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Field Based Evidence on the Impact of COVID-19 on Citizens in Zimbabwe

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1. Introduction and Background

Since March 2020 Zimbabwe has been fighting the COVID–19 virus using an already weak health delivery system. The COVID–19 outbreak occurred while the country is undergoing massive economic decline with the unpredictable local currency forcing service providers to increase their prices. The cost of living for a family of five increased by 254.27% from January 2020 to December 2020 while salaries have not increased correspondingly (Murisa, 2020)[1]. The government has largely had to 'learn-on-the-go' in addressing the competing yet equally important priorities of the citizens, business community and its oversight responsibilities. Globally COVID–19 has been a formidable challenge even for the more advanced economies. There have been some attempts to assist developing economies to effectively respond to COVID1–19. Zimbabwe, alongside others, has received some assistance from multilateral agencies such as the World Bank.

The Government of Zimbabwe (GoZ) has also come up with a number of mitigatory measures. On the 30th of March 2020, the GoZ announced a ZWL$600 million cash transfer program targeting 1 million vulnerable households during the COVID–19 lockdown period. The GoZ also announced a COVID–19 economic recovery and stimulus package[2] which is aimed at supporting different economic sectors such as agriculture (ZWL$6 billion), mining (ZWL$1 billion), tourism (ZWL$0.5 billion), SMEs (ZWL$0.5 billion), and arts (ZWL$0.02 billion) and for the expansion of social safety nets (ZWL$3.9 billion), setting up a health sector support fund (ZWL$1 billion), and scaling investments in social and economic infrastructure in Cyclone Idai affected communities (ZWL$18 billion). It is in this context that the SIVIO Institute is implementing the *"Improving Citizen Participation in Influencing and Overseeing the National Response to COVID–19"* program. This report presents evidence on the broad impact of COVID–19 on citizens across the country.

The COVID–19 outbreak occurred while the country is undergoing massive economic decline with the unpredictable local currency forcing service providers to increase their prices.

1. Murisa, T. 2021 The Fate of Livelihoods Under COVID–19 Lockdowns and Neoliberal Restructuring Harare: SIVIO Institute - https://www.sivioinstitute.org/wp-content/uploads/2021/02/The-Fate-of-Livelihoods-Under-COVID-19-and-Neo-Liberal-Restructuring.pdf
2. The Herald 5 May, 2020 "Covid–19 Economic Recovery and Stimulus Package: A $18 billion package: (9pc of GDP)" https://www.herald.co.zw/covid-19-economic-recovery-and-stimulus-package-l-a-18-billion-package-9pc-of-gdp/
See also - http://www.zimtreasury.gov.zw/index.php?option=com_phocadownload&view=category&id=56:press-statements&Itemid=759

1.1 Background

In March 2020, the President of Zimbabwe declared the outbreak of the COVID–19 virus a national disaster and called for the cancellation of all national and public events until a time when the government was satisfied that the country was no longer at risk[3]. As part of measures to control the spread of COVID–19, the government announced the Public Health (COVID–19 Prevention, Containment and Treatment) Order of 2020[4] and the Statutory Instrument 76 of 2020 the Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe) (COVID–19) Notice 2020 through which the government declared the COVID–19 pandemic a national disaster and announced a national lockdown for 21 days on the 27th of March 2020. Under the national lockdown, all non-essential services were banned, a 6 PM - 6 AM curfew was imposed, businesses providing essential services were limited to operate between 9 AM and 3 PM. This adversely impacted the formal and informal economy[5] increased poverty and vulnerability[6], and added pressure to livelihoods that were already buckling under pressure[7]. Many people's already limited access to health care was restricted further by the scaling down of services by government and private health care providers as well as the movement and travel restrictions[8].

In April 2020, the GoZ announced a ZWL$18 billion (US$720 million) economic recovery and stimulus package, which primarily targeted formally constituted and registered businesses[9]. The objective was to strengthen and expand existing social safety nets, including direct income support for vulnerable groups and individuals, improvement of financial inclusion through banks and micro-finance institutions and upscaling investments in economic and social infrastructure, while building the resilience of affected communities. The Minister of Finance and Economic Development also put in place a Coronavirus Crowdfunding Scheme to gather resources for national use. The 2% Intermediated Money Transfer Tax (IMTT) for social protection and capital development projects, and proceeds from the tax were also ringfenced and channelled towards COVID–19 related mitigatory expenditure[10]. These interventions are meant to strengthen households' economic resilience and food security[11]. The lockdown restrictions were relaxed using a phased approach which for instance, from 17 May 2020, companies and the private sector were allowed to operate after meeting certain conditions such as the compulsory wearing of masks wearing and testing employees at their workplaces.

3. ZBC News BREAKING NEWS: President Mnangagwa declares Covid–19 a national disaster https://www.zbcnews.co.zw/breaking-news-president-mnangagwa-declares-covid–19–a-national-disaster/?fbclid=IwAR3zyDOI7VcGyCJ2vLiz3bupshYI30punRSWGnyHODc9yc7UOtr4ggYY7I8
See also http://www.zim.gov.zw/index.php/en/news-room/latest-news/504–lockdown-measures-gazetted.
4. See The Public Health (COVID–19 Prevention, Containment and Treatment) (National Lockdown) (Consolidation and Amendment) Order, 2020 which details the consolidated Order after various amendments in 2020
5. https://www.sivioinstitute.org/wp-content/uploads/2020/09/SI-Report-Impact-of-COVID–19–Lockdown-on-Micro-Small-Medium-Scale-Enterprises-in-Zimbabwe.pdf
6. https://www.undp.org/content/dam/rba/docs/COVID–19–CO-Response/UN-Zimbabwe-COVID19–Socio-economic-Framework-Final.pdf
7. Murisa, T. 2021 *The Fate of Livelihoods Under COVID–19 Lockdowns and Neoliberal Restructuring* Harare: SIVIO Institute
8. Women and Law in Southern Africa 2020 Gender Needs Assessment. Unpublished Report
9. http://www.veritaszim.net/sites/veritas_d/files/Details%20on%20the%20COVID19%20Economic%20Recovery%20and%20Stimulus%20Package.pdf
10. https://zimbabwe.actionaid.org/news/2020/government-urged-allocate-and-utilise-covid–19–resources-transparent-and-accountable
11. https://docs.wfp.org/api/documents/WFP–0000119650/download/

The government's health response, through the Ministry of Health and Child Care (MoHCC), has been guided by the US$26 million National COVID-19 Preparedness and Response Plan[12] and through the Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (Consolidation and Amendment) Order of 2020 and its various amendments. Initially, the government introduced a blanket ban on all activities that were deemed "non-essential" to prevent the spread of the COVID-19 virus. With subsequent amendments to the Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (Consolidation and Amendment) Order, the government relaxed the population's movements and public gatherings to varying degrees depending on the appraisal of the statistics on new infection, hospitalisation and deaths. The government also set up structures to facilitate an effective response to the pandemic such as isolation and quarantine centres mainly at hospitals, schools and vocational training centres in the country. The government also instituted the national Inter-ministerial Taskforce, the Provincial Inter-ministerial and the District Taskforce led by the District Development Coordinator of the COVID 19 Team. The GoZ's effort to respond to the pandemic is also reflected in other different policy documents such as the Humanitarian Response Plan 2020 and the National Development Strategy 1 (NDS1).

Several policy documents have been drafted including the United Nation's Immediate Socio-Economic Response to COVID-19 in Zimbabwe framework which seeks to respond to the pandemic in an integrated way[13]. The most notable response action was when declaring COVID-19 a national disaster and the lockdown and movement restrictions. The government has, through the MoHCC, partnered with non-state actors including international agencies such as the United Nations Children's Fund (UNICEF) Zimbabwe, Medicines Sans Frontieres (MSF) and World Health Organisation (WHO) Zimbabwe to train medical personnel on the management of infectious diseases including COVID-19. The GoZ also created an interactive WhatsApp Platform with COVID-19 related information provided by the MoHCC and carried out awareness roadshows in various high-density residential areas at mapped potential COVID-19 hotspots.

12. http://www.zim.gov.zw/index.php/en/news-room/latest-news/covid-19-updates/497-covid-19-preparedness-plan-launched
13. https://zimbabwe.un.org/en/download/13451/50201

2. Methodology

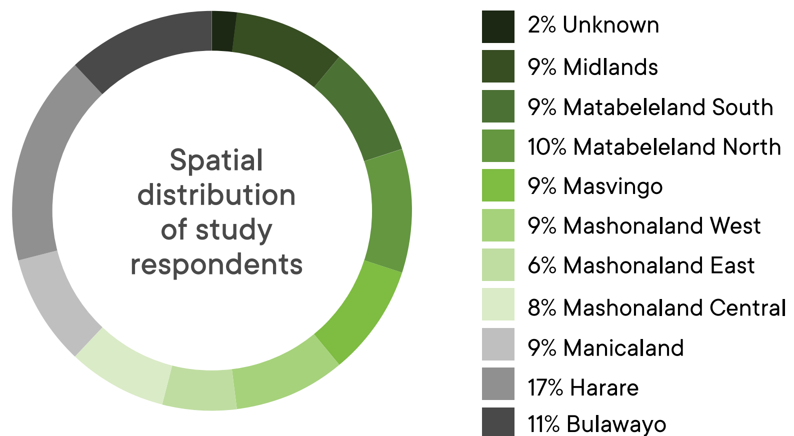
2.1 Data Collection Approach

We collected through a nationwide survey from the 11th of February to the 5th of March 2021. A mixed-methods approach was deployed whereby quantitative evidence on the socio-economic impacts of the pandemic was collected using a questionnaire. The questionnaire was completed by 3,162 respondents. Qualitative evidence was collected using key informant interviews who have been engaged in the response to the COVID-19 pandemic. This was augmented by a desktop study of the Government of Zimbabwe's public health interventions in response to COVID-19 and key informant interviews.

2.2 Description of sample

2.2.1 Spatial distribution of sample

Figure 1: Spatial distribution of study respondents



Harare contributed 17%, followed by Bulawayo (11%) and Matabeleland North (10%). Midlands, Matabeleland South, Masvingo and Mashonaland West and Manicaland all contributed 9% followed by Mashonaland Central (8%) and Mashonaland East (6%). A total of 2% of the respondents failed to properly indicate their location.

2.2.2 Age of respondents

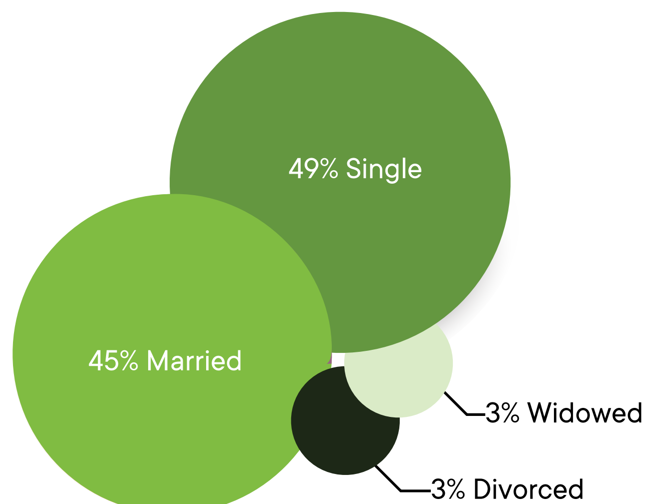
Figure 2: Age of respondents

The majority of the study's respondents (35%) belonged to the 26–35 age group, followed by 16–25 (28%) and the 36–45 age group (24%). The 46–55 age group contributed 9% while the 56–65 age category had 3% and lastly, the 66 and above category contributed 1% to the sample. The study managed to achieve an almost 50–50 representation of female and male respondents as female respondents were 50.44% and male respondents were 49.56% of the sample. A total of 63% of the sample was made up of youth respondents (i.e., those aged between 16 and 35 years).

2.2.3 Marital Status

Respondents were asked for their marital status and 49% indicated they were single while 45% indicated they were married. Three per cent (3%) indicated that they were divorced indicated they were divorced and 3% were widowed.

Figure 3: Marital status



2.2.4 Description of accommodation agreement

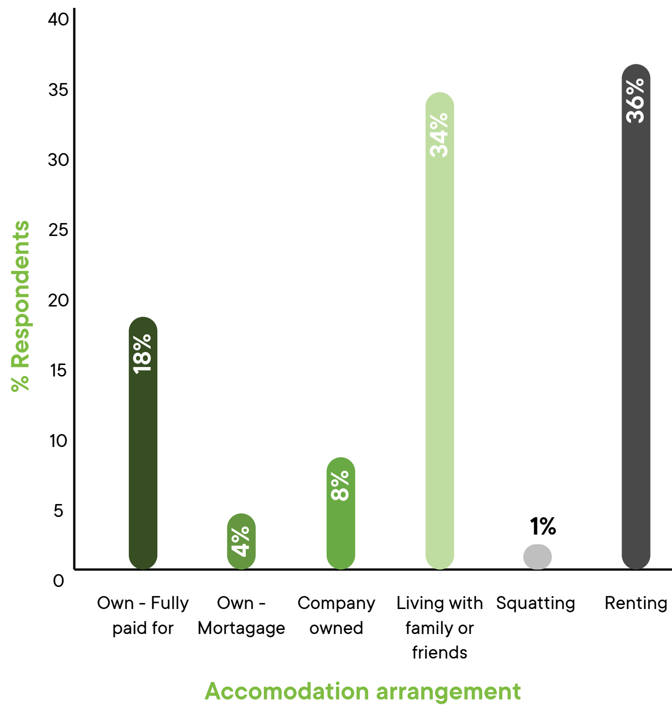


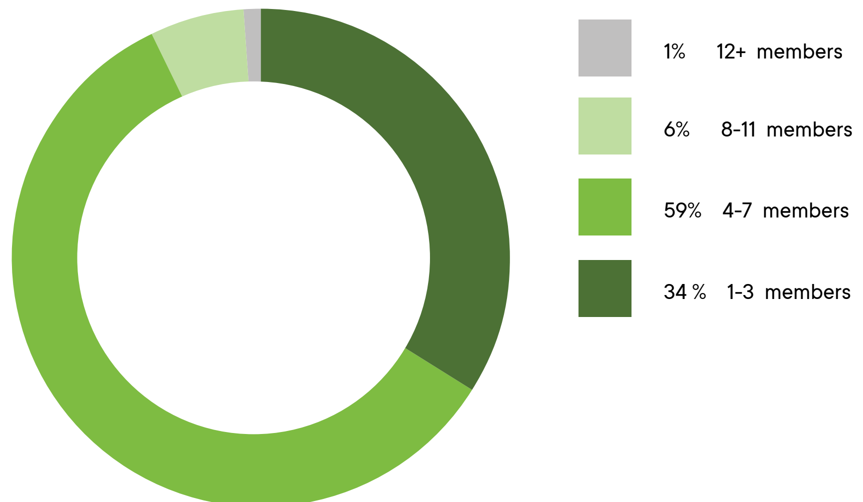
Figure 4: Description of accommodation arrangement

In response to this question, 36% indicated they were "Renting", 34% were "Living with family or friends" and 18% lived in "Own-fully paid for" accommodation, 8% lived in "Company-owned" accommodation, 4% in "Own-mortgaged" accommodation and just 1% indicated they were "squatting". Respondents were asked to indicate the number of people living in their household. Figure 5 shows the responses.

2.2.5 Number of people in each household

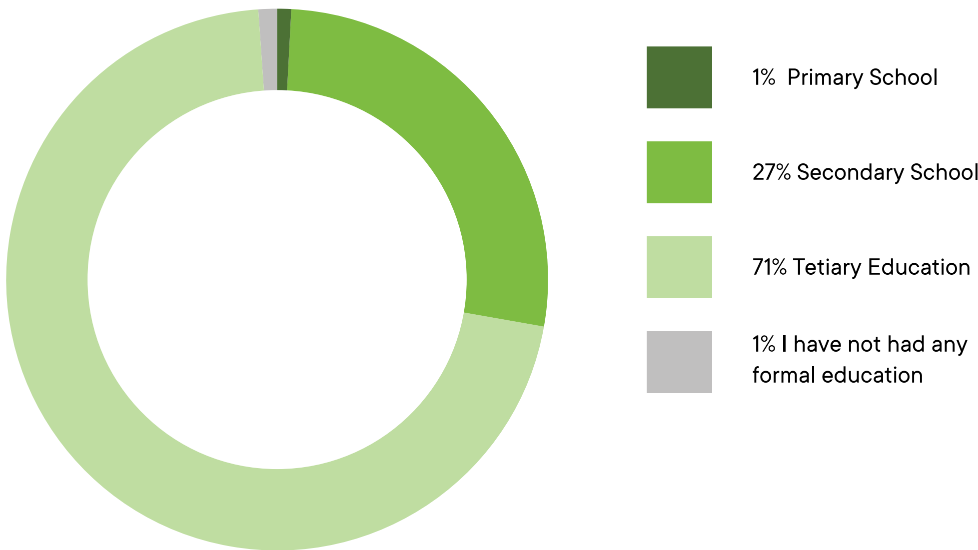
Figure 5: Number of people in each household

Fifty-nine per cent (59%) of respondents indicated their households had between "4–7 members", 34% had "1–3 members", 6% of the respondents had "8–11 members" and 1% of respondents had "12+" members in their households.



2.2.6 Highest Level of education attained

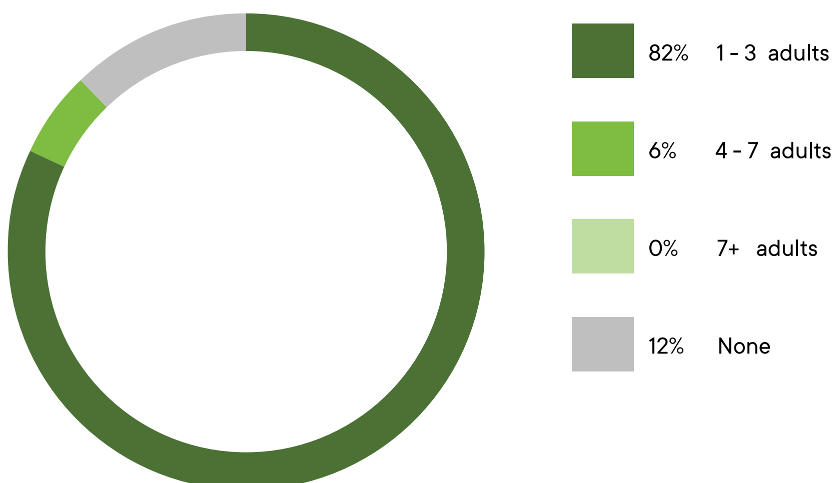
Figure 6: Highest level of education



Respondents were then asked for their highest level of education. The majority (71%) of the respondents have completed tertiary education followed by 27% who indicated they have completed secondary education. Respondents whose highest level of education was primary school were 1% and another 1% also indicated they had not had any formal education.

2.2.7 Employment status

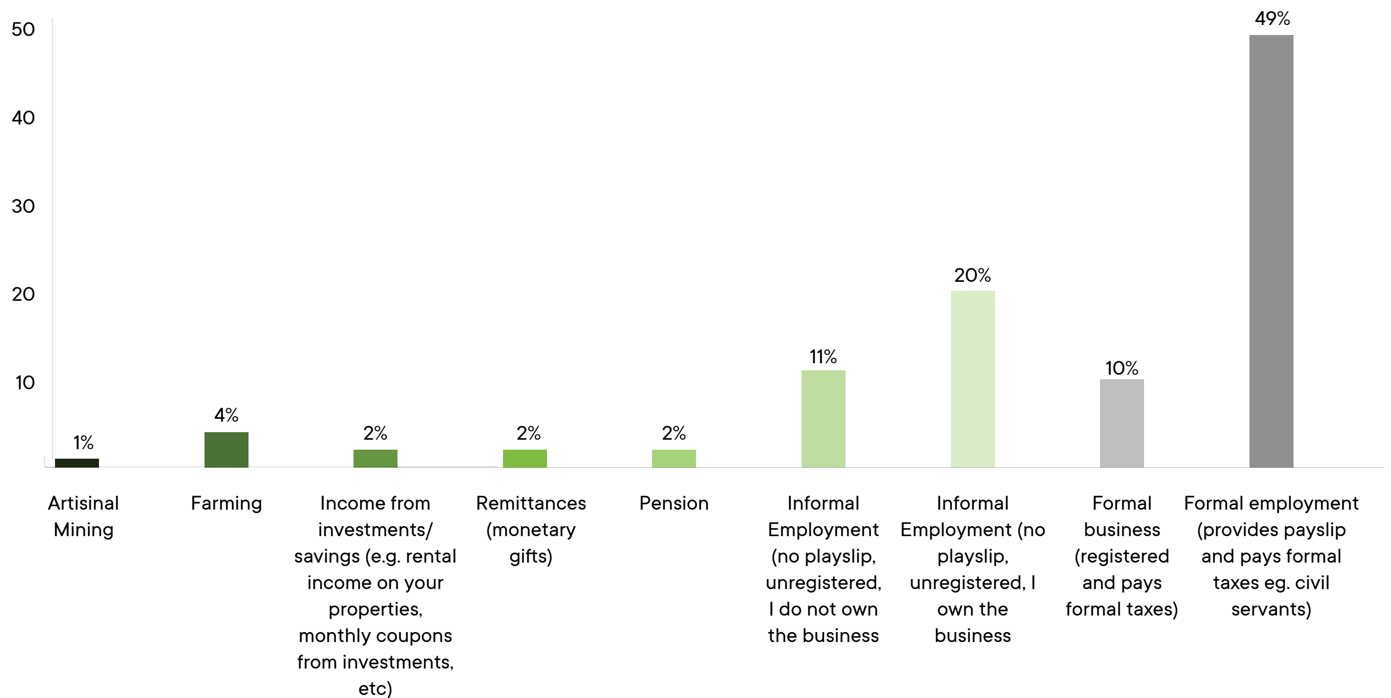
Figure 7: Number of employed adult members per household



Respondents were asked a set of related questions to establish the employment status and sources of livelihood for their households. Eighty-two per cent (82%) of the respondents indicated that their households had between 1 and 3 adults who are employed either formally or informally.

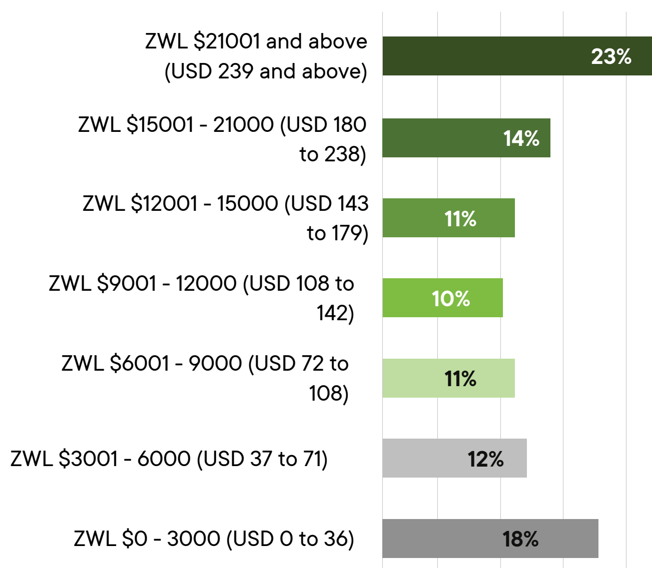
2.2.8 Households' income

Figure 8: Source of income



Most (49%) of the respondents indicated that they are engaged in formal employment, described as registered and pays taxes, was the main income source for their households, while 10% of respondents indicated that they own a formal business, described as a registered and tax-paying business, was their main income source. Approximately 20% of the respondents are in informal employment described as unregistered and which the respondents did not own and did not get a payslip. There were about 11% of respondents who own an unregistered informal business. Other sources of income include farming (4%), pension (2%), incomes from investments and savings such as rental incomes from own properties (2%), remittances (2%) and artisanal mining (1%).

Figure 9: Monthly household income



Respondents were asked to select the income bracket that covers their income for the previous three months and this was indicated in the local ZWL currency. Approximately 18% indicated that they had a monthly income of between “$0 and $3,000”, (US$0 to $36 at the Reserve Bank of Zimbabwe foreign currency auction rate at the time),[14] 12% selected “$3,001–$6,000” (equivalent to US$37 to $71), 11% selected “$6,001 - $9,000” (equivalent to US$72 to $107). 10% selected the “$9,001 - $12,000” (equivalent to US$108 to $142) bracket, 11% chose “$12,001 - $15,000” (equivalent to US$143 to $179) and 14% selected “$15,001–$20,000” (equivalent to US$180 to $238). The highest income bracket of “$20,001 and above” (US$239 and above) was selected by the highest percentage of respondents (23%).

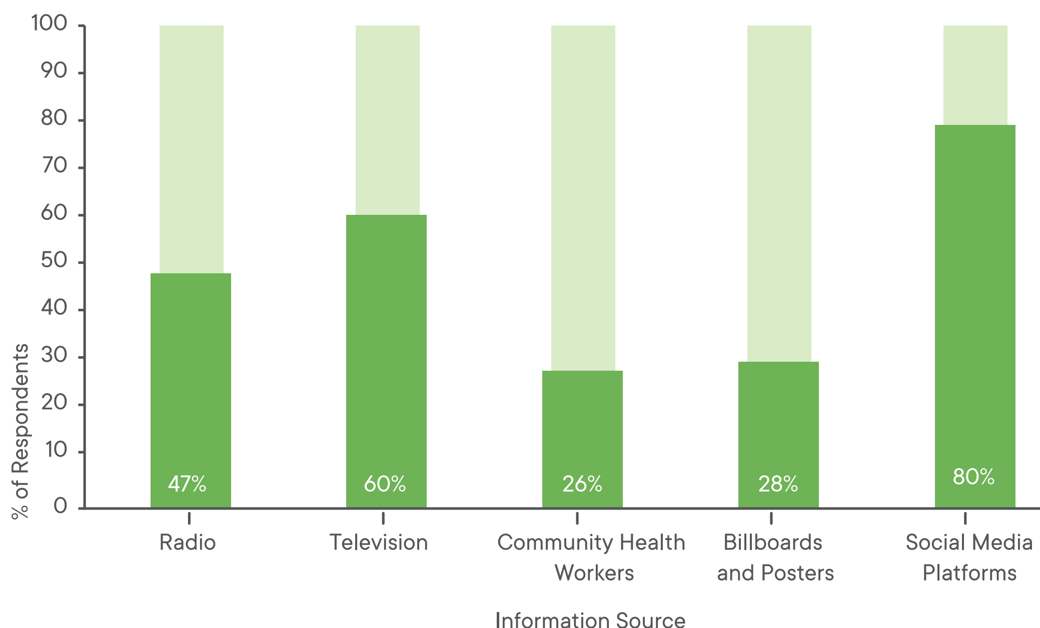
14. At the time of data collection the official Reserve Bank of Zimbabwe foreign currency auction rate was ZWL$84 to US$1

3. Findings

3.1 Sources of information on COVID-19

Respondents were asked to identify the sources of information from which they got to know about COVID-19. Figure 10 below shows the sources from which respondents obtained information and knowledge on COVID-19.

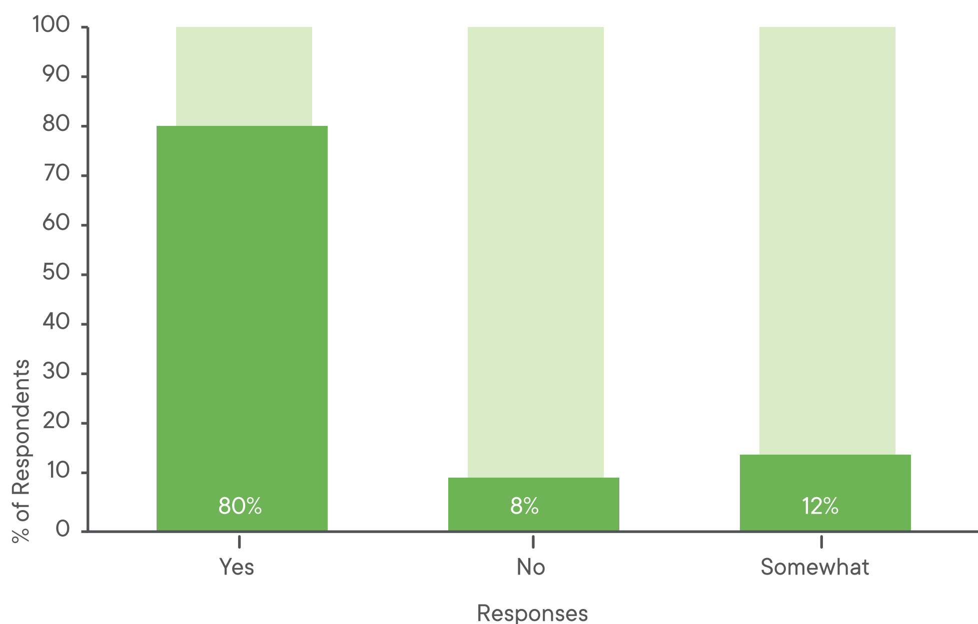
Figure 10: Sources of knowledge about COVID-19



In a question that allowed for multiple responses, we learn that the majority (80%) of respondents indicated that they received most of the COVID-19 related information via social media platforms. The second most influential source of information when it comes to COVID-19 was Television (60%) followed by Radio (47%). Billboards and posters were identified as sources of information by 28% of respondents, while Community Health Workers were identified by the least number of respondents (26%).

Respondents were asked if they knew how to proceed if they suspected that they could be infected with COVID-19 and the responses are shown in Figure 11 below. Most of the respondents (80%) indicated they knew how to proceed if they suspected they were COVID-19 positive while 8% did not and 12% reported that they "Somewhat" knew what to do.

Figure 11: Responses after testing positive



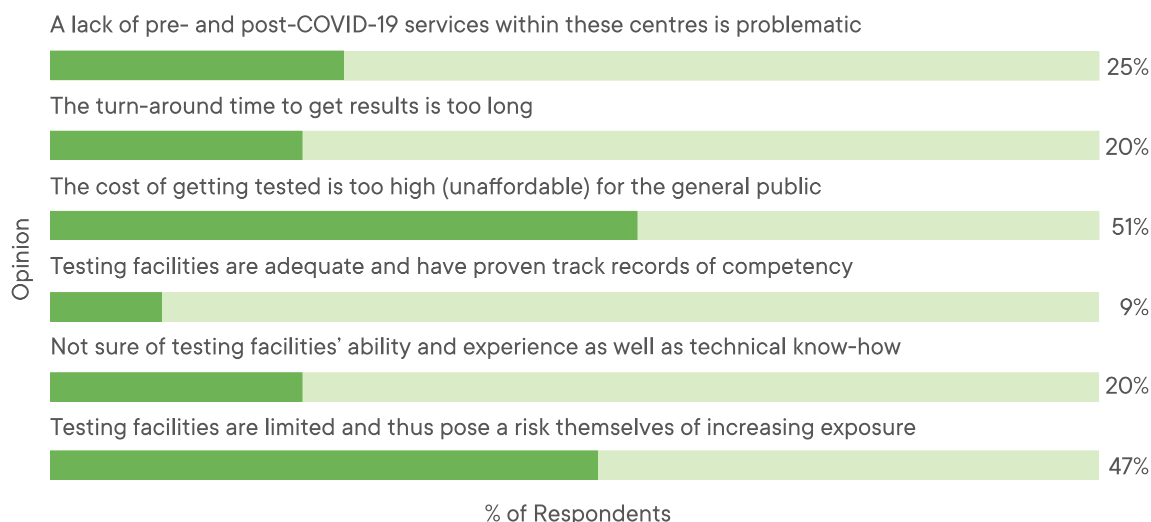
(80%) indicated they knew how to proceed if they suspected they were COVID-19 positive

3.2 Challenges with COVID–19 testing facilities

On the 12th of April 2020, the government decentralised COVID–19 testing as the Global Fund released US$5 Million to support the national COVID–19 testing strategy[15]. Respondents were asked to assess access to, and the costs of COVID–19 testing and treatment.

Many of the respondents (51%) reported that the cost of getting tested was too high and unaffordable while 47% of respondents indicated that "testing facilities were limited and thus pose a risk themselves of increasing exposure". The lack of pre-and post-COVID–19 services within the testing centres was cited as a problem by 25% and 20% indicated their uncertainty with testing facilities' ability and expertise with COVID–19 testing. An equal percentage (20%) cited the lengthy lag time between getting tested and getting your results as a problem and 9% affirmed that testing facilities were adequate and had a proven track record of competency in COVID–19 testing.

Figure 12: Challenges with COVID–19 treatment

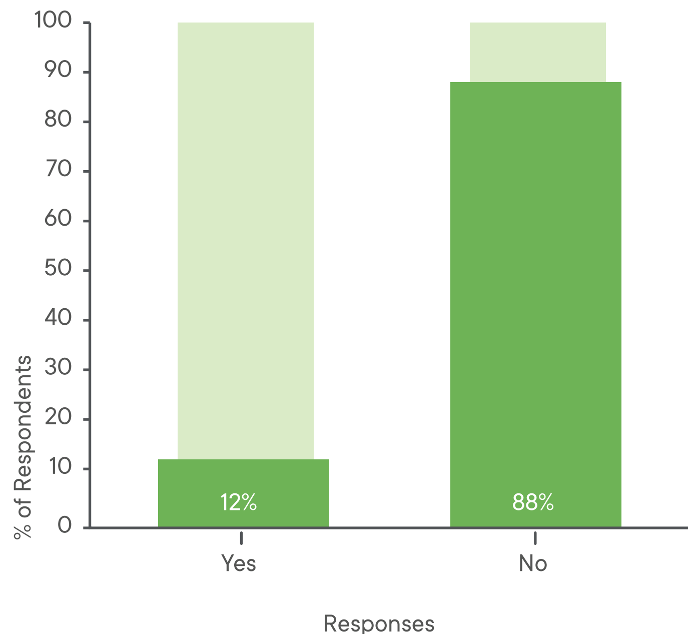


3.3 Experiences with testing for COVID–19

Respondents were asked if they or anyone in their household has ever been tested for COVID–19. From the survey sample, 61% indicated "Yes" while 39% indicated "No". Furthermore, 55% of the respondents indicated that they did not pay for the test while 45% paid for the COVID–19 test. Respondents were asked if they had ever tested positive for COVID–19. Figure 13 below shows the responses given.

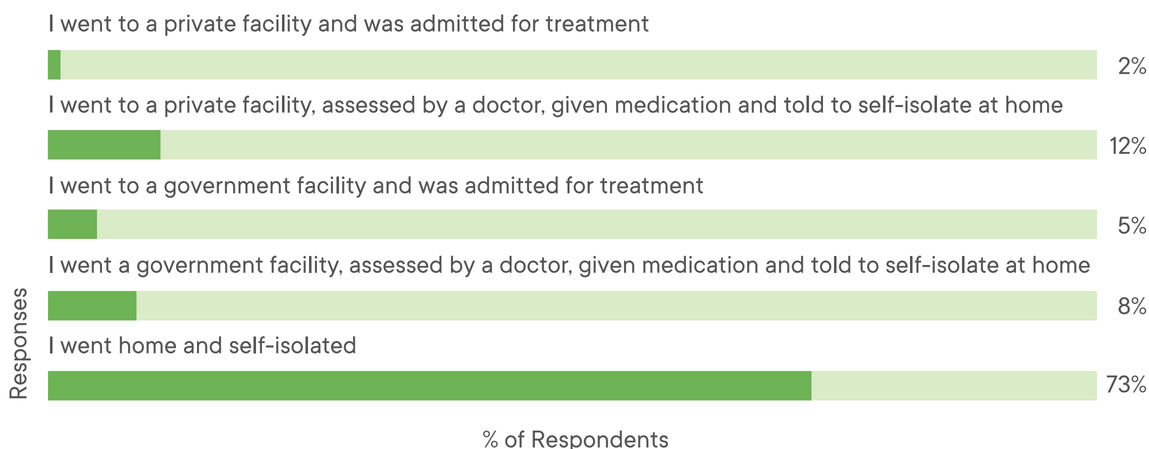
15. https://www.sundaymail.co.zw/govt-decentralises-covid-19-testing-as-global-fun.d-releases-us5-million

Figure 13: Percentage of respondents who have ever tested positive to COVID-19



Of the 39% of respondents that have been tested or have a member of their household who has been tested, 12% tested positive and 88% tested negative for COVID-19. The respondents who tested positive for COVID-19 were then asked for the exact responses they had after testing positive. The responses are shown in Figure 14 below:

Figure 14: Responses after testing positive

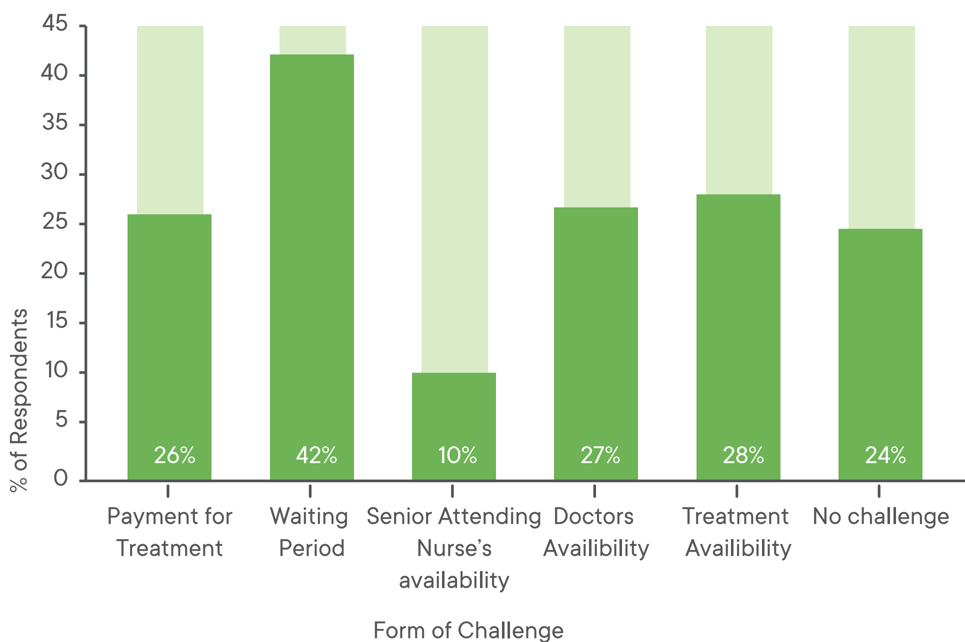


Most of the respondents (73%) indicated "I went home and self-isolated" while 12% went to a private facility, were assessed by a doctor, given medication and told to self-isolate at home. A lesser number (8%) went to a government facility were assessed by a doctor, given medication and told to self-isolate at home and 5% went to a government facility and were admitted for treatment. The least chosen option was going to a private facility and getting admitted for treatment. This was indicated by just 2% of the respondents. Out of the 12% that tested positive for COVID-19 (shown in Figure 10) 83% did not require hospitalisation and 17% required hospitalisation after testing positive. Of the 17% that required hospitalisation after testing positive, 62% paid for hospitalization while 38% did not pay for hospitalisation.

3.4 Challenges with COVID–19 treatment

Respondents were asked to identify the areas in which they faced challenges with COVID–19 treatment. The questionnaire gave them several options from which to choose and indicate "All that apply" the challenges they faced. They had an option to choose "Other" and then specify if the challenges they faced were not included on the list in the questionnaire. The responses are shown in Figure 15 below.

Figure 15: Challenges with COVID–19 treatment



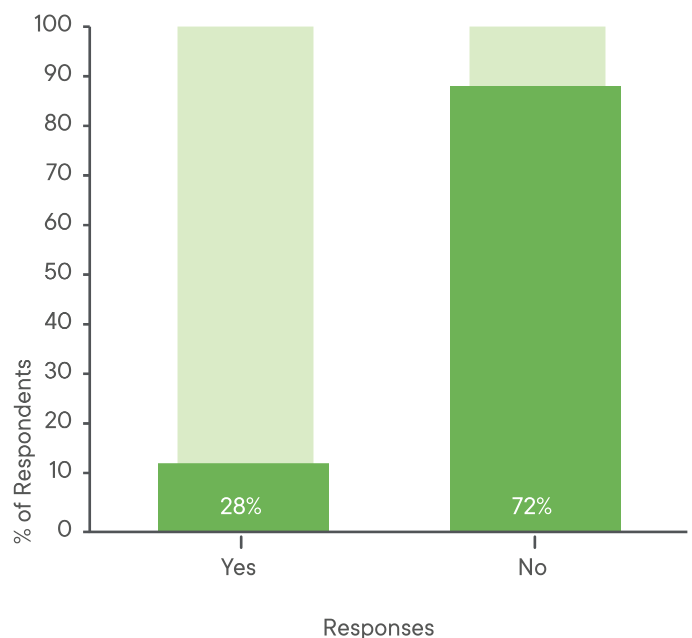
The biggest challenge **42%**, identified was the waiting period followed by the unavailability of treatment **28%**

The challenge identified by the highest percentage of respondents was the waiting period (42%), followed by the unavailability of treatment (28%), the unavailability of doctors (27%), the high financial cost of treatment (26%) and the unavailability of the senior nurses attending to COVID–19 cases (10%). Twenty-four per cent (24%) of the respondents indicated that they faced no challenges with accessing or paying for COVID–19 treatment.

3.5 Loss of family member/friend to COVID–19

Figure 16: Respondents that lost a close family member/friend to COVID–19

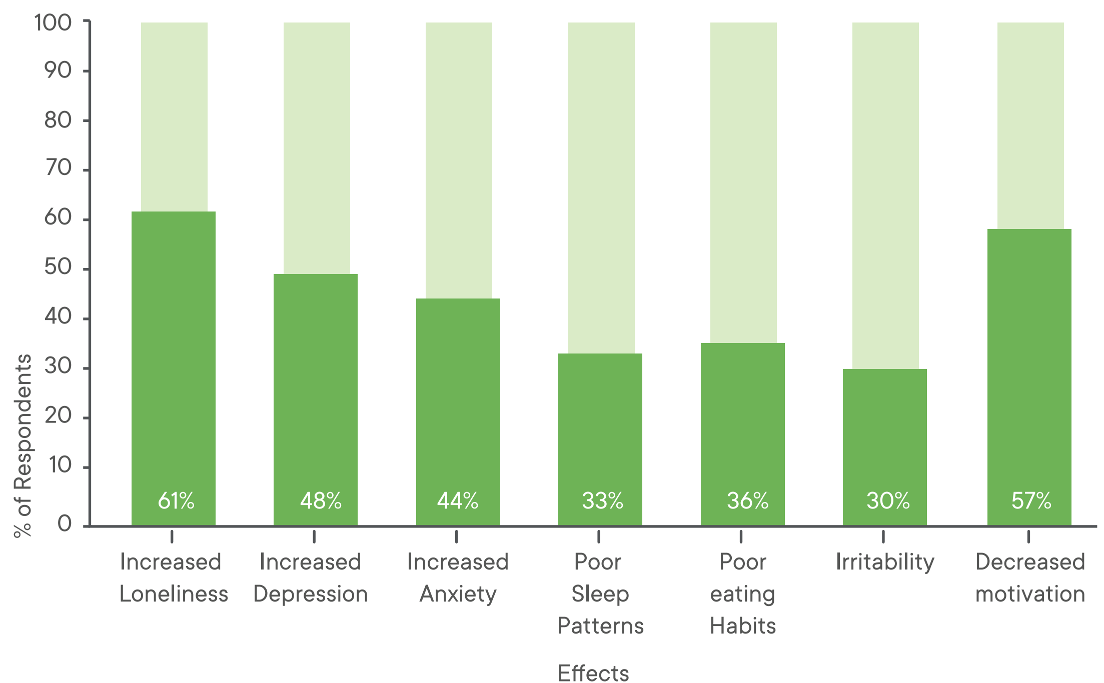
Respondents were asked if they had experienced any death of a close family member or friend due to COVID–19 and 72% indicated “No” while 28% stated that they had.



3.6 Effects of social distancing and lockdowns on respondents' individual mental/emotional well-being

Respondents were also asked if the social distancing and lockdown measures have had any impact on their mental and emotional wellbeing. Many of the respondents (63%) indicated "Yes" while 34% indicated "No". Respondents were asked to indicate, from a list of categories, the effects of social distancing protocols and lockdowns on their mental and emotional wellbeing and how they responded to those effects and challenges. The responses are shown in Figure 17 below

Figure 17: Effects of social distancing and lockdowns on mental/emotional wellbeing



For 61% of the respondents, social distancing and lockdown measures caused "Increased Loneliness" while 57% indicated "Decreased Motivation", 48% experienced "Increased Depression" and 44% experienced "Increased Anxiety". 36% reported "Poor eating habits" while 33% reported "Poor sleep patterns" and 30% reported "Irritability".

3.7 Effects of COVID–19 lockdowns on the household welfare

Respondents were asked how COVID–19 has affected their households and 52% said they had lost income, 38% lost savings, 37% had challenges in accessing education services, 35% were forced to reduce their level of support to others such as parents. Twenty-seven per cent (27%) said they did not have enough food and 28% said their businesses were negatively affected and they lost profits while financial obligations increased for 26% of the respondents. Twenty-three per cent (23%) lost employment and 22% experienced limited access to raw materials. COVID–19 also introduced new health-related costs for 17% and brought new health challenges for 15% of the respondents. Table 1 below shows the full set of responses. COVID–19 also prevented 13% of the respondents from delivering their produce to markets and an equal percentage (13%) also indicated that their businesses were negatively affected as they lost suppliers.

Table 1: Impact of COVID–19 on households' welfare

Effects of COVID-19 on households	Percentage (%)
Loss of income	52%
Loss of Savings	38%
Unable to access education services	37%
Reduced your level of support to others	35%
Business negatively affected lost profits	28%
We do not have enough food	27%
Financial obligations have increased	26%
Loss of employment	23%
Limited access to raw materials/ suppliers	22%
New health-related costs	17%
New health challenges	15%
Unable to deliver my produce to markets	13%
Business negatively affected lost suppliers	13%
Limited labour force	11%
Loss of dwellings because of rent-related challenges	11%
Delays in planting/maintenance of my fields due to lack of inputs	10%
Loss/decline in Remittances	9%
Other (please specify)	3%

Eleven percent (11 %) of the survey respondents indicated that they lost their dwellings because of rent-related challenges and another 11% reported challenges with accessing labour for their economic activities. A further 10% experienced delays in planting or maintenance of their fields due to a lack of inputs and 9% reported a loss or decline in remittances.

11% indicated that they lost their dwellings because of rent-related challenges

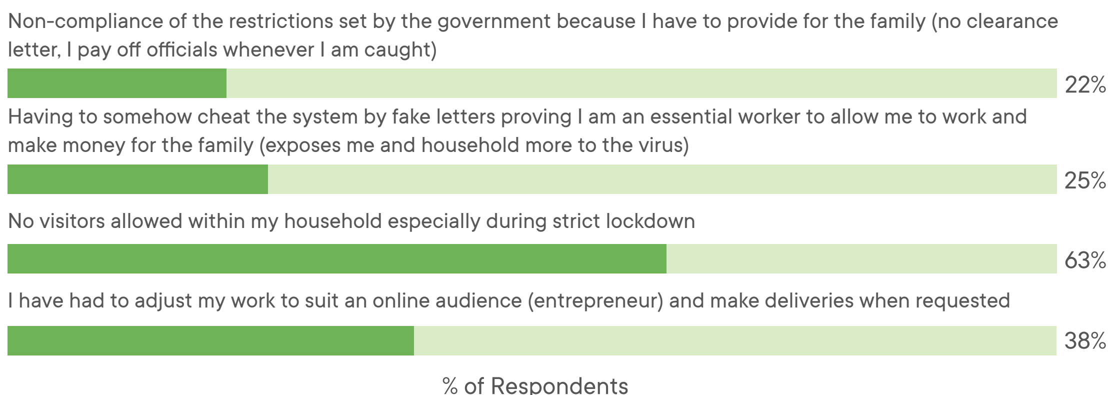
3.8 Adaptations to the health, legal and economic realities of COVID-19 and the national lockdown measures

Respondents indicated the various ways in which they had adjusted their routines to cope with the impacts of COVID-19 and the lockdown. The responses are shown in Figure 18.

63% indicated that they stopped allowing visitors within their households

25% devised strategies to cheat the system by securing forged letters designating them as carrying out work or providing services that were deemed as essential under the lockdown order.

Figure 18: Adaptations in daily routines due to COVID-19 restrictions and realities



Most respondents (63%) indicated that they stopped allowing visitors within their households especially during the strict lockdown period when conditions of the initial 21-day lockdown had not been relaxed or lifted. A further 37% of respondents reported that they had to adjust their work to suit the shift to online marketing and ensure that they could make deliveries as requested by clients. Others (25%) reported they had to devise strategies to cheat the system by securing forged letters designating them as carrying out work or providing services that were deemed as essential under the lockdown order. They reported that this allowed them to work and earn money to support their families, but this also exposed them and their households to the risk of getting infected with the virus. However, 21% of respondents indicated that their response was non-compliant with the restrictions set by the government, and this included bribing officials whenever they got caught.

Respondents were asked for the household level adaptation measures which they had taken up in response to the economic impacts of COVID-19. Figure 19 below shows the range of these adaptation measures.

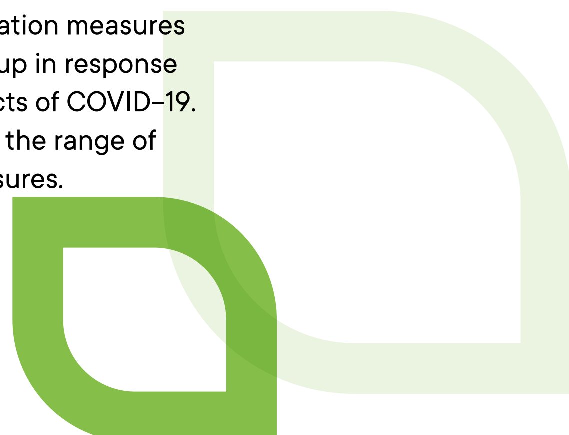
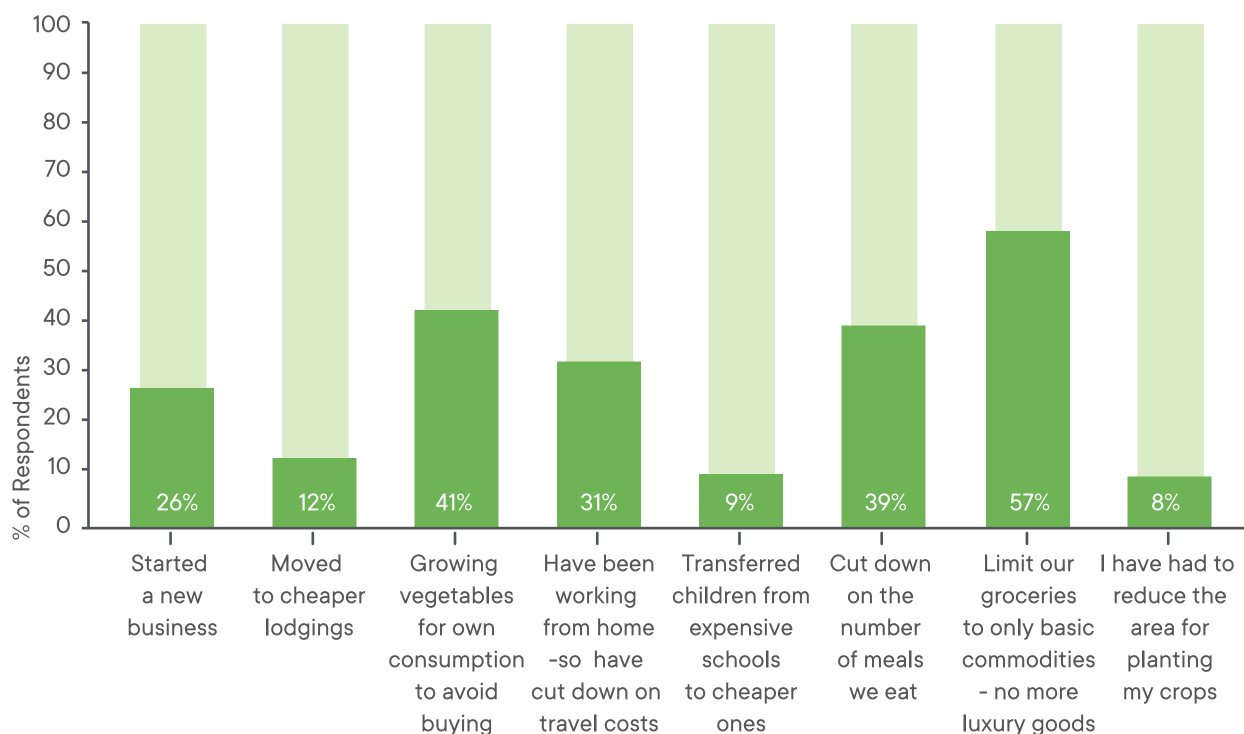


Figure 19: Household-level adaptations to the economic impacts of COVID–19

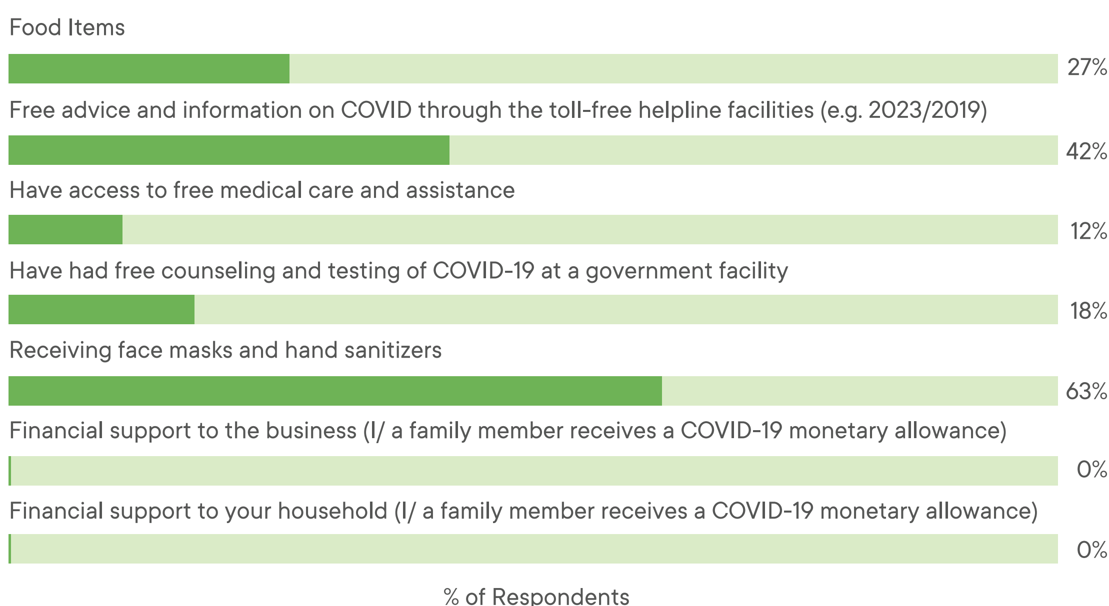


Respondents adopted multiple strategies in response to the problems they identified, and these included among others, 57% limited groceries to only basic commodities and not buying any goods considered to be luxuries. While 41% indicated that they grew vegetables for their consumption to avoid buying. Some households (39%) cut down on the number of meals they had per day while 31% of the respondents indicated they started working from home to cut on travel costs. Twenty-six (26) % started a new business (26%) while 12% moved to cheaper lodgings, (9%) transferred children from expensive to cheaper schools and 8% reduced the total area for crop planting.

3.9 Support received from the Government of Zimbabwe

Respondents were asked if they or any of their relatives received any form of Government support to mitigate and cope during the pandemic Ninety-two per cent (92%) indicated "No" while 8% said "Yes". Figure 20 below shows the form of support received by respondents from the government.

Figure 20: Support received from the government

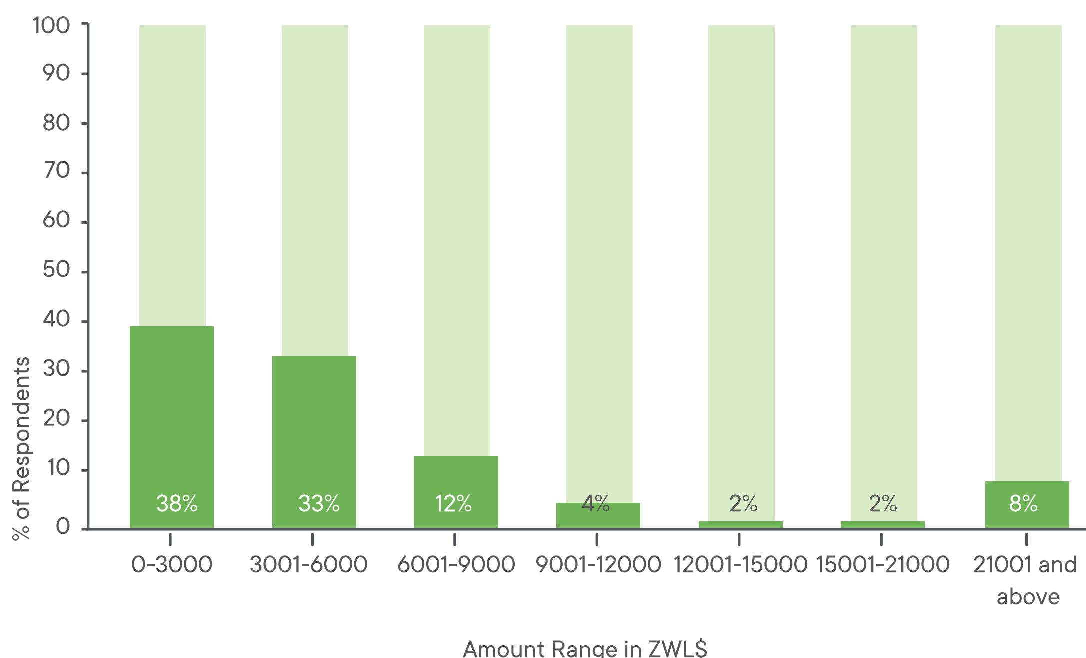


The majority of survey respondents (63%) indicated that they received face masks and hand sanitizers while 42% received advice and information on COVID–19 through the toll-free helpline facilities and 23% received food items from the government.

Eighteen (18) % reported that they benefitted from free counselling and testing of COVID–19 at a government facility and 12% had access to free medical care and assistance.

To get a more comprehensive understanding of support received from the government, respondents were then asked if they or anyone related to them received any financial support from the Government to mitigate and cope during the pandemic?" Fifty-two per cent (52%) of the respondents indicated "No" and 48% indicated "Yes". Thirty-eight per cent (38%) of respondents received between "ZWL$1–3,000" (USD0 to $36) in financial support from GoZ to mitigate and cope during the pandemic, 33% got "ZWL$3,001–6,000" (USD37 to $71), 12% got "ZWL$6,001–9,000" (USD72 to $107), while 8% got "ZWL21,001 and above" (USD180 to $238) and 4% got "ZWL$9,001–12,000" (USD108 to $142). Respondents were further asked to indicate the form of support they received from the government and the responses are shown in Figure 21 below.

Figure 21: Amount of financial aid received from GoZ[16]

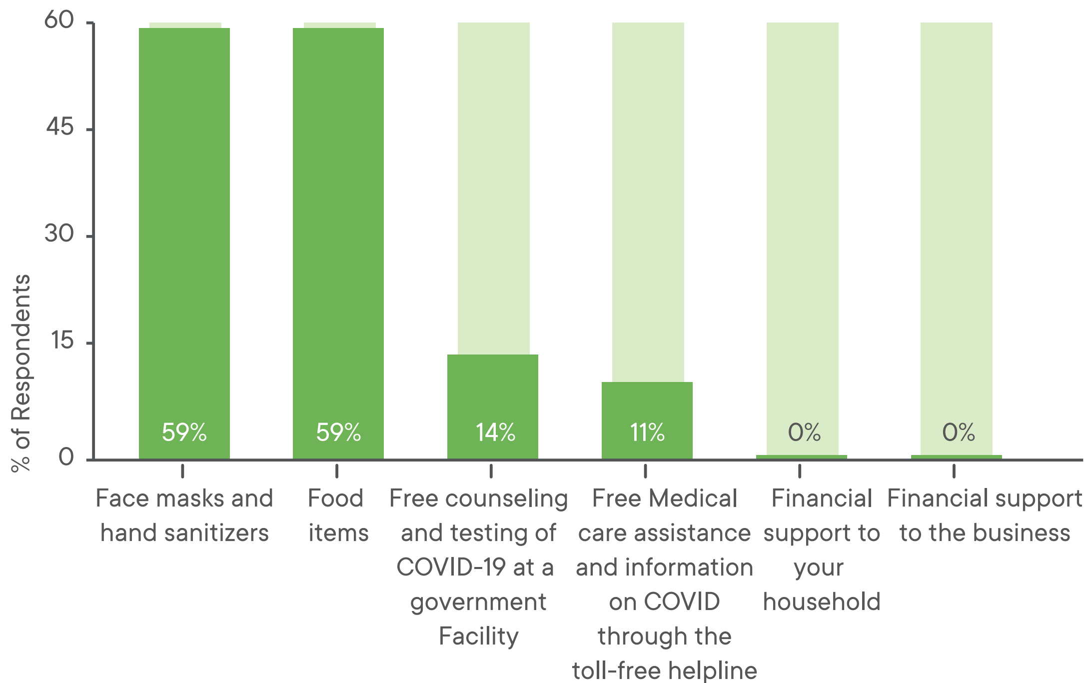


3.10 Support provided by non-state actors

Study participants were asked to identify the form of support that they received from non-State actors and the responses are shown in Figure 22 below.

16. At the time of data collection, the official Reserve Bank of Zimbabwe foreign currency auction rate was ZWL$84 to US$1

Figure 22: Support received from non-State actors



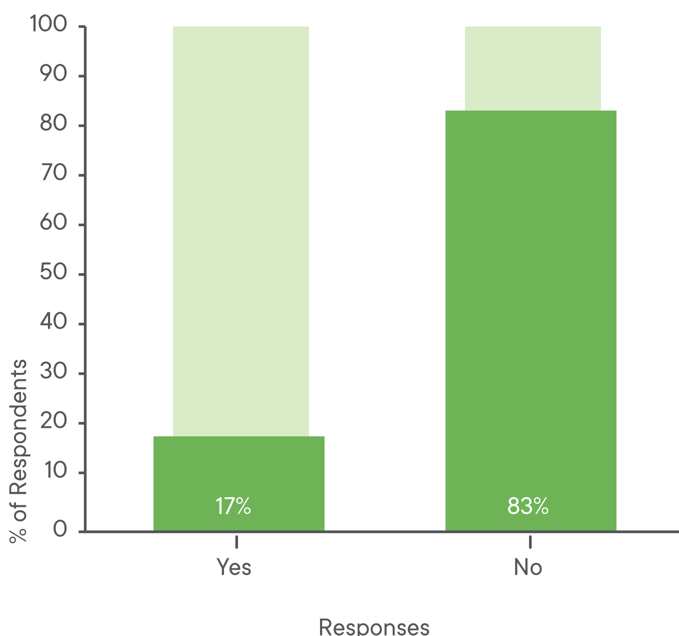
Fifty-nine per cent (59%) received face masks and hand sanitizers while another 59% of the respondents also received food items. Fourteen per cent (14%) received free counselling and testing of COVID-19 at a government facility and 11% got free medical care, advice and information on COVID-19 through the tollfree helpline facilities such as "2023" and "2019". None of the respondents indicated that they or a family member got financial support in the form of a monetary allowance for their household or monetary support for their business.

3.11 Community-level initiatives introduced by citizens in their communities

3.11.1 Participation in community initiatives

Respondents were asked "are there any COVID–19 response initiatives that you/ the youth in your community developed and are currently working on? e.g. feeding scheme for the vulnerable, awareness campaigns, entrepreneurial-skills training for the youth, provision of face masks, sanitizers, free counselling services by local registered nurses". A total of 83% of respondents indicated "No" and 17% indicated "Yes". Figure 23 below shows the responses.

Figure 23: Participation in community COVID–19 response initiatives

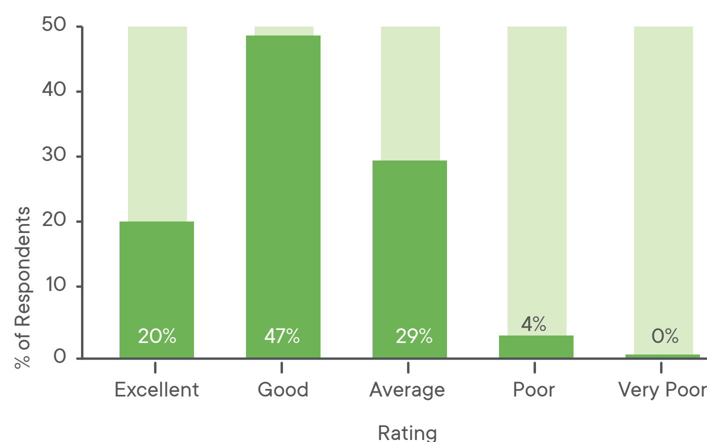


Some respondents participated in the distribution of free Personal Protective Equipment (PPE) such as face masks and hand sanitizers, and in training unemployed young people to sew home-made face masks and manufacture home-made sanitizers. Other survey respondents were involved in the provision of contraceptives to adolescents and young women while some offered counselling and health care treatment support. Some respondents participated in public awareness initiatives focusing on methods of transmission, preventing transmission and raising awareness on the government's lockdown regulations including social distancing. Non-state based key informants highlighted that these initiatives were done via roadshows at shopping complexes, bus termini in the residential areas and on WhatsApp. Some respondents conducted these awareness activities on platforms such as WhatsApp and community radio stations. Other respondents supplied sanitary wear to vulnerable girls and others participated in the distribution of food packs to vulnerable households in their communities.

3.11.2 Impact of community-led COVID–19 initiatives

Respondents were asked to rate the impact of the community-led initiatives in which they participated. The responses are shown in Figure 24 below.

Figure 24: Citizen assessment of the impact of community-led response initiatives

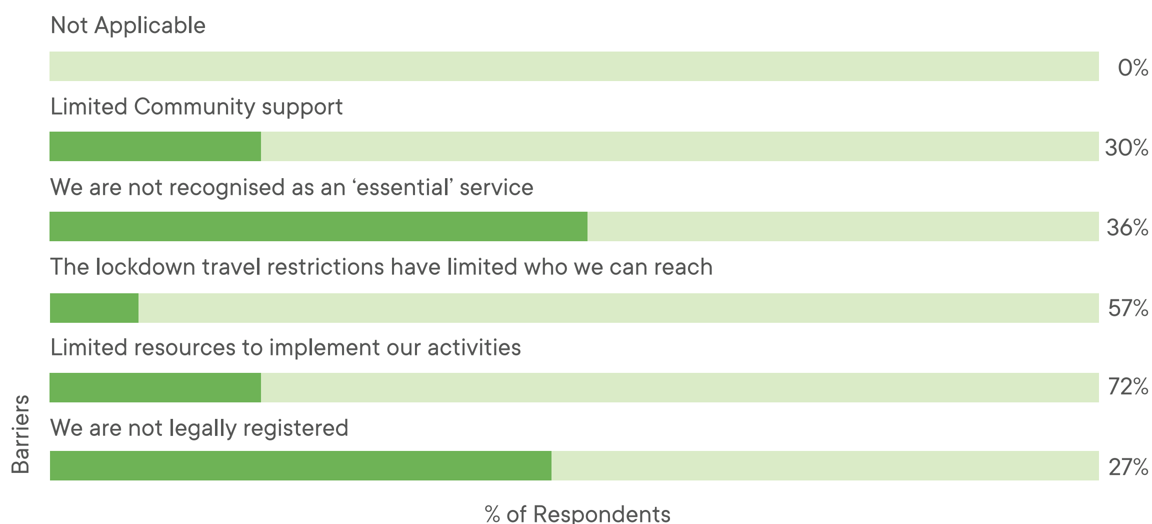


Forty-seven per cent (47%) of the respondents rated the impact as “Good” followed by 29% that rated the impact as “Average”, 20% rated the impact as “Excellent” and 4% rating the impacted as “Poor”. None of the respondents rated the impact of these initiatives as “Very Poor”.

3.11.3 Barriers to executing community-led COVID–19 response measures

Survey respondents were asked to indicate some of the barriers and challenges which they have faced in trying to execute COVID–19 response initiatives. As shown in Figure 25 below, barriers included limited resources. This was highlighted by 72% of respondents, the lockdown travel restrictions as highlighted by 57%, not being recognised by the government as providing an essential service (36%), and limited support from the community (30%). Twenty-seven per cent (27%) of the respondents indicated that they “are not legally registered” and this served as a barrier to the implementation of their interventions.

Figure 25: Barriers to executing COVID–19 response measures

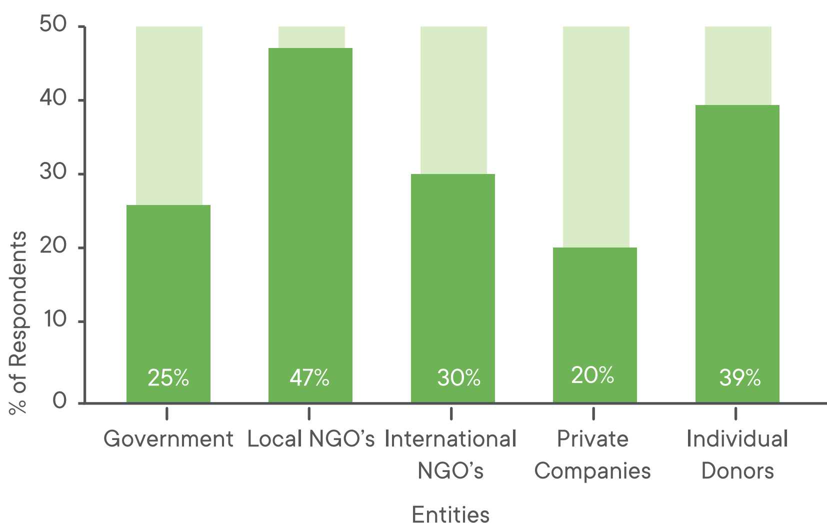


Key informants alluded to multiple barriers faced by communities including the lockdown restrictions on movement and the requirement for exemption letters for one to freely move around. They also pointed out that most community COVID–19 initiatives were not defined as essential services and were prohibited under the lockdown regulations. Furthermore, most non-state responses were poorly funded since the organisations had to shift budgets that were earmarked for other activities and repurpose them for COVID–19 response activities. As emphasised by some key informants, the little funding that they got from donors and GoZ was consumed by administration costs and did not go towards community COVID–19 response activities. Other issues highlighted include the high costs of mobile data which hindered youth participation in online awareness activities and other activities that were conducted online during the lockdown period.

3.11.4 Support received for community-led COVID–19 initiatives

Respondents were asked if their community-level COVID–19 response activities had received any support from external partners or persons. Fifty per cent (50%) of respondents said “Yes”, and 50% said “No”. Respondents were also asked to identify the entities and organisations that supported these initiatives. The responses are shown in Figure 26 below:

Figure 26: Entities that supported community initiatives



Forty-seven per cent (47%) of respondents indicated that their initiatives were supported by “Local NGOs” and 39% received support from “Individual donors”, 30% were supported by “International NGOs”, 25% were supported by “The government” and 20% were supported by “Private companies”. Key informants from non-state entities indicated that their organisations continued with much of the work that they were doing before the COVID–19 pandemic, but they slightly altered their approach to suit the COVID–19 pandemic period, particularly the lockdown restrictions. Some organisations indicated that they assisted young people to get exemption letters from village heads and councillors. Others non-state actors such as Solidarity Trust Zimbabwe (SOTZIM)[17] provided infrastructural support for scaling up testing services, resources for equipping hospitals to treat cases of COVID–19 and provided protective clothing for frontline personnel. SOTZIM also ran an online platform that disseminated information on the COVID–19 response initiatives being run by non-state actors and providing accurate information on COVID–19 to the public, established partnerships to support pre-screening through a remote call centre.

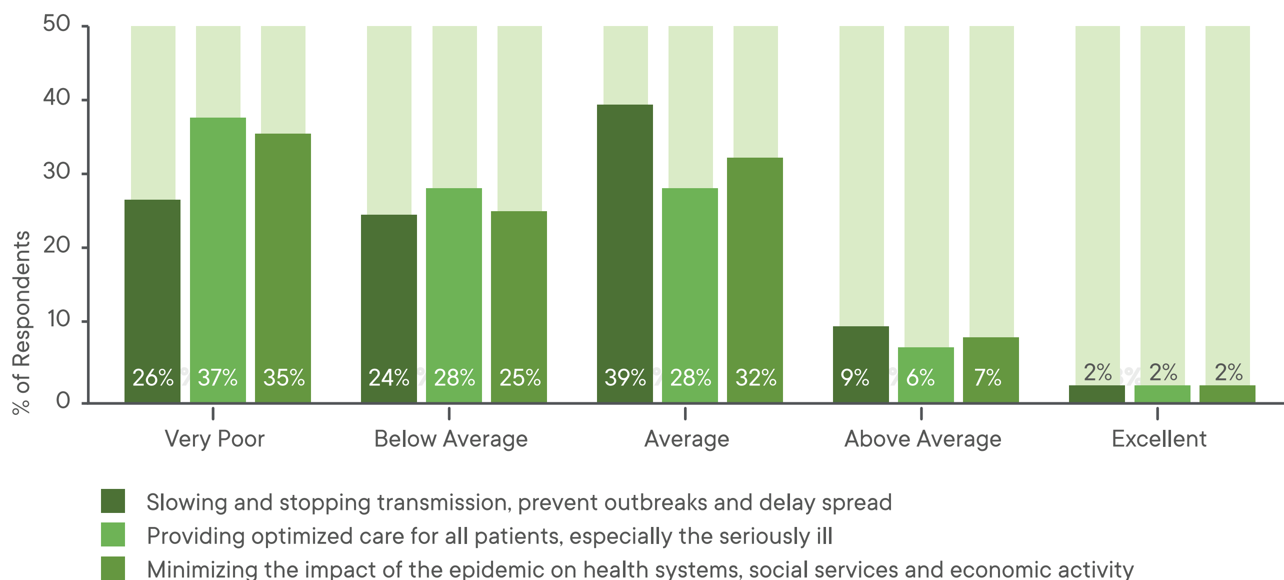
17. www.sotzim.org

4. Citizen assessments of the government's COVID–19 response

4.1 Assessment of the Health Response Strategy

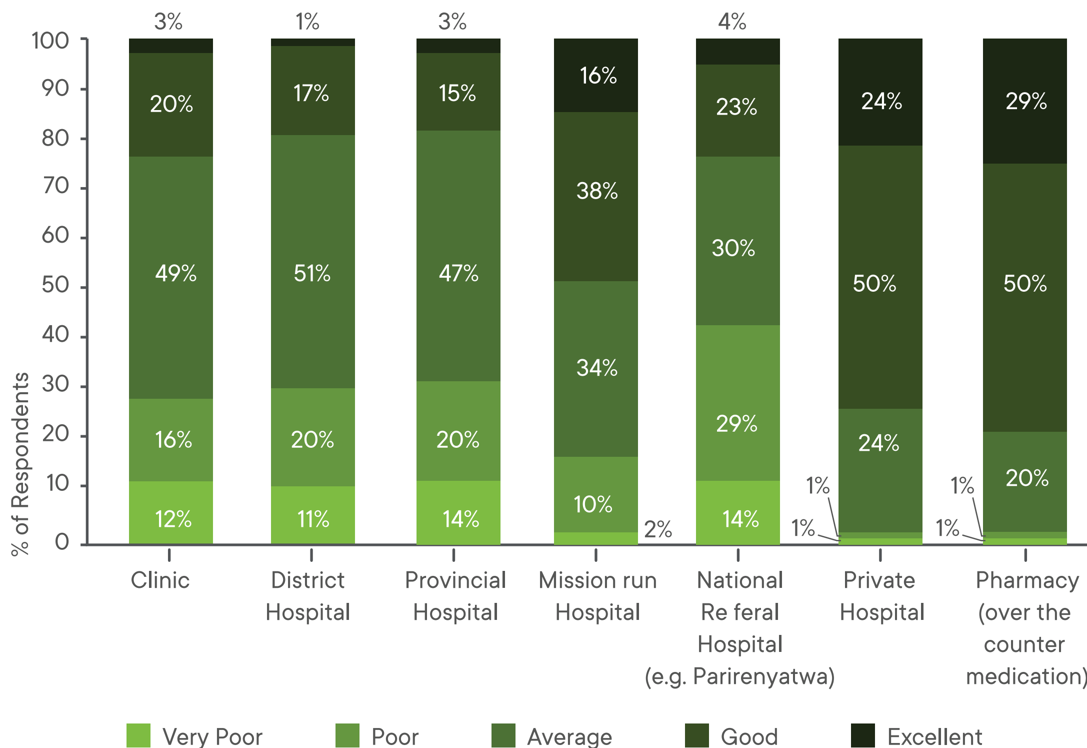
Respondents were asked to rate the government response strategies on three variables/indicators of "Slowing and stopping transmission, preventing outbreaks and delaying the spread", "Providing optimised care for all patients, especially the seriously ill" and "Minimising the impact of the epidemic on health systems, social services and economic activity". Figure 27 below shows the ratings.

Figure 27: Rating the Health Response Strategy



Respondents were asked to comment on the state of service delivery at the health care facility which they visited since March 2020 seeking treatment for themselves or when accompanying or visiting the sick. Figure 28 shows the respondents' assessments of local clinics, government hospitals and mission-run hospitals and private hospitals as well as pharmacies, from which respondents accessed over-the-counter medications.

Figure 28: Assessment of the state of service delivery at health facility visited



Pharmacies as well as private hospitals were rated as "Good" by 50% of respondents while district hospitals were rated as "Average" by 51%. Mission-run hospitals were rated "Good" by 38% and "Average" by 34%. Some key informants indicated that government health facilities were very poorly equipped to deal with the pandemic mainly because of challenges with funding, equipment, and infrastructure challenges.

4.2 Assessment of the overall COVID-19 National Response

Respondents were asked to rate the government's response to COVID-19 on a 5-point Likert scale of "Very Poor, Poor, Average, Good, Excellent". The ratings are shown below.

Table 2: Rating the GoZ response to COVID–19

Rating the GoZ response to COVID-19	Very Poor	Poor	Average	Good	Excellent
Raising awareness on COVID-19 and how to stop the spread of the virus	19%	16%	39%	21%	5%
Development of clear communication on what to do when one tests positive	18%	24%	37%	18%	3%
Communication on where to go when one is not feeling well	17%	22%	36%	20%	4%
Improving health care facilities	40%	30%	22%	6%	2%
Provision of healthcare services	39%	31%	23%	6%	2%
Support to health care providers (doctors/nurses etc)	41%	31%	21%	6%	2%
Support to affected households	48%	30%	17%	4%	1%
Allocating resources towards the fight against COVID-19	41%	31%	22%	5%	2%
Addressing corruption to do with COVID-19 funds	53%	24%	17%	5%	1%
Equipping Hospitals and Clinics	46%	28%	20%	5%	1%
Sufficiently communicating its COVID-19 strategy to citizens	29%	25%	32%	11%	3%

The government was rated “Very Poor” on 7 out of the 11 indicators that were deployed in the study. Fifty-three per cent (53%) of the survey respondents view the government as very poor on addressing corruption to do with COVID–19 funds, 48% rated GoZ as very poor on support to affected households, 46% rated GoZ as very poor on equipping hospitals and clinic, 41% rated GoZ as very poor on allocating resources towards the fight against COVID–19, 41% rated GoZ as very poor on providing support to health care providers. The GoZ was also rated as very poor at improving health care facilities and in the provision of health care services, by 40% and 39% respectively.

4.3 Suggestions for improvement of the GoZ COVID–19 response

The study participants were then asked for suggestions on how to improve the government's response to prevent new infections. The responses are shown in Table 3:

Table 3: Suggestions for improvement of the GoZ national COVID–19 response

Suggestions for improving the government's national COVID-19 response	Percentage (%)
Increase allocation towards health delivery	79%
Provide better salaries to health care workers	65%
Ensure that COVID-19 surveillance teams are well equipped	66%
Offer free testing for everyone exposed and with symptoms of the virus	70%
Offer free pre-and post-testing counselling to curb spreading due to ignorance and negligence	58%
Enforce stricter restrictions to people travelling in their local area or one location to another	35%
Open more facilities and provide healthcare and machinery to assist those affected with the virus and needing clinical help	60%
Increase awareness and communication channels to disseminate information	52%
Ensure frontline healthcare providers are well provided for with essential PPEs	59%
Increase the incentives for frontline healthcare providers	50%
Reduce the number of people who can attend funerals especially those COVID-19 related to limit interactions and potential exposure	37%
Provide masks and sanitizers especially in high-density suburbs	56%
Provide vaccines for all Zimbabweans	43%

Seventy-nine per cent (79%) suggested increased governmental resource allocation towards health delivery, while 70% suggested that the government should offer free testing for everyone exposed and with symptoms of the virus. Sixty-six per cent (66%) of respondents suggested that the government must ensure the availability of adequate equipment for surveillance teams. According to 60% of the respondents, the government should open more facilities and provide healthcare and machinery to assist those affected with the virus and needing clinical help while
56% suggested that GoZ provides masks and sanitizers to people especially in high-density suburbs. Fifty-nine per cent (59%) suggested that the GoZ must ensure that frontline healthcare providers are provided with essential PPE and 52% suggested that an increase in awareness and communication channels to disseminate information, and 50% recommended that incentives for frontline healthcare providers be increased. Thirty-seven per cent (37%) emphasized the need to reduce the number of people who can attend funerals to limit interactions and potential exposure and 43% advocated the provision of vaccines for all Zimbabweans.

5. Conclusion and pointers for what could be done

5.1 Governance and management of the national response

Zimbabwe, like the rest of the world, was unprepared to deal with the COVID–19 pandemic and has had to re-purpose funds from other areas and channel them towards the COVID–19 response. The theme that reverberates, mainly in key informant interviews, is that response measures were developed “on-the-go” hence the limited consultation of the public. The absence of public consultation is a significant barrier to understanding and addressing the priorities of people most affected by response measures. Respondents rated the GoZ as “Very Poor” on 7 out of 11 performance indicators deployed in the survey. This points to a serious disillusionment with the government’s response hence participants describe the GoZ as “corrupt”, “incompetent”, “simply doing nothing” and “not transparent”. The handling of procurement of COVID–19 supplies, the opaque identification, and selection of beneficiaries of the government’s social assistance program as well as the management of public complaints against police and army brutality against civilians violating lockdown protocols all add weight to calls for radical changes in the approach towards managing the national response. Improved consultations of the public and community-level stakeholders can secure broad inputs into the national response strategy and the mechanisms of implementation. This can secure buy-in from the public and get the public to identify with and participate in the response activities.

5.2 Socio-economic support measures

The national lockdown, controlled population movements and as intended, helped bring down the curve of infections, but also barricaded most people’s access to their sources of livelihood and incomes. With most people’s livelihoods being reliant on informal sector activities, the lockdown and abrupt halting of informal economy activities was a formidable threat to household food security.
Respondents highlighted that providers of basic goods and services kept increasing their prices to stay afloat in a contracting economy and some sought to profiteer. The net effect was that conditions worsened for poor households. In many instances, breadwinners who used to support their family/extended family were forced to cut down on that support. The government needs to put in place clear measures and a transparent road to safeguard the vulnerable and poor. Such a roadmap must incorporate input from the poor and vulnerable before it is implemented and, in this way, GoZ can honour its social assistance promises to vulnerable groups.

5.3 Health services including prevention and treatment

The health response was handicapped by resource and infrastructural limitations. Non-state actors managed to contribute financially and materially but the overarching responsibility for this lay with the government. Health care delivery was also negatively affected by the strikes by health workers in public hospitals. The reduced operating hours imposed under the lockdown and the scaling down of available staff restricted communities’ access to health care facilities even for patients presenting with non-COVID–19 related conditions. Shortages of PPE and other essential medications and sundries operations were a double-edged sword: healthcare workers feared for their lives and the public lost confidence in the public health care delivery system. When respondents rated the GoZ as “Very Poor”, “Below Average” and “Average” on “Stopping transmission, preventing outbreaks and delay spread”, “Providing optimized

care for all patients, especially the seriously ill" and "Minimising the impact of the epidemic on health systems, social services, and economic activity". These ratings reflect the general perception towards the government's health measures and indicate that multiple factors including strikes by medical personnel over remuneration, working conditions, unavailability of drugs and equipment were a major hindrance to an effective response. The government needs to improve on the availability of infrastructure at health facilities and to ensure that women and youth can access health services.

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