

Pack 115, Item

Type: Backgrounder

2020

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**COVID-19 and farmers: Responding to a pandemic in rural Rwanda**

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**Introduction**

Rwanda is one of the smallest countries in Africa at just over 26,000 square kilometres. In contrast, its neighbour, Tanzania, is 35 times as large. Rwanda borders Uganda, Burundi, the Democratic Republic of the Congo, and Tanzania. The country is hilly with highly fertile soils, and its economy is largely based on subsistence agriculture. An estimated 90% of the working population is involved in activities related to agriculture, and agriculture accounted for an estimated 42 percent of GDP in 2010 and 29 percent in 2019.

The 1994 genocide against the Tutsi brought the country to its knees, and nobody expected a miracle from this landlocked country. But since then, Rwanda has been continuously investing in services, infrastructure, education, and decentralized health services and administration. This has enabled the country to almost reach Universal Health Coverage (UHC)\*. Eighty-five percent of the population has access to a vast network of quality health services. Local authorities and local leaders are key to the government’s communication plan for health threats such as COVID-19, as they are the ones who know the location of vulnerable people in communities.

Compared to other resource-poor African health systems, Rwanda has an advantage—its decentralized referral system. Health threats such as epidemics are managed at the lowest level of the system, at the local and community level—in both urban and in remote or rural areas. From the smallest health entity (called a “cell”) to the community health workers to whom all rural and farming communities have access, individuals in rural and farming areas who need immediate attention have access to medical care within one mile of their homes. With cells as the first entry point, over 2,500 health posts receive patients in rural and remote areas. Health centres target more populated areas. From medically-equipped health centres, patients can be referred to a district hospital.

Rwanda has made good progress in responding to and managing the COVID-19 pandemic. Its success in tackling COVID-19 is largely related to its decentralized health system, combined with the government’s surveillance operations, and the collaboration between national agencies (for example, the Ministry of Health, the Rwanda Biomedical Centre, the National Police, the Defence Forces) and local governments. Community health workers at the national and decentralized village levels with experience in providing primary health care were mobilized to treat COVID-19. Another factor that contributed to success is that Rwandans already had experience with systematic reporting and handwashing as part of the ongoing national response to the Ebola virus.

**COVID-19 in Rwanda: The timeline**

After the first patient tested positive on March 14 2020, the Rwandan government instituted containment measures, including contact tracing\* and quarantining\*. Health authorities communicated with the public through social media and through public agency websites such as the Ministry of Health, and used drones and outdoor screens, television, radio sketches, mobile text alerts, and theatre dramas to raise awareness. These channels regularly informed Rwandans of recent COVID-19 developments and explained safety precautions related to handwashing, avoiding large gatherings, social distancing, encouraging cashless payment, and reporting symptoms to a toll-free number. Within a short time, handwashing taps were installed at bus parks, markets, businesses, and buildings in the capital city of Kigali as well as in rural areas.

Seven days later, a two-week countrywide lockdown came into force to contain the spread of COVID-19. At the time, there were 17 cases in the country. Non-essential movements were banned, schools and university classes suspended, and a ban on public gatherings followed. The public was warned to provide accurate information for contact tracing or risk punishment. Rwandan police enforced compliance with curfews and other containment measures with fines and temporary arrests. There is also widespread surveillance, including people reporting each other to authorities for even the suspicion of violating government directives.

In addition, the government directed pharmacies and other businesses to avoid increasing the price of sanitizers and paracetamol (acetaminophen) to ensure access to medical supplies or face penalties.

As prices for basic food staples rose across Africa, and as shoppers stocked up on essentials and sellers sought to profit amid the coronavirus scare, Rwanda was the first African government to impose a total lockdown in March and close its borders. The government distributed food to vulnerable households all over the country. Before the end of March, the trade ministry supported families by fixing prices for 17 essential foods, including rice, spaghetti, maize flour, beans, soap, cooking oil, and porridge flour. This process was led by local leaders at the cell and village levels. The government also fixed prices for processed foods, many of which are imported from China.

The primary beneficiaries of government efforts to distribute food and fix prices were the most vulnerable groups, including those who lost their jobs and daily income, and people working in the informal sector such as casual masons, hair salon employees, motor taxi drivers, those working in bars, and casual labourers.

To stop the spread of the COVID-19 pandemic, the nationwide lockdown was extended beyond March 21. But due to the ongoing lockdown, many farmers faced challenges, especially those engaged in livestock and poultry farming. By May 2020, the distribution channels for their produce had been disrupted by the coronavirus confinement measures.

The government used technological innovations to test and monitor compliance with government directives. In Kigali, robots delivered medicine and food to people in quarantine, performed COVID-19 screening tests, and communicated the data to health workers. Drones monitor and trace people who disobey lockdown measures. In July, the Rwandan Ministry of Health launched a random testing scheme designed to test 5,000 drivers, pedestrians, and taxi moto drivers per day in Kigali city and at national border points.

**COVID-19 in numbers**

As of October 2, 2020, Rwanda has the 136th highest number of cases in the world, with 5,060 documented cases, 4.806 of which have completely recovered, and none of the 220 active cases classified as “critical.” Thirty-four people have died since the first case was registered in March 2020.

Until the beginning of June, the weekly average of new cases was 36. Since then, the weekly average has risen to 284. Total deaths followed a similar pattern—from three in the period before the peak to the current 34.

On first sight, this situation could be viewed as alarming or as a failure to manage the pandemic. But a closer look reveals that Rwanda is among the countries that have most successfully managed the pandemic.

For every million people, Rwanda has 388 cases and 3 deaths, both very low by global standards. The low number of deaths and the high rate of total recoveries indicates an effective response to the pandemic and suggests the positive impact of the high level of health coverage in Rwanda.

The recent rise in total confirmed cases is almost certainly due to the increasing number of tests conducted in the country. The country started testing even before the first case had been confirmed and expanded its testing capacity from 891 per day in April to the current 2,421. By the end of August, daily testing had increased to 5,382, before declining to the current rate due to limited identification of new cases through contact tracing. In comparison, the UK government is testing over 270,000 people a day, South Korea over 9,000 a day, and Germany is performing one million tests per week as a robust response to “test, trace, isolate.” By October 25, 2020, Rwanda has conducted over half a million tests, representing more than 41,000 tests per one million people, putting the country in 12th position in Africa.

Other potential reasons for the increasing number of cases might include the end of the lockdown and the reopening of businesses and borders, but these require further exploration.

The country plans to implement a contact tracing system that employs 1,900 tracers working across rural areas of the country and includes regional collaboration with neighbouring countries.

In summary, Rwanda is among the model countries when it comes to responding to the coronavirus pandemic.

**How Rwanda farmers were assisted in response to COVID, heavy rains, and floods**

Because farmers have been allowed to continue working in their fields, rural areas had been less impacted by the COVID-19 pandemic in terms of economic loss and poorer access to food. However, rainfall in April and May triggered extensive landslides and floods. These affected the livelihoods, agriculture, housing, infrastructure. and environment sectors among others, as well as access to income-generating activities. The most vulnerable areas are in the north, namely Nyabihu, Rubavu, and Gakenke.

Until the floods, farmers had expected increased access to food from their own production, given the above average harvest which ended in March 2020, and the expected normal harvest in May-July.

By October 9, 2020, the Food and Agriculture Organization (FAO) had started delivering urgent agriculture inputs and tools to flood victims, in collaboration with various partners, including the International Organization of Migration (IOM). IOM provided shelter to vulnerable families whose houses were destroyed by the rains. Households that benefitted from this support included those headed by women, older people, pregnant and lactating women, and included children and people with disabilities. Vulnerable individuals with agricultural land planted to various crops that were destroyed by the floods received packages composed of iron-rich beans, hybrid maize, fertilizer, and agricultural tools.

**Difficulties with social distancing and other precautionary measures**

Nyagatare District in Rwanda’s Eastern province is the largest and second most populous district in Rwanda. The district has a large number of cattle, and land is not farmed as extensively as in other areas of the country, a situation that might decrease the risk of COVID-19 infection and the necessity for strict social distancing.

An observer from a UN agency who visited the area at the end of August 2020 to speak to vegetable farmers reported on farmers’ uptake of COVID-19 precautionary measures. With regard to physical distancing, wearing masks, and practicing hand hygiene, including situations where it’s difficult to follow these measures, farmers are sanitizing and washing their hands regularly whenever possible, though it is unclear whether they wash at home or with handwashing taps installed by local authorities. Farmers also report that they adhere strictly to the 10 p.m. to 5 a.m. curfew.

Despite the high population density in Nyagatare, handwashing and respecting the curfew may have paid off, as no COVID-19 cases have been recorded and no people have been isolated in COVID centres due to symptoms related to COVID. Rwanda did not use existing facilities such as Ebola treatment centres but created treatment and isolation centres specifically for COVID-19.

Restrictions on movement and gatherings and other measures have had a variety of impacts on farmers. Some farmers have needed to divert the money they would have invested in agricultural activities into helping their families meet more immediate needs and secure basic health.

Transporting goods and contacting regular customers are challenging, and acquiring new customers almost impossible. One farmer noted that he travels to Kigali to sell his produce rather than relying on permanent customers. But the farmer has been unable to travel to Kigali, and could not transport his produce to existing clients. Normally, about five tonnes of fruits and vegetables are harvested per hectare in this region, but this has dropped to three tonnes, with the remaining produce going to waste.

Rwandan farmers are supported not only by the government and various UN programs and agencies, but can also rely on *Ubudehe*. Ubudehe is an ancestral tradition, a long-standing Rwandan practice of collective action, care, and mutual support to solve community problems. Many farm co-operatives and individual members have provided food assistance to fellow community members impacted by the COVID-19 lockdown. For example, the Kabiyaki Farm Cooperative and the neighbouring Tuzamurane-Cyeza Cooperative in Eastern Rwanda donated nearly one tonne of maize produced by the co-operatives, along with other food commodities, to nearly 200 people from 42 families. Each family received a food package containing 20 kilos of maize, five kilos of rice, two kilos of nutritious porridge for young children, one litre of vegetable oil, and a bar of soap.

Rural women in Rwanda are fully engaged in agriculture—as producers, processers, marketers, and informal traders—but their participation in these activities has been heavily curtailed by the crisis. Women's reduced opportunities to earn a livelihood due to travel restrictions and increased unemployment impacts their decision-making power in the home, negatively effecting household nutrition and resilience.

Gender-based violence has been termed [a “shadow pandemic](https://www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls)” to COVID-19. UN Women notes that, in Africa as well as elsewhere in the world, domestic violence hotlines and shelters are reporting increased calls for help. According to the World Health Organization, the stress caused by COVID-19 lockdowns and economic uncertainty is exacerbating violent assaults. The pandemic has forced many women in abusive relationships to remain at home with their abusers, escalating their risks.

One of the positive side effects of the COVID-19 pandemic in Rwanda is that the country has focused on and started championing gender equality and the fight against gender-based violence in rural areas. Located within the Kacyiru Police Hospital in Kigali, the Isange One Stop Center has become a hub for survivors of gender-based violence. At the centre, survivors can access all required services in one place and for free. The centre is operated by the country’s Gender and Family Promotion, Health, and Justice Ministries in addition to the Rwanda National Police. The initiative started in 2009 as a pilot and has since expanded across the country. Rwanda now has a One Stop Centre in every district. Every day, up to a dozen survivors are received at the centre.

Reduced livelihood opportunities for women has other knock-on effects, as women’s income is generally directed towards education, health care, and re-investment in women's agriculture or entrepreneurial activities. For Rwanda, re-examining gender-specific COVID-19 impacts and integrating women’s empowerment remains essential to post-COVID-19 strategies for survival and recovery.

Rwanda’s success in managing the global pandemic started by implementing science-based policies and technologies. Rwanda has set an example for other countries to follow, especially in Africa. The question now is whether the country will be able to ensure that people entering the East African nation are free of COVID-19 following the August 1 re-opening of its airports.

Like other African countries, Rwanda requests a certified negative COVID-19 test result from arriving travellers. In addition, travellers are tested upon arrival and must self-isolate in their accommodation until reception of the test result, at least 24 hours. It is not yet clear to what extent these measures will be successful, but one indicator for success is the fact that Rwanda is the only African country featured on the European Union Council’s list of 11 epidemiologically safe countries worldwide.

**Key definitions**

*Contact tracing*: A monitoring process that involves three basic steps: contact identification, contact listing, and contact follow-up.

***Isolation***: Separating people with a contagious disease from people who are not sick.

***Quarantining***: Separating and restricting the movement of people who were exposed to a contagious disease to observe if they become sick.

*Universal Health Coverage (UHC):* The state when all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that using these services does not expose the user to financial hardship.

**Acknowledgements**

Contributed by: Elisabeth Wilson, Journalist and Communication Specialist

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*This resource is undertaken with the financial support of the Government of Canada provided through Global Affairs Canada.*