



**Socio-economic impact of Corona Virus on livelihoods of low-income households in Zimbabwe: A case of Masvingo urban**

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**Abstract**

*The COVID-19 pandemic is one of the global health calamity of the 21<sup>st</sup> century and the greatest problem that nations faced since the Second World War. Global institutions and nations have emphasised more on the impact of Coronavirus from biomedical science point of view despite the devastating effects of the pandemic on socio-economic development. This paper is among the fewer incipient exploratory studies that assess the socio-economic effects of COVID-19 on the livelihoods of low-income households in Zimbabwe. Both quantitative and qualitative methodologies were used to collect data from 120 randomly sampled respondents. Telephone interviews and a web-based survey informed by evidence from previous literature were the data collection methods used in this study. Timeline and social network mapping techniques were also*

*used to validate data obtained from the interviews. Principal component (PC) and descriptive analysis were the analytical tools used to examine the socio-economic effects of COVID-19 on livelihoods of low-income households in Masvingo District. The PCA results revealed that shortage of medicines, household food insecurity, increase in the prices of basic commodities, disruption of food supply chain, job losses, gender-based violence and closure of schools were the major impacts of COVID-19 in the study area. Furthermore, COVID-19 increased distrust, grievances and inequalities over access to jobs, education and healthcare services in the study area. Thus, the study recommends that stakeholders should concentrate efforts on averting the spread of Covid-19, set up emergency assistance relief and divert attention towards preparedness and early-detection strategies. Response initiatives should address potential household grievances, discrimination and stigmatisation over access to resources, livelihoods and health care.*

**Keywords:** Corona virus, Urban livelihoods, Masvingo, Zimbabwe



## **1. Introduction**

The Coronavirus Disease (COVID-19) is a respiratory infection caused by a new coronavirus, called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coibion et al., 2020; Fauci et al., 2020; WHO, 2020). The virus was first detected in the city of Wuhan in Hubei province, China in December, 2019 (WHO, 2020). The symptoms range from flu-like signs such as fatigue (Coates, 2020; WHO, 2019) and sore throat (Fauci, 2020; WHO, 2019), coughing (Rohr et al., 2019) and shortness of breath (Shang, 2020; Valavan & Mayer, 2020). Deng & Peng (2020) and WHO (2019) posit that there is proof that COVID-19 is transmitted from person to person, but cleanliness can reduce the rate of infections. While numerous clinical trials are underway in China and many other developed nations, there are currently no certified vaccines available (Chen et al., 2020; Deng & Peng, 2020). Since December 2019, the virus quickly spread all over China and other nations (Chen et al., 2020; WHO, 2020), killing over 490 000 and infected 8.8 million people by June 2020 (UNCTAD, 2020; WHO, 2020). Poor households have been affected more due to poor health security (Huang et al., 2020; McKibben & Fernando, 2020) and

limited access to awareness programmes (Boone et al., 2020, WHO, 2020).

Most Asian nations were caught unprepared to face the consequences of the pandemic

(Adams et al., 2020; Fauci et al., 2010; WHO, 2020). Shang (2020) and WHO (2020) postulate that the Covid-19 pandemic resulted in over 3 million infected cases and 280 000 deaths among Asian countries by end of June, 2020. Thus, most health institutions became overcrowded with patients and mortality rates rose steeply (Adams et al., 2020; Makwana, 2020; WHO, 2020). In order to reduce the effects of the Covid-19 pandemic, most Asian countries introduced social distancing regulations such as shutting down of airports, schools, borders, shopping malls and restaurants (Fauci et al., 2020, UNCTAD, 2020; WHO, 2020). Furthermore, lockdown restricted citizens from leaving their households. These restrictions resulted in economic slump (Gilbert et al., 2020; ILO, 2020; Li et al., 2020): lockdown fatigue (Bonne et al., 2020; Huang et al., 2020) plummeting of stock markets (UNCTAD, 2020), slowing of international trade (Nicola et al., 2020) and increase of unemployment rates (Deng & Peng, 2020, Zhu et al., 2020). Thus, the socio-economic effects of the COVID-19



pandemic affected the economies of Asian countries.

## **2. Literature Review**

Covid-19 developed into a crisis, with devastating effects on the socio-economic and political developments among European Union (EU) countries (Chen et al., 2020; Coates, 2020). Despite the existing evidence that most EU countries have succeeded in flattening the curve, the risk of developing new strains of SARS-CoV-2 still exist. Like in other continents, the infection and death rates differs by age (Nicola et al., 2020; World Health Organisation, 2020), location (Conteh et al., 2020) and health circumstances (Adams et al., 2020) of the infected persons. UNCTAD (2020) states that on 15<sup>th</sup> of June 2020, European Union leaders held a virtual summit on the EU's proposal for a 750 billion euros (\$840 billion) rescue package. The package was meant to stimulate and shield industries from the devastating effects of COVID-19 pandemic. Despite the efforts made to revivify industries, the package failed to meet the needs of most industries affected by the pandemic among EU countries such as Spain, Italy and Netherland (ILO, 2020). Valavan and Meyer (2020) posit that the

intervention agenda failed because it targeted to rescue affected industries, while denying assistance to vulnerable households. Thus, unless measures are put in place to address the plight of vulnerable households, most counties in the EU block may continue to grapple with the consequences of COVID-19 pandemic for a longer period of time.

Anxiety abounds concerning the novel COVID-19 pandemic among countries in the American continent (Nicola et al., 2020; Smith et al., 2019). The confirmed Covid-19 cases in the United States surpassed 2 157 000, with over 118,000 death by end of June 2020 (Fauci et al., 2020; John Hopkins University Tally, 2020). Furthermore, a COVID-19 model produced by the Institute for Health Metrics and Evaluation revised its projections from 140 000 to over 180 000 deaths in the United States by October, 1, 2020 (WHO, 2020). At the time of writing this paper (June 7, 2020), as all 50 states moved to relax restrictions, hot spots emerged in states such as Missouri and South Carolina. Week-over-week case counts were on the rise in half of all states in the United States of America. Furthermore, the reopening of businesses and school drew concerns over a wave of new infections across Latin American



countries (Coates, 2020; WHO, 2020). According to WHO (2020), Brazil reported a record of 55 000 new infections on the 17<sup>th</sup> of June 2020. Furthermore, Colombia and Mexico also passed bleak milestones as their death toll exceeded 2 000 and 20 000 respectively (Fauci et al., 2020; WHO, 2020). The socio-economic consequences are unfavourable not only to public health systems (Shang et al., 2020) but also to tourism (Coibion et al., 2020), trade (Rohr, 2019; WHO, 2020), retail chains (Fauci et al., 2020), food and farming businesses (Mahanty, 2020) and informal trading (WHO, 2020; ILO, 2020) among others. Most Latin American countries failed to address the challenges affecting poor communities during the lockdown period. This caused disillusionment among citizens in countries such as Brazil (Fauci et al., 2020) and Mexico (ILO, 2020).

Numerous studies are emerging in diverse disciplines, documenting the impact of the COVID-19 pandemic in Africa. However, there are still few studies that record the socio-economic effects of the pandemic at the household level in Africa (Nkengasong & Mankoula, 2020, WHO, 2020). Existing empirical studies examine the effects of the pandemic from a medical point of view (Valavan & Meyer, 2020). Literature that

exist illustrates how the pandemic will affect the continent due to insufficient surveillance and laboratory testing capacity (Nkengasong & Mankoula, 2020; WHO, 2020) and shortage of both human and financial resources (Kapata et al., 2020). Furthermore, Africa is expected to be the most affected continent due to increased population traffic between Africa and China (Valavan and Meyer, 2020, WHO, 2020). On the other hand other studies (Nkengasong & Mankoula, 2020; Valavan & Meyer, 2020) argue that Africa is better prepared to deal with the impacts of the COVID-19 pandemic due to lessons learnt from previous Ebola outbreaks in 2014. However, without essential resources to address the effects of the pandemic, many African nations find it difficult to rescue their industries and provide sufficient relief to the affected households.

Africa confirmed its first COVID-19 case in Egypt on the 14<sup>th</sup> of February, 2020 (WHO, 2020; Makwana, 2020). WHO (2020) posits that 52 countries reported over 44 873 and over 2 807 deaths by 4 May 2020. According to Nkengasong & Mankoula (2020), cases that were primarily restricted to capital cities are also reported in rural areas and small towns where health facilities are poor. African nations with the highest number of infections at the time of



writing this paper were Egypt, South Africa, Morocco, Algeria and Burundi. However, the actual number of cases remain unclear due to underreporting. WHO (2020) warned that Africa could be the next epicentre of the COVID-19 pandemic. Countries with fragile economies, protracted conflicts, recurrent natural disasters or forced displacements grapple with compound challenges due to the current coronavirus pandemic. WHO (2020) and Adams et al. (2020) further posit that many African countries are less prepared to respond effectively to COVID-19 infections due to poor health amenities. The outbreak of Covid-19 has ignited social unrest (Gentile & Abenavoli, 2020), mistrust and a sense of injustice over access to health services (Nicola et al., 2020), decent jobs and livelihoods (ILO, 2020; Makwana, 2020). Makwana (2020) further suggests that Covid-19 has potential to generate conflicts that can undermine economic growth, social cohesion and peace in the continent. For example, the outbreak of Covid-19 in South Sudan and Burundi created a vicious circle resulting in greater instability. Thus, the need to address the biomedical dynamics of COVID-19 should not undermine efforts designed to provide immediate basic requirements to vulnerable households.

The first Covid-19 case in Zimbabwe was discovered on the 10<sup>th</sup> of March, 2020 (Consumer Council of Zimbabwe (CCZ), 2020). The government declared isolation as a social distancing strategy to avoid further spread of the pandemic in April, 2020. From that day till the date of writing (7, June 2020), with some exemption of emergency and critical amenities, all private and public businesses ceased all operations. The socio-economic effects of quarantining patients and social distancing measures were not identical across all social and economic sectors of the economy. The swelling of Covid-19 cases made it difficult to provide accurate statistics of infected, recovered and death cases. The first three death cases of Covid-19 were recorded on March 3, 2020. The number of recorded cases remained depressed but rose to over 530 by the end of June, 2020 (CCZ, 2020). This increased the need for medical supplies across the country. The food sector also faced demand and supply bottlenecks due to uncertainty induced buying and hoarding of foodstuffs. Lack of awareness, huge number of informal workers, lack of government rescue package and hyper-inflationary environment exacerbated the already volatile situation in the country. These challenges affected the poor, women,



children and the disabled more than any other social groups. Low-income household members living in congested accommodation and employed in low skills work in the informal sector were also affected. Thus, this study sought to assess the socio-economic effects of the COVID-19 pandemic. The study is conceivably the first empirical paper which utilises information obtained through both quantitative and qualitative data from urban household heads in Zimbabwe.

### **3. Materials and Methods**

Masvingo urban district is located in the southern part of Zimbabwe, with total land area of 1, 287km<sup>2</sup>. The study area composed of ten wards during the time of the survey in 2020. Four wards were purposively selected due to their high levels of poverty (ZimVAC, 2019), concentration of informal activities and high level of growing population (Population Services, 2013). Furthermore, these were documented as the most affected areas in Masvingo urban (Government of Zimbabwe (GOZ), 2020). Exploratory research design was used to gather both qualitative and quantitative data on the socio-economic effects of COVID-19 on the livelihoods of low income households in Masvingo urban.

Data collection comprised of two distinct stages which involved gathering of qualitative data followed by the quantitative phase. Qualitative data was collected from 25 April to 10 May 2020. This was a period when the area was under strict lockdown period. Thus, for the sake of reducing the risk of COVID-19 infection, data utilised in this paper was gathered through google forms and telephone interviews. Furthermore, Data disseminated by the media namely Zimbabwe Broadcasting Corporation (ZBC), Radio Zimbabwe, TellZim, Herald and other media houses in the province were also used as secondary data. On average, three (3) articles addressing the COVID-19 outbreak and its ramifications on livelihood were collected per day between 25<sup>th</sup> of April and the 10<sup>th</sup> of May 2020. Furthermore, government and civil society communications about the impact of COVID-19 on livelihoods were recorded in a created special log-book. Quantitative data was collected using key informant interviews with 10 community leaders, representatives of local authority and staff at Mucheke hospital after the government relaxed the lockdown restrictions between the 10<sup>th</sup> and the 15<sup>th</sup> of May, 2020. The researcher adhered to strict WHO guidelines on social distancing. A five (5)



litres of sanitiser liquid and 100 face masks were distributed to respondents prior to the scheduled interviews. Respondents were requested to put on their face masks and the interview venues were sanitized before convening the meeting.

The study used Principal Component Analysis (PCA) and descriptive analysis to analyse the data. PCA is a data reduction method used to extract data from a set of numerous variables. Using PCA, data was reduced by combining a number of indicators into limited comparable groups. Each group defined the core aspects of the socio-economic effects forming the sets. In this case, an Eigen value was a coefficient attached to an eigenvector arranged in sliding order of the Eigen values to come up with the principal components in order of importance. Thus, in this study, the Eigen values estimated the covariance of the data. In total, the PCA extracted five (5) components with Eigen values bigger than one (1), explaining a total variance of 5.6%. The extracted five (5) components explained 12.7%, 12.4%, 11.3%, 10.7% and 10.6% respectively as indicated in table 1. Qualitative data was presented in their direct narrative speech. The data were sorted and analysed using SPSS version 2.0.

#### 4. Results and Discussion

*Varimax-rotated principal component analysis of the socio-economic impact of Covid-19 pandemic on low-income households in Masvingo Urban District.*

Table 1 below shows the results of the Varimax-rotated principal component analysis of the socio-economic impact of COVID-19 on livelihoods of low-income households in Masvingo urban district of Zimbabwe. The choice of the dominant socio-economic factors was selected using the Kaiser criterion (1960). The total number of the socio-economic factors used in this study was determined by leaving out those factors with matching Eigen values below 1. Only the factors with significant loading of 0.455 and above at 10 % overlapping variance were used in describing variables that were significant at 1% level of probability. All the socio-economic effects that loaded below plus or minus 0.455 were omitted in the analysis. The communality figures included in table 1 represent the squared multiple relationship between the item and all other items (Cambell, 2017). The factors included in this study are: Factor 1 (Household food insecurity, food supply disruptions); Factor 2 (shortages of medicines, closure of health centres); factor



3 (Gender-based violence, social distancing and social exclusion of Covid-19 infected persons); Factor 4 (job losses, closure of the informal sector, and schools) and Factor 5 (effects on religious beliefs and cultures).

After rotation, factor 1 (Household food insecurity, food disruptions) accounted for 12.7% of the variance, factor 2 (shortages of medicines, closure of health centres and perceptions associated with health workers) had 12.4% of the variance and factor 3 (Gender-based violence, social distancing and social exclusion of Covid-19 infected persons) accounted for 11.3%. Factor four (job losses, closure of the informal sector and schools) and Factor 5 (effects on religious beliefs and cultures) accounted for 10.7% and 10.6% respectively. The factors that were considered explained 57.7% of the total variance in all the 10 socio-economic factors used in this study. Table 1 shows the results of the Varimax-rotated principal component analysis of the socio-economic effects of Covid-19 on the livelihoods of low-income households in Masvingo urban district of Zimbabwe.

**Factor 1 (Household food insecurity, reduction in remittances, food supply disruptions, increase in prices of basic commodities)**

The factors that loaded high included household food insecurity (0.989), reduction in remittances (0.973), disruptions of food supply (0.965), and increase in prices of basic commodities (0.956). Participants lamented the upsurges in prices of food and other basic commodities as a result of high demand, inflationary micro-environment and disturbances in the food supply chain. The prices of groceries increased by more than 150% in the month of June (CCZ, 2020). Participants pointed out that malnutrition increased among food insecure households. It was further noted that household food insecurity exacerbated the risk of diseases among adults and stunting growth in children. A decline in remittances further compromised access to basic social amenities among low-income households in the study area. These results agree with Nwaogwugwu and Evans (2019) and Fourie (2020) who noted food supply disruptions and increase in prices of basic commodities in Democratic Republic Congo and Congo Brazzaville during the outbreak of Ebola virus in 2014. Furthermore, these results corroborates Lee & Ki (2015) who documented the disruption of food supply in Mexico during the outbreak of the H1N1 influenza in 2008.





**Factor 2 (Shortage of medicines and closure of health centres)**

Shortage of medicine (0.876), closure of health centres (0.865) and perceptions associated with health workers in contact with Covid-19 patients (0.847) were the factors that loaded high. The pandemic disrupted local medical supplies, thereby compromising the availability of contraceptive among major dispensers in the study area. Female participants reiterated that the lockdown dissuaded them from using contraceptives due to travel restrictions and shortage of medicines among the major pharmacies. These results corroborates Rohr (2019) who draws similarities between the 1929 Spanish bug and the COVID-19 pandemic. The spread of the two diseases resulted in the shortage of medicines and pressure on health centres, with devastating effects on the overall health delivery system.

**Factor 3 (Gender-based violence, social distancing, social exclusion of Covid-19 infected persons and perceptions associated with health workers)**

The factors integrated gender-based violence (0.654), social distancing (0.642), social exclusion of COVID-19 infected persons (0.634) and perceptions associated with health workers (0.544). Participants

revealed that social distancing and isolation restrictions created anxiety among household members. The lockdown restrictions constrained their social movements and economic activities. Female participants indicated that the restrictions resulted in dreariness due to undue household activities. Furthermore, gender-based violence related cases were reported in the study area. Participants concurred that the lockdown restrictions undermined their dignity, health, and autonomy. One female participant indicated that:

*“Physical abuse is part of my life. However, it has increased during the lockdown period. During normal times, I sought shelter in my sister’s house. The lockdown period has made it difficult to travel about 15 kilometres to my sister’s house”.*

Participants further stated that social distancing guidelines were unfamiliar with local cultures and values. It was emphasised that communal networks which functioned through interactions were disrupted in the study area. Numerous households found it difficult to overcome the ethos and culture shocks witnessed during the lockdown period. However, participants concurred that few social networks that still existed were



indispensable parts of a sustained, robust and multi-sectoral response to the COVID-19 pandemic in the district.

Households with a family member working in the COVID-19 frontline were worried of contracting the virus. Similarly, families with members suffering from chronic diseases such as HIV/Aids, kidney and heart problems were also stressed over the risk of losing their relatives. During the interviews, participants revealed that contagion fear caused isolation of households that had a member who worked in the COVID-19 frontline. It was further noted that frontline workers such as journalists, nurses, doctors, and other health workers were largely unprotected. This challenge caused numerous households to feel susceptible staying with a COVID-19 frontline worker. These results validate Deng and Peng (2020) who recorded discrimination among health workers during the outbreak of Ebola in the Democratic Republic of Congo and Congo Brazzaville in 2014.

#### **Factor 4 (Job losses, closure of the informal sector and schools)**

The variables that loaded high were job losses (0.786) and closure of the informal sector and schools (0.779). Participants noted that the daily increase in the number

of Covid-19 cases elicited closure of the informal sector, loss of earnings due to contagion fear and prolonged absence from work. It was noted that the closure of schools affected daily learning of children who were enrolled in various learning institutions. One local councillor in the study area pointed out that:

*“The most vulnerable children in my ward have not benefited from the home-schooling programmes during the school closure period. This has widened inequalities in the learning gap between children who come from the highest and lowest quintile”.*

Furthermore, another participant noted that:

*“Restrictions on movement and school closure disrupted children’s social support and routine schedules while placing novel stressors on parents and care givers who had to spend time with their children at home”.*

Participant concurred that the long-term impacts relating to disrupted schooling and early childhood nutrition will have disproportionate effects on vulnerable households, in terms of future earning potential and human capital development. These results confirms Dimmock et al., (2016) who recorded 13% school dropouts



among children during 2014-2016 Ebola outbreak in the Democratic Republic of Congo and Sierra Leone. Furthermore, ILO (2016) recorded increased conscription of child soldiers, child abuse and pregnancies during the Ebola outbreak in the Democratic Republic of Congo in 2014. Table 1 shows the Principal Component analysis of the socio-economic effects of COVID-19 on livelihoods of low-income households in Masvingo urban.

resulted in the cancellation of worship services, pilgrimages and festivals. However, over 87% of the participants revealed that they continued to benefit from livestream broadcasted amid the pandemic. Participants indicated that some churches and religious affiliated institutions distributed fumigation materials, gloves, hypodermic and infusion pumps, face masks, patient monitors, coronavirus nucleic acid detection components and food hampers to the affected communities in the study area.

\*Factor 1: Household food insecurity, food supply disruptions and increase in prices of basic commodities; Factor 2: Shortage of medicines and closure of health centres; Factor 3: Gender-based violence, social distancing and social exclusion of Covid-19 infected persons and perceptions associated with health workers; Factor 4: Job losses, closure of the informal sector and schools; Factor 5: religious beliefs and cultures disruptions

\*\* Socio-economic effects that loaded under more than 1 factors

### **Factor 5 (Implication on religious beliefs and cultures)**

Disruption of religious beliefs and cultures also loaded high with a 0.765 variance. Participants revealed that COVID-19



**Table 1: Socio-Economic effects of Coronavirus on Livelihoods of Low-Income Households in Masvingo Urban**

	Socio-economic effects	Components *					Communality
		F1	F2	F3	F4	F5	
1.	Household food insecurity	0.986					0.879
2.	Disruption of food supply chain	0.965					0.753
3.	Increase in prices of basic commodities	0.956					0.747
4.	Shortages of medicines		0.876				0.543
5.	Closure of health centres		0.865				0.524
6.	Negative perceptions **	0.845	0.847				0.987
7.	Gender-based violence			0.654			0.531
8.	Social distancing **	0.711		0.642			0.849
9.	Social exclusion **	0.613		0.544			0.672
10.	Job loses				0.786		0.643
11.	Closure of informal sector and schools				0.779		0.631
12.	Religious beliefs and cultures disruptions					0.765	0.622
	<b>Percentage of total variance</b>	<b>12.7</b>	<b>12.4</b>	<b>11.3</b>	<b>10.7</b>	<b>10.6</b>	



The results presented in this paper indicate that the economic decline has caused exponential growth of the informal economy. The closure of the informal sector affected low-income households in diverse ways. Households surviving through selling wares in the informal sector cannot avoid going to work in the absence of social security interventions. In order to reduce suffering, Andayi et al., (2019) suggest that subsidisation of social amenities such as electricity, housing and water to low-income households during the lockdown period will address the plight of vulnerable households. In the same vain, Ayithey et al., (2020) and Boone et al., (2020) proposes that interventions for immediate relief should focus on identifying and protecting vulnerable households. The adoption of these interventions will go a long way in lessening the suffering among families who barely have the resources to meet daily household food requirements.

COVID-19 pandemic has devastating effects on household social capital. Mhlanga and Ndlovu (2020) posit that social capital include networks, task relations and cultural norms that bind communities or households together. ILO (2020) posits that households in low-income quintiles rely on each other during stressful times. However, the lockdown disrupted social cohesion as households could not relate, share information, exchange productive assets or work together. The disruption of household ties through quarantines and lockdowns affected the livelihoods of low-income households. Thus, stakeholders should enliven these social network through creation of 'e-groups' that share vital information in the community.

The COVID-19 pandemic has resulted in dire household food deficit in Masvingo urban district. The ongoing return from restrictions will determine how well stakeholders have handled the pandemic and what other precautions should have been adopted. Household food security remain an exigent matter as the impacts of COVID-19 continue to wreak havoc in the district. Zimvac (2019) forecasts that over 95 000 households face extreme food deficit by December 2020. Thus, stakeholders should consider all conceivable precautions that address household food requirements when easing the lockdown restrictions. Ayithey et al., (2020) highlight that the COVID-19 relief funds and food hampers distributed to low-income



households in Kenya played a critical role in assisting vulnerable households. Thus, the reopening of the economy should consider provision of food security as one of the key priority areas. Stakeholders should consult vulnerable households affected by the pandemic in order to make informed decisions. However, if stakeholders fail to respond accordingly, it may take a longer time to convalesce from the current household food insecurity status.

The study revealed that gender-based violence erupted due to prolonged stay in confinements. In other related studies (AUC, 2020, Boone et al, 2020, Baldwin & di Mauro, 2020) gender mainstreaming in all intervention programmes is conceived as a panacea for reducing gender-based violence. To safeguard the success achieved towards realizing gender associated sustainable development goals, stakeholders should demonstrate political will to reduce gender-based violence during the Coronavirus shutdown period. This study also recommends that resources allocated for gender-transformative programmes during the pre-COVID-19 era should not be diverted during the shutdown period. In Kenya and Uganda, gender-based economic programming played an essential role in reducing gender-based violence during the shutdown period (Gao et al., 2020). Thus, in order to minimise the impact of COVID-19 on marginalised groups, interventions should consider the gender-specific needs of vulnerable households.

The COVID-19 pandemic brought direct and incidental expenses linked to early mortality, medical care and loss of production due to absenteeism from work. The economic costs of Covid-19 related production losses devastated low-income households. These costs created obstacles in accessing other essential household commodities. Moreover, other non-medical outlays, such as food and accommodation also increased household vulnerability. WHO (2020) and Ayittey et al. (2020) posit that a comprehensive health policy framework should address the social determinants of health in order to contain such social costs. Consequently, reducing these medical cost is a key obligation of government and other stakeholders in the health sector. The establishment of a Covid-19 rapid response team is long overdue. In order to reduce the rate of contamination, stakeholders should establish a rapid response team, with members drawn from government agencies and the private sector. The team should control the spread of



COVID-19 and ease the related socio-economic and health threats. The response team should establish effective collaboration mechanisms that provide evidence-based recommendations to the government and other private stakeholders. Furthermore, the rapid response team should detect gaps in the readiness, tracking, financing and biomedical countermeasures. It is also vital to note that there is no urgency in reopening the economy because lives are more important than livelihoods.

#### **4 Conclusions**

Lockdown has brought stress and anxiety due to limited health care provision, unrelenting financial losses, school closure and gender-based violence among many other challenges. Considering the serious socio-economic, political and human implications of the COVID-19 pandemic, there is urgent need for stakeholders to support the recovery of the informal sector. Priority should be directed towards facilitating the transition of the informal sector to formality. Furthermore, the government should introduce a rescue loan package with low interest rate in order to rescue the informal sector. The package should target individual traders from low-income households. Furthermore, stakeholders should consider pro-poor initiatives that reduce the socio-economic and psychological effects of Covid-19. Stakeholder collaboration is pertinent because the prevention mechanisms are beyond the scope of individual institutions. To flatten the COVID-19 curve, it is vital for all the stakeholders to take the leadership role in designing and employing inclusive strategies that prioritise the testing, isolation and disease tracing. Responses should be designed and implemented on the basis of social dialogue in order to ensure equitable and effective interventions. Without a concerted local 'call to action', COVID-19 will continue to affect households in the study area.

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