# Diagnosis of barriers to Effective management in the fight against Covid-19 Pandemic in Zimbabwe

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## Abstract

The purpose of this study was to analyze the barriers towards the Corona Virus Disease (COVID-19) crisis management by the government of Zimbabwe between March and August 2020. This came after several anomalies which animated the country's response to the pandemic were reported. The study was qualitative in nature which operated within the descriptive design. Data collection was done through the review of secondary data from newspapers, policy reports, national reports and journal articles published between March and August 2020. These were purposively sampled on the basis that they captured the COVID-19 issues. This study established that the COVID-19 pandemic landed in Zimbabwe while the country was unprepared. As a result, the country's early response measures were characterised by inefficiencies. In that regard numerous reports emerged about more than 100 000 citizens arrested for defying the lockdown measures, lack of protective personal equipment (PPE) for health care workers, returnees from neighbouring countries absconding from the mandatory quarantine facilities, poverty levels widening and crime rates ballooning. All this pointed to the gaps in the country's disaster preparedness. The study recommends Zimbabwe needs to ramp up its disaster management preparedness capacity to be able to handle all future forms of disaster.
**Keywords**: COVID-19, Barriers, Effective management, Zimbabwe.

## Introduction and background

The outbreak of the coronavirus (COVID-19) is a litmus test of disaster preparedness within the health sectors of many countries across the globe. The fact that the first world countries with tried and tested health care facilities failed to contain the pandemic

brewed a myriad of uncertainties on what could become of African countries in the wake of the deadly virus (Moyo 2020). It is significant to note that there are anxieties that evolved around past experiences where most African countries, Zimbabwe included failed to manage the pandemics such as cholera and malaria (Dzobo et al. 2020). Nevertheless, following the declaration of COVID-19 as a global pandemic by the WHO on the 11th of March 2020, most countries pronounced nationwide lockdowns in a bid to implement contingent measures to curtail the transmission of the virus while preparing for the management of the possible surge in infections (Dzinamarira et al. 2020a). This was done in tandem with the health guidelines provided by the WHO. In line with these guidelines, Zimbabwe pronounced its lockdown on the 26th of March 2020 with subsequent reviews per forty night. As a result, a plethora of mitigation strategies were put in place. These included the closure of various business sectors, schools, universities, borders for human traffic, restriction of movements except for essential services, suspension of gatherings of more than 50 people and suspension of prayer meetings at churches and mosques (Dziva 2020). It was demanded that these measures be implemented in tandem with hand sanitization, the mandatory wearing of face masks in public spaces and adherence to guidelines on physical distancing (WHO 2020).

As for Dziva (2020), against militating circumstances, Zimbabwe made remarkable strides in responding to the COVID-19 pandemic. To this end, quarantine and treatment centres were established in every district and ports of entries. Testing services were also expanded. From the first of July 2020, Zimbabwe witnessed a surge in the number of COVID-19 infections mainly imported, to clusters of infection and local infections within communities as prevention behaviours slackened (Moyo 2020). In response, the government tightened the lockdown restrictions by introducing a dusk to dawn curfew. Some of the restrictions that had been lifted in June to salvage the economy were reinstated especially on informal businesses and intercity travels (Gilbert et al. 2020). As of 18 August 2020, Zimbabwe had recorded a total of 5378 cumulative number of COVID-19 cases with 4105 recoveries and 141 deaths (Dzinamarira et al. 2020b). What should be highlighted is that, despite all these mitigating measures, Covid-19 pandemic landed in Zimbabwe when the country was saddled with an avalanche of economic woes for three decades. As such, the country was caught unprepared by the pandemic.

To substantiate the above inference, Moyo (2020) avers that Zimbabwe started refurbishing its hospitals, purchasing of ventilators and improvement of water supply systems after the declaration of the pandemic as a national disaster. In support, Mutizwa (2020) denotes that Zimbabwe's COVID-19 management modalities are marred by a lot of glitches. These include weak contact tracing and testing capacity, limited capacity to manage severe cases, poor management of returnees at quarantine facilities, lack of personal protective equipment and limited intensive care unit beds. Dziva (2020) weighs in by positing that within months of touching base in Zimbabwe, COVID-19 had dismantled the already shambolic health care system and disfiguring the livelihoods of millions of people.

As for Price (2020), the pandemic amplified the economic quagmires in the country. Numerous reports emerged that about more than 100 000 citizens were arrested

for defying the lockdown measures as they strived to make ends meet, lack of personal protective equipment, the relentless strikes by health care workers over poor working conditions and returnees from neighbouring countries absconding from the mandatory quarantine facilities (Dzinamarira et al. 2020b; Dzobo et al. 2020; Muronzi 2020). All these point to the gaps backlashing the effective management of the pandemic. Against this backdrop, we found it imperative to diagnose the barriers to effective management in the fight against COVID-19 in Zimbabwe between March and August 2020. This study can be used as a springboard for future management of pandemics once the identified barriers are addressed at institutional and policy levels.

**Progress made by the zimbabwean government in the fight against Covid-19**

Though this paper is poised to delineate the barriers to effective management in Zimbabwe's response to the COVID-19 pandemic, it is of paramount importance to illuminate the strides moved by the Zimbabwean government in mitigating the ramifications of COVID-19. In light of this, Dzobo et al. (2020) denote that Zimbabwe announced its national lockdown on 30 March 2020 that spanned for three weeks. At this point, all public activities were suspended and non-essential businesses were closed except for health services and manufacturing (Mhlanga & Ndlovu 2020). Moreover, universities, colleges and schools were closed and social gatherings of more than 50 people were suspended (Dzinamarira et al. 2020a). were closed for human traffic except for cargo and Zimbabwean returning residents (Dzobo et al. 2020). As for Mutizwa (2020), the government also instituted the screening and contact tracing, thermal scans and mandatory disclosure for travel history within 14 days. In a bid to salvage both the economy and livelihoods, the lockdown was relaxed in the 4$^{th}$ week from the initial date of its pronouncement and some formal businesses were given the green light to operate. These were supposed to adhere to the WHO guidelines including the mandatory wearing of face masks, conducting temperature checks and observing of physical distancing at workplaces (Machivenyika 2020, Moyo 2020; Muronzi 2020; Price 2020).

The lockdown was indefinitely extended on the 16$^{th}$ of May 2020 and informal businesses remained closed (Dzobo et al. 2020). In the same vein, intercity public transport, taxis and kombis were banned. Only government-subsidized buses were allowed as the mode of transport (Price 2020). Most schools and colleges were used as quarantine facilities for returning residents. Screening, tests and isolation centres were established at all ports of entry (Moyo 2020). As for Mutizwa (2020), toll-free numbers were created for emergency purposes. Also, radio and television adverts on COVID-19 were constantly aired to foster a comprehensive understanding of how to deal with the virus. At the policy level, the Zimbabwe National Preparedness and Response Plan for COVID-19 was launched to steer the government's response to the pandemic (Moyo 2020). The Statutory Instrument 99 of 2020 was promulgated setting out guidelines on the resumption of business operations (Machivenyika 2020). Dzinamarira et al. (2020b) further contend that the government announced the COVID-19 stimulus package of ZWL $ 18 billion that include ZWL $1 billion

health sector support fund, ZWL$3.9 billion for social safety nets and whopping budgets were announced for liquidity support to different sectors namely; mining, agriculture, tourism and arts.

Contrary to the above, we argue that, despite a gamut measures taken by the Zimbabwean government in the fight against COVID-19, the management is marred with irregularities which rendered the control of infections a mammoth task. In the same vein, proper disaster management connotes a holistic subjugation of the situation without amplifying the social problems on humanity. What should be highlighted is that COVID-19 response measures adopted by the government caused a catalogue of challenges on people's livelihoods and some backlashes on the expected outcomes of certain measures. The fact that people were absconding from quarantine centres, hundreds of thousands arrested for defying lockdown measures and essential health care workers on strike point to some glitches in the management processes of the pandemic. These shall be dissected in the forthcoming section on barriers to effective management in the fight against COVID-19.

## Barriers to effective management of Covid-19

Eisenack et al. (2014) define barriers as impediments amidst the implementation of initiatives, measures and strategies. Also, barriers could be factors or conditions that are largely insurmountable which render the implementation of certain initiatives ineffective (Kruse et al. 2013). To add on, Hudzik (2014) denotes that barriers can be overcome by individual or concerted collective effort, changed way of thinking, reprioritization of resources, institutional support and political will. To extrapolate from this, we argue that the barriers identified in the management of COVID-19 are avoidable through a broad-based transformation of service delivery approaches in Zimbabwe. This might not be holistically attainable during the COVID-19 pandemic because the country has been saddled with a plethora of challenges but for the management of future pandemics/epidemics, these barriers could be overcome. It is also important to note that the barriers we identified in this study are cross-cutting in the sense that one factor influences the other in impeding the effectiveness of COVID-19 measures.

## Materials and methods

This qualitative study benefited from the review of secondary data namely; newspaper articles capturing the COVID-19 issues, journals, policy reports, and reports from national and international organisations. As such, a systematic search for literature on google and other academic search platforms was guided by the following key terms; COVID-19 and management. On that note, the authors adopted the inclusion and exclusion criteria to eliminate articles that were not relevant to the objective of the study. As such, sources that captured response measured to the COVID-19 crisis in Zimbabwe and Southern Africa were included in the study. The study adopted the Discourse Analysis to analyse the data from which the findings were derived. Tirivangasi and Rankoana (2015) denote that the discourse analysis is premised

on critiquing literature for the purpose of coming out with new interpretation. Tirivangasi (2018) further contend that the discourse analysis allows the researchers to look beyond what was being said and start looking at what was not said. Guided by the underpinnings of the discourse analysis, the authors identified the barriers towards effective management to COVID-19 in Zimbabwe and presented them as follows.

## Findings

*Lack of adequate capacity*

This study established that Zimbabwe was found unprepared by the COVID-19 hence she lacked the adequate capacity to deal with the ramifications of the pandemic. In as much as all countries were unprepared at the eruption of the pandemic, the Zimbabwean health sector was found incapacitated to effectively manage the dynamics of the pandemic. There were compounding factors bedevilling the country's health sector before the pandemic and there was no transformation at the time of its outbreak. To start with, the health sector is incapacitated due to the relentless strikes by nurses and doctors over poor remuneration and diabolic working conditions (Moyo 2020). As of 18 August 2020, 5 months after the outbreak of the pandemic, more than 15 000 nurses had been on strike over lousy wages. The strike was also ignited by the lack of COVID-19 protective gears for health care workers and they opted to down their tools instead of exposing themselves to infections (Mutizwa 2020; Moyo 2020). This means that essential services that should have been at the frontlines of conducting tests and screening for COVID-19 related cases were not sufficient to meet the demands in managing the pandemic.

Lack of adequate capacity within the Zimbabwean health sector is attributed to the brain drain that has been the order of the day in the country for the past three decades. The inimical effects of the economic quagmires pushed thousands of skilled medical personals out of the country to overseas and neighbouring countries in search of greener pastures (Machivenyika 2020; Dzobo et al.2020). According to the data released by the Health Services Board in December 2019 reveal that 64 percent of medical laboratory scientist positions in public laboratories were vacant (Dzinamarira et al.2020b). What it means is that Zimbabwe is saddled with human capital deficiencies. In this regard, laboratories are not able to meet the testing capacity because of shortages of personals to prepare and process the samples. Also, this compromised the quality of testing in public laboratories because less skilled medical personals ended up shouldering the responsibility of managing the tests. Lack of adequate capacity also connotes a deficiency of health care services, especially in rural areas.

Lack of adequate capacity in managing the pandemic is also attributed to the failure by the government of Zimbabwe to refurbish and maintain hospitals in line with international standards. Zimbabwe failed to draw lessons from the past epidemics about the need to invest in infrastructural development. As such, chronic shortages of drugs and avoidable deaths cases have decorated the health delivery system of the country for the past three decades (Dzinamarira et al. 2020b). The outbreak

of the COVID-19 pandemic worsened the situation (Mutizwa 2020). Besides, the Zimbabwean health care system is vulnerable to pandemics of any nature because they lack the basic equipment such as ventilators, testing kits, PPEs, and testing kits (Moyo 2020; Machivenyika 2020). At the time of the outbreak of the COVID-19 pandemic, Zimbabwe had less than 50 functional ventilators in all public hospitals (Dziva 2020). Majority of primary health care facilities are in a dysfunctional state with archaic medical equipment. This has become a structural barrier to how the country manages pandemics and epidemics. The country was bailed out by well-wishers and the international community where some donations were made to equip the health sector in the wake of the pandemic (Dzinamarira et al. 2020a). From the above inferences, we argue that these compounding factors of the depleted health care system, dilapidated infrastructure and depleted workforce are compromising the quality of service in the fight against the pandemic and serve as barriers to effective emergency response services.

*Corruption*

This study noted corruption as one of the barriers impeding the effective management of COVID-19 and other developmental aspirations in Zimbabwe. According to Mutizwa (2020), Zimbabwe's public sector is revered as the oasis of corruption. As such, corruption serves as a backlash towards intended measures manifesting through unrealised outcomes. Moyo (2020) weighs in by alluding that illicit financial flows have depleted the country's resources making it unable to finance its developmental aspirations including the fight against pandemics. In light of this, this study found corruption as an albatross around the neck of Zimbabwe's response to the pandemic and other social ills. Corruption manifested in multifarious ways since the eruption of the COVID-19 pandemic. To start with, the Minister of Health and Child Care was fired owing to corruption allegations in connection with the procurement of COVID-19 medical supplies (Daily Nation News 2020). The then Minister was fingered in a USD 60 million scandal where he was alleged to have granted the procurement tender of COVID-19 equipment to his proxies without following due processes as prescribed by the law (Chidaushe 2020). This resulted in medical supplies pegged at inflated prices. In the same wavelength, the litany of corruption scandals in the health sector emerged while the nurses and doctors were on strike over eroded wages and lack of COVID-19 equipment.

Sadly, hospital directors were living opulent lives evidenced by the procurement of state-of-the-art vehicles in the middle of a crisis while nurses and doctors were living below the poverty datum line (Mutizwa 2020). Like we indicated earlier that barriers to the management of COVID-19 in Zimbabwe are intertwined, the lack of adequate capacity to manage the pandemic is also linked to corruption which made the working conditions for health care workers unpalatable. Furthermore, ZANU PF members of parliaments occupied headlines in most newspapers for corrupt activities where they diverted the subsidised mealie meal meant for the poor to the parallel market (New Zimbabwe Newspaper 2020; The Chronicles Newspaper 2020). These egregious corrupt activities were meant to sell the mealie meal at exorbitant prices. This exposed many households to hunger during the lockdown which points to why people ended up defying the lockdown measures to make ends meet. This

exposed the citizens to the risk of infection because the lockdown was meant to curb the transmission of the virus.

Corruption was witnessed in the management of COVID-19 at quarantine centres created for returning residents. As of 30 June 2020, more than 150 people had escaped from the quarantine facilities (Dzobo et al.2020; Daily Nation News 2020). Some of the cited reasons behind the escape of these returnees were hunger and squalid living conditions (Moyo 2020). What should be highlighted is that these absconders were supposedly believed to have paid bribes to the security officials manning the quarantine facilities to be given the green light to leave. Some returnees even used undesignated entry points to evade the quarantine processes and upon being apprehended by the border patrol crew, they would pay bribes to be released (Chidaushe 2020). The calamitous effect of this development is that most of Zimbabwe's COVID-19 infections were imported through returnees. Therefore, the normalisation of corruption by security officials through allowing untested returnees to abscond after paying bribes served as a daunting backlash because they would spread the infection to their compatriots. On the 29th of May 2020, 7 out of 9 people who had absconded from Beit Bridge quarantine centre tested positive for COVID-19 after a manhunt by the police (Chronicle Newspaper 2020).

The lockdown measures prohibited unnecessary movements and informal businesses were closed to curtail the transmission of the virus in public spaces while measures were put in place to prepare the health care systems for the surge of the virus (Dziva 2020). However, the cancer of corruption rendered these measures futile because numerous reports of corruption emerged whereby soldiers and police officers enforcing the lockdown measures were soliciting for bribes to let people pass at the roadblocks. The exemption permits required for essential travel were bypassed as long one would pay a bribe to the soldiers or police officers manning the roadblocks (Machivenyika 2020). Also, informal traders whose livelihoods were dismantled by the lockdown restrictions were asked to pay bribes by the soldiers and police officers to be granted permission to sell their wares. This means is that the control measures of depopulating public spaces were defeated by the penchant to corruption in the wake of the pandemic.

*Centralised Approach*

The effective management through broad-based testing and screening as prescribed by the WHO wasn't a lived reality in Zimbabwe because of the centralised approach in the testing of COVID-19 samples. As mentioned earlier that the factors serving as barriers to the effective management of COVID-19 are diffused and interwoven, lack of adequate capacity owing to human capital and equipment deficiencies caused this backlash. This can be attributed to the abysmal corruption within the public sector which compromised service delivery in the health sector and preparation of emergencies such as COVID-19. As of 18 August 2020, Zimbabwe had conducted cumulative tests of 183 163 with 5308 positive cases, 1776 recoveries and 135 deaths (Ministry of Health and Child Care 2020; Machivenyika 2020). Making comparisons with South Africa which had conducted more than 3 million tests by the same period reveals that the process in Zimbabwe was slower than expected (Price 2020). Unlike other African countries such as South Africa and Rwanda that decentralised the

testing process to district and ward levels, in Zimbabwe, all samples from various provinces were taken sent to Harare for diagnostic tests in the early phases of the pandemic (Moyo 2020). On the same note, South Africa rolled out mobile testing units across the country to curb the movement of potentially infected people without being tested (Price 2020). The same cannot be said for Zimbabwe.

There were slight improvements in the testing process where each province established central testing sites of samples from various areas within the province (Dzinamarira et al. 2020). In the early phases of the pandemic, transportation of the samples was a challenge owing to fuel shortages bedevilling the country. To this end, the centralisation of the testing processes served as a barrier because most infected people would be gallivanting around town infecting others unknowing because they are not tested. This also validates arguments that the depicted numbers are not a true reflection of the situation because the testing process is too slow and not broad (Dzobo et al.2020). From this, we argue that effective management of the pandemic evolves around the true reflection of the impact that would ignite appropriate measures.

*Lack of safety nets for the poor*

This study noted that though the Zimbabwean government announced a whopping budget of ZWL$ 18 billion stimulus packages for COVID-19 relief and recovery, these funds were not disbursed especially the ZWL 600 million cash transfer targeting the poor (Daily Nation News 2020; Karombo 2020; Nyoka 2020). The cash transfer programme targeted 1 million households (Mutizwa 2020). In light of this, we argue that the criteria used to determine the beneficiaries of the cash transfers was not clear. Also, despite the funds not being disbursed, targeting only 1 million households in a country where 73.3 percent of the population is trapped under the manacles of poverty was not a prudent measure (Mhlanga and Ndlovu 2020). To add on, this was a parochial intervention given the eroded value of the local currency against the galloping inflation that was seating at 850 percent in June 2020 (Mutambanengwe 2020). Unlike South Africa which demonstrated capacity and institutional preparedness to the pandemic by announcing a whopping budget of R500 billion economic package for relief of social distress, hunger support of financial markets and unemployment and practically delivered, the same cannot be said for Zimbabwe (Price 2020).

In Zimbabwe as elsewhere, the lockdown measures disfigured and dismantled the livelihoods of the already poor hence the lack of a broad-based disbursement of social protection services aggravated their dire circumstances. The social ills of Zimbabwe are animated by the unemployment rate of 95 percent among others (Mutizwa 2020). As such, 80 percent of Zimbabweans are in the informal sector such as hawking, street vending and cross border trading (Moyo 2020). That being the case, only formal businesses were given the green light to operate and informal businesses were left in a quandary where the majority of Zimbabweans especially women and youths are predominant (Dzinamarira et al. 2020a; Dzobo et al. 2020). The boomerang effect of this is that people ended up defying the lockdown regulations to pursue their survival schemes thereby exposing themselves to the risk of COVID9-19 infections. In support of this, Dziva (2020) posits that nocturnal activities were on the rise especially in Mutare and Harare markets where people would sell their wares at night to evade from law enforcement agents. To argue further, the majority of the citizens with

limited access to food and income vouched to die of COVID-19 instead of hunger because the government failed to intervene as expected.

*Standards at quarantine facilities*

The Zimbabwean government established 37 quarantine facilities to across the country to cater for the returning residents from neighbouring countries. These were school, colleges and training centres improvised for the habitation of returning residents (Dzinamarira et al.2020b). Earlier we indicated that the pandemic landed in Zimbabwe in the middle of dire economic crisis animated by infrastructural underdevelopment in all sectors, the quarantine facilities were in a flimsy state. Most of them had no running water electricity and PPEs and food was in short supply (Mutizwa 2020). There were no proper guidelines on how these quarantine facilities should operate. Also, safety measures were difficult to adhere to by the occupants. Furthermore, testing upon arrival was delayed that most returnees would get tested after the 10th day of arrival. People were not oriented through the mandatory 21-day quarantine period to ensure compliance (Dzinamarira et al. 2020a). All these factors point to why most people escaped from the quarantine facilities without being tested or satisfying the requirements of the quarantine processes before they interact with other people. The fact that Zimbabwe registered its first COVID-19 cases from imported infections should have ignited the government to provide succinct modalities required for the prevention and control of infections at quarantine facilities (Dzinamarira et al. 2020b). Other barriers identified in this chapter such as corruption and lack of adequate capacity underlines the lack of effective control measures at quarantine facilities.

*Inconsistent mitigation measures*

This study also noted barriers to the effective management of the COVID-19 pandemic through inconsistent mitigation measures adopted by the government. To start with, the introduction of a hard lockdown which led to the closure of the informal sector that anchor the livelihoods of many Zimbabweans without the provision of safety nets was a shot in the leg. This led people to defy the lockdown measures in pursuit of their survival strategies thereby risking being infected or transmitting the virus to others. Another retrogressive measure in the management of COVID-19 was the curfew introduced by the government on the 23rd of July 2020 (Mutizwa 2020; Dzinamarira et al. 2020b). The curfew was introduced under the guise of responding to the surge of COVID-19 cases while in essence, it became a political repressive measure meant to thwart the demonstrations against the government slated for the 31st of July 2020. The demonstrations were choreographed by opposition party leaders to ventilate the citizens' discontentment against corruption, oscillating poverty levels and human rights violations. In this regard, formal businesses were allowed to operate from 8 am to 3 pm and no one was expected in the Central Business District of the major cities after 6 pm. Soldiers and police officers were deployed to show heavy-handedness to would-be offenders (Nyoka 2020). This was in the wake of the ban on private transport operators. Only ZUPCO buses were designated to operate but they couldn't meet the demand. The pressure over transportation saw people stampeding to get spaces in the few available buses. Commuters would queue for long hours before getting transport. Reports emerged that people were bunched at bus terminuses with no social distancing being followed (Nyoka 2020). Also, the carrying capacity

of the buses was not regulated in observation of the WHO guidelines of maintaining social distancing. This was a perilous measure in the wake of the contagious virus. There was no modicum of logic in banning private transport operators in the wake of such a demand and draconic political curfew measures. What it means is that people were exposed to the risk of infection because of conflicting response measures by the government.

**CONCLUSION**

This chapter noted that the COVID-19 pandemic landed in Zimbabwe when the country was already in a crisis mode hence the COVID-19 crisis found the country unprepared. Although the country made some remarkable efforts in responding to the pandemic, the process had glitches, resulting in the lack of efficiency of the interventions. The barriers in the management of COVID-19 have been centred on inadequate investment by the government in the health system over the years. This mainly involved the pervasive disregard for better working conditions and salaries for health frontline workers. As we indicated that barriers are circumstances that can be surpassed through broad-based institutional transformation, we maintain that the barriers identified in this chapter can be overcome. In this regard, we recommend that the government must address issues of corruption across all levels of its value chain. There is also a need to embrace the fundamentals of transparency and good governance and the channelling of resources to where they are needed most. Moving forward, Zimbabwe needs to ramp up its disaster management preparedness capacity to be able to handle all future forms of disaster. To ease pressure on the national health care system, it is also recommended that the country should invest in community-based health care systems.

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