The Potential and Challenges for Traditional Leadership in Combating the COVID-19 Pandemic in Rural Communities of Zimbabwe

COWEN DZIVA
Great Zimbabwe University
cdziva@gzu.ac.zw

Abstract

This article explores the prospects and challenges of traditional leaders combating the Covid-19 novel virus in vulnerable rural communities of Zimbabwe. The potential of traditional leadership in combating the pandemic is yet to be widely explored despite traditional leadership being a key institution in rural development. Extant grey and white literature and key informant interviews were largely relied on to gather data for this study. As custodians and enforcers of traditional customs and values, endogenous leaders are widely relied on and respected in rural communities such that their encouragements, orders and coercive interventions can positively combat the deadly coronavirus. With the fear for punishment in the form of cursing or being ostracized, ruralites often listen to and abide by traditional leaders' calls and pleas to stay at home, practice personal hygiene and observe social distancing. Based on these cutting edge advantages, chiefs and their decentralized structures can play a key role in community mobilization, raising awareness, dispelling pandemic rumours and myths, vaccine utilization and pushing for compromises where measures are incompatible with local traditions, cultural values and norms. The article vouches for the resourcing and capacitation of traditional leaders to effectively realize their capacities in combating COVID-19 and future pandemics.

Key Words: Combat, Coronavirus, traditional leaders, rural areas

Introduction

The COVID-19 disease is a mild to severe respiratory illness caused by coronavirus (Paules, Marston & Fauci 2020). Its symptoms include, among others, tiredness, dry cough, fever and shortness of breath that may later develop into pneumonia and subsequent respiratory failure (WHO 2020). The pandemic is unprecedented in almost all its forms, including the speed at which it is spreading and the scale at which it is negatively impacting human lives across the globe. In a majority of cases, the virus is transmitted by contact with objects infected with respiratory droplets. Since its first outbreak in the city of Wuhan, Hubei province of China in December 2019, the disease has spread over to the rest of the world. The World Health Organization declared the disease a Public Health Emergency of International Concern on the 30th of January 2020 and later on a pandemic on 11 March 2020 (WHO 2020). The government of Zimbabwe declared COVID-19 a national disaster on 17 March 2020 (Makurumidze 2020). As of 7 September 2020, the pandemic had been contracted by 27 032 617 people and claimed 881 464 lives worldwide (WHO 2020). During the same period, the Ministry of Health and Child Care (MoHCC) in Zimbabwe reported that 7116 Zimbabweans had contracted COVID-19 while 208 of them had succumbed to the disease (MoHCC 2020b).

In response to the spread of the coronavirus and the concomitant death trail, Zimbabwe promulgated the Statutory Instrument 83 of 2020: Public Health (COVID-19 Prevention, Containment and Treatment), which effectively closed all public and private institutions and instituted nationwide travel restrictions except for essential service providers (MoHCC 2020a). While at home, communities were encouraged to quarantine, stay indoors, constantly wash hands with soap, avoid touching the face, use masks, face shields and practice social distancing whenever outside the home (MoHCC 2020c). The Statutory Instrument 83 of 2020 provided that those diagnosed and suspected of having COVID-19 should be quarantined at home and in health institutions to contain the virus. In quarantine centres, COVID-19 patients received a combination of drugs, often used to treat influenza and severe respiratory illnesses (WHO 2020). In extreme cases, seriously ill patients ended up in Intensive Care Unit, with ventilators to assist in their breathing (MoHCC 2020c).

In many developing countries, Zimbabwe included, poverty exemplified by limited access to basic services including health and pandemic information, makes communities more vulnerable to pandemics (Scoones 2020). The ability of poor communities to understand and comprehend pandemic preventative measures largely depends on strong institutions to coordinate and implement measures that ultimately influence appropriate health outcomes at all levels (Karan, Hartford & Coates 2017; Marashe 2014; Walsh et al 2015; Manguvo and Mafuvadze 2015).

In the face of the COVID-19 pandemic, this article finds it imperative to explicate rural communities' vulnerabilities to the disease and to examine the potential of traditional leadership to combat this health crisis in rural communities of Zimbabwe. Traditional leaders (chiefs, headmen and village heads) derive their power and mandate from the Traditional Leadership Act, the Constitution of Zimbabwe (2013), tradition and customs to govern and manage development affairs in peri-urban and rural areas. At the lowest level of traditional governance in Zimbabwe, there exists around 2500 village heads, each of which governs around 35 households in the rural areas (CCMT 2014). The 2500 village heads report to over 452 headmen countrywide (Musekiwa 2012). As sub-chiefs, the headmen are accountable to 271 paramount chiefs in the country (Chigwata 2016). It is this decentralized nature of the traditional leadership institution that makes it an immediate player in local governance, development and in the fight against diseases, including the Covid-19 pandemic. Any effort to ignore traditional authority in rural governance and development is, therefore, unconstructive and unsustainable as endogenous leaders command more support, legitimacy and respect in their areas of jurisdiction, even more than elected leaders (Chigwata 2016). Indeed, the proximity of traditional leaders to communities and the respect they command in many rural and peri-urban areas make them a strategic port of call institution when it comes to combating pandemics at grassroots levels.

Specifically, the study untangles rural communities' vulnerabilities to the COVID-19 pandemic, and the potentialities of and challenges traditional leaders can face in combating the crisis in rural Zimbabwe. The projections are based on traditional leaders' roles in community development activities. Thus, the study dwells on what the endogenous leaders can do to combat the COVID-19 crisis. This study builds a case on the need by policy makers and other stakeholders to strengthen the traditional leadership institution in the fight against pandemics, including covid-19 in rural areas. Beyond this, the government, health and development policy makers and experts are informed about what it takes to empower and strengthen the capacities of traditional leaders in combating infectious diseases in rural areas.

The article is divided into five sections. It commences with the current introduction and background. Thereafter, it reveals the susceptibilities of rural communities to the COVID-19 disease, followed by the methodology section. This is followed by an analysis of the potentiality of traditional leaders to combat the spread of COVID-19 in rural Zimbabwe. The fourth section envisages some of the impediments to local leaders' roles in combating the COVID-19 pandemic before concluding with some recommendations.

The Vulnerability of Rural Communities to COVID-19 Pandemic

Many concerns have been raised regarding developing countries' preparedness and capacity to combat the Coronavirus pandemic. Despite repeated assurances on the state of preparedness by the Zimbabwean government, evidence on the ground suggests limited

capacity by the central government to combat the disease (Dzobo, Chitungo & Dzinanarira 2020; Scoones 2020; Chingono 2020; Zaba 2020). These worries were substantiated by subsequent revelations by family members upon the death of Zororo Makamba, the first Zimbabwean causality to succumb to the pandemic. The case of Zororo, and many others recorded in Zimbabwe so far, have exposed the inadequacies at Wilkins Hospital, one of the only two hospitals specialising in infectious diseases in Zimbabwe. Likewise, emerging cases of covid-19 in Zimbabwe suggest limited access to intensive care ventilation facilities and inadequate protective clothing for frontline health workers. According to Scoones (2020), there were supposedly only 16 ventilators in Zimbabwe when the first COVID case was confirmed in March 2020. Owing to these challenges, the Zimbabwe Association of Doctors for Human Rights (ZADHR) took the Ministry of Health and Child Care to court over the government's failure to provide doctors working on the frontline of the COVID-19 pandemic with protective clothing (Chingono 2020).

While the above mentioned challenges are evident countrywide, the consequences are disproportionately felt in both rural and urban communities in Zimbabwe. The limited access to drugs and the much needed protective personal equipment is extensive in rural areas. Coupled with an already less robust and ailing rural health system characterised by limited skilled personnel, medical supplies and dilapidated infrastructure, many rural areas remain ill-prepared to combat COVID-19 (UNDP 2020). Limited access to ventilators, test kits, hand sanitizers, protective clothing (masks, gloves, gowns) and other essential supplies is more pronounced in rural health institutions compared to urban areas (Chingono 2020; UNDP 2020). Likewise, many of the rural health centres have limited isolation facilities, let alone food for patients suspected to have Coronavirus. In many instances, patients diagnosed with mild symptoms of Coronavirus are sent back home for self-quarantining due to resource constraints faced at isolation centres (Dzobo, Chitungo & Dzinanarira 2020). This exposes family members and the wider community to the deadly virus.

Amid increased poverty, as exemplified by food insecurity and limited access to income, many rural communities remain constrained in adhering to lockdown measures. Estimates put 95 percent of rural Zimbabweans to be living below the poverty datum line (Manjengwa, Kasirye & Matema 2012). With limited access to food and income, many rural dwellers are likely to defy the lockdown and stay at home. Instead, they would choose to work in farms and pursue their survival tactics, thereby exposing themselves and others to the risk of the infectious COVID-19 (Musarandega & Chitongo 2020).

Due to increased poverty levels, many rural families hardly get disposable income to purchase requisite protective clothing including gloves, face masks and sanitisers (Chazovachii 2020). The same applies to retail shops and service centers in many rural areas of Zimbabwe which find it difficult to offer sanitisers and practice good hygiene whilst conducting their businesses. Furthermore, the call to practice good hygiene is hampered

by limited access to running water in rural communities (Musarandega & Chitomgo 2020). More often than not, rural communities rely on water from boreholes and wells. Having received less rainfall in the 2019/2020 rainy season, residents of many rural communities queue to fetch water at these communal sources with limited observation of Covid-19 guidelines (Musarandega & Chitongo 2020). These conditions expose communities to Coronavirus.

The vulnerabilities of communities in rural areas are also worsened by existing communication inequalities in rural Zimbabwe. Access to reliable broadcasting and print information remains a challenge in many rural communities of the global South (Ndlovu 2008). In Zimbabwe, very few elites access mass media communications in rural areas. For the broadcasting media, the barriers remain the limited access to television sets, radios and smart phones, poor transmission and power shortages (Ndlovu 2008; Dziva & Dube 2014). As such, communities who wish to access information on national programmes about pandemics such as COVID-19 often rely on hearsay from local leaders, relatives and social media platforms. Yet, overreliance on hearsay from community members and the unregulated social media platforms may result in pandemic infodemic. Amid the COVID-19 crisis, confusing stories have been spread on social media and by community leaders, biblically linking the virus to the end of the world, 5G technologies and biological warfare (Scoones 2020). Due to limited regulation of social media, anyone who is technologically literate can take to the internet and social media to post or rather circulate whatever they come across and sign off as a journalist or health expert (Dziva & Shoko 2018). As these rumours spread, they lay the basis upon which most rural people build misconceptions and uptake of wrong precautionary behaviours which may expose and endanger rural communities to the covid-19 pandemic.

Altogether, the poverty situation in Zimbabwe's rural areas, as exemplified by limited access to health communications and basic healthcare, water and food shortages, poor sanitation and lack of other essential services converge to limit rural communities' agency in the face of the COVID-19 pandemic. With these underlying factors, many rural communities remain compromised to undertake COVID-19 preventative measures such as practicing good hygiene and social distancing. As such, institutions in these peripheral communities would have to remain on high alert and expect the worst of the pandemic.

Method and Materials

This qualitative study primarily relied on grey and white literature on the role of traditional leadership in rural development and disease prevention. The body of consulted white literature includes peer-reviewed articles and books on the subject, whereas the consulted grey literature includes newspaper reports, government health bulletins and commentaries on the COVID-19 crisis and the role played by endogenous leaders. The researcher extrapolated from these previous and emerging works to examine the

opportunities and challenges that, if understood and addressed, have the potential to help combat the COVID-19 pandemic in rural Zimbabwe.

Extant literature review was triangulated with the views of eight purposively and conveniently sampled traditional leaders and public health officials from Masvingo province. The key informants were interviewed through the phone to get insights regarding the actual role being played by traditional leaders in combating Covid-19. The telephone interviews were preferred as there was a national lockdown, and to reduce the risk of contracting the deadly disease. Even with a focus on Zimbabwe, the study is poised to benefit many African countries in strengthening their endogenous institutions to effectively combat COVID19, and other pandemics like Cholera, HIV and AIDS, EBOLA and other deadly diseases.

Results and Discussion

Prospects of traditional leaders curbing COVID-19 in rural Zimbabwe

The potential of traditional leaders to combat pandemics in rural Zimbabwe hinges on a myriad of factors. Amid community challenges to access credible broadcasting and print media, traditional leaders remain one of rural people's reliable sources of information about pandemics. When faced with calamities of the Coronavirus' nature, rural communities often rely on traditional leaders for wisdom and answers (Chigwata 2016). Due to the respect traditional leaders command in rural areas, many rural communities look to traditional leaders for wisdom and important information about pandemics (Walsh et al 2018). Having benefited from the government's rural electrification programme, many chiefs in Zimbabwe have access to credible state communications on television and radios. It is upon receiving this credible COVID-19 information that chiefs utilise their networks that include the headmen and village heads to mobilise and cascade the Coronavirus information and knowledge to the wider society for improved adoption and implementation of prevention measures.

Similarly, tradition leaders in Zimbabwe take advantage of the varied governance and community development forums such as village groups and contacts including their police to disseminate credible pandemic information to ruralites (Mohlala et al. 2011; Marashe 2014). With their state provisioned vehicles, traditional leaders can also travel across communities to sensitise them about the COVID-19 pandemic and its preventative measures. Contacted traditional leaders revealed how they take advantage of crowds at their meetings, traditional court sessions, funerals and food distribution points to educate communities about the need to observe good hygiene and social distancing for effective pandemic prevention. As one leader explained,

> *I normally take advantage of our periodic community meetings to share information and good practices taught to us in combating COVID. Sometimes, I call*

upon those with deeper understanding of these issues, such as the village health workers, to come and explain to people and demonstrate how to wear masks.

Courtesy of technological advancement and the increased usage of smartphones, traditional leaders also utilize WhatsApp messages and calls written in vernacular languages to encourage communities to practice good hygiene, social distancing and quarantining of the sick. These efforts by traditional leaders result in local communities' increased access to knowledge of the pandemic and ultimately their agency to adopt effective precautionary behaviours in face of the deadly virus.

The institution of traditional leadership also remains the primary link between rural communities and primary health service providers in pandemic prevention. Humanitarian and societal norms often require and expect organisations bringing development interventions in an area to make a courtesy call to local leadership and work hand in glove with locals for the realisation of the projects' intended goals. This study argues that government ministries and NGOs working in community heath should capitalise on local leadership's networks to effectively implement activities meant to avert the spread of the Coronavirus. With their contacts and knowledge of their respective areas, local leaders are poised to mobilise and link externals to key persons who can strategically cascade crucial COVID information to wider society. Commendably, the study learnt how chiefs, headmen, village heads and their messengers are working with externals to distribute Information, Education and Communication (IEC) material to rural communities. One of the interviewed chief headmen stated that,

We have been doing Coronavirus awareness in our community. With the assistance of my village heads and their neighborhood police, we have been able to place Coronavirus awareness posters at strategic community points such as schools, health centres, shops, dip-tanks, community water sources and even on trees for easy reach of the message to community members.

Previous studies show that collaborations between local leadership and community outsiders have resulted in effective community awareness about epidemics and pandemics (Walsh et al 2018; Jung, Lin, Viswanath 2013). It is based on such collaborations that the rural communities' actions, perceptions and behaviours in the face of the Coronavirus are ultimately improved.

Traditional leaders are reliable partners of the central government in interpreting and monitoring the compliance of their local communities to national lockdowns and declarations meant to combat the COVID-19 pandemic. Likewise, traditional leaders interpret government and WHO COVID-19 guidelines and advise their subjects on their implications. In cases where there exist misunderstandings between local communities and outsiders, mainly health experts, traditional leaders mediate and often persuade their subjects to compromise their cultural and traditional values for the sake of disease control

or prevention. Information from the interviewed chiefs also confirms that they monitor their community members to reduce the number of people who attend funerals and other traditional gatherings in line with the WHO and national guidelines for COVID-19 prevention. As the custodians of local culture, tradition and values, traditional leaders' pleas for communities to compromise are often complied with, thereby preventing communities from contracting the deadly virus.

The potential of traditional leaders to combat the COVID-19 pandemic lies in their power and ability to coerce their communities to change their behaviours in the face of pandemics. Deriving their powers from the Traditional Leaders' Act, the Constitution, tradition and customs, endogenous leaders can sanction and fine community members that fail to abide by set COVID-19 guidelines. With their decentralised structures, chiefs effectively oversee, enforce and track non-compliance to COVID-19 curfews in their areas of jurisdiction. More positively, local leaders confirmed that they summon and fine those who fail to observe Covid-19 prevention directives. Depending on the gravity of the matter, those found guilty are made to pay in the form of a cows, goats and chicken or fines equivalent to the value of the charged livestock (Chigwata 2016). This resembles the Malawi scenario, in which mothers were fined 500 to 3000 Malawian Kwacha (US$1-$5) for giving birth at home, instead of going to the clinic (Walsh et al 2018). Although unpopular in many instances, these fear-inducing traditional rulings have for long been relied on to govern affairs in rural communities. Hence, they can be key in enforcing the Coronavirus lockdowns and limiting unnecessary practices and movements that expose individuals and the wider community to the deadly virus.

Traditional leaders are also vital in transporting the sick to health centres and providing food to affected individuals and families. The provision of food and other necessities remains important to deter poor families from breaking lockdown rules to look for food. This confirms previous studies in which traditional leaders provided free transport for their sick community members to access health facilities (Walsh et al 2018; Marashe 2014). Concomitantly, local chiefs provide isolation rooms and food aid supplies to the sick and their families. With some food reserves courtesy of the *Zunde RaMambo* (chiefs' granaries) schemes to feed indigent communities in the face of disasters (Rimgson 2017), traditional leaders are prioritising the provision of food to COVID-19 patients in isolation and health centres. Similarly, Musarandega and Chitongo (2020) explained how the *Zunde raMambo* stocks cushion those households befallen by serious sickness and also deter them from working in their own fields. These interventions by traditional leaders are crucial in ensuring the sustenance of those affected by the disease and in limiting movements by the poor and indigent rural households in search of food.

Challenges of traditional leaders in combating COVID-19

Despite the touted opportunities of traditional leaders combating the deadly COVID-19 in rural areas, there exist many challenges, hence, the need for concrete solutions to strengthen endogenous leadership's greater impact in pandemic prevention. One such challenge relates to limited knowledge on the part of traditional leaders amidst fears of the pandemic. With news from across the globe showing patterns of transmission and the rate of Coronavirus contagion, many people's sense of safety has been disturbed. The fear in traditional leaders is worsened by the fact that WHO is yet to confirm a cure for this pandemic. This makes many of the local leaders fear to move around relaying COVID-19 information to communities. Amidst these fears, the activities of traditional leaders have been limited to virtual information dissemination through the use of cellphone calls and text messages to their decentralised structures. While important for their safety and that of the wider society in COVID-19 prevention, virtual communications are not easily accessible to all rural communities in Zimbabwe.

The ability of traditional leaders to effectively combat pandemics of the COVID-19's nature hinges on their understanding of the pandemic, its causes, symptoms and prevention measures. Previous disaster and pandemic studies stress the importance of a well-informed local leadership to disaster risk reduction (Chigwata 2016; Musarandega, Chingombe & Pillay 2018), for instance, combating EBOLA (Manguvo & Mafukidze 2015). In this study, however, some leaders demonstrated a limited understanding of the Coronavirus pandemic. While commendable, the office of the President of Zimbabwe and the COVID-19 Taskforce that met and enlightened some chiefs about the pandemic at State House in Harare on 4 April 2020 did not reach out to all traditional leaders across the country. This means that some traditional leaders remained ignorant when it comes to critical information concerning the pandemic. Some leaders who attended this half day interface meeting commended it for breaking the news about the impending danger to them. The leaders however said they wished the duration of such interfaces would be increased to enable them to gain a deeper understanding of the pandemic. It is after gaining a deeper understanding of the COVID-19 pandemic that local leadership's capacity and ability to combat the disease can be effectively enhanced.

Traditional leaders' limited knowledge about pandemics is also worsened by their low literacy rates. The appointment to chieftainship is hereditary in Zimbabwe and does not take into consideration one's educational attainment. As such, many traditional leaders have no formal education (Chigwata 2018). The challenge of limited education for local leadership is also echoed in rural development and disaster risk reduction studies (Bland 2011; Marango 2017). Consequently, the low literacy rates amongst traditional leaders may mean limited ability to comprehend, let alone demystify, controversies surrounding the outbreak and prevention of COVID-19 in their communities.

Resource constraints also work to limit the potential of traditional leaders to combat disasters such as the COVID-19 pandemic in rural Zimbabwe (Chigwata 2016). Despite them having state provisioned motor vehicles, some traditional leaders stated that problems of limited fuel affect their mobility and outreach activities. This challenge is the absence of a budget line for the traditional leaders' community activities. Local leaders also complained of limited access to IEC materials to assist in their information dissemination activities.

Related to their safety, traditional leaders face a shortage of personal protective equipment (overalls, gloves and face masks) and sanitisers for use whilst conducting public health education. Without protective clothing, many local leaders' movement is limited as they fear contracting the deadly virus. The article, thus recommends the enhancement of traditional leaders' access to protective clothing and sanitisers to improve their safety and fight against COVID-19. If personal protective clothing and sanitisers are provided to traditional leaders, they may be in a position to disseminate information to communities for safe and hygienic practices, while holding critical gatherings, including funerals.

Another barrier to traditional leaders' influential role in fighting COVID-19 in Zimbabwe's rural communities relates to strong religious and cultural beliefs. Some leaders indicated that their communities cling on to strong religious and traditional beliefs and that largely impeded efforts to combat COVID-19. In Nigeria, Manguvo and Mafuvadze (2015) noted how some communities, based on their religious and traditional beliefs, boycotted polio vaccination campaigns amidst rumors that the vaccine contained infertility drugs that resulted in HIV/AIDS and polio-myelitis. Equally challenging has been the task by traditional leaders and their communities to regulate local religious and traditional gatherings, something that is inherently human and traditional to them as they appease and intercede to spirits. Indeed, some leaders confessed how some communities defied lockdown measures and continued to hold church services and traditional ceremonies including *Biras* and *Kurova Guva* (bringing back spirits of the dead to look after their families). As one chief explained,

> *It sometimes become difficult to refrain communities from holding functions since many of these traditional functions and rituals are held with the pretext of appeasing the supposedly angry spirits to spare the community of the impending disaster and dangers such as COVID.*

In the event of funerals, huge gatherings have cultural significance as they are a reflection of love and concern for both the deceased and the bereaved family (Musarandega & Chitongo 2020). Important as these social gatherings are believed to be by local people, they come with a high disregard of social distancing and hygienic practices. As Musarandega and Chitongo (2020: 319) noted in Biriiri communal area, people who attended funerals paid no strict attention to requirements for social distancing despite their awareness of it. This thus becomes a recipe for widespread infections of COVID-19.

The other challenge relates to rising clashes of culture and mistrust between health officials and rural communities regarding the burial of relatives who succumb to COVID-19. Burials for COVID-19 victims, like those for EBOLA causalities, are supposed to be rapidly done by trained health officials, sometimes without relatives' consent (Manguvo and Mafuvadze 2015). This contradicts many local cultures, something that is likely to brew conflicts between health officials and rural communities. At the peak of the EBOLA outbreak in West Africa, communities suspected and linked the rapid burial of their deceased relatives without their consent to the need by medical professionals to use corpses for nefarious purposes (Manguvo and Mafuvadze 2015). Resultantly, communities attacked health officials and barred them from executing required scientific measures aimed at combatting the spread of the disease. Traditional leaders are therefore caught in-between tradition and medical principles, something which might affect their ability to combat pandemics.

Conclusion and Recommendations

The potential of traditional leadership with regard to combating pandemics is yet to be widely explored. The outbreak of COVID-19 and its threats to rural communities has sparked the need for studies that examines the potential of traditional leadership to combat the deadly pandemic in remote areas. Taking advantage of their legal, customary and traditional norms, traditional leaders are rising to the occasion through performing tremendous roles of building local peoples' agency to combat the deadly virus. Traditional leaders remain well-positioned to localise the global and national fight against COVID-19 in rural areas. As the closest local government institution, traditional leaders command respect in rural areas and are therefore well-positioned to raise awareness concerning good hygienic practices and social distancing and to dispel pandemic rumors, mistruths and myths which affect rural communities' effective response measures. More importantly, the institution of traditional leadership can institute a wide range of preventative actions including enforcement of lockdown and restrictions at local level, even well before the pandemic strikes.

Despite the opportunities available to traditional leaders to combat pandemics in rural areas, their potential to maximise on these prospects is, to a larger extent, limited because of a variety of challenges. Amongst the hindrances, the study revealed traditional leaders' illiteracy and lack of education as the major drawback to their understanding and effective fight against the pandemic in rural areas. Other challenges include resource constraints including finances, protective clothing and sanitisers for use and onward distribution to their structures and the wider community.

The article calls for capacity building and the resourcing of traditional leaders with knowledge, finances, protective clothing, IEC materials and their much needed resources

for use and onward distribution in respective communities. For their capacitation, there is need to forge partnerships between government offices responsible for health and traditional leaders for synergised actions to fight pandemics.

References

Bland, G. (2011). Overcoming a decade of crisis: Zimbabwe's local authorities in transition. *Public Administration and Development*, 31 (3), 340-350.

Bentley, K. (2005). Are Powers of Traditional Leaders in South Africa Compatible with Women's Equal rights?: Three Conceptual Arguments. *Human Rights Review*, *6*, 48-68. https://doi.org/10.1007/s12142-005-1010-3.

Centre for Conflict Management and Transformation (CCMT). (2014). *Role and responsibilities in rural local Governance in Zimbabwe: parallels, overlaps and conflict*. Harare: CCMT.

Chakaipa, S. (2010). Local government institutions and elections. In: de Visser J, Steytler N & Machingauta N (Eds.), *Local government reform in Zimbabwe: A policy dialogue*. Western Cape: Community Law Centre, pp. 31-68.

Chazovachii, B. (2020). Understanding Strategies for Resilient Livelihoods by Masvingo Urban's Vulnerable Groups During the Covid-19 Pandemic in Zimbabwe. *African Journal of Governance & Development*, *9*(1.1), 139-159. Retrieved from https://journals.ukzn.ac.za/index.php/jgd/article/view/1686.

Chigwata, T. (2016). The role of traditional leaders in Zimbabwe: Are they still relevant? *Law, Democracy & Development*, *20* (1), 69–90.

Chingono, N. (2020, April). *Doctors sue Zimbabwe government over lack of Covid-19 protective equipment*, Mail & Guardian. https://www.theguardian.com/global-development/2020/apr/09/doctors-sue-zimbabwe-government-over-lack-of-covid-19-protective-equipment. Accessed 22 June 20120.

Constitution of Zimbabwe. (2013). *Amendment, No. 20 Act of 2013.* Harare: Fidelity Printers and Refiners.

Crook, R. (2005). The Role of Traditional Institutions in Political Change and Development. *Policy Brief* No: 4. Accra, Ghana: CDD/ODI.

Dziva, C., & Dube, B. (2014). Promoting and protection of minority rights using the UN Declaration for minorities in Zimbabwe. *International Journal for Minority and Group Rights*, *21*: 395-413.

Dziva, C., & Shoko, M. (2018). Transnationals, social media and democratisation of Africa in the 21st century. In Addaney, M. & Nyarko, G. M. (Eds). *Ghana@ 60: Governance and Human Rights in Twenty-First Century Africa*, Pretoria: Pretoria University Law Press, pp. 245-365.

Dzobo, M., Chitungo, I,.,& Dzinamarira, T. (2020). COVID-19: a perspective for lifting lockdown in Zimbabwe. *Pan Africa Medical Journal*, 35 (2): 1-3.

Jung, M., Lin, L., & Viswanath, K. (2013). Associations between health communication

behaviors, neighborhood social capital, vaccine knowledge, and parents' H1N1 vaccination of their children. *Vaccine*, 31: 4860-6.

Karan, A., Hartford, E., & Coates, T. J. (2017). The potential for political leadership in HIV/AIDS communication campaigns in Sub-Saharan Africa. *Global Health Action*, 10(1), 1-8.

Logan, C. (2013). The roots of resilience: exploring popular support for African traditional authorities. *African Affairs* 112 (448), 353–76.

Makurumidze, R. (2020). Coronavirus-19 Disease (COVID-19): a case series of early suspects reported and the implications towards the response to the pandemic in Zimbabwe. *J Microbiol Immunol Infect*, 53, 493 498. https://doi.org/10.1016/j.jmii.2020.04.002.

Manjengwa, J., Kasirye, I., Matema, C. (2012). Understanding poverty in Zimbabwe: A sample survey in 16 Districts, Paper prepared for presentation at the Centre for the Study of African Economies Conference 2012 "Economic Development in Africa", Oxford, United Kingdom, March 18-20, 2012.

Mangirazi, N. (2020). Marginalised communities left out in COVID-19 campaign. *NewsDay*, Tuesday, April 14.

Manguvo, A., & Mafuvadze, B. (2015). The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift. *Pan African Medical Journal*, *22* (1), 1-4.

Marango, T. (2017). Potential strategies for harnessing indigenous rainmaking practices to combat the negative effects of climate change in Chimamimani District of Zimbabwe, PhD thesis, Institute for Rural Development, University of Venda, Thohoyandou, South Africa.

Marashe, J., 2014, 'The African traditional religious landscape: An examination of the role of traditional leaders in the fight against HIV and AIDS in Chipinge, Zimbabwe. *Verbum et Ecclesia*, 35 (1), 1-8.

Ministry of Health and Child Care (2020a). Coronaviirus (COVID-19) Update: Zimbabwe, 19 June 2020.

Ministry of Health and Child Care (2020b). Zimbabwe COVID-19 SitRep: Update: Zimbabwe, 6 September 2020. http://www.mohcc.gov.zw/index.php?option=com_phocadownload&view=category&id=15&Itemid=742. Accessed 6 September 2020.

Ministry of Health and Child Care (2020c). Stay at Home # Stay Safe # Defeat COVID-19, 8 April2020.http://www.mohcc.gov.zw/index.php?option=com_content&view=category&layout=blog&id=103&Itemid=743. Accessed 20 April 2020.

Mohlala, B. K., Boily, M. C., & Gregson, S. (2011). The forgotten half of the equation: randomized controlled trial of a male invitation to attend couple voluntary counselling and testing. *AIDS, 25* (15), 35–41.

Musarandega, H., & Chitongo, L. (2020). A Contextual COVID-19 Social Distancing

Monitoring Strategy for Remote Communal Settings: Insights from Biriiri Communal Lands, Zimbabwe. *African Journal of Governance & Development*, *9*(1.1), 309-328. Retrieved from https://journals.ukzn.ac.za/index.php/jgd/article/view/1755

Musarandega H., Chingombe, W., & Pillay, R. (2018). Harnessing local traditional authorities as a potential strategy to combat the vagaries of climate change in Zimbabwe. *Jàmbá: Journal of Disaster Risk Studies*. https:// doi.org/10.4102/jamba.v10i1.651.

Musekiwa, N. (2012). The role of local authorities in democratic transition. In: E. Masunungure & J. Shumba (Eds), *Democratic Transition.* Harare: Weaver Press & IDAZIM, pp. 230-251.

Ndhlovu, F. (2008). Language and African Development: Theoretical Reflections on the Place of Languages in African Studies. *Nordic Journal of African Studies*, *17* (2), 137–151.

Nyoka, N. (2020, April 6). *Zimbabweans warned over coronavirus self-test kits*. BBC News. https://www.bbc.com/news/topics/crr7mlg0rpvt/zimbabwe.

Paules, C. I., Marston, H. D., and Fauci, A. S. (2020). Coronavirus Infections-More Than Just the Common Cold. *JAMA,* 323 (8), 707-708.

Ringson, J. (2017). *Zunde RaMambo* as a traditional coping mechanism for the care of Orphans and Vulnerable Children: Evidence from Gutu District, Zimbabwe. *African Journal of Social Work,* 7 (2), 52-59.

Rural District Councils Act (RDCA) (1988). [Chapter 29:13].

Scoones, I. (2020). Surviving COVID-19: Fragility, Resilience and Inequality in Zimbabwe, *African Arguments*. https://africanarguments.org/2020/03/27/surviving-covid-19-fragility-resilience-and-inequality-in-zimbabwe/.

Traditional Leaders Act [Chapter 29: 17].

Walsh, A., Matthews, A., Manda-Taylor, L., Brugha, R., Mwale, D., Phiri, T., Byrne, E. (2018). The role of the traditional leader in implementing maternal, newborn and child health policy in Malawi. *Health Policy and Planning*. *33* (8): 878-887. https://doi: 10.1093/heapol/czy059.

World Health Organization (WHO). (2020). *Coronavirus Disease (COVID-19) Outbreak Situation*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019?gclid=EAIaIQobChMIv5yAiOfY6wIVpoBQBh2LEwgEEAAYASAAEgLku_D_BwE . Accessed September 7 2020.

United Development Programme (UNDP). (2020). A Preliminary Assessment of the Socio-economic Impact of Coronavirus (COVID -19) on Zimbabwe: Policy Brief, United Development Programme: Harare.

Zaba, F. (2020, March 27). *Zim not ready for coronavirus*. The Independent, https://www.theindependent.co.zw/2020/03/27/zim-not-ready-for-coronavirus/. Accessed April 20 2020.