COVID-19 RESPONSE SERVICES IN ZIMBABWE

What is the Way Forward?

HEAL ZIMBABWE
celebrating diversity • overcoming adversity

NATIONAL ASSOCIATION of SOCIAL WORKERS

COVID-19 RESPONSE SERVICES IN ZIMBABWE

What is the Way Forward?

Published by

National Association of Social Workers Zimbabwe
Makombe Government Complex, Block 3, Office 83 & 9
Email address: info@nasw.org.zw
Tel: +263 242 799001

Heal Zimbabwe Trust
36 Arundel School Road, Mount Pleasant, Harare
Email address: info@healzimbabwetrust.org
www.healzimbabwetrust.org

Research Team
Pride Mungwari (HZT)
Trust Zadzi (NASWZ)

Editorial Team
Prolific Mataruse (PhD)
Edknowledge Mandikwaza

TABLE OF CONTENTS

1. INTRODUCTION

Global health, economies, polities and social systems are overwhelmed by the COVID-19 pandemic. The outbreak of COVID-19 in December 2019 in Wuhan China became another example exposing how legacies of global inequality, privilege, mismanagement, corruption and poor resourcing had crippled health care and social protection systems in the developing world.

Findings in this article are based on interviews with COVID-19 survivors and frontline workers. What came out of the research is that the devastating nature of the disease and the speed with which the virus spread across the globe demands that countries devise well supported health care and migration governance systems that swiftly test, isolate and manage cases of COVID-19 on one hand. On the other hand, the pandemic demands that sound social protection measures be activated to provide:

a) social assistance to income constrained households including Persons With Disabilities (PWD), Child Headed Families and the elderly,

b) social insurance to cushion working groups from descending into situational poverty,

c) social equity to survivors of COVID-19 from discrimination and stigmatization, and

d) social services including safe educational services for children throughout the country, services for detecting and responding to sexual and gender based violence, and stabilizing the supply of potable water in urban areas and waste management services.

For Zimbabwe, these essentials have long been compromised by decades of economic collapse, politicization of welfare programs and lack of resources by the Department of Social Welfare and other key government departments. The discovery of the first case of COVID-19 in Zimbabwe on the 20th of March, the declaration of a national lockdown from the 30th of March and influxes of Zimbabweans returning into the country all implied a heightened risk for every citizen in the country. The case also implied heightened vulnerability for labor constrained citizens including PWD, Orphans and Vulnerable Children (OVC), the elderly and disadvantaged women whose livelihoods depend on informal trade. This is the context in which sound social protection becomes fundamentally urgent as a life saving and life assisting tool. This research brings out a complex primary description from which suggested strategies to effectively respond to COVID-19 pandemic can be built.

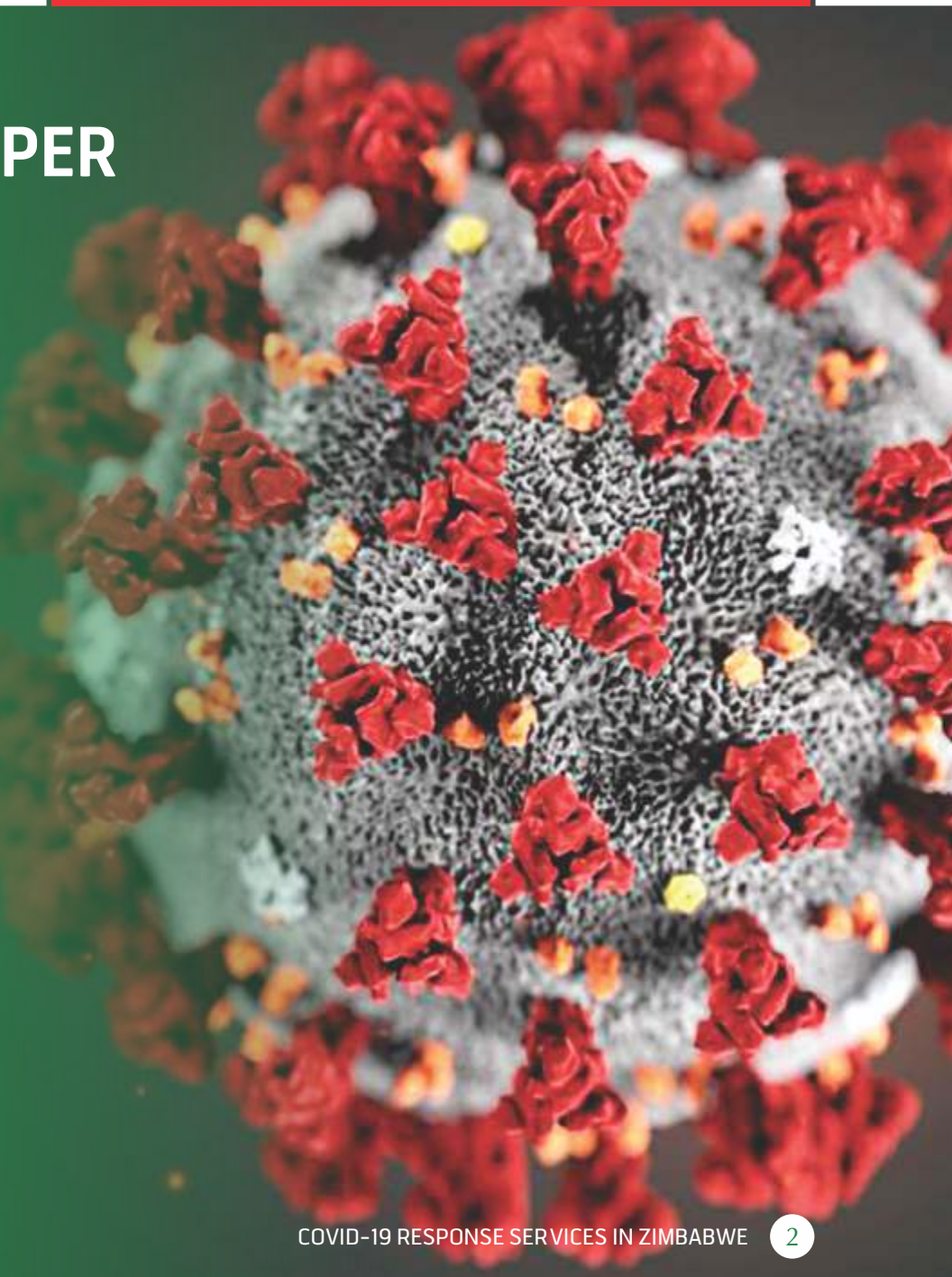
2. OBJECTIVES OF THIS PAPER

This brief seeks:

a) To outline the experiences of communities affected by COVID-19

b) To highlight emerging social protection challenges within the COVID-19 response framework

c) To propose strategies for enhancing COVID-19 response services.



3. METHODOLOGY

Heal Zimbabwe Trust (HZT) in partnership with the National Association of Social Workers Zimbabwe (NASWZ) collected the data used in this report from April to end of July 2020, using Participatory Action Research, with the aim of enhancing COVID-19 response services in Zimbabwe.

A total of 40 survivors of COVID-19 and 10 frontline workers were engaged on the second objective of this report. HZT and NASWZ also used HZT's Early Warning and Early Response network to collect data on the first and third objectives of this report.

4. COMMUNITIES EXPERIENCE WITH COVID-19

For most grassroots communities, COVID-19 was indeed a distant novel virus marred in myths that only the affluent, urban based and whites were vulnerable. This later changed as citizens began to receive more information about the virus, witnessed the government introducing drastic measures to combat the virus, and felt the irking economy and deteriorating social services in the country. Their experiences shaped the following socio-economic categories:

4.1. Restricted Social Life

The government of Zimbabwe introduced Statutory 83 of 2020 banning all public gatherings of more than 50 people and ordering people to stay at home. Stay at home orders were further tightened on the 21st of July 2020, with a 12 hour public curfew. This provision implied limited space for spiritual and educational activities for churches and students respectively. During the first 21 days of the lockdown, people's compliance with the stay at home orders varied with geography. As the lockdown prolonged, people started gathering in market places especially in Mbare, Mutare, Chitungwiza, Masvingo and Chipinge. In rural communities, gatherings such as huge family functions and community gatherings decreased. It was noticed, however, that in the rural areas especially in Mutasa, Chipinge, Hurungwe, Mt Darwin and Gutu, community members continued to shake hands during community meetings and funerals due to misinformation.

Most rural communities at first thought COVID-19 only affected urban areas, and proceeded with their usual gatherings. Village Health Workers (VHWs) were, however, instrumental in transforming risky behaviors, albeit their limited protection from the virus. Arguably apart from the enforced wearing of masks and a few other regulatory requirements life has continued as business as usual in many parts of Zimbabwe.

Joint operations by members of the Zimbabwe Republic Police (ZRP) and the Zimbabwe National Army (ZNA) at Growth Points and townships such as Mupandawana, Jerera, Murambinda, Nyika, Ngundu, Birchenough Bridge, Mushumbi, Mutawatawa, Hauna, Mutora, and Wedza helped to reduce people's gatherings, and enhanced consciousness to the fact that the virus was real. Nonetheless, gatherings including traditional beer gatherings,

cooperative works (Nhimbes/amalima) continued uninterrupted in areas where the police were not monitoring. Some of these areas include, Wedza, Chivindani in Chivi, Nyamupfukudza in Magunje, Sihazela community in Tsholotsho, and Mabee in Chipinge.

In urban areas, especially high density suburbs, such as Chitungwiza, Mabvuku, Glen Norah, Highfields and Warren Park in Harare queues at community boreholes and other water points increased. Most of the boreholes did not have sanitizers to help reduce transmission through borehole handles. These queues continued throughout to July. In Chitungwiza for example, unsafe water sources like wells are the usual source of everyday water, largely as a result of an existing water problem. This has been exacerbated by current droughts and climate change related reasons. Similarly, more people increasingly queued for subsidized mealie-meal and transport in Harare, Chitungwiza, Gweru, Mutare, Chipinge, Masvingo, Zvishavane, Bulawayo, Mutoko, Murehwa, Marondera, Bindura, Norton, Karoi and Chinhoyi among other major towns. Police attempts to enforce social distancing at queues for basic goods and services were futile in most areas, especially on mealie-meal queues. The queues were further made longer by the fact that there were no other social assistance modules to help feed people during the restrictive lockdown. It is important to highlight the nationalization of public transport under the Zimbabwe United Passenger Company (ZUPCO) as a measure to curb Covid-19 although this did not curb queues and left commuters stranded.

4.2. Restrictive Business Environment

Statutory Instrument (SI) 83 of 2020 further restricted business operating hours and banned the informal sector from operating, making it difficult for people to buy essential goods and services whenever they required them. This was further worsened by the fact that by mid-May, most shops in rural areas had run out of stocks on sugar, salt, mealie-meal and cooking oil. Heal Zimbabwe was interested in this dimension, given its watchdog role in ensuring that people's right to sufficient food and water provided for by Section 77 of the Constitution of Zimbabwe are observed.

Only well-established supermarkets were open in urban areas during the first 35 days of the lockdown. This partially explains why there were long queues for mealie-meal in most urban areas. In rural communities, most of the shops were closed and the few that were open took advantage of the situation to hike prices for basic commodities such as cooking oil, sugar, dried carpenter and flour. This was observed in Chivi, Gutu, Chirumhanzu, Muzarabani, Bikita, Chipinge, Mazowe, Mt Darwin and Mbire among other districts. This problem continued unabated despite the government issuing a directive that all prices should be restored to those of 25 March.[1] Some of these shops also stopped accepting the Zimbabwean Dollars (Bond

1. Vice President Kembo Mohadi announced that prices of basic commodities should revert to those of 25 March: https://www.zimeye.net/2020/04/23/price-controls-govt-orders-businesses-to-go-back-to-march-25-prices-is-it-feasible/

notes and RTGS), demanding that all payments be made in US dollars or South African Rands. An increase in backdoor tuck shops was also recorded in most high density suburbs in Harare, Masvingo, Chitungwiza, Nyika, Chiredzi, Lupane and Banket. Most of these tuckshops charged their goods in US dollars, arguing that the Zimbabwean dollar will swiftly lose its value before the country's lockdown ends and force them out of business. Extreme cases were recorded in Magunje and Chimanimani in which local bars were opening at night and people would flock in their numbers. In Norton, a local beerhall operator opened a Shebeen at his residence for some days, until police managed to stamp it out. Nevertheless, a new phenomena has been the emergence and proliferation of the shebeens/informal beer outlets in many areas in Zimbabwe under the COVID-19 restrictions. Also consumption of illegal liquor types and drugs increased. Notably, cross border trading also continued despite the closure of the borders notably to South Africa at Beitbridge, to Mozambique, and Zambia. By the 31st of May, most communities were being charged between ZW$150.00 and ZW$300.00 for a 2 litres of cooking oil, ZW$150.00 and ZW$220.00 for a 2kg of sugar and between ZW$220.00 and ZW$300.00 for a 10kg of mealie meal when one was using cash. These prices increased with at least 40% when one was using Ecocash (a mobile money platform in Zimbabwe) to make a payment. Community members in Chivi highlighted that the charges went as high as 60% for all Ecocash transactions when the lockdown was initiated. Below are two graphs indicating these price changes across 5 districts.

Figure 1: Prices of basic commodities by 30 April 2020

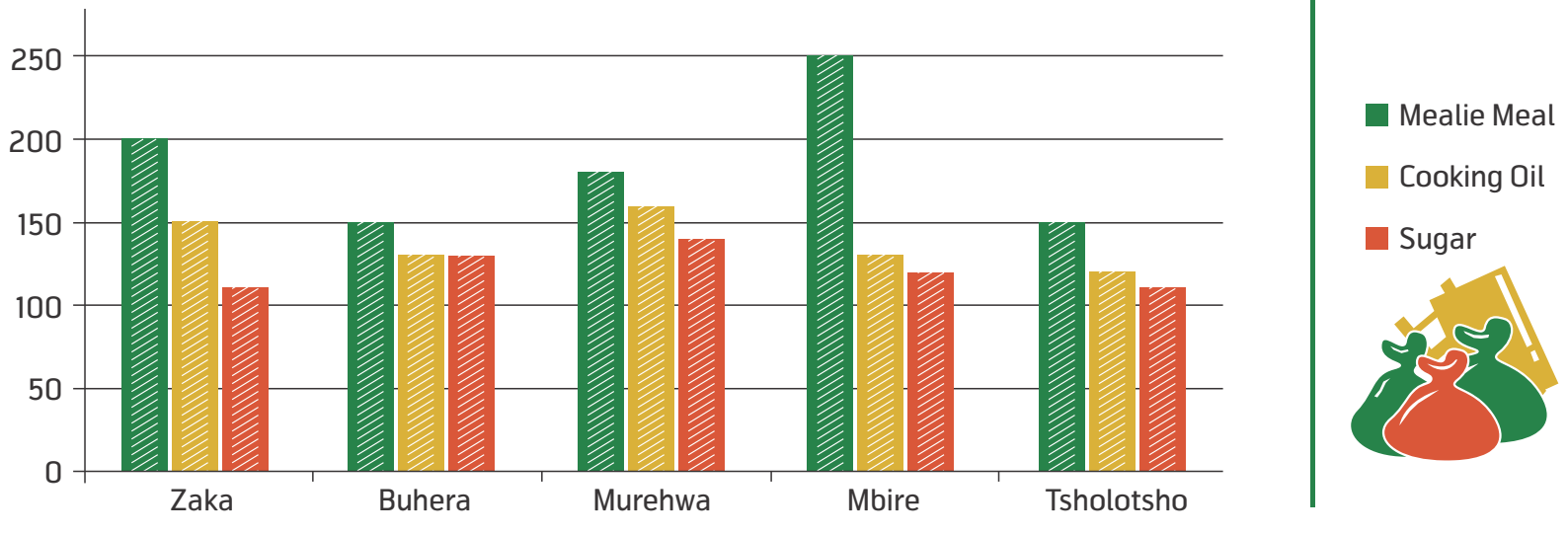
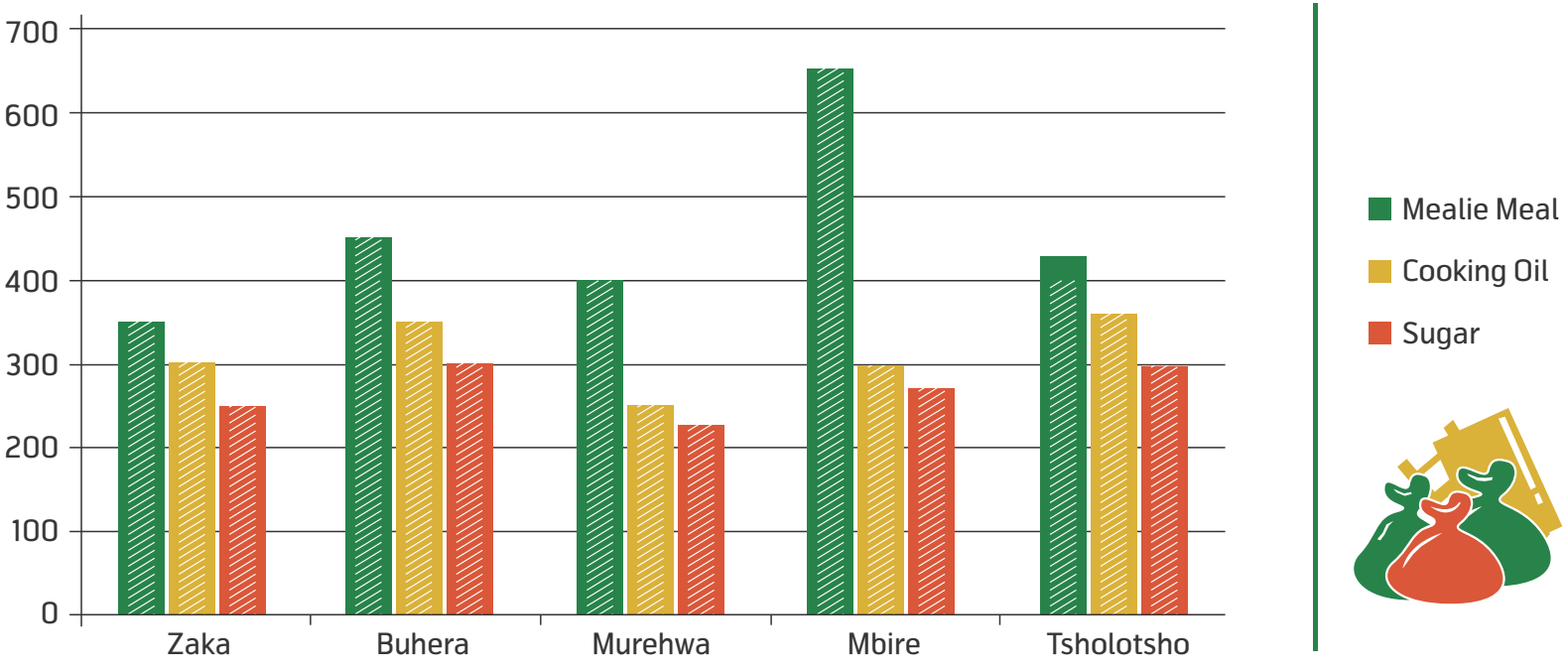


Figure 2: Prices of basic commodities by 20 July 2020



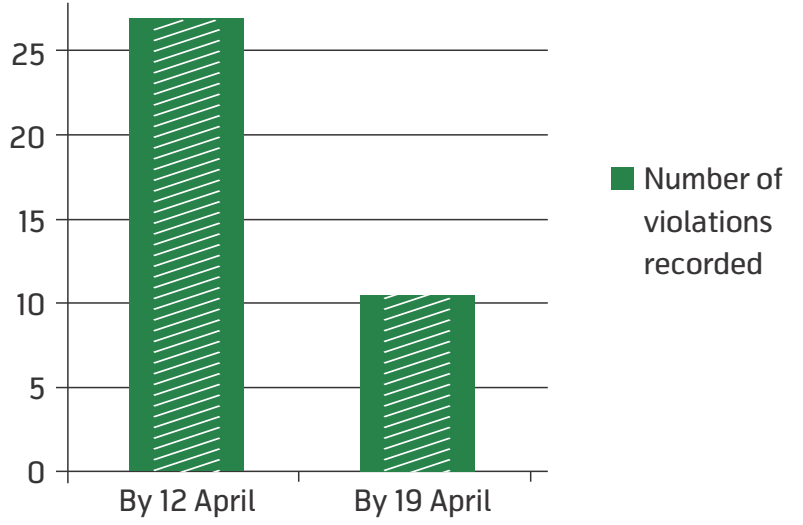
Although income ranges for most Zimbabweans, who are employed in the informal sector, could not be established, this report utilized publicly available estimates on civil servants' salaries to establish the ability of formally employed persons to afford a decent living during the COVID-19 pandemic. The government of Zimbabwe introduced a non-taxable monthly COVID-19 allowance of US$75.00 for all civil servants, a non-taxable monthly allowance of US$30.00 for pensioners and increased salaries of all civil servants by 50%, ensuring that the least paid government employee would get ZWL$3,000.00.[2] The adjustments were crucial in enhancing the resilience and motivation to perform among frontline workers and protecting the buying power of government employees. Nonetheless, inconsistencies in disbursing COVID-19 allowances and hyperinflation eroded the purpose and value of these salary increments.

2. Chronicle 18 June, 2020: https://www.chronicle.co.zw/forex-allowances-salary-hike-for-civil-servants

By June 30, nurses had received ZW$3 500 (ZW$2000 less of their salaries).[3] Teachers whose salaries range between ZWL$3 800.00 and ZWL$4 200.00 were yet to receive their COVID-19 allowances by 31st of July. Teachers were also questioning salary disparities between them and uniformed services who were allegedly pocketing between ZW$10 000.00 and ZWL$18 000.00.[4] According to the Consumer Council of Zimbabwe, an urban based family of 6 would require ZW$8 725.00 for it to sustain itself for a month;[5] implying that most urban based nurses and teachers are facing difficulties in sustaining themselves. The situation could be dire for families surviving on the informal sector.

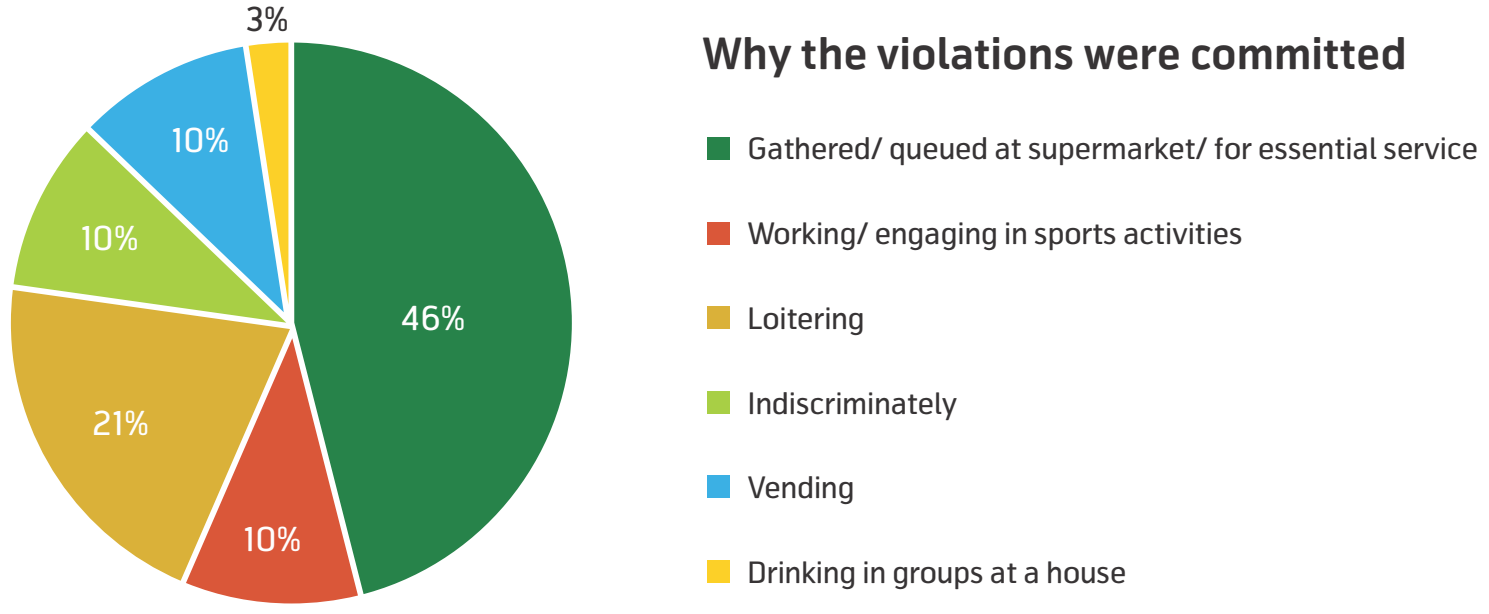
Communities also had difficulties in accessing business centres during the initial restrictive 35 days of national lockdown, a situation that continues to date. This also implied limited access to cash and savings, which without it, household livelihoods were at stake. Pensioners' monthly earnings, diaspora remittances, workers' salaries and other incomes saved in banks were all exposed to losing their value as their owners could not easily withdraw them. Queues could be observed at major supermarkets nationwide and at times social distance was observed or violently enforced by the police and army. In Masvingo, Harare, Gweru and Mutare community members were randomly beaten by police officers and soldiers even when they were looking for essential goods and services. It was common in high density suburbs to see civilians running away from police and army patrols during the day. Civil society mechanisms for responding to public violence were shutdown during the first weeks of the lockdown, leaving people without an alternative protection system. Below is a graph showing the brutality of enforcement officers in 1 week of the first 35 days of the lockdown. Later on the introduction of 6pm to 6 am curfew would further restrict movement with widespread reports of beatings of those caught moving outside the curfew times.

Figure 3: Human rights violations recorded



3. Voice of America: https://www.voazimbabwe.com/a/zimbabwe-soldiers-salary-protests/5466520.html
4. Bulawayo 24, 3 August 2020: https://bulawayo24.com/index-id-news-sc-national-byo-189808.html
5. Chronicle 18 June, 2020: https://www.chronicle.co.zw/forex-allowances-salary-hike-for-civil-servants/

Figure 4: Reasons for the violations



4.3. Social distancing at exempted gatherings (Right to food and water)

SI 83 of 2020 required that people observe a distance of at least a metre whenever in public spaces. Heal Zimbabwe's EWER Committee members observed that rural communities embraced this principle, except at funerals and traditional beer drinking gatherings. During the first weeks of the lockdown, motorists queuing for fuel at Gokwe Centre parked their cars with at least a metre in between them. Most aid distribution exercises observed in Buhera, Maramba-Pfungwe, Chipinge and Gutu also observed social distancing and hand hygiene practices. Nonetheless, the principle has proved difficult for urban citizens queuing for essentials especially mealie-meal, transport and water. For example, in Zaka, on April 13, the police ended up dispersing everyone from Flex Mart and forcing the shop to close after people who were in the queue failed to observe social distancing. In Norton Katanga and Mutoko Centre, police officers and soldiers failed to order people who wanted to buy mealie-meal to maintain social distancing during the month of April. The enforcement officers ended up abusing the queues and bought their own mealie-meal and left community members shoving each other in the queues.

4.4. General mobility (Freedom of movement)

HZT's Early Warning and Early Response network also noted that this was difficult to assess in rural communities except when considering long distance travels. The report compared the way people used to move to and from local townships and business centres and between towns. Community members kept their movements to farms and gardens as usual. In urban areas, particularly high density suburbs, the number of people moving around was lower during the first days of the lockdown.

This could be attributed to the fact that people were afraid of the virus as well as the enforcement officers as they were beating up people caught moving around. However, Heal Zimbabwe noted that people started moving around with the extension of the lockdown. Most of the people highlighted that they could no longer stay in their homes since food stocks and income savings had depleted during the first 21 days of the lockdown.

Small taxis plying in urban areas and between major towns resurfaced soon after an extension of the lockdown on the 1st of May. By the 20th of May 2020, community members from Lupane, Tsholotsho, Mwenezi, Buhera, Gutu, Chipinge, Wedza, Mutare, Zaka, Chivhu and Chiredzi were raising concerns over the way in which taxis dubbed "mishikashika" were overloading people. Reports from these districts show that these transport operators were escaping fines through physically avoiding roadblocks and bribing officers manning road blocks. Transport operators took advantage of the fact that ZUPCO, the only transport company allowed to ferry people travelling for essential goods and services, was only servicing a fraction of urban dwellers. Government's emphasis on the need for one to produce a stamped letter showing that he or she is an essential service provider or travelling for an emergency opened a floodgate of people traveling. Several people used letters with fake stamps and enforcement officers could not verify the authenticity of these documents. This can be related to the sudden spike in the number of confirmed cases of locally transmitted COVID-19 later on.

Heal Zimbabwe also noted that since the start of the lockdown on the 30th of March right through the time of writing in August 2020, citizens returning from Mozambique and South Africa or cross border traders using undesignated points of entry in Beitbridge, Mwenezi, Chipinge – Mt Selinda and Zamuchiya areas, Chimanimani, Mutare, Mutasa, Mudzi and Mt Darwin areas have continued unabated. These returnees are escaping mandatory testing and quarantine services. An informal network of corruption was facilitated by commuter drivers commonly known as Malaitsha who moved people, dead bodies, and goods through undesignated areas. It is noted that security officers (South African and Zimbabwean police and soldiers) manning the borderline would be bribed. Some of the cases became tabloid scandals and some were reported to relevant organizations. Heal Zimbabwe received two cases of suicides in April, where community members alleged that, two of the three involved individuals had travelled to Mozambique and returned with symptoms similar to those of COVID-19.

It is alleged that the two persons decided to commit suicide after their relatives stigmatized and discriminated against them. Returnees entering the country through illegal means were also raising fear among community members, who by the 1st of May were becoming conscious to the fact that the virus was aggressively spreading due to unsafe migration and mobility practices. But generally it can be noted that cross border movement was sustained right through the lockdown period using undesignated border crossing points.

4.5. Levels of information about COVID-19 (Right to information)

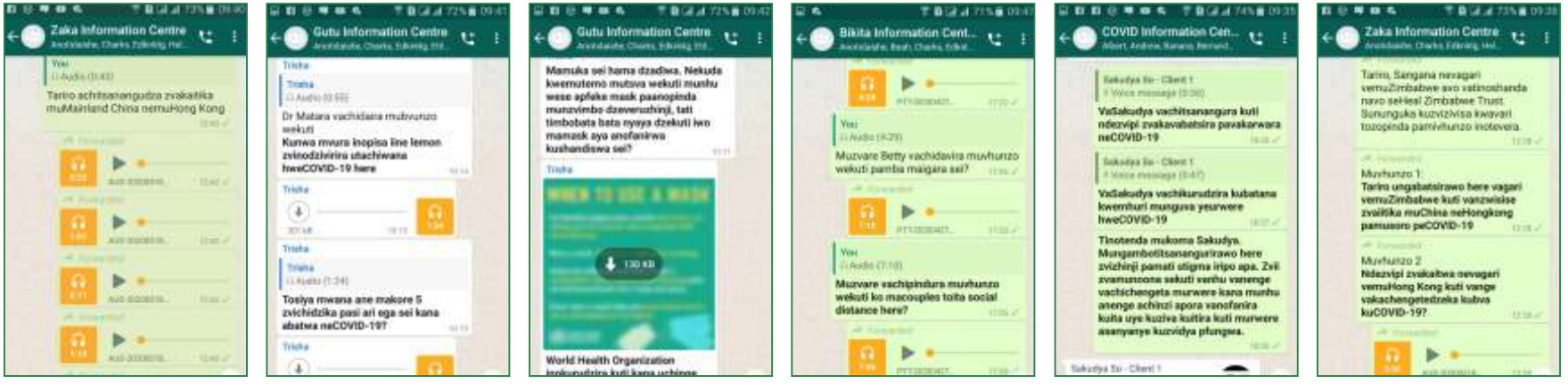
HZT and NASWZ observed that Zimbabweans are now, to a significant extent, knowledgeable about the virus, although this has had limited impact in terms of change of behaviour, which makes it important to sustain information campaigns. There is some clarity on where to get specialized COVID-19 services, key symptoms to track, preventative measures and ways of managing COVID-19 patients although there are significant information gaps. The new understanding could be as a result of widespread campaigns by the government, non-governmental organizations and churches on the virus through radio and television programs. Community members from across Heal Zimbabwe's operating areas also highlighted that they were receiving important information about the virus through social media platforms such as WhatsApp and Facebook. Heal Zimbabwe also observed that Village Health Workers (VHWs) were also playing a critical role in providing communities with information on the virus. By the 31st of May, most community members highlighted that they had installed hand washing tools at their gates so that visitors wash their hands before entering the gates, with the assistance of VHWs.

To help close the information gap, Heal Zimbabwe has been providing verified updates on the virus to grassroots communities on WhatsApp Groups. The organization has also provided an opportunity for frontline workers in the United Kingdom, China – Hong Kong and

Zimbabwe to interact with grassroots communities sharing information on the virus, debunking myths about COVID-19 and sharing preventative measures that other countries are pursuing. The organization has also hosted two survivors of COVID-19 on the WhatsApp platform as a way of strengthening the resilience of communities in fighting the virus. These groups have a total of 429 participants, who also share this information to their contacts.

Heal Zimbabwe also observed that Village Health Workers (VHWs) were also playing a critical role in providing communities with information on the virus.

Screenshots of Heal Zimbabwe Virtual Information Centres



The import of such solidarity across nations is apparent in the conversations above. What is worrying is the trend that there is widespread disregard of COVID-19 safety measures. This may point to the need for concerted efforts to provide information not only about how not to contract COVID-19 but to also share information on how to manage it once one has it. This also means thinking of ways of overcoming fear of being tested, overcoming stigma from the disease, health diets, what to do in self-isolation and being able to tell stories of those that recovered from COVID-19. Also, in the age of fake news and social media, it is important to create locally credible sources of information that can be reference points for verified information dissemination.

4.6. Preparedness of relevant state institutions (Right to basic health care services & government obligation to provide health services)

Heal Zimbabwe's EWER Committee members reported that there was gradual improvement in the preparedness of key institutions as compared to the first 14 days of the lockdown. The Department of Social Welfare is manning several quarantine centres across the country in which all returning citizens are kept for at least 14 days. The Ministry of Health and Child Care have also increased its testing and isolation centres across the country. However, by the 5th of June, Heal Zimbabwe received reports of human rights abuses in quarantine centres, overcrowding and inadequate food, especially, in Harare, Masvingo, Bikita and Lupane quarantine centres. This resulted in many returnees protesting against their continued stay, and others fleeing from the centres before their quarantine period lapsed. By the 14th of July, 215 returnees had fled from quarantine centres and the ZRP was searching for them.

During the initial restrictive 35 days of the lockdown, most hospitals and clinics in the countryside refused to treat any other ailments except for chronic diseases and refused assisting expecting mothers, relegating such patients to Village Health Workers. In Gokwe South, Chipinge, Mazowe, Chimanimani, Masvingo, Maramba-Pfungwe and Mudzi, hospitals and clinics were stating that they do not have adequate Personal Protective Equipment (PPE). Yet, VHWs who had to help their fellow community members also lacked PPEs.

They did not have sufficient knowledge on how to handle their patients in a manner that will not expose either of them to infection. In Maramba-Pfungwe, a local clinic refused to administer baby vaccines and conducting regular check-ups that are recommended for infants.

Nonetheless, it emerged that most of the frontline workers were still afraid of rendering their services even when provided with PPEs. This was further aggravated by the fact that some of the frontline workers who were being infected across the country were not getting adequate social assistance and social insurance services from the government.

4.7. Social Assistance (Government's obligation to ensure social protection)

By end of 2019, over 5 million people in Zimbabwe were deemed as food insecure.[6] By the lapse of the first 21 days, the Government of Zimbabwe had not rolled out any social assistance program to vulnerable groups who, before the lockdown, survived from hand to mouth across the country. This was against the fact that government had announced that by the 14th of April, one million households had been shortlisted for the COVID-19 relief funds through the Department of Social Welfare. The implementation of this policy remains unclear and there is some contestation on whether government ever distributed any such funds. Although government announced that it had earmarked funds for issuing out social assistance programs under COVID-19 Fund on the 19th of April, none of the funds had been disbursed by the 31st of May. On the 2nd of June, Heal Zimbabwe received reports that close to 500 NetOne sim cards that were supposed to be used for the fund beneficiaries in Masvingo urban were stolen. It is alleged that the thieves thought that the sim cards had already been loaded with the COVID-19 funds. Informal traders at Wedza Growth Point also highlighted that they had submitted their names to the Ministry of Women Affairs, Gender and Community Development after they had been promised of assistance. However, by the 16th of May, none of them had received the funds. They were concerned that the promised amount of ZWL$200.00 per trader was going to lose value before the Ministry even dispatches it to them. A US$75.00 Covid-19 allowance was however extended to civil servants, although most civil servants failed to access this money as banks refused to give them as cash, as government indicated that it can only be used as swipe money, and as shops refused to transact the US$75.00 allowance.

> *Most vulnerable groups comprises of people with disabilities, child headed families, children and women who work and live on the streets, the chronically sick, and the elderly among many others. However, people in the informal sector, business operators, pensioners, returnees, COVID-19 patients and frontline workers qualify in the category of vulnerable groups. Assistance in the form of cash transfers, food and non-food items particularly hygiene and sanitary wares would have helped insulating both vulnerable groups against starvation, loss of investment/income and involuntary breaching of the lockdown terms.*

The state is obliged by the constitution to provide social security and social care to those who are in need.[7] COVID-19 pandemic came at a

6. Retrieved from: https://www.aljazeera.com/news/2019/11/zimbabwe-food-crisis-food-security-national-security-191128194417897.html
7. Section 30 of the Constitution of Zimbabwe

time when citizens were struggling to sustain themselves in a highly volatile political, economic and climate change affected environment. Incidences of partisan distribution of social assistance programs in the countryside continue to be reported, and government has not taken any corrective measures. For instance on the 1st of July 2020, Chimanimani East Member of Parliament, Joshua Sacco forced community members from Ward 15 and Ward 4 to chant ZANU PF slogans during a rice distribution meeting. In Chiredzi, a local legislator hijacked the government subsidized mealie-meal from local shops and ensured that only members of ZANU PF access the mealie-meal. This was also observed in Zaka Central, where the legislator highlighted that ZANU PF Chairpersons were going to sell subsidized mealie-meal in the constituency, instead of supermarkets.

In April, in Gutu Ward 31, food aid from the Department of Social Welfare was distributed as a token of appreciation to ZANU PF supporters who had attended a Presidential Rally at Matizha business centre. ZANU PF structures were used to compile names of beneficiaries, avoiding Village Heads who usually compile the names. In a similar development, in Mvurwi ward 28, ZANU PF position bearers demanded ZW$5.00 from community members stating that these will help them organize government aid during the lockdown. The process was done without the Councilor's knowledge and approval. A similar development was also reported in Mutasa Ward 21, where the ZANU PF Ward Chairperson moved around the ward asking for details of known ZANU PF supporters, stating that he was going to use them to compile names for the government's promised COVID-19 assistance. The link to ZANU PF political actors confirms the ruling party's control of state resources at its disposal and the unfair ability it creates for partisan activities. Largely, other political parties generally lack the resources and may face legal and political restrictions for partisan activity.

4.8. Social service delivery in urban areas especially water (Right to safe, clean potable water)

The provision of safe water, sanitation and hygienic conditions is essential for protecting human health during all infectious disease outbreaks, including of coronavirus disease 2019 (COVID-19).[8] COVID-19 was confirmed in Zimbabwe when Harare city and Chitungwiza town had long had poor supply of clean potable water. This continued without any improvement up to date. Community members in Mabvuku, Mbare, Budiriro, Highfields, and Glen Norah among other high density suburbs in Harare spend hours queuing at community boreholes for potable water. Adult women and young girls make up a greater population in these queues, eating into the time they are supposed to be engaged in their educational and other productive

8. Water, sanitation, hygiene and waste management for COVID-19: https://www.who.int/publications/i/item/water-sanitation-hygiene-and-waste-management-for-covid-19

activities. This exposes the gendered nature of the water crisis in Zimbabwe. Even in suburbs such as Warren Park and some parts of Kuwadzana, Dzivarasekwa and Mufakose where Harare City provides water more frequently, community members reported that they spend hours at community boreholes due to the poor quality of the water supplied by Harare City Council. In most cases, community members do not observe social distancing on queues.

There are no disinfectants at community boreholes, posing a great risk of widespread transmission of the virus through borehole handles. In Chitungwiza, some community members highlighted that they start queuing up at community boreholes from as early as 0300 hours. City councils especially Harare and Chitungwiza were accused of failing to ensure constant solid waste management services. Bins with waste in high density suburbs lie uncollected for days.

It has become common for households to buy water for drinking from individuals with private water sources. But given the economic crisis in Zimbabwe, with high levels of unemployment and a weak currency buying of water exposes serious inequalities and privileges that damn a lot of people to unsafe water sources. Decreasing availability of safe water, sanitation and hygiene have heightened the risk of communicable disease outbreaks for 3.7 million vulnerable people.[9]

9. Zimbabwe Situation Report 11 June 2020: https://reliefweb.int/sites/reliefweb.int/files/resources/Situation%20Report%20-%20Zimbabwe%20-%2011%20Jun%202020.pdf

5. EMERGING SOCIAL PROTECTION ISSUES

5.1. Returnees and Quarantine Centres

The Department of Social Welfare is mandated to manage Quarantine Centres throughout the country. By end of May, the Department had insufficient Social Workers to man all the quarantine centres. Although the number of Zimbabwean returnees is projected to rise close to 20 000 in the near future, the country received a total of 9 546 returnees by the 22nd of June, 2 136 of which were quarantined in 44 centres.[10] Heal Zimbabwe noted that by mid-May, most returnees who were under mandatory quarantine at Masvingo Poly-technique College and Belvedere Teachers College in Harare were complaining of overcrowding, sharing one bucket when bathing and sharing toilets. Returnees who were quarantined at Lupane State University also complained over lack of adequate bed linen and toiletries. Statistical data on returnees does not capture other returnees who came into the country through undesignated border points. By the 15th of May, Heal Zimbabwe received reports from borderline communities including Mudzi, Mutasa, Chipinge, Chiredzi, Mwenezi and Lupane of influxes of people crossing into Zimbabwe from neighbouring countries. Extreme cases were received from Chipinge in which 3 community members committed suicide allegedly after they were deserted by their family members for exhibiting COVID-19 like symptoms. Generally, quarantine centres have been institutions of learning like colleges and schools while there are some private centres in hotels or low density suburbs for the rich.

9 546

Returnees received

Returnees have also complained over the chaotic medical health care services in the quarantine centres. There seems to be lack of clarity on the number of days that returnees are expected to undergo mandatory quarantining and how cases are referred across different Taskforces. For instance, in May, groups of returnees at Masvingo Polytechnic College blocked staff from the Provincial Ministry of Health and Child Care from leaving the quarantine centre protesting that they had been kept for more than 21 days. By the 14th of July, 215 returnees had escaped from the quarantine centres, fleeing into their homes. At ZIPAM Quarantine Centre in Zvimba, returnees stayed more than 9 days without being swabbed. Furthermore, one of the returnees at ZIPAM could not be released after the Medical Doctor servicing the quarantine centre recommended that he immediately sees a specialist. He was released after 3 days, living in pain and this was due to bureaucracies around emergence releases.

10. Zimbabwe Situation Report 11 June 2020: https://reliefweb.int/sites/reliefweb.int/files/resources/Situation%20Report%20-%20Zimbabwe%20-%2011%20Jun%202020.pdf

Many returnees who were confirmed positive on COVID-19 were not even given pre-test or post-testing counseling. They only got to know about their results when ambulances came to transfer them to isolation centres. Experiences in quarantine centres are clearly an issue that requires further research to understand what happens/happened inside them, especially taking into consideration children and babies who are also brought into these centres.

5.2. Isolation Centres

Government controlled isolation centres lack entertainment facilities for the patients. Most of the isolated persons were exhibiting symptoms of depression due to boredom and idleness. This was also exacerbated by the fact that most of the patients were returnees into the country and had no locally registered phones to help them connect with their relatives. Yet no visitors are allowed for patients. As a result, most patients relied heavily on medical personnel to help them cope with the boredom and idleness. This put too much pressure on the medical personnel, who also lack skills in handling stress and are outnumbered by the number of confirmed cases requiring concerted psycho-emotional services. Heal Zimbabwe also received complains that in some instances, pain killers to deal with chest pains, cough and colds were taking too long to be delivered.

Most of the persons who were under self-isolation were complaining that the Ministry of Health and Child Care rarely follows up on the patients. This was over-burdening family care systems with the responsibility of ensuring that a fellow family member effectively adheres to infection prevention and control guidelines and healthy living in order for him or her to recover swiftly without infecting others. Although the National Association of Social Workers of Zimbabwe (NASWZ) was providing tele-counselling services, their services were concentrated in Harare Province and Mashonaland East only by the 30th of June. It also discovered that there were no smooth referral pathways for different task forces. This was complicating follow-ups, and de-isolation services. Patients and survivors of COVID-19 also complained that when the MoHCC visit them, they use ambulances creating stereotypes, perceptions and fear in local communities. This has resulted in entrenched discrimination and stigmatization of persons caring for COVID-19 patients and even confirmed survivors of COVID-19. Community members and members of the extended families socially exclude such persons in fear that they may contact the virus from them.

5.3. Frontline Workers

Frontline workers including Doctors and Nurses, Environmental Health technicians, oncologists and in some instances, Medical Social Workers have been complaining over the lack of adequate personal protective equipment in hospitals. The case has been more pronounced in hospitals and clinics that are not designated as COVID -19 isolation centres. For instance, Heal Zimbabwe received reports that by the 17th of May, nurses at Mutawatawa General Hospital were turning away patients citing lack of PPEs. From mid-April to May,

nurses at Masvingo Provincial Hospital were protesting over the lack of PPEs against an increasing number of returnees who were coming into the province. This has resulted in frontline workers protesting and turning away patients, fearing that they may end up contacting the virus. By the 21st of July, cases of frontline workers testing positive in Harare, Chivhu, Gweru and Bulawayo had hiked, creating tension and discomfort among frontline workers. Their main concern was that they had no sound measures for providing for their families, in the event that they are infected, let alone die from the virus or infect their family members. This also increased chances of burnout, yet the frontline workers do not have anyone to help debriefing them, let alone stable social insurance covers to help them balance between being in isolation and fending for their families. Frontline workers from Harare Isolation centres highlighted that the demands of their job were draining them. They felt they needed counselling services to help them cope with the trauma of working directly with COVID-19 patients. They also highlighted that there was a huge need for hospitals to have resident Social Workers, in particular in this COVID-19 situation, who would help with counselling and support of depressed workers and clients.

By the 15th of July, two returnees in isolation centres had lost their close relatives. They could not attend their funerals and medical workers in the isolation centres failed to assist them cope with their grief. The two patients exhibited symptoms of anxiety, depression and spent most of their times withdrawn and crying.

By the 14th of July, 3 Social Workers who were providing psycho-social support services in quarantine centres in Harare, Marondera and Chikomba districts had tested positive on COVID-19. They reported that they had not received any assistance from the government. Their families were distressed and were never assisted in raising food and other essentials during the isolation of their members. In Bulawayo, 13 health care workers tested positive on COVID-19 and several others were isolated, raising fear and panic among frontline workers in Zimbabwe. Most of the workers were mainly concerned with the security of their livelihoods and their families during isolation. They were concerned with the services that the government and other players were going to render in ensuring that their children attend school with adequate resources whilst they remain in isolation.

The lack of PPEs has resulted in frontline workers protesting and turning away patients, fearing that they may end up contacting the virus.

6. STRATEGIES FOR ENHANCING COVID-19 RESPONSE SERVICES IN ZIMBABWE

Given the highlighted experiences, Heal Zimbabwe and the National Association of Social Workers Zimbabwe propose that:

6.1. The Department of Social Welfare (DSW)

There is a great need to increase the number of resident Social Workers in all the quarantine and isolation centres. These Social Workers must be supported with adequate personal protective equipment and social insurance measures including medical and bereavement insurance policies to help cushion them in the event that they contract the virus. Their protective equipment must allow them to effectively engage with traumatized patients and other frontline workers. This makes space suites inappropriate for meaningful psycho-emotional services that the Social Workers are supposed to render within institutions.

The Department must also enhance performance of its current teams by ensuring that they are debriefed constantly to insulate them against possible burn-out and secondary trauma. Placement of Social Workers in institutions should be prioritized and focus on preparing returnees and their families before they are tested and before they receive their test results, and help them cope with the virus in the event they test positive. It is also imperative that the DSW supports COVID-19 patients in self-isolation at home with social assistance packages such as school fees assistance, food and non-food items, hygiene and toiletries. These are crucial resources. Their absence in a household may force COVID-19 patients who are under self-isolation to disregard isolation. Reports of pressure mounting on breadwinners who were racing against ensuring that their families have adequate food, savings and above all school fees before the end of July were common among patients in self isolation. The Department must therefore put in place ad hoc arrangements to ensure that breadwinners in such depressing circumstances are supported in meeting their social obligations in ensuring a basic maintenance of their families. This can be done by enlisting the COVID-19 patients on Harmonised Social Cash Transfers (HSCTs), Assisted Medical Treatment Order (AMTOs) and Basic Education Assistance Module (PBEAM) among other modules that the government is currently rolling out to vulnerable groups.

6.2. The Ministry of Health and Child Care

The Ministry of Health and Child Care must ensure that frontline workers servicing COVID-19 referral centres are adequately resourced

and trained in handling COVID-19 cases. Medical teams must have a basic training in handling trauma and facilitating referrals to Social Workers for trauma and grief counselling. The Ministry must also provide a social safety net for frontline workers, beyond the COVID-19 allowance to help provide for the dependants of frontline workers during self-isolation.

It is important for information campaigns to now shift from a focus on prevention measures like wearing masks towards disseminating information on how to manage possible cases, confirmed cases, and post-recovery cases. There is need for the Ministry to ensure that WHO guidelines on COVID-19 are uniformly applied across all hospitals and institutions. There has to be clarity and uniformity on how long a returnee can stay in quarantine and isolation, how returnees who fall sick in quarantine are treated and ensuring that drugs are readily available in quarantine and isolation centres. COVID-19 Taskforces must have a seamless procedure of referring patients. The Ministry can adopt digital technologies in ensuring that patients do not end up waiting for too long without follow-up from their respective medical teams.

6.3. The Civil Society Community

There is need for the donor community and civil society organizations to invest in protecting the rights of returnees, confirmed COVID-19 patients and frontline workers. Much of the services that the government and non-governmental organizations are providing focus on raising awareness of the existence of COVID-19, without laying down measures to protect and promote the rights of the persons directly affected by the virus. Social services especially those supporting education, nutrition and general welfare of children and other vulnerable groups remain underfunded. Similarly, social equity programs targeting business people in the formal and informal sector also remain critical during the fight against COVID-19 as these operators may end up sliding into poverty.

Civic organizations also need to increase awareness raising/case management initiatives on the virus in rural communities to strengthen infection prevention and control mechanisms at the grassroots level. Communities would benefit from increased advocacy around COVID-19 in order for them to effectively complement efforts in quarantine and isolation centres.

National Association of Social Workers Zimbabwe
Makombe Government Complex, Block 3, Office 83 & 9
Email address: info@nasw.org.zw
Tel: +263 242 799001

Heal Zimbabwe Trust
36 Arundel School Road, Mount Pleasant, Harare
Email address: info@healzimbabwetrust.org
www.healzimbabwetrust.org