjects had not been subjected to any medical examination to determine whether their entry into Malawi would pose a health risk to the public.

In Botswana, Part VIII of the Public Health Act, No. 11 of 2013 makes provision for the prevention of introduction of disease and control of disease in rather progressive terms. Rather than prescribe specific diseases in the legislation, the approach is to give power to the Minister to make a necessary order after consultation with health authorities.[398] This gives room for the control of any emerging or novel situation as advised by health authorities. Under section 76, where a person arriving in Botswana by aircraft, train or other conveyance, or on foot, is found to be suffering from any communicable disease, and, in the opinion of a health officer, cannot be accommodated or cannot be nursed and treated so as to guard against the spread of the disease or to promote recovery, a health officer may order the removal of that person to a health facility or place of isolation for such period as may be necessary in the interests of the patient or to prevent the spread of infection. All expenses incurred in dealing with a patient under the section are to be borne by the patient and may be recovered from that patient as a civil debt. Further, section 77 provides for medical surveillance and isolation of individuals entering Botswana in the following terms –

> "(1) Where a person arriving in Botswana by aircraft, train or other conveyance, or on foot, is believed to have been recently exposed to infection, or to be in the incubation stage of any communicable disease, a health officer or authorised officer may —
>
> (*a*) require that person to be removed to some health facility or place of isolation until considered free from infection; or
>
> (*b*) allow that person to proceed to his or her place of destination and there report himself or herself to a health officer or an authorised officer for medical surveillance by the health officer or the authorised officer until declared free from infection.

395 Judicial Review Cause No. 19 of 2020.
396 Pages 57-59, [9.3.7., 9.3.8].
397 Draft Immigration Report.
398 Section 75 of the Public Health Act, No. 11 of 2013.

(2) A health officer or authorised officer shall, in each case, notify the medical officer of the district where the destination of the person referred to in subsection (1) (*b*) is, of the fact that that person is believed to have been recently exposed to infection or to be in the incubation period of a communicable disease and has been allowed to proceed to his or her destination."

Section 80 provides for power to enforce precautions at the border in the following terms –

"(1) Where it is considered necessary for the purpose of preventing the introduction of a communicable disease into Botswana, the Minister may, by Order published in the *Gazette* —

(*a*) regulate, restrict or prohibit the entry into Botswana, at its borders or any specified part of Botswana, of any person;

(*b*) regulate, restrict or prohibit the introduction into Botswana, at its borders or any specified part of Botswana, of any animal, article or thing;

(*c*) impose requirements or conditions as regards the medical examination, detention, quarantine, cleansing, vaccination, isolation or medical surveillance or otherwise, of persons entering Botswana; or the examination, detention or cleansing or otherwise of any article or thing introduced into Botswana, at its borders or any part of Botswana; and

(*d*) apply, with or without notification, any provisions of this Part to persons, animals, articles or things entering or introduced into, departing or removed from, Botswana by means of aircraft, train or other conveyance.

(2) A person who contravenes or fails to comply with any order issued under subsection (1) commits an offence."

Arguably, such provisions could not have been surmountable had they been applicable in the *Lin Xiaoxiao* case. As found by the sister special Law Commission on the Review of the Immigration Act, it is necessary that provisions for prevention of introduction of infectious diseases at points of entry should be maintained in the proposed legislation in order to protect the health of those in Malaŵi. However, in light of the decision of the court in the *Lin Xiaoxiao* case, the provisions should be recrafted in progressive terms, adopting and adapting from the scenario in Botswana where necessary.

Therefore, the Commission recommends the adoption of the following provisions—

...PART.... — PREVENTION OF INTRODUCTION OF DISEASE AND CONTROL OF DISEASE

Introduction of disease

... — (1) The Minister may, after consultation with the Directorate of Public Health, by Order published in the *Gazette*, prohibit, restrict or regulate the immigration or importation, into Malawi, of any person, animal, article or thing likely to introduce any disease that is communicable, infectious or contagious in nature or impose restrictions or conditions as regards the examination, detention, cleansing or otherwise of any person, animal, article or thing.

(2) A person entering Malawi shall be in possession of a valid certificate of vaccination against notifiable diseases subject to the International Health Regulations, 2005 otherwise, that person shall be vaccinated on arrival.

(3) A person who contravenes or fails to comply with any order referred to in subsection (1) commits an offence and shall be liable, upon conviction to a fine of two million Kwacha (K2,000,000.00) or to imprisonment for a term of one year or to both.

Production of health documents by immigrants

...— (1) Any person entering Malawi shall, at the port of entry produce, upon demand of an immigration or health officer such health documents as the Minister may from time to time prescribe.

(2) Without prejudice to the generality of sub-section (1), the health documents shall be in respect of –

(*a*) vaccinations required of any person traveling from any prescribed country, region, or area;

(*b*) proof of tests for any disease required of a person traveling from any prescribed country, region, or area; or

(*c*) proof of vaccination against or test for any internationally prescribed disease.

Removal of infected persons

...—(1) Where a person arriving in Malawi by any vessel, or on foot, is found to be suffering from any disease that is communicable, infectious or contagious in nature, and, in the opinion of a health officer, cannot be accommodated or cannot be nursed and treated so as to guard against the spread of the disease or to promote recovery, a health officer may order the removal of that person to a health facility or place of isolation for such

period as may be necessary for the interests of the patient or to prevent the spread of infection.

(2) All expenses incurred in dealing with a person under this section shall be borne by the person and may be recovered from that person in civil proceedings.

Medical surveillance or isolation

...—(1) Where a person arriving in Malawi by any vessel, or on foot, is believed to have been recently exposed to any disease that is communicable, infectious or contagious in nature or to be the incubation stage of any such disease, a health officer or authorized officer may —

(*a*) require that person be removed to some health facility or place of isolation until considered free from infection; or

(*b*) allow that person to proceed to his or her place of destination and there report himself or herself to a health officer or an authorized officer for medical surveillance by the health officer or the authorized officer until declared free from infection.

(2) A health officer or authorized officer shall, in each case, notify the medical practitioner of the district where the destination of the person referred to in subsection (1) (*b*) is, of the fact that that person is believed to have been recently exposed to a disease that is communicable, infectious or contagious in nature or to be in the incubation period of such disease and has been allowed to proceed to his or her destination.

Powers of health officers

... — (1) Any health officer or authorized officer may, at any time, board any vessel arriving within Malawi and may inspect any portion of the vessel or anything and may medically examine or cause to be medically examined, any person travelling by any vessel and require that person to answer any question for the purpose of ascertaining whether that person suffers from a disease that is communicable, infectious or contagious in nature.

(2) A person who refuses to allow a health officer or authorized officer to board any vessel or to make any inspection or medical examination referred to in subsection (1) or otherwise obstructs or hinders any officer in the execution of that person's duty, or who fails or refuses to give any information which he or she may lawfully be required to give, or who gives false or misleading information to a health officer or authorized officer knowing it to be false or misleading information, commits an offence.

(3) A person who contravenes this section commits an offence and shall, upon conviction, be liable to a fine of two million kwacha (K2, 000,000.00) or to imprisonment for a term of one (1) year or to both.

Health officers to inspect vessels, etc.

...—The Minister may, when it is deemed necessary for the prevention of the spread of any disease that is communicable, infectious or contagious in nature, designate any health officer to inspect any vessel and any article or thing in the vessel and to examine any person travelling by the vessel or on foot and whether entering, leaving or travelling within Malawi.

Powers to enforce precautions

...—(1) The Minister may, by Order published in the *Gazette*, where it is considered necessary for the purpose of preventing the introduction of a disease that is communicable, infectious or contagious in nature into Malawi—

(*a*) regulate, restrict or prohibit the entry into Malawi, at its borders or any specified part of Malawi, of any person;

(*b*) regulate, restrict or prohibit the introduction into Malawi, at its borders or any specified part of Malawi, of any animal, article or thing;

(*c*) impose requirements or conditions as regards the medical examination, detention, quarantine, cleansing, vaccination, isolation or medical surveillance or otherwise, of persons entering Malawi; or the examination, detention or cleansing or otherwise of any article or thing introduced into Malawi, at its borders or any part of Malawi; and

(*d*) apply, with or without notification, any provisions of this Part to persons, animals, articles or things entering or introduced into, departing or removed from, Malawi by means of any vessel.

(2) A person who contravenes or fails to comply with any order issued under subsection (1) commits an offence, and shall upon conviction, be liable to a fine of one million kwacha (K1,000,000.00) or to imprisonment for one year.

Agreement with other Governments

...The Minister may enter into agreements with any foreign country providing for the reciprocal notification of outbreaks of any disease subject to International Health

Regulations, 2005 or any other matter affecting the public health relations of Malawi with other countries.

Government not liable

...— The Government of Malawi shall not be liable to pay compensation where the Minister or any authorized officer, exercises powers under this Part and by reason of the exercise of the power —

(*a*) any person, vessel, article or thing is delayed or removed or detained;

(*b*) any article or thing is damaged or destroyed; or

(*c*) any person is deprived of the use of any article or thing provided due care and reasonable precautions have been taken to avoid unnecessary delay, damage or destruction.

7.0 ENVIRONMENT AND WASTE

7.1 General

Environment generally means the physical factors of the surroundings of the human being including land, water, atmosphere, climate, sound, odour, taste, and the biological factors of fauna and flora, and includes the cultural, social and economic aspects of human activity, the natural and the built environment.[399] The law guarantees the right of every person to a clean and healthy environment.[400] Waste includes domestic, commercial or industrial waste whether in a liquid, solid, gaseous or radioactive form which is discharged, emitted or deposited into the environment in such volume, composition or manner as to cause pollution.[401] (Introduce waste management in general, and nuisance in general briefly, then go to the sub-headings).

7.2 Nuisance

Public health nuisance means the use of any premises or place in a manner which creates conditions that significantly increase the risk of a public health hazard occurring or which compromises any aspect of public health to an extent that is more than trivial or insignificant, and without limitation, includes those circumstances in which a public health nuisance is considered to exist. Nuisance mainly causes extreme annoyance on both housing and health. The Commission noted that the Act prohibits causing a nuisance or perpetuating a nuisance on any land or premises. An owner, occupier or a person in charge of the land or premises

[399] Section 2 of the Environment Management Act.
[400] Section 5 of the Environment Management Act.
[401] Section 2 of the Environment Management Act.

in question commits an offence, if the nuisance is injurious or dangerous to health.[402]

The Commission also noted that the Act does not provide a definition for nuisance. It was however acknowledged that section 62 of the Act provides an exhaustive list of what constitutes nuisance. According to the section, a nuisance includes any noxious matter, or waste water, flowing or discharged from any premises, wherever situated, into any public street, or into the gutter or side channel of any street, or into any gully, swamp, or watercourse or irrigation channel not approved for the reception of such discharge. A nuisance also includes any collection of water, sewage, rubbish, refuse, odour, or other fluid or solid substances which are offensive or which are dangerous or injurious to health or which permit or facilitate the breeding or multiplication of animal or vegetable parasites of men or domestic animals, or of insects or of other agents which are known to carry such parasites or which may otherwise cause or facilitate the infection of men or domestic animals by such parasites.

The Commission was aware that, generally, the law on nuisance is spread across different pieces of legislation. The Environment Management Act of 2017 prohibits any person from polluting, or permitting or causing any other person to pollute the environment.[403] The Water Resources Act also prohibits nuisance in the form of water pollution.[404] The Water Resources Act defines pollution as follows:

> " "pollute", in relation to water, means directly or indirectly to alter the physical, thermal, chemical, biological or radioactive properties of any water so as to render the water less fit for any beneficial purpose for which it is, or may reasonably be, used or to cause a condition which is hazardous or potentially hazardous to public health, safety or welfare, or to animals, birds, fish or aquatic life or other organisms or to plants; and "pollution" has a corresponding meaning."

The Penal Code considers any act that causes any common injury, or danger or annoyance, or obstructs or causes inconvenience to the public in the exercise of common rights, as a common nuisance.[405] Examples of common nuisances under the Act that have a bearing on public health include making loud noises or offensive or unwholesome smells in such places and circumstances as to annoy any considerable number of persons in the exercise of their common rights[406];

Nuisance as a branch of the law of torts is most closely concerned with the protection of the environment. Nuisances are divided into public and private. A public nuisance is a crime, while a private nuisance is only a tort. At common law, public nuisances include such diverse activities as carrying on an offensive trade, keeping a disorderly house, selling food unfit for human consumption,

402 Section 59 of the Public Health Act.
403 Section 44 of the Environment Management Act.
404 Cap 72:03 of the Laws of Malaŵi.
405 Section 168 (1) of the Penal Code.
406 Section 199 of the Penal Code

obstructing public highways and holding an ill-organized music festival. The Commission noted that certain activities that constitute a nuisance are not covered under any of the pieces of legislation considered under this part. It was noted that in recent years, funeral ceremonies are conducted right in the middle of public access roads especially in the high density areas of Lilongwe, Blantyre, Zomba and Mzuzu; heavy articulated trucks are parked in residential areas; and that sometimes parties or festivals take place in public access roads. The Commission was of the view that some of these activities, in the absence of satisfactory enforcement mechanisms, constitute nuisances.

Local government authorities have several duties under the Act. These include:

(*a*) to maintain cleanliness and prevent nuisances;[407]

(*b*) to prevent or remedy danger to health arising from unsuitable dwellings by taking all lawful, necessary and reasonable practicable measures;[408]

(*c*) to take persons who do not obey orders to court;[409]

(*d*) to put on sale by public auction any matter or thing removed in abating any nuisance;[410] and

(*e*) to demolish unfit buildings.[411]

In deliberating the issue of duty bearers further, the Commission observed that there are complementary mandates between the National Water Resources Authority; the Environmental Affairs Department; the Local Councils; and other key stakeholders in implementing laws and policies relating to nuisance and pollution. For instance, section 2 (6) of the Local Government Act places the responsibility for the draining, cleansing and sanitation of its area and the prohibition and control of pollution of any water in any river or stream on the local councils. Again, section 105 of the Act places a duty on local authority to take all lawful, necessary and reasonably practicable measures for preventing any pollution dangerous to health of any supply of water which the public within its district has a right to use and does use for drinking or domestic purposes (whether such supply is derived from sources within or beyond its district). The section also mandates a local authority to take measures (including if necessary, proceedings at law) against any person so polluting any such supply or polluting any stream so as to be a nuisance or danger to health.

Further, section 33 (2) (*b*) of the Environment Management Act vests in the Director of Environmental Affairs the power to make environmental protection orders in relation to pollution The Mandate extends to prohibition of water pollution when the mandate to ensure the safety of water, and enforcement of

407 Section 60 of the Act.
408 Section 61 of the Act.
409 Section 66 of the Act.
410 Section 69 of the Act.
411 Section 71 of the Act.

compliance with the provisions on the other hand rests with the National Water Resources Authority under the Water Resources Act.[412] Furthermore, it was observed that sections 79-86 of the Public Health Act has extensive provisions on public sewers which are similar to the provisions of sections 26-33 of the Water Works Act. However, whereas the Public Health Act refers to Local Authorities as being responsible in managing sewerage, the Water Works Act gives the same powers to water boards.

While recognising the complementary function of the mandates of the duty bearers, the Commission was aware that where the complementarity results in duplication and confusion of mandates, it would pose challenges in the discharge of the stakeholders' duties and responsibilities as it results in denial of responsibilities, non-compliance and limited enforcement, the effects of which are noticeable in poor waste segregation, waste collection and transportation as well haphazard waste disposal.

The Commission therefore recommends a review of the Local Government Act, to among other things, provide a clear definition of the duties of local council, and the scope of their mandate in relation to waste management and nuisance. The Commission further recommends assigning the duty to prevent water pollution to the National Water Resources Authority, as opposed to the Director of Environmental Affairs.

In relation to penalties, the Public Health Act prescribes a penalty of £5 for acting in contravention of any of the nuisances listed under section 62 of the Act. The fine applies for every day during which the contravention continues. Under the Environment Management Act, any person who discharges or emits any pollutant into the environment otherwise than in accordance with the Act, shall be guilty of an offence and shall be liable, upon conviction, to a fine of not less than K20,000 and not more than K1,000,000 and to imprisonment for ten years.[413] It is an offence, under the Water Resources Act for a person or public authority who, unless authorized under the Act, to cause or allow effluent to come into contact with any water; to be discharged directly or indirectly into water; or water to be polluted.[414] Where damage is caused, the person shall be liable to pay the cost of remedying the damage caused and restoring the environment, as far as is possible, to the condition that would have existed if the damage had not been caused.[415] A person who neglects or fails to comply with any order or requirement given or imposed on him by or under the Act commits an offence and on conviction shall be liable to a fine of K1,000,000 and to four years imprisonment.[416] Under Section 144 (2) of the Water Resources Act, any person who discharges effluents in contravention to the provisions of the Act commits an offence and is liable to a fine of K10,000,000 and to ten years imprisonment upon conviction.

412 Section 88 (5) (*a*) and (*b*) of the Water Resources Act.
413 Section 67 of the Environment Management Act.
414 Section 88 (1) (*c*) of the Water Resources Act.
415 Section 88 (4) of the Water Resources Act.
416 Section 143 of the Water Resources Act.

The Commission observed, that local government authorities face problems when it comes to determining penalties in their by-laws. This is due to the fact that, under the General Interpretation Act,[417] subsidiary legislation is restricted from making provisions for fines which are higher than those provided for in the enabling statute, thus by-laws enacted by local government authorities are not supposed to prescribe penalties which are higher than those provided in the Act or any other statute. The Commission, therefore, recommends that offences and penalties under section 66 of the Act should be expanded. The Commission also recommends that the disparities in the penalties under the different pieces of legislation be resolved. The Commission thus recommends the adoption of the following provisions on nuisance—

PART VIII—PUBLIC HEALTH NUISANCE

Public health nuisance

...— (1) A person shall not cause or permit to exist on land or premises owned or occupied by him, or of which he is in charge, a public health nuisance or other condition liable to be injurious or dangerous to health.

(2) A person who contravenes subsection (1) commits an offence and shall, on conviction, be liable to a fine of five million Kwacha (K5,000000.00) and to imprisonment for five (5) years. In the case of a legal person, a fine of fifty million (K50,000,000.000)

(3) The following are public health nuisances which can be offensive, injurious or dangerous to health and liable to be dealt with in the manner provided under this Part—

(*a*) any vehicle in such a state or condition as to be injurious or dangerous to health;

(*b*) any dwelling or premises which is or is constructed in a poor state or is situated in contaminated area or so dirty or so verminous or so liable to favour the spread of a notifiable infectious disease;

(*c*) a stream, pool, lagoon, ditch, gutter, watercourse, sink, cistern, sanitary convenience, urinal, cesspool, cesspit, drain, sewer, water tank, soak –away pit, septic tank, dung pit, refuse pit, dust bin, garbage receptacle, slop-tank, ash pit or manure heap so foul or in a state or so situated or constructed as to be offensive or to be likely to be injurious or dangerous to health or a collection of water which may serve as a breeding place for mosquitoes or other vectors;

[417] Cap. 1:01 of the Laws of Malaŵi.

(*d*) any well or other sources of water supply or cistern or other receptacle for water, whether public or private, the water from which is used or likely to be used by humans for drinking or domestic purposes or in connection with a dairy or milk-shop, or in connection with the manufacture or preparation of an article of food intended for human consumption which is polluted or otherwise liable to render the water injurious or dangerous to health;

(*e*) stable, kraal, cow-shed or other building or premises used for the keeping of animals or birds which is so constructed, situated, used or kept as to be offensive or injurious or dangerous to health;

(*f*) any carrion, offal, manure, filth, dirt, refuse, rubbish, or other matter which is offensive or which is injurious or dangerous to health placed on a street, yard, an enclosure, or open space except at the places designated by the local authority or the environmental health officer for that purpose;

(*g*) a dwelling which—

(i) is overcrowded as to be injurious or dangerous to health; or

(ii) does not conform with applicable laws in force in the area with regard to –

(*a*) air or floor space;

(*b*) lighting or ventilation;

(*c*) sanitary conveniences;

(*d*) ablution facilities;

(*e*) or cooking facilities;

(*h*) public building which is so situated, constructed, used or kept as to be unsafe or injurious or dangerous to health;

(*i*) excessive noise that infringes the right of others;

(*j*) occupied dwelling for which a proper, sufficient and wholesome water supply is not available within a reasonable distance as is under the circumstances possible to obtain;

(*k*) factory or business premises not kept in a clean state and free from offensive smells arising from a drain, sanitary convenience or urinal, or not ventilated so as to destroy or render harmless and offensive as far as practicable, gases, vapours, dust or other impurities generated, or so overcrowded or so badly lighted or ventilated as to be injurious or dangerous to the health of employees therein;

(*l*) factory or business premises causing or giving rise to smells or effluvia which are offensive or which are injurious or dangerous to health;

(*m*) an area of land kept or permitted to remain in a state as to be offensive or liable to cause a notifiable infectious, communicable or preventable disease, injury or danger to health;

(*n*) chimney, any machinery sending forth smoke in a quantity or in a manner as to be offensive or injurious or dangerous to health;

(*o*) cemetery, burial place, crematorium or place of sepulcher so situated or so crowded or otherwise so conducted as to be offensive or injurious or dangerous to health; or

(*p*) any loud or an unseemly noise to the annoyance or disturbance of any other person as determined by the local authority;

(*q*) any other condition which is offensive, injurious or dangerous to health.

Local authority to maintain cleanliness and prevent public health nuisance

...— (1) A local authority shall take all lawful, necessary and reasonable practicable measures to –

(*a*) maintain its local authority area at all times in a clean and sanitary condition; and

(*b*) prevent the occurrence of or for remedying or causing to be remedied, a public health nuisance or condition liable to be injurious or dangerous to health.

(2) In addition to the measures in subsection (1), the local authority may take proceedings at law against a person causing or responsible for the continuance of public health nuisance or condition.

...— (1) A local authority shall take all lawful, necessary and reasonable practicable measures to prevent or cause to be prevented or remedied all conditions liable to be injurious or dangerous to health arising from –

(*a*) the erection of or occupation of unhealthy dwellings or premises;

(*b*) the erection of dwellings or premises on unhealthy sites or on sites of insufficient extent;

(*c*) overcrowding; or

(*d*) the construction, condition or manner of use of a factory or business premises.

(2) In addition to the measures in subsection (1), the local authority may take proceedings under the law or rules in force in its area against a person causing or responsible for the continuance of the condition.

Notice to abate nuisance

...— (1) A local authority or health officer, if satisfied of the existence of a nuisance, may serve a notice—

(*a*) on the author of the nuisance; or

(*b*) where the author of the nuisance cannot be found, on the occupier or owner of the dwelling or premises on which the nuisance arises or continues, requiring him to abate it within the time specified in the notice and may in the same notice, specify any work to be executed to abate or prevent a recurrence of the said nuisance.

(2) A local authority shall serve the notice on the owner, where the nuisance arises from any want or defect of a structural character.

(3) Where the dwelling or premises are unoccupied the local authority shall serve the notice to the last known address of the owner.

(4) Where the author of the nuisance cannot be found or it is clear that the nuisance does not arise or continue by the act or default or sufferance of the occupier or owner of the dwelling of premises, the local authority shall abate the nuisance and may do what is necessary to prevent the recurrence thereof.

(5) A person aggrieved by a decision of a local authority made under sub-section (3) may appeal to the Court of a Resident Magistrate.

(6) For purposes of this Part, the author of a nuisance means the person by whose act, default or sufferance the nuisance is caused, existed, exists or is continued, whether he be the owner or occupier or both owner and occupier or other person.

Local Authority to execute works in certain cases

... A local authority may execute or cause to be executed the works to remove a public health nuisance and the cost of executing the works concerned shall be a charge on the property on which the public health nuisance concerned exists, where a local authority is satisfied that the person by whose act or omission the public health nuisance arises or that the owner or occupier of the premises is not known or cannot be found.

Demolition of unfit dwellings

...—(1) Where a public health nuisance is proved to exist with respect to a dwelling and the court is satisfied that the dwelling is -

(*a*) dilapidated;

(*b*) defectively constructed; or

(*c*) situated in a wrong place, that repairs to or alterations of the dwelling are not likely to remove the health nuisance and make the dwelling fit for human habitation, the local authority may by court order instruct the owner to demolish the dwelling and other structures on the premises and remove the materials from the site.

(2) The local authority shall give notice of not less than ninety (90) days to a person in respect of whom an order under subsection (1) has been issued.

(3) A person who fails to comply with a notice given under subsection (2) or who enters the dwelling or premises after the date determined by the court for the demolition of the dwelling, except for the purpose of demolition, commits an offence, and upon conviction is liable to a fine of fifty million Kwacha (K50,000,000.00) or to imprisonment for ten (10) years.

(4) Where a person fails to comply with an order for demolition, the local authority may –

(*a*) cause the dwelling and other structures on the premises to be demolished; and

(*b*) recover from the owner the expense incurred in doing so after deducting the net proceeds of the sale of the materials which the local authority may sell by auction.

(5) Any compensation shall not be payable by a local authority to the owner or occupier of a dwelling or other structure in respect of the demolition provided for in this section, and from the date of the demolition order, no rent shall become due or payable by or on behalf of the occupier in respect of the dwelling or structure.

Prohibition of business in noxious or offensive trade

...— (1) A person who without lawful authority—

(*a*) carries on a business in noxious trade or offensive matter at a place or causes or permits a business in noxious or offensive matter to continue to be conducted at any place, or keeps animals at a place that—

(i) impairs or endangers the health of the public inhabiting or using the neighbourhood of that place;

(ii) causes damage to the lands, crops, cattle, or goods of the public;

(iii) causes material interruption to the public in its lawful businesses or occupations; or

(v) materially affects the value of the respective properties of the public;

(vi) pollutes or fouls the water of a well, tank, spring, reservoir, or place used or intended to be used for the supply of water for human or animal consumption,

commits an offence and shall, on conviction, be liable to a fine of fifty million Kwacha (k50,000,000.00.00) and to imprisonment for three (3) years and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00).

Noxious trade

...—For the purposes of this Part—

(*a*) "noxious trade" includes the carrying out of an offensive or noisy business at a place or causing or permitting offensive or noisy business to continue at a place;

(*b*) "business" includes a trade, manufacture, work or occupation carried on for gain or charity, or a continued or frequent repetition of an act or a series of acts of any kind where the prejudice or danger caused by the act or omission extends to persons inhabiting or occupying not less than three (3) houses under separate tenancies or any other place of accommodation.

7.3 Waste Management

The Commission was aware that the Environment Management Act[418] provides for waste management.[419] The Act provides for the proper removal and disposal of waste, so as not to endanger the environment. The Act also prohibits littering in public places, and designates the Environmental Affairs Department to oversee creating of waste management standards and controlling the handling, storage, transportation, classification, importation, exportation, and destruction of waste.[420] It further bans anyone from handling, transporting, or storing waste without a license. The Commission also considered the Environment Management (Waste Management and Sanitation) Regulations 2008. These Regulations specifically provide for waste management and sanitation. The Regulations place a duty on local authorities to prepare waste management plans and to operate and maintain a municipal sewage collection system for their area of jurisdiction, and to promote integrated waste management systems. The Regulations further provide for management of general or municipal solid waste including: waste separation at source; the collection of the general or municipal solid waste at such a frequency as to prevent the piling of waste; and disposal of solid waste at a plant identified and maintained by a competent local authority.[421]

In relation to hazardous waste, the Commission took note of the Environment Management (Chemical and Toxic Substances Management) Regulations of 2008. The Regulations apply to any person in Malaŵi whose undertaking involves or includes the manufacturing, repackaging, importation, exportation, transportation, distribution, sale or other mode of handling toxic substances and chemicals and in respect of any activity in relation to toxic substances and chemicals which involves a risk of harm to human health or the environment. This includes chemical wastes which are defined as any unwanted or waste chemical or chemical formulation generated from any process which can cause danger to both human health and the environment. Under the Regulations, local authorities are required to make by-laws for the management of chemicals and toxic substances and chemical wastes in their respective areas of jurisdiction. Such by-laws should ensure that the disposal method of chemical wastes is environmentally sound. The Regulations also place a duty on industries or medical facilities not to discharge any chemical wastes in any state into the

418 No. 19 of 2017.
419 Schedules to the Environment Management Act adequately provide for waste management.
420 Section 37 of the Environment Management Act.
421 Part III of the Environment Management (Waste Management and Sanitation) Regulations 2008.

environment unless such wastes have been treated in accordance with acceptable international methods. The Regulations further provide for requirements on disposal or treatment of highly toxic or hazardous chemical wastes.

The Commission deliberated at length on the issue of penalties. The Commission observed the disparities between the penalties provided for under the Environment Management Act, and those entrenched in the Penal Code. Under the Environment Management Act, anyone who disposes off waste in contravention with the provisions of the Act is liable to a fine of one million Kwacha (K1,000,000.00).[422] On the other hand, Section 245A of the Penal Code which is couched in a similar manner as the Environment Management Act, provides for a stiffer penalty for contravention of the provision. The section provides that any person who handles waste in such a manner as to endanger or to be likely to cause harm to the environment shall be guilty of an offence, and liable to a fine of ten million Kwacha (K10,000,000.00) and to imprisonment for ten years.

Despite the existence of legislation and Regulations on waste management, the Commission noted enforcement challenges in the handling of and dealing with waste in the following areas:

(a) Housing

Consideration of the environment and waste is closely linked to housing. A house can be defined as the usual residential home of an individual or family. Housing is one of the important components for a dignified life. The association between housing conditions and physical and mental health illnesses has long been recognized. There is a broad range of specific elements relating to housing that can affect health outcomes. These include:

(*a*) agents that affect the quality of the indoor environment such as indoor pollutants (for example, asbestos, carbon monoxide, radon, lead, moulds and volatile organic chemicals);

(*b*) cold, damp, housing design or layout (which in turn can affect accessibility and usability of housing), infestation, hazardous internal structures or fixtures;

(*c*) factors that relate more to the broader social and behavioural environment such as overcrowding, noise, sleep deprivation, neighbourhood quality, infrastructure deprivation (that is, lack of availability and accessibility of health services, parks, stores selling healthy foods at affordable prices), neighbourhood safety and social cohesion; and

[422] Section 66 of the Environment Management Act.

(*d*) factors that relate to the broader macro-policy environment such as housing allocation, lack of housing (that is, homelessness, whether without a home or housed in temporary accommodation), land tenure, housing investment, and urban planning.[423]

The Commission further considered how enhancing good health through good housing could be achieved in Malaŵi. During its deliberations, the Commission struggled to define "good housing" in the context of Malaŵi. The Commission noted that when constructing a house in urban areas, the law provides for standards to be followed. It is, therefore, the house which meets those standards that may be described as "good housing". However, it is difficult to describe good housing in the case of rural areas. The Commission opined that from a public health point of view it entails provision of basic sanitary facilities such as latrine, bathroom, kitchen, waste disposal facility, for instance a rubbish pit, proper ventilation and the number of inhabitants.

The Commission recommends strict adherence to Public Health (Minimum Building Standards for Traditional Housing Areas) Rules. Further, the Commission recommends making provision for the prohibition of human beings sharing accommodation with animals. The Act provides that the Minister may make rules regarding inspection of land, construction of buildings, keeping of animals and control of houses let in lodging, among others,[424] which may assist in preventing nuisances. The Commission noted that the Minister has made some of the rules.[425] However, the Commission noted that the major challenge affecting the implementation of the rules was lack of enforcement. Further, some provisions promulgated under Part IX and the subsidiary legislation are outdated.[426]

(b) Management of Radioactive Materials

The control and regulation of the importation, exportation, production, processing, handling, use, holding, storage, transportation and disposal of radiation sources, nuclear materials, and any other radioactive materials is governed by the Atomic Energy Act.[427] The Atomic Energy Regulations 2012 give effect to the Atomic Energy Act. The Regulations comprehensively deal with radioactive waste management. The Atomic Energy Regulatory Authority (AERA) is responsible for the implementation of the Act and the Regulations thereunder.[428] The Commission held consultations with officials from the institution. The mandate of AERA is to provide for adequate protection of people as well as the environment against

423 Taske Nichole and others, 'Housing and public health: a review of reviews of interventions for improving health,' (2005). Available at http://www.nice.org.uk/niceMedia/pdf/housing_MAIN%20FINAL.pdf Accessed on 23 September, 2011.
424 Section 75 of the Act. See also section 76 for provision of standards regarding construction of buildings.
425 For instance, the Public Health (Minimum Building Standards for Traditional Housing Areas) Rules which regulate traditional housing in urban areas.
426 For instance, the Public Health (Construction of Trading Stores) Rules which came into force in 1932.
427 Atomic Energy Act, Cap 61:03 of the Laws of Malaŵi.
428 Section 5 of the Atomic Energy Act.

the harmful effects of radiation sources, nuclear material and radioactive materials. AERA is currently an institution within the Environmental Affairs Department, however, and plans are underway to establish it as a parastatal institution.

With regard to ensuring the safety of the public, the Commission noted that section 7 (*a*) of the Act[429] mandates AERA to play an advisory role to Government on policies, measures and matters related to protection and prevention of harmful effects of ionizing radiation to the public, workers and the environment. The Commission found that AERA dispatches dosimeters to health facilities upon receiving a request from the facilities. The dosimeters are read at the institution's dosimeter Lab to determine how much radiation the workers have been exposed to. AERA also monitors radiation exposure of industrial workers, construction workers and cement manufacturing companies. The monitoring is mandatory where it forms part of AERA's regulatory and enforcement mandate, and voluntary when approached by institutions or companies wishing to be monitored. The service is provided at a fee.[430]

Further, AERA facilitates appointment of radiation protection officers in hospitals and industries that use radioactive substances. The protection officers monitor and ensure compliance with the standards of the institution in its absence. The institution has also been involved in the establishment of the cancer centre in terms of procurement and licencing of all equipment at the facility. AERA will monitor usage of the equipment and qualification of the personnel. AERA is also responsible for recommending efficient use of equipment and enforces measures that aim at ensuring the safety of patients. The Commission learnt that AERA has been involved in setting up of a military hospital since it has departments such as cardio therapy, radiography and radiotherapy, which involve issues of radiology.

In relation to transportation of radioactive materials, the Commission noted that safety and security are two main issues of concern. The Commission was concerned that due to lack of human resources, machinery and detectors, there is a lot of radiography and radioactive orphan sources in Malaŵi, for instance scrap metal dealers. The Commission also noted that section 58 of the Act states that no person or entity shall engage in the transportation of radioactive material without a licence. A licence is only issued upon satisfaction that all the conditions for transporting radioactive substances have been met, and that the conditions of the neighbouring countries, through which the substances will pass, have been met as well.[431] The Commission learnt that AERA has an understanding with Zambia and Namibia to ensure that transporters comply with regulations in all the

429 Atomic Energy Act, Cap 61:03 of the Laws of Malaŵi.

430 The special Law Commission on the Review of the Public Health Act, a Report on the Consultation with the Officials from Atomic Energy Regulatory Authority. pp.3

431 The special Law Commission on the Review of the Public Health Act, a Report on the Consultation with the Officials from Atomic Energy Regulatory Authority. pp.3

countries concerned before a licence can be issued, and before they are allowed passage. Where transporters do not have authorisation to transport radioactive substances, they are not allowed passage.[432] The Commission observed that there is a need for countries involved in the handling of vehicles carrying radioactive materials, for instance uranium 'yellow cake' from Malaŵi, to harmonize procedures for handling and transporting the materials. The Commission recommends that Malaŵi should consider the procedures applicable in other countries and compare them with international protocols for handling hazardous substances as recommended by the International Atomic Energy Agency (IAEA) from time to time.The Commission learnt that AERA coordinates with other institutions such as the Department of Energy and Mining, the Water Department, Malaŵi Energy Regulatory Authority, and the Department for Environmental Affairs to ensure safety and security when transporting radioactive substances.[433] The Commission also learnt that AERA is in the process of formulating a strategy which will address issues of orphan sources of radioactive materials.

(c) Incentives for Waste Separators

The Commission was aware that any person who generates or collects solid waste is required to sort out the waste by separating hazardous waste from the general or municipal solid waste.[434] The Commission however recognised the absence of incentives for people to segregate waste generally. This has resulted in mixing of different types of wastes, including hazardous waste. The Commission noted that in Japan, for example, different types of waste are collected on different days. The Commission was of the view that it would be proper to segregate waste at source and to develop the necessary legal and policy frameworks to encourage segregation of waste and providing incentives to waste separators. In addition, the Commission noted that recycling of waste is an innovation which has not adequately been practiced in Malaŵi. Recycling is easy where people are taught to practice segregation of waste, which involves putting waste of the same class in one disposal bag.

The Commission learnt various lessons during comparative study visits to Zambia and Namibia. The Commission observed that in the two countries, private companies complement the efforts of government in waste management.[435] In Namibia for example, a company called "Rent a Drum" collects waste, and municipalities collect waste in their respective towns. With regard to medical waste, about seventy to eighty percent of health facilities have incinerators for burning medical waste. Some incinerators are

423 The special Law Commission on the Review of the Public Health Act, a Report on the Consultation with the Officials from Atomic Energy Regulatory Authority. pp.3

433 The special Law Commission on the Review of the Public Health Act, a Report on the Consultation with the Officials from Atomic Energy Regulatory Authority. pp.3

434 Environment Management (Waste Management and Sanitation) Regulations, 2008.

435 The special Law Commission on the Review of the Public Health Act, a Report on a Comparative Study Visit to Namibia conducted from 4th to 11th September, 2021, pp.12

designed to treat all types of medical waste. Waste management activities such as erecting of dumping sites and landfills are being monitored by the Ministry of Environment and Tourism.[436] In Zambia, the Local Government Act mandates city councils to collect and dispose off general waste in townships.[437] However, due to logistical and capacity challenges, the councils engage franchises to manage waste. A franchise collects and disposes off waste while the council manages the damping site by issuing franchises with permits to dump at the sites for an annual fee of ZK12, 000 paid to the councils.[438] The residents who solicit the services of the franchise in turn pay a service fee to the franchise.

The Commission noted that, although some local government authorities segregate waste, the efforts are made difficult by households that do not segregate waste at source. The Commission was, therefore, of the view that local government authorities should be compelled under law to handle waste, and failure to discharge the duty should attract the be imposition of penalties under the law. The Commission was aware that currently, waste collection is very low at about thirty percent due to factors such as inadequate collection vehicles and financial constraints. However, the Commission was of the view that the excuse that local government authorities do not have resources to enable them to discharge their functions should not be used to justify failure to provide essential services, including waste management. Finally, the Commission recognized the need for public awareness to citizens on their right to a clean environment and their responsibility in handling and dealing with waste.

(d) Water Pollution and Industrial Waste

Industrial wastes include all types of solid wastes and semi-solid wastes which result from industrial processes and manufacturing.[439] Most industrial waste is not pre-treated before reuse, recycling or disposal. The Commission was aware that the Environment Management (Waste Management and Sanitation) Regulations of 2008 prohibit any person from treating industrial waste in any other way except as provided for under the Regulations. The Commission was however concerned that there are companies that are releasing industrial waste into rivers, for example, Mudi River in Blantyre. Local Government authorities have not been proactive in enforcing the law against the companies involved in this kind of environmental degradation and hazardous activities. The Commission thus recommends that authorities should intensify efforts to register any person involved in conduct on premises that generate special, industrial, hazardous or infectious waste for proper monitoring of such activities.

436 As above.

437 The special Law Commission on the Review of the Public Health Act: A report on a comparative study visit to Zambia conducted from 6th to 12th June, 2021, pp.13.

438 As above.

439 Environment Management (Waste Management and Sanitation) Regulations, 2008.

(e) Prohibition of Plastics for Carriage

It is estimated that more than 280,000 tons of solid waste remains uncollected in urban areas and plastics make up about 10 % of waste which amount to 28, 000 tons of plastic waste that enters the environment every year.[440] It has been argued that failure to manage plastic waste can bring about serious consequences to the health and well-being of this generation as well as future generations.[441] Three strategies have been identified as being key to addressing plastic pollution in Malaŵi. These are: (i) reduction of production and use of plastic through banning the use of plastics, introducing levies and taxes; (ii) improving waste management systems such as financing and initiating programs aimed at waste management at community level and recycling of waste; and (iii) enacting and enforcing legislations, educating and creating awareness of the public about the dangers of waste pollution to human and animal health as well as conducting research and innovation for coming up with alternatives to single-use plastic.[442] The Commission opined and agreed with the observation that uncontrolled waste and plastic pollution would only worsen as population increases resulting in increased waste management costs, higher cost associated with more intense cleaning operations, increased incidences in flooding events and its associated damage to infrastructure, rising health care costs and biodiversity impacts and associated welfare losses.[443]

It is to this background that the Commission noted that from around 2012, there were efforts by the Government to ban the production, sale and use of plastics with a thickness of less than 60 micrometre (μm). The Commission considered whether the production, sale and use of all plastic bags should be prohibited so that it is only bio-degradable, re-usable and recyclable carrier bags which are allowed.

The Commission noted that Regulation 3 of the Environment Management (Plastics) Regulations (2015) prohibit the importation, manufacture, trade and commercial distribution of plastics, plastic bags and plastic sheets made of plastic film with a wall thickness of less than sixty micrometers in Malaŵi. Thus, the Government implemented this Regulation by banning the use of thin plastics of less than 60 microns. Persons allegedly aggrieved by the implementation of the Regulations sought to block the implementation of the ban through court process. *In the State and The Director of Environmental Affairs and Ex-parte AERO Plastic Industries Limited and Abdul Majid Sattar T/A Rainbow Plastic and 12 Others*,[444] the applicants challenged the constitutionality of the adoption, implementation

440 Turpie, J et al, The Case for Banning Single-Use Plastics in Malaŵi. Available at: https:// www.lilongwewildlife.org/wp-content/uploads/The-Case-for-Banning-Single-Use-Plastics-Report-in-Malaŵi.pdf. Accessed on 26 August 2022.
441 As above.
442 As above.
443 As above.
444 Judicial Cause No. 20 of 2016

and enforcement of the Regulations, particularly, Regulation 3. In 2016, the respondents inspected factories run by the applicants, and found that they were producing plastics of less than 60 microns, in contravention of Regulation 3. In determining the matter, the Court considered the fact that prior to the adoption of the Regulations, Government had sensitized stakeholders and interest's groups on its decision to ban the production of plastics that did not meet its specifications. The sensitization culminated into a public notice in the local media that the ban would be effected from April, 2013. The court dismissed the case and held that the respondents were at liberty to implement the regulations and ban.

The Commission found that the decision of the court in the cited case reinforces the polluter pays principle where the polluter pays for the damage done to, among others, the environment. The Commission thus recommends enforcement of legislation, rules and regulations dealing with the problem of single-use plastics in Malaŵi.

(f) Handling of Expired Medicine

The Environmental Affairs Department is charged with the responsibility of issuing guidelines and prescribing measures for the management of toxic and hazardous substances, in consultation with the relevant lead agency. No regulations for the disposal of expired Medicine have been formulated under the Act. The PMRAA however, provides that the Minister may make regulations for the disposal of obsolete, expired or unwanted medicines or allied substances, in consultation with the Environmental Affairs Department established under the Environment Management Act.[445] Pursuant to the PMRAA, the Pharmacy and Medicines Regulatory Authority adopted the guidelines for the Destruction of Medicines and Allied Substances. The guidelines were formulated in accordance with the WHO Guidelines for Safe Disposal of Unwanted Pharmaceuticals in Emergencies; WHO Guidelines for Drug Donations,1996; and the WHO/DAP96.

The Commission thus recommends the provision of medium temperature and high temperature incinerators in designated facilities for the proper destruction of expired or unwanted medicines as envisaged by the guidelines. The Commission noted that very few Government hospitals have functional incinerators.

(g) High Voltage Electric Magnetic Fields in Residential Areas

The Commission noted that there is no evidence to support the existence of dangers associated with radio signals emitted by telecommunication towers. In relation to electrical lines however, the Commission noted that there are two main issues associated with high-voltage lines; potential health risk from electric and magnetic fields (EMF),

[445] Section 129 (1) (i) of the Pharmacy and Medicines Regulatory Authority, 2019.

and a negative impact on property values. A study in Epidemiology has shown a fairly consistent pattern that associated potential EMF exposure with a small increased risk for leukaemia in children and chronic lymphocytic leukaemia in adults.[446] The Commission considered if high voltage lines carrying power in excess of 300 volts are associated with causing cancer. The Commission was however informed by the Electricity Supply Corporation of Malaŵi (ESCOM) that current available data and research publications indicate that there is no serious health hazards associated with high voltage lines carrying power in excess of 300 volts apart from risk of electrical shock and fire.[447] The Commission therefore did not belabour the issue any further.

(h) Packaging and Labeling of Waste

The Commission was aware that local authorities are required to promote colour coding of waste containers by waste type to ensure and promote waste segregation.[448] The Commission, understanding the hazards that come with waste in transit, was of the view that persons responsible for conveying waste, including drivers, must receive training in the handling and management of waste, including labelling and packaging of toxic waste .

The Commission noted that medical facilities such as cancer centres use radioactive machinery. The Commission, therefore, recommends that there should be proper guidelines for the disposal of radioactive chemicals and heavy metals such as lead, mercury, cadmium, manganese; and paint and asbestos. The Commission also noted that disposal of medical waste in public hospitals is a serious challenge despite the requirement that a hospital should have an incinerator. Further, the Commission noted that local government authorities do not have capacity and knowledge about handling e-waste thus any waste which is collected is dumped in a landfill. In conclusion, the Commission recommends the development of regulations on transportation of bio-hazardous materials and medical laboratory specimens. At a minimum, bio-hazardous materials should be packed, sealed and labeled when being transported; and the packaging should follow international standards. The Commission also makes a policy recommendation that every hospital in the country should be provided with an incinerator for burning hospital waste.

Having considered the legal framework on waste management in Malaŵi, and the practice in other jurisdictions, the Commission was of the view that the main problem in waste management is enforcement of the various pieces of legislation on specific matters. This is mostly because there is no central authority to regulate and most of the enforcement is left to local

446 National Institute of Environmental Health Sciences National Institutes of Health https://www.niehs.nih.gov/health/materials/electric_and_magnetic_fields_associated_with_the_use_of_electric_power_questions_and_answers_english_508.pdf

447 ESCOM response to Law Commission Request on Effects of High Voltage

448 Environment Management (Waste Management and Sanitation) Regulations, 2008.

authorities. The local authorities have resource and capacity challenges, Therefore, the Commission recommends that local authorities as enforcement agents, should be provided with sufficient resources and capacity for the management of waste in the public health interest. To ensure that the local authorities diligently perform their functions, the proposed legislation should impose a duty on local authorities regarding waste management.

The Commission, therefore, recommends adoption of the following provisions on environmental sanitation and waste management—

PART... ENVIRONMENT AND WASTE MANAGEMENT

Waste disposal

...—(1) Subject to written laws on the management of the environment in Malawi, and other applicable laws, waste shall only be disposed of at a waste disposal site, including an incinerator approved by the local authority concerned.

(2) A person who intends to operate a waste disposal site for business, household, industrial, hazardous and infectious waste shall apply for registration with the local authority concerned as contemplated under this Act.

(3) A waste disposal site shall be—

(*a*) adequately fenced off to prevent illegal entry and windblown litter; and

(*b*) kept at all times in the manner as to prevent fly breeding or any other public health risk.

(4) A person shall not burn waste in a public or private place or at a waste disposal site.

(5) A local authority shall regulate the transportation of different waste streams to the waste disposal site in accordance with the applicable laws to prevent environmental pollution and public health risks.

(6) In this section, "special waste" means waste which requires special handling and treatment before it may be may be discharged into a plumbing system.

Waste collection, disposal and recycling

…—A local authority shall ensure –

(*a*) that all waste generated within its local authority area is collected, disposed of, and recycled. in accordance with the requirements of all laws governing the management of the different waste streams;

(*b*) efficient, affordable and sustainable access of the collection, disposal and recycling of waste to the community;

(*c*) for reasons of health safety and environmental protection, that waste collection is done in an appropriate manner; and

(*d*) that approved receptacles of waste shall be kept–

(i) in clean and hygienic condition to prevent the breeding of flies or any other health risk; and

(ii) in accordance with requirements of laws governing a particular waste stream.

Generation and storage of special and industrial waste, etc

...—(1) A person, duly licensed or authorized under applicable laws, who intends to conduct on any premises activities which generate special, industrial, hazardous or infectious waste shall be registered for that purpose with the local authority concerned.

(2) A person engaged in activities contemplated in subsection (1) shall ensure that the waste generated on the premises concerned is kept and stored –

(*a*) under conditions that cause no harm to human health or damage to the environment; and

(*b*) in accordance with applicable laws.

(3) All waste contemplated in this section shall be stored in approved containers and for the maximum period determined by the authority or agency responsible for the subject waste.

(4) A generator or transporter of hazardous and infectious waste shall ensure that containers –

(*a*) are properly labeled with universal biohazard symbol signs; and

(*b*) stored in accordance with applicable laws.

Offences relating to this Part

...—A person who contravenes or fails to comply with this Part commits an offence, and shall upon conviction, be liable to a fine of fifty million Kwacha (MK50,000,000) or to imprisonment for ten (10) years.

8.0 HOSPITALITY, PUBLIC CONVENIENCE, AND PUBLIC GATHERINGS

8.1 Hospitality

In general terms, hospitality refers to kindness and friendly behaviour, especially to guests.[449] It may also be understood as the food, drink, entertainment, etc that an organisation provides to its customers.[450] There are four segments of the hospitality industry which are: food and beverages; travel and tourism; lodging; and recreation.[451] Though each segment is distinct from the next, they often work in conjunction with one another. The Commission observed that in the hospitality industry, there are public health issues that arise, especially in relation to food and drink, and lodging. Matters of food and drink as they relate to public health have been discussed under chapter 9.0 of this report. This part focuses on lodging and smoking in relation to public health.

8.2 Lodging

The Commission observed that the provision of lodging facilities raises a lot of public health concerns especially in relation to accommodation, which involves the sharing of beddings, toilets and bathrooms; and the provision of food which leads to the sharing of cutlery, plates, and cups among other items. The Commission noted section 7 of the Tourism and Hotels Act,[452] which provides for the conditions under which a licence can be granted to run a hotel. Among other things, it is a requirement for proper provision to be made for the sanitation of the hotel; storage, preparation, cooking and serving of food in the hotel; and the premises in respect of which the application is made should comply with the requirements of the Public Health Act. A licence to run a hotel may be cancelled where the hotel is being run in an unclean or insanitary manner; and where the food served in the hotel is not properly prepared, cooked or served.[453]

According to section 2 of the Tourism and Hotels Act, hotel includes a boarding-house and any other building or premises used for the accommodation of the public in which lodgings are provided and provisions are supplied by the keeper or manager thereof, but does not include any hostel or any school or any other premises or class of premises. Section 4 of the Public Health Act defines a lodging-house as a building or part of a house including the veranda thereof, if any, which is let or sublet in lodgings or otherwise, either by storeys, by flats, by rooms, or by portions of rooms.

One of the dangers of poor lodging to public health is the likelihood of the spread of infectious diseases. The Commission noted that section 17 of the Act grants power to a local authority to cleanse and disinfect any premises in order to

449 Cambridge Dictionary.
450 Ibid.
451 https://www.hospitalitynet.org/opinion/4082318.html#:~:text=There%20are%20four%20segments%20of,Tourism%2C%20lodging%2C%20and%20recreation. Accessed on 16/03/2023 at 15:43.
452 Cap 50:01.
453 Section 9 of the Tourism and Hotels Act, Cap 50:01.

prevent the spread of any infectious disease. The local authority has immunity against any proceedings for compensation for deprivation of the premises or use of the premises during disinfection. Again, section 24 of the Act penalises any keeper or owner of a lodging-house who knowingly lets for hire the premises to any person has been suffering from an infectious disease. The Commission also noted that section 121 of the Act gives power to the Minister to make Regulations for the conduct and inspection of lodging-houses. However, the Commission found that the Regulations are yet to be made.

The Commission considered the Tourism and Hotels (Minimum Standards) Regulations and found that the Regulations set the minimum standards to be complied with by the owners of hotels and tourism enterprises. The regulations cover the specific requirements for the size, design, interior, and items for a bedroom, bathroom, kitchen, storeroom, bar, public cloakrooms, and lounge and dining room. The regulations address public health concerns such as the requirement to provide running water, proper ventilation and good lighting; and the requirement to maintain cleanliness and good repair of facilities. The Regulations also require that all catering units should comply with the Code of Hygienic Conditions for food and food processing units of the Malaŵi Bureau of Standards.

The Commission was of the view that the regulations under the Tourism and Hotels Act were generic as they largely cover the required standards for the registration of lodging facilities. They do not specifically address public health issues.

The Commission also noted that section 75(j) of the Act gives power to the Minister to make rules, having for their object the protection of the health of lodgers or surrounding inhabitants. The Commission therefore recommends retention of the provision under the proposed legislation.

8.3 Smoking

The Commission observed that smoking raises public health concerns in the hospitality industry. The Commission noted that in some instances, restaurants provide a separate room for people who intend to smoke while accessing the services, and in other instances, a public notice completely prohibiting smoking in a lodging facility or restaurant is made. However, the Commission observed that there are cases where there is no explicit prohibition of smoking in hotels or restaurants, and occupants or users of restaurants smoke while using the facilities which is detrimental to the health of other occupants or users. The Commission observed that both the Public Health Act and the Tourism and Hotels Act are silent on the matter. Nonetheless, the Commission was of the view that in the interest of public health, smoking in public places should be prohibited under the proposed legislation.

8.4 Public Convenience Facility

Public convenience facility means a sanitary convenience to which the public ordinarily has access, whether by payment of a fee or not. [454] The Commission noted with concern that certain public places such as banks, shopping complexes and sporting arenas hold clients on queues for long periods of time without provision for toilets for the clientele. The Commission was aware of the argument that provision of sanitary convenience facilities in banks would compromise the security of the banks. However, the Commission was of the view that the facilities need not be accessible directly from banking halls as they could be provided outside banking halls and even as detached facilities.

The Commission was of the view that it is essential that owners or operators of certain public places should be obliged to provide sanitation and convenience facilities. The Commission, further, noted that another avenue for ensuring that owners or operators of certain public places provide sanitation and convenience facilities is through Planning Committees of local government authorities which consider, scrutinize and approve development plans for buildings and structures. The Commission recommended that Planning Committees should ensure that development plans for certain public facilities are only approved if there is provision for public sanitary convenience facilities.

The Commission was of the further view that provision of sanitary convenience facilities is not enough. Owners or operators of the public places should ensure that there is adequate signage leading persons to the facilities and that the facilities should be kept in a clean and healthy state. The Commission observed that, as public places are likely to attract a lot of litter and materials for disposal, owners or operators of public places should ensure provision of refuse bins; and that the bins are emptied periodically. The Commission considered the possibility of owners or operators of premises providing facilities that are not user-friendly for persons with disabilities and recommended that Planning Committees of local government authorities should ensure that premises have facilities that may be easily accessed by persons with disabilities. In the same vein, the Commission recommended that the provision of public sanitary convenience facilities should take into account socio-cultural and religious considerations.

The Commission also noted that open defecation is a serious public health problem in Malaŵi. The detrimental effects of open defecation on health include water, sanitation, and hygiene (WASH)-related diseases, such as diarrhoea, cholera, and typhoid. The Commission learnt that the Malaŵi government adopted the Community Led Total Sanitation (CLTS) in 2008 with an aim of attaining Open Defecation Free status countrywide by promoting sanitation and hygiene in communities.[455]

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454 https://www.la https://www.lawinsider.com/dictionary/public-sanitary-conveniencewinsider.com/dictionary/public-sanitary-convenience. Accessed on 8th February, 2023.

455 https://borgenproject.org/tag/community-lead-total-sanitation.

The Commission noted with approval that International and Non-Governmental Organizations have collaborated with the Ministry of Health to advocate for Open Defecation Free status in rural areas. United Nations (UN) and other international organisations such as World Vision have established that extreme poverty and lack of sanitation are statistically linked; and eliminating open defecation is a vital part of development efforts since it is correlated with a high child mortality rate, under nutrition, poverty and disparities between the rich and poor. [456] The organizations have partnered with traditional leaders and government to end open defecation, provide clean water and achieve total sanitation and hygiene in Malaŵi. [457] In this regard, the Commission makes a policy recommendation that the Government should continue to support and promote the efforts and initiatives of the Open Defecation Free status and the CLTS.

The Commission thus recommends adoption of the following provisions on matters relating to provision of public convenience facilities –

Public sanitary convenience

…— (1) A local authority shall ensure that adequate and suitable public sanitary convenience for males and females are provided at convenient locations and are properly maintained.

(2) The provision of public sanitary conveniences under sub-section (1) shall take into account the peculiar needs of males, females, and persons with disabilities.

(3) For purposes of this Part, "public convenience" means a sanitary convenience to which any person ordinarily has access, whether upon being required to pay a fee or not.

Power of a local authority to order provision of public sanitary conveniences

...—(1) where it appears to the local authority that any building, public facility or part thereof is not having or is without sufficient and adequate sanitary conveniences, the local authority shall, by notice in writing require the owner of the building or facility to provide the building or any part thereof with such number of sanitary conveniences as may be necessary for the persons using the building or facility, within such period as may be specified in the notice.

(2) Any person who fails to comply with the notice under subsection (1) commits an offence and shall, upon conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) or to imprisonment for a term of three (3) years.

456 https://www.environewsnigeria.com/Malaŵian-communities-seek-end-open-defecation/.
457 https://www.wvi.org/stories/Malaŵi/world-vision-spearheads-sanitation-efforts-Malaŵi.

(3) In case of a legal person to a fine of five million Kwacha (K5, 000, 000.00), and fifty thousand kwacha (K50,000.00) for each day the non-compliance continues.

Cleaning and maintenance of sanitary conveniences

…— (1) Where it appears to the local authority that any sanitary convenience provided for or in connection with a building or part thereof is defective or in a condition that is prejudicial to health or a nuisance and it cannot without reconstruction be put into a satisfactory condition, the local authority shall, by notice in writing, require the owner or occupier of the building to execute such works or to take such steps as may be necessary to remedy the defects within such period as may be specified in the notice.

(2) Any person who fails to comply with the notice under subsection (1) commits an offence and shall, upon conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00), and K20,000.000 for each day the non-compliance continues or to imprisonment for a term of three (3) years.

8.5 Public Gatherings

Generally, "public gathering" may be defined as any function, event, activity, open to the public, whether indoors or outdoors, and whether by free admission, invitation or by ticket.[458] The Commission noted that it would be difficult to define a public gathering by using a specific number as this is likely to vary on a case by case basis. Public gatherings include political rallies, religious gatherings, voting, music or arts festivals, or sporting events.

Section 38 of the Constitution guarantees the right of every person to assemble and demonstrate with others peacefully and unarmed. The Commission noted that pursuant to their mandate under section 153 (2) of the Constitution, police officers monitor assemblies and demonstrations to ensure that they are peaceful and harmless. Part IX of the Police Act [459] provides for the regulation of assemblies and demonstrations. Section 92 defines "assembly" as any assembly, meeting, rally, gathering, concourse or procession of more than fifteen persons in or on any public place or premises or on any public road. The Police Act prescribes an assembly as a gathering of more than fifteen people, and the definition does not extend to other gatherings the purpose which is religious in nature, voting, sporting, music or art festivals. However, due to the functions conferred on the police service under the Act, which include the protection of life, property, fundamental freedoms and rights of individuals, the police are required to render their services in other assemblies and gatherings which are not political in nature.

458 Law Insider, 'Definition of Public gathering'. Available at https://www.lawinsider.com/dictionary/public-gathering Accessed on 9 December, 2019.

459 Cap 13:01

The Commission noted that the regulation of assemblies and public demonstrations under the Police Act focuses on the logistical or operational issues but the Act does not address public health issues that may arise out of an assembly or a demonstration. Additionally, the Public Health Act does not address public health issues related to public gatherings. However, the Commission was aware of the public health issues associated with public gatherings which need to be addressed using legislation. These issues include the extent to which the law or policy should provide for the minimum standards for washroom facilities; fire exit points; or the maximum capacity for public gatherings on a given land or premises.

The Commission considered how epidemics and pandemics affect the nature and conduct of public gatherings. It was observed that pursuant to the declaration of COVID-19 as a formidable disease, the Minister made new regulations in relation to COVID-19 in accordance with section 31 as read with section 29 of the Act. The rules were made in order to promote and protect public health, and to prevent the spread of the Corona Virus. According to the Public Health (Corona Virus and COVID-19) (Prevention, Containment and Management) Rules, 2020[460], "gathering" is defined as an assembly of more than ten persons whether wholly or partially in open air or in a building. Rule 11 provides for the regulation of public gathering. Sub-rule (1) prohibits public gatherings, subject to the exceptions provided in the Rules. Sub-rule (2) gives an enforcement officer power to order a public gathering to disperse and may use reasonable force to cause the public gathering to disperse. Some gatherings were exempted from the prohibition subject to compliance with preventive measures provided under the rules. These gatherings include funerals where the deceased was not diagnosed with COVID-19, meeting of the National Assembly, and a meeting convened to discuss COVID-19 interventions. The Commission observed that since the substantial reduction of COVID-19 cases in Malaŵi, and worldwide, the measures that were being enforced through the rules have been relaxed.

The Commission learnt that under WHO guidelines, mass gatherings are recognized as an area of concern that needs public health interventions. [461] Mass gathering events if not well planned and managed may result into serious public health consequences.[462] Mass gathering increase the spread of infectious disease and are a common conduit for transmission of respiratory infections such as influenza.[463]The Commission observed that challenges which have been documented include the following:

460 Government Notice No.48 of 2020

461 See World Health Organization, 'Managing health risks during mass gatherings' Available at https://www.who.int/activities/managing-health-risks-during-mass-gatherings Accessed on 19 August, 2020.

462 World Health Organisation: Key planning recommendations for Mass Gathering in the context of the current Covid-19 outbreak, Interim Guidance, 14 February 2020. Available at: https://apps.who.int/iris/bitstream/handle/10665/331004/WHO-2019-nCoV-POEmassgathering-2020.1-eng.pdf?sequence=1&isAllowed=y. Accessed on 26 August 2022.

463 As above.

(*a*) increased transmission of infections during and in transit to and from the event as well as participants' home countries upon their return from the gatherings;

(*b*) communication of risks to participants for example, amidst health crises is a challenging practice since participants may be multinational and multilingual;

(*c*) stretching of health systems to operate at surge capacity for extended periods of time in case of for example, a terrorist attack that result in massive casualties and critical injuries to an enormous number of victims;

(*d*) high visibility and pressures coming from extensive media coverage mostly through social media and even worse often in global live broadcast; and

(*e*) unhealthy behaviour among participants due to among others, alcohol and drug abuse.[464]

In Malawi, timing of events in the rainy season may pose risks of infectious water-borne diseases, as an example. The Commission was of the view that local government authorities are best placed to supervise, monitor and oversee public gatherings which might raise public health concerns within their jurisdiction. Items that local government authorities would oversee include the provision of safe water, first aid facilities, toilet and sanitation facilities. The local government authorities would also monitor the wholesomeness of the food provided at public gatherings. The Commission was of the view that where there is a request or notice for the holding of a public gathering of a size that the local government authority would be concerned with, the local government authority should demand proof of provision and consideration of the public health concerns before the gathering or event is allowed to proceed. The local government authority would further be under a duty to engage law enforcement agencies where persons contravene requirements of the local government authority.

The Commission, further, agreed that where organizers of public events or gatherings cannot provide services or facilities to satisfy requirements of public health considerations, local government authorities should be obliged to make provision at a cost to the organizer. Where the organizer is able to provide the services or facilities, the local government authority should provide supervision and co-ordination.

Regarding gatherings that occur in private spaces, these could be regulated by orders or notices issued by the Minister from time to time. The concern was with gatherings such as funeral ceremonies and weddings, which attract up to fifty or more people at a time and food and drink may be served. In times of a pandemic such as COVID-19, or an epidemic such as cholera outbreak, it is necessary that

464 Zafeirakis, A and Efstathiou, P (2020): Health care challenges at mass gathering in Journal of Clinical medicine of Kazakhstan. Available at: https://www.clinmedkaz.org/download/health-care-challenges-at-mass-gatherings-9257.pdf accessed on: 27 August 2022.

such gatherings although in private places be regulated in the public health interest. The orders or notices may among others, prescribe the maximum number of people who may convene, ban the serving of food and drink at such gathering, provision of sanitary facilities or the maximum number of hours allowed for the gathering.

The Commission thus recommends adoption of the following provision on public gathering:

Public gathering

...—(1) A person shall not organize or host a gathering at a public place unless there is adequate provision of safe water, first aid facilities, toilets and sanitary facilities at the place.

(2) Where organizers of a public gathering referred to under subsection (1) cannot provide services or facilities to satisfy requirements of public health considerations, the local authority concerned may make provision for such amenities at a cost to the organizers.

(3) A local authority shall not issue a permit or license to an operator of a place for public gatherings unless the local authority is satisfied that the place has sufficient sanitary facilities relative to the population capacity of the place.

(4) The Minister may, where there is a public health threat either at national level or in a given locality, and upon advice from health authorities issue an order or a notice in the gazette regulating public gatherings in public or private places.

(5) All persons at a public gathering referred to under this section shall at all times adhere to the measures to combat, prevent and suppress the spread of infectious diseases as specified in or under regulations, an order or notice issued under this Act or any other written law.

(6) A person who fails to comply with the provisions of this section, commits an offence and shall, upon conviction, be liable to a fine of one million Kwacha (1,000,000.00) and imprisonment for two years (2).

(7) All persons at a public gathering referred to under this section shall at all times adhere to the measures to combat, prevent and suppress the spread of infectious diseases as specified in or under regulations, an order or notice issued under this Act or any other written law.

(8) A person who fails to comply with the provisions of this section, commits an offence and shall, upon conviction, be liable to a fine one million Kwacha (1,000,000.00) and imprisonment for two years (2).

9.0 FOOD AND PUBLIC HEALTH

9.1 Right to Food

The Commission noted that the Constitution does not provide for the right to food. However, under section 30 of the Constitution, the State is required to take all necessary measures for the realization of the right to development. Such measures include equality of opportunity for all in their access to basic resources, health services, and food, among other things. The Commission further observed that section 13(b) of the Constitution does not specifically provide for food or the right to food. The section places an obligation on the State to adopt and implement policies and legislation aimed at achieving adequate nutrition for all in order to promote good health and self-sufficiency.

The Commission also noted that the Act does not expressly provide for the right to food. The Act defines food as any article used for food or drink other than drugs or water, but includes ice, and any article which ordinarily enters into or is used in the composition or preparation of human food, and includes flavouring matters and condiments. [465] The Act prohibits the sale of food which is tainted, adulterated, diseased or in an unwholesome state. [466] A health worker, local government authority or any person duly authorized under the Act has power to seize such food. [467] It is therefore an offence to put on sale unwholesome food[468]. Further, the Minister has powers to make rules regarding inspection of dairy stock of animals intended for human consumption; taking and examination of milk, dairy produce, meat and removal of animals suspected of being diseased or unwholesome for human consumption; and veterinary inspection of dairy stock, among others. [469]Additionally, the Minister has powers to specify, by order, standards of quality, composition and condition, and minimum standards, in respect of any foodstuffs, goods or other articles.[470]

The Commission observed that the right to food can be justiciable. It is a basic right that aids the enjoyment of other human rights. It was also observed that the right to food is very crucial, and the realization of this right requires the State to take active steps through various state actors. The Commission noted that under the Local Government Act, Local Councils have the function of ensuring that the food sold for consumption in public places is wholesome. The Commission considered the Second Schedule to the Local Government Act[471] which provides for additional functions of the Council which include inspecting premises where

[465] Section 4 of the Public Health Act.
[466] Section 106 of the Public Health Act.
[467] Section 108 of the Public Health Act.
[468] Section 109 of the Public Health Act.
[469] Section 109 of the Public Health Act.
[470] Section 110 of the Public Health Act.
[471] Cap 22:01.

food is produced. The Local Councils therefore have power to carry out inspections within its Area where food or drink are manufactured or prepared for use or sell including where meat, meat products, milk, milk products, fish, and fish products are stored or processed. Further, the Councils have power to control and license slaughter houses and the killing of livestock. It is therefore recommended that the additional functions of the Local Councils should be provided in the main legislation and not subsidiary legislation to attract stiffer penalties for breach of the provisions.

The Commission looked at other pieces of legislation that regulate food. It was found that under the Meat and Meat Products Act, [472] provision is made for the improvement and control of the production, processing, manufacture, grading, sale, marketing and distribution of meat, and meat products. It is a requirement for meat to be graded in accordance with the Act by a designated grader. Under regulation 3(1) of the Meat Inspection Regulations, it is prohibited to add any substance to meat or meat products, use any substance as an ingredient in the preparation of meat or meat products, abstract any constituent from meat or meat products, or subject meat or meat products to any other process or treatment, so as (in any case) to render the meat or meat products injurious to health, with intent that such meat or meat products will be sold for human consumption in that state.

In addition, Malaŵi in a bid to reduce micronutrient malnutrition in many Malaŵians particularly women and children, has implemented food fortification. For example, Malaŵi has adopted mandatory fortification standards drafted in 2002 for salt, oil, sugar, maize and wheat flour.[473] Also, there is collaboration between industry, government and NGOs to fortify Illovo sugar with vitamin A. Likewise, some local producers of, among others, salt, maize flour and vegetable oil have begun fortifying voluntarily, mostly in order to differentiate their products and gain a competitive advantage in the market.[474] The Commission learnt that government is in the process of drafting the Food and Nutrition legislation which is at Cabinet level so as to strengthen and give legal backing to these efforts. The Commission noted that Clause 3 of the Food and Nutrition Bill provides that every person shall have a right to food and adequate nutrition. However, from the public health angle, the Commission thought it wise to legislate on matters relating to food to complement government efforts in ensuring a healthy population.

The Commission observed that the "Nuffield Council on Bioethics Report on Public Health: Ethical Issues" noted that choices of food and drink by the consumer are at least driven by the availability of products and the way they are promoted, priced and distributed.[475] The Report, further, noted that although the

472 Cap 67:02.

473 Situation Assessment (May 2010), Addressing Micronutrient Malnutrition: Fortification Efforts in Malaŵi. Available at: https://files.givewell.org/files/DWDA%202009/Project_Healthy_Children/PHC_Malaŵi_situation_assessment_2010.pdf. Accessed on 27 August 2022.

474 As above.

475 'Public health: ethical issues - Nuffield Council on Bioethics'. Available at https://www.yumpu.com/en/document/read/24828069/public-health-ethical-issues-nuffield-council-on-bioethics. Accessed on 10 December, 2019.

regulation of industry can be necessary, much can be achieved through industry self-regulation. The Commission was of the view that in the context of Malaŵi, industry self-regulation may not be feasible thus the state has a duty to help everyone lead a healthy life by, among others, providing and enforcing standards for the manufacture, import, export, distribution, sell or supply of food or exposure of food for sale. In that regard, the Commission noted that in the context of Malaŵi, there had been increased importation of various unregulated food, herbal medicinal products, cosmetic, drugs, medical devices and household chemical substances.

The Commission noted that there is no regulatory body to enforce adequate and effective food standards under the Act. The Commission observed that according to the Malawi Bureau of Standards Act[476] (the MBS Act), the Malaŵi Bureau of Standards (the Bureau) has the role of promoting the standardization of commodities and the manufacture, production, processing or treatment of such commodities including foodstuffs. It was observed that the Bureau implements two regulations, namely, the Certification Marks Regulations; and the Imports Quality Monitoring Regulations. The Certification Marks Regulations operationalises section 26 of the MBS Act, which provides that a person shall not manufacture a commodity to which a mandatory standard applies unless he or she first obtains permission to do so from the Bureau. The regulations cover the manufacture, production and sale of locally manufactured or processed products. Where a mandatory standard exists, it is required under the Imports Quality Monitoring Regulations that any imported product should meet the requirements of that standard.

It was found that public health standards which ensure that food is free from food-borne illnesses are considered in the development of a Malawi Standard for foodstuffs[477]. The standards also ensure that the food will not cause a significant health problem to the people by ensuring that it is free from health hazards, that is microbiological hazards, physical hazards, and safety standards. The Bureau has recourse to the standards developed by the Codex Alimentarius Commission which serve as a guide.

In relation to foodstuffs , the Bureau developed the MS21-Food and Food Processing Units Code of Hygienic Conditions which sets out the requirements to be met in relation to the processing and production of food. With regards to hygiene, the standard specifically provides that the product shall be prepared and handled on premises that comply with the requirements of the MS21. These conditions include the location of processing units. For example, a processing unit cannot be planted near a sewer plant or system; a coal mine with exposure to coal dust; or flood-prone areas. The location has to be free from contamination. The conditions also cover the nature and construction of the unit (here, factors such as distance from the floor to the ceiling, the material used for the ceiling and the floor of the unit are considered); facilities used in the unit, including a

476 Cap 51:01
477 Consultative Report with the Malawi Bureau of Standards

requirement that utensils and equipment used should be of a hygienic nature; and the hygiene of the personnel handling the food. For the personnel, the requirements are that persons suffering from a communicable disease should not be allowed to handle food. Further, the standard provides for the maximum levels of food additives and the levels of mercury a product contains. The final part of the standard looks at the packaging and labelling of the product. This is to ensure the protection of the food from deterioration and any health hazards.

Despite having these standards, the Commission observed that there is an increase of the sale and supply of unregulated foodstuffs on the market. It was found that the Bureau mainly enforces compliance with the Malawi Standards on formal markets as opposed to informal markets. The informal markets are left to the local authorities who are empowered by both the Act and the Local Government Act[478] to enforce food standards by seizing unwholesome food. The regulation of food standards in informal markets creates challenges because there is an overlap and duplication of mandates among several institutions. It was observed that there are eating establishments that are monitored by the Bureau, local authorities and the Tourism and Hotel Board at the same time. This causes overlaps and duplication of mandates among the institutions. One of the challenges arising from the overlapping of mandates is the differences in the criteria used for monitoring the food and enforcing food standards. For example, in the dairy industry, whereas the Bureau monitors dairy products in compliance with Malawi Standards, the Ministry of Agriculture monitors the same based on the Milk and Milk Products Act.[479] Another challenge is the lack of regulation in other areas of public health concern such as the transportation of food stuffs. There are no institutions coordinating or enforcing public health measures in that area. However, the Commission learnt that the Bureau is working on developing regulations in that area in consultation with relevant stakeholders.

Despite the overlaps, it was found that in some instances, the Bureau, the Ministry of Health, Ministry of Agriculture, City Councils, and the Competition and Fair Trading Commission work in collaboration, especially on food safety. However, there is need for a mechanism where all the relevant institutions on the subject matter of food coordinate and collaborate their efforts to eliminate duplication of efforts.[480]

The Commission considered whether it would be feasible to have inspectors or auditors of food under the proposed legislation to ensure that food standards are complied with in both formal and informal markets. Again, the Act appears to confer responsibilities regarding formulation and enforcement of food standards on multiple authorities which results in uncoordinated and ineffective regulation of food standards. It was observed that the Bureau has inspectors and auditors appointed under sections 37 and 38 of the MBS Act who are mandated to carry out inspection of food to ensure compliance with a relevant Malawi Standard. The

478 Second Schedule to the Local Government Act
479 Consultative Report with the Malawi Bureau of Standards
480 Ibid

inspectors look at compliance with both public health and non-public health requirements in conducting inspections and audits. The Commission considered whether the proposed legislation should have the inspectors and auditors from the Bureau to enforce food standards under the proposed legislation. It was observed that specifying that food inspectors or auditors should be drawn from the Bureau would be a narrow approach which would be problematic in terms of enforcement. The reason is that in some instances, the Bureau develops the Malawi standards and another institution enforces the standards due to their mandate. For instance, the Bureau could develop Malawi Standards for fish and fish products but the enforcing institution would be the Department of Fisheries. It was thus resolved that the proposed legislation should simply give powers to the Minister to designate officers in the Gazette from relevant institutions who could enforce food standards in consultation with the relevant institutions.

In an effort to address the challenge of poor collaboration and coordination among the various institutions enforcing food standards, the Commission initially resolved that the proposed legislation should provide for a central body to coordinate the implementation of food standards. However, the Commission observed that the Food and Nutrition Bill proposes the establishment of a central body named the National Nutrition Council (the Council) to coordinate and implement food standards in the interest of public health, among other functions. The Council will have powers and functions that are extensive, and are necessary in aiding the realization of the right to food that is wholesome, and for the implementation of the provisions on food under the proposed legislation. The Commission further observed that the Bill makes general provisions on food which include prohibition against sale or offer of unwholesome, poisonous, or adulterated food. The Bill also makes it an offence for a person to manufacture, sale, prepare, convey, or package food under unsanitary conditions. It is also important to note that the Bill in clause 82 provides that, "the provisions of this Act shall be in addition to and not in derogation of the provisions of the Public Health Act and the Dangerous Drugs Act.". To avoid duplication, the Commission recommends the adoption of the legislative framework proposed under the Food and Nutrition Bill.

9.2 Infant and Children Food

Section 23 of the Constitution states that the best interests and welfare of children are a primary consideration in all decisions affecting them. A child is defined under the Constitution as a person under the age of eighteen years.[481] Infant is not defined under the Constitution or other Acts of Parliament, but infant is often understood as a child in the first year of its life. Section 13(h) provides a principle of national policy with regards to children. The section states that the State shall adopt and implement policies and legislation to encourage and promote conditions conducive to the full development of healthy, productive and responsible members of society.

[481] Section 23(6).

The Commission noted that the Act has Public Health (Marketing of Infant and Young Child Foods) Rules which apply to all breast-milk substitutes and other designated products, whether locally made or imported. The Rules affect the quality and information concerning the use of the breast-milk substitutes. Under the Rules, every manufacturer, importer, wholesaler or retailer of designated products, is required to apply annually to the Ministry of Health for registration.[482] The Rules prohibit any form of promotion of a designated product by advertising; and distribution of information or educational material regarding infant or child feeding, among others.[483] The Rules, further, provide for labelling of every designated product.[484]

The Commission further observed that the Bureau has the MS 477: 1997 Malaŵi Standard which prescribes the Food for infants and Children-Code of hygienic practice. The Standard provides a code of hygienic practice for all pre-packed foods intended to be for special use for infants or children. It contains the minimum hygienic requirements for the handling, including production, processing, packaging, storage, transportation, distribution and sale, of such foods to ensure a safe, sound and wholesome product.[485]

The Commission therefore recommends adoption of the following provisions relating to food industry and public health:

PART…—FOOD

Certification of food

…A person shall not manufacture, import, export, distribute, sell or supply food or expose food for sale unless the food has been certified by Malawi Bureau of Standards.

Prohibited acts

(1) A person who sells or offers for sale food that—

(*a*) has in or on it a poisonous or harmful substance;

(*b*) is unwholesome or unfit for human or animal consumption;

(*c*) consists in whole or in part of a filthy, putrid, rotten, decomposed or diseased animal or vegetable substance;

(*d*) is adulterated;

(*e*) is injurious to health; or

(*f*) is not of the nature, substance, quality or prescribed standards, commits an offence.

482 Rule 14 of the Public Health (Marketing of Infant and Young Child Food) Rules.
483 Rule 19 of the Public Health (Marketing of Infant and Young Child Food) Rules.
484 Part VI of the Public Health (Marketing of Infant and Young Child Food) Rules.
485 Malaŵi Bureau of Standards (Malaŵi Standards) (Effective Date) (Declaration) Order

(2) For the purposes of subsection (2), food is adulterated if—

(*a*) a constituent of the food has in whole or in part been omitted or abstracted;

(*b*) a damage to or the poor quality of the food has been concealed in any manner;

(*c*) a substance of the food has been substituted wholly or in part;

(*d*) a substance has been added to, mixed or packed with,the food to increase its bulk or weight or reduce its quality or strength or to make it appear better or of greater value than it is;

(*e*) it contains an additive not expressly permitted by the Malawi Standards;

(*f*) a constituent of the food exceeds the amount stated on the label or permitted in the Malawi Standards; or

(*g*) its nature, substance and quality has been affected to its detriment.

(3) A person who sells, prepares, packages, conveys, stores or displays for sale food under insanitary conditions commits an offence.

(4) A person shall store or convey food in a manner that preserves its safety, composition, quality and purity and minimizes the dissipation of its nutritive properties from climatic and other deteriorating conditions.

(5) A person who—

(*a*) sells, offers or exposes for sale, or has in possession for sale; or

(*b*) deposits with or consigns to a person for the purposes of sale, food intended for but unfit for human or animal consumption commits an offence.

(6) A person who instructs another person to sell, offer or expose for sale, food intended for but unfit for human or animal consumption commits an offence.

(7) Where a person is charged with an offence under subsection 6, it shall be a defence if the person satisfies the court that—

(*a*) notice was given to the person to whom the food was sold, deposited or consigned;

(*b*) the food in question was not intended for human or animal consumption; or

(*c*) at the time when the person delivered or dispatched the food to that person—

(i) it was fit for human or animal consumption; or

(ii) the person did not know or could not, with reasonable diligence, have ascertained that the food was unfit for human or animal consumption.

(8) A person convicted of an offence under this section shall be liable to a fine of two million Kwacha (K2, 000,000.00) and to imprisonment for four (4) years.

... The Minister may in consultation with the Malaŵi Bureau of Standards, or such other body responsible for enforcement of standards, in the interest of public health designate inspectors and auditors of food whether manufactured, imported, exported, distributed, sold, supplied or otherwise.

General penalty

...— (1) A person who commits an offence under this Part, for which a penalty has not been specified shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000.00) and to imprisonment for five (5) years.

(2) In proceedings for an offence under a provision of a section referred to in subsection (1), in respect of food containing an extraneous matter, unless the presence of the extraneous matter has rendered the food injurious to health, it shall be a defence if the accused satisfies the court that the presence of the matter was an unavoidable consequence and forms part of the process of preparation or collection of the food.

9.3 Food Handling

The Commission considered the process of food handling in relation to public health. It was observed that the Act does not define food handling or food handlers. The provisions covering matters relating to food handling include: Part XII which provides for the protection of foodstuffs; Part XIII which regulates the provision of water and food supplies; and section 54 which proscribes employment of a person with venereal disease to handle food. The Act makes it a requirement for all warehouses or buildings of whatever nature in regular use for

the storage of foodstuffs for trade purposes to be constructed of such materials and in such manner as shall render such warehouses or buildings rat-proof.[486] The Act also prohibits any person to reside or sleep in any kitchen or room in which foodstuffs for sale are prepared or stored. In the event that any kitchen or room is being used under the said circumstances, such that the foodstuffs are likely to be contaminated or made unwholesome, the Act gives power to a medical officer to issue a notice prescribing measures to be taken to prevent the improper use of such kitchen and premises within a specified time. If such notice is not complied with, the party upon whom it was served shall be guilty of an offence.[487]

Further, it is prohibited under the Act, for any person to collect, prepare, manufacture, keep, transmit or expose for sale any foodstuffs without taking adequate measures to guard against or prevent any infection or contamination thereof.[488] Additionally, it is an offence for the occupier of any premises to keep any dead body in any room in which food is kept or prepared or eaten.[489]

The Commission was of the view that the provisions discussed were substantive in relation to food handling, and should thus be retained under the proposed legislation. The Commission thus recommends adoption of the provisions with the necessary modifications.

The Commission also noted that it is a requirement under public health for food handlers, mainly in designated food shops, hotels and restaurants to be regularly tested for diseases and infections such as typhoid and hepatitis. The Commission acknowledged that it is a challenge to test food handlers operating in shacks and undesignated structures. However, the Commission was of the view that local government authorities need to develop necessary legal interventions to ensure that food is only sold in designated places and structures. The Commission was mindful of the argument that prohibition of the sale of food in undesignated places and structures may be contrary to section 29 of the Constitution which provides for the right to economic activity. Nevertheless, the limitations under section 44 of the Constitution would recognise that the right to pursue economic activity should not defeat the purpose of disease prevention or place food, consumers, at risk of contracting infections.

The Commission was aware that the law provides for the routine medical examination for venereal disease (STI) on persons whose job entails the handling of food and provision of care to others. However, the Commission noted that medical examination is not done regularly. During regional consultative workshops, stakeholders suggested that the legislation to be developed should provide for mandatory medical examination of food handlers to prevent diseases. The mandatory medical examination should be done at regular intervals of every six (6) months. The stakeholders, further, suggested that owners of institutions and employers of food handlers should be actively involved in the whole process.

[486] Section 103.
[487] Section 104.
[488] Section 106.
[489] Section 26(2).

The legislation to be developed should provide for penalties for both food handling institutions and the food handlers themselves in case of non-compliance. The Commission recommends regular medical examination of food handlers. Further, the Commission recommends that local government authorities should be proactive in dealing with food handlers or food vendors. At a minimum, it should be the duty of local government authorities to construct vegetable and fruit stalls in strategic places where food vendors should conduct their trade than let the vendors construct structures on their own.

The Commission further noted the substantive provisions made under the Local Government (Blantyre City Council) (Food) By-Laws on food handling. It was observed that the handling of food is defined as the carrying out or assisting in carrying out any process or operation of food for the purpose of food business or the transportation, storage, packaging, wrapping or exposure for sale, or for service or delivery of food and includes the cleaning, of articles or equipment with which food comes into contact.

Part V of the By-Laws provide for food handling. Under by-law 17, it is prohibited for a person to layout or display food on a road, path, lane or pavement or expose the food for sale except in a sealed container of which at least one side is constructed with transparent material. It is also a requirement for every container, counter, shelf, tray, display cabinet, refrigerator and other equipment with which food or meat comes into contact during sale or display for sale of the same should be kept clean and in a good state of repair. Persons handling food are regulated under Part VI. The Part provides that no person should be employed in a food business unless such person has been examined and certified fit therefore by a Medical Officer. Additionally, every person engaged in the handling or preparation of food or meat should, while so engaged:

(*a*) not place or expose food to the risk of contamination;

(*b*) wear clean washable head and neck covering and washable clothing;

(*c*) keep any open cut, abrasion or wound covered with waterproof dressing;

(*d*) not smoke or snuff tobacco; or

(*e*) refrain from spitting.

The Commission observed that the Act does not have similar substantive provisions on food handling. Consequently, the Commission recommends that the proposed legislation should make extensive provisions on food handling by also adopting and adapting some provisions from the By-Laws. The Commission further, observed that some of the provisions in the By-Laws are very prescriptive and be adopted and adapted under regulations to the proposed legislation.

The Commission thus recommends adoption of the following provisions relating to food handing–

Construction and regulation of buildings used for the storage of foodstuffs

...— (1) A person who constructs a warehouse or building of whatever nature for the storage of food stuffs or trade purposes shall use such material and construct in such a manner prescribed by a local authority, as shall protect the warehouse or building from pollution, vermin, rodents or insects.

(2) Where any warehouse or building intended for the storage of foodstuffs as foresaid has fallen into a state of disrepair, or does not afford sufficient protection on account of its design or construction or by reason of the materials used being defective, a local authority may by written notice require the owner or occupier to effect such repairs and alterations as the notice shall prescribe within a time to be specified in the said notice, and where the owner or occupier does not comply with such requirement, the local authority may enter upon the premises and effect such repairs and alterations, and may recover all costs and expenses incurred from the owner.

(3) Where in the opinion of a health officer any foodstuffs referred to in sub-section (1) within a warehouse or building are insufficiently protected against pollution, vermin, rodents or insects, the health officer shall issue a notice to the owner or occupier thereof who shall observe all written instructions and directions of the health officer within a time to be specified in the notice for the better protection of the same.

(4) A person upon whom a notice is served pursuant to sub-section (3), and fails to comply commits an offence, and shall upon conviction, be liable to a fine of two million kwacha (K2,000,000.00), and imprisonment for two (2) years.

(5) The Court may in its discretion acquit a person accused of an offence under sub-section (4), where the Court is satisfied that all reasonable steps were taken to secure such warehouse or building from pollution, vermin, rodents or insects having regard to all the circumstances of the case.

Residing or sleeping in any room in which foodstuffs are stored prohibited

...— (1) A person shall not reside or sleep in any kitchen or room in which foodstuffs are prepared or stored for sale.

(2) Where it appears to a health officer that any kitchen or room is being used contrary to this section, or that any part of the premises adjoining the room in which foodstuffs are stored or exposed for sale is being used as a sleeping

apartment under such circumstances that the foodstuffs are likely to be contaminated or made unwholesome, he may serve upon the occupier or upon the owner of the house or upon both a notice calling for such measures to be taken as shall prevent the improper use of such kitchen and premises within a time to be specified in the notice.

(3) Where the notice in sub-section (2) is not complied with, the owner or occupier as the case may be, commits an offence and shall upon conviction be liable to a fine of two million Kwacha (K2,000,000.00) and to imprisonment for one year.

Medical examination of food handlers

...—(1) Any person who handles food intended for human consumption, including the care of children at a public facility shall, undergo medical examination at regular intervals of every six (6) months.

(2) An employer shall ensure that any food handler under subsection (1) undergoes regular medical examination.

(3) A person who contravenes this section commits an offence and shall, on conviction, be liable to—

(*a*) a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for one (1) year; and

(*b*) in case of a legal person to a fine of five million Kwacha (K5,000,000.00).

10.0 SUBSTANCE ABUSE

10.1 General

Substance abuse has been recognized as a major public health problem across the globe[490]. Substances that are misused or abused can be categorized into two forms. These include illicit and legally approved substances of various types[491]. The most common illicit types of substances include cannabis, amphetamines, ketamine, methamphetamines, cocaine, and heroin[492], which are largely banned in most countries. Legal substances include nicotine, alcohol, and caffeine among others. Tobacco and alcohol are two legally approved types of substances that have been widely used by different social groups across different

490 Degenhardt L, Chiu WT, Sampson N, Kessler RC, Anthony JC, et al. (2008) 'Toward a global view of alcohol, tobacco, cannabis, and cocaine use: findings from the WHO World Mental Health Surveys'. PLoS Med 5: e141.

491 Peacock A., Leung J., Larney S., Colledge S., Hickman M., Rehm J., Giovino G.A., West R., Hall W., Griffiths P., et al. Global statistics on alcohol, tobacco and illicit drug use: 2017 status report.

492 Ibid.

societies and cultures[493].The Commission noted that the Act does not address issues relating to substance abuse. The Commission noted that substance abuse is linked to mental health problems. Alcohol, and other intoxicating or mind-altering substances as well as tobacco were identified as contributors to this growing problem. The abuse of dangerous drugs, alcohol, and tobacco is a serious public health concern. The Commission found that even some legally prescribed drugs, such as cough medications have been misused and abused by the public[494]in schools, homes, streets, and by some medical personnel. The Commission was aware that mental health had not been a priority for public health interventions in Malaŵi and many other countries. However, mental health problems are on the rise and many countries have started responding to this problem.

10.2 Alcohol Abuse

Alcohol is defined as "[A] colourless volatile flammable liquid which is produced by the natural fermentation of sugars and is the intoxicating constituent of wine, beer, spirits, and other drinks, and is also used as an industrial solvent and as fuel."[495] It is one of the substances that often has immediate and long-term devastating effects. Domestic violence and motor accidents are some of the problems often associated with alcohol abuse. Further, there are other far-reaching and long term effects of alcohol abuse that are of a psychological, physiological or socio-economic nature on individuals and families.[496]

The Commission noted that there are a number of dimensions to the problem of alcohol abuse and considered how the law addresses the problem. In addition, the Commission noted that the Liquor Act[497] is the principal legislation on the manufacture and sale of intoxicating liquor. Section 2 of the Liquor Act defines intoxicating liquor as "any spirits, wine, beer, cider or other potable liquor intended for human consumption, which, on analysis of a sample thereof at any time, is found to contain more than two per centum by volume of proof spirits". Further, the Commission noted that some critical issues relating to intoxicating liquor have been addressed by the Liquor Act. For instance, sale of intoxicating liquor to a "young person" is prohibited.[498] Nevertheless, the Commission noted that the penalties are not deterrent enough and that enforcement of the statute is generally poor.

The Commission considered section 71 of the Liquor Act which regulates the manufacture of liquor and noted that alcohol may have extremely adverse effects if its production is unregulated and does not comply with the standards

493 Degenhardt L, Chiu WT, Sampson N, Kessler RC, Anthony JC, et al. (2008) 'Toward a global view of alcohol, tobacco, cannabis, and cocaine use: findings from the WHO World Mental Health Surveys'. PLoS Med 5: e141.

494 Peacock A., Leung J., Larney S., Colledge S., Hickman M., Rehm J., Giovino G.A., West R., Hall W., Griffiths P., et al. Global statistics on alcohol, tobacco and illicit drug use: 2017 status report.

495 Ibid.

496 Ibid.

497 Mignon S. 'Substance Abuse Treatment: Options, Challenges, and Effectiveness'. Springer; New York, NY, USA: 2014.

498 Section 74. The Act defines a young person as "any person who is, or who appears to be, under the age of eighteen years."

under law. Some of the side effects of alcohol include blindness, liver and kidney damage.[499] The Commission acknowledges the importance of continued regulation of the manufacture of liquor for sale. The Commission, therefore, recommends the enhancement of the penalties provided under the Liquor Act under section 71 to K10,000,000.00 and imprisonment for five years. Where the offender is a legal person, the Commission recommends the fine of K100,000,000.00. Further, the Commission recommends that section 71 of the Liquor Act should provide for revocation of licence where applicable.

The Commission also considered the provision on the minimum age for supply of liquor to a person and proposed that the penalties under section 74 of the Liquor Act should be revised to include revocation of a licence for the supplier, where applicable; enhancement of the fine to K10,000,000; and enhancement of the custodial sentence to two years. The Commission suggested widening the categories of offenders under the provision to include persons who supply liquor without the existence of a transaction, that is, supplying liquor to a person below the minimum age for consumption of liquor indirectly through an adult who gets the supply of the liquor on behalf of the underage consumer.

The Commission further considered section 75 of the Liquor Act and resolved to adopt the recommendation made in relation to section 74 on penalties; and that the proviso under section 75 should be deleted. The Commission proposes the enhancement of the penalty under section 78 to K1,000,000 and imprisonment for two years. The Commission, therefore, recommends that sections 75 and 78 be amended accordingly. The proposed amendment provisions are included in Appendix 4 of this Report.

With regard to enforcement and implementation of the Liquor Act, the Commission noted that there are Local Licensing Boards established under that Act. However, it appeared that the Boards were not fully functional in all local government authorities. The Commission resolved that there is need to ensure that the Boards are functional where they are not functioning; and that local government authorities should ensure that applicable provisions are being enforced. In the same vein, the Commission compared provisions on contamination of food[500] and provisions on contamination of liquor. The Commission was of the view that liquor should be specified under law as a consumable which may be supplied in an unwholesome state. In that regard, liquor has been included in the definition of food under the proposed legislation. Further, the Commission noted that there may be need to conduct a comprehensive review of the Liquor Act, in addition to the proposed amendments.

[499] National Alcohol Policy 2017, pp.1,3.
[500] Part XIII of the Public Health Act provides for food and water supplies.

10.3 Tobacco Abuse

The Commission noted that the WHO considers tobacco smoking a global epidemic.[501] The Commission considered the extent to which tobacco abuse is a problem in Malaŵi. The Commission noted that tobacco contains nicotine which has carcinogenic properties; that tobacco is at the centre of most respiratory diseases; and that it is dangerous even to secondary smokers.

The Commission considered the regulation of tobacco smoking, treatment of addiction and sponsorship in light of its hazardous effects. The Commission considered measures which may be introduced in Malaŵi to regulate tobacco generally and tobacco smoking by considering what other jurisdictions have already regulated and the hazardous effects of tobacco smoking.

The Commission was aware that tobacco remains the mainstay of the economy but was of the view that there is need to strike a balance between economic aspirations and public health. The Commission noted the scarcity or lack of data on the use of tobacco in Malaŵi and that even the record of the WHO has numerous gaps on key issues. Nevertheless, the Commission was of the view that there is need for evidence-based interventions to address the issue of tobacco abuse.

The Commission also considered the WHO Framework Convention on Tobacco Control (the Convention) which was ratified on 18th August 2023.The Commission upon perusal of the Convention observed that the theoretical underpinning the Convention are not to ban the use of tobacco but to put in place control measures for its use. This is evidenced by Article 3 of the Convention which stipulates the objectives to the effect that the object of the Convention and its protocol is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by member States in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke. The Commission has therefore adopted the approach expounded in the Convention in crafting the provisions on tobacco control under the legislation to be developed, that is, putting in place measures to control the use of tobacco rather than completely banning its use.

The Commission considered the impact of advertisements of liquor and cigarettes in promoting alcohol and tobacco abuse, respectively. The Commission was aware that both alcohol and tobacco products are freely advertised in the media in Malaŵi. The Commission noted that almost invariably, the advertisements carry a warning sign that alcohol or cigarettes should not be sold to persons under the age of 18 years in case of alcohol and a Ministry of Health warning in case of tobacco. The Commission resolved that while advertisements for alcohol and cigarettes should be allowed, the legislation to be developed

[501] https://www.who.int/news-room/fact-sheets/detail/tobacco.

should require the prohibition of offering, selling and supplying these products to persons under the age of eighteen years. This information should be conspicuously placed on the container or wrapper of alcohol and tobacco products; and on all advertisements of these products, regardless of the media of advertisement.

The Commission thus recommends the introduction of measures which would militate against the effects of tobacco smoking at the national level under the legislation to be developed. The Commission also recommends that the details regarding control of consumption of tobacco should be provided for in regulations that the Minister may promulgate from time to time. The Commission thus recommends adoption of the following provisions on tobacco control measures:

PART … — CONTROL OF CONSUMPTION OF TOBACCO

Prohibition of smoking in public places

...— A person who, except in a designated area—

(*a*) smokes tobacco or a tobacco product; or

(*b*) holds a lighted tobacco product,

in an enclosed or indoor area of a work place or in a public place, commits an offence.

Minimum age restrictions

...—(1) A person who—

(*a*) sells or offers for sale tobacco or a tobacco product to a child;

(*b*) sends a child to sell or buy tobacco or a tobacco product;

(*c*) requests a child to light tobacco or a tobacco product; or

(*d*) exposes a child to tobacco or a tobacco product,

commits an offence.

(2) Where a person who sells or offers for sale tobacco or a tobacco product is in doubt about the age of a purchaser of tobacco or a tobacco product, the person shall demand a valid picture identification document from the purchaser as a proof of age.

(3) A person shall not sell tobacco or a tobacco product to a purchaser unless the document referred to in subsection (2) offers adequate evidence of age.

(4) A valid picture identification document includes—

(*a*) a passport;

(*b*) a driving licence;

(*c*) a national identity card; and

(*d*) any other documentation that may be prescribed by the Minister.

(5) It shall not be a defence for an accused person charged with an offence under this section to prove that the person concerned did not appear to be less than eighteen (18) years of age.

Penalties for offences under this Part

...— (1) A person who contravenes a provision under this Part commits an offence and shall, on conviction, be liable to—

(*a*) in the case of an individual, a fine of one million five hundred thousand Kwacha (K1,500,000.00) and to imprisonment for three (3) years and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00); and

(*b*) in the case of a legal person, a fine of three million Kwacha (K3,000,000.00) and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00).

(2) Notwithstanding subsection (1), a person shall not be convicted of an offence if the person satisfies the court that the offence was committed without the knowledge or consent of that person, or that the person took the necessary steps, having regard to the circumstances, to prevent the commission of the offence.

Regulations on control of tobacco abuse

...— (1) The Minister may make regulations under this Part for the better carrying into effect the objective of control of tobacco abuse.

(2) Without prejudice to the generality of subsection (1), the regulations may provide for—

(*a*) advertisement of tobacco and tobacco products;

(*b*) tobacco sponsorship;

(*c*) promotion of tobacco and tobacco products;

(*d*) tobacco packaging and labelling;

(*e*) health warning on tobacco package;

(*f*) point of sale health warning;

(*g*) public education against tobacco use;

(*h*) treatment of tobacco addiction;

(*i*) prohibition of sale of tobacco in certain places;

(*j*) tobacco inspectors and analysts; and

(*k*) testing of tobacco and tobacco products.

(3) Notwithstanding section 21 (*e*) of the General Interpretation Act, regulations made under this Part may stipulate a fine of up to three million for Kwacha (K3,000,000.00) and imprisonment for two (2) years.

10.4 Dangerous Drugs and other Substances

The Commission observed that the Dangerous Drugs Act[502] is relatively old to address modern day challenges with respect to what are called dangerous drugs. The Commission noted that the Dangerous Drugs Act only deals with controlling the importation, exportation, production, possession, sale, distribution, and use of dangerous drugs.[503] However, the Dangerous Drugs Act does not address public health issues.

The Commission observed that most drugs listed under the Dangerous Drugs Act have both recreational and medicinal or therapeutic properties. This alone presents problems relating to regulation. The Commission observed that other products which were classified as dangerous drugs have in many countries been declassified, for example, Indian Hemp, since it can be used as modern medicine for other health problems. The Commission found that regulation of dangerous drugs can best be done under the Dangerous Drugs Act which itself is presently outdated. Therefore, the Commission recommends that a special Law Commission should be empaneled to conduct a comprehensive review of the Dangerous Drugs Act.

The Commission also appreciated the challenges of abuse of otherwise regulated drugs within health care facilities. The Commission was of the view that special provision must be made within the law to punish abuse of drugs that are assigned for medicinal or therapeutic purposes by health personnel. In that regard, the Commission noted with approval that section 65 of the PMRAA prohibits the sale or supply of prescription only the medicines without prescription for which the penalty under section 102 is as follows:

(*a*) in the case of a first offence, a fine of K2,000,000 and imprisonment for two years; and

502 Cap. 35:02 of the Laws of Malaŵi.
503 See long title to the Act.

(*b*) in the case of a subsequent offence, imprisonment for six years.

The Commission observed that the provisions on the subject matter under the PMRAA were sufficient.

The Commission noted that another aspect is pilferage of drugs. However, the Commission was of the view that the Penal Code[504] already provides for an offence relating to theft of Government property.[505]

The Commission considered the regulation of medical devices and substances such as, herbal medicinal products, cosmetics and household chemical substances, and it was observed that the PMRAA. The Commission resolved to make a consequential amendment to the PMRAA relating to regulation of drugs, herbal medicinal products, cosmetics, medical devices and household chemical substances. The recommended provisions on the consequential amendments are included in Appendix 5 of this report.

10.5 Rehabilitation

The Commission found that there are a few rehabilitation centres in Malaŵi. Known rehabilitation centres are Saint John of God Centre in Mzuzu, and Sandi Rehabilitation, Assessment and Therapy Centre in Lilongwe. The Commission therefore recommends that the Government through the Ministry of Health should prioritize mental health by providing adequate rehabilitation facilities in all regions across the country for patients to have free access or access the services at a reasonable fee.

11.0 IMPLEMENTATION AND ENFORCEMENT

The Act is a multi-sectoral law, as such there are multiple players in the enforcement and implementation of the Act. Effective enforcement and implementation of the Act therefore depends on the coordination among different institutions including the Ministry responsible for health, the Local Authority, and Law Enforcement Agencies. The public health law aims at attaining the highest possible level of physical and mental well-being of the population. This purpose of public health law is attained through different mechanisms including the prohibition of certain conduct or acts. As such, the Act[506]creates a number of offences which include: failure to give notification of infectious disease;[507] failure to provide for disinfection of a vehicle;[508] letting out an infected house;[509] failure to report suspected plague;[510] prohibition of employment of a person suffering from a venereal disease in a communicable form;[511]prohibition of publication of

504 Cap. 7:01 of the Laws of Malaŵi.
505 See section 283 which provides for the offence of stealing by persons in public service.
506 Laws of Malaŵi, Cap. 34:01.
507 Section 14.
508 Section 23.
509 Section 24.
510 Section 34.
511 Section 54.

advertisements of the cure of a venereal disease including sexual impotence;[512] wilful infection of another with a venereal disease;[513] prohibition of back-to-back dwellings and rooms without through ventilation (windows);[514] and prohibition of sale of unwholesome food.[515]Apart from criminal offences, there are also remedies of a civil nature in case of contravening provisions of the Act.

The Commission observed that according to section 7 of the Constitution, the responsibility for the implementation of all laws rests in the Executive branch of Government. The Act accordingly confers on different institutions and public officers within the Executive, the power or function to enforce and implement the Act. The Commission noted that coordination among the different institutions is poor or non-existent. The institutions or officers include:

(*a*) Ministry of Health[516];

(*b*) Local Authority[517];

(*c*) Law Enforcement Agency[518];

(*d*) Medical Health Officer[519] ; and

(*e*) Veterinary Officer.[520]

The Commission further observed that over the years, the structures of the institutions coordinating the enforcement and implementation of the Act have changed which creates an enforcement and implementation challenge.

In Kenya, the responsibility for enforcement and implementation of the Public Health Act is conferred on the Medical Department. The functions of the Medical Department include: (*a*) to prevent and guard against the introduction of infectious diseases into Kenya from outside; (*b*) to promote public health and the prevention and limitation or suppression of infectious, communicable and preventable diseases; and (*c*) to advise and direct local authorities in regard to matters affecting public health.

The Commission also found that public health legal preparedness has a role to play in effective implementation of the Act. The Commission considered the state of preparedness against public health emergencies in Malaŵi, and found some gaps in the procedures, laws or identifiable action in place. The Commission found that under the Constitution, the President has powers to declare a state of emergency but such powers do not fit into the framework of public health emergencies envisaged in public health discourse. The Commission observed that while powers of the President to declare a state of emergency under the

[512] Section 55.
[513] Section 57.
[514] Section 72.
[515] Section 106.
[516] Sections 31 and 52.
[517] Section 32.
[518] Sections 27, 106, and 131.
[519] Sections 106 and 107.
[520] Section 106.

Constitution could remain intact, powers exercisable in public health emergencies under the legislation to be developed should be vested in the Minister. The Commission recommends laying down processes in this regard, to guide a Government to declare or announce the emergency, and the processes to be followed.

The Commission further observed that there is a need for a body that shall be mandated to identify and forecast emergencies on a continuous basis. As such, the Commission recommends that the proposed legislation should make provision for multi-sectoral collaboration and coordination on matters of public health. The Commission also reiterates its earlier recommendation relating to the establishment of a Public Health Institute and considers that it could form an integral part of the institutional framework to enhance implementation.

Further, the Commission observed that the Minister has powers to make subsidiary legislation under the Act for the better carrying into effect the provisions of the Act. The Commission found that subsidiary legislation made pursuant to the powers could be more effective if made upon the recommendations of an institution with the requisite technical expertise and in consultation with other public institutions dealing with matters relating to public health.

Therefore, the Commission recommends the adoption of the following provisions under the proposed legislation:

Multi-sectoral collaboration and coordination

... The Minister shall in consultation with public institutions dealing with matters relating to public health put in place measures as shall allow for collaboration and coordination among the institutions for the better carrying into effect the objects of this Act.

11.1 Retained Provisions

The Commission considered the value, effectiveness, and applicability of some of the provisions of the Act that were not included under any of the parts of the Report. The Commission agreed that those provisions which are relevant should be retained and incorporated into the proposed legislation. In order to align the provisions with the objectives and scope of the new legislation, the Commission was of the view that the provisions should be modified, or redrafted where necessary. In view of the foregoing, the Commission therefore recommends the adoption of the following provisions—

Powers and duties of the officers of the Ministry of Health

... Any duties imposed or powers conferred by this Act on medical officers of health or health officers may be carried out or exercised by the Secretary for Health or any person designated by him for that purpose.

Provisions as to appeals against the enforcement of notices

...— (1) A person served with a notice under this Act may appeal in the manner hereinafter provided on any of the following grounds—

(*a*) that the notice or requirement is not justified by the terms of the law under which it purports to have been given or made;

(*b*) that there has been some defect or error in, or in connexion with, the notice;

(*c*) that the works required by the notice to be executed are unreasonable in character or extent;

(*d*) that the time within which the works are to be executed is not reasonably sufficient for the purpose; or

(*e*) that the notice might lawfully have been served on the occupier of the premises in question instead of on the owner, or on the owner instead of on the occupier, and that it would have been equitable for it to have been so served.

(2) Where and in so far as an appeal under this section is based on the ground of some informality, defect or error in or in connexion with the notice, the appeal shall be dismissed, if it is shown that the informality, defect or error was not a material one.

(3) Subject to this Act, any appeal against a notice issued under this Act shall be to the court of a Resident Magistrate and shall be filed within thirty (30) days from the date of such notice.

Recovery of expenses, etc.

...— (1) Any sum which a local authority is entitled to recover under this Act and with respect to the recovery of which no other provision is made, may be recovered as a simple contract debt in any court of competent jurisdiction.

(2) The time within which summary proceedings may be taken for the recovery of any such sums shall, except where otherwise expressly provided, be reckoned from the date of the service of a demand therefor.

Penalties where not expressly provided

... Any person guilty of an offence under this Act or any Regulations made hereunder, shall, if no penalty is expressly provided for such offence, be liable to a fine of two million Kwacha (K2,000,000.00) and if the offence is of a continuing nature, to a further fine of fifty thousand Kwacha (K50,000,000.00) for each day the offence continues.

Prosecution

...Subject to the Criminal Procedure and Evidence Code, a local authority may, by any of its officers or by any person generally or specially authorized in writing by such local authority, prosecute for any contravention of, offence against, or default in complying with, any provision of this Act or any Rule made or deemed to be made hereunder, if the contravention, offence, or default is alleged to have been committed within or affects its district.

Power of local authority outside its

...— Nothing in any law specially governing any local authority shall be construed as preventing such local authority from exercising any power or performing any duty under this Act by reason only that in exercising such power or performing such duty it must do some act or thing or incur expenditure outside its district.

Non-communicable diseases

... The Ministry responsible for health shall educate the public on non-communicable diseases and provide facilities for screening, early detection and management of non-communicable diseases and for the promotion of public health.

Protection from liability

...— (1) A member of the Institute, local authority, an authorized officer or an employee of the Institute or local authority shall not, in his personal capacity, be liable in civil or criminal proceedings in respect of any act or omission done in good faith in the performance of his functions under this Act.

Where in any proceedings a question arises on whether or not an act or omission was done in good faith in the course of carrying out the provisions of this Act, the burden of proving that the act or omission was not done in good faith shall be on the personal alleging that it was not so done.

12.0 INCIDENTAL PROVISIONS

12.1 Long Title

The long title sets out the purposes of the Act. Currently, the long title to Act is, "An Act to amend and consolidate the law regarding the preservation of public health". The Commission observed that following the review process, there was an expansion in the purposes of the Act, for instance, the introduction of the Public Health Institute as a lead implementation agency. Therefore, the Commission recommends that the long title to the Act should be changed to reflect the purposes of the proposed legislation as follows—

An Act to provision for the establishment of the Public Health Institute for its powers and functions; the regulation of public health generally; and to provide for connected and ancillary matters.

12.2 Short Title and Commencement

The Commission resolved to maintain the short title of the Act as the "Public Health Act" Regarding commencement, the Commission resolved that the Act should come into operation on a date to be appointed by the Minister as this would allow the line Ministry to put in place necessary implementation mechanisms before the Act comes into force. Therefore, the Commission recommends the adoption of the following provision:

Short title and Commencement

… This Act may be cited as the public Health Act and shall come into force on a date appointed by the Minister by notice published in the *Gazette*.

12.3 Definitions

The Commission recommends that the following words and phrases that has been use in the proposed legislation should be defined under the interpretation clause as follows—

Interpretation

...—In this Act, unless the context otherwise requires—

"animal" includes cattle, sheep, goats, rabbits and any other ruminating domestic animal, horses, mules, asses, swine, dogs, cats, monkeys, captured wild reptiles fish, rodents, mammals, birds, ostrich and poultry comprising domestic fowls, ducks, geese, pigeons, guinea fowl and eggs thereof;

"authorized health officer" means a person authorized by the Minister to perform a function under Part V;

"authorized officer" means a medical officer, a health inspector or a person authorized in writing by the Chief Executive Officer, the Minister or a local government authority, or any other person authorized by the Authority to perform a function under this Act;

"Board" means the Board appointed under section 6;

"child" means a person below the age of eighteen (18) years;

"client" means any person accessing health services at a health facility whether at a fee or for free;

"clinical trial" means an investigation consisting of a particular description by, or under the direction of a medical practitioner, dentist or veterinary surgeon to the patient or animal where there is evidence that a medicine, medical device or procedure or herbal medicine of that description has effects which may be beneficial to and safe to the patient or animal, and the medicine, medical device or procedure or herbal medicine is for the purposes of ascertaining beneficial or harmful effects;

"communicable disease" means an illness caused by a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment;

"court" means the Court of a first grade magistrate or above

"Director General" means the Director General appointed under section 20;

"environmental health officer" means a health professional who is involved in health promotion and education and who controls activities that have adverse consequences on the environment, public health and safety;

"food" includes water, liquor, a food product, a live animal or a live plant, and—

(*a*) a substance or a thing of a kind used, capable of being used or represented as being for use, for human or animal consumption whether it is live, raw, prepared or partly prepared;

(*b*) a substance or a thing of a kind used, capable of being used or represented as being for use, as an ingredient or additive in a substance or a thing referred to in paragraph (*a*);

(*c*) a substance used in preparing a substance or a thing referred to in paragraph (*a*);

(*d*) chewing gum or an ingredient or additive in chewing gum or a substance used in preparing chewing gum; and

(*e*) a substance or a thing declared by the Minister to be a food under Part XII;

"food handling" means the carrying out or assisting in carrying out any process or operation of food for the purpose of food business or the transportation, storage, packaging, wrapping or exposure for sale, or for service or delivery of food and includes the cleaning, of articles or equipment with which food comes into contact.

"health inspector" means a person lawfully appointed to be a health inspector or a sanitary inspector;

"health officer" means a medical practitioner, environmental officer, nurse or midwife.

"indoor or enclosed" means a space covered by a roof or enclosed by two (2) or more walls or partition regardless of the material used for the roof, walls or partition and regardless of whether the structure is temporary or permanent;

"infectious disease" means a clinically evident illness resulting from the presence of disease causing agents liable to spread quickly;

"inoculation" means to treat a person or animal with a small quantity of the agent of a disease in the form of a vaccine or serum usually by scarification to provide immunity against the disease;

"insanitary conditions" means the conditions or circumstances which might contaminate a product regulated under this Act with dirt or filth or might render the article injurious or dangerous to health;

"Institute" means the Public Health Institute of Malaŵi established under section 6;

"label" includes a legend, tag, brand, work or mark, pictorial or a descriptive matter written, printed, stenciled, marked, embossed or impressed on or attached to a product

"manufacture" includes the operations involved in the production, preparation, processing, compounding, formulating, filling, refining transformation, packing, packaging, re-packaging and labelling of products

"medical officer" means a dental or medical practitioner registered under the relevant law;

"Ministry" means the Ministry responsible for health;

"non-communicable diseases" includes cancers, diabetes, cardiovascular diseases, hypertension, malnutrition, obesity, conditions arising from road traffic accidents, environmental and work place hazards;

"One Health Approach" means a collaborative, multi-sectoral and trans disciplinary approach aimed at achieving optimal health outcomes recognising the interconnection between people, animals, plants and their shared environment;

"owner" includes an occupier, and in respect of—

(*a*) premises, the person receiving the rent of the premises in connection with which the word is used, whether personally or who would receive the rent if the premises were let to a tenant; and

(*b*) a vessel, the person in actual or constructive possession of the vessel;

"parent" includes the father or mother of a child, and a person who cares for or has custody of a child;

"police officer" means a member of the Malaŵi Police Service constituted under the Police Act;

"premises" includes land, buildings, structures, basements and vessels, and—

(*a*) in relation to a building, includes a part of a building and the cartilage, forecourt, yard or place of storage used in connection with the building or part of the building; and

(*b*) in relation to a vessel, includes a ship, boat, an aircraft, a carriage or receptacle of any kind, whether open or closed;

"prescribe" means prescribed by Regulations;

"protocol" means a document that describes the objective(s), design, methodology, statistical considerations and organization of a study including the background and rationale;

"public place" includes a building, or a facility which is accessible to the general public regardless of ownership or right of access;

"research ethics committee" means a committee duly recognised, registered and accredited by the National Commission for Science and Technology or a relevant authority to promote the safety, rights and wellbeing of humans and compassion for animals as subjects in research;

"vermin" means various small animals or insects, such as mice or cockroaches that are destructive, annoying or injurious to health;

"smoke" includes being in possession or control of a lit tobacco product regardless of whether the smoke is being actively inhaled or exhaled;

"sponsorship" means any form of contribution to an event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

"successful vaccination" means vaccination which is sufficient to protect against the relevant disease;

"tobacco product" means a product entirely or partly made of tobacco leaf as raw material which has been treated or manufactured to be smoked, sucked, chewed or sniffed or handled;

"vector" means an intermediate host of a disease causing agent;

"vessel" includes any vehicle whether motorized or not, an aircraft, a ship, tug boat, lighter boat, boat, barge, canoe or other floating craft used or capable of being used for transport;

"work place" includes—

(*a*) an area, whether permanent or temporary, in which a person performs a duty of employment or work regardless of whether the work is done for compensation or on voluntary basis; and

(*b*) common areas and any other area generally used or frequented during the course of employment.

12.4 Subsidiary Legislation

The Commission took note of its findings and recommendations at 11.0 (Implementation and Enforcement) regarding the powers of the Minister to make subsidiary legislation. Therefore, the Commission recommends the adoption of the following provisions–

Regulations by the Minister

…(1) The Minister may on the recommendation of the Institute and in relating to Public health make regulations for the effective carrying out of this Act and, without prejudice to the generality of the foregoing, such regulations may provide for–

(*a*) the form and mode of service or delivery of notice of communicable diseases;

(*b*) the control and handling of communicable disease cases;

(*c*) prescribing the procedure to be observed in the proceedings of the Compensation Board;

(*d*) for the disposal or destruction of waste;

(*e*) prescribing the reporting of cases of sickness or death;

(*f*) giving effect to International Health Regulations;

(*g*) vaccination;

(*h*) disease prevention, notification and surveillance;

(*i*) sale of meat for human or animal consumption; and

(*j*) generally for carrying into effect the provisions of this Act.

(2) Notwithstanding section 21 (*e*) of the General Interpretation Act, regulations made pursuant to this section may prescribe a penalty of a fine not exceeding two million Kwacha (K2,000,000.00) and imprisonment for two (2) years.

12.5 Repeal and Savings

The Commission recommends the adoption of the following provisions–

Repeals and savings
Cap. 34:01
Cap. 34:01

…. — (1) The Public Health Act is hereby repealed.

(2) Regulations, schedules, rules, orders, proclamations, forms, notices and appointments made under the Public Health Act (now repealed) shall, in so far as they are not inconsistent with this Act, be deemed to have been made under this Act and applicable penalties for contravention of the regulations, rules, orders, proclamations and notices shall be as provided under this Act.

(3) The regulations, schedules rules, orders, proclamations, forms, notices and appointments referred to in subsection (2) shall continue in force until replaced by regulations, schedules, rules, orders, proclamations, forms, notices and appointments made under this Act.

Transfer of assets, funds and liabilities

...—(1) The Minister may by order designate any department directorate, or unit whatsoever under the Ministry responsible for health to be a part of the Institute and, upon such designation, all property, funds and assets vested in such department, Directorate or unit shall, on commencement of this Act, be vested in the Institute.

(2) All debts, obligations, liabilities, agreements and other arrangements existing at the commencement of this Act and vested in, acquired, incurred or entered into by or on behalf of a department, directorate, or unit referred to in subsection (1) shall, on the commencement of this Act, be deemed to have vested in or to have been acquired, incurred, or entered into by or on behalf of the Institute.

12.6 Schedules

Firstly, the Commission recommends the adoption of the following Schedule on certificate of vaccination

…Schedule

FIRST SCHEDULE

(*Section ...*)

CERTIFICATE OF VACCINATION

I, the undersigned, hereby certify that …… (full name), a man, woman, boy, girl of the apparent age of …… years, a resident of …… (Physical Address) was successfully vaccinated against

…….by me at …… (Exact place e.g. name of hospital) in the District of ……. on the …… day of .....20....

……..
Signature
Public Vaccinator

Official Stamp

SECOND SCHEDULE

(*Section ...*)

PATIENT'S CHARTER

The Ministry of Health is for all people living in Malaŵi irrespective of age, sex, ethnic background or religion.

The Ministry requires collaboration between health workers, patients, clients and society. The attainment of optimal health care is, therefore, dependent on team work. Health facilities should provide for and respect the rights and responsibilities of patients, clients, families, health workers and other health care providers. The health facilities should be sensitive to the socio-cultural and religious backgrounds, age, gender and any other differences of the patient; and the needs of patients with disabilities. The Ministry expects health care institutions to adopt the Patient's Charter to ensure that health personnel as well as patients, clients and their families understand their rights and responsibilities.

This Charter is made to protect the rights of the patient generally. It addresses:

1. the right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country;
2. respect for the patient as an individual with a right of choice in respect of health care plans;
3. the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability; and
4. the responsibility of the patient or client for personal and communal health through preventive, promotive and simple curative strategies.

RIGHTS OF THE PATIENT

1. The patient has the right to quality basic health care irrespective of the patient's geographical location.

2. The patient is entitled to full information on the patient's condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
3. The patient is entitled to know of the alternative treatments and other health care providers within the Ministry if these may contribute to improved outcomes.
4. The patient has the right to know the identity of the caregivers and any other persons who may handle the patient including students, trainees and ancillary workers.
5. The patient has the right to consent or decide to participate in a proposed research study involving the patient after a full explanation has been given; and the patient may withdraw at any stage of the research project.
6. A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.
7. The patient has the right to privacy during consultation, examination and treatment and in cases where it is necessary to use the notes of the patient's case for teaching and conferences, the consent of the patient must be sought.
8. The patient is entitled to confidentiality of information obtained about the patient and that information shall not be disclosed to third party without the consent of the patient or the person entitled to act on the consent of the patient or the person entitled to act on behalf of the patient except where the information is required by law or is in the public interest.
9. The patient is entitled to the relevant information regarding policies and regulation of the health facilities that the patient attends.
10. Procedures for complaints, disputes and conflict resolution shall be explained to patients or their accredited representatives.
11. Hospital charges, mode of payment and the forms of anticipated expenditure shall be explained to the patient prior to treatment.
12. Exemption facilities shall be made known to the patient.
13. The patient is entitled to personal safety and reasonable security of property within the confines of the institution.
14. The patient has the right to a second medical opinion if the patient so desires.

RESPONSIBILITIES OF THE PATIENT

The patient should understand the responsibilities of the patient as regard the patient's own health and therefore co-operate fully with the health care providers.

The patient is responsible for:

(*a*) providing full and accurate medical history for diagnosis, treatment, counseling and rehabilitation purposes;

(*b*) requesting additional information or clarification regarding the patient's health or treatment, which may not have been well understood;

(*c*) complying with the prescribed treatment, reporting adverse effects and adhering to follow up requests;

(*d*) informing the healthcare providers of any anticipated problems in following prescribed treatment or advice;

(*e*) obtaining the necessary information, which has a bearing on the management and treatment including the financial implications;

(*f*) acquiring knowledge on preventive, promotive and simple curative practices and where necessary for seeking early professional help;

(*g*) maintaining safe and hygienic environment in order to promote good health;

(*h*) respecting the rights of other patients or clients and personnel in the Ministry of Health; and

(*i*) handling with care the property of the health facility.

These rights and responsibilities shall be exercised by accredited and recognized representatives on behalf of minors and patients who are unable for whatever reason to make informed decisions by themselves. In all health care activities the patient's dignity and interest must be paramount.

RIGHTS AND RESPONSIBILITIES OF HEALTH CARE WORKER

The rights of health care workers include:

(*a*) access to equipment and supplies;

(*b*) respect and dignity;

(*c*) fair working hours and adequate rest;

(*d*) occupational health and protection;

(*e*) fair administrative remedy;

(*f*) not to be unfairly discriminated against on account of health status;

(*g*) to be protected against injury or damage to the person and property.; and

(*h*) refuse treatment to a user who is physically or verbally abusive or who sexually harasses him or her.

The responsibilities of a health care worker include:

(*a*) continuous education;

(*b*) treat patients with respect and dignity;

(*c*) discharge duties in a professional manner; and

(*d*) to prevent disease transmission.

THIRD SCHEDULE

(*Section…*)

OATH OF SECRECY

I ……., being a member/having been employed in the service of the Institute, do hereby swear/affirm that I will freely without fear or favour, affection or ill will, discharge the functions of a member/an employee, of the Institute, and that any matters related to such functions shall not be provided to any unauthorised person or otherwise than in the course of my duty.

SWORN at ……. this ……. day of ……20…….

Signature:…….....

Before …….....
Commissioner for Oaths

APPENDICES

APPENDIX 1

PUBLIC HEALTH BILL, 20...

PUBLIC HEALTH BILL, 20...

ARRANGEMENT OF SECTIONS

SECTION

SECTION

A BILL

entitled

An Act to provide for the establishment of the Public Health Institute and for its powers and functions; the regulation of public health generally; and to provide for connected and ancillary matters.

PART I—PRELIMINARY

Short title and commencement

1. This Act may be cited as the Public Health Act and shall come into force on a date appointed by the Minister by notice published in the *Gazette*.

Interpretation

2.—In this Act, unless the context otherwise requires—

"animal" includes cattle, sheep, goats, rabbits and any other ruminating domestic animal, horses, mules, asses, swine, dogs, cats, monkeys, captured wild reptiles fish, rodents, mammals, birds, ostrich and poultry comprising domestic fowls, ducks, geese, pigeons, guinea fowl and eggs thereof;

"authorized health officer" means a person authorized by the Minister to perform a function under Part V;

"authorized officer" means a medical officer, a health inspector or a person authorized in writing by the Chief Executive Officer, the Minister or a local government authority, or any other person authorized by the Authority to perform a function under this Act.;

"Board" means the Board appointed under section 6;

"child" means a person below the age of eighteen (18) years;

"client" means any person accessing health services at a health facility whether at a fee or for free;

"clinical trial" means an investigation consisting of a particular description by, or under the direction of a medical practitioner, dentist or veterinary surgeon to the patient or animal where there is evidence that a medicine, medical device or procedure or herbal medicine of that description has effects which may be beneficial to and safe to the patient or animal, and the medicine, medical device or procedure or herbal medicine is for the purposes of ascertaining beneficial or harmful effects;

"communicable disease" means an illness caused by a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment;

"court" means the Court of a first grade magistrate or above;

"Director General" means the Director General appointed under section 20;

"environmental health officer" means a health professional who is involved in health promotion and education and who controls activities that have adverse consequences on the environment, public health and safety;

"food" includes water, liquor, a food product, a live animal or a live plant, and—

(*a*) a substance or a thing of a kind used, capable of being used or represented as being for use, for human or animal consumption whether it is live, raw, prepared or partly prepared;

(*b*) a substance or a thing of a kind used, capable of being used or represented as being for use, as an ingredient or additive in a substance or a thing referred to in paragraph (*a*);

(*c*) a substance used in preparing a substance or a thing referred to in paragraph (*a*);

(*d*) chewing gum or an ingredient or additive in chewing gum or a substance used in preparing chewing gum; and

(*e*) a substance or a thing declared by the Minister to be a food under Part XII;

"food handling" means the carrying out or assisting in carrying out any process or operation of food for the purpose of food business or the transportation, storage, packaging, wrapping or exposure for sale, or for service or delivery of food and includes the cleaning, of articles or equipment with which food comes into contact.

"health inspector" means a person lawfully appointed to be a health inspector or a sanitary inspector;

"health officer" means a medical practitioner, environmental officer, nurse or midwife.

"indoor or enclosed" means a space covered by a roof or enclosed by two (2) or more walls or partition regardless of the material used for the roof, walls or partition and regardless of whether the structure is temporary or permanent;

"infectious disease" means a clinically evident illness resulting from the presence of disease causing agents liable to spread quickly;

"inoculation" means to treat a person or animal with a small quantity of the agent of a disease in the form of a vaccine or serum usually by scarification to provide immunity against the disease;

"insanitary conditions" means the conditions or circumstances which might contaminate a product regulated under this Act with dirt or filth or might render the article injurious or dangerous to health;

"Institute" means the Public Health Institute of Malaŵi established under section 6;

"label" includes a legend, tag, brand, work or mark, pictorial or a descriptive matter written, printed, stenciled, marked, embossed or impressed on or attached to a product;

"manufacture" includes the operations involved in the production, preparation, processing, compounding, formulating, filling, refining transformation, packing, packaging, re-packaging and labelling of products;

"medical officer" means a dental or medical practitioner registered under the relevant law;

"Ministry" means the Ministry responsible for health;

"non-communicable diseases" includes cancers, diabetes, cardiovascular diseases, hypertension, malnutrition, obesity, conditions arising from road traffic accidents, environmental and work place hazards;

"One Health Approach" means a collaborative, multi-sectoral and trans disciplinary approach aimed at achieving optimal health outcomes recognising the interconnection between people, animals, plants and their shared environment;

"owner" includes an occupier, and in respect of—

(*a*) premises, the person receiving the rent of the premises in connection with which the word is used, whether personally or who would receive the rent if the premises were let to a tenant; and

(*b*) a vessel, the person in actual or constructive possession of the vessel;

"parent" includes the father or mother of a child, and a person who cares for or has custody of a child;

Cap. 13:01 "police officer" means a member of the Malaŵi Police Service constituted under the Police Act;

"premises" includes land, buildings, structures, basements and vessels, and—

(*a*) in relation to a building, includes a part of a building and the cartilage, forecourt, yard or place of storage used in connection with the building or part of the building; and

(*b*) in relation to a vessel, includes a ship, boat, an aircraft, a carriage or receptacle of any kind, whether open or closed;

"protocol" means a document that describes the objective(s), design, methodology, statistical considerations and organization of a study including the background and rationale;

"public place" includes a building, or a facility which is accessible to the general public regardless of ownership or right of access;

"research ethics committee" means a committee duly recognised, registered and accredited by National Commission for Science and Technology or a relevant authority to promote the safety, rights and wellbeing of humans and compassion for animals as subjects in research;

"smoke" includes being in possession or control of a lit tobacco product regardless of whether the smoke is being actively inhaled or exhaled;

"sponsorship" means any form of contribution to an event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

"successful vaccination" means vaccination which is sufficient to protect against the relevant disease;

"tobacco product" means a product entirely or partly made of tobacco leaf as raw material which has been treated or manufactured to be smoked, sucked, chewed or sniffed or handled;

"vector" means an intermediate host of a disease causing agent;

"vermin" means various small animals or insects, such as mice or cockroaches that are destructive, annoying or injurious to health;

"vessel" includes any vehicle whether motorized or not, an aircraft, a ship, tug boat, lighter boat, boat, barge, canoe or other floating craft used or capable of being used for transport;

"work place" includes—

(*a*) an area, whether permanent or temporary, in which a person performs a duty of employment or work regardless of whether the work is done for compensation or on voluntary basis; and

(*b*) common areas and any other area generally used or frequented during the course of employment.

Part II—Right to Health

Right to Health

3.—(1) Every person has the right to the highest attainable standard of health which includes—

(*a*) the right to basic health services from the State;

(*b*) progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services;

(*c*) right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act;

(*d*) right to get information about his medical treatment; and

(*e*) the right to have equal access to health services.

(2) Where the State claims that it does not have the resources to implement the right, a court shall be guided by the following principles—

(*a*) it is the responsibility of the State to show that the resources are not available;

(*b*) in allocating resources, the State shall give priority to ensure the widest possible enjoyment of the right having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and

(*c*) the court, may not interfere with a decision by a State organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion.

(3) For purposes of enforcing the right referred to in subsection (1), any person may bring an action in the High Court to—

(*a*) prevent or stop any act or omission which is deleterious or injurious to the health of any person;

(*b*) procure any public officer to take measures to prevent or stop any act or omission which is deleterious or injurious to the health of any person for which the public officer is responsible under any written law;

(*c*) require that any on-going project or other activity be subjected to a health audit in accordance with this Act.

(4) Any person who has reason to believe that his or her right to health has been violated by any person may, instead of proceeding under subsection (3), file a written complaint to the Minister outlining the nature of his or her complaint and particulars, and the Minister shall, within thirty days from the date of the complaint, institute an investigation into the activity or matter complained about and shall give a written response to the complainant indicating what action the Minister has taken or shall take to restore the claimant's right to health, including instructing the Attorney General to take such legal action on behalf of the Government as the Attorney General may deem appropriate.

(5) Subsection (4) shall not be construed as limiting the right of the complainant to commence an action under subsection (3):

Provided that an action shall not be commenced before the Minister has responded in writing to the complainant or where the Attorney General has commenced an action in court against any person on the basis of a complaint made to the Minister.

Obligation of the eployer

4.—(1) Every employer shall make provision for every person under his or under his or her employment to be a member of a medical scheme provided that such employees are not ten.

(2) The Minister in consultation with the Minister responsible for Minister for Labour, may by order published in the gazetted exempt any class or category of employers or employees for complying with the requirements of this part.

(3) An employer who contravenes this section commits an offence and shall on conviction be subject to—

(*a*) a written warning and order to remedy the effects of the contravention

(*b*) compensating persons who have suffered loss because of the contravention; and

(*c*) a fine of ten million (10,000,000.00) Kwacha

Contributions to health service

5.—(1) A person accessing health services at a public health facility shall be required to pay a nominal fee as prescribed by the Minister from time to time

(2) Notwithstanding subsection (1), a person who has insufficient means to enable him to pay the nominal fee shall have access to health services at the expense of the State.

(3) The Minister may by order published in the *gazette* issue directives for the implementation of subsection (2).

Part III–Public Health Institute

Division 1–Public Health Institute

Establishment of the Institute

6.—(1) There is hereby established an Institute to be known as the Public Health Institute (hereinafter referred to as the "Institute"), which shall be a body corporate with perpetual succession and a common seal.

(2) The Institute shall—

(*a*) be capable of—

(i) acquiring, holding and disposing of real and personal property;

(ii) suing and being sued in its own name;

(iii) doing or performing all acts and things as body corporate may, by law, do or perform; and

(iv) performing such functions and exercise such powers as conferred by this Act or by any other written law; and

(*b*) be composed of a Board (hereinafter referred to as the "Board") which shall be the governing body of the Institute, and a Secretariat.

Independence of the Institute

7.—(1) The Institute shall perform the functions and exercise the powers provided for in this Act independent of the direction, undue influence or interference of—

(*a*) any public office;

(*b*) any organ of the Government;

(*c*) any person or organization or Authority or organization whatsoever:

(2) Notwithstanding subsection (1), solely for purposes of accountability, the Institute shall be and report bi-annually and directly to the Parliamentary Committee responsible for Public Health matters on the overall fulfilment of the functions and powers of the Institute.

Functions of the Institute

8. The functions of the Institute shall be to—

(*a*) prevent, detect, monitor and control diseases of national and international public health concern, including emerging and re-emerging diseases;

(*b*) develop, maintain and coordinate surveillance systems to collect, analyse and interpret data on diseases of public health importance;

(*c*) detect public health threats, guide health interventions and set public health priorities;

(*c*) support the response to disease outbreaks and public health emergences in order to minimize the impact on health;

(*d*) develop and maintain a network of reference and specialized laboratories for pathogen detection, disease surveillance and outbreak response;

(*e*) conduct, collate, synthesize and disseminate public health research to inform policy and guidelines on a disease or diseases of public health importance, and put in place a national public health research agenda and database;

(*f*) support national health information systems to strengthen prevention and control measures of communicable diseases;

(*g*) provide information and awareness to the public on diseases and public health events;

(*h*) coordinate the operationalization of on-going international health regulations, including trans-border disease surveillance and control activities;

(*i*) collaborate with health agencies within and outside Malaŵi;

(*j*) provide support and coordinate the control of national and trans-border responses to public health events of international concern, including mass casualties, flood, nuclear, biological or chemical terrorism, disease outbreaks and heavy metal poisoning;

(*k*) develop and maintain a communication network with all public health institutions, with roles in mitigating the impact of diseases;

(*l*) provide support to the Ministry responsible for public health for the development of evidence-based guidelines and policies as well as the implementation of programmes relating to disease prevention and control, in accordance with international guidelines and recommendations;

(*m*) provide guidance, technical and logistical support for the planning, implementation and management of diseases of public health importance and on activities to reduce health risk and impact from public health events;

(*n*) provide technical support to communities, organizations and institutions on environmental health activities, as it relates to disease prevention, control and disaster emergency response;

(*o*) implement One Health Approach;

(*p*) contribute to the development of human resources, in particular, in the technical-professional and scientific areas specific to health;

(*q*) disseminate information of a technical-scientific nature, for the scientific community, health workers and the public in general;

(*r*) form partnerships with other national and international institutions for the execution of research, training, and public health activities; and

(*s*) carry out such activities as may be necessary or expedient for the performance of its functions under this Act.

Powers of the Institute

9. The Institute shall in the discharge of its functions, have power to—

(*a*) request and obtain information, data, clinical samples and report on diseases of public health importance;

(*b*) support the control of public health emergencies;

(*c*) develop and enforce the use of standards, protocols and guidelines for disease prevention and control including diagnostic, disease detection and reporting in compliance with international best practice;

(*d*) enter through its designated officers any public place to inspect and enforce compliance with public health standards;

(*e*) manage, insure, lease, sell, dispose of, maintain, improve or in any way deal with any of its property;

(*f*) receive donation of funds, materials and technical assistance for the furtherance of its work; and

(*g*) do and perform all such things or acts as are necessary or expected for the execution of its functions and duties under this Act.

Composition of the Board

10.—(1) The Board of the Institute shall consist of the following members appointed by the Minister—

(*a*) a representative from local research institution, nominated by the National Commission for Science and Technology;

(*b*) an epidemiologist, nominated by a school of public health at an accredited university;

(*c*) a representative of the Medical Council with expertise in public health, nominated by the Medical Council;

(*d*) a representative of the Nurses and Midwives Council with expertise in public health, nominated by the Nurses and Midwives Council;

(*e*) a member with expertise in veterinary medicine, nominated by a school of veterinary medicine at an accredited university; and

(*f*) the following ex-officio members—

(i) Secretary responsible for Health;

(ii) Secretary responsible for Local Government;

(iii) Secretary responsible for Agriculture;

(iv) Secretary responsible for Water;

(v) Secretary responsible for Environmental Affairs; and

(vi) Commissioner responsible for disaster management.

(2) The Minister may designate any member of the Board, other than an *ex-officio* member under subsection (1)(*f*), as chairperson of the Board.

(3) A member of the Board, other than the *ex-officio* member shall not, by reason only of his appointment as a member of the Board, be deemed to be an employee in the public service.

(4) A person, other than an *ex-officio* member, shall not be qualified for appointment as a member of the Board, if he—

(*a*) does not possess—

(i) a minimum education of a master's degree or its equivalent obtained subsequent to a bachelor's degree, both qualifications obtained from a recognized or accredited higher education institution; and

(ii) expertise and experience in a field relevant to the functions and responsibilities of the Institute;

(*c*) holds a political office or is an active member of a political party;

(*c*) is adjudged or declared bankrupt; and

(*d*) would for any other reason be disqualified by law from serving as a director of a company or as a trustee.

(5) The Board may, where necessary taking into account the nature of the matter to be deliberated, invite any person to—

(*a*) attend a meeting of the Board or any of its committees and participate in the deliberations; or

(*b*) make a presentation or to be asked questions on any matter.

(6) A person invited to deliberations of the Board pursuant to subsection (5) shall not be entitled to vote.

Functions of the Board

11.—(1) The Board shall control, oversee and supervise—

(*a*) the performance of functions and duties; and

(*b*) the exercise of powers of the Institute to ensure efficiency and effectiveness in the implementation of the mandate of the Institute.

(2) Without prejudice to the generality of subsection (1), the Board shall—

(*a*) provide strategic guidance for the management of the Institute;

(*b*) approve annual plans and budgets of the Institute;

(*c*) monitor the implementation of the plans and programmes of the Institute;

(*d*) oversee the proper management of finances and assets of the Institute;

(*e*) review regularly the structure of the Institute, the staffing levels, emoluments and terms and conditions of the members of staff of the Institute;

(*f*) appoint senior management staff;

(*g*) monitory the performance of the Institute;

(*h*) consider and advise the Minister on matters relating to public health as the Board may, from time to time, consider appropriate or which may be referred to it by the Minister; and

(*i*) perform such functions as may be necessary for the achievement of the objectives of the Institute.

Tenure of office

12.—(1) A member of the Board, other than an ex-officio member, shall hold office for a period of three years and shall be eligible for re-appointment for one final term of three years.

(2) When making an appointment after expiry of three years, the Minister shall have regard to the need for continuity in the membership of the Board so that at least half of the appointed members shall be re-appointed for the next term of office.

Vacancy

13.—(1) A vacancy in the office of a member of the Board shall occur, if the member—

(*a*) dies;

(*b*) is adjudged or declared bankrupt;

(*c*) is convicted of an offence and sentenced under any written law for an offence to a term of imprisonment without the option of a fine;

(*d*) fails, without good and justifiable cause, to attend three consecutive meetings of the Board of which he has notice;

(*e*) is certified by a medical practitioner to be incapacitated by reason of physical or mental illness;

(*f*) is removed by the Minister, in accordance with subsection (3); or

(*g*) is in a situation that had it arisen before the person was appointed, it would have disqualified him from being appointed as a member of the Board.

(2) A member of the Board, other than an *ex-officio* member, may at any time resign his office by giving one month written notice to the Chairperson who shall then forward the resignation to the Minister.

(3) The Minister may remove any member of the Board or an entire Board, except an *ex-officio* member, on any of the following grounds—

(*a*) misconduct or misbehaviour that brings the office of the member into disrepute;

(*b*) incompetence in the execution of the function of his office as a member of the Board;

(*c*) in circumstances where the member is compromised to the extent that his ability to impartially and effectively exercise the duties of his office is seriously in question.

(4) Notwithstanding subsection (3), before a member is removed from office, he shall be given an opportunity to be heard.

(5) A vacancy in the membership of the Board shall be filled by the Minister within twenty-eight days.

(6) A person appointed to fill a vacancy shall serve for the remainder of the term but the period served by a person appointed under subsection (5) shall not be regarded as a term for the purposes of section 9.

(7) A vacancy in the membership of the Board shall not affect its decisions, the performance of its functions or the exercise of its powers under this Act or any other written law.

Honoraria, etc.

14.—(1) Members of the Board and of its committees shall be paid such honoraria and other allowances as the Minister shall from time to time determine.

(2) The Board may make provisions for reimbursement of any reasonable expenses incurred by a member of the Board or a member of a committee or a person invited under section 7(5) in connection with the business of the Institute.

Meetings

15.—(1) The Board shall meet at least once every three months.

(2) The Chairperson shall convene ordinary meetings of the Board by giving members not less than fourteen days written notice and may, on his own motion, convene an extraordinary meeting of the Board at a place and time as he may determine.

(3) The Chairperson or in his absence, the Vice Chairperson shall at the written request of a simple majority of members call for an extraordinary meeting of the Board, at any place and time as determined.

(4) An extraordinary meeting of the Board shall be held within seven days of a request for the meting

(5) A quorum for a meeting of the Board shall be formed by five members

(6) The Chairperson or, in his absence, the Vice Chairperson shall preside at meetings of the Board.

(7) The members present and forming a quorum shall, in the absence of both the Chairperson and the Vice Chairperson, elect one of their number to preside over such meeting.

(8) The member so elected shall exercise all the powers and perform all the duties of the Chairperson.

(9) A decision of the Board shall, at any meeting of the Board, be that of the majority of the members present and voting.

(10) The person presiding over a meeting of the Board shall, in the event of an equality of votes, have a casting vote in addition to a deliberative vote.

(11) The Board or a committee shall, as the case may be, confirm the minutes at the subsequent meeting.

(12) The Board may, subject to the provisions of this Act, make rules to regulate the conduct of its proceedings and business or the proceedings and business of any of its committees.

Personal attendance of meetings

16.—(1) A member of the Board or committee shall not attend a meeting of the Board or committee by proxy.

(2) Where a member of the Board or a committee is unable to attend a meeting, he may request that his apologies for failure to attend be recorded.

Committees

17.—(1) The Board may, for the better carrying into effect of its functions, establish committees necessary to perform such functions and responsibilities as the Board may deem fit.

(2) A committee may consist of either members of the Board only or members of the Board and such other suitably qualified persons other than members of staff of the Institute as the Board may deem fit.

(3) The Chairperson of the Board shall appoint the chairperson and vice chairperson of each committee from among the members of the Board.

(4) The provisions of this Act relating to the meeting of members of the Board shall apply with necessary modifications to the meetings of its committee.

(5) Every committee shall act in accordance with any directions given to the committee in writing by the Board.

Disclosure of interest

18.—(1) If a member of the Board or a committee is present at a meeting of the Board or a committee at which any matter which is the subject of consideration is a matter in which that member or his immediate family member or his professional or business partner is directly or indirectly interested, he shall, as soon as practicable, after the commencement of the meeting, disclose his interest.

(2) The member shall not take part in any consideration or discussion of, or vote on any question relating to the matter.

(3) A disclosure of interest by a member of the Board or a committee shall be recorded in the minutes of the meeting at which it is made.

Division 2 — Administration

Secretariat

19. The secretariat of the Institute shall consist of the Director General and other employees of the Institute appointed under this Part.

Director General

20.—(1) The Director General shall be appointed by the Board in an open and competitive process on terms and conditions as the Board may determine.

(2) The Director General shall, subject to the general supervision and control of the Board—

(*a*) provide technical leadership in matters of public health in the implementation of this Part:

(*b*) ensure that the Institute has information, data, statistics documents and other materials pertinent to the efficient performance by the Institute of its functions and responsibilities under this Act or any other written law;

(*c*) have custody of the common seal of the Institute;

(*d*) be in charge of day to day operations of the Institute;

(*e*) be responsible for the management of funds, property and business of the Institute;

(*f*) ensure effective administration and implementation of the provisions of this Act; and

(*g*) provide secretarial functions to the Board.

(3) A person shall not be appointed as Director General unless he—

(*a*) is a health professional with at least ten years postgraduate qualification and experience in public health specialized in epidemiology obtained subsequent to a bachelor's degree obtained from a recognized educational institution;

(*c*) does not hold a political office or is not an active member of a political party.

(4) The Director General shall be appointed for a term of three years and be eligible for re-appointment for one final term of three years.

Removal of Director General

21.—(1) The Board may remove the Director General from office on the following grounds—

(*a*) misbehaviour or misconduct that brings the office of the Director General or Institute into disrepute;

(*b*) incompetence in the execution of his functions as Director General;

(*c*) incapacity by reason of physical or mental illness as certified by a medical practitioner or medical board;

(*d*) if he is declared or adjudged bankrupt by a competent court; or

(*e*) if he is sentenced for an offence against any written law to any term of imprisonment without the option of a fine.

(2) The Director General shall not be removed from office unless he has been given an opportunity to be heard.

Other staff of the Institute

22.—(1) There shall be employed in the service of the Institute, subordinate to the Director General other staff as the Institute shall consider necessary for the exercise of its powers and performance of its duties and functions.

(2) The staff of the Institute referred to under subsection (1) shall be appointed by the Board on terms and conditions as the Board shall determine in consultation with the department responsible for human resource management and development.

(3) The Board may, by directions in writing delegate to the Director General, the appointment of members of staff of the Institute in specified junior ranks.

(4) The Director General shall, pursuant to subsection (3), report to the Board every appointment made.

(5) The Director General may, with the approval of the Chairperson, delegate senior members of staff of the Institute to act as secretary to committees of the Institute.

(6) Where, in any meeting, the deliberations of the Board or of its committees concerns the Director General or any officer of the Institute designated to attend the meeting, the Board or the committee, as the case may be, may exclude the Director General or the officer from the meeting.

Division 3—Finances

Funds of the Institute

23.—(1) The funds of the Institute shall consist of—

(*a*) sums appropriated by Parliament for the purposes of the Institute;

(*b*) sums or assets that may accrue to or vest in the Institute whether in the course of the performance by the Institute of its functions or the exercise of its powers or otherwise;

(*c*) sums or assets that may accrue to or vest in the Institute by way of grants, subsidies, bequests, donations, gifts, from the Government or any other person; and

(*d*) fees and charges for services rendered by the Institute including fees for publication.

(2) Notwithstanding subsection (1) (*c*), sums or assets received pursuant to the subsection shall not jeopardize or compromise the independence of the institute.

(3) The funds and assets of the Institute shall—

(*a*) exclusively be under the control of the Institute; and

(*b*) be utilized solely for the purposes of this Act in accordance with the written directions of the Board and for no other purpose.

(5) The Institute shall at all times comply with the provisions of the Public Audit Act, the Public Finance Management Act and the Public Procurement and Disposal of Assets Act. Cap. 37:01 Cap. 37:02 Act No. 27 of 2017

24.—(1) There is hereby established the National Public Health Emergency Fund for— Establishment of Fund

(*a*) the provision of public health emergency commodities;

(*b*) the operations of the epidemic preparedness, prevention, control and management committees, in the management of public health emergencies in their areas; and

(*c*) any other matter relating to the preparedness, prevention and mitigation of a public health emergency.

(2) The fund consists of monies that may—

(*a*) be appropriated to the Institute by Parliament for the purposes of the Fund;

(*b*) be collected from levy that the Minister responsible for finance may prescribe, in consultation with the Minister;

(*c*) be paid to the Institute by way of fees, donations and grants from any source, with the approval of the Minister;

(*d*) vest in, or accrue to, the Fund; and

(*e*) by or under any written law, be payable to the Fund.

25.—(1) The Institute shall administer and manage the funds for purposes specified under section 21 Administration and management of Fund

(2) The Board shall ensure that prudent controls are established for the Fund relating to—

(*a*) fiscal controls and accounting procedures governing the Fund;

(*b*) reporting procedures for the matters relating to the Fund; and

(*c*) investment of monies of the Fund.

(3) The Board shall cause to be kept proper books of accounts and other records relating to the Fund.

(4) The Fund shall be audited annually by the Auditor-General or an auditor appointed by the Auditor-General.

Accounting and audit

26.—(1) The Institute shall cause to be kept proper books and other records of accounts in respect of receipts and audit expenditures of the Institute in accordance with acceptable principles of accounting.

(2) The accounts of the Institute shall be liable to audit annually by the Auditor General or by independent professional auditors appointed by the Board in consultation with the Auditor General, and the expenses of the audit shall be paid out of the funds of the Institute.

Financial year of the Institute

27. The financial year of the Institute shall be the same as the financial year of the Government.

Oath of secrecy

28. Every—

(*a*) member of the Board;

(*b*) member of a committee;

(*c*) member of staff or service provider of the Institute; or

(*d*) person invited under section 7(5),

shall, upon assumption of his office before attending a meeting, take an oath of secrecy in the form set out in the Schedule to this Part and the oath shall be administered by a commissioner for oaths.

Protection from liability

29.—(1) No criminal or civil proceedings shall be brought personally against any member of the Board, a committee or staff of the Institute in respect of any act or omission done in good faith in the performance of the functions and duties under this Act.

(2) Where, in any proceedings, a question arises on whether or not an act or an omission was done in good faith in the course of carrying out the provisions of this Part, the burden of proving that the act or the omission was not done in good faith shall be on the person alleging that it was not so done.

PART IV—PREVENTION, SUPPRESSION AND NOTIFICATION OF DISEASE

Application of this Part

30.—(1) The Minister may, by notice published in the *Gazette*, declare that a disease is communicable, infectious or contagious in nature.

(2) Where a notice is published in the *Gazette* declaring a disease as communicable, infectious or contagious in nature the provisions of this Part shall apply.

Declaration of infected area and subsequent

31.—(1) The Minister—

(*a*) shall, by notice published in the *Gazette*, declare an area in which a disease that is communicable, infectious or contagious in nature has occurred as an infected area; and

(*b*) may by the same or a subsequent notice published in the *Gazette* issue orders for the control, suppression or prevention of the diseases including restrictions on movements or the evacuation of the whole or a part of the infected area.

(2) A person shall not reside, enter or carry on business within an area to which an order under subsection (1) has been issued except under an order and on conditions specified by the Minister.

(3) A person who contravenes any order issued under this section commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for three (3) months.

Stopping of vehicles

32.—(1) A medical officer, a veterinary officer, an environmental health officer, a police officer, or a person designated by the Minister, may for the purpose of medical examination and any other public health concern—

(*a*) stop a vehicle travelling in, or suspected to be travelling in or travelling to or from an infected area; and

(*b*) detain any of the persons travelling or being conveyed in or on the vehicle.

(2) A person suffering or suspected to be suffering from a communicable disease, or a corpse, or an article suspected to be capable of spreading infection may be removed from the vehicle and dealt with as prescribed.

(3) The driver of a vehicle who refuses or fails to stop when asked by any of the persons mentioned in subsection (1), commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Post-mortem examination Cap. 4:02

33. Subject to the Inquests Act, a medical officer, an authorized health officer who suspects that a person has died of a communicable disease, whether in an infected area or not, shall—

(*a*) order that the body of the deceased person be conveyed to a specified place for an examination that the medical officer or authorized health officer considers necessary; and

(*b*) notify the directorate responsible for public health services in the area or a veterinary officer as the case may be, about the suspected case.

Marking

34.— (1) A medical officer, authorized health officer or veterinary officer may place, or cause to be placed, on a house, structure or at an area where a case of a communicable disease has occurred, whether in

an infected area or not, a marking denoting the occurrence of the disease as prescribed by Regulations.

(2) The mark referred to in subsection (1) shall be kept affixed for a period that the medical officer, authorized health officer or veterinary officer considers necessary.

(3) A person who unlawfully removes or obliterates the mark commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Disinfection

35. A medical officer, veterinary officer or an authorized health officer may order the disinfection of—

(*a*) a house, structure or an area in which a case or suspected case of a communicable disease has occurred, whether in an infected area or not;

(*c*) property belonging to a person residing or being in that house, structure or area; and

(*d*) order the disinfection of the vehicle and the person inside it.

Demolition of building

36.—(1) A local government authority may, by order of the court, and subject to such compensation and ancillary order as the court may determine, cause the demolition of a house or structure whether in an infected area or not, where a case of a communicable disease has occurred and of anything in that house or building, or elsewhere which a medical officer, authorized health officer or veterinary officer considers necessary in the interest of public health.

Destruction of animals

37.—(1) A veterinary officer or an authorized health officer may by order of the court, and subject to such compensation and ancillary order as the co urt may determine order the destruction of an animal whether or not the animal is in an infected area if the officer is satisfied that the animal is likely to be an agent in the transmission of a communicable disease.

(2) A veterinary officer shall dispose of the carcass of an animal destroyed pursuant to subsection (1) in the manner specified by the court.

Declaration of place as quarantine area

38. The Minister may, by notice published in the *Gazette*—

(*a*) declare a place to be an area for purposes of quarantine; and

(*b*) provide for any matter necessary for the purposes of quarantine.

Appointment of officers

39. The Minister may, by notice published in the *Gazette*, appoint persons to be officers to enforce and carry out the provisions of this Part.

Provision of sanitary stations, anchorages

40.—(1) A local government authority shall provide appropriate equipment, houses, structures and sanitary stations for the purposes of this Part.

(2) The Minister may, by notice published in the *Gazette*, declare an area as a sanitary station or sanitary anchorage for the purposes of this Part.

Removal and isolation of infected persons

41.—(1) A medical officer or an authorized health officer may—

(*a*) cause a person suffering or suspected to be suffering from a communicable disease, whether in an infected area or not, to be removed to a health facility or designated place; and

(*b*) detain the person until the medical officer or health officer determines that the person is safe to be discharged.

(2) The State shall bear the cost of the removal of a person contemplated in subsection (1) and of his or her maintenance at the hospital or place of isolation.

Quarantine of contacts or suspects

42.—(1) A medical officer may order a person living in the same house or compound, or a person who has come into contact with another person suffering or suspected to be suffering from a communicable disease, whether in an infected area or not, to be quarantined in a designated place provided by the Government until the person is considered safe to be discharged.

(2) A person who refuses or fail without reasonable cause to comply with an order made under subsection (1) commits an offence and shall upon conviction be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment to six (6) months.

Removal and bodies of persons who have died of an infectious disease

43.—(1) A medical officer or an authorized health officer may, where he is satisfied or has reason to believe that the remains of a deceased person are likely to be an agent in the transmission of a communicable disease, whether or not the deceased person is in an infected area—

(*a*) determine the manner in which the remains of a person who has died of an infectious disease can be disposed of; or

(*b*) authorize the disposal of the remains of a deceased person in a specified manner,

(2) A person who retains a dead body—

(*a*) in contravention of subsection (1); or

(*b*) in any premises in circumstances which, in the opinion of a health officer of health, are likely to cause nuisance or endanger health,

commits an offence and shall upon conviction be liable to a fine of five million Kwacha (K5,000,000.00) and to imprisonment for five (5) years.

Notification of deaths and removal of bodies of persons dying of infectious diseases

44.—(1) An occupier of the building shall immediately notify the local authority of the death of a person who has died from an infectious disease.

(2) A local authority shall on receipt of a notice under sub-section (1) notify the nearest health officer and make the necessary arrangements pending the removal of the body and for the carrying out of thorough disinfection to prevent the spread of such disease.

(3) Any person who removes the body of a person who has died of an infectious disease or for the purpose of immediate burial commits an offence.

(4) Any person who keeps the dead body of person who has died of an infectious disease in any place other than a mortuary or other place set apart for the keeping of dead bodies, without first obtaining the permission of the local authority or a health officer commits an offence.

(5) An occupier of any premises who keeps a dead body in any room in which food is kept or prepared or eaten; or keeps a dead body for more than twenty-four hours in any room in which any person lives commits an offence.

(6) Any person who contravenes this section shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Presumption of knowledge of disease

45.—(1) A person in charge of, or attending to, or living with a person or animal suffering from a communicable disease and has reasonable cause to believe that the person or animal is suffering from a communicable disease shall report to any appropriate health authority in the area of the existence of the disease in the person or animal.

(5) A person who contravenes subsection (1) commits an offence shall, upon conviction be liable to a fine of one hundred thousand Kwacha (K100,000.00) and to imprisonment for three (3) months.

(3) Subsection (2) shall not apply where it is proved to the satisfaction of the court that the person did not have that knowledge and could not with reasonable diligence have obtained that knowledge.

Obstruction, impeding, inciting, etc.

46.— A person who, without lawful authority or excuse—

(*a*) contravenes a provision of this Part for which a punishment is not provided, or does anything which, under this Part that person ought not to do; or

(*b*) obstructs, impedes, aids or incites a person to obstruct or impede a medical officer, veterinary officer, police officer, health officer, or a person lawfully acting in the execution of a provision of this Part,

commits an offence and shall, on conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Transmission of infectious diseases

47.—(1) A person commits an offence who, having knowledge that he is suffering from a disease in a communicable form, accepts or continues in employment either as an employee or on his own account—

(*a*) in or about a factory, shop, hotel, restaurant, dwelling-house;

(*b*) in other place in any capacity entailing the care of children;

(*c*) in handling of food intended for consumption; or

(*d*) engages in handling of food utensils for use by any other person.

(2) Notwithstanding subsection (1), it shall be a defence for the person if he satisfies the court that he did not know or suspect, and did not have reasonable means of knowing or suspecting, that he was so suffering.

(3) A person who—

(*a*) while caring for children;

(*b*) in the course of handling of food intended for consumption; or

(*c*) while handling household utensils, willfully transmits a disease of a communicable form commits an offence and shall, on conviction, be liable to imprisonment for five (5) years.

(4) An employer shall ensure that a person suffering from a disease in a communicable form who, by reason of his employment is required or permitted to—

(*a*) have the care of children;

(*b*) handle food intended for consumption; or

(*c*) handle household utensils,

(*d*) does not report for work for the duration that the person has the infection.

(5) Notwithstanding subsection (4), it shall be a defence for the employer if he satisfies the court that he did not know or suspect, and did not have reasonable means of knowing or suspecting, that the person so employed by him was suffering from such disease.

(6) An employee employed in any manner set out in the preceding subsections shall communicate to the employer any certificate signed by a registered or licensed medical practitioner that serves to show that the employee is suffering from a disease in a communicable form.

(7) An employer shall, upon receipt of communication under subsection (6), grant leave of absence from work to the employee for a reasonable period to allow the employee receive treatment.

(8) Where an employer has reasonable cause to suspect that an employee is suffering from a disease in a communicable form, and the employee refuses to submit himself to medical examination, it shall be lawful for the employer summarily to dismiss the employee with payment of wages up to the date of dismissal.

Part V—Vaccination

Public vaccinators

48.—(1) For the purposes of this Part, a medical officer or licensed health professional in public service shall be a public vaccinator.

(2) The Minister may appoint a person having the necessary competence, skill and knowledge to be an assistant public vaccinator.

(3) An assistant public vaccinator shall perform the functions of a public vaccinator in accordance with the Regulations made under this Act.

Public vaccination

49.—(1) A public vaccinator shall vaccinate a person who presents himself or is presented for the purpose, or a person who is or becomes liable to be vaccinated.

(2) Subsection (1) shall not apply where vaccination would be injurious to health, or where there is satisfactory evidence that a person is already successfully vaccinated or otherwise has natural immunity to the disease.

Exemption from vaccination

50. Subject to this Part, a public vaccinator shall not vaccinate a person who produces to the public vaccinator—

(*a*) a certificate issued by a registered medical practitioner to the effect that the person named has within a prescribed period for the vaccine been successfully vaccinated; or

(*b*) a certificate issued within the prescribed period referred to in paragraph (*a*) to the effect that the person named in the certificate is medically unfit to undergo vaccination.

Compulsory vaccination

51.—(1) The Minister may, by notice published in the *Gazette*, generally or with reference to a particular district, area, or place or with respect to a particular class of persons, order the persons to whom the notice applies who do not produce satisfactory evidence of successful

vaccination, to be vaccinated by a public vaccinator, unless in the opinion of the public vaccinator, the vaccination would be injurious to health.

(2) A notice under this section may be made subject to the appropriate qualifications and exceptions as the Minister may prescribe.

Vaccination of adults

52. An adult to whom a notice made under section 50 (1) applies shall—

(*a*) attend for examination and if necessary, for vaccination, within the period and at the time and place appointed by the notice made under section 50 (1); and

(*b*) subsequently attend at the times and at the place that the public vaccinator may direct for the purpose of examination as to whether or not the vaccination has been successful, and if necessary, for re-vaccination.

Vaccination of children

53. A parent of a child to whom a notice made under section 50 (1) applies shall—

(*a*) within the stipulated period after the birth of the child and within the time appointed under section (50) (1), bring the child to a public vaccinator at the time and place appointed for examination and, if necessary, for vaccination; and

(*b*) subsequently produce the child at the times and places that the public vaccinator shall direct, for the purposes of examination as to whether or not the vaccination has been successful and, if necessary, for re-vaccination.

Examination and vaccination at point of entry

54. A public vaccinator or assistant public vaccinator may examine and vaccinate a person who arrives in the Republic who does not produce satisfactory evidence of successful vaccination.

Certificate of vaccination
First Schedule

55. A public vaccinator who has vaccinated an adult or a child, and has ascertained that the vaccination has been successfully administered, shall record the vaccination in the appropriate form and issue a certificate in the Form set out in the First Schedule or in a form prescribed for the vaccination under notice published in the *gazette*.

Prohibition of the practice of inoculation

56.—(1) The practice of inoculation is prohibited, unless it is conducted under controlled research conditions.

(2) A person who engages in a practice of inoculation, or is present at the performance of an operation of inoculation, not being under controlled research conditions, commits an offence and shall, on conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for three years.

Deceiving, misleading, obstructing public vaccinator, etc.

57. A person who—

(*a*) fails to comply with a provision of this Part for which a penalty has not been prescribed;

(*b*) deceives or misleads by a false statement or otherwise in respect of a provision of this Part; or

(*c*) obstructs a public vaccinator in the performance of his functions,

commits an offence and shall, on conviction, be liable to a fine of two million Kwacha (K2,000,000.00) and to imprisonment for three years.

Part VI—Vector Conrol

Destruction of vectors including mosquitoes

58.—(1) A local authority shall establish, whenever necessary, a vector control team for the purposes of the control of vectors of public health importance in the area of jurisdiction of the authority.

(2) A vector control team shall include—

(*a*) a medical officer;

(*b*) a veterinary officer;

(*c*) an environmental health officer or public health officer; and

(*d*) a person with knowledge and qualification in entomology

(3) A vector control team shall collaborate with the committee responsible for health in the area of jurisdiction of the authority.

(4) The team may—

(*a*) enter any premises between the hours of six o'clock in the morning and six o'clock in the evening for the purposes of vector control; and

(*b*) (i) take immediate steps or order the owner of the premises to take the necessary action to destroy vectors, including mosquitoes, found on the premises; and

(ii) render the habitat permanently unfit for the breeding of the vectors.

Protection of water receptacles

59.—(1) An owner of premises or a person in occupation of premises shall not—

(*a*) allow on the premises the presence of a receptacle for water containing mosquito larvae, or water to be kept uncovered in a receptacle that has not been emptied and cleaned to the satisfaction of the local government authority; and

(*b*) allow on the premises a preventable condition which may be favourable to the breeding of mosquitoes and other vectors.

(2) Subsection (1) shall not apply where the receptacle is properly protected to the satisfaction of the local government authority from access to mosquitoes or other vectors.

Recovery of cost

60.—(1) A local authority shall recover from the owner of premises the expenses incurred in carrying out measures in respect of premises under this Part.

(2) Where an owner of premises fails or refuses to pay expenses incurred by the local authority in carrying out a provision of this Part, the local authority shall recover the incurred expenses in a summary manner before a Court.

Penalty for refusal to comply with an order and obstruction

61. A person who—

(*a*) refuses to comply with an order made under this Part; or

(*b*) obstructs an officer empowered to carry out a provision of this Part or an act authorized by this Part,

commits an offence and shall, on conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for one (1) year and, in addition shall, for each day the offence continues, be liable to a fine of fifty thousand Kwacha (K50,000.00); or in the case of a legal person, a fine of five million Kwacha (K5,000,000.00), and in addition, shall, for each day the offence continues, be liable to a fine of one hundred thousand Kwacha (K100,000.00).

Payments to local authority Cap. 37:02

62.—(1) Subject to the Public Finance Management Act the amounts of money recovered under this Part shall be paid to the local authority of the place where the offence was committed.

(2) The amounts of money recovered shall, in addition to other resources provided by the local authority, be used for public health management in the local authority.

Application of this Part to vessels

63. This Part shall apply to vessels in the same manner as it applies to premises, with the modifications that are appropriate and necessary.

Part VII—Burial of a Dead Body

Confirmation of death

64.—(1) Every death shall be confirmed by a registered medical practitioner.

(2) A registered medical practitioner shall, where he is satisfied, that the death of any person has occurred complete a death report in the prescribed manner and state the cause death.

(3) A death report shall be completed no more than twenty-four hours after death has occurred, or earlier where if reason of a religious belief, health reasons or any other reason, burial is required to take place earlier.

(4) Where death occurs in a place other than a health care facility, a registered medical practitioner shall visit such place as soon as possible, to examine the body and confirm death.

(5) Where a person is suspected to be dead on arrival at a health care facility, the person in charge of the health care facility shall immediately notify a registered medical practitioner as the case may be, for the confirmation of such death.

(6) In this section, a registered medical practitioner means a health assistant, a nurse, a midwife, a medical assistant, clinical assistant, clinical officer or doctor.

Unlawful confirmation and burial

65.—(1) Any person who confirms death other than a person authorized under this section commits an offence, and shall upon conviction, be liable to a fine of two hundred thousand Kwacha (K200,000.00) and to imprisonment for six months.

(2) A person having charge of a place of burial, cremation or other means of disposal of human bodies who—

(*a*) buries;

(*b*) cremates;

(*c*) disposes of the body of a deceased person; or

(*d*) knowingly permits such burial, cremation or disposal,

without the confirmation specified under section 64 (1) commits an offence, and shall, upon conviction, be liable to a fine of two hundred thousand Kwacha (K200,000.00) and to imprisonment for six (6) months.

(3) It shall be a defence to an offence under subsection (2) if the death occurred in a place other than a health care facility, and no registered medical practitioner was able to visit such place to examine the body and confirm death.

Removal and burial of bodies of persons who have died of an infectious disease

66.—(1) A medical officer or an authorized health officer may, where he is satisfied or has reason to believe that the remains of a deceased person are likely to be an agent in the transmission of a communicable disease, whether or not the deceased person is in an infected area—

(*a*) determine the manner in which the remains of a person who has died of an infectious disease can be disposed of; or

(*b*) authorize the disposal of the remains of a deceased person in a specified manner.

(2) A person who retains a dead body—

(*c*) in contravention of subsection (1); or

(*d*) in any premises in circumstances which, in the opinion of a health officer of health, are likely to cause nuisance or endanger health,

commits an offence and shall upon conviction be liable to a fine of five million Kwacha (K5,000,000.00) and to imprisonment for five (5) years.

Notification of deaths and removal of bodies of persons dying of infectious diseases

67.—(1) An occupier of the building shall immediately notify the local authority of the death of a person who has died from an infectious disease.

(2) A local authority shall on receipt of a notice under sub-section (1) notify the nearest health officer and make the necessary arrangements pending the removal of the body and for the carrying out of thorough disinfection to prevent the spread of such disease.

(3) Any person who removes the body of a person who has died of an infectious disease or for the purpose of immediate burial commits an offence.

(4) Any person who keeps the dead body of person who has died of an infectious disease in any place other than a mortuary or other place set apart for the keeping of dead bodies, without first obtaining the permission of the local authority or a health officer commits an offence.

(5) An occupier of any premises who keeps a dead body in any room in which food is kept or prepared or eaten; or keeps a dead body for more than twenty-four hours in any room in which any person lives commits an offence.

(6) Any person who contravenes this section shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Regulation of cemeteries and crematoria

68.—(1) The Minister may in consultation with the Ministry responsible for Local Government make regulations for the designation and regulation of cemeteries and crematoria

(2) A local authority shall, subject to the regulations in subsection (1) be responsible for the designation and regulation of cemeteries and crematoria within its own jurisdiction;

(3) A local authority shall be responsible for the removal and burial of bodies of destitute persons and of unclaimed bodies within its area of jurisdiction.

Export of a corpse from Malawi

69.— (1) A person who intends to export any corpse from Malaŵi, shall obtain the written permission of the Minister.

(2) A person who contravenes this section shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Permit to exhume

70.— (1) Subject to this Act, a person shall not exhume a body or the remains of the body which may have been interred in any authorized cemetery or in any other cemetery, burial ground or other place without a permit.

(2) A permit under subsection (1) may be granted by the Minister on such terms and conditions as the Minister may prescribed to the legal personal representative or next of kin of the person buried, or to his or their duly authorized agent.

(3) Any person who exhumes a body or the remains of a body in contravention of this Act, or who does not comply to with the terms and conditions of the permit commits an offence and shall upon conviction be liable to a fine of two million Kwacha (K2,000,000.00) or imprisonment for two years.

Right of a coroner to order the exhumation of a body

71. Notwithstanding section 68 (1), a coroner may order the exhumation of a body or the remains of a body for the purpose of holding an inquiry into the cause of death of any person.

Exhumation needed for execution of public work etc

72.— (1) The Minister, in consultation with the Minister responsible for local government, may by Order whenever he deems it expedient for the execution of any public work or any public purpose, direct the removal of a body or the remains of a body from any grave whether in an authorized cemetery or other place.

(2) The Minister shall not make an Order under sub-section (1) unless a prior notice of six months has been published in the *Gazette*.

(3) Copies of a notice issued under sub-section (2) shall be posted at or near such grave, and shall be served on the legal personal representative or next of kin of the person buried and on the local authority of the area in which the grave is situated.

(4) The Minister shall cause proper and fitting arrangements to be made for the re-interment of a body or remains of a body removed under this section, and for the removal and re-erection of any monument, and all charges in connexion therewith shall be borne by the State.

Record of permit for exhumation

73.— (1) There shall be kept at the office of the District Commissioner or Chief Executive Officer a record of every permit

granted under section 68 (1) and of every order made under section 70 (1) other than an order made by a court.

(2) The record shall—

(*a*) contain particulars, so far as the same can be ascertained, of the race, nationality, name, sex and age of the persons buried, date of burial and of the place of original burial and re-burial or removal; and

(*b*) be open for inspection by any person during office hours.

Closing of cemeteries by Minister

74.—(1) The Minister in consultation with the Minister responsible for local government, may by Order published in the *Gazette* direct that any authorized crematorium or cemetery be closed for a period specified in such Order.

(2) A person who contravenes an Order issued under sub-section (1) shall, upon conviction, be liable to a fine of One Million Kwacha (K1,000,000.00) and to imprisonment for six (6) months.

Burial in places where cemetery or crematorium is not available

75. In a place where a cemetery or crematorium is not available, the local authority may, in consultation with a health officer permit the burial of a body to be carried out at such place and under such conditions as the local authority may determine.

Offences relating to dead bodies

76.— A person who—

(*a*) unlawfully hinders the burial of a dead body;

(*b*) without lawful authority disinters, dissects or mutilates a dead body; or

(*c*) being under a duty to cause a dead body to be buried, fails to discharge that duty,

commits an offence and shall, upon conviction, be liable to a fine of one hundred thousand Kwacha (K100,000.00) and to imprisonment for three (3) months.

Part VIII —Public Health Nuisance

Public health nuisance

77.— (1) A person shall not cause or permit to exist on land or premises owned or occupied by him, or of which he is in charge, a public health nuisance or other condition liable to be injurious or dangerous to health.

(2) A person who contravenes subsection (1) commits an offence and shall, on conviction, be liable to a fine of five million Kwacha (K5,000000.00) and to imprisonment for five (5) years. In the case of a legal person, a fine of fifty million (K50,000,000.00)

(3) The following are public health nuisances which can be offensive, injurious or dangerous to health and liable to be dealt with in the manner provided under this Part—

(*a*) any vehicle in such a state or condition as to be injurious or dangerous to health;

(*b*) any dwelling or premises which is or is constructed in a poor state or is situated in contaminated area or so dirty or so verminous or so liable to favour the spread of a notifiable infectious disease;

(*c*) a stream, pool, lagoon, ditch, gutter, watercourse, sink, cistern, sanitary convenience, urinal, cesspool, cesspit, drain, sewer, water tank, soak –away pit, septic tank, dungpit, refuse pit, dust bin, garbage receptacle, slop-tank, ashpit or manure heap so foul or in a state or so situated or constructed as to be offensive or to be likely to be injurious or dangerous to health or a collection of water which may serve as a breeding place for mosquitoes or other vectors;

(*d*) any well or other sources of water supply or cistern or other receptacle for water, whether public or private, the water from which is used or likely to be used by humans for drinking or domestic purposes or in connection with a dairy or milk-shop, or in connection with the manufacture or preparation of an article of food intended for human consumption which is polluted or otherwise liable to render the water injurious or dangerous to health;

(*e*) stable, kraal, cow-shed or other building or premises used for the keeping of animals or birds which is so constructed, situated, used or kept as to be offensive or injurious or dangerous to health;

(*f*) any carrion, offal, manure, filth, dirt, refuse, rubbish, or other matter which is offensive or which is injurious or dangerous to health placed on a street, yard, an enclosure, or open space except at the places designated by the local authority or the environmental health officer for that purpose;

(*g*) a dwelling which—

(i) is overcrowded as to be injurious or dangerous to health; or

(ii) does not conform with applicable laws in force in the area with regard to—

(*h*) air or floor space;

(*i*) lighting or ventilation;

(*j*) sanitary conveniences;

(*k*) ablution facilities;

(*l*) or cooking facilities;

(*m*) public building which is so situated, constructed, used or kept as to be unsafe or injurious or dangerous to health;

(*n*) excessive noise that infringes the right of others;

(*o*) occupied dwelling for which a proper, sufficient and wholesome water supply is not available within a reasonable distance as is under the circumstances possible to obtain;

(*p*) factory or business premises not kept in a clean state and free from offensive smells arising from a drain, sanitary convenience or urinal, or not ventilated so as to destroy or render harmless and offensive as far as practicable, gases, vapours, dust or other impurities generated, or so overcrowded or so badly lighted or ventilated as to be injurious or dangerous to the health of employees therein;

(*q*) factory or business premises causing or giving rise to smells or effluvia which are offensive or which are injurious or dangerous to health;

(*r*) an area of land kept or permitted to remain in a state as to be offensive or liable to cause a notifiable infectious, communicable or preventable disease, injury or danger to health;

(*s*) chimney, any machinery sending forth smoke in a quantity or in a manner as to be offensive or injurious or dangerous to health;

(*t*) cemetery, burial place, crematorium or place of sepulcher so situated or so crowded or otherwise so conducted as to be offensive or injurious or dangerous to health;

(*u*) any loud or an unseemly noise to the annoyance or disturbance of any other person as determined by the local authority; or

(*v*) any other condition which is offensive, injurious or dangerous to health.

Local authority to maintain cleanliness and prevent public health nuisance

78.— (1) A local authority shall take all lawful, necessary and reasonable practicable measures to—

(*a*) maintain its local authority area at all times in a clean and sanitary condition; and

(*b*) prevent the occurrence of or for remedying or causing to be remedied, a public health nuisance or condition liable to be injurious or dangerous to health.

(2) In addition to the measures in subsection (1), the local authority may take proceedings at law against a person causing or responsible for the continuance of public health nuisance or condition.

Local authority to prevent or remedy danger to health arising from unsuitable dwelling

79.— (1) A local authority shall take all lawful, necessary and reasonable practicable measures to prevent or cause to be prevented or remedied all conditions liable to be injurious or dangerous to health arising from—

(*a*) the erection of or occupation of unhealthy dwellings or premises;

(*b*) the erection of dwellings or premises on unhealthy sites or on sites of insufficient extent;

(*c*) overcrowding; or

(*d*) the construction, condition or manner of use of a factory or business premises.

(2) In addition to the measures in subsection (1), the local authority may take proceedings under the law or rules in force in its area against a person causing or responsible for the continuance of the condition.

Notice to abate nuisance

80.— (1) A local authority or health officer, if satisfied of the existence of a nuisance, may serve a notice—

(*a*) on the author of the nuisance; or

(*b*) where the author of the nuisance cannot be found, on the occupier or owner of the dwelling or premises on which the nuisance arises or continues,

requiring him to abate it within the time specified in the notice and may in the same notice, specify any work to be executed to abate or prevent a recurrence of the said nuisance.

(2) A local authority shall serve the notice on the owner, where the nuisance arises from any want or defect of a structural character.

(3) Where the dwelling or premises are unoccupied the local authority shall serve the notice to the last known address of the owner.

(4) Where the author of the nuisance cannot be found or it is clear that the nuisance does not arise or continue by the act or default or sufferance of the occupier or owner of the dwelling of premises, the local authority shall abate the nuisance and may do what is necessary to prevent the recurrence thereof.

(5) A person aggrieved by a decision of a local authority made under sub-section (3) may appeal to the Court of a Resident Magistrate.

(6) For purposes of this Part, the author of a nuisance means the person by whose act, default or sufferance the nuisance is caused, existed, exists or is continued, whether he be the owner or occupier or both owner and occupier or other person.

Local authority to execute works in certain cases

81. A local authority may execute or cause to be executed the works to remove a public health nuisance and the cost of executing the works concerned shall be a charge on the property on which the public health nuisance concerned exists, where a local authority is satisfied that the person by whose act or omission the public health nuisance arises or that the owner or occupier of the premises is not known or cannot be found.

Demolition of unfit dwellings

82.— (1) Where a public health nuisance is proved to exist with respect to a dwelling and the court is satisfied that the dwelling is—

(*a*) dilapidated;

(*b*) defectively constructed; or

(*c*) situated in a wrong place, that repairs to or alterations of the dwelling are not likely to remove the health nuisance and make the dwelling fit for human habitation, the local authority may by court order instruct the owner to demolish the dwelling and other structures on the premises and remove the materials from the site.

(2) The local authority shall give notice of not less than ninety (90) days to a person in respect of whom an order under subsection (1) has been issued.

(3) A person who fails to comply with a notice given under subsection (2) or who enters the dwelling or premises after the date determined by the court for the demolition of the dwelling, except for the purpose of demolition, commits an offence, and upon conviction is liable to a fine of fifty million Kwacha (K50,000,000.00) or to imprisonment for ten (10) years.

(4) Where a person fails to comply with an order for demolition, the local authority may—

(*a*) cause the dwelling and other structures on the premises to be demolished; and

(*b*) recover from the owner the expense incurred in doing so after deducting the net proceeds of the sale of the materials which the local authority may sell by auction.

(5) Any compensation shall not be payable by a local authority to the owner or occupier of a dwelling or other structure in respect of the demolition provided for in this section, and from the date of the demolition order, no rent shall become due or payable by or on behalf of the occupier in respect of the dwelling or structure.

Prohibition of business in noxious or offensive trade

83.—(1) A person who without lawful authority—

(*a*) carries on a business in noxious trade or offensive matter at a place or causes or permits a business in noxious or offensive matter

to continue to be conducted at any place, or keeps animals at a place that—

(i) impairs or endangers the health of the public inhabiting or using the neighbourhood of that place;

(ii) causes damage to the lands, crops, cattle, or goods of the public;

(iii) causes material interruption to the public in its lawful businesses or occupations; or

(iv) materially affects the value of the respective properties of the public; or

(*b*) pollutes or fouls the water of a well, tank, spring, reservoir, or place used or intended to be used for the supply of water for human or animal consumption, commits an offence and shall, on conviction, be liable to a fine of fifty million Kwacha (K50,000,000.00) and to imprisonment for three (3) years and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00).

Noxious trade

84.—For the purposes of this Part—

(*a*) "noxious trade" includes the carrying out of an offensive or noisy business at a place or causing or permitting offensive or noisy business to continue at a place;

(*b*) "business" includes a trade, manufacture, work or occupation carried on for gain or charity, or a continued or frequent repetition of an act or a series of acts of any kind where the prejudice or danger caused by the act or omission extends to persons inhabiting or occupying not less than three (3) houses under separate tenancies or any other place of accommodation.

Part IX—Prevention of Introduction of Disease and Control of Disease

Introduction of disease

85.— (1) The Minister may, after consultation with the Directorate of Public Health, by Order published in the *Gazette*, prohibit, restrict or regulate the immigration or importation, into Malawi, of any person, animal, article or thing likely to introduce any disease that is communicable, infectious or contagious in nature or impose restrictions or conditions as regards the examination, detention, cleansing or otherwise of any person, animal, article or thing.

(2) A person entering Malawi shall be in possession of a valid certificate of vaccination against notifiable diseases subject to the International Health Regulations, 2005 otherwise, that person shall be vaccinated on arrival.

(3) A person who contravenes or fails to comply with any order referred to in subsection (1) commits an offence and shall be liable, upon conviction to a fine of two million kwacha (K2,000,000.00) or to imprisonment for a term of one year or to both.

Production of health documents by immigrants

86.— (1) Any person entering Malawi shall, at the port of entry produce, upon demand of an immigration or health officer such health documents as the Minister may from time to time prescribe.

(2) Without prejudice to the generality of sub-section (1), the health documents shall be in respect of—

(*a*) vaccinations required of any person traveling from any prescribed country, region, or area;

(*b*) proof of tests for any disease required of a person traveling from any prescribed country, region, or area; or

(*c*) proof of vaccination against or test for any internationally prescribed disease.

Removal of infected persons

87.— (1) Where a person arriving in Malawi by any vessel, or on foot, is found to be suffering from any disease that is communicable, infectious or contagious in nature, and, in the opinion of a health officer, cannot be accommodated or cannot be nursed and treated so as to guard against the spread of the disease or to promote recovery, a health officer may order the removal of that person to a health facility or place of isolation for such period as may be necessary for the interests of the patient or to prevent the spread of infection.

(2) All expenses incurred in dealing with a person under this section shall be borne by the person and may be recovered from that person in civil proceedings.

Medical surveillance or isolation

88.— (1) Where a person arriving in Malawi by any vessel, or on foot, is believed to have been recently exposed to any disease that is communicable, infectious or contagious in nature or to be the incubation stage of any such disease, a health officer or authorized officer may—

(*a*) require that person be removed to some health facility or place of isolation until considered free from infection; or

(*b*) allow that person to proceed to his or her place of destination and there report himself or herself to a health officer or an authorized officer for medical surveillance by the health officer or the authorized officer until declared free from infection.

(2) A health officer or authorized officer shall, in each case, notify the medical practitioner of the district where the destination of the person referred to in subsection (1) (*b*) is, of the fact that that person is

believed to have been recently exposed to a disease that is communicable, infectious or contagious in nature or to be in the incubation period of such disease and has been allowed to proceed to his or her destination.

Powers of health officers

89.— (1) Any health officer or authorized officer may, at any time, board any vessel arriving within Malawi and may inspect any portion of the vessel or anything and may medically examine or cause to be medically examined, any person travelling by any vessel and require that person to answer any question for the purpose of ascertaining whether that person suffers from a disease that is communicable, infectious or contagious in nature.

(2) A person who refuses to allow a health officer or authorized officer to board any vessel or to make any inspection or medical examination referred to in subsection (1) or otherwise obstructs or hinders any officer in the execution of that person's duty, or who fails or refuses to give any information which he or she may lawfully be required to give, or who gives false or misleading information to a health officer or authorized officer knowing it to be false or misleading information, commits an offence.

(3) A person who contravenes this section commits an offence and shall, upon conviction, be liable to a fine of two million kwacha (K2,000,000.00) or to imprisonment for a term of one (1) year or to both.

Health officers to inspect vessels, etc.

90. The Minister may, when it is deemed necessary for the prevention of the spread of any disease that is communicable, infectious or contagious in nature, designate any health officer to inspect any vessel and any article or thing in the vessel and to examine any person travelling by the vessel or on foot and whether entering, leaving or travelling within Malawi.

Powers to enforce precautions

91.— (1) The Minister may, by Order published in the *Gazette*, where it is considered necessary for the purpose of preventing the introduction of a disease that is communicable, infectious or contagious in nature into Malawi—

(*a*) regulate, restrict or prohibit the entry into Malawi, at its borders or any specified part of Malawi, of any person;

(*b*) regulate, restrict or prohibit the introduction into Malawi, at its borders or any specified part of Malawi, of any animal, article or thing;

(*c*) impose requirements or conditions as regards the medical examination, detention, quarantine, cleansing, vaccination, isolation or medical surveillance or otherwise, of persons entering Malawi; or the examination, detention or cleansing or otherwise of any article

or thing introduced into Malawi, at its borders or any part of Malawi; and

(*d*) apply, with or without notification, any provisions of this Part to persons, animals, articles or things entering or introduced into, departing or removed from, Malawi by means of any vessel.

(2) A person who contravenes or fails to comply with any order issued under subsection (1) commits an offence, and shall upon conviction, be liable to a fine of one million kwacha (K1,000,000.00) or to imprisonment for one year.

Agreement with other Governments

92. The Minister may enter into agreements with any foreign country providing for the reciprocal notification of outbreaks of any disease subject to International Health Regulations, 2005 or any other matter affecting the public health relations of Malawi with other countries.

Government not liable

93. The Government of Malawi shall not be liable to pay compensation where the Minister or any authorized officer, exercises powers under this Part and by reason of the exercise of the power—

(*a*) any person, vessel, article or thing is delayed or removed or detained;

(*b*) any article or thing is damaged or destroyed; or

(*c*) any person is deprived of the use of any article or thing provided due care and reasonable precautions have been taken to avoid unnecessary delay, damage or destruction.

Part X— Environment and Waste Management

Waste disposal

94.— (1) Subject to written laws on the management of the environment in Malawi, and other applicable laws, waste shall only be disposed of at a waste disposal site, including an incinerator approved by the local authority concerned.

(2) A person who intends to operate a waste disposal site for business, household, industrial, hazardous and infectious waste shall apply for registration with the local authority concerned as contemplated under this Act.

(3) A waste disposal site shall be—

(*a*) adequately fenced off to prevent illegal entry and windblown litter; and

(*b*) kept at all times in the manner as to prevent fly breeding or any other public health risk.

(4) A person shall not burn waste in a public or private place or at a waste disposal site.

(5) A local authority shall regulate the transportation of different waste streams to the waste disposal site in accordance with the applicable laws to prevent environmental pollution and public health risks.

(6) In this section, "special waste" means waste which requires special handling and treatment before it may be may be discharged into a plumbing system.

Waste collection, disposal and recycling

95. A local authority shall ensure—

(*a*) that all waste generated within its local authority area is collected, disposed of, and recycled.in accordance with the requirements of all laws governing the management of the different waste streams;

(*b*) efficient, affordable and sustainable access of the collection, disposal and recycling of waste to the community;

(*c*) for reasons of health safety and environmental protection, that waste collection is done in an appropriate manner; and

(*d*) that approved receptacles of waste shall be kept—

(i) in clean and hygienic condition to prevent the breeding of flies or any other health risk; and

(ii) in accordance with requirements of laws governing a particular waste stream.

Generation and storage of special and industrial waste, etc

96.— (1) A person, duly licensed or authorized under applicable laws, who intends to conduct on a premises activities which generate special, industrial, hazardous or infectious waste shall be registered for that purpose with the local authority concerned.

(2) A person engaged in activities contemplated in subsection (1) shall ensure that the waste generated on the premises concerned is kept and stored—

(*a*) under conditions that cause no harm to human health or damage to the environment; and

(*b*) in accordance with applicable laws.

(3) All waste contemplated in this section shall be stored in approved containers and for the maximum period determined by the authority or agency responsible for the subject waste.

(4) A generator or transporter of hazardous and infectious waste shall ensure that containers—

(*a*) are properly labeled with universal biohazard symbol signs; and

(*b*) stored in accordance with applicable laws.

97. A person who contravenes or fails to comply with this Part commits an offence, and shall upon conviction, be liable to a fine of fifty million Kwacha (MK50,000,000) or to imprisonment for ten (10) years. Offences relating to this Part

Part XI—Hospitality, Public Convenience, and Public Gatherings

98.— (1) A local authority shall ensure that adequate and suitable public sanitary convenience for males and females are provided at convenient locations and are properly maintained. Public sanitary convenience

(2) The provision of public sanitary conveniences under sub-section (1) shall take into account the peculiar needs of males, females, and persons with disabilities.

(3) For purposes of this Part, "public convenience" means a sanitary convenience to which any person ordinarily has access, whether upon being required to pay a fee or not.

99.— (1) Where it appears to the local authority that any building, public facility or part thereof is not having or is without sufficient and adequate sanitary conveniences, the local authority shall, by notice in writing require the owner of the building or facility to provide the building or any part thereof with such number of sanitary conveniences as may be necessary for the persons using the building or facility, within such period as may be specified in the notice. Power of a local authority to order provision of public sanitary conveniences

(2) Any person who fails to comply with the notice under subsection (1) commits an offence and shall, upon conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00) or to imprisonment for a term of three (3) years.

(3) In case of a legal person to a fine of five million Kwacha (K5,000,000.00), and fifty thousand Kwacha (K50,000.00) for each day the non-compliance continues.

100.— (1) Where it appears to the local authority that any sanitary convenience provided for or in connection with a building or part thereof is defective or in a condition that is prejudicial to health or a nuisance and it cannot without reconstruction be put into a satisfactory condition, the local authority shall, by notice in writing, require the owner or occupier of the building to execute such works or to take such steps as may be necessary to remedy the defects within such period as may be specified in the notice. Cleaning and maintenance of sanitary conveniences

(2) Any person who fails to comply with the notice under subsection (1) commits an offence and shall, upon conviction, be liable to a fine of five hundred thousand Kwacha (K500,000.00), and twenty thousand

Kwacha (K20,000.00) for each day the non-compliance continues or to imprisonment for a term of three (3) years.

Public gathering

101.—(1) A person shall not organize or host a gathering at a public place unless there is adequate provision of safe water, first aid facilities, toilets and sanitary facilities at the place.

(2) Where organizers of a public gathering referred to under subsection (1) cannot provide services or facilities to satisfy requirements of public health considerations, the local authority concerned may make provision for such amenities at a cost to the organizers.

(3) A local authority shall not issue a permit or license to an operator of a place for public gatherings unless the local authority is satisfied that the place has sufficient sanitary facilities relative to the population capacity of the place.

(4) The Minister may, where there is a public health threat either at national level or in a given locality, and upon advice from health authorities issue an order or a notice in the *gazette* regulating public gatherings in public or private places.

(5) All persons at a public gathering referred to under this section shall at all times adhere to the measures to combat, prevent and suppress the spread of infectious diseases as specified in or under regulations, an order or notice issued under this Act or any other written law.

(6) A person who fails to comply with the provisions of this section, commits an offence and shall, upon conviction, be liable to a fine of one million Kwacha (K1,000,000.00) and imprisonment for two (2) years.

Part XII—Food

Certification of food

102. A person shall not manufacture, import, export, distribute, sell or supply food or expose food for sale unless the food has been certified by the Malawi Bureau of Standards.

Prohibited acts

103.— (1) A person who sells or offers for sale food that—

(*a*) has in or on it a poisonous or harmful substance;

(*b*) is unwholesome or unfit for human or animal consumption;

(*c*) consists in whole or in part of a filthy, putrid, rotten, decomposed or diseased animal or vegetable substance;

(*d*) is adulterated;

(*e*) is injurious to health; or

(*f*) is not of the nature, substance, quality or prescribed standards, commits an offence.

(2) For the purposes of subsection (1), food is adulterated if—

(*a*) a constituent of the food has in whole or in part been omitted or abstracted;

(*b*) a damage to or the poor quality of the food has been concealed in any manner;

(*c*) a substance of the food has been substituted wholly or in part;

(*d*) a substance has been added to, mixed or packed with, the food to increase its bulk or weight or reduce its quality or strength or to make it appear better or of greater value than it is;

(*e*) it contains an additive not expressly permitted by the Malawi Standards;

(*f*) a constituent of the food exceeds the amount stated on the label or permitted in the Malawi Standards; or

(*g*) its nature, substance and quality has been affected to its detriment.

(3) In this section, "constituent" means substances that provide nourishment essential for the maintenance of life and for growth which include carbohydrates, proteins, fats, vitamins, minerals, fiber and water

(4) A person who sells, prepares, packages, conveys, stores or displays for sale food under insanitary conditions commits an offence.

(5) A person shall store or convey food in a manner that preserves its safety, composition, quality and purity and minimizes the dissipation of its nutritive properties from climatic and other deteriorating conditions.

(6) A person who—

(*a*) sells, offers or exposes for sale, or has in possession for sale; or

(*b*) deposits with or consigns to a person for the purposes of sale, food intended for but unfit for human or animal consumption commits an offence.

(7) A person who instructs another person to sell, offer or expose for sale, food intended for but unfit for human or animal consumption commits an offence.

(8) Where a person is charged with an offence under subsection 6, it shall be a defence if the person satisfies the court that—

(*a*) notice was given to the person to whom the food was sold, deposited or consigned;

(*b*) the food in question was not intended for human or animal consumption; or

(*c*) at the time when the person delivered or dispatched the food to that person—

(i) it was fit for human or animal consumption; or

(ii) the person did not know or could not, with reasonable diligence, have ascertained that the food was unfit for human or animal consumption.

(9) A person convicted of an offence under this section shall be liable to a fine of two million Kwacha (K2, 000,000.00) and to imprisonment for four (4) years.

Enforcement of Public Health Standards

104. The Minister may in consultation with the Malawi Bureau of Standards, or other bodies responsible for enforcing standards, in the interest of public health designate inspectors and auditors of food whether manufactured, imported, exported, distributed, sold, supplied or otherwise.

General penalty

105.— (1) A person who commits an offence under this Part, for which a penalty has not been specified shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000.00) and imprisonment for five (5) years.

(2) In proceedings for an offence under a provision of a section referred to in subsection (1), in respect of food containing an extraneous matter, unless the presence of the extraneous matter has rendered the food injurious to health, it shall be a defence if the accused satisfies the court that the presence of the matter was an unavoidable consequence and forms part of the process of preparation or collection of the food.

Construction and regulation of buildings used for the storage of foodstuffs

106.— (1) A person who constructs a warehouse or building of whatever nature for the storage of food stuffs or trade purposes shall use such material and construct in such a manner prescribed by a local authority, as shall protect the warehouse or building from pollution, vermin, rodents or insects.

(2) Where any warehouse or building intended for the storage of foodstuffs as foresaid has fallen into a state of disrepair, or does not afford sufficient protection on account of its design or construction or by reason of the materials used being defective, a local authority may by written notice require the owner or occupier to effect such repairs and alterations as the notice shall prescribe within a time to be specified in the said notice, and where the owner or occupier does not comply

with such requirement, the local authority may enter upon the premises and effect such repairs and alterations, and may recover all costs and expenses incurred from the owner.

(3) Where in the opinion of a health officer any foodstuffs referred to in sub-section (1) within a warehouse or building are insufficiently protected against pollution, vermin, rodents or insects, the health officer shall issue a notice to the owner or occupier thereof who shall observe all written instructions and directions of the health officer within a time to be specified in the notice for the better protection of the same.

(4) A person upon whom a notice is served pursuant to sub-section (3), and fails to comply commits an offence, and shall upon conviction, be liable to a fine of two million kwacha (K2,000,000.00), and imprisonment for two (2) years.

(5) The Court may in its discretion acquit a person accused of an offence under sub-section (4), where the Court is satisfied that all reasonable steps were taken to secure such warehouse or building from pollution, vermin, rodents or insects having regard to all the circumstances of the case.

Residing or sleeping in any room in which foodstuffs are stored prohibited

107.— (1) A person shall not reside or sleep in any kitchen or room in which foodstuffs are prepared or stored for sale.

(2) Where it appears to a health officer that any kitchen or room is being used contrary to this section, or that any part of the premises adjoining the room in which foodstuffs are stored or exposed for sale is being used as a sleeping apartment under such circumstances that the foodstuffs are likely to be contaminated or made unwholesome, he may serve upon the occupier or upon the owner of the house or upon both a notice calling for such measures to be taken as shall prevent the improper use of such kitchen and premises within a time to be specified in the notice.

(3) Where the notice in sub-section (2) is not complied with, the owner or occupier as the case may be, commits an offence and shall upon conviction be liable to a fine of two million Kwacha (K2,000,000.00) and to imprisonment for one year.

Medical examination of food handlers

108.— (1) Any person who handles food intended for human consumption, including the care of children at a public facility shall, undergo medical examination at regular intervals of every six (6) months.

(2) An employer shall ensure that any food handler under subsection (1) undergoes regular medical examination.

(3) A person who contravenes this section commits an offence and shall, on conviction, be liable to—

(*a*) a fine of five hundred thousand Kwacha (K500,000.00) and to imprisonment for one (1) year; and

(*b*) in case of a legal person to a fine of five million Kwacha (K5,000,000.00).

PART XIII— CONTROL OF CONSUMPTION OF TOBACCO

Prohibition of smoking in public places

109.— A person who, except in a designated area—

(*a*) smokes tobacco or a tobacco product; or

(*b*) holds a lighted tobacco product, in an enclosed or indoor area of a work place or in a public place, commits an offence.

Minimum age restrictions

110.— (1) A person who—

(*a*) sells or offers for sale tobacco or a tobacco product to a child;

(*b*) sends a child to sell or buy tobacco or a tobacco product;

(*c*) requests a child to light tobacco or a tobacco product; or

(*d*) exposes a child to tobacco or a tobacco product, commits an offence.

(2) Where a person who sells or offers for sale tobacco or a tobacco product is in doubt about the age of a purchaser of tobacco or a tobacco product, the person shall demand a valid picture identification document from the purchaser as a proof of age.

(3) Person shall not sell tobacco or a tobacco product to a purchaser unless the document referred to in subsection (2) offers adequate evidence of age.

(4) A valid picture identification document includes—

(*a*) a passport;

(*b*) a driving licence;

(*c*) a national identity card; and

(*d*) any other documentation that may be prescribed by the Minister.

(5) It shall not be a defence for an accused person charged with an offence under this section to prove that the person concerned did not appear to be less than eighteen (18) years of age.

Penalties for offences under this Part

111.— (1) A person who contravenes a provision under this Part commits an offence and shall, on conviction, be liable to—

(*a*) in the case of an individual, a fine of one million five hundred thousand Kwacha (K1,500,000.00) and to imprisonment for three

(*b*) years and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00); and

(*b*) in the case of a legal person, a fine of three million Kwacha (K3,000,000.00) and, in addition shall, for each day the offence continues, be liable to a fine of twenty thousand Kwacha (K20,000.00).

(2) Notwithstanding subsection (1), a person shall not be convicted of an offence if the person satisfies the court that the offence was committed without the knowledge or consent of that person, or that the person took the necessary steps, having regard to the circumstances, to prevent the commission of the offence.

Regulations on control of tobacco abuse

112.— (1) The Minister may make regulations under this Part for the better carrying into effect the objective of control of tobacco abuse.

(2) Without prejudice to the generality of subsection (1), the regulations may provide for—

(*a*) advertisement of tobacco and tobacco products;

(*b*) tobacco sponsorship;

(*c*) promotion of tobacco and tobacco products;

(*d*) tobacco packaging and labeling;

(*e*) health warning on tobacco package;

(*f*) point of sale health warning;

(*g*) public education against tobacco use;

(*h*) treatment of tobacco addiction;

(*i*) prohibition of sale of tobacco in certain places;

(*j*) tobacco inspectors and analysts; and

(*k*) testing of tobacco and tobacco products.

(3) Notwithstanding section 21 (*e*) of the General Interpretation Act, regulations made under this Part may stipulate a fine of up to three million for Kwacha (K3,000,000.00) and imprisonment for two (2) years.

(4) In this section a "desigrated area" means an area set aside for smoking in a work place or a public place specified and designated in a manner to prevent smoke from spreading to a non-smoking area.

Part XIV—Clinical Trials

Ethics Approval of Biomedical Research Involving Human Subjects

113.— (1) Any form of biomedical research protocols which involves human research participants to be conducted in Malaŵi shall conform to research ethics principles or Respect for persons, Beneficence and Justice.

(2) Without prejudice to the generality of subsection (1), any form of biomedical research conducted in Malaŵi which involves the participation of humans shall,

(*a*) be relevant both to the overall health and developmental needs of the people of the Republic and the individual needs of those who suffer from the disease and or concerns of the study;

(*b*) have a valid scientific methodology and a high probability providing answers for the specific research questions that are posed;

(*c*) be managed and conducted by a suitably qualified principal investigator and co-investigator in the field of biomedical research;

(*d*) ensure that research participants are well informed to make informed choices;

(*e*) ensure that participants' right to privacy and confidentiality are protected;

(*f*) ensure that selection, recruitment and inclusion or exclusion of research participants in research project are just and fair;

(*g*) be preceded by a risk-benefit analysis; or

(*h*) undergo independent review and ethics clearance by a recognised and accredited research ethics committee.

(*i*) commence implementation of biomedical research protocal only after obtaining research ethics approval from a reconized and accredited research ethics committee.

Ethics Approval of Research Involving Animal subjects

114. Any form of research which involves animals to be conducted in Malaŵi shall conform to research ethic principles of Compassion for animals.

(*a*) the National Animal Research Ethics Committee shall approve research involving animals as subject.

(*b*) ethical approval of research involving animals as subject shall be granted by the animal research ethics committee.

Part XV—Public Health Emergency

Declaration of public health emergency

115.— (1) The Minister may declare a public health emergency by notice published in the *Gazette* where there is a situation that poses an immediate risk to health, life, property or the environment and may, in the same notice, prescribe preventive measures.

(2) To meet the criteria for a public health emergency, the incident should—

(*a*) immediately threaten life, health, property or the environment;

(*b*) have already caused loss of life, detriment to health, damage to property or the environment; or

(*c*) have a high probability of escalating to cause immediate danger to life, health, property and the environment.

Emergency powers in respect of public health matters

116.— (1) The Minister may direct a public health official or other authorised officers to respond immediately to a public health emergency;

(2) The officers in subsection (1) shall have the power to enforce preventive measures prescribed under a notice in section 119 (1) or order an individual to be isolated or quarantined.

(3) A public health officer or authorized officer under subsection (1) may act outside his normal area of operation.

Power of entry for vaccination

117.— (1) In a public health emergency, a public vaccinator may—

(*a*) enter a house, yard, compound, building or structure in an area prescribed by notice and inspect a person found in that place on any day, or as agreed between the public vaccinator and the community leaders; and

(*b*) vaccinate the person unless satisfied that the person is already successfully vaccinated, otherwise has natural immunity to the disease or the vaccination would be injurious to health.

Part XVI—Miscellaneous Provisions

Regulations by Minister

118.— (1) The Minister may, on the recommendation of the Institute, and in consultation with a relevant Ministry, department, agency, or other public institution dealing with matters relating to public health, make regulations for the better carrying out of this Act and, without prejudice to the generality of the foregoing, such regulations may provide for—

(*a*) the form and mode of service or delivery of notice of communicable diseases;

(*b*) the control and handling of communicable disease cases;

(*c*) for the disposal or destruction of waste;

(*d*) prescribing the reporting of cases of sickness or death;

(*e*) giving effect to International Health Regulations;

(*f*) vaccination;

(*g*) disease prevention, notification and surveillance;

(*h*) sale of meat for human consumption; and

(*i*) generally for carrying into effect the provisions of this Act.

(2) Notwithstanding section 21 (*e*) of the General Interpretation Act, regulations made pursuant to this section may prescribe a penalty of a fine not exceeding two million Kwacha (K2,000,000.00) and imprisonment for two (2) years.

Application of International Health Regulations

119. International Health Regulations (2005) and as amended from time to time shall form part of the law on public health in Malawi and shall come into effect by notice published in the *Gazette*

Emergency treatment

120.— (1) A health care provider, public or private health worker or health establishment shall provide emergency treatment to any person requiring such service.

(2) For the purposes of this section, emergency treatment means medical treatment of sudden and life threatening bodily injuries and illnesses.

Consent to medical treatment for child

121.— (1) Where a medical officer determines that a child requires a medical procedure or treatment or surgical treatment, the following persons may grant consent for the medical procedure or treatment or surgical operation to be undertaken on the child—

(*a*) the parent or guardian of the child; or

(*b*) where the child is in an emergency or where a parent or guardian—

(i) is not present or cannot be readily traced or is deceased;

(ii) unreasonably refuses to give consent; or

(iii) for good and justifiable reasons, is incapable of doing so,

the hospital administrator or a person in charge of the hospital in the absence of the hospital administrator shall sign as a guardian ad litem.

(2) Where the hospital administrator gives or withholds consent for medical procedure or treatment or surgical operation to be undertaken on a child, the hospital administrator shall sign the consent certificate and explain the reasons thereof.

Consent to medical treatment for adult

122.— (1) A health service may not be provided to a client without the informed consent of the client , unless—

(*a*) the client is unable to give informed consent and such consent is given in writing by a person—

(i) mandated by the client in writing to grant consent on his behalf; or

(ii) authorized to give such consent in terms of any law or court order;

(*b*) the client is unable to give informed consent and no person is mandated or authorized to give such consent, in which case, such consent may be given by a spouse of the client or, in the absence of such spouse, a parent, grandparent, an adult child or a brother or sister of the client;

(*c*) the provision of a health service without informed consent is authorized under any law or a court order;

(*d*) failure to treat or provide a health service to the client, or group of people which include the client, will result in a serious risk to public health; or

(*e*) any delay in the provision of the health service to the client might result in his death or irreversible damage to his health and the client has not expressly, implicitly or by conduct refused that service.

(2) A health care provider shall take all reasonable steps to obtain the informed consent of the client.

Confidentiality

123.— (1) Information concerning a client including information relating to his health status, treatment or stay in a health establishment, is confidential.

(2) Subject to section 128, a health service provider shall not disclose any information contemplated in subsection (1) unless—

(*a*) the client consents to that disclosure in writing;

(*b*) a court order or any law requires that disclosure;

(*c*) non-disclosure of the information represents a serious threat to public health; or

(*d*) the information is needed for research or clinical purposes.

Access to health records

124.— (1) A health worker or a health service provider that has access to the health record of a client may disclose such personal information to any other person, health service provider or health establishment as is necessary for a legitimate purpose within the ordinary course and scope of his duties where such access or disclosure is in the interests of the client.

(2) For purposes of this section, "personal information" means factual or subjective information, whether recorded or not, about an identifiable individual.

Patient's charter, *Second Schedule*

125. The principles contained in the Second Schedule shall apply to all persons who relate to patients or clients.

Prohibition of reproductive cloning of human beings

126.— (1) A person who—

(*a*) manipulates any genetic material, including genetic material of human gametes, zygotes or embryos; or

(*b*) engages in any activity, including nuclear transfer or embryo splitting, for purposes of reproductive cloning of a human being,

commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha and to imprisonment for five years. In case of a legal person, a fine o two hundred million kwacha and revocation of their Material Transfer Certificate.

(2) The Minister may, under such conditions as may be prescribed permit—

(*a*) therapeutic cloning utilising adult or umbilical cord stem cells; or

(*b*) research on stem cells and zygotes which are not more than fourteen (14) days old on a written application and if—

(i) the applicant undertakes to document the research for record purposes; and

(ii) prior consent is obtained from the donor of such stem cells or zygotes.

(3) A person who imports or exports human zygotes or embryos without the prior written approval of the Minister commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000) and to imprisonment for five years

(4) In case of a legal person, a fine of two hundred thousand Kwacha (K200,000,000.00), and revocation of their Material Transfer Certificate.

(5) For the purposes of this section—

(*a*) "reproductive cloning of a human being" means the manipulation of genetic material in order to achieve the reproduction of a human being and includes nuclear transfer or embryo splitting for such purpose; and

(*b*) "therapeutic cloning" means the manipulation of genetic material from either adult, zygotic or embryonic cells in order to alter, for therapeutic purposes, the function of cells or tissues.

Multi-sectoral collaboration and coordination

127. The Minister shall in consultation with public institutions dealing with matters relating to public health put in place measures as shall allow for collaboration and coordination among the institutions for the better carrying into effect the objects of this Act

Powers and duties of the officers of the Ministry of Health

128. Any duties imposed or powers conferred by this Act on medical officers of health or health officers may be carried out or exercised by the Secretary for Health or any person designated by him for that purpose.

Provisions as to appeals against the enforcement of notices

129.— (1) A person served with a notice under this Act may appeal in the manner hereinafter provided on any of the following grounds—

(*a*) that the notice or requirement is not justified by the terms of the law under which it purports to have been given or made;

(*b*) that there has been some defect or error in, or in connexion with, the notice;

(*c*) that the works required by the notice to be executed are unreasonable in character or extent;

(*d*) that the time within which the works are to be executed is not reasonably sufficient for the purpose; or

(*e*) that the notice might lawfully have been served on the occupier of the premises in question instead of on the owner, or on the owner instead of on the occupier, and that it would have been equitable for it to have been so served.

(2) Where and in so far as an appeal under this section is based on the ground of some informality, defect or error in or in connexion with the notice, the appeal shall be dismissed, if it is shown that the informality, defect or error was not a material one.

(3) Subject to this Act, any appeal against a notice issued under this Act shall be to the court of a Resident Magistrate and shall be filed within thirty (30) days from the date of such notice.

Recovery of expenses, etc

130.— (1) Any sum which a local authority is entitled to recover under this Act and with respect to the recovery of which no other provision is made, may be recovered as a simple contract debt in any court of competent jurisdiction.

(2) The time within which summary proceedings may be taken for the recovery of any such sums shall, except where otherwise expressly provided, be reckoned from the date of the service of a demand therefor.

Penalties where not expressly provided

131. Any person guilty of an offence under this Act or any Regulations made hereunder, shall, if no penalty is expressly provided for such offence, be liable to a fine of two million Kwacha (K2,000,000.00) and if the offence is of a continuing nature, to a further fine of fifty thousand Kwacha (K50,000,000.00) for each day the offence continues.

Prosecution

132. Subject to the Criminal Procedure and Evidence Code a local authority may, by any of its officers or by any person generally or specially authorized in writing by such local authority, prosecute for any contravention of, offence against, or default in complying with, any provision of this Act or any Rule made or deemed to be made

hereunder, if the contravention, offence, or default is alleged to have been committed within or affects its district.

Power of local authority outside its district

133. Nothing in any law specially governing any local authority shall be construed as preventing such local authority from exercising any power or performing any duty under this Act by reason only that in exercising such power or performing such duty it must do some act or thing or incur expenditure outside its district.

Non-communicable diseases

134. The Ministry responsible for health shall educate the public on non-communicable diseases and provide facilities for screening, early detection and management of non-communicable diseases and for the promotion of public health.

Protection from liability

135.— (1) A member of the Institute, local authority, an authorized officer or an employee of the Institute or local authority shall not, in his personal capacity, be liable in civil or criminal proceedings in respect of any act or omission done in good faith in the performance of his functions under this Act.

(2) There in any proceedings a question arises on whether or not an act or omission was done in good faith in the course of carrying out the provisions of this Act, the burden of proving that the act or omission was not done in good faith shall be on the personal alleging that it was not so done.

Part XVII—Transitional Provisions

Repeals and savings
Cap. 34:01
Cap. 34:01

136.— (1) The Public Health Act is hereby repealed.

(2) Regulations, schedules, rules, orders, proclamations, forms, notices and appointments made under the Public Health Act (now repealed) shall, in so far as they are not inconsistent with this Act, be deemed to have been made under this Act and applicable penalties for contravention of the regulations, rules, orders, proclamations and notices shall be as provided under this Act.

(3) The regulations, schedules rules, orders, proclamations, forms, notices and appointments referred to in subsection (2) shall continue in force until replaced by regulations, schedules, rules, orders, proclamations, forms, notices and appointments made under this Act.

Transfer of assets, funds and liabilities

137.— (1) The Minister may by order designate any department directorate, or unit whatsoever under the Ministry responsible for health to be a part of the Institute and, upon such designation, all property, funds and assets vested in such department, Directorate or unit shall, on commencement of this Act, be vested in the Institute.

(2) All debts, obligations, liabilities, agreements and other arrangements existing at the commencement of this Act and vested in,

acquired, incurred or entered into by or on behalf of a department, directorate, or unit referred to in subsection (1) shall, on the commencement of this Act, be deemed to have vested in or to have been acquired, incurred, or entered into by or on behalf of the Institute.

SCHEDULES

FIRST SCHEDULE

(Section 55)

CERTIFICATE OF VACCINATION

I, the undersigned, hereby certify that …… (full name), a man, woman, boy, girl of the apparent age of ..… years, a resident of …… (Physical Address) was successfully vaccinated against …….....……. by me at ……..… (Exact place e.g. name of hospital) in the District of … ……. on the …… day of .....20....

Official Stamp

.....
Signature
Public Vaccinator

SECOND SCHEDULE

(*Section 125*)

PATIENT'S CHARTER

The Ministry of Health is for all people living in Malaŵi irrespective of age, sex, ethnic background or religion.

The Ministry requires collaboration between health workers, patients, clients and society. The attainment of optimal health care is, therefore, dependent on team work. Health facilities should provide for and respect the rights and responsibilities of patients, clients, families, health workers and other health care providers. The health facilities should be sensitive to the socio-cultural and religious backgrounds, age, gender and any other differences of the patient; and the needs of patients with disabilities. The Ministry expects health care institutions to adopt the Patient's Charter to ensure that health personnel as well as patients, clients and their families understand their rights and responsibilities.

This Charter is made to protect the rights of the patient generally. It addresses:

5. the right of the individual to an easily accessible, equitable and comprehensive health care of the highest quality within the resources of the country;
6. respect for the patient as an individual with a right of choice in respect of health care plans;
7. the right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability; and
8. the responsibility of the patient or client for personal and communal health through preventive, promotive and simple curative strategies.

RIGHTS OF THE PATIENT

15. The patient has the right to quality basic health care irrespective of the patient's geographical location.
16. The patient is entitled to full information on the patient's condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
17. The patient is entitled to know of the alternative treatments and other health care providers within the Ministry if these may contribute to improved outcomes.
18. The patient has the right to know the identity of the caregivers and any other persons who may handle the patient including students, trainees and ancillary workers.
19. The patient has the right to consent or decide to participate in a proposed research study involving the patient after a full explanation has been given; and the patient may withdraw at any stage of the research project.
20. A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.
21. The patient has the right to privacy during consultation, examination and treatment and in cases where it is necessary to use the notes of the patient's case for teaching and conferences, the consent of the patient must be sought.
22. The patient is entitled to confidentiality of information obtained about the patient and that information shall not be disclosed to third party without the consent of the patient or the person entitled to act on the consent of the patient or the person entitled to act on behalf of the patient except where the information is required by law or is in the public interest.

23. The patient is entitled to the relevant information regarding policies and regulation of the health facilities that the patient attends.
24. Procedures for complaints, disputes and conflict resolution shall be explained to patients or their accredited representatives.
25. Hospital charges, mode of payment and the forms of anticipated expenditure shall be explained to the patient prior to treatment.
26. Exemption facilities shall be made known to the patient.
27. The patient is entitled to personal safety and reasonable security of property within the confines of the institution.
28. The patient has the right to a second medical opinion if the patient so desires.

RESPONSIBILITIES OF THE PATIENT

The patient should understand the responsibilities of the patient as regard the patient's own health and therefore co-operate fully with the health care providers. The patient is responsible for:

(*a*) providing full and accurate medical history for diagnosis, treatment, counseling and rehabilitation purposes;

(*b*) requesting additional information or clarification regarding the patient's health or treatment, which may not have been well understood;

(*c*) complying with the prescribed treatment, reporting adverse effects and adhering to follow up requests;

(*d*) informing the healthcare providers of any anticipated problems in following prescribed treatment or advice;

(*e*) obtaining the necessary information, which has a bearing on the management and treatment including the financial implications;

(*f*) acquiring knowledge on preventive, promotive and simple curative practices and where necessary for seeking early professional help;

(*g*) maintaining safe and hygienic environment in order to promote good health;

(*h*) respecting the rights of other patients or clients and personnel in the Ministry of Health; and

(*i*) handling with care the property of the health facility.

These rights and responsibilities shall be exercised by accredited and recognized representatives on behalf of minors and patients who are unable for whatever reason to make informed decisions by themselves. In all health care activities the patient's dignity and interest must be paramount.

RIGHTS AND RESPONSIBILITIES OF HEALTH CARE WORKER

The rights of health care workers include:

(*i*) access to equipment and supplies;

(*j*) respect and dignity;

(*k*) fair working hours and adequate rest;

(*l*) occupational health and protection;

(*m*) fair administrative remedy;

(*n*) not to be unfairly discriminated against on account of health status;

(*o*) to be protected against injury or damage to the person and property. ; and

(*p*) refuse treatment to a user who is physically or verbally abusive or who sexually harasses him or her.

The responsibilities of a health care worker include:

(*e*) continuous education;

(*f*) treat patients with respect and dignity;

(*g*) discharge duties in a professional manner; and

(*h*) to prevent disease transmission.

THIRD SCHEDULE

(*Section 28*)

OATH OF SECRECY

I ……., being a member/having been employed in the service of the Institute, do hereby swear/affirm that I will freely without fear or favour, affection or ill will, discharge the functions of a member/ an employee, of the Institute, and that any matters related to such functions shall not be provided to any unauthorised person or otherwise than in the course of my duty.

SWORN at ……. this ……day of ……20…….

Signature:…….

Before ……..

Commissioner for Oaths

APPENDIX 2

ANATOMY (AMENDMENT) BILL, 20..

ANATOMY (AMENDMENT) BILL, 20..

ARRANGEMENT OF SECTIONS

SECTION

A BILL

entitled

An Act to amend the Anatomy Act

ENACTED by the Parliament of Malawi as follows:

Short title

1. This Act may be cited as the Anatomy (Amendment) Act, 20…

Amendment of section 2 of the principal Act

2. Section 2 of the principal Act is amended by inserting immediately after the definition of "examine anatomically" the following new definition ""human organ" means a group of tissues that perform a specific function or a group of functions, such as the heart, lungs, brain, eye, stomach and skin"".

Amendment of section 11 of the principal Act

3. Section 11 of the Anatomy Act is deleted and replaced by the following new section—

"Removal of tissue from bodies of living persons

11.— (1) A medical practitioner may remove tissue from the body of a living person for educational, scientific, research, therapeutic or diagnostic purposes—

(*a*) with the consent of the person, his spouse or close relative; or

(*b*) in the case of a child or a person with a mental disability, with the consent of a parent, guardian or close relative.

(2) Notwithstanding subsection (1), the close relative referred to in paragraphs (*a*) and (*b*) shall not himself be a child or a person with a mental disability.

(3) At least two (2) medical practitioners with relevant practical experience shall provide guidance concerning the removal of tissue from the body of a living person.".

Insertion of section 3A in the Principal Act

The principal Act is amended by inserting immediately after Part II the following new section 3A—

"Use of cadavers

3A.— (1) A person may donate a human body, tissue, blood or blood products of deceased persons to any prescribed institution or person for the purposes of—

(*a*) training of students in health sciences;

(*b*) the advancement of health sciences;

(*c*) therapeutic purposes, including the use of tissue in any living person; or

(*d*) the production of therapeutic, diagnostic or prophylactic substance.

(2) A person shall, for purposes of subsection (1), be issued with a donor card.

(3) The donor card issued under subsection (2) shall, specify whether the person is donating a tissue or an organ.".

APPENDIX 3

LIQUOR (AMENDMENT) BILL, 20..

LIQUOR (AMENDMENT) BILL, 20..

ARRANGEMENT OF SECTIONS

A BILL

entitled

An Act to amend the Liquor Act

ENACTED by the Parliament of Malawi as follows:

Short title

1. This Act may be cited as the Liquor (Amendment) Act, 20…

Amendment of section 71 of the principal Act

2. Section 71 of the principal Act is deleted and replaced by the following new section—

"Illegal manufacture of liquor for sale

71.—(1) Subject to provisions of this Act, a person, not being the holder of a manufacturer's licence under this Act, shall not, for purposes of sale, manufacture liquor whether by brewing, distilling, fermenting or any other process.

(2) Notwithstanding subsection (1), the provision shall not apply to a person who, being the holder of a valid liquor permit issued under Part VII, for purposes of sale, manufactures traditional beer by traditional methods in accordance with the terms and conditions of the permit.

(3) A person, being a holder of a manufacturer's licence, or of a liquor permit issued under Part VII, shall not, for purposes of sale—

(4) manufacture by any process liquor of a kind other than that which he is entitled to manufacture under the licence or permit; or

(5) manufacture liquor by any process other than that which he is entitled to use under the licence or permit.

(6) A person who contravenes this section commits an offence and shall, on conviction, be liable to—

(*a*) in the case of an individual, a fine of K10,000,000.00 and to imprisonment for five years; or

Amendment of section 74 of the principal Act

3. Section 74 of the principal Act is deleted and replaced by the following new section—

"Supply of liquor to a child

74.— (1) A licensee under a sales licence issued under this Act who supplies liquor to—

(*a*) a child, irrespective of whether the liquor is supplied for the personal use of the child or of some other person; or

(*b*) an adult for the purposes of consumption by a child,

commits an offence and shall, on conviction, be liable to a fine of K10,000,000.00 and to imprisonment for two (2) years.

(2) Notwithstanding the provisions of subsection (1), a court may, in addition to a penalty imposed on a person convicted, order revocation of a sales licence of the licensee.

Amendment of section 75 of the principal Act

4. Section 75 of the principal Act is deleted and replaced by the following new section—

"Employment of child to sell liquor

75. A licensee under this Act who employs a child—

(*a*) to sell, control or supervise the sale of, liquor on behalf of the licensee; or

(*b*) to have the custody and control of liquor on the licensed premises, on behalf of the licensee,

commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000.00) and to imprisonment for two (2) years.".

Amendment of section 78 of the principal Act

5. Section 78 of the principal Act is deleted and replaced by the following new section—

"Commercial sex workers on licensed premises

78. A licensee, under an on-licence, or a holder of a premises permit, issued pursuant to this Act, who—

(*a*) permits his licensed premises, or permitted premises, as the case may be, to be used as a brothel or as a place of habitual meeting or resort of reputed commercial sex workers or other persons for immoral purposes;

(*b*) permits, on his licensed premises, or permitted premises, as the case may be, reputed commercial sex workers or other person to engage in soliciting members of the public for immoral purposes; or

(*c*) knowingly employs a reputed commercial sex worker in and about any part of the licensed premises, or permitted premises, as the case may be, ordinarily used for the sale of liquor,

commits an offence and shall, on conviction, be liable to a fine of ten million Kwacha (K10,000,000.00) and to imprisonment for two (2) years.".

APPENDIX 4

List of workshop participants

FOCUS GROUP DISCUSSIONS

SALIMA DISTRICT FROM 13TH TO 14TH July, 2016

No.	Name of Participants	Designation	Organization and Address
1	Mr. Lyton Chinoko	Environmental Health Officer	P. O. Box 21 Salima
2	Ms. Mary Gama	Sex Worker Chairperson	Salima
3	Mr. Allan Gomani	S. Manager	Salima Council P/Bag 3, Salima
4.	Ms. Faines Chikanga	Sex Worker	Salima
5.	Mr. Harold Maloya	World Relief Coordinator	P. O. Box 247 Salima
6	Mr. Archanjel Munthali	M & E Officer	We Effect Organisation P. O. Box 224, Salima
7.	Mr. Mcderrex Chavala	District Labour Officer	P. O. Box 31 Salima
8.	Mr. Jonas H. Petros	District Labour Officer	P. O. Box 31 Salima
9.	Mr. Maxwell Bowa	Brickmaker/Nursery	P. O. Box 146, Salima
10.	Mr. Mathews Ndasowa	Manager	Exipa Fresh Food P. O. Box 192, Salima
11.	Mr. Pearson Dimba	Market Chairman	P. O. Box 77, Salima
12.	Ms. Temwapo Mzengeza	District Environmental Health Officer	P. O. Box 21, Salima
13.	Mr. George Peter Bulombola	District Information Officer	MANA P/Bag 1, Salima
14.	Mr. Howard Banda	Social Welfare Officer	P. O. Box 47, Salima
15.	Jane Chikopa	Central Region	P. O. Box 136, Salima Water Board
16.	Wezi Nyekanyeka	District Coordinator	Womens Voice P. o. Box 38, Salima
17.	Geoffry E. Kondwani	Chairman	Village Health Committee Salima

18.	Mr. Alex Gwaza	Community Policing Coordinator	MPS P. O. Box 122, Salima
19.	Mr. Enock Kachitsa	Social Welfare Assistant	P. O. Box 47, Salima
20.	Mr. Grey Chinamale	Coffin Seller	Salima
21.	Mrs. Dorothy Chatama	Central Region Water Board	P. O. Box 136, Salima
22.	Mr. Gift Chikwembeya	Coffin Seller	Salima
23.	Mrs. Takondwa Banda	Ass. Social Welfare Officer	P. O. Box 47, Salima
24.	Mr. Charles Kachingwe	DADO	Ministry of Agriculture P. O. Box 491, Salima
25.	Mr. Adamson Chiwawa	Committee Member	Village Health Committee Salima
26.	Mr. Dennis Chinula	Clinician	Banja La Mtsogolo Clinic Salima
27.	Mrs. Grace Banda	Nurse	Tachira Clinic P. O. Box 395, Salima
28.	Mr. Aubrey Nyasulu	District Education Manager	P. O. Box 85, Salima
29.	Mr. Golden Banda		Salima Town Council Box 2 Salima
30.	Mr. Robert Gondwe	Pastor	Living Waters Church P. O. Box 93, Salima

FOCU S GROUP DISCUSSION ON THE REVIEW OF PUBLIC HEALTH ACT

MWANZA DISTRICT – MWANZA HOTEL: 14TH SEPTEMBER 2016

List of Participants

No.	Name of Participants	Designation	Organization and Address
1.	Jamillah Mzembi		C/O Ntchotseni Village
2.	Mrs. Agness Mtonga	Nursing Officer	DHO P. O. Box 80, Mwanza
3.	Mr. Moses Walota	Councillor	Mwanza Council P/Bag 3, Mwanza

4.	Mr. Thomson Sikweya	Magistrate	Magistrate Court P. O. Box 49, Mwanza
5.	Mr. Clement Chilalire	HIV Diagonosis Assistant	Banja La Mtsogolo P. O. Box 106, Mwanza
7.	Mr. Innocent Chalera	GVH Nchotseni	Blantyre
8.	Mr. Patrick Mwandira	Committee Member	Mwanza Main Market P/Bag 3, Mwanza
9.	Mrs. Estele Muhoko	Committee Member	Mwanza Main Market P/Bag 3, Mwanza
10.	Mrs. Florence Chawanje	Secretary	Mwanza Main Market P/Bag 3, Mwanza
11.	Mr. Gonani Ndeketeya	Treasure	Mwanza Main Market P/Bag 3, Mwanza
12.	Widze Zalinga	Committee Member	Mwanza Main Market
13.	Mr. Alfred Mbinga	Secretary	Mwanza Main Market
14.	Pastor Dikirani Chadza	Health Promotion Officer	Mwanza District Health Office P. O. Box 80, Mwanza
15.	Mr. Kenedy Chiwaya	District Labour Officer	Ministry of Labour com P. O. Box 73, Mwanza
16.	Haneef Wisiki	Sheikh	Mwanza Central Mosque P. O. Box 70, Mwanza
17.	Mr. Joseph Chimwemwe Chiwaya	Information Officer	Ministry of Information P/Bag 3, Mwanza
18.	Rev. Hudson Saulosi	Church Pastor	P. O. Box 64, Mwanza
19.	Mr. Lottie Nduta Phiri	Coordinator	Zambezi Evangelical Faith Based Organization P/Bag 5, Mwanza
20.	Mr. Augustine Iphani	Director	Nkhwibvi Coffin Workshop
21.	Ms. Myless Mhango	Environmental Health Officer	Mwanza District Health Office P. O. Box 80, Mwanza
22.	Mr. Simeon Chidetsa	Health Worker	P. O. Box 80, Mwanza
23.	Febbie Mwelemba	Women's Organization Representative	Mwanza Parish / P. O. Box 65, Mwanza

24.	Mr. Mcwellngton Bender	Clinical Officer	Life Style PVT Clinic C/O P. O. Box 161, Mwanza
25.	Edward Jackson Chigaru	Chairperson	Kunenekude Health Centre Mwanza
26.	Ms. Ester Yuda	Social Welfare Officer	Social Welfare Office
27.	Mr. Kumbukeni Kauwa	DSWO	Social Welfare Officer P/Bag 3, Mwanza
28.	Mr. Govati	Chief	Mwanza District Council Thambani Headquarters P/Bag 3, Mwanza
29.	Mr. Allan Helix Kazembe	Acting Director of Administration	Mwanza District Council P/Bag 3, Mwanza
30.	Mr. Jack Nguluwe	DC	Mwanza Disctrict Council P/Bag 3, Mwanza
31.	Rev. A. Mangitsa	C.C.A.P	P. O. Box 54, Mwanza
32.	Mr. Steven Chimpeni	Member	Mwanza Civil Society Organization P. O. Box 180, Mwanza
33.	Mr. Martin Munduka	Director	MWASO
34.	Ms. Mariana Misi	Youth Representative	Mwanza DEMO,s Office P. O. Box 98, Mwanza
35.	Mr. Alfred Dick	Secretary	Youth Club P. O. Box 64, Mwanza
36.	Dr. Arnold Kapachika	Disrtict Medical Officer	Mwanza District Hospital P. O. Box 80, Mwanza
36.	Ms. Hana Nyanga	Chairlady	Umodzi Girls Sex Workers P. O. Box 64, Mwanza
37.	Mr. Pearson Mphangwe	District Aids Coordinator	Mwanza District Council P/Bag 3, Mwanza
38.	Mrs. Elluby Racheal Maganga	Health Specialist	UNICEF P. O. Box 30375 LILONGWE

GROUP DISCUSSION ON THE REVIEW OF PUBLIC HEALTH ACT BLANTYRE DISTRICT – LEGACY LODGE: 15TH SEPTEMBER 2016

List of Participants

No.	Name of Participants	Designation	Organization and Address
1.	Mrs. Nitta Masautso	Chairperson	FEDOMA P/Bag 67, Blantyre
2.	Chrissy Kambewa	Committee Member	Malawi Congress Party C/O Nazombe vg, Blantyre
3.	Mrs. Elizabeth Machinjiri	V. Secretary	FEDOMA P/Bag 67, Blantyre
4.	Ms. Charity Luya	Chairperson	Lunzu Youth P. O. Box 162, Lunzu
5.	Mr. Ronald Kachinga	Managing Director	Coffin Workshop P. O. Box 923, Blantyre
6	Mr. Clemence Masilika	Chairperson	Lunzu Market P. O. Box 207, Lunzu
7.	Mrs. Olive Wulera		P. O. Box 50, Blantyre
8.	Mrs. Bernadetta Maseko		P. O. Box 136, Lunzu
9.	Mr. Enock Dawadawa	Bar Attendant	Council Bar P. O. Box 32, Lunzu
10.	Mr. Lester Kacheche	Food & Nutrition Office	District Agriculture Officer P. O. Box 32, Blantyre
11.	Dr. John Pilate Kothowa	Veterinary Investigation Officer	DAHLDO Ministry of Agriculture P. O. Box 32, Blantyre
12.	Mrs. Rose Simfukwe	District Civic Education Officer	NICE P.O. Box 3449, Blantyre
13.	Mrs. Eluby Maganga	Health Specialist	UNICEF P. O. Box 30375, Lilongwe
14.	Mrs. Mary Asani	District Nursing Officer	DHO P/Bag 66, Blantyre
15.	Dr. Lilian	DMO	DHO P/Bag 66, Blantyre
16.	Anthony Mitambo	Managing Director	Coffin Workshop P. O. Box 923, Blantyre
17.	Ms. Shyreen Liwonde	Sex Worker	P. O. Box 72, Lunzu

18.	Ms. Flora James	Sex Worker	Ndilindi udindo Group P. O. Box 50, Lunzu
19.	Emily Mkwezalamba		Tikondane Club GVH Kumponda, Lunzu
20.	Mr. Tambula Tawanda	Councilor	Bt District Council P. O. Box 5, Blantyre
21.	Mr. Joseph Kankondo	Traditional Healer	
22.	Mr. James Zalirankhuku	Chairperson	Kadidi Government Health Centre
23.	Mrs. Harriet Mlambuzi	Vice Chairperson	Kadidi Government Health Centre
24.	Mr. Daniel Mataula	Planning Officer	Blantyre Agriculture Office P. O. Box 32, Blantyre
25.	Mr. Clemence Kamwendo	Manager	Hard Rock Motel P. O. Box 12, Lunzu
26.	Mr. Walasi Lewis	Chairman	Village Committee Nazombe Village T. A. Kapeni, Blantyre
27.	Mr. Witness Samson Mulole	Executive Director	Chitani Community Sustainable Dev. Organization P. O. Box 41, Lunzu
28.	Mr. Henry Tambula	Chief Executive	Phirilongwe Spices Association P. O. Box 136, Lilangwe
29.	Mr. James Chiwale PAsani	GVH PAsani	P. O. Box 1, Lunzu
30.	Bejamin R. Mponda		Lilangwe
31.	Mrs. Emily Sungeni	GVH Chiwalo	P. O. Box 16, Lunzu
32.	Mr. Thomas Simon	Pastor	Lunzu Living Waters P. O. Box 923
33.	Mrs. Agness Ngonga	Station Officer	Police P. O. Box 3, Chileka
34.	Esmie Waya Thipa		District Council P/Bag 97, Blantyre
35.	Mr. Bwanali Chimimba	Traditional Healer	Nchipera
36.	Mr. Wilson Gama		Nkhwitsa

FOCUS GROUP DISCUSSION ON THE REVIEW OF PUBLIC HEALTH ACT

MAME LODGE – MZIMBA DISTRICT: 17TH OCTOBER 2016

List of Participants

No.	Name of Participants	Designation	Organization and Address
1.	Botha Robson	Scheme Supervisor	NRWB Box 32, Mzimba
2.	Rose Tembo	Secretary	Takumanapo Sex Workers Ass. Box 132, Mzimba
3.	Valerie Longwe	Director	Mzimba business Centre Box 167, Mzimba
4.	Enallah Kamwendo	Assistant Social Welfare Officer	Mbelwa District Council P. O. Box 86, Mzimba
5.	Mrs. Lucy Muyafula		Mbelwa Disctrict Council
6.	Amin Mwamlima		Pastors Fraternal, C/O Box 134, Mzimba
7.	Jonathan Ziba	Director	Mubi Coffin Workshop Box 79, Mzimba
8.	Stanely Munthali	HTS Coordinator	Ministry of Health Box 131, Mzimba
9.	Russell Mhone	District Labour Officer	District Labour Office Box 27, Mzimba
10.	Thandie Galima	Secretary	Mzimba Youth Organization P. O. Box 20, Mzimba
11.	Jayne Mkoka	HRMO	Mzimba DHO P. O. Box 131, Mzimba
12.	Dr. Patrick Nachipo	DHO	Mzimba South DHO P. O. Box 131, Mzimba
13.	Mr. Andrew Somaliland	Environmental Health Officer	DHO P. O. Box 131, Mzimba
14.	Kondwani Ng'ambi	HTC Coordinator	Tovwirane P/Bag 20, Mzimba
15.	Geoffrey Nyirenda		P. O. Box 149, Mzimba
16.	Ruth Nyirenda		Chisengezi F. P. School P. O. Box 30, Bulala, Mzimba

17.	Paul Mwafika		Enthunzini F.P. School, Box 126, Mzimba
18.	William Mustafa	Muslim Community	Mzimba Muslim Community
19.	Henry Nkhata	Information & Civic Education	P. O. Box 139, Mzimba
20.	Gilingo Bilima	Vice Chair (Councillor)	Mabiri School, Box 7, Mabiri, Embangweni
21.	Mr. Sunday Ndolo	Administrator	Mzimba Community Radio P. O. Box 224, Mzimba
22.	George Longwe	District Magistrate	Judiciary P. o. Box 41, Mzimba
23.	Mrs. Mafunase Hara	Project Assistant	COIDA P. O. Box 58, Mzimba
24.	Themba Munthali	Clerk	TAMA Depot Mzimba
25.	Christopher Malele	Executive Director	Youthnet & Advocacy P. O. Box 139, Mzimba
26.	Absacom Chumachaazungu	Executive Director	Young Politicians Union P. O. Box 250, Mzimba
27.	Zipaly Didier Kamanga	Bar Man	Mini Café Bar P. O. Box 168, Mzimba
28.	Kampingo Siwande	T/A	Enswanzini H.Q P. O. Box 132, Mzimba
29.	Mr. Emmanuel Ng'ambi	Chairman	Mzimba Market P. O. Box 303, Mzimba

GROUP DISCUSSION ON THE REVIEW OF PUBLIC HEALTH ACT KARONGA DISTRICT – DEMOs OFFICE: 18TH AUGUST 2016

List of Participants

No.	Name of Participants	Designation	Organization and Address
1.	Mrs. Sekani Tembo	Officer In Charge	Karonga Police P. O. Box 22, Karonga
2.	Mr. Albert Dube	Senior Reserch er	MEIRU – KA Prevention Study P. O. Box 46, Chilumba Karonga

3.	Mr. Paul Chavula	AHRMO	District Hospital P/Bag 1, Karonga
4.	Mr. Mabvuto Kawonga	HRMO	Karonga DHO C/O P/Bag 1, Karonga
5.	Mr. Stephen Mkwapatira	Health Service Administrator	Karonga District Hospital P. O. Box 1, Karonga
6.	Mr. Aggrey Wazingwa Munthali	Assistant Health Service Administrator	DHO P/Bag 1, Karonga
7.	Mr. James Tembo	Director of Administrator	District Council P. O. Box 35, Karonga
8.	Mr. Dennis K. Mwafulirwa	Secretary	Tobacco Association P. O. Box 21, Nyungwe, Karonga
9.	Ms. Queen Kaira		Sex Worker
10.	Ms. Aida Mwakarogho	Member	Sex Worker
11.	Mr. Herrings Shola	Secretary	Women Collusion
12.	Mrs. Jane Mbowe	Project Coordinator	Kachila youth Innitiative P. O. Box 92, Karonga
13.	Mr. Sunduzwayo Mashunga	District Project Officer	Malawi Red Cross Society P. O. Box 137, Karonga
14.	Mr. Amin Bilali	Secretary/Sheikh	Muslim Association of Malawi P. O. Box 59, Karonga
15.	Mr. Pauper C. B. Mkandawire	DDEMO	Ministry of Education P. O. Box 37, Karonga
16.	Mr. Bernard Sichali Kanjawala	H.A.C Chairperson	Lupembe Health Centre
17.	Mr. Boyd Msiska	HCP	Kasowa V/H, Mwentanga 3
18.	Mr. Felix Saul W. Mwakyanjala	Hospital Advisory Chair	P. O. Box 256 Karonga
19.	Mr. Jonathan Katema	Manager	Tufklaghe Coffin Workshop C/O Box 101, Karonga
20.	Mr. Hensley Mdoka	Manager	Mdoka Welding Shop & Coffin P. O. Box 151, Karonga
21.	Mr. Davie Nyasulu	Child Protection Supervisor	Social Welfare P. O. Box 225, Karonga

22.	Mr. Enson Kayange	District Labour Officer	District Labour Office P. O. Box 30, Karonga
23.	Mr. Tendai Mkwinda	HRO	Ministry of Education P. O. Box 37, Karonga
24.	Mr. Cosmas Chimaliro	District Information	MANA P. O. Box 35, Karonga
25.	Mr. Wanamgwa Malaya	CT Counsellor	Banja La Mtsogolo Karonga
26.	Mr. Lupakisho Nthakomwa	Child Protection Worker	District Social Welfare Office P. O. Box 225, Karonga
27.	Mr. Aaron Mwenelupembe	District Scout Project Officer	Scouts Association of Malawi P. O. Box 37, Karonga
28.	Mr. Gedion Duncan Ntenje	Vendor	Karonga Main Market P/Bag 5, Karonga
29.	Mr. Cleanwell Chirwa	Vendors Cahirperson	Market Vendor P/Bag 5, Karonga
30.	Mr. Friday Mwausegha	Vendors Member	Vendors Committee P/Bag 5, Karonga
31.	Mr. Taonga Chawinga	Data Preparations Officer	District Council P. O. Box 35, Karonga
32.	Mr. Franklin Mtambo	HRMO	District Council P. O. Box 35, Karonga
33.	Ms. Racheal Phiri	Member	Sex worker Karonga

Regional Consultative Workshop

Central Region

Sunbird Capital Hotel, 29th May, 2018

No.	Name of Participants	Institutions
1.	Mr. Thom Chakweza	Clinic Coordinator Lighthouse Trust P. O. Box 106, Lilongwe
2.	Mrs. Mariette Kadewere	Principal Administrative Officer (DC Rep) P. O. Box 93 Lilongwe
3.	Mr. Peter Collins Kamuloni	DEHO Nkhotakota DHO P. O. Box 50, Lilongwe

4.	Dr. Gracewell Mathewe	District Health Officer P. O. Box 136, Dedza
5.	Mr. Elison Chipale	Traditional Healer Chikhutu Village, Box 19, T/A Kalumo, Ntchisi
6.	Mrs. Mdaphawachete Msanganiza	Traditional Healer T/A Kanyenda Nkhotakota
7.	Mr. Issah Muhamed	Traditional Healer P. O. Box 21, Salima
8.	Ms. Memory Chakonza	Female Sex Workers Association P. O. Box 30421, Lilongwe
9.	Mr. Lyson Makumba	Hospital Information Service Representative Association of Jehovah's Witness P. O. Box 30749, Lilongwe 3
10.	Mr. Augustine Semo	Board Member of Directors The Association of Jehovah's Witness P. O. Box 30749, Lilongwe 3
11.	Mr. William Chumbi	Board Member of Directors The Association of Jehovah's Witness P. O. Box 30749, Lilongwe 3
12.	Captain Thomson Tumpale Gondwe	Legal Officer, Malawi Defence Force P/Bag 43, Lilongwe
13.	Mr. Rapheal S. K. Mushali	Regional Prison Officer Malawi Prison Service P. O. Box 130, Lilongwe
14.	Mr. Samson Kumphale	MEHA P. O. Box 31791, Lilongwe
15.	Mr. Benson Edwinson Phiri	The Executive Director National Organization of Nurses & Midwives of Malawi P. O. 30393, Lilongwe 3
16.	Dr. Charles Mazinga	Deputy Director Ministry of Gender P/Bag 330, Lilongwe
17.	Mr. Precious Chimphangu	Deputy College Registrar Malawi College of Health Sciences P. O. Box 30368, Lilongwe
18.	Ms. Bwighane Mwenifumbo	Chief Legal Aid Advocate Women Lawyer's Association/Legal Aid Bureau P. O Box 645, Lilongwe

19.	Mrs. Constance E. P. Chisala	Social Worker Baylor College of Medicine Children's Foundation P/Bag B 397, Lilongwe
20.	Mr. Jolly Josiah Kenan	Programme Manager Water Aid P/Bag 364, Lilongwe
21.	Ms. Zinenani Mayera	Dental Therapist Bwaila District Hospital P. O. Box 1274, Lilongwe
22.	Mr. Montfort Misunje	Senior Resident Magistrate Judiciary P/Bag 15, Lilongwe
23.	Mr. Edwin Chilenje	Registration Officer Pharmacy, Medicines & Poisons Board P. O. Box 30241, Lilongwe
24.	Mrs. Malla Kawale	Administrative Director ABC Community Clinic P. O. Box 161, Lilongwe
25.	Mr. Wilson Kamboyi	Senior Clinical Officer LUANAR P. O. Box 219, Lilongwe
26.	Major Lutufyo Kayange	Public Health Officer Malawi Defence Force Kamuzu Barracks 43, Lilongwe
27.	Ms. Sungani Kamwendo	Information Officer Ministry of Information & Communication Technology P/Bag 310, Lilongwe
28.	Ms. Mervis Gonani Sibande	Programme Officer MTHUO Section Ministry of Health P. O. Box 30372, Lilongwe 3
29.	Mr. Shadreck Lupwayi	Clinical Anaesthetic Therapist Bwaila Maternity Hosp LL DHO P. O. Box 1274, Lilongwe
30.	Mr. Richard M. Ndovie	Acting Registrar Medical Council P. O. Box 30787, Lilongwe 3
31.	Mr. Chrispin Sachuluka	Judiciary P. O. Box 23, Ntcheu

32.	Mr. Sydney Paul	DEHO Dedza District Council Health P. O. Box 136, Dedza
33.	Mr. Alex Mdooko	District Commissioner Dowa District Council P/Bag 2, Dowa
34.	Mr. Lennox Charles Mwawembe	District Commissioner P/Bag 15, Salima
35.	Dr. Juliana Kanyengambeta Mubanga	AgDHSS Mchinji DHO P. O. Box 36, Mchinji
36.	Dr. Mwayi Phiri	Medical Officer Dowa District Health Officer P. O. 25, Dowa
37.	Dr. Ireen Kamlodza Zuze	Ag DHSS Kasungu DHO P. o. Box 19, Kasungu
38.	Dr. Sosten Lankhulani	DHO P. O. Box 50, Nkhotakota
39.	Mr. Emmanuel Mpoola	District Nursing Officer Mchini District Hospital P. O. Box 36, Mchinji
40.	Dr. Ivy Chilingulo	Director of District and Social Services DHO P. O. Box 55, Salima
41.	Mr. Francis Chipewa	DEHO P. O. Box 53, Salima
42.	H/W Agness Chirambo	Magistrate Judiciary P. O. Box 140, Salima
43.	Dr. Mike Chisema	DHO P/Bag 5, Ntcheu
44.	Mr. Simon Allisen Mwambo	First GradeMagistrate Judiciary Dedza
45.	Mr. William Moyo	DEHO District Health Officer P/Bag 5, Ntcheu
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50.	Mphatso Kamangira	MHEN P. O. Box 1618, Lilonwe
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52.	Mr. William Zale	Cameraman MBC P. O. Box 162, Lilongwe
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Regional Consultative Workshop – Southern Region

Sunbird Mount Soche Hotel, 11th June, 2018

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4.	Mr. Alferd Phiri	District Environmental Health Officer DHO P. O. Box 21, Thyolo

5.	Mr. Francis Mwanoka	Environmental Health Officer Mangochi District Hospital P. O. Box 42, Mangochi
6.	Mrs. Mercy Chinkhunda	District Nursing Officer Balaka District Hospital P. O. Box 138, Balaka
7.	Mr. Saulos Namani	District Education Manager Mwanza Education Office P. O. Box 98, Mwanza
8.	Dr. Ketwin Kondowe	DHO Phalombe P. O. Box 79, Phalombe
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12.	Mr. Kapalepale Banda	Traditional Healer P. O. Box 98, Neno
13.	Dr. Henry Chibowa	DHO Mangochi DHO P. O. Box 42, Mangochi
14.	Dr. Stalin Zinkanda	DHO Chikwawa District P. O. Box 32, Chikwawa
15.	Mr. Willie Jeke	Magistrate Judiciary P. O. Box 45, Neno
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19. Mr. Denson Masukwa	Zion Church Mapeto DWSM P. O. Box 30070, Blantyre 3
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26. Ms. Elizabeth Mlato	District Social Welfare Officer P. O. Box 148, Thyolo
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31. Mrs. Veronica Nkukumila	District Environmental Health officer Chikwawa District Hospital P. O. Box 32, Chikwawa
32. Mr. Thomas Mchipha	District Environmental Health Officer Balaka DHO P. O. Box 138, Balaka

33. Mr. Mathews Josani Kalaya	District Environmental Health Officer Machinga District Hospital P. O. Box 44, Machinga
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43. Mrs. Reinghard Chavula	District Commissioner Nsanje District council P/Bag 1, Nsanje
44. Mrs. Fridah Zintambila	Laboratory Manager Blantyre DHO P/Bag 66, Blantyre
45. Ms. Annie Gumulira	Senior Resident Magistrate Judiciary P/ Bag 524, Blantyre

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51. Ms. Brenda Ngalande	Female Sex Worker Rep Blantyre
52. Ms. Vynida Nyirenda	Blantyre DHO P/Bag 66, Blantyre
53. Mr. Penjani Chunda	District Environmental Health Officer DHO P/Bag 66, Blantyre
54. Mr. Paul Chiphanda	District Education Manager Blantyre District Council P/Bag 11, Lunzu
55. Dr. Andrew Gonani	Hospital Director Queen Elizabeth Hospital P. O. Box 95, Blantyre
56. Dr. Gift Kawalazira	Director of Health and Social Services Blantyre District Council P/Bag 66, Blantyre
57. Mr. Eddie Manda	Nursing Officer Blantyre DHO P. O. Box 66, Blantyre
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59. Ms. Marriam Taimu	College of Medicine P/Bag 360 Blantyre 3

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62. Ms. Hannah Kankhande	Personal Assistant FEDOMA P. O. Box 30022, Blantyre 3
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67. Mr. Lenius Tinashe Daiton	Regional Labour Officer Ministry of Labour (S) P. O. Box 110, Blantyre
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73. Mr. Alfred Guta	ZBS P/Bag 312, Blantyre

74.	Ms. Ida Kazembe	Jounalist Malawi News Agency P. O. Box 494, Blantyre
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76.	Mr. Piwayo Chilombo	Cameraman MBC
77.	Mr. George Mkandawire	MBC TV P. O. Box 30133, Blantyre 3

Regional Consultative Workshop – Northern Region

Sunbird Mzuzu Hotel, 14th June, 2018

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4.	Mr. Lloyd Magweje	Regional Prosecution Officer Northern Region Police HQs P. O. Box 16, Mzuzu
5.	Mrs. Leah Sinyiza	Senior Nursing Officer Mzimba North DHO P. O. Box 299, Mzuzu
6.	Mr. Kingsley Jonas	Midwife Mzimba North DHO C/O P. O Box 299, Mzuzu
7.	Mr. Zondiwe Banda	MHCO St. John of God Hospitaller Services P. O. Box 744 Mzuzu
8.	Mr. Joseph Phiri	Laboratory Officer Northern Region Support Office P/Bag 1, Mzuzu

9. Mr. Wisdom Ngwira	District Information Officer Ministry of Information P. O. Box 22, Mzuzu
10. Mr. Harry Chisanga	Social Welfare Officer Mzimba North DSWO P. O. Box 60, Mzuzu
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14. Mr. Allan Nyirenda	Reporter Voice of Livingstonia P. O. Box 112, Mzuzu
15. Mr. Robert Mbetewa	Reporter MIJ FM Radio P. O. Box 1142, Katoto, Mzuzu
16. Mr. Draxon Maloya	Reporter Angaliba Television/Radio
17. Mr. Kumbukani Kadiwa	MBC P. O. Box 61, Mzuzu
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20. Mr. Chilani Msukwa	Traditional Healer Kalembo F. P. School Iponga, Karonga
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22. Mr. Jositeni Zimba	Zion Church
23. Mr. Mathews Msiska	Chief Resident Mag – Representative Judiciary P. O. Box 12, Mzuzu

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26. Chikumbuso Kachipande	Magistrate, Judiciary P. O. Box 12, Mzuzu
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28. Mrs. Joyce Luhana	Social Welfare Officer DSWO P. O. Box 47, Chitipa
29. Mr. Joseph Kamwela	Midwife Karonga District Hospital P/Bag 1, Karonga
30. Dr. Wongani Mzumara	DMO Likoma DHO P. O. Box 16, Likoma
31. Mr. Radson Gamaliel	Magistrate Judiciary Karonga Magistrate Court P. O. Box 48, Karonga
32. Mr. Sam Chirwa	District Environmental Health Officer (DEHO) P. O. Box 95, Chitipa
33. Mr. Mphatso Nkosi	Registered Nurse Midwife DHO, P. O. Box 95 Chitipa
34. Mr. Owner Ngulube	District Environmental Health Officer Likoma DHO P.O. Box 16, Likoma
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42. Mcjoy Msowoya	Clinical Technician Mzuzu HLC P. O. Box 299, Mzuzu
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44. Mr. Nameson Ngwira	District Education Manager, DC Rep P/Bag 2, Likoma
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46. Dr. Alinafe Lakanga	DMO Mzimba South DHO P. O. Box 131, Mzimba
47. Dr. Mwatikonda Mike Mbendera	Ag. Director of Health & Social Services P. O. Box 4, Nkhatabay
48. Mr. Albert Dube	Senior Research Scientist Karonga Prevention Study P. O. Box 46, Chilumba, Karonga
49. Mr. George Thomson Longwe	Magistrate Judiciary P. O. Box 41, Mzimba
50. Mr. Thomson Ligowe	Judge, Judiciary P. O. Box 12, Mzuzu
51. Bonnifancio Ndovi	District Nursing Officer Nkhatabay DHO P. O. Box 4, Nkhatabay

NATIONAL CONSULTATIVE WORKSHOP ON THE REVIEW OF THE PUBLIC HEALTH ACT

BICC UMODZI HOTEL: 24TH MARCH 2022

No.	Name of Participants	Designation	Organization
1	Mr. Ellos Lodzeni	Policy Governance & Partnership Advisor	Patient & Community Welfare Foundation of Malawi (PAWEM) P. O. Box 27, Chikwawa
2	Mr. Keith Lipato	President	AMAMI P. O. Box 45, Mulanje
3	Mr. Frank Manyowa	President	Malawi Tradition Healers Umbrella Organisation P. O. Box 2146, Lilongwe
4	Mr. Yamikani Lipato	Nursing Officer	NONM P. O. Box Lilongwe
5	Mr. Masozi Mwenifumbo	Acting Deputy Director of Quality Assurance Services	MBS P. O. Box 946 Blantyre
6	Mr. Ellias Chimulambe	President	MEHA P. O. Box 680, Blantyre
7	Mr. Clement Mandala	President	Diabetes Association of Malawi Box 31456, Blantyre
8	Dr. Sylvester Nthachi	Executive Member	Society of Medical Doctors P. O. Box 20, Blantyre
9	Dr. Chimwemwe Thango	DMO	Mangochi District Council P/Bag 138, Mangochi
10	Dr. Louisa Alfazema	Executive Director	Laboratory Association of Malawi P/Bag 360, Blantyre
11	Mr. Maziko Matemba	Executive Director	Health & Rights Education Program P. O. Box 30322, Blantyre 3
12	Dr. Kelvin Mponda	Deputy Hospital Director	Queens Elizabeth Central Hospital P. O. Box 95, Blantyre

13	Dr. Steven Taulo	Lecturer	MUBAS P/Bag 303, Blantyre 3
14	Dr. Gift Kawalazira	Director of Health & Social Services	Blantyre DHO P/Bag 66, Blantyre
15.	Dr. Boston Munthali	Chief Specialist-Orthopedic	Mzuzu Central Hospital P/Bag 209, Luwinga Mzuzu
16	Dr. Yonasi Chise	Director of Health & Social Services	Salima District Council P/Bag 15, Salima
17	Prof. Balwani Mbakaya	Associate Professor	University of Livingstonia P. O. Box 112, Mzuzu
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26	Dr. Alexander Chijuwa	Director of Health & Social Welfare Services	Zomba District Council P/Bag 18, Zomba
27.	Dr. Rhona Mijumbi	Head Policy	Malawi Liverpool-Welcome Trust Queen Elizabeth Central Hospital
28.	Sufia Dadabhai	Country Director	John Hopkins Research Project P. O. Box 1131, Blantyre, Malawi

29.	Mr. John Gutsu	Pastor	Zion Church P. O. Box 49, Lilongwe
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44.	Dr. Nellie Wadonda	Branch Chief Officer	DCD
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68.	Ms. Memory Zikapanda	Principal OSH Officer	Ministry of Labour P/Bag 344, Lilongwe
69.	Mrs. Hanna Thandie Ngulinga	Ass HRMO	Nkhoma College of Nursing and Midwifery P. O. Box 48, Nkhoma
70.	Mr. Edmund Mvula	Regulatory Officer	Atomic Energy Regulatory Authority
71.	Mrs. Emily Gama	Deputy Director for Nursing/Midwifery	Ministry of Health-Nursing Directorate P. O. Box 30377, Lilongwe
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83.	Racheal Julaye	Reporter	Rainbow TV P/ Bag 2211, Lilongwe
84.	Roy Nkosi	Photographer	Malawi News Agency P/Bag 310, Lilongwe 3
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86.	Mphatso Nkuonera	Coordinator	Ministry of Information P/Bag 310 Lilongwe

87.	Macneil Kalowekamo	Reporter Agency	Malawi News P/Bag 310, Lilongwe 3
88.	Levie Bokosi	Camera man	Rainbow TV P/Bag 2211, Lilongwe
89.	Ntchindi Meki	Journalist	NPL P/Bag 419, Lilongwe
90.	Fostina Kamanga	Reporter	Malawi News Agency P/Bag 310, Lilongwe 3

CONSULTATION WITH MINISTRY OF HEALTH - FGDs

8th November, 2016

No.	Name of Participants	Institutions
1.	John Nepiyala	Nurses & Midwives Council
2.	Harriet Bwanali	NONM
3.	Annie Tsakalaka	MoH 0 999 953 199
4.	Matthew Kagoli	MoH
5.	George Chithope Mwale (2)	MoH
6.	Tulipoka Soko	MoH – Nursing
7.	Immaculate Kambiya	MoH – Nursing
8.	Allone Ganizani	MoH
9.	Holystone Kafanikhale	MoH
10.	Doreen Ali	MoH
11.	Harold Chimphepo	MoH
12.	Trish Araru Jere	MoH
13.	Gerald Manthalu	MoH
14.	Jevas Chidwala	MoH
15.	Mervis Siwande	MoH
16.	Micheal Kayange	MoH
17.	Emma Mabvumbe	MoH
18.	Alet Khuwi	MoH
19.	Dr. Storn Kabuluzi	MoH

PUBLIC HEALTH ACT

MEETING WITH KEY STAKEHOLDERS – MINISTRY OF HEALTH

14TH - 15TH DECEMBER, 2021

No.	NAME	OCCUPATION/TITLE
1.	Dr. Charles Mwansambo	Secretary for Ministry of Health
2.	Dr. Queen Dube	Chief of Health Services
3.	Dr. Ben Chilima	Director
4.	George Mwale	Director
5.	Fannie Kachale	Director
6.	Wilkes Silema	Deputy Director
7.	Charity Kasawala	Director
8.	Kate Longwe	Director
9.	Mr. Billy Nyambalo	PRDO – MOH Research
	Other Key Stakeholders	
10.	Richard M. Ndovi	Clinician – Medical Council of Malawi
11.	Mr. George Jobe	Executive Director- MHEN
12.	Dr. Parth Patel	Doctor – Society of Medical Doctors
13.	Prof. Adamson Muula	Lecturer – KUHES
14.	Prof. John Phuka	Lecturer – KUHES

MEETING WITH STAKEHOLDERS - MEDHEALTH

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MEETING WITH STAKEHOLDERS - MASM

3.	Tilera Dzingomvera	MASM P. O. Box 30381 Lilongwe 3

4.	Sydney Chikoti	MASM01 770 678 P. O. Box 30381 Lilongwe 3
5.	Dorica Chirwa	MASM P. O. Box 30381 Lilongwe 3

ESCOM

6.	Esther Deleza	ESCOM P. O. Box 2047 Blantyre
7.	Eston H. Macheche	ESCOM P. O. Box 2047 Blantyre
8.	Chaona Kwakwala	ESCOM P. O. Box 2047 Blantyre
9.	Charles Kagona	ESCOM P. O. Box 2047 Blantyre
10.	Vera Mede	ESCOM P. O. Box 2047 Blantyre

ZION CHURCH – 12TH APRIL, 2020

11.	John Gutsu	Zion Church

MALAWI BUREAU OF STANDARDS- 7TH APRIL, 2020

12.	Mr. Fred Sikwese	Director of Standards and Development Malawi Bureau of Standards P. O. Box 946 Blantyre
13.	Mr. Wanangwa Sindani	Acting Director of Quality Assurance Services Malawi Bureau of standards P. O. Box 946 Blantyre