Humanitarian Aid
and Civil Protection

COVID-19 Quarantine Centres Assessment Report

An assessment of the COVID-19 situation in quarantine centres of Zimbabwe in the following provinces:

Bulawayo, Manicaland, Masvingo, Mashonaland Central, Matabeleland North, Matabaleland South, and Midlands

July 2020

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European Union
Civil Protection and
Humanitarian Aid

Acknowledgements

This assessment was successfully conducted with support from the Zimbabwe Disaster Rapid Response Mechanism (ZDRRM) project funded by ECHO. We are grateful to ECHO for availing funds to conduct the assessment when COVID-19 cases were on the rise and the number of returnees was increasing in Zimbabwe.

The team is also grateful to the Government of Zimbabwe specifically the various departments and structures the teams interacted with during data collection. These included provincial and district Civil Protection Committees (CPCs), Department of Social Welfare, Ministry of Health and Child Care (MOHCC), District Water and Sanitation Coordination Committee (DWSCC), Provincial Development Coordinators (PDCs), District Development Coordinators (DDCs) and the District Development Fund (DDF). They provided insightful details on what they are doing to curb COVID-19 infections.

ZDRRM is indebted to the following partners, CARE International, Plan International and Dan Church Aid (DCA) together with their partners Action Against Hunger (ACF), Africa Ahead, Nutrition Action Zimbabwe (NAZ) and Mercy Corps who reached out to 21 quarantine centres across seven provinces to collect data on needs and gaps. The project is grateful for their critical commitment to conducting and completing this exercise. Partnerships continue to be a cornerstone towards emerging recommendations for effectiveness, efficiency and relevance during the response.

Abbreviations

ACF	Action Against Hunger
COVID-19	Corona Virus Disease 2019
CPC	Civil Protection Committee
CPU	Civil Protection Unit
DCA	DanChurchAid
DDC	District Development Coordinator
DDF	District Development Fund
DWSCC	District Water and Sanitation Coordination Committee
GoZ	Government of Zimbabwe
HCP	Health Care Personnel
IDH	Infectious Diseases Hospital
IOM	International Organisation for Migration
IPC	Infection, Prevention and Control
MOHCC	Ministry of Health and Child Care
NSSA	National Social Security Agency
PDC	Provincial Development Coordinator
PHEIC	Public Health Emergency of International Concern (PHEIC)
PPE	Protective Personal Equipment
PRAZ	Procurement and Regulatory Authority of Zimbabwe
PSEA	Prevention of Sexual Exploitation and Abuse
QC	Quarantine Centre
SGBV	Sexual and Gender Based Violence
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation
ZDRRM	Zimbabwe Disaster Rapid Response Mechanism

Background

The novel coronavirus (COVID-19) was initially detected in Wuhan, the capital city of the Hubei province of China in December 2019. The virus has a high contagion rate and people are usually infected with the virus through unprotected exposure with an infected person. COVID-19 was declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organisation on the 30th of January 2020. By the 31st of May 2020 the disease had spread to 213 countries and territories with 5 934 936 confirmed cases and 367 166 reported deaths. Globally infections continue to rise with deaths also increasing. Initially research showed that older persons, and people with pre-existing health conditions are most likely to suffer serious complications from the disease.

The Government of Zimbabwe declared COVID-19 a national disaster on the 19th of March 2020. The first case was reported on the 21st of March 2020. As of the 13th of July, Zimbabwe had 982 COVID-19 confirmed cases with 18 deaths. By 31 July the cases had shot to 3,169 cases and 67 deaths.

Through Statutory Instrument 83 of 2020, Public Health COVID-19, Prevention, Containment and Treatment, National Lockdown Order, the Government put in place a number of measures to slow the rates of local transmission, including a 21-day national lock down, which started on Monday 30th March. The lockdown was then extended for two weeks until the 3rd of May 2020. The country is now on partial lockdown with some key sectors having resumed operations. The partial lockdown allows for not more than 50 people to gather, provided they observe the COVID-19 guidelines.

The potential impact of the spread of COVID-19 in Zimbabwe could be devastating. The country has a mix of populations vulnerable to COVID-19, including 12.7% of people living with HIV or around one in eight people (UNAIDS, 2018) as well as an estimated 5% diabetic (WHO). Amongst adults living with HIV women are particularly affected with a prevalence of 60.83%. These conditions are risk factors and make people susceptible to severe COVID-19 illness. Only about 6% of the population is over 65. However, these elderly are primary caregivers for orphaned children and their prolonged illness or death would adversely impact young children who are dependent on them. COVID-19 has had gross socio-economic impacts, disrupting the livelihoods of many people including that of men and women who had sought employment outside Zimbabwe. This has resulted in a high influx of returnees and deportees from other countries, especially neighbouring South Africa where the rate of infections has grown exponentially, putting the country at the risk of new infections. While some Zimbabweans were returning to the country voluntarily, others were being deported. Upon their return, private quarantine was on offer for those who could afford. However, the majority of returnees could not afford the option and were accommodated at public quarantine centres established by the GoZ.

From 1 April to 7 July, over 10,886 (5,982 men, 4,708 women and 196 children) Zimbabwean migrants had returned from other countries and as of 7 July, 1,297 (708 men, 494 women, 48 girls and 47 boys) returnees were quarantined in 44 centres. This report will present findings of the state of 21 selected quarantine centres and isolation centres across Midlands, Matabeleland North, Matabeleland South, Masvingo, Bulawayo, Mashonaland Central and Manicaland provinces.

Border jumpers are posing a serious threat to efforts by the Government to curb the rise in infections. Most of the border districts are too porous resulting in frequent movement between Zimbabwe and neighbouring countries, specifically South Africa, Botswana and Mozambique. Most people are using undesignated points to cross and bring in goods for resale. Beitbridge, Plumtree and Mutare are some of the districts sharing borders with neighbouring countries where Zimbabweans are finding their way back home due to lockdowns in neighbouring countries where some work.

Background – Definition of Quarantine

Quarantine is the separation and restriction of movement or activities of persons who are not ill but who are believed to have been exposed to infection, for the purpose of preventing transmission of diseases. Persons are usually quarantined in their homes, but they may also be quarantined in community-based facilities [Centres for Disease Control and Prevention (CDC)].

Quarantine can be voluntary meaning one isn't ordered to go into quarantine but chooses to do so out of caution. This is often called self-quarantine. This is mostly done by locals who feel they may have had exposure to COVID-19 as they engage in day to day activities, travel locally, regionally or internationally or in public gatherings.

Another type of quarantine is mandatory where one is forced by authorities to go into quarantine.

The Government of Zimbabwe is also allowing private quarantine at registered accommodation facilities dotted around the country. These are mostly hotels and lodges.

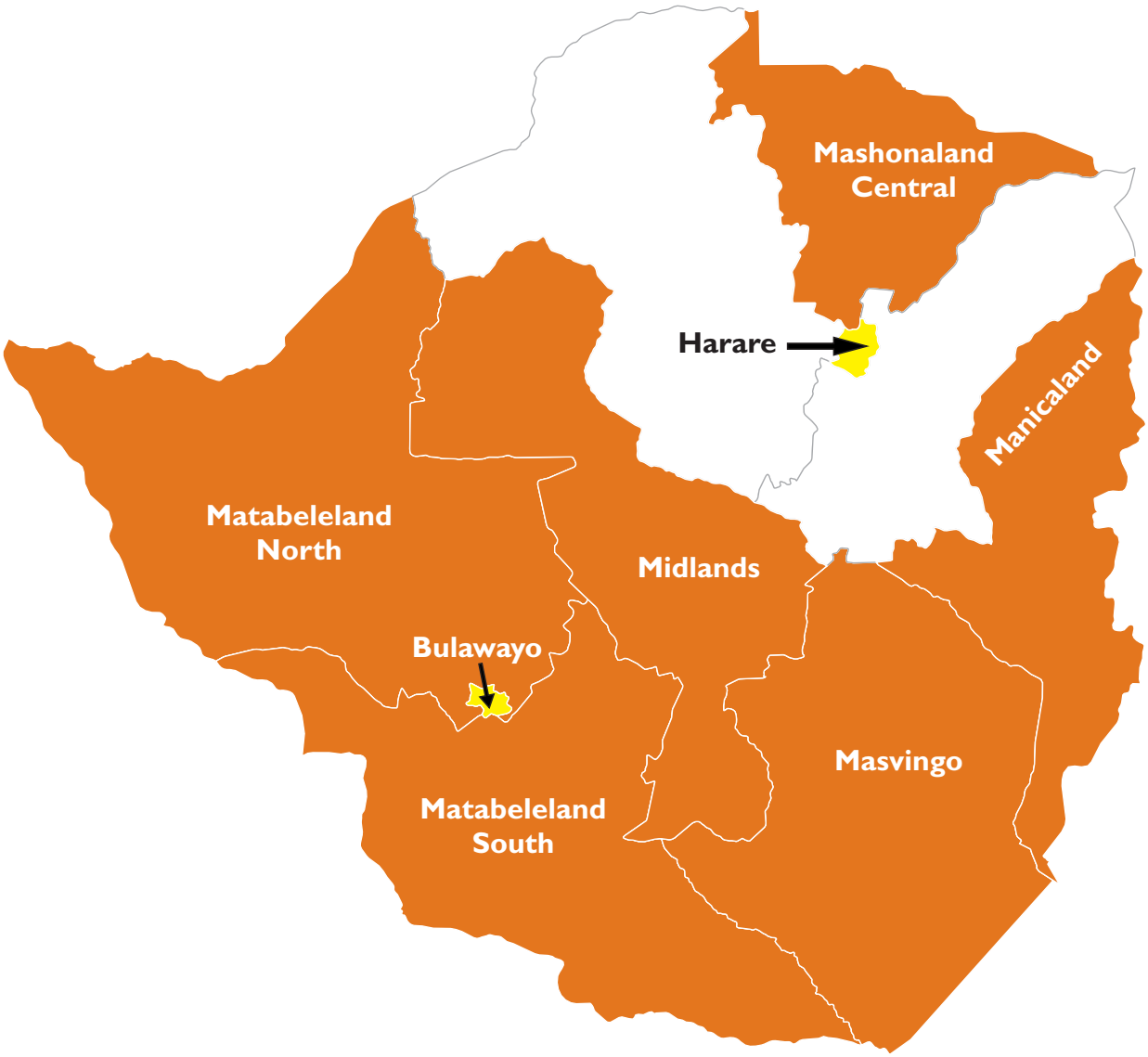
All forms of quarantine have the same objective – reducing the transmission of diseases.

The recommended quarantine period for returnees is 21 days of which 8 are spent at institutions and the last 13 days at home. On the 8th day the returnees are subjected to a COVID-19 test whose results determine whether one goes home and continues under quarantine or goes under isolation, that is, when they test positive.

The purpose of quarantine during the current outbreak can be explained as reducing transmission by;

- Separating possible contacts of COVID-19 patients from communities
- Monitoring contacts for development of sign and symptoms of COVID-19, and
- Segregation of COVID-19 suspects, as early as possible from among other quarantined persons.

QUARANTINE CENTRES ASSESSED



Bulawayo
Standard Hotel
Encho Budge Hotel
Gifford High School
Insinga Youth Centre
Khumalo Hotel

Manicaland
Rowa Training Centre
Vumba Training Centre
Magamba Training Centre
Toronto Training Centre

Masvingo
Mushagashe Training Centre
Bikita Training Centre
Rupangwana Centre

Mashonaland Central
Chawarura Training Centre

Matabeleland North
Inyathi Training Centre

Matabeleland South
Plumtree Reception Centre
Beitbridge NSSA Hotel
Esikhoveni Training Centre
Avoca Youth Training Centre
Matobo Research Centre

Manicaland
Rowa Training Centre
Vumba Training Centre
Magamba Training Centre
Toronto Training Centres

Study Purpose, Objectives, Methodology & Limitations

1. Purpose of Study

This study seeks to assess the challenges, needs and capacities of quarantine and isolation centres in Zimbabwe so as to understand the gaps on the ground and establish opportunities for humanitarian response. Findings of the assessment will be shared with relevant Government ministries and other players in the humanitarian sector, including the Food Security and Nutrition Committee.

2. Objectives of the Assessment

- To assess the current status of quarantine and isolation centres and explore opportunities for humanitarian action.
- To establish infrastructural, social and physical needs and priorities of the quarantine and isolation centres, including food security and nutrition requirements.
- To assess capacities and opportunities at quarantine and isolation centres that humanitarian actors can leverage on during project implementation.

3. Methodology

The assessment employed purposive sampling and data was gathered through quantitative and qualitative methods. A questionnaire was administered followed by focus group discussions and in-depth interviews with key frontline staff, field observations and face to face interviews with beneficiaries across provinces. Telephone interviews came in handy as a follow up method and where some centres could not be physically visited. Secondary data was reviewed from media reports, MOHCC websites, UNOCHA COVID-19 reports and WHO situational reports.

The processes involved interacting with Provincial teams, led by the Provincial COVID-19 Taskforce. Key sources of information were drawn from the Department of Social Services, the Ministry of Health and Child Care, the Provincial Development Coordinators (PDC) and the DDCs as well as district level government departments. All these are part of the Civil Protection Committees.

4. Limitations

a. Limited access to quarantine and isolation centres as well as district stakeholders, especially in Midlands Province. This meant the assessment team could not observe situations at all quarantine centres and could not interact with returnees in most cases. The assessment teams had to rely on available relevant officers to provide information at both provincial and district levels on quarantine centres under study.

b. Lack of previous research studies on the area of assessment. Citing and referencing prior assessments was limited and could have helped constitute the basis of the literature review for the exercise. Prior assessments tend to provide theoretical foundations for questions under investigation. The assessment teams consulted secondary sources widely resulting in extended knowledge about the COVID-19 situation in most provinces.

Summary of Findings

- Following plans to open schools end of June 2020, many centres were decommissioned, reducing the number of quarantine centres available to house increasing returnees.
- The Civil Protection Unit (CPU) expects each district to have at least one quarantine and one isolation centre.
- A total of 21 quarantine centres were assessed across 6 provinces. Quarantine centres are manned by the Department of Social Services and isolation centres are managed by the Ministry of Health and Child Care (MOHCC).
- Food, clothing, bedding, water, toiletries and menstrual hygiene support are all provided to returnees and deportees although more support is required following the daily surge in numbers.
- Quarantine centres lack dietary diversity on meals. This is attributed to procurement delays by the Procurement and Regulatory Authority of Zimbabwe (PRAZ) and has resulted in returnees consuming mostly beans and sadza which falls short of what is on the diversified menu.
- Over 90% of the centres have inadequate water supplies. These are a result of water rationing owing to falling dam water levels and damaged or low yield boreholes.
- At some centres, ablution facilities are not properly secured posing a threat to the privacy of returnees.
- Laundry management differs from one quarantine centre to the other. Some get laundry done at provincial hospitals as other centres do it on site and others are failing to manage laundry for fear of infection, instead they leave it piling. This is linked to waste management which is greatly compromised at most centres as they do not have bins and laid down procedures for its management. The waste is also not segregated.
- Border towns are heavily affected by the influx of returnees. The NSSA Centre in Beitbridge is overwhelmed as it serves as a holding, quarantine and isolation centre. Plumtree has no quarantine facilities and only holds returnees and deportees as they wait to be moved to other districts.
- Across Quarantine Centres, significant WASH and Infection, Prevention and Control (IPC) and protection gaps were noted, necessitating an urgent and coordinated multi-sectoral intervention.
- Psycho-Social Support was not being provided in most QCs.
- Most of the quarantine centres were in deplorable states and the Government was in the process of mobilising resources for renovations to be done.

7a. Current Water Situation

The main water sources at most Quarantine Centres were taps and hand pumped boreholes which drew water from either storage tanks or municipal reservoirs. At most centres, water was readily available but supply was erratic in some. In Gweru, Beitbridge and Plumtree, water was not readily available due to damages on some sources and rationing. Some boreholes were of low yield and water was not always adequate to meet the needs of returnees' at Chawarura in Mashonaland province, Magamba in Manicaland, Gweru's Senga Training Centre in Midlands and Beitbridge's NSSA Rainbow Hotel in Matabeleland South. Due to erratic supplies, people resorted to the bucket system. Some QCs did not have adequate storage facilities and this resulted in water shortages for QCs that depended on electricity for water supply. The lack of sustained, equitable access to safe water negatively impacts public health and the dignity of people especially women and girls because of their sexual and reproductive health needs. The limited access to water is also likely to create challenges for the successful prevention, containment and management of COVID 19 in quarantine and isolation centres although availability varied from one quarantine and isolation centre to the other. One of the key messages with regards to the prevention of the spread of the coronavirus is washing hands with soap and clean water for at least 20 seconds. For centres already facing water supply challenges, this will pose a great challenge.

In Mangwe district, there were 2 proposed sites for QCs, following the decommissioning of educational institutions (Plumtree Reception Centre and Avoca Youth Training Centre). Both required major renovations on water works since they had been lying idle for a long time. For Avoca Youth Training Centre, the main source of water is a nearby dam whose connecting pump system was vandalised and the solar powered borehole damaged. The government has allocated a budget through the District Development Fund (DDF) to rehabilitate water sources at quarantine and isolation centres but the funds are not adequate to cover for all the centres.

Figure 1: Water storage at some Quarantine Centres

7b. Sanitation facilities

Sanitation refers to public health conditions such as the provision of clean drinking water and adequate treatment and disposal of human excreta and sewage. While isolation centres were mostly at health centres, Quarantine Centres (QCs) were established at vocational training centres and educational institutions. Ideally, sanitation facilities should be designed in such a way that they adequately address the needs of staff and returnees. However, a gap was noted where latrines in most QCs were neither child nor disability-friendly. Returnees regardless of whether they could be positive and negative shared the same facilities following the delay in testing and release of results. Most centres did not have cleaners and there was no roster for the cleaning of toilets.

At most QCs in Manicaland, Masvingo and Mashonaland Central, returnees were responsible for cleaning the sanitation facilities as and when they wished, posing challenges for increased infection. In Midlands province particularly Dadaya and Senga, there was no proper maintenance of sanitary facilities due to poor water reticulation. The situation was also noted in QCs in some parts of Bulawayo metropolitan and Matabeleland North (Encho Budge Hotel, Gifford, Inyathi Training centre, Insinga Youth Centres), where returnees resorted to using the bucket system. Bathrooms and toilets at Dadaya (Midlands), Insinga Youth centre and Gifford (Bulawayo Metropolitan) required some renovations particularly on door locks and windows. Broken doors and windows on sanitary facilities could compromise the safety, security and privacy of users specifically women and girls, hence prompt action should be taken to address the gap. Standard Hotel in Bulawayo metropolitan had a different story since sanitation was in good condition and there was a cleaner for the facilities.

Figure 2: WASH facilities at some Quarantine Centres

In Matabeleland South, sanitation facilities were in good condition. However, there was poor water supply at most of the quarantine centres. Beitbridge, in particular, reported sewer blockages in town which increased the risk of diarrheal related diseases like cholera and typhoid. In Mashonaland Central, Masvingo and Manicaland, the ratio of returnees versus number of squat holes was found to be within the prescribed SPHERE guidelines of 1 squat hole per 20 people. Some latrines at Rupangwana (Masvingo) were beyond repair and there is need for new sanitary facilities.

7c. Hygiene

Hygiene conditions and practices at quarantine and isolation centres helped to maintain the physical, mental and social well-being of returnees and staff to prevent the spread of COVID-19. Across all centres, hygiene was promoted at personal and facility levels. Every returnee had access to a bed, clean linen and blankets. All functional QCs had bathing facilities with showers though water availability remained a big challenge and people ended up using the bucket system. Quarantine and isolation centres were equipped with hand washing stations, most of which were functional. A few required repairs and there was a need to increase the number of hand washing stations. Hand washing stations come in different forms and it is advisable to consider facilities that reduce the possibility of COVID-19 infection like the on the next page.

A gap loomed on trainings, where staff and returnees across QCs had not received Health and Hygiene Education training in the last six months, save for Inyathi training centre and Standard hotel (Bulawayo Metropolitan). As part of hygiene promotion, the Department of Social Services with support from partners provided toiletries (soap, toothpaste, towels, lotion), to all the returnees and sanitary wear to women and girls. This helped women and girls gain and retain their dignity during the COVID-19 crisis. Although menstrual hygiene material was found to be available for women and girls at most

Qcs across provinces, it was not in stock at Toronto, Magamba (Manicaland), Rupangwana (Masvingo), Gifford and Insinga (Bulawayo Metropolitan/ Matabeleland North). There were also reports of women who were forcibly deported from countries like Botswana and had no adequate underwear. They only came with clothes on their backs. Attention is needed to support these female returnees especially those of the reproductive age group, with undergarments for the proper management of challenges associated with menstrual hygiene, among other things. Returnees without clothes were assisted with clothes.

Figure 3: Hand washing station and sleeping space at one of the Quarantine Centres

At the date of assessment, laundry management was a big challenge in Midlands specifically Dadaya QC where used blankets were piled up as staff at the facility hesitated to wash them for fear of getting infected. The centre had linen and blankets for 2000 people so they drew from the unused blankets and each time a returnee left the centre they gave new returnees unused blankets and piled used ones. If this is not managed properly, it is a recipe for spreading infection. The case was different in other provinces where laundry was handled on site.

Cooking at all centres in the Midlands and Matabeleland South provinces was done on site. However, at the NSSA Rainbow Hotel (Beitbridge), the contractor did the cooking in the open and the district stakeholders expressed the need to improve the cooking area.

7d. Waste Management

The disposal of waste in QCs is supposed to be done in accordance with WHO guidelines. The absence of waste management protocol across all facilities was an indication that waste management was not conducted in a coordinated manner. Different ways of waste disposal included burning, refuse collection by city council and open pit. Insinga Youth and Inyathi training centres disinfected using chemicals and incinerated respectively.

Figure 4: Open burning of waste at Chawarura (Mashonaland Central) Quarantine Centre

Waste was not separated. Bins did not have bin liners. PPE was in short supply across most QCs except for the Standard hotel (Bulawayo metropolitan), where staff responsible for waste management had PPE and had also undergone training on waste management. MOHCC was tasked by the Government to come up with a plan to construct incinerators but it had not materialized by the time of the assessment. Most QCs required an increase in the disposal points and support in the form colour coded bins.

7e. Infection, Prevention and Control

Infection Prevention and Control (IPC) measures are guided by WHO standards and have been put in place at all centres by the MoHCC. When applied consistently in quarantine and isolation centres these can prevent or reduce the risk of transmission of COVID-19 to returnees, staff and residents.
Common measures being observed across provinces in a bid to prevent infection included hand washing and sanitizing, cleaning and disinfecting surfaces, wearing masks, staff capacitation on COVID-19 management, temperature checks upon entry into quarantine and isolation centres and screening and testing of returnees and health education on management of COVID -to returnees.

All provinces were facing an acute shortage of PPE, test kits, and thermometers. This put both the staff managing the centres and returnees at risk of infecting COVID 19. Collection of samples was done on time but test results took long to be released making the returnees stay longer than the stipulated 8 days in a quarantine facility. Based on information provided at most centres, some returnees and deportees had stayed for over 21 days as results were not released on time. Testing was done on day 1, and day 8 with the second test determining whether one should be released to go home or to an isolation centre. If one tested positive on day 8 they were taken to an isolation centre pending inspection of the habitability of their home. If they could self-isolate at home they were taken home. If the home was not habitable they could stay at the isolation centre where the disease had to be managed with the assistance of MOHCC. Overstay at quarantine centres caused a lot of anxiety and mental health issues since the sites did not have entertainment. Ultimately returnees ended up engaging in negative copying strategies like prostitution, which then increased the risk of sexual exploitation and abuse for women and girls. Some even ended up escaping from the quarantine centres.

Figure 5: Returnees at one of the Quarantine Centres

Efforts to curb prevention and infections at border towns were threatened by border jumpers who risked spreading infections in communities. Border jumpers were peculiar in districts close to neighbouring countries ie Mangwe, Bulilima, Gwanda, Beitbridge and Mutare. Under normal conditions most businesses buy their goods from neighbouring countries. Lockdowns distorted their income sources forcing business owners to use illegal entry points to access supply markets in neighbouring countries. This happened on a daily basis and it posed challenges again to women and girls who were bound to be abused along the way. Whistle blowing mechanisms in rural and urban Beitbridge were in place, but not effectively utilised. Mechanisms put in place to report issues that would affect the fight against COVID-19 included use of the national toll-free number, 2019, and reporting cases to local leaders and the Zimbabwe Republic Police. Incidences of returnees escaping centres were a big challenge to the local authorities, considering that they might be COVID 19 positive.

Uptake of condoms being distributed at most centres to prevent the transmission of other infectious diseases had been high. Staff at centres received training on handling and managing COVID-19 butmore trainings is needed as new information about the disease emerged.

Gaps Identified during the assessment:

- Limited staff capacitation on COVID-19 management
- Cleaning and disinfecting items in short supply ie brooms, mops, buckets, disinfectants
- Temperature checks upon entry into quarantine and isolation centres
- Limited and delayed testing of returnees
- Limited or unavailability of critical PPE ie face masks, coveralls, boots
- Safe movement of returnees and deportees from foreign countries. There is too much contamination especially in buses. Social distancing is not effectively observed.
- Limited capacity and failure to identify the positive on the pool of returnees resulting in increased infections at quarantine centres

7f. Personal Protective Equipment

Personal Protective Equipment (PPE) was used every day by the frontline staff who included healthcare personnel (HCP), Social Services and ancillary staff, returnees, patients, and others when providing care. Although most QCs indicated that PPE was provided, it was observed that most essential items were either not available or in short supply. Frontline staff providing care and treatment to returnees were at high risk of infection. The increase in numbers of returnees at quarantine centres meant more demand for PPE. Items required included face masks, gloves, gowns, aprons, gumboots, work suites, overalls, surgical scrubs and hand sanitizers.

Contact tracing was an important part of COVID-19 management and required mobility into communities, however it was delayed by shortage of PPE. Thermometers, air time for phone calls, fuel/vehicles to enhance mobility were also inadequate. The risk was high at border towns, especially Matabeleland South Province's Beitbridge and Plumtree towns where border jumpers were in contact with the community daily. The influx of returnees and deportees was at times overwhelming and PPE remained critical for the control of the spread of the epidemic.

The failure to provide adequate personal protective clothing put the lives of staff and returnees in danger and ran contrary to the objective of reducing the spread of COVID 19.

7g. Food Security and Nutrition

In all the assessed Provinces, the department of Social Welfare had the mandate to provide food in the quarantine centres. Stakeholders in both Provinces hailed the department for the great work which they were doing regardless of the drought situation being experienced in the country. Returnees managed to get 3 meals a day and an additional porridge meal for children. However, the Department of Social Welfare in the different provinces indicated that the food stocks had depleted significantly and they would be happy having partners coming to assist with food needs. They could not project how long the remaining stocks would last.

There was great concern around dietary needs especially in Beitbridge and Midlands province where complaints were raised of having failure to meet dietary needs of people. This would impact negatively on the health of people with special dietary requirements like the chronically ill patients, pregnant and lactating mothers, children under the age of five and the elderly. There is a need to complement Government efforts and ensure consumption of minimum dietary intake for all people especially the groups mentioned above. Across the assessed provinces, there were no quarantine centres offering fruits to the people. Fruits are very essential in optimising people's health. However, the rapid assessment did not use standard indicators to measure dietary diversity and food consumption for people in the quarantine centres and had to heavily rely on information extracted from the key informant interviews with key district stakeholders who were manning the quarantine centres.

While all the quarantine and isolation centres had a standard menu card developed with the help of a dietician, most of the food stuffs were not available in stock. The Department of Social Welfare indicated that they were only able to support with basic standards meals and did not have capacity to meet dietary needs for the different groups.

7h. Gender and Gender Based Violence/Protection

In most provinces including Matabeleland South, Bulawayo metropolitan and Matabeleland North, Social Welfare continued to place the safety and security of women, children and people with special needs (disability, elderly) at the centre. Department of Social Services staff including Child Protection Specialists were deployed at the quarantine centres to assist with profiling and Psycho-Social Support (PSS) services to child and adult returnees. In Mangwe and Beitbridge, there were cases of 12 (3 girls and 9 boys) and 7 unaccompanied children (as young as 15 years) respectively, and Social Welfare had since reunited them with their families. Family tracing of unaccompanied children was one key responsibility for Social Welfare. On education, 5 (1 girl and 4 boys) child returnees were candidates for the June 2020 examinations and Social Welfare organised with the responsible authorities in Mangwe (Matabeleland South), for the children to write their exams in quarantine.

In Bulawayo metropolitan and Matabeleland North QCs, staff received training on child protection, gender and gender-based violence. At the standard hotel QC (Bulawayo Metropolitan), and broadly Manicaland, Mashonaland Central and Masvingo, there were no adequate counselling services onsite. While most QCs had no onsite services to respond to sexual and GBV and relied on the coordinated referral system, Encho Budge Hotel, Gifford and Khumalo hotel in Bulawayo and Matabelelnad North had mechanisms in place for responding to sexual abuse and exploitation. Among other protection measures, the elderly and people living with disability (Matabeleland South) received once off allowances. Security personnel escorted buses from the Beitbridge and Plumtree holding centres to other quarantine destinations across the country. Despite efforts made to provide PSS services, support was still required to boost the capacities of staff on the ground since they feel understaffed.

Measures put in place by the government to protect and ensure the safety of people, especially women and children in quarantine centres, were effective. However they required improvement. Attention should be given to psycho-social needs of staff manning the centres. Adequate psycho-social support should also be considered in isolation centres where inadequate staffing caused staff to work long hours increasing their exposure to COVID 19 and risk of burnout. Hence PSS is required on medical personnel as well.

Incidences of consensual sex amongst the first groups of returnees were reported at Plumtree holding centre, Beitbridge/NSSA building and Esikovheni quarantine centre. Students from Esigodini Agriculture College (Umzingwane) were reported to have traded sex for 35-40 SA Rands. All this happened during the very first days of the pandemic when no-one had knowledge on how to manage the epidemic and there was a mix of accommodation for men and women. It was through these incidences that measures were put in place to separate accommodation for females and males in all quarantine centres across the country.

On another note, there were reports around an increase in the number of residents and returnees going to South Africa through illegal routes in Beitbridge. This naturally posed high risk of sexual exploitation and abuse on women and adolescent girls. While the quarantine and isolation centres had a strong focus on COVID-19 prevention and mitigation, there was a call to also provide services including Sexual Reproductive Health, HIV treatment, care and support and maternal/neo-natal health, safe migration and PSEA.

7i. Coordination

Platforms to coordinate COVID 19 efforts were created and regular meetings held at district, provincial and national levels. Data was documented and shared. Social Welfare and the Ministry of Health and Child Care (MoHCC) continued to get support from other government departments, NGOs, CBOs, UN and the private sector. Coordination challenges were around inadequate storage space (Bulawayo metropolitan and Matabeleland North), unstable network connections forcing staff to walk long distances to search for mobile network. A case in point is Chawarura QC (Mashonaland central), where staff travelled 1,5km on a daily basis to submit information.

7j. Referral System

The referral system for COVID-19 was very clear following the delegation of roles and responsibilities between MOHCC and Social Welfare. There was a communication mechanism in place between the quarantine centres and the isolation health care facility. The individuals showing signs and symptoms of COVID-19 had their own designated area. In the same vein there were personnel responsible for recording the people who would show signs and symptoms of COVID-19. A lot of people required psychosocial support and in some instances facilities, in Matabeleland South for instance, offered such services to returnees, but more needs to be done in terms of providing counselling to staff and boosting the numbers of counsellors on the ground. There was a protocol in place to deal with separated and unaccompanied child returnees, guided by Children's Act and Social Welfare Policy. There were no recreational materials/facilities and literature available for children and adult returnees. There was no designated ambulance at the centres to ferry suspected COVID-19 cases to the isolated facilities. The ambulance was requested as per need.

7k. Accountability

The GoZ established a national toll free line (2019) though it was not being effectively used in most provinces. The number was shared with communities to report cases of returnees who absconded quarantine centres.

Fifty percent of the assessed quarantine centres indicated that they set-up a help desk to receive, document and respond to complaints raised by returnees. However, it was noted that there was no option allowing for the lodging of complaints anonymously either by using Toll free numbers or suggestion boxes. There was no monitoring system to document and report the number of complaints made within a given period. It was therefore difficult to trace the extent to which complaints made were addressed to the satisfaction of the complainant. Feedback on complaints was given verbally, making it difficult to have a reference point on how complaints of similar nature were addressed.

7l. Data Management

It was noted that all QCs had a focal person responsible for data management. All QCs shared data on a daily basis by 12pm with the district, provincial and the national command centres. However, there was no real-time access to QCs information or a clearly centralised platform where different players accessed and checked the current status for the QCs.

The data capturing process was done on paper then later transferred to excel which delayed the processing of data and made the profiling process hectic and time consuming. IOM at Beitbridge engaged some data capture clerks to help with data capturing which significantly eased pressure of profiling on Social Welfare officers. The Government also engaged Social Work graduate interns to support with the profiling of returnees. Beitbridge received the highest numbers of returnees and at the time of the assessment government had started to pilot the use of tablet based profiling system in a bid to reduce the pressure on data entry.

Conclusions

Overall, the assessment revealed a significant number of challenges, gaps, capacities and opportunities at QCs, calling for the adaptation and adoption of best practices to prevent the spread of infections in these centres. Of importance is the need to ensure quarantine centres are habitable and do not emerge hotspots of new infections. The assessment explored a number of domains that needed to be strengthened in as far as fighting COVID-19 is concerned. Recommendations proffered included provision of adequate PPE, investment in WASH infrastructure and facilities, regular and consistent training of staff and returnees on COVID-19 management, provision of PSS, entertainment and setting up of feedback and complaints mechanisms for returnees to lodge issues which would help in service delivery improvement.

Recommendations

WASH and Waste Management

- Water availability is limited at over 90% of the centres assessed. Rehabilitation and solarisation of existing boreholes or drilling of solar powered boreholes across all QCs and procurement of storage tanks for QCs without sufficient storage tanks are close options.
- More trash bins and sanitary bins should be availed at all centres and labelled with different kinds of waste disposed in different bins.
- There is need for adequate sanitary wear and undergarments for women of the reproductive age group, disinfectants, cleaning detergents and toiletries for all returnees.
- There is need for water quality testing and a testing schedule that adheres to WHO guidelines.
- Plumtree's Reception Centre can be quickly turned into a holding facility/ and quarantine centre for Botswana returnees as it has space and facilities for such. There is need to revamp the place to make it more habitable.
- There is need for new toilets at some centres and rehabilitation of existing ones in bad shape.
- Some incinerators require rehabilitation and some centres require new incinerators for waste management.

Infection, Prevention and Control

- PPE shortages pose great risk of infections to both staff and returnees. There is need to supply PPE in QCs.
- Staff and returnees at centres require regular capacitation and training on management of COVID-19.
- Expedite testing, timely release of results and transportation of returnees who are COVID-19 positive to Isolation Centres.
- Provide adequate transport, fuel and airtime to all QCs for contact tracing.
- Avoid establishing Quarantine centres proximity to public facilities ie Rupangwana QC in Masvingo.
- Strengthen information dissemination on COVID 19 prevention at QCs.

Food Security and Nutrition

- Low dietary diversity. Quarantine centres should provide a balanced diet to all returnees, taking cognisant of special needs of various age groups and sexes and special needs of pregnant and lactating women and children.
- Few hand-washing stations at centres. Additional hand-washing stations should be erected across centres.
- Commit to in-time investments in relief, recovery and resilience to protect against the impacts of the pandemic to affected populations in QCs.

SGBV and Child Protection

- Develop and operationalise guidelines on dealing with unaccompanied child returnees.
- Currently, the GoZ is focusing more on COVID-19 and less on other emerging issues critical to the well-being of people i.e. malaria and diarrheal diseases. There is need to integrate other health issues into the COVID-19 response. For instance HIV & AIDS services, Sexual Reproductive Health services (family planning), vaccinations.
- The conversion of hospital sections into COVID-19 isolation centres (Gweru Mkoba 1 and Infection Disease Hospital), requires stakeholders to ensure traditional health services are not disturbed and alternatives provided.
- There is need for some assistance to be channelled to the deported returnees who come back home with no food, shelter and with their livelihood disrupted.
- There is a need to provide entertainment to occupy the minds and time of returnees. This can be in the form of literature for children and adults, toys for infants, television or radio sets, newspapers and access to the Internet.
- It is critical that children have access to education even, and especially, in quarantine or under isolation. As the pandemic exposes existing inequities in education, self-sufficient strategies to support learning under such circumstances are required to ensure all children can continue to learn.

Coordination, Accountability and Information Management

- The need to continue collaborating with local communities, government and non-governmental organisations to create an enabling environment for pandemic prevention and preparedness
- Protection committees should be set up at each centre as a way of ensuring proper management of SGBV and child protection needs. The need for PSS services for staff.
- All quarantine centres should have a complaints and feedback mechanism in place, so that returnees and deportees can lodge issues and comments in a structured manner ie suggestion boxes or help desks.
- The need to provide training on data management.

STORIES FROM RETURNEES

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.

TRYNOS, 30

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.

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

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.

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