QUARANTINE AND ISOLATION CENTER SITUATION ALERT

JULY 2020

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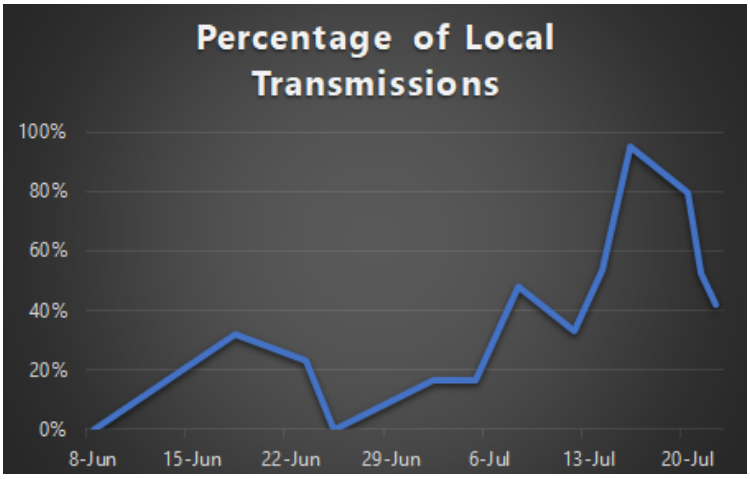
ACTION AGAINST HUNGER
ACTION CONTRE LA FAIM

SITUATION OVERVIEW

As of 8 July 2020, approximately 80 percent of COVID-19 cases in Zimbabwe were reported as imported and coming from within Quarantine Centres (QCs), which hold Zimbabweans returning to the country. As of the week of 20 July this trend has reversed with local transmission now exceeding imported cases. This is thought to be largely attributable to returnees illegally crossing the border to evade quarantine due to the fear and misinformation surrounding the centres. This is leading to many re-entering communities without being tested and quarantined. In early July, Action contre la Faim (ACF) and partners launched an assessment of some of the key QCs in collaboration with MoPSLSW and MoHCC to understand the cause of the spread of infection within Quarantine Centres and to identify key gaps to be urgently addressed in an attempt to contain the spread.



On March 29, 2020, Zimbabwe implemented a country-wide lockdown due to the COVID-19 pandemic with limitations on movement and border closures. Nationals and residents are allowed to re-enter but must be tested upon entry and sent to a state-allocated quarantine centre closest to their residence for 7-21 days in accordance with Statutory Instrument 83 of 2020. Prior to COVID-19, many Zimbabweans travelled to neighbouring countries such as South Africa and Botswana in search of economic opportunities or to rejoin family members. While some Zimbabweans are now returning voluntarily, others have been forced to do so due to deportation or loss of employment as a result of lockdown measures associated with the pandemic. Private quarantine is on offer for those who can afford it and represents a safer option. However, for the majority of returnees this is not a viable option. Up to July, most state-run Quarantine Centres were housed in primary and secondary schools., Although the Government of Zimbabwe (GoZ) has delayed the re-opening of schools to full-time students, it is clear that alternative structures will be required in coming months and provinces are investigating where else returnees can be accommodated. The lack of fit-for-purpose structures means some provinces have limited (in some cases just one) facilities and those that exist are ill-equipped to ensure the safety of returnees. Across Quarantine Centres, significant WASH and Infection, Prevention and Control (IPC) and protection gaps are observed requiring an urgent and coordinated multi-sectoral intervention.

COORDINATION & TESTING PROTOCOL

Coordination Structures

Coordination of QCs is a joint operation. The Ministry of Public Service, Labour, and Social Welfare is the responsible institution for provision and distribution of supplies including food and NFIs and cleaning of linens; while the Ministry of Health and Child Care (MoHCC) is responsible for testing, monitoring, and hygiene sessions. UNICEF and IOM are assisting with transportation and supplies and several NGOs are supporting to the extent possible but funding is limited and the gaps are significant.

Within the framework of the National COVID-19 Response Strategy, the centers fall under the Point of Entry (PoE) Pillar. However, their management overlaps with several other pillars including the Infection, Prevention and Control (IPC) Pillar. There is also a UN-led working group seeking to bring together partners working under the PoE Pillar. Coordination across the pillars is a work in progress.

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Testing Protocol

According to the Response Strategy, all returnees should be tested: 1) upon re-entry (prior to transportation to QCs); 2) upon arrival at QCs; and 3) after 7 days in the centre. If a PCR test after 7 days is negative, returnees should be issued with a clearance letter and released. However, if the PCR is positive, they should be transferred to isolation and another test should be administered on day 21.

However, due to the lack of test kits and reagents available, returnees report that the first test is often administered several days after arrival. This puts existing and new returnees at risk of infection and also pushes back their quarantine completion date. In addition, test results come back 5-13 days later, implying the mixing of unknown positive and negative cases at centres. Furthermore, isolation centers do not admit asymptomatic or mild cases; with such cases advised to self-isolate at home. However, self-isolation can represent a challenge in both rural and urban settings.

SITUATIONAL ANALYSIS

For millions of Zimbabweans, the restrictive measures put in place to slow the spread of the virus have exacerbated the already hard-felt effects of recent shocks such as Cyclone Idai, consecutive droughts leading to a widespread food security crisis as well as an ongoing socio-economic crisis. With 80 percent of Zimbabweans working in the informal sector, the extended lockdown has hit urban livelihoods particularly hard. The pandemic has disproportionally affected vulnerable households who had already exhausted their coping mechanisms as a result of other shocks.

It is expected that an increasing COVID-19 caseload, especially within communities, further deterioration of the economic situation, combined with newly arriving migrants and returnees (many of whom do not have existing support systems in-country) will compound the situation by burdening the already weakened healthcare system and social infrastructure. IOM projects 20,000 new arrivals in the coming months, and as existing quarantine centres close (to re-open as schools) with no clear provision for additional centres, there is a risk overcrowding (or evasion from QCs) may increase the spread of COVID-19. Women and children are particularly at risk since they bear the brunt of the burden of taking care of the ill, purchasing goods and food and fetching water. In addition, since lockdown started there has been a spike in cases of gender-based violence (GBV), particularly within the household. This is largely thought to be associated with loss of income and subsequent inability of breadwinners to provide for their families leading to mounting frustration and anguish.

Fear, misinformation and stigmatisation have also taken a toll on social dynamics and health-seeking behaviour. Due to the delays in testing within quarantine centres some returnees have left the centres before receiving their final test and proper clearance while others evade quarantine altogether. As a result, they are criminalised in the neighbouring communities and seen as “escapees” rather than returnees attempting to regain control of their lives. This has heightened the fear of these people coming back into communities, as well as the fear of going to a local clinic for any illness in that they might also be perceived as dangerous or infiltrating the community whether or not they actually have contracted the virus. It has been reported that people are choosing to forego treatment at local clinics due to negative perceptions, or are preferring to travel to larger central hospitals that are already overstretched in terms of human and physical resources.

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KEY GAPS & CHALLENGES

Major gaps are largely related to the ongoing resource shortage faced by the Government of Zimbabwe. This has affected key supplies with shortages ranging from chemicals for water treatment to essential equipment. Test kits have been particularly difficult to procure, with reagents and test kits being donated or purchased in differing quantities and times, affecting the in-country capacity to test efficiently and at-scale.

Additionally, as non-medical facilities, Quarantine Centres require certain upgrades and provisions to safely support and protect the returnees and adjacent communities during this time. Many lack basic necessities and do not meet minimum WASH and IPC standards. The situation varies from site to site according to the recent quarantine assessment report by IOM, WHO, and the MoHCC (17-21st May, 2020) and confirmed by recent assessments by ACF and partners. Some centres have consistent access to water, blankets, IPC supplies, hand-washing stations, and proper sanitation, while others do not. Additionally, many lack adequate human resources to clean the facility, disinfect and launder blankets and linens, and stock supplies, either due to the unavailability of community health workers or their refusal to work due to insufficient PPE and supplies. Despite the Standard Operating Procedures (SOPs) specifically laid out for Quarantine Centres by the MoHCC, according to the IOM report, only 30% have PPE for staff, 16% reported monitoring symptoms and testing of staff, 62% of centres have running water - some facilities reporting that all water supplies have run out, and equipment and supplies to support regular hand-washing are insufficient in 5 provinces. Regarding testing, 32% of facilities are monitoring and reporting details of returnees, 100% of facilities admit results come late or never, and less than half of facilities are completing routine data collection.

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PARTNER COVERAGE & FUNDING

In June, following the report by IOM, ACF began to engage in discussions with the WASH Cluster, MSF, IOM, relevant ministries, and other NGO partners engaged in the space. It quickly became apparent that Quarantine Centres are becoming clusters of contamination with high levels of infection being reported and significant gaps in terms of WASH and IPC. Although the planning at national level and dedication country-wide from the government has been impressive, due to the lack of PPE, insufficient staffing, and lack of basic services, the QCs and entry points appear to be increasing, rather than limiting, the spread of the disease.

At this time, a few WASH Cluster partners have begun to assist in this space, however the need is far greater than the current capacity of any single organisation. ACF Zimbabwe undertook to further investigate the situation through a series of multi-sectoral rapid assessments of a few key centres in existing areas of operation to identify possible interventions. ACF and partners shared the tool widely with other NGO partners in the hope that some would contribute to assessing QCs within their own areas of operation to gauge the true extent of the problem and enable NGOs to jointly advocate on how to close gaps, leveraging the respective technical expertise and established presence in affected areas. In this context, ACF and local partner organizations, Nutrition Action Zimbabwe (NAZ) and Africa Ahead (AA), have begun conducting assessments of QCs to better understand the situation specifically in terms of WASH, IPC, nutrition, and protection. Assessment methodologies include a combination of physical observation, Key Informant Interviews with staff and Focus Group Discussions with resident returnees. As a WASH Cluster partner strong in coordination, ACF is conducting assessments in close coordination with the relevant ministries, namely the MoHCC, Provincial District Development Fund (DDF), National Department of Environmental Health Services, Department of WASH Coordination, Provincial Department of Social Welfare, and Mutare Local Council.

The Joint Assessment Report will be available as of 31 July. However, preliminary findings already clearly show there is an urgent need for a coordinated, multi-sectoral response to rapidly bring the centres up to standard and slow the rate of infection. ACF is well-placed to support on WASH, IPC, Food and Nutrition Security gaps within QCs that fall within its geographical reach (see map below). However, funding for intervention is extremely limited and partners are relying on the re-allocation of existing resources, meaning significant gaps will remain until additional funding is made available.

LIST OF QUARANTINE CENTRES*

MANICALAND

- Magamba
- Toronto
- Vumba Training Centre

MASVINGO

- Rupangwana Training Centre
- Bikita Training Centre
- Mushagashe Training Centre

MASHONALAND EAST

- Ruwa Rehabilitation Centre
- Domboshawa Training Centre
- Jamaica Inn
- Murehwa Training Centre
- Beatrice Rehabilitation Centre

MASHONALAND WEST

- ZIPAM Hotel
- Makonde Training Centre
- Rukawo Hotel
- Sanganai Scripture Union

BULAWAYO

- Khumalo Hotel
- Insinga Youth Centre
- Standard Hotel

MIDLANDS

- Dayadaya Vocational Training Centre
- Senga Training Centre

MATEBELELAND NORTH

- Mabhikwa High School
- Mosi oa Tunya High
- Phezulu Lodge

MATEBELELAND SOUTH

- Matopo Research Institute
- Mzingwane
- Thuli Institute
- Esikhoveni Training Centre
- Insiza Panagni Training Centre
- Beitbridge Rainbow Hotel
- Gwanda DDF

MASHONALAND CENTRAL

- Chawarura

HARARE

- Girls High School
- Prince Edward High School
- Queen Elizabeth School
- Courtney Selous
- Carry's Guest Lodge
- Allan Wilson High School
- Rainbow Towers Hotel
- Marantha Lodge
- Monomotapa Hotel

*This list is being updated by IOM and Ministry of Social Welfare in view of the re-opening of some schools and technical colleges in July 2020 and subsequent closure of many centres. Private Quarantine Centres are not listed here.

COORDINATION & RESPONSE FRAMEWORKS

As part of the National Preparedness Plan launched by the MoHCC to minimize morbidity and mortality caused by COVID-19 and mitigate the socio-economic impact of this newest crisis, the National Response Framework was developed adopting the 8 WHO pillars: 1) Coordination, planning and monitoring; 2) Risk Communication and community laboratory system; 6) Infection prevention and control (IPC), 7) Case management and continuity of essential services; and 8) Logistics, procurement and supply management. A key part of this approach is identifying priority areas for intervention to be able to contain the spread of the disease, particularly in terms of healthcare infrastructure.

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CURRENT STATUS OF ISOLATION CENTRES & PARTNER COVERAGE

Prior to the COVID-19 pandemic, water scarcity and failing WASH infrastructure was already an issue in many parts around the country. Many institutions, including some large provincial hospitals, did not have the capacity to pump enough water for storage to provide water to users throughout the week, and did not have sufficient chemicals to adequately treat the water. Since the outbreak began in March 2020, within existing district and provincial healthcare facilities, specific wards or buildings have been designated as COVID-19 Isolation Centres. However, significant works need to be carried out to render these ready to handle the influx of cases they are facing as numbers begin to rise rapidly. A number of private sector actors have stepped up to support basic infrastructure renovation. However, key gaps remain including water supply and storage, sanitation, waste management and Infection, Prevention and Control training and supplies.

Together with the MoHCC and the WASH Cluster, UNICEF has re-allocated some existing DFID funds to improve access to critical WASH supplies, information enhancing IPC measures and improving availability of WASH services in COVID-19 isolation centres within strategic healthcare facilities. In order to do so, UNICEF has engaged IMC, ZCC, and ACF (with Africa Ahead) to implement these rehabilitations and improvements in 50 (of the 80) key facilities around the country selected in coordination with MoHCC. The remaining 30 top priority facilities are in urgent need of support with no funding allocated to date. There is also a list of second tier facilities with no allocated support at this time. ACF and partners have the expertise and capacity to take on the additional priority facilities within the framework of its arrangement with UNICEF. should additional resources become available.

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KEY GAPS & CHALLENGES

As of 9 July 2020, the MoHCC estimates they are at 9 percent readiness to accept and treat severe COVID-19 cases. Rehabilitation has been completed on just 3 of the 80 prioritised Isolation Centres, and these are all in Harare. According to the MoHCC, key challenges include significant delays in procurement, staff burnout, and insufficient supply of reagents as well as an overall lack of financial resources to support the response.

As the outbreak intensifies, frontline healthcare workers face delays in receiving salaries and necessary protection, which has led to them downing tools just as they are needed most. As Quarantine Centres refer more cases, healthcare facilities are becoming overwhelmed. Very few Isolation Centres were originally conceived to handle infectious disease. Thus, most are in need of support to ensure minimum Infection, Prevention and Control (IPC) standards. Some facilities are struggling to adequately isolate confirmed COVID cases from other patients, heightening infection risk, particularly for those with pre-existing illnesses or chronic underlying conditions.

MoHCC recently completed an evaluation of Isolation Centres which confirms the lack of readiness of centres nationwide in terms of quantity, capacity and location. MoHCC acknowledges that without significant and rapid intervention, Isolation Centres will not be able to absorb the expected influx of cases. Another key challenge emerging is the change in health-seeking behaviour of non-COVID patients due to fear and stigma surrounding COVID. There is a need to continue to communicate effectively with communities to ensure those with chronic or acute conditions continue to seek and access adequate care.

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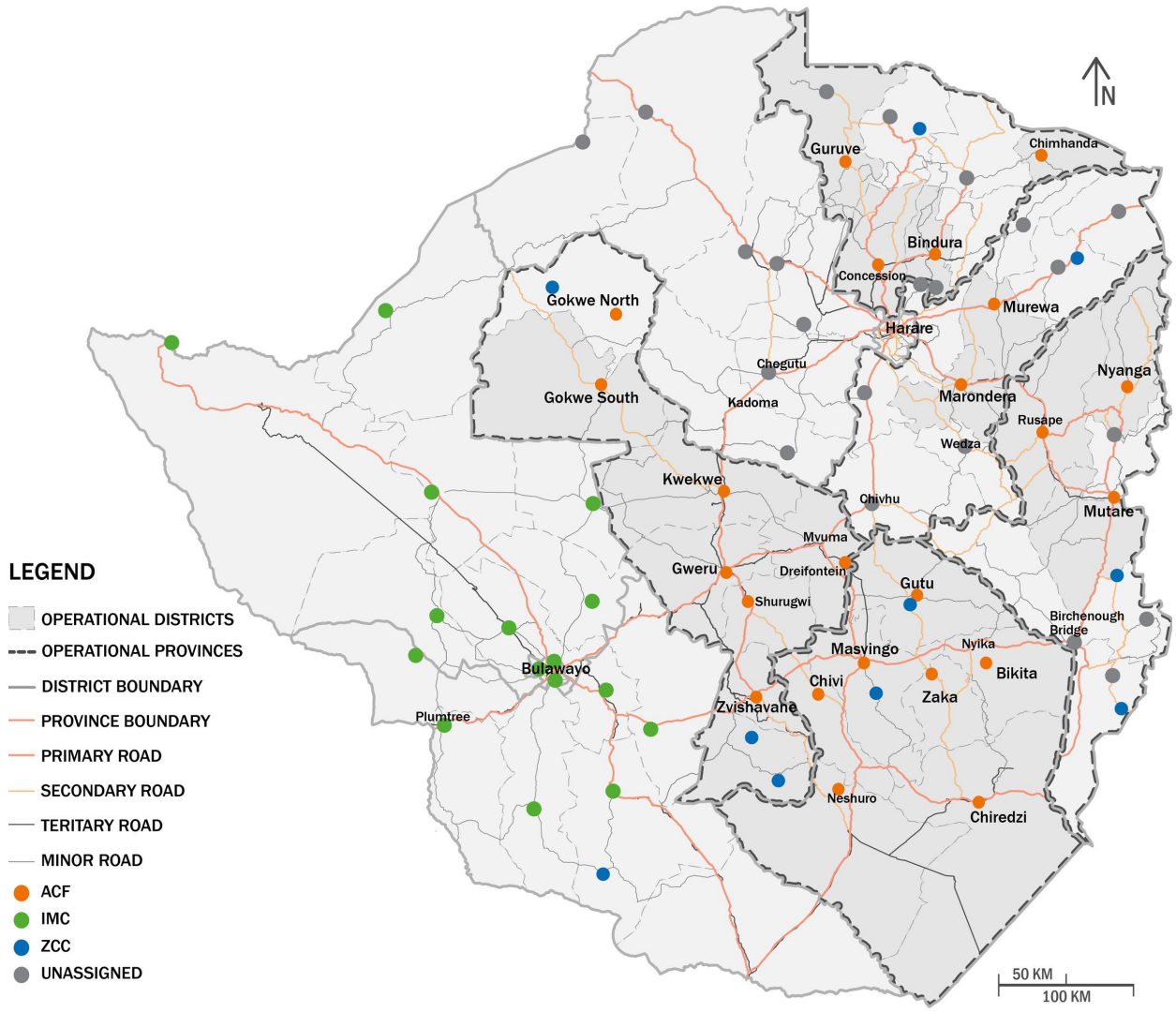
MAP OF ISOLATION CENTRES & CURRENT COVERAGE



ACF - Action contre la Faim (with Africa Ahead)
IMC - International Medical Corps
ZCC - Zimbabwe Council of Churches

NEED FOR A COORDINATED & MULTI-SECTORAL RESPONSE

In addition to the urgent need to improve WASH and IPC standards across Quarantine and Isolation centres, there is a need to coordinated and integrated response to ensure other emerging issues - such as Food and Nutrition Security, Protection and Reintegration of returnees - are considered.

The multi-sectoral assessment conducted by ACF and other partners highlights several other issues of concern. In particular, ACF's partner Nutrition Action Zimbabwe emphasises the need for more attention to the special needs of pregnant and lactating women, mothers and young children held in Quarantine Centres. There is also a need to ensure appropriate segregation and child and parent-friendly spaces in the centres. Basic needs, such as pampers for young children, must be urgently attended to. Partners also noted the presence of unaccompanied minors, who will be in need ongoing assistance once they are released from the centres.

In the absence of robust social protection schemes, as many youth return from urban settings into their rural communities of origin, there is also a need to provide support for livelihood opportunities to enable returnees and their families to meet basic needs.

While WASH and IPC remain key challenges, a multi-sectoral response is required to fully address the multitude of issues highlighted by the Joint Assessment.

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A DEEPENING SOCIO-ECONOMIC CRISIS

Trynos was in South Africa working in Johannesburg when COVID struck. His place of work closed and he was unable to find another job. Originally from Honde Valley in Manicaland, his wife and children had travelled with him to South Africa in search of opportunities. He tells us he knew they would be quarantined upon re-entry but did not know what to expect. They plan to return to the Valley once released but expressed concern at the lack of jobs available in Zimbabwe; they would like to return to South Africa as soon as possible.


Photocredit: ACF, 2020

Many like Trynos are making their way back to Zimbabwe following the strict and extended lockdown in South Africa. However, many find themselves without livelihood prospects as they transition from an urban setting back to their rural areas of origin. This is likely to exacerbate the food security and economic crisis rural and urban communities are already facing in Zimbabwe, as well as potentially lead to tensions between returnees and local communities as they battle job scarcity and limited livelihood opportunities.

With many Zimbabweans employed in the informal economy, the extended lockdown has wreaked havoc on urban livelihoods. Rural livelihoods continue to be severely affected by the ongoing impact of consecutive years of drought which has led to lost harvests. This has been worsened by the inability of rural and urban vulnerable households - due to lockdown measures - to activate traditional coping mechanisms such as casual labour due to restrictions on mobility.

The combination of the pre-existing crisis coupled with the effects of the COVID-19 crisis is expected to have a lasting impact on livelihoods for the most vulnerable populations in Zimbabwe.

"There are no jobs here for me. How am I to provide for my family?" - Trynos, 30

STORIES FROM RETURNEES

LOICE, 47

Recently returned from Mozambique, she tells us she was doing odd jobs and volunteered to return to Zimbabwe in order to rejoin her family. She had begun to face stigma as a foreigner in Mozambique due to COVID-19 and struggled to find work. She was tested 8 days after her arrival at the center and does not know when she will get the results. Staff told her she could expect to be in the centre for 21 days. Originally from Harare, she plans to return there once she is released. She says medical staff at the Center have been unable to provide medicine for her chronic condition. She tells us she is very worried about her health as she is the one to clean the bathrooms since staff do not do so and no other resident is willing.

TAKENDA, 40

Takenda was making a living as a fisherman in Botswana but was recently deported due to lack of a work permit. He has a wife and 3 children in rural Buhera and is planning to go there once he is released from the centre where he will attempt to make a living by rearing chickens. He did his PCR test several days after arrival and has been waiting 13 days for his test results. He tells us he spent 10 days in the same room as a man who tested positive to COVID-19 before being transferred to an isolation centre.