Finding the Balance: Public Health and Social Measures in Zimbabwe

What is the purpose of this report?

This report describes findings from a telephone survey with 1,284 people conducted in February 2021. The survey examined how people respond to public health and social measures (PHSMs) to prevent COVID-19. The sample is representative of households with access to a landline or cell phone, but does not include people without access to phones. As phone penetration varies by country, findings should be interpreted with caution.

Survey data are analysed alongside epidemiological, mobility, and media data. Triangulating these data sources offers valuable context to better understand the acceptability, impact and effectiveness of PHSMs.

This is the third survey and analysis conducted since the pandemic began (see the first and second reports).

New daily cases, 14-day rolling average

Survey 1 — Apr 2020
Survey 2 — Aug 2020
Survey 3 — Feb 2021

National COVID-19 Data Snapshot on 26 February 2021

Total reported cases	36,044
Cumulative incidence rate per 100,000 people	208
Test positivity rate — Proportion of people who test postive for COVID-19 among all people who took a test, averaged over 7 days	2.6%
Total confirmed COVID-19 deaths	1,463
Case fatality ratio — Proportion of total reported deaths among all people reported as testing positive for COVID-19	4.1%

What are the highlights from this report?

Disease Dynamics and PHSM Implementation

Zimbabwe reported a daily average of 900 new cases during its second COVID-19 wave in January 2021, about five times more cases than during its first wave in August 2020. As a result, hospitals were overwhelmed, with reports of oxygen shortages. The test positivity rate fell in February, but the case fatality rate remains high, suggesting PHSMs are still needed to mitigate transmission.

PHSM Support and Self-Reported Adherence

Support for and self-reported adherence to both individual measures and measures restricting social gatherings and movement were higher in Zimbabwe compared to the other African Union Member States surveyed in the Southern Region (Mozambique, South Africa and Zambia). Indicating that despite the economic consequences of PHSMs, people in Zimbabwe still understand their importance and are willing to adhere to them.

Risk Perceptions and Information

Respondent satisfaction with the government was high in Zimbabwe, aligning with the high support for and self-reported adherence to PHSMs. However, belief in misinformation narratives was common in Zimbabwe. About two-thirds of respondents thought that COVID-19 could be cured with herbal remedies, and nearly half thought health care workers should be avoided because they could spread the virus.

Secondary Burdens

Disruptions to health care access and people's livelihoods continue to be severe in Zimbabwe. Since August, difficulty accessing medication decreased. However, more than four in 10 reported skipping or delaying health services, unchanged since August. Income loss was widespread. Additional government aid will likely be required to improve food access, and particularly so to maintain adherence to PHSMs.

Disease Dynamics and PHSM Implementation

What is the relationship between PHSMs and cases reported?
The political and social context influences how well PHSMs are implemented and adhered to, which affects COVID-19 disease transmission and mitigation.

Situational Awareness

At the peak of its second COVID-19 wave in January 2021, Zimbabwe averaged more than 900 new cases and 40 new deaths reported per day, which is almost five times more than at the peak of its first wave in August 2020. The test positivity rate reached as high as 25%, indicating that cases were likely going undetected.

On 18 December, Zimbabwe announced public gathering restrictions in response to rising cases. By 2 January, the government instituted a national lockdown, closed borders and announced schools would not be reopened following December break. While these measures decreased mobility, there were reports of overcrowding and unsafe conditions at the border with South Africa. Additionally, 26% of survey respondents reported they travelled outside their town or village for the holidays.

The daily average of new cases and deaths started to decrease steadily by the end of January. While the test positivity fell below 5% in early February, the case fatality rate remains high. During the second wave, media reported that hospitals were overwhelmed, with critical shortages of staff, personal protective equipment (PPE), ICU beds and oxygen supply. Nurses at a major hospital in Harare went on strike over lack of PPE, and there were reports of people bidding for oxygen on social media. Multiple prominent government officials died from COVID-19. Recent genomic surveillance showed that the B.1.351 variant was widespread in Zimbabwe, accounting for about 95% of the 100 tests sequenced in January.

The Zimbabwe Medical Association reported on 25 January that more than 1,500 health care workers had contracted the virus since the start of the pandemic. In February, Zimbabwe started the distribution of 200,000 doses of China's Sinopharm vaccine, with the goal of vaccinating 60,000 health care workers in coming weeks. In March, shortly after the fielding of this survey, Zimbabwe lifted its lockdown.

A limitation of this survey is that it only includes respondents with access to phones, making it likely that they are more educated (25% of respondents completed college/post graduate degree) and have higher incomes than the general population.

Zimbabwe implemented a nationwide lockdown after cases increased following the December holidays. Mobility started to decrease soon after and reported cases fell steadily from the end of January to February.
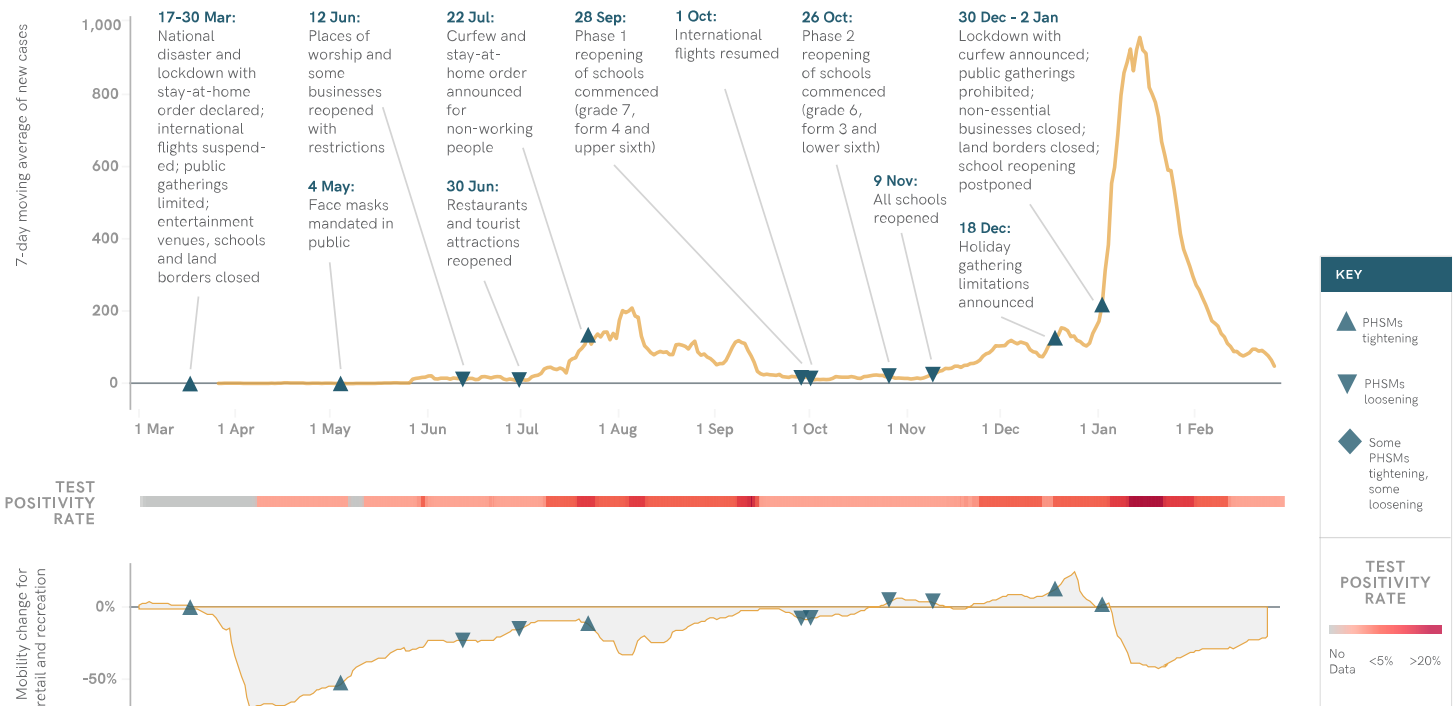
PHSM Support and Self-Reported Adherence

Do people support and follow measures?

PHSM effectiveness relies on widespread acceptance and behavior change.

What the data say

Between August 2020 and February 2021, support for COVID-19 preventive behaviors remained largely unchanged in Zimbabwe while self-reported adherence increased for some measures.

- Adherence to measures restricting social gatherings and movement increased since August, perhaps reflecting the more restrictive measures in place at the time of this survey and recovery from the intense second wave in January.

- Similar to August, support for and self-reported adherence to individual measures was higher on average than for measures restricting social gatherings and movement.
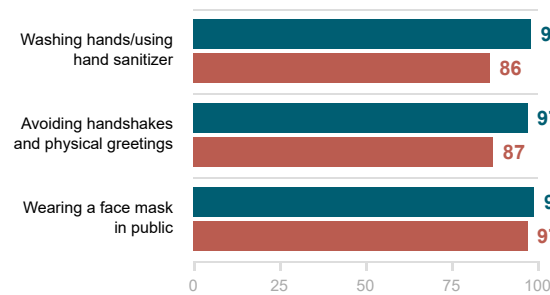
In the media

"A gentle reminder to us all. Covid 19 is real, lets: - Wear a mask always - Sanitize regularly - Wash your hands - Always respect social distancing - Sneeze or cough safely - Open windows"

— Twitter user in Zimbabwe, 17 Jan 2021

Individual measures

Support for and self-reported adherence to individual measures, particularly wearing a face mask, are the highest in the Southern Region. There has been little change since August.

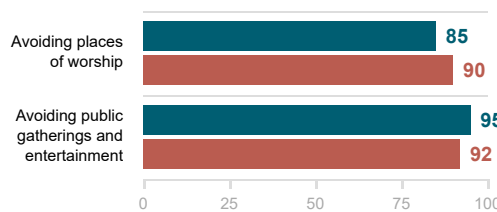*Percent that support and adhere to each individual measure in Feb 2021*

Washing hands/using hand sanitizer: 98 / 86
Avoiding handshakes and physical greetings: 97 / 87
Wearing a face mask in public: 99 / 97

Trend in percent that support and adhere to all individual measures (composite score)
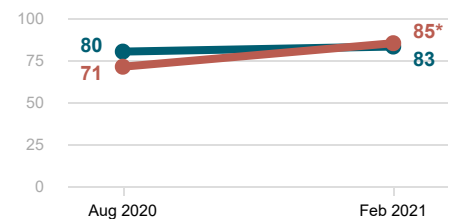

Aug 2020: 96 / 76 — Feb 2021: 95 / 77
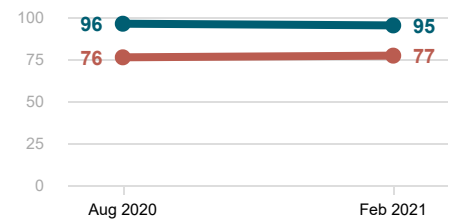
Measures restricting social gatherings

Compared to August, reported adherence to measures restricting social gatherings increased, in line with more restrictive measures implemented during the second wave.

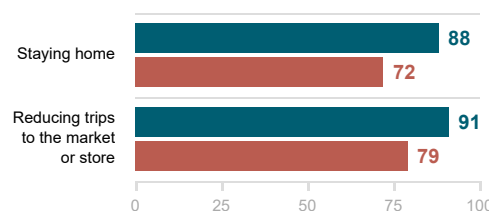*Percent that support and adhere to each social measure in Feb 2021*

Avoiding places of worship: 85 / 90
Avoiding public gatherings and entertainment: 95 / 92

Trend in percent that support and adhere to all social measures (composite score)
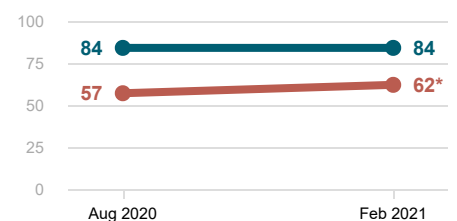

Aug 2020: 80 / 71 — Feb 2021: 85* / 83

Measures restricting movement

Compared to August, reported adherence to measures restricting movement increased slightly, in line with more restrictive measures implemented during the second wave.

Percent that support and adhere to each movement measure in Feb 2021

Staying home: 88 / 72
Reducing trips to the market or store: 91 / 79

Trend in percent that support and adhere to all movement measures (composite score)

Aug 2020: 84 / 57 — Feb 2021: 84 / 62*

PHSM Support and Self-Reported Adherence

Whom do people trust?

Public trust in government and institutions is a key driver of support for and adherence to PHSMs.

What the data say

Nearly 80% of respondents in Zimbabwe reported that they were satisfied with the government's pandemic response, a significant increase from August 2020 (73%). This finding aligns with the high support for and self-reported adherence to COVID-19 preventive behaviors among survey respondents.

- Trust was high for international organizations (UNICEF and WHO) which may be due to the community mobilization campaign UNICEF launched in October to raise awareness on COVID-19 and gender-based violence.
- While survey respondents reported high satisfaction with the government, some social media users expressed frustration with the government's virus response. Teachers unions criticized the government's reopening of schools due to a lack of personal protective equipment (PPE), and citizens called on the government to supply hospitals with oxygen and ventilators.

What do people think about their country's institutions?

About 80% of respondents in Zimbabwe reported they were satisfied with the government's COVID-19 response, slightly higher than the regional average.

79% are satisfied with the government's pandemic response
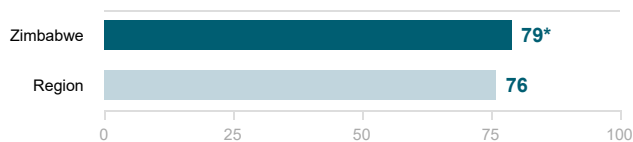
Top five most trusted institutions and individuals

Percent of people reporting trust in each source

UNICEF	83%
World Health Organization (WHO)	82%
Ministry of Health	80%
Hospitals/health centers	77%
The President	76%

What are people saying in the news and on social media?

There was an increase in negative social media posts towards the Zimbabwean government following its decision to reopen schools in October. Teachers went on strike, highlighting unsafe COVID-19 conditions in the classroom (e.g. overcrowding and a lack of PPE). At a school in Matabeleland North province, there were reports that 100 students tested positive for the virus. Although most students sat for exams in December, school reopening was delayed after the holiday break due to the second wave.

The government's tightening of measures during the second wave led some social media users to call for affordable PPE and COVID-19 testing. Citizens also questioned the legitimacy of the government's report that it spent USD $25 billion on the COVID-19 response.

In the media

"This is simply not true. We never saw this money! Health workers never got PPE, hospitals never got equipment, citizens never got free testing."

—Twitter user in Zimbabwe reacting to government reported expenditure on COVID-19, 31 Jan, 2021

Risk Perceptions and Information

How do people understand risk?

Perceptions of risk are influenced by the epidemiology of an outbreak as well as the type and quality of information disseminated by trusted sources.

What the data say

Nearly 70% of respondents thought that COVID-19 would affect many people in their country, but only about one in four believed their risk of catching it was high. About one in three believed their health would be seriously affected if they contracted COVID-19.

- While personal risk perception is lower than the regional average, self-reported adherence to PHSMs was still high, indicating that lower risk perception is not necessarily reducing adherence.
- Nearly two-thirds of respondents reported that COVID-19 could be cured with herbal remedies—an increase since August (53%).
- About half (47%) of respondents reported that health care workers should be avoided because they could transmit COVID-19, and 40% thought people recovered from COVID-19 should be avoided. Stigma towards health workers was higher among respondents that reported skipping health services since the start of the pandemic (47%) compared to those that did not miss health services (37%).

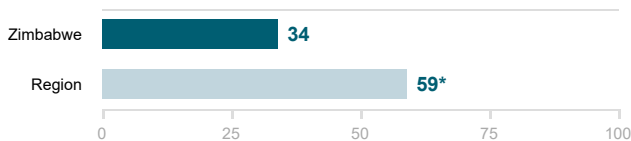## How do people understand the risk of COVID-19?

69% believe that COVID-19 will affect many people in their country

Zimbabwe	69
Region	80*

0   25   50   75   100
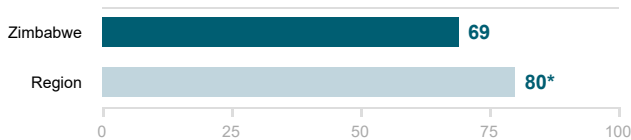
26% believe that their personal risk of being infected with COVID-19 is high

Zimbabwe	26
Region	40*

0   25   50   75   100
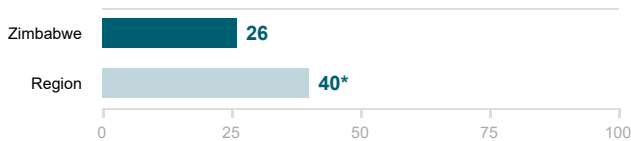
34% believe that their health would be seriously affected by COVID-19

Zimbabwe	34
Region	59*

0   25   50   75   100

Do people stigmatize others?

47% think they should avoid health care workers because they could get COVID-19 from them

40% think they should avoid people who have had COVID-19 in the past because they remain infectious

Do people believe accurate information?

85% understand that infected people may never show symptoms but could still infect others

76% understand that infected people may not show symptoms for five to 14 days

63% believe that COVID-19 can be cured with herbal remedies

Risk Perceptions and Information

# How are perceptions of risk informing actions?

How people understand risk influences key behaviors and decisions that could mitigate disease transmission, including adherence to PHSMs and vaccine uptake.

## How do people feel about resuming day-to-day activities?

More than two-thirds of respondents reported feeling hesitant about resuming normal activities.

- Only about one in four reported resuming normal activities. Low resumption is likely due to the restrictive measures still in place.
- Reported resumption of normal activities were slightly higher among higher-income households than lower-income households.
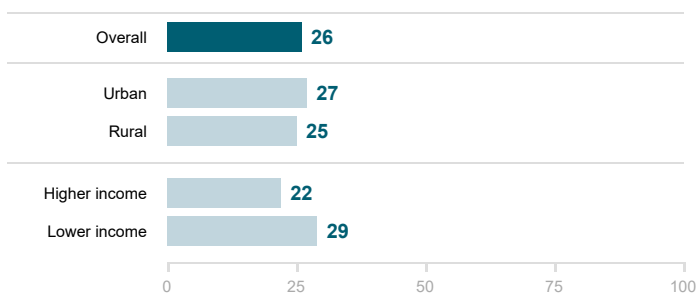
68% feel anxious about resuming normal activities

Overall	68
Urban	70
Rural	67
Higher income	68
Lower income	72
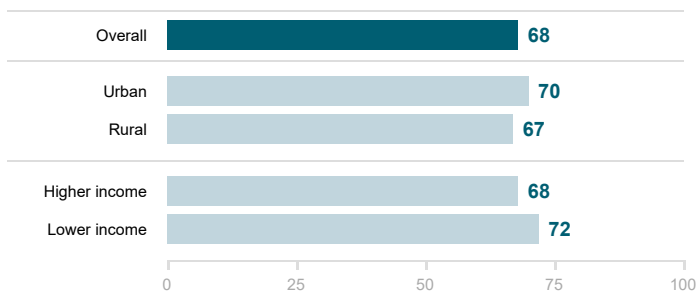
24% have already resumed normal activities because they believe COVID-19 risk is low

Overall	24
Urban	27
Rural	23
Higher income	32*
Lower income	26
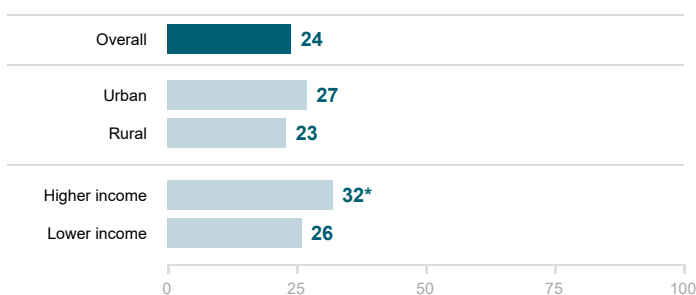
26% feel comfortable taking public transportation

|	
Overall	26
Urban	27
Rural	25
Higher income	22
Lower income	29

What do people think about vaccines?

About six in ten respondents reported they plan to get vaccinated, similar to the regional average.

- Likelihood of getting vaccinated was notably high among respondents with higher-income (66%), high COVID-19 risk perception (68%) and high government satisfaction (68%).
- Among those who did not plan to get vaccinated, the most frequent reason was a lack of information about the vaccine—which could potentially be remedied with information from trusted sources.

61% plan to get a vaccine when available

Overall	61
Region	63
Urban	61
Rural	61
Higher income	66*
Lower income	56
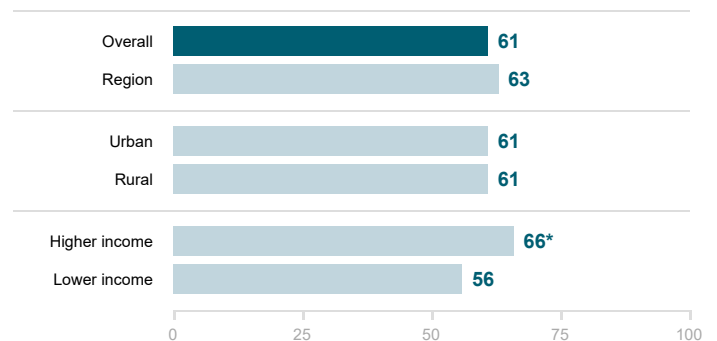
Top reasons people would not get the vaccine

Among people who said they would not get the vaccine, their reasons were:

I do not yet know enough about the vaccine to make a decision	35%
I do not feel I am at risk of catching the virus	21%
Approval/development for the vaccine may be rushed and not thoroughly tested	17%

In the media

"From the best evidence available, the Sinopharm vaccine is safe and effective. Vaccines are the world's best fight against Covid-19. I will get the Sinopharm vaccine when my turn arrives. I recommend vaccination to all my fellow Zimbabweans."

—Twitter user in Zimbabwe, 21 Feb, 2021

Secondary Burdens

Are people skipping or delaying health care?

Mobility restrictions, overburdened health care facilities, and fear of catching COVID-19 can prevent people from seeking essential health care; understanding the barriers to access can help improve linkages to care.

What the data say

Among respondents reporting they or someone in their household needed health care, more than 40% skipped or delayed services—similar to August (38%). Difficulty accessing medication dropped more than 20 percentage points compared to the August survey.

- More than 60% of missed health services were attributed to mobility restrictions (e.g lockdown or limited transportation) and health facility disruptions (e.g. staff shortages or hospitals being too busy). This is likely due to the recent surge in cases during the second wave that led to reports of oxygen shortages and overstretched staff, with limited PPE.

- More than one-third reported missing reproductive, maternal and child health care, with 15% reporting skipped services for children under age five and 10% for family planning.

Difficulty getting medicines

In August, respondents in Zimbabwe reported more difficulty accessing medications compared to other Member States surveyed. Since then, difficulty accessing medication decreased significantly. Still, almost half of lower-income households reported access issues.

Trend in percent of households having difficulty getting medicines in the past three months
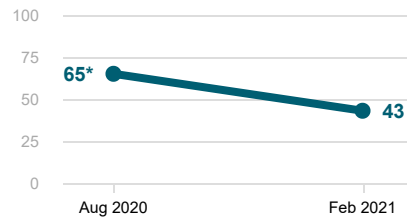

Percent having difficulty getting medicines by category

|	
Urban	44
Rural	42
Higher income	38
Lower income	48
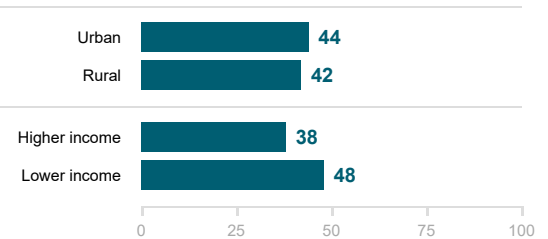
Skipping or delaying health visits

The percentage of households reporting skipped or delayed services was unchanged since August in Zimbabwe, although still high compared to other Member States surveyed.

Trend in percent of households skipping or delaying health care visits in the past six months
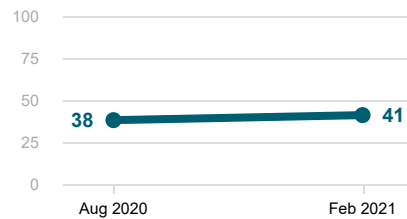
Percent skipping or delaying health care visits by category

Urban	44
Rural	40
Higher income	42
Lower income	48
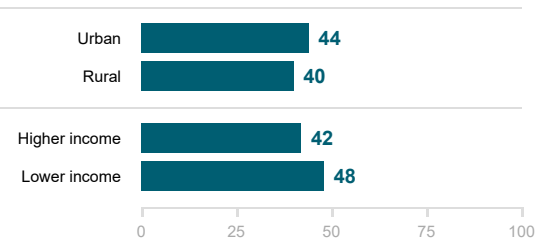
The reasons why visits were skipped or delayed
People could choose multiple responses

Mobility restrictions/transport challenges	33%
Health facility disruption	30%
Cost/affordability	14%
Worried about catching COVID-19	12%
Caretaker responsibilities	7%

The types of visits which were skipped or delayed
People could choose multiple responses

General/routine check-up	34%
Reproductive, maternal and child health	34%
Non-communicable diseases	23%
Diagnostic services/symptoms	16%
Communicable diseases	5%

Secondary Burdens

Are people experiencing income loss or food insecurity?
Measures restricting economic activities can severely disrupt livelihoods and access to markets; understanding the type and extent of these burdens can help inform policy changes and identify people who need support.

What the data say
More than half (54%) of respondents reported that they reduced the amount of food they typically eat in the past week, and 80% reported a loss in income since the start of the pandemic. The findings are consistent with the significant income loss and food insecurity reported in August.

- In February, about two-thirds reported their problems accessing food were due to loss of income. The findings indicate that although mobility restrictions and food market closures limited some people's ability to access food, economic factors were the key driver.
- About 15% of respondents reported they lost all their income since the start of the pandemic. Complete income loss was highest among already vulnerable groups, including those with the lowest education level (21%), lowest income (25%) and longstanding health issues (21%).
- Media reported that the recent lockdown and closure of Zimbabwe's land borders have kept truckers and informal traders from earning income, with many no longer able to rely on cross-border trade with South Africa. The World Food Programme reported that there was an 11% increase in the price of key commodities in January compared to December, with availability of maize grain continuing to be low. Only 7% of respondents reported receiving government aid in the past month compared to 12% in August.
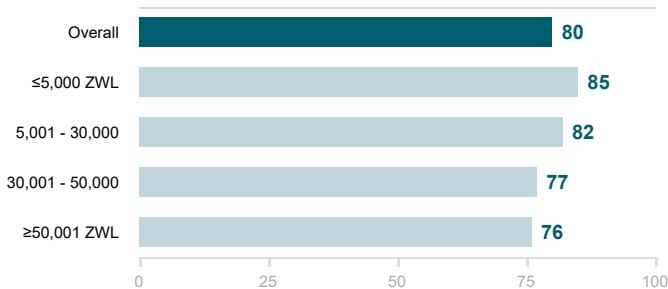
Reported barriers to food access
Percent of people reporting each barrier

Less income	65%
Higher food prices	58%
Food markets closed	45%
Mobility restrictions	50%
Food market supply shortages	36%

Household income

*Percent of households experiencing **income loss** by category*

Overall	80
≤5,000 ZWL	85
5,001 - 30,000	82
30,001 - 50,000	77
≥50,001 ZWL	76

*Household income is significantly associated with income loss.

*Percent of households **missing meals** by category*

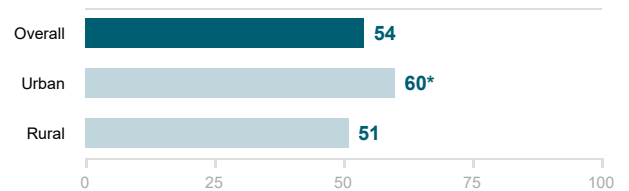|	
Overall	54
≤5,000 ZWL	68
5,001 - 30,000	54
30,001 - 50,000	45
≥50,001 ZWL	40
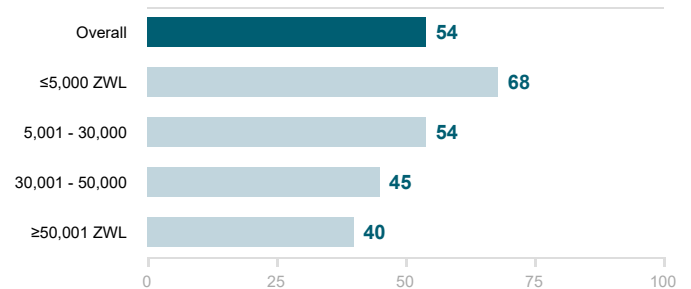
*Household income is significantly associated with missing meals.

Location

*Percent of households experiencing **income loss** by category*

Overall	80
Urban	78
Rural	81

*Percent of households **missing meals** by category*

Overall	54
Urban	60*
Rural	51
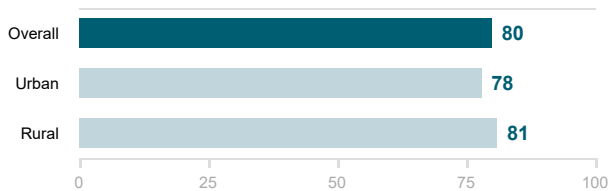
Endnotes

Report notes

Regional comparisons were conducted as per the following categories: East Africa (Ethiopia, Kenya, Uganda, Sudan); West Africa (Ghana, Nigeria, Liberia, Guinea Conakry, Senegal, Côte d'Ivoire); Northern Africa (Tunisia, Morocco, Egypt); Central Africa (Cameroon, Democratic Republic of Congo); and Southern Africa (Mozambique, South Africa, Zambia, Zimbabwe).

Two-tailed t-tests to compare two categories, and chi-square tests to compare more than two categories were conducted to assess whether there were statistical differences. An asterisk (*) indicates statistical significance where $p < 0.05$.

The figure on page 2 of the report shows the 7-day rolling average of new cases alongside test positivity and mobility data from March 2020 to February 2021. Where test positivity data and/or mobility data are missing, the data are unavailable.

Full survey results are available here and on the PERC online dashboard. *For full details on data sources, methods and limitations, see preventepidemics.org/perc.*

- Ipsos conducted a telephone *survey* of a nationally representative sample of households with access to a landline or cell phone. Results should be interpreted with caution as populations without access to a phone are not represented in the findings. The percentages reported in Ipsos charts may be different from percentages reported in other PERC products and communication of these data. Differences may be reconciled by investigating the denominator and/or weights used.
- Novetta Mission Analytics conducted research to collect insights from *traditional and social media* sources using online, open-source African media, and geolocated African Twitter and Facebook sources. These qualitative data reflect public narratives in online media sources and among social media users. Quotes have been edited where necessary for clarity, with modified text in brackets. Content from social media sources in the public domain should be interpreted with caution given that views reflected might be extreme in nature and are not representative of the population of a given country or demographic.
- Africa Centres for Disease Control and Prevention (Africa CDC) provides *epidemiological* data daily for African Union (AU) Member States. Africa CDC receives case, death and testing data from each AU Member State. Because not all AU Member States report daily, numbers could be delayed, especially for testing data which is more commonly reported late, or in periodic batches (e.g. weekly).
- Other Data is drawn from publicly available sources.

Findings reflect the latest available information from listed sources at the time of analysis, and may not reflect more recent developments or data from other sources. Data vary in completeness, representativeness, and timeliness.

Country notes

The survey sampled from Zimbabwe consisted of 1,284 adults (837 urban, 164 rural), collected between 9 to 19 February 2021.

Income classifications were based on existing data on local income distributions, which were used to create three income bands, defined as:

- Low income: Monthly household income 5,000 ZWL and below
- Low middle income: Monthly household income 5,001 ZWL - 30,000 ZWL
- High middle income: Monthly household income 30,001 ZWL - 50,000 ZWL
- High income: Monthly household income 50,001 ZWL and above