Meeting on the Implementation of Health Impact Assessment in Zimbabwe REPORT

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Ministry of Health and Child Care

With

Regional Network for Equity in Health in East and Southern Africa (EQUINET)
Training and Research Support Centre

August 22ND 2025,

Monomotapa Hotel, Harare

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1. Background

In the same way as environmental impact assessment (EIA) was institutionalized in the region to play a role in protecting ecosystems, health impact assessment (HIA) similarly needs to be implemented to inform decision-makers about the potential health effects of a project, programme, economic activity, law or policy, and to make recommendations to improve it. HIA can be carried out separately, or alongside Environmental impact assessment. HIA is thus included in Zimbabwe's Public Health Act (Chapter 15:09, 2018) as one of the tools we have to apply and ensure compliance with the general duty on all (including corporations and institutions) to prevent harm to health that is specified in the Act.

HIAs seek to inform decision-makers about the potential health effects of a project, programme, economic activity, law or policy, to make recommendations to improve it and to prevent avoidable health-related risks and liabilities. HIAs can be carried out separately to, or alongside other forms of impact assessments (eg economic, environment).

In recognition of the critical mass of people with health impact assessment (HIA) capacities in Zimbabwe and inclusion of HIA in Zimbabwe's Public Health Act (Chapter 15:09, 2018) the Ministry of Health and Child Care (MoHCC) in co-operation with the Training and Research Support Centre (TARSC) and EQUINET invited key stakeholders to a meeting on Friday 22nd August 2025 to discuss practical steps for advancing regulatory guidance, capacities and implementation of health impact assessments in Zimbabwe.

The meeting was held at Monomotapa Hotel, Harare from 9.15am to 1330pm, followed by lunch. It included an overview on HIA, presentation of HIA work already implemented in Zimbabwe, followed by discussion on proposals for priority sectors for HIA implementation, and the provisions in the Public Health Act and other laws related to HIA.

The programme is shown in *Appendix 1* and the delegate list in *Appendix 2.* Some of the logistic costs of the meeting were supported by TARSC and the AEGT SSHRC Partnership Grant.

The summary of next steps from the meeting is shown on page 12.

2. Opening, introductions and an overview of HIA

The meeting was opened by Mr Victor Nyamandi, Director Environmental health, MoHCC. He welcomed delegates and noted that while the Public Health Act is under the Minister of Health and Child Care, the ministry implements it by working in partnership with other ministries and stakeholders. The same applies to implementing HIA where whole of government cross sectoral approaches and whole of society cross stakeholder collaboration is important. He thus welcomed key stakeholders to this meeting to identify priority sectors and guidance, measures to build further decentralised capacities and collaboration and other practical steps to implement the legal provisions for HIA. He thanked the co-operation between MoHCC, TARSC and EQUINET in organising this meeting, and all delegates for their participation.

Mr Nyamandi introduced the objectives for the meeting as to

a. Introduce HIA, its policy and legal basis, and its purpose, methods, and implementation progress to date
b. Share selected case studies of implementation of HIA in Zimbabwe
c. Identify practical steps, measures, key stakeholders to advance regulation, guidance and capacities for HIA
d. Agree on next steps, milestones and timings, and a co-ordinating mechanism for taking them forward

Following this, delegates Introduced themselves and their institutions (See *Appendix 2)*

2.1 Overview of HIA, its regional policy basis, and application in the region

Dr R Loewenson, Director TARSC/ EQUINET gave an overview of HIA, its international policy basis and purpose, its methods and the progress made in east and southern Africa in capacity building and implementation to date. She noted that HIA is a combination of procedures, methods, and tools" that systematically assesses the potential direct and indirect effects of a policy, plan, programme, economic activity or project on the health of a population. HIA assesses the distribution of those effects within the population, whether intended or unintended, and identifies appropriate actions to manage those effects. Its aim is to improve laws, policies and activities. It can be done before an intervention/project at planning stage to modify the plan, but also while an activity is ongoing, including for improvement /relicensing. It can be done at the same time as the Environmental impact assessment (EIA). She noted that HIA recommendations include measures for prevention and mitigation, and for healthier alternatives. It thus helps to prevent emergencies, address public concerns and reduce subsequent costs, contestation and reputational damage.

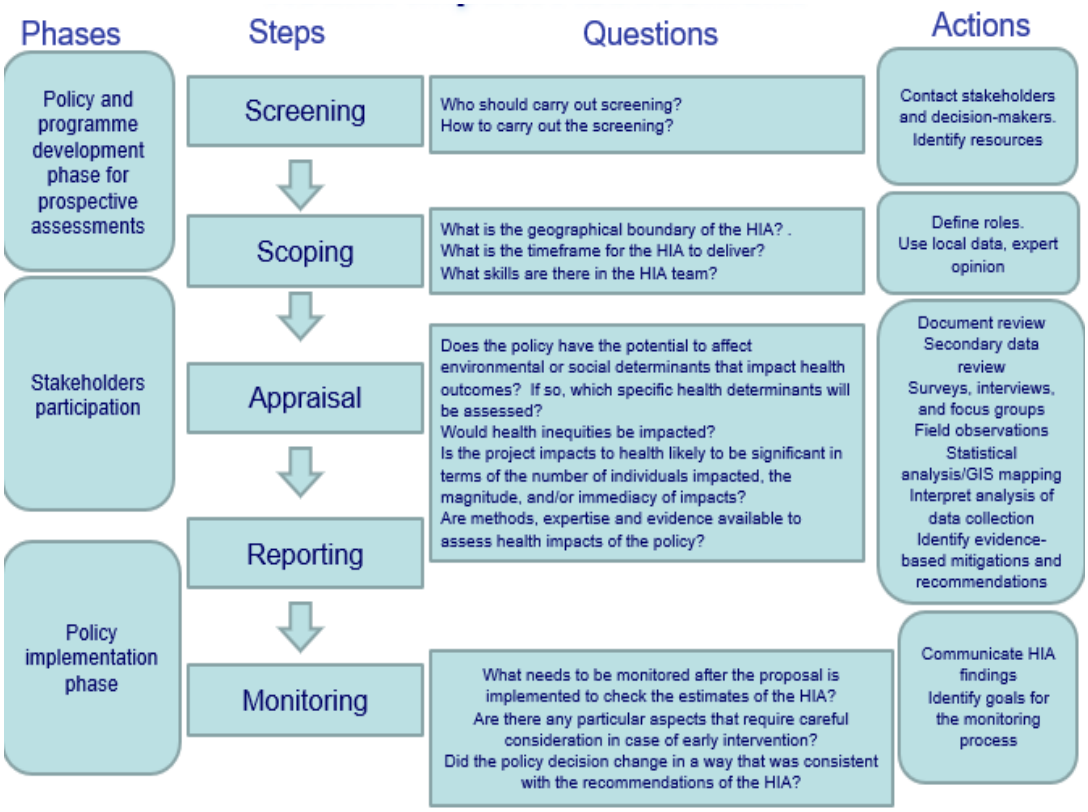
Dr Loewenson noted that there is regional policy to implement HIA in the WHO AFRO Regional multi-sectoral strategy to promote health and well-being, 2023–2030 that includes a target by 2030 to have institutionalized and integrated health impact assessment and in the Resolutions of the 2024 73rd ECSA Regional Health Ministers Conference on HIA 2024 CSA/HMC73/R8 that urges the Member States to harmonize local and national laws, policies and regulations by integrating and institutionalizing relevant evidence, including health impact assessments to strengthen public health systems and implement health impact assessment to monitor the effectiveness of climate and health interventions. She noted that with the demand from new areas of economic activity, new innovations such as artificial intelligence, the opening of trade, including under the African Continental Free Trade Agreement, and major challenges such as climate change and pandemics, we need this tool to inform our decision making and ensure we prevent unnecessary costs to health to individuals, economic actors and the state by integrating measures to improve them by preventing health risks and maximising health benefits. Using the example of the emerging oil extractive sector in Ghana she showed the sort of public health impacts that call for an HIA (see below). While some of these are from environmental factors, not all are, and an HIA provides deeper further information on human impacts. It also allows for public health principles, such as the precautionary principle, and public health law, authority, duties and guidance to be applied.

For example health impacts identified in extractive sector activities

Project induced pressures	Environmental, social, or institutional determinant of health affected	Resulting health impacts
Population influx	Competition for resources or livelihood opportunities	Change in diet, nutritional status
Rapid development	Competition for project related benefits	Increased risk for infectious diseases
High expectation of benefits	Change in household/individual purchasing power	Non-communicable diseases
Land use changes	Strain on infrastructure/social services	Stress and mental health disorders
Environmental degradation or pollution	Change in social demographics	Substance abuse, alcoholism
	Exposure to environmental risk factors (chemicals, noise, air pollution, etc.)	Violence, crime, conflict
	Loss of access to land	Accidents and injuries
	Loss of biodiversity, ecosystems services	

Dr Loewenson noted that all ESA countries have public health law that requires all persons (including institutions and companies as legal persons) to prevent harms to health. South Africa, Zimbabwe explicitly include HIA in law in Zimbabwe's Public Health Act 2018; DRC in a mining sector decree, and Kenya in guidelines.

Dr Loewenson gave an outline of the steps carried out in implementing an HIA, as shown in the graphic below, giving brief information on each step. She noted that the methods are internationally recognised.



WHO, 2023

The Profiling and assessment stage organises relevant evidence/information on the health impacts in terms of their nature, direction, magnitude, severity, and likelihood, and on the basis of this and their distribution in the population, judging their significance. This is used to identify specific, actionable measures and roles to respond effectively to predicted impacts. The process also includes monitoring of how the agreed decisions and recommendations from the HIA are implemented and provides triggers and early warning of unexpected consequences and a mechanism to address them.

There has been progress in ESA in HIA capacity building to date, with EQUINET (TARSC with TalkABMR, SATUCC) Australia, Brazil consultants with ECSA Health Community having implemented online regional training on HIA in 2024 and 2025 and further training planned for 2026.70 people trained in 7 ESA countries and 2 other African countries and Zimbabwe has the highest critical mass of people trained. There are plans to develop model curricula and integrate in professional, post-graduate training. Within the regional training 16 mentored HIA case studies have been implemented in different countries. Some have focused on laws and policies, such as the HIA in South Africa **on** the proposed draft occupational health and safety (OHS) policy for farm workers in South Africa or in Tanzania on the Integration of health in the draft Critical and Strategic Minerals Strategy, and and some on economic activities, such as a WHO AFRO HIA of a proposed initiative in Zambia to shift from tobacco growing to alternative crops or of A small-scale mining operation and onsite milling in Bubi District, Matabeleland North Province in Zimbabwe. In prior regional dialogue various sectors were identified as key for HIA, viz mining, energy, infrastructure, agribusiness, health, commercial dumpsites and new areas such as climate. There is a proposal to develop model guidance for implementing HIA generally, in key sectors and to promote harmonised regional guidance and standards in this area.

2.2 HIA alignment with Zimbabwe's National Development goals, the 2018 Public Health Act and economic and environment impact assessment

Mr V Nyamandi, Director Environmental health, MoHCC explained the legal foundation for HIA in Zimbabwe's Public Health Act [Chapter 15:17] (Amended in 2018) that explicitly provides for HIAs. Section 89 (1) empowers the Minister of Health to require HIA for any activity, project, or policy likely to affect public health. The Minister may, via Statutory Instrument, prescribe:

- Categories of projects requiring an HIA
- Procedures for conducting HIA
- Qualifications of HIA assessors
- Penalties for non-compliance

HIA is legally linked to Environmental Impact Assessments (EIA), ensuring synergy with environmental legislation (like the Environmental Management Act).

He outlined the link also to Zimbabwe's National Development Strategy 1 (NDS1: 2021–2025), which is Zimbabwe's flagship socio-economic blueprint. It outlines goals to improve public health and strengthen national resilience to economic and environmental shocks. NDS1 health-related goals include: improving health financing and infrastructure; reducing disease burden and increase life expectancy; promoting climate-resilient and disaster-prepared health systems; achieving Universal Health Coverage (UHC) and enhancing surveillance and preparedness for environmentally linked diseases (e.g., cholera, malaria). HIA is aligned to this as it identifies health risks of climate-sensitive projects; ensures that infrastructures such as hospitals, roads, dams consider community health impacts; integrates health in land use and mining policies and activities; and promotes intersectoral coordination (e.g., water, sanitation, energy).

Mr Nyamandi explained that Zimbabwe's Environmental Management Act (EMA) mandates Environmental Impact Assessments (EIA) for projects likely to affect the environment. While health is one of many components in EIA, HIA provides a more in-depth analysis of health risks. HIA also assesses public health costs/benefits of development (e.g., pollution-related diseases, nutrition losses). It helps policymakers to understand long-term financial implications of health neglect in economic planning and supports cost-effective investments that improve both health and economic productivity. In summary the links are shown below:

Summary: How They Align

Framework	How HIA Aligns
Public Health Act (2018)	Provides the legal mandate for HIA; links it to licensing and penalties
NDS1 (2021–2025)	Enables achievement of health, climate, and resilience targets
Environmental Management Act	Promotes joint HIA–EIA frameworks for sustainability
Economic Planning	Supports evidence-based investment in health and productivity

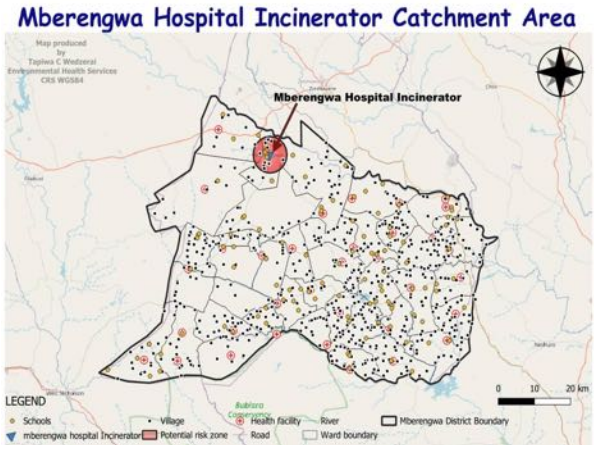
He concluded by recommending that to maximize the alignment between HIA and Zimbabwe's development framework it was important to operationalize HIA regulations under the Public Health Act via statutory instruments; train multi-sectoral stakeholders on conducting integrated HIA/EIA processes; mandate HIA in all high-impact sectors (e.g., mining, agriculture, energy, infrastructure) and use HIA findings to inform national budgeting and strategic health investments under NDS2.

3. Selected examples of HIAs implemented in Zimbabwe

Three brief presentations provided examples of HIAs implemented in Zimbabwe. They are drawn from longer detailed reports and presented selected key information to show what HIAs include.

3.1 HIA of the Mberengwa Incinerator project, Midlands

Mr S Betera, MoHCC presented this HIA implemented with Ms P Fusire, Mr T Chivasa, Mr T Moyo MoHCC and Dr Munyaradzi Murwira, Kwekwe City Council. The prospective HIA reviewed the proposal to build an incinerator at Mberengwa District Hospital, Midlands province with 38 Health facilities to benefit (See map below). Current practices involved open burning, with no proper incineration, poor compliance with regulations and a risk of exposure to PM 2.5, dioxins and furans, health risks.



The HIA reviewed five elements, showing the causal pathway to impacts for each:

- Incinerator design and siting impacts
- Community engagement
- Waste Collection, Transportation, and Integrated Waste Management
- Regulatory Compliance and Oversight
- Operation and maintenance

An example of their profiling and assessment findings on three of these elements is shown below:

Health Impact Profiling and Assessment

Element	Health/SDH Impact	Direction & Severity	Significance & Priority
1. Incinerator Design & Siting	Air pollution (PM2.5, dioxins, furans) increases asthma (↑ to 26%) and respiratory illnesses; cancer and CKD risk (Pinedo-Bardales, 2013; Emiru, 2018; Schecter, 2006; Hsu, 2021)	**Negative if emissions not addressed** High magnitude, long-term effects	**High** Health effects on 22,000+ people
2. Community Engagement	Low awareness (22%), Oppose local siting (75%), reducing trust and cooperation. (Patthanasak et al., 2011; World Bank, 2023)	**Negative** Psychosocial stress, poor acceptability **Positive** Employment	**High** Adults - 2,750; Children - 1,500. Includes local community, children, elderly, pregnant women
3. Waste Collection, Transport, Integrated Waste Management	Exposure to contaminated increases respiratory illness and occupational infections (HIV, Hep B/C). (WHO, 2023; Okolimong, 2024; García-Pérez et al., 2013)	**Negative** High magnitude chronic illness risk	**High** Inpatients (96-bed District hospital) -92 staff members -8898 residents within a 5km radius - 4 188 school children

The presenter outlined other assessment findings and the priority recommendations from the assessment, shown below.

Recommendations – High Priority

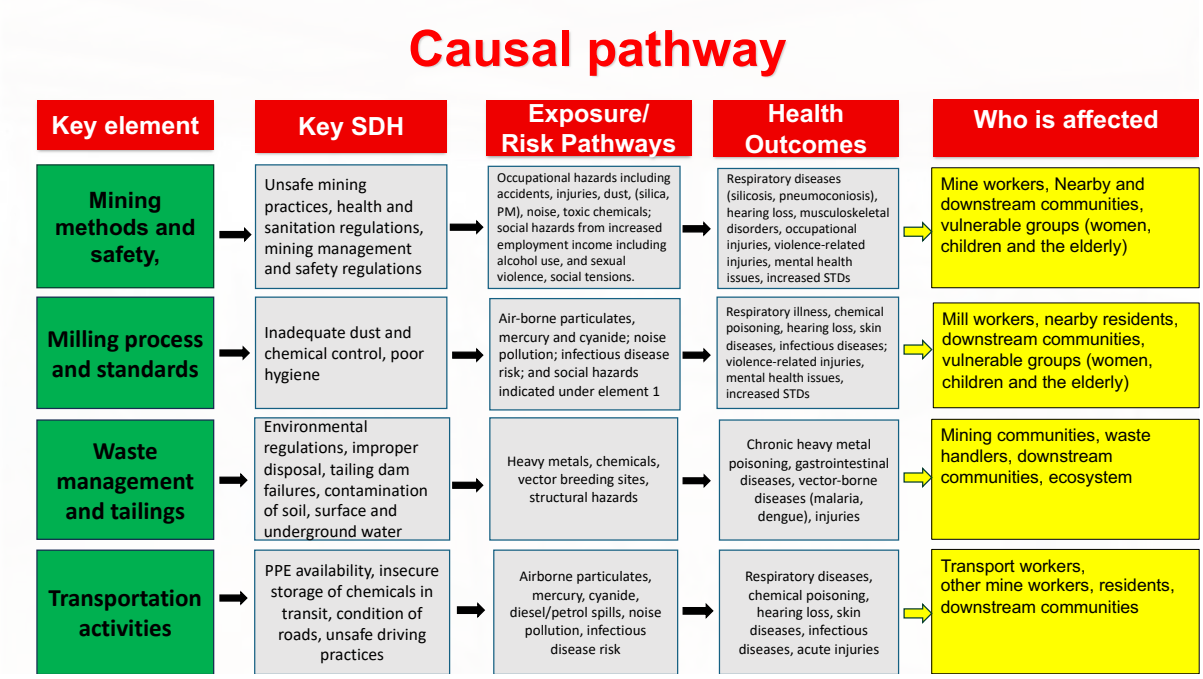
Element	Action	By
Incinerator design and siting impacts	• Double-chamber, ≥850°C incinerator with scrubbers • Leachate containment + site ≥100m from water sources	Public Works
Community engagement	• Community feedback & environmental education • Safety reports to be accessible to the public	DDC
Waste Collection, Transportation, and Integrated Waste Management	• Develop and enforce SOPs for all waste handling steps • Ensure consistent PPE provision and routine training • Implement strict waste segregation at source	MoHCC and MRDC
Regulatory Compliance and Oversight	• Stack & ambient air testing (PM2.5, dioxins) • Independent compliance auditing	MoHCC and EMA
Operation and maintenance	• Occupational safety program + PPE tracking • Routine equipment servicing logs	Public Works

3.2 HIA of the Bubi Mining and Milling, Matabeleland North

Mr Paul Matshona presented the above HIA, implemented as a team with Mr L Mlambo, Mr P Sithole, AEGT and Mr P Moyo, NUST. With the activity already underway this was a concurrent HIA of

1. Mining methods & safety
2. Milling processes & standards
3. Waste discharge & management
4. Transportation activities

The causal pathway between these elements and the health outcomes is shown below.



The presentation covered the impacts identified for each of the elements. For example, for Mining Methods and Safety, the impact was identified as increased morbidity and mortality due

to accidents, injuries, and occupational diseases. They estimated a high incidence of injuries and fatalities e.g., 237 fatalities in 2023, representing a 96% increase over 2021; with 200+ miners and nearby residents affected, and with a risk of long-term disability from respiratory conditions and injuries that had a high likelihood given increased production demands and unsafe practices. They thus judged the impact to have high significance. Similar assessment was presented for the other elements.

As a result, the priority recommendations made in the HIA included:

a. For Mining Methods and Safety- Ministry of Mines and Mining Development to enforce safety standards through frequent inspections and penalization for non-compliance. (Immediate)
b. For Milling Process and Standards - Milling operators guided by the Metallurgical Department of the Ministry of Mines and Mining Development to introduce enclosed milling systems, automated controls, and enforce PPE usage. (immediate)
c. For Waste Discharge and Management- Ministry of Mines, EMA, and Ministry of Water (through ZINWA) to prescribe stricter environmental requirements, enforce tailings dam detoxification protocols, and conduct regular water monitoring (medium-long term).

The HIA report is being submitted to Gold More Milling Centre, with measures and key indicators to monitor the recommendations (e.g., silicosis rates, mercury levels). They are also monitoring for policy reform to mandate HIAs in ASM operations.

3.3 HIA of the Watervlei Cemetery project, Harare

Ms Winfilder Dhambure MoHCC presented the above HIA implemented with Mr V Nayamandi, Mr R Mapfumo, Ms M Tawodzera, MoHCC. She noted that the Watervlei Cemetery project sparked significant public health concerns, prompting the Ministry of Health and Child Care to initiate the HIA. The 77-hectare site, 55 hectares for 35,000 burial spaces has been proposed near the Prince Edward Water Treatment Plant which is critical for Harare's water supply. Health authorities, the public and environmental experts raised alarms about the risk of water contamination from decomposing human remains and chemicals seeping into groundwater. A prospective HIA was implemented using a mix of secondary qualitative and quantitative data analysis methods.

She presented the elements assessed in relation to the proposed design, siting, legal compliance, waste management and operation and showed the key health impacts identified for these in the profiling and assessment stage, as exemplified in the table below for one of the elements.

Key Element	SDH/Health Impact	Direction, Magnitude, severity, likelihood Significance & Priority
Proposed design and siting: Interference of the cemetry with the water treatment plant	**Water pollution: A**djacent to Prince Edward Water Treatment Plant and chemical and biological contaminants from decomposing bodies. EG cemetery groundwater in Tanzania - 91.3% of boreholes near cemeteries exceeded WHO nitrate limits From Nigeria elevated lead, acidic ph -> leachates. Risk of cancers , infant methemoglobinemia; disease outbreaks if leaches to treated water	**High** Direction, Magnitude, severity, likelihood **Medium to High (*)-** could trigger widespread outbreaks violates Public Health Act and WHO guidelines

As a result of the HIA findings 3 key recommendations were made:

- Local Government to relocate the cemetery or redesign layout to comply with WHO-recommended buffer distances (1–2 km) to protect water quality and public health.
- Ensure routine water quality monitoring, clear guidelines on burial depths, sanitation infrastructure in cemetery design, integrated bio-waste treatment facilities
- Watervlei burial park project implementers to conform to all environmental laws and urban planning regulations.

The presenter noted that cemetery construction has been halted until the issues raised have been addressed. In follow up the team is providing the HIA findings to relevant stakeholders for follow up of the recommendations. They propose setting up a multi-agency committee under MoHCC to develop a monitoring framework to track the implementation of the recommendations and assess the environment, social impacts, and public health indicators; with independent audits and periodic reporting to the public and responsible authorities to ensure accountability beyond the project's implementation phase.

3.4 Discussion of the presentations

Delegates expressed appreciation for the presentations. Those from other ministries (transport and infrastructure and EMA) suggested that implementing HIAs was necessary and that it was overdue to have them carried out in key sectors in Zimbabwe. Others raised issues of many unresolved issues and that carrying out an HIA on a single activity could lose sight of the wider risks from the other activities in an area. An example was given of the cemetery next to Watervlei that may have similar risks. Mr Nyamandi explained the critical risk of the Watervlei proposal due to its proximity to the main water treatment plant for Harare affecting 2 million people. It was also noted that strategic HIAs can also integrate the activities in the same area or the linked activities to a project to be able to assess these spillover risks and benefits.

4. Working group discussions and reports on implementing HIA in Zimbabwe

Delegates divided into three working groups to discuss how to take forward HIA in Zimbabwe in relation to

a. Key sectors, and stakeholders (government, non-government and partners) for HIA implementation; co-ordination mechanism and milestones for scale up
b. Building decentralized capacities for HIA, and
c. Implementing the Public Health Act and other legal provisions on HIA; and measures to address gaps in policy, guidance, and regulation

4.1 Group 1 report on: Key sectors, and stakeholders (government, non-government and partners) for HIA implementation. Co-ordination mechanism and milestones for scale up

The **key sectors** to target for HIA implementation were identified as the social services sectors including health; infrastructure-roads, dams, housing, power plants, new energy projects; mining; agriculture and trade. Overall, it was suggested to review the list of activities that require Environmental Impact Assessments (EIAs) and use that as an entry point for those that have identified public health impacts, including risks identified in the 2018 Public Health Act.

The suggested **steps and milestones for scale up** would be to focus on the EIA prescribed list that overlap with public health impacts as above and to focus on major projects of national significance and high health impact. The latter could include new projects being assessed by the Zimbabwe Investment Centre.

The group identified Involving key **stakeholders for HIA implementation** as coming from government (all relevant ministries, departments and agencies), non-government agencies (community, unions) and various partners (technical, academic, other).
The proposed **mechanism for coordination** across sectors and stakeholders was suggested to be (while noting that this would also draw on the discussions of groups 2 and 3):

- With MOHCC being the Lead Ministry, establishing a Technical Working Group (TWG) for developing a framework for conducting HIA, inviting key stakeholders.
- The TWG to write position paper to be presented to the Office of the President to lead the coordination of establishing a framework for HIAs.

4.2 Group 2 report on: Building decentralised capacities for HIA- Current capacity assets and gaps, and training of whom, by whom, and in what institutional programmes, collaborations and processes

The group discussed the **current capacity assets and gaps,** with

- assets identified as human resources to implement, train, enforce and regulate; legal frameworks in place; institutions (field of practice and academia) and partners and partnerships, and
- gaps identified as knowledge of how to do a structured HIA; Finance/Funding; a statutory instrument to spell out the mandate parameters, etc; a formalized cadre trained in HIA and with mandatory HIA training and in community empowerment, viz: community lack knowledge on the conduct and importance/benefits of such assessments.

The training targets were identified as lecturers (academia); pre-service training/students; post-professional training and in service training of qualified cadres; community cadres. Training institutions include government/parastatals; tertiary institutions; technical/research and other non state agencies and community organisations. International and local experts already trained in HIA can train the trainers and policymakers.

Training approaches include training of trainers, pre- and in-service training and community based training. Training can be integrated in winter and summer school courses and in current courses/modules. It can be face-to-face and online. Various institutions Integrated offer potential for integrating training including School of Mines (MOSH – Module on Occupational Health and Safety); the Mining Degree (Module on Occupational Health); the Environmental Health Science Degree and Public Health (Masters in Public Health – e.g at UZ, NUST, Africa University)

Training can be supported by a range of **collaborating/partnerships** at international and regional level, within interdisciplinary and inter-ministerial partnerships and with academia and non state institutions that offer training. **Co-ordinating mechanisms** were suggested to support and co-ordinate these processes, including through a taskforce/steering committee/inter-ministerial portfolio committees or technical working group. Conferences and Research weeks can disseminate information on capacity building and training can be supported by joint monitoring visits and joint external evaluations to support practice.

As recommendations the group proposed developing an interdisciplinary or stand-alone module on HIA; and to integrate HIA within existing modules/courses.

In the discussion it was noted that the EQUINET online training used mentored HIAs as a practical training approach and found this to be particularly effective. It could be integrated in other training approaches.

4.3 Group 3 report on: Implementing the Public Health Act and other legal provisions on HIA; Gaps and measures to address gaps in policy, guidance, and regulation

Beyond the Public Health Act, the group identified a number of Acts that may be pertinent to HIA, including the EMA 20:27, the Radiation Protection Act; the Mines and Minerals Act; the Food and Food Standards Act 15:04; the Pneumoconiosis Act and Occupational Health Act. Various

infrastructure and resource related Acts are relevant, including the Water Act; the Regional Town and Country Planning Act; the Urban Councils Act and the Rural District Councils Act; the Communal Lands Act; Factories and Works Act; Forest Act; Parks and Wildlife Act; Conservation of Biological Diversity Act; National Museums and Monuments Act and National Agriculture Policy Framework 2019-2030. In addition, the Traditional Leaders Act; Human Settlement Policy; Disaster Management Bill and Council Bylaws may have pertinence to particular HIAs.

To take forward implementation of the Public Health Act clauses in HIA, the group recommended **r**eview and development of Statutory Instruments (eg for specific sectors); , issuing national guidance and standards; strengthening institutional arrangements and organizing capacity building and resources. The group also noted the need for monitoring of enforcement and accountability and for public and stakeholder engagement.

The group noted the weak integration of health into environmental & development decisions and the lack of detailed regulations yet supporting the provisions in the Public Health Act or clear linkages to the Environmental Management Act (EMA) EIA process. As a result, many infrastructure or extractive projects currently overlook health effects. The group thus recommended **drafting HIA regulations under the PHAct,** harmonised with EMA's EIA regulations. It was also suggested to have joint MoHCC–EMA guidelines so health is systematically considered in EIAs/SEAs with concurrent HIAs.

Fragmented institutional roles generate overlaps between MoHCC, EMA, local authorities, and sector ministries (Mines, Water, Local Government). This leads to duplication, weak enforcement, and confusion about who leads on community health risks. The group recommended issuing a **statutory instrument or inter-ministerial MOU clarifying mandates** and establishing a National Public Health Coordination Committee (similar to NEPC for environment) to ensure cross-sectoral health protection.

Councils are legally tasked with public health (waste, sanitation, inspections) but lack funding, trained personnel, and updated by-laws. As a way forward the group proposed updating local government **by-laws to align with the Public Health Act**; providing **earmarked funding or revenue streams** (e.g., a health levy in local taxes) for public health functions and rolling out **capacity-building programmes** for Environmental Health Practitioners (EHPs).

Occupational safety laws (Factories and Works Act, Pneumoconiosis Act) were felt to be outdated and enforcement to be limited. Community health impacts of industries are thus poorly covered. As a way forward the group proposed **updating the Factories and Works Act** to contemporary and ILO standards; **expanding coverage to informal sector and community health risks from industrial activity** and **linking NSSA monitoring data** with national HIA and public health reporting.

COVID-19 exposed legal/policy gaps on rapid response, quarantine, financing, and data sharing. Current frameworks are reactive, not proactive. As a way forward the group proposed developing Public Health Emergency Regulations under the PHAct; establishing a Public Health Emergency Fund for rapid mobilization and aligning policy and practice with International Health Regulations (IHR 2005) obligations.

At present the group perceived that there is no strong legal backing for integrated disease/environmental surveillance, and weak requirements for public reporting on population health. As a way forward the group proposed enacting **regulations mandating routine health surveillance and reporting** by councils and ministries. They also suggested that the MoHCC publish an **annual State of Public Health Report** to Parliament and the public (linking to constitutional rights under Sections 73, 76, 77).

The Public Health Act recognizes the right to health but does not provide strong mechanisms for community participation in health-related decision-making. The group proposed introducing

regulations on public consultations for HIAs and health policies and **strengthening access-to-information rights for communities** on pollution, water quality, and disease outbreaks.

In summary, the group recommended

- Drafting subsidiary legislation to support HIA implementation and in related areas such as for emergencies, surveillance, and local authority by-laws.
- Harmonising mandates of MoHCC, EMA, local councils, and sector ministries in implementing HIA and related mandates.
- Updating outdated health & safety laws (Factories & Works Act, Pneumoconiosis Act).
- Strengthening local authority capacity and financing for public health functions, and
- Institutionalising accountability mechanisms (public reports, community participation).

5. Next steps and closing

Dr Loewenson, TARSC/EQUINET and Mr Nyamandi MoHCC summarised the immediate next steps from the discussions as:

a. With MOHCC being the Lead Ministry, establishing a Technical Working Group (TWG) for developing a framework for conducting HIA, inviting key stakeholders from this meeting and pertinent others. An email list will be circulated for follow up communications. This TWG will take up the follow up issues, from the meeting including writing a position paper to be presented to the Office of the President so that this institution with MoHCC and EMA co-lead in co-ordinating ongoing processes for national implementation of HIAs.

b. Implementing an exercise to review the list of activities that require EIAs and identify those that have identified public health impacts, including risks identified in the 2018 Public Health Act. This list may be proposed as the first group for HIA implementation, particularly where there are major projects of national significance and high health impact and new projects being assessed by the Zimbabwe Investment Centre.

c. Drafting guidelines and subsidiary legislation to support HIA implementation, particularly in the priority sectors identified in (b) and ensuring harmonising of mandates of MoHCC, EMA, local councils, and relevant sector ministries in implementing HIA in these sectors.

d. Developing an interdisciplinary or stand-alone module on HIA; and initiating dialogue with relevant institutions to integrate HIA within existing modules/courses.

Mr Nyamandi indicated that MoHCC would follow up on these steps, in close liaison with partner ministries and others. Dr Loewenson noted that EQUINET will be running online HIA training in 2026 for further teams, and would be happy to implement training for cross-sectoral teams in Zimbabwe in 2026. She also noted that in association with ECSA HS there were regional proposals to develop a generic modular HIA course curriculum and to develop generic guidelines on implementing HIA to support country processes. She also noted that it would be useful to share Zimbabwe's experience with others in the region given the progress made in taking forward HIA in Zimbabwe.

In closing remarks Mr Tserayi Machinda UCAZ thanked the meeting convenors, the delegates and all presenters for covering a significant amount of information in a short time and for the productive deliberations in the meeting. He welcomed the implementation of HIA in Zimbabwe and observed that the meeting had provided an important opportunity for key stakeholders to identify steps to take it forward. He reiterated that the information presented and issues under discussion made it clear that health was everybody's business and that HIA provided one means to operationalise it.

The meeting closed at 1330pm

Appendix 1: Programme

Time	Session	Facilitated by
Session 1: Opening, introductions and an overview of HIA		
0915 – 09:40	Welcome. Opening remarks Meeting objectives, Delegate Introductions	MoHCC Delegates
09.40-10:00	Overview of health impact assessment (HIA), regional / global policy basis, and capacity building / implementation in the region to date	Dr R Loewenson, Director TARSC/ EQUINET
10.00-10.20	HIA alignment Zimbabwe's National Development goals, the 2018 Public Health Act and economic and environment impact assessment	Mr V Nyamandi, Director Environmental health, MoHCC
Session 2: Selected examples of HIAs implemented in Zimbabwe		
10:20-10:30	HIA of the Mberengwa Incinerator project, Midlands	Ms P Fusire, Mr S Betera, Mr T Chivasa MoHCC
10:30 – 10.40	HIA of the Bubi Mining and Milling, Matabeleland North	Mr L Mlambo, Mr P Matshona, Mr P Sithole, AEGT
10:40-10.50	HIA of the Monovlei Cemetry project, Harare	Ms W Dhambure, Mr V Nayamandi, MoHCC
10.50-11.10	Discussions of presentations Introduction to working groups	
Session 3: Working group discussions on implementing HIA in Zimbabwe		
11:30–12.30	Three working groups Group 1: Key sectors, and stakeholders for HIA implementation. Co-ordination mechanism and milestones for scale up Group 2: Building decentralised capacities for HIA Group 3: Implementing the Public Health Act and other legal provisions on HIA;	Delegates, facilitators and rapporteurs
Session 4: Proposals from working groups, next steps and closing		
12.30-13.00	Plenary feedback of the working groups Discussion	Group rapporteurs Delegates
13.00-13.20	Summary of next steps, actions and roles from the discussions Taking forward next steps:	Dr R Loewenson, TARSC Mr V Nyamandi, MoHCC
13.20-13.30	Closing remarks	Mr T Machinda UCAZ

Background documents

1. The Public Health Act 2018 (one copy per group)
2. Information brief on HIA

Appendix 2: Delegate list

NAME	INSTITUTION
Mr Victor Nyamandi	Director Environmental health, Ministry of Health and Child care
Dr Rene Loewenson	Director, Training and Research Support Centre/ EQUINET
Ms Margaret Tawodzera	Food safety manager, MoHCC
Mr Nelton Mangezi	ESIA & Ecosystems Protection manager, Environmental Management Authority
Ms Tafadzwa Dehwe	Human resources, Ministry of Transport and Infrastructural development
Mr Kakura Vengesa	Deputy Director, Ministry of Transport and Infrastructural development
Ms Florence Ruzive	Legal officer, MoHCC
Ms Winfilder Dhambure	Environmental Health Officer, Ministry of Health and Child care
Ms Punha Fusire	Environmental Health Officer, Manicaland Province, Ministry of Health and Child care
Mr Same Betera	District Environmental Health office, Midlands Province, MoHCC
Mr Tafadzwa Chivasa	District Environmental Health office, Mberengwa MoHCC & NUST
Mr Tserayi Machinda,	Programmes Manager, Urban Councils Association of Zimbabwe
Mr Lyman Mlambo	Zimbabwe Country manager, AEGT project
Mr Paul Matshona	Zimbabwe school of Mines, AEGT Researcher
Mr Pemberai Sithole	Gwanda State University, AEGT
Mr Wellington Takavarasha	Chief Executive Officer, Zimbabwe Miners Federation
Mr Jokoniah Mawopa	Food Federation and Allied Workers Union of Zimbabwe, (in ZCTU)
Ms Lorraine Mumba	Legal officer, Community Working Group on Health
Ms Ashley Sabao	The Zimbabwe School of Mines
Engineer T Masiya,	Chairman, Institute of Mining Research, University of Zimbabwe
Dr Shepherd Shamu	Dep of Global Public Health and Family Medicine University of Zimbabwe Medical School

Also invited

Mr Makumba Nyenje,	Director, Zimbabwe Mining Safety, Health and Environmental Council (ZIMSHEC)
Mr Nathan Banda	Southern African Trade Union Co-ordinating Council/ EQUINET
Mr Stableck Savere	Programmes manager, Rural District Council Association of Zimbabwe
Ms Pamela Mudziviti	Ministry of Local Government and Public Works
Ms Patience Jongwe	North Eastern Regional office, ZCTU