LEARNING IN A PANDEMIC
Reflections on COVID-19 in Rural Zimbabwe

Iyleen Judy Bwerinofa, Jacob Mahenehene, Makiwa Manaka, Bulisiwe Mulotshwa, Felix Murimbarimba, Moses Mutoko, Vincent Sarayi and Ian Scoones
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Cover photos: Pastor Gumbo talking to Felix Murimbarimba near Chikombedzi (front); Zumbani growing at the edge of field near Mvurwi (back). All photos in this book were taken by members of the team.

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INTRODUCTION

LEARNING IN A PANDEMIC: REFLECTIONS ON COVID-19 IN RURAL ZIMBABWE

The first case of COVID-19 was identified in Zimbabwe on March 20 2020. Having seen what was happening elsewhere in the world, Zimbabweans were fearful of what was to come. Following World Health Organisation guidelines, the government imposed a strict lockdown on March 30. While there were very few cases in the country by this stage, the lockdown had a dramatic impact on people’s livelihoods. Markets were closed, transport was restricted, curfews were imposed, schools were shut and church and other gatherings were banned.

As a group of researchers interested in agriculture, livelihoods and rural change – and with most of us living in Zimbabwe’s rural areas - we switched our research plans and started to document how COVID-19 – both the disease and the public health measures imposed – affected the rural populations we had long been working with. Our first blogpost came out on the day of the first lockdown, speculating on how the pandemic might affect our study sites and how local capacities of resilience might help. Like everyone at that point, we had no idea how long the pandemic would last nor what its effects would be. In the end, we continued our reporting and reflection on what was happening on the ground for two years, with 20 posts published.

This book is a compilation of these blogposts, a documentation of the unfolding story of the pandemic in different sites in rural Zimbabwe. Given that our reports appeared in real-time, the compilation gives a sense of the changing phases; the contrasting fears and perceptions; the different roles people played; the processes of learning and innovation that took place in the absence of state support and the shifting tenor of politics through the period.

Overall, the pandemic emerged in a series of phases, associated with different ‘waves’ of different variants (Figure 1). Overall recorded cases and
deaths were (relative to other countries) low, but of course there was massive under-reporting. Even if direct effects remained limited, the consequences of the pandemic were huge. Each wave was associated with a lockdown, lasting for different periods, and each all with major impacts on rural people.

There has been a huge amount written about the COVID-19 in Africa, including in Zimbabwe. But much of this work offers intermittent insights only from a distance. Time delimited phone interviews, snapshot surveys and big picture overviews tell us little about the how the pandemic felt to different people at different times and how disease, death and lockdowns were experienced. By contrast, our more immersed, engaged and real-time approach offers textured and nuanced insights as they were observed, with different themes highlighted as they arose.

![Daily new confirmed COVID-19 cases](image)

**Figure 1: Daily new confirmed cases**

**THE LEARNING AND REFLECTION PROCESS**

How did we go about this learning and reflection process? Our team is a mixed group, coming from different backgrounds. Most of us are farmers,
with several working as agricultural extension workers for the government. All of us are researchers, having worked together on projects focusing on agriculture over many years, but only one of us is an ‘accredited’ researcher, who works at a UK university-based research institute. Each month, the Zimbabwe based team lead, Felix Murimbarimba, would speak to each of the team based in Mvurwi (Mazowe district), Natisa (Matobo district), Chatsworth (Gutu district), Wondedzo (Masvingo district), Hippo Valley and Chikombedzi (Chiredzi district), and also reflect on his own experience in Masvingo town (Figure 2).

![Figure 2: Map of study sites](image)

Team members reflected on what they had seen and learned in a very open-ended way, identifying themes from their own experience and discussions with people in the communities where they lived. Everyone would also share photos via WhatsApp, giving a sense of the experience on
the ground. Felix would then compile the information and discuss this with Ian Scoones who was in the UK during the pandemic. Ian would then write up a blogpost that would be posted on the zimbabweland.wordpress.com site. These posts included a selection of the photos, which necessarily are not the best quality but give a feel for the settings at the time. After publication, the blogs would generate debate both within our sites and more generally (especially as most were also republished in Zimbabwean newspapers) and we would feed this into our next iteration of learning and reflection.

As the blogposts show, a huge array of themes emerged, and different blogs focus on particular dimensions; for example, the effects of the lockdowns on women and young people; the innovation around local traditional herbs; the emergence of a plural health system; the importance of migration to rural areas and the role of resettlement areas as sources of resilience; the role of politics in framing the pandemic in Zimbabwe and many more.

The book can be read in many ways. You can read the whole lot sequentially to get a sense of how the pandemic changed over time, or you can dip in and look at an entry that particularly interests you. Each post has its date of publication and is based on our collective reflections and analysis in the previous period. The blogposts are presented chronologically, ending in February 2022. There is some repetition across the posts, as some themes were just so important that they came up again and again in our discussions, but there is a very tangible sense of shifts in views and attitudes.

**PANDEMIC PHASES**

At the beginning there was fear and shock, and people found it difficult to navigate the strict lockdown regulations as they were strictly enforced. Later, as the feared growth of COVID-19 cases and mortalities did not materialise, anxieties reduced and people learned how to cope, not least through their own experimentation, innovation, learning and sharing around COVID-19 treatments. However, in 2021 concerns grew again around vaccines. Misinformation and rumour spread fast, especially focusing on vaccines from China. Without movement, WhatsApp became a vital form of communication, both providing important insights into treatments shared amongst family members and friends, although also a source of false information and fearmongering. Navigating competing claims about pandemic knowledge remained a challenge throughout.

When the Delta wave arrived in Zimbabwe in mid-2021 mortalities spiked. It
was no longer seen as a rich person’s disease affecting only those in town, but something that had a direct effect in the settings where the team was working. This heightened concerns, but also added to the determination to find local treatment solutions. By this stage, people had an increasingly good idea about how to manage the disease, although sadly at this point a number of people died. Yet, case rates and mortalities remained far lower than experienced by relatives in the UK and even in South Africa. People commented on their own resilience and offered hypotheses about how the virus affected different people in different places in different ways. Especially by 2021, everyone was fed up with the lockdowns, seeing them increasingly as political impositions rather than public health measures. With crops to send to market, social obligations to fulfil and jobs to be done, by necessity people increasingly found ways round the restrictions. Even if fined, they surmised that breaking the law was better than starving at home. By the time the Omicron variant arrived at the end of 2021, most felt confident in confronting it. Luckily the variant was relatively mild and even though people fell ill for some days, Christmas and New Year holidays, as well as the agricultural season, proceeded without too much disruption, despite another lockdown.

EMERGING LESSONS
Together, the blogs clearly show how the COVID-19 as a disease became entwined with located economic, social and political processes. The disease did not operate independently of context, and in order to address any pandemic – for there will surely be more – an integrated perspective is always required; one that most effectively comes from the sort of real-time, embedded research that we undertook over two years. Of course, the pandemic is not over and the economic, social, political, psychological and physical health effects of COVID-19 will continue for some time. However, there are many important lessons that emerge from our reflections, including on how public health and politics need to be negotiated in a pandemic and how community forms of resilience can be built. We have drawn on the blog material in several articles, which offer wider, more analytical overviews, with lessons for the future:

*Living through a pandemic: Confronting COVID-19 in rural Zimbabwe.*

*What is ‘community resilience'? Responding to COVID-19 in rural Zimbabwe.*

We hope that you find this collection interesting. Perhaps as a reminder of what you yourself experienced; perhaps as a comparison with where you live; perhaps as a set of lessons for what needs to be done in the future. While we never planned to continue for two years, we believe that this sort
of real-time documentation and reflection offers important and novel insights into the dynamics of the COVID-19 pandemic in rural, African setting, highlighting the multiple, contested dimensions of a pandemic. We hope this book will serve as an important record, as well as source of inspiration to help planning for future pandemics.
Zimbabwe had three confirmed cases and one recorded death of COVID-19 (coronavirus) as of 26 March, and a national disaster has been declared. So far suspected cases have been limited, but once the virus spreads through the population, it could be devastating.

In thinking about COVID-19 in Zimbabwe, and in Africa more broadly, three dimensions are important – fragility, resilience and inequality. It may be that obvious fragilities are counteracted to some extent by capacities to adapt and be resilient, but this depends on who you are and where you live.

**FRAGILITY**

The conditions for rapid spread of COVID-19, certainly in townships in urban centres, are all there – crowded housing, poor sanitation, lack of water, immune-compromised populations due to HIV and lack of services. For pandemic preparedness planners, this is a recipe for a major disaster.

As people get sick, the ability of the health services to respond is seriously limited. The one infectious disease hospital (Wilkins in Harare) has limited capacity, and apparently no intensive-care ventilation facilities. There are supposedly only 16 ventilator machines in the country.

The medical profession is disillusioned and under-paid, and has recently been on a long strike, unheard of among committed doctors. Yesterday, nurses and some doctors walked out complaining of a lack of basic protective equipment. Many well-qualified doctors have left the country; even Cuban doctors, who have come to Zimbabwe’s aid in the past, may be fewer this time.
State neglect of the health service has been long-running, ever since the imposition of structural adjustment policies from 1991. In the past years it has got worse, and the public system has nearly collapsed. Private providers offer good services to the rich who can pay, but this is limited. And they are not geared up for a public health emergency.

The government’s response has been patchy so far. After ignoring warnings, an emergency declaration was made banning public gatherings and encouraging social distancing, but the President still proceeded with a rally the next day. Meanwhile, the defence minister caused an international sensation, and much opprobrium, by declaring that coronavirus had come from God to punish the West for imposing sanctions on Zimbabwe. The government distanced itself, but it rather highlights the dismal calibre of some at the highest level.

This current regime clearly doesn’t garner much trust. The political settlement has fallen apart. The state seems simply not to care. As Simukai Chigudu describes for the 2008 cholera outbreak a mixture of disdain and callous contempt is shown by the state. With the economy continuing to
free-fall, Zimbabwe, by any indicator, is a ‘fragile state’ – and so one of the least able to respond to a pandemic.

**RESILIENCE**

Yet, indicators of fragility tend to focus on the functioning of the state, assuming that states must replicate those in the West or China. In a crisis, however, well-ordered, functioning states are often unable to cope. They are not used to responding to surprise, high variability, random shocks and an inability to plan and predict. They do not have systems of reliability at their core.

While the Zimbabwean state is clearly highly fragile, given years of neglect and a serious lack of resources, there are other aspects of the Zimbabwe setting that give hope. Resilience – the ability to respond to and bounce back from shocks, even transforming the situation along the way – is built by people in networks, embedded in social relations, with values and commitments that go beyond narrow individualism. We see a lot of these characteristics in Zimbabwe; and people have had to learn these skills and practices the hard way.

Over twenty years of economic and political chaos has ensured that food is supplied through informal means, across multiple social networks, even as food emergencies are declared at a central level. The informalisation of life – the sense of getting by and living with uncertainty (débrouillardise in the Congolese rendition) – has affected all relations. If there is nothing in the shops or no fuel at the pumps, then look elsewhere, ring someone up, find an alternative. Something will happen, always. It is these capacities that are essential for surviving in a pandemic, and that those in the West are learning fast, as shops empty, people panic buy and services cease.

The painful lessons of the HIV/AIDS pandemic are imprinted on Zimbabwe’s consciousness: first it was a blame game – gays, foreigners, sex workers, truck drivers; and then everyone realised this was affecting everyone, and many friends and family were dying. Leadership from Timothy Stamps, the health minister, the commitment of front-line health workers and community changes in behaviour (along with the supply of cheap anti-retrovirals) turned the tide, and Zimbabwe was one of the first in the region to show declines in the disease. These lessons will be important now; just as in West Africa where the lessons from Ebola will be vital. Pointing the finger elsewhere doesn’t stop a virus, and everyone has to be committed to a collective response.

So now will be an important moment for rebuilding solidarities and forms of mutualism and moral economy that are at the heart of social resilience.
With the UK Premier League cancelled, the WhatsApp groups dedicated to following Chelsea or Arsenal can be repurposed to helping each other, while churches will take on new meanings amongst congregations, even if not gathering physically. International connections are important too, although South Africa’s plan to build a fence on the Zimbabwe border to prevent illegal, ‘diseased’ migrants entering sends out a dismal signal. Networks of kin across the world, connected though remittances flows and Western Union, will be vital, just as messages (and good Zimbabwean jokes and memes) via social media will be important.

Even in the UK, so subsumed in an individualistic culture for generations, the importance of community, connection and solidarity are being rediscovered through ‘mutual aid’ groups. This will be much easier in Zimbabwe and, in the absent of a caring or competent state, will be essential.

INEQUALITY

While at one level it’s true that viruses respect no borders and affect all people, the consequences are very unevenly felt. While we are all in it together, some are more exposed. Who is most likely to catch the disease? Who is most likely to become ill? Who is most likely to suffer from the failure of health services?

Some of this is to do with biology – it is the elderly, for example, who seem to get the worst symptoms – but a lot is to do with deep structural inequalities. The colonial shape of cities is one aspect: crowded townships (for black African workers), distant from places of work and the suburbs originally reserved for whites, require daily travel on crowded transport networks. This is the perfect setting for contagion.

Add to this the crowded nature of such ‘high-density’ townships (yes it’s in the name – blacks were not deemed to need space), and the decline in services, mean that ‘social-distancing’ is impossible. This was ruled out in the colonial era, and has been made worse by economic decline, where travelling for precarious work and endless queuing are part of daily life.

Meanwhile, the edicts of ‘hand-washing’, good hygiene and healthy food are impossible to follow if tap water doesn’t run, people share boreholes and poverty restricts what food can be bought. This is what Paul Farmer refers to as ‘structural violence’ – the violence of deep inequality that causes vulnerability and disease.

By contrast, those living in the low- or medium-density suburbs, and with resources, can distance themselves, and have resources to buy alternatives
– privately pumped water, insurance for health care, money to buy things at inflated prices, or they’re even able skip the country if needs be.

Workers from the townships who service the city and offer labour in businesses and factories are those who are the most vulnerable to economic shutdown. They have experience of this, and many have already lost their formal jobs as the economy collapsed. They travel in to take up precarious, informal work, which can cease at a stroke without recompense. Knee-jerk reactions by the state, in shallow attempts at asserting control, are often directed at the most vulnerable. Informal markets are closed because of notional hygiene concerns, for example. Those operating in recognised trading sites are taxed exorbitantly, even though this restricts access to toilets and washing facilities, especially for women. Extreme quarantine measures, in the context of a fragile state, may end up doing more harm than good, undermining social resilience.

It’s probably those in the rural areas who are the most resilient in the face of the COVID-19 crisis. Having food to eat or sell, and solid local networks to draw on, with limited expectations of the state anyway, many have successfully ridden out the roller-coaster ride that has been the Zimbabwean economy. Forms of collective action that can regrade roads in rural areas can surely also assist with pandemic response, in alliance with Zimbabwe’s many committed health care workers, community leaders and others.

Of course, as people become very critically ill, this is outside anyone’s ability to respond – and in Zimbabwe this includes the whole health system – so this is why enhancing the ability to stop the spread and building resilience is the essential challenge of the moment. As winter approaches, there is probably very little time.

This article first appeared on African Arguments’ Debating Ideas blog

3 https://twitter.com/daddyhope/status/1240671653547425801?s=12
4 https://twitter.com/daddyhope/status/1240671653547425801?s=12
5 https://www.bbc.co.uk/news/world-africa-51205619
Over the last few weeks we have been tracking what’s been happening in our rural study sites in Zimbabwe as a result of the COVID-19 lockdown (see the earlier blog too).1 Last week, I caught up with a colleague in Masvingo who had been recently in touch with others in our team in Chatsworth, Chikombedzi, Hippo Valley, Matobo, Mvurwi and Wondedzo. This blog is a report on current conditions, summarising a long phone conversation.

The lockdown was first announced by the President Mnangagwa on 30 March, and was subsequently extended on 19 April for a further 14 days. As of April 26 there were 31 reported cases and 4 deaths,2 spread unevenly across the country.3 But of course the fear is that the disease will spread and strike hard. The lockdown measures have been heavily enforced and have caused massive hardship, particularly in the poorer urban areas, where informal traders in particular have been targeted.4 Farmers have suffered too due to movement restrictions and the collapse of markets.

As my conversation last week revealed, Zimbabwe’s experience, like elsewhere in Africa,5 raises questions as to the costs of a heavy-handed lockdown,6 particularly on the poor and marginalised, and whether there are alternative approaches both to confront the virus now and for different approaches to society and economy in the future.
HOW HAVE MOVEMENT RESTRICTIONS AFFECTED PEOPLE’S LIVES IN THE RURAL AREAS?

Massively. Although you can go to the local shops (between 9am and 3pm) and move about your area, you cannot move further without a permit, and have to prove that travel is essential. Security people can stop you at any moment. You can get a permit from Agritex (extension service) locally for agriculture-related movement, or from the councillor or police. But if you have to move further you have to go to the provincial level. It can take days. You can try your luck and negotiate at the road-blocks, but you will likely be turned back. There are so many police out – they’re everywhere! There is no public transport these days. If you travel in your private vehicle, you can only have two people. All the private Kombis and buses are grounded. ZUPCO (a government-owned company) operate buses, which are disinfected after each trip, but there are very few. This has had a disastrous effect on business, and farmers cannot get crops to market. Right now people need workers to help with the harvest, and although this is allowed as agriculture is essential, you can easily be stopped, and it makes getting help on the farm more difficult than before.

SO WHAT ABOUT AGRICULTURAL PRODUCE MARKETS?

It’s a disaster. All the main ones have been shut down. There was an outcry and they opened them again for a bit, but people crowded there. It was
chaos, so they shut them again. This means for horticultural farmers in our study areas things are tough. Vegetables, especially cabbages and tomatoes, are rotting at their farms. In the south, huge number of melons have gone to waste. For some, vegetable-drying is possible, and people are creating ‘mufushwa’ in large quantities. But overall it’s a disaster. Some are selling individually, travelling to the ‘locations’ (high density suburbs) and selling from their pick-ups. Some can sell to the supermarkets if they have contracts, but demand has gone down. You can’t move from the location to town in Masvingo without permission, and so people just buy locally, informally. Other markets have also dried up. The boarding schools are closed, so are the universities, along with all hotels, restaurants and so on. These all used to be so important for horticulture markets, as well as for poultry. Income from these sources has ceased. Same too with the massive church gatherings, attended by thousands. In some of our sites, people had been growing for the Easter gatherings, but now they have had to dispose of the produce. It’s a disaster for farmers.

**WHAT ABOUT BUSINESSES MORE GENERALLY?**

Most of these are closed. It means that as a farmer you can’t get your pump repaired, or a car fixed. You can’t go and buy key bits of equipment. Even if the shop opens for a short time, which some are allowed to, getting a permit to travel from your rural farm and ensuring you are there at the right time is impossible. A big problem is cash. This has been a problem for a time. The electronic RTGS Zim dollar is worth less than the Zimbabwe bond notes, but people are not keen to use cash notes as it might transfer the virus. Even if you have money in the bank, you cannot get it. They’ve opened banks only for forex, and for short periods, to allow remittances from the diaspora to be paid. This is vital for many of us, including farmers.

**HOW ARE PEOPLE SURVIVING?**

The rural people are on their own. There is a big chain reaction – without markets, producers, transporters, and all others suffer. And then there is no cash to buy food or other inputs. For example, there is a big theileriosis disease outbreak among cattle currently, but people have not been able to buy spray dip chemicals and cattle are dying in numbers. They cannot be driven to other places to avoid the ticks, so they just die. Of course people in the rural areas are in some way better off. It’s the beginning of the main harvest season and, although the season was bad, people at least have something. It’s much tougher in town. There’s subsidised mealie-meal, but a packet of 10kg that should be Z$70 it’s being sold for Z$90. Traders are exploiting the situation. Some are illegally doing business. In one study site
the grinding mills open at night to allow people to get food. The money changers operate under cover and there is a growth of private business, from people’s homes, including brewing beer, baking and selling food. In the south, some are even risking crossing the border to get supplies for resale in South Africa. The danger is that they can smuggle the virus too.

**WHAT ARE SOME OF THE SOCIAL ISSUES EMERGING?**

Certainly there are reports of increased domestic violence. People cannot go out, and tensions rise. Some are consuming illegal brews – including spirits made at home. This can be dangerous, just like we are seeing increased drug use among the youth. Normal life is disrupted. You cannot even bury the dead – you again need a permit, and a health worker has to be present to supervise the burial, and a maximum of 50 can attend, but following social distancing rules. Travelling to funerals is impossible if outside your area. Family relations – and life in general – are being challenged by this virus.

**WHAT ABOUT HEALTH SERVICES?**

Yes the clinics and hospitals are open. The problem is that you have to get a permit to move. And then the nurses at a clinic may not see you. They don’t always have the full personal protective equipment (PPE) and are really scared. Even though there are no cases in Masvingo as yet, people may be dying of malaria or childbirth complications or whatever, because of the lockdown. It’s killing people. The government is investing seriously in the health service, even employing more health workers. They are creating emergency beds, even in the rural areas, but it may not be enough. We have seen what has happened in Europe and the US on the news.

**WHAT ARE PEOPLE’S ATTITUDES TO COVID-19?**

People ask, what disease is this? Where has it come from? It is such a shock! There are so many rumours. People say it’s God’s revenge; they blame the superpowers; they say it has been manufactured to kill us. But mostly people are just scared. They have seen the news. We know pandemics, we had HIV/AIDS, but this is worse. It’s the number 1 disease. With AIDS people died over a long time, but this is sudden. With HIV you knew how it was transmitted, and people changed their behaviour. It could be avoided. This is just meeting someone – it’s so contagious. Even though he’s allowed, one of our colleagues who works with Agritex was moving around and was told in one village to go home – to ‘keep to your place’!
WHO ARE THE MAIN PEOPLE INVOLVED IN THE RESPONSE?

There are so many. The government actually has organised quite well, it is doing something. Before they’d forgotten the health system – there was a freeze on health posts, people were paid badly and the hospitals and clinics were in a terrible state. Now they see the importance. This crisis has at last awakened the administration. For years we haven’t had an effective health service, but now something at least is happening. In each area there are COVID-19 task-forces – and mines, business people, well-off individuals and others are contributing resources. The universities and some businesses are making things – sanitiser, masks, PPE materials and so on. It’s a joint effort with government. The chiefs are involved too, and so are the spirit mediums who are seeking spiritual help to get through the crisis. The churches are doing the same; although they are not meeting, the church leaders, prophets and others are mobilising. Everyone is praying! There are WhatsApp groups giving advice on what to do, including some ideas for remedies. There seems to be a unified approach, and all the political parties are involved.
WHAT NEXT?

So far we haven’t suffered from the disease, only the lockdown. We have a few cases only. We accept that this lockdown period is for building the capacity of the health system to cope. Let’s hope that’s possible. It’s a Catch 22. We see what has happened in the UK, US and even South Africa. We don’t want this to happen here. But with lockdown most people are surviving hand-to-mouth. Life has become very, very difficult. There is mass suffering, and so far in Masvingo we haven’t had a single case recorded. Is it worth it? I don’t know, but everyone is very scared. Maybe there can be a process where kids can go to school, markets can open and we can move around because we cannot go on like this for long. There must be ways to make the places where lots of people gather safe – schools, transport hubs, markets, shops, religious gatherings and so on. Surely we can think of ways. Good hygiene, distancing and so on. Once the health service is adequate and built up things will be better; maybe there will be some anti-viral medicines too, like we have for HIV. Hopefully we can then live with the virus, and still survive.
WHAT LESSONS CAN WE DRAW FROM THE EXPERIENCE SO FAR?

We know that health services are important, and the government needs to invest. We know that farmers are essential and contribute to combatting a crisis, especially getting food to urban areas. We also know that lock downs are really impossible – and they can kill. They may be worse than the virus! We also know that we can do things ourselves. Good diets bring immunity. There are traditional remedies that may help. And hygiene in the home and at work is always important. In the past we used to be self-reliant, making and selling things locally. There were often big crises, such as droughts, but our parents had granaries to tide them over. In future, we have to be prepared, we have to use our own resources. In the past we used to make things ourselves, not go to the shop to buy. Why are we importing so many things like face masks? We can make them. We produce huge amounts of ethanol from sugar, so we can make sanitisers. We have forgotten self-reliance. We have been taught a very big lesson by this virus. We should not rely on the outside, and individuals and households have to take the responsibility ourselves.

2 https://coronavirus.jhu.edu/map.html
4 https://allafrica.com/stories/202004240602.html
5 https://www.bbc.co.uk/news/world-africa-52268320
JUNE 15 2020

COVID-19 LOCKDOWN IN ZIMBABWE: ‘WE ARE GOOD AT SURVIVING, BUT THINGS ARE REALLY TOUGH’

On the 13th June we had a follow up conversation on how people are coping with the COVID-19 lockdown in Zimbabwe. As with the previous discussion on April 23rd it was based on a compilation of insights and
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reflections from across our rural field sites – from Chikombedzi, Masvingo district, Gutu, Matobo and Mvurwi. It was a long and fascinating call, and this blog offers only some highlights.

Compared to when we first talked, there are now more recorded cases in Zimbabwe (currently 356), although no more deaths (still at four recorded). The country is in ‘indefinite’ lockdown, but in Level 2 mode, which allows some more flexibility. However, things remain tough for all those in our study areas. Below are some themes that emerged from the discussion:

RESTRICTED MOVEMENT

Movement restrictions are very strict. You have to get a permit to travel, and it can take days for these to be issued. The police are everywhere, and the army. They will stop you at roadblocks and turn you back if you don’t have the paperwork. It’s a real challenge as farmers need to get to town to sell things or buy inputs. It’s really impossible. Shops are now open longer, but if you cannot travel, what can you do? It’s even difficult to get to hospital or the clinic. Those with conditions like HIV/AIDS or TB are suffering as they are not getting the medicines on time. If there’s a complication with a pregnancy there’s nothing you can do. You have to rely on local herbalists and others. The same is for livestock – they are dying of diseases as we can’t travel to town to get the dip chemicals or treatments. Movement is essential for life. People will always find a way though. They have to in order to survive. We have had 20 or more years of practice of living under hardship, we are good at surviving, but things are really tough.

WE RELY ON THE TRUCKERS

For supplies, we now rely on the truckers. Traders are not allowed to go to South Africa anymore (although some sneak through unregulated border crossings), and the buses that used to bring things from down South are not moving. So the truckers who are allowed to move bring things. It’s illegal, but there is a well-established network these days. And those who used to buy and sell from South Africa have set up tuck-shops in the locations (high density suburbs in town) and in the rural areas, and things are supplied. You can buy agri-inputs, groceries, phone credit, and much more. But it’s expensive. They are buying in Rand, and the Zimbabwe dollar is fast losing strength. The black market rate is three times the official rate, so buying goods these days is seriously expensive.

REMITTANCES ARE NO LONGER COMING

People used to rely a lot on remittances. Either in kind – usually sent by bus from South Africa – or in cash – through transfer services like Mukuru,
World Remit or Western Union. But relatives outside the country – even in the UK – have lost their jobs. They no longer send remittances. This is a big problem as these funds used to pay for labour or for agricultural inputs, or for fees or groceries. It’s a big gap. For example, the tobacco harvest in Mvurwi is being delayed as there’s no money to pay for labour.

**WE ARE ALL VENDORS NOW**

To survive, everyone must become a vendor. It seems something is being sold from every house in the location, and even in the rural areas too. People stock some small things and sell. Some deal in groceries, others sell farm or garden produce (vegetables, peanut butter etc.), others do sewing and repairs, others sell clothes. There are so many shebeens (informal drinking places), and beer brewing is a massive business particularly in the locations. There are hair and beauty salons – all informal – in people’s houses, along with electrical repair shops, tailors – you name it, you can find it. It’s all illegal and the police can always close things down, so people wait until they knock off. It’s the evenings when there is so much activity. Some sell from their cars, as they can quickly move if the police come. Others use wheelbarrows, push carts, large dishes. Markets are everywhere, despite
the older ones being closed. The government has destroyed the old informal markets and is building new ones, but these are not complete, so people must improvise. Some have even started online trading, but this is only feasible in the towns, given the cost of (phone) bundles. The action is all in the locations, and farmers must link with relatives and others there. In town, some buildings are registered for trade, and people can then set up tables there, but they will pay the tax. The government doesn't like the informal traders and is trying to formalise everything. Although they are building new hygienic structures for people to trade from, much of this is just to control people and collect taxes. Right now, we need to live.

EVERYONE IS A GARDENER

Gardening is essential too. Every bit of ground near people’s houses is now a garden. It’s vital to stay alive, and with the markets closed it’s difficult to buy things. You have to grow your own. It’s good as people stay healthy, and some can also sell as part of vending from their homes. In an area you know who has what. Wider markets are coming back too, as schools, universities and other institutions begin to open. The demand is not as it was, but there is business to be done if you are a farmer or gardener.
RESTRICTIONS ON AGRICULTURAL MARKETS PERSIST

Moving produce to markets is difficult. The police will stop you, ask for permits. It’s a total hassle. So some farmers will move early in the morning, offloading produce in the locations where others sell. Others move in the evening and sell from their pick-up trucks. There’s always a way, even if it’s more difficult. For more formal marketing there are so many regulations. For example in Mvurwi, people can come together and sell at a single point to a company representative who comes to the area. A farmer representative can travel with the crop to the auction floors, but the selling is not transparent. You cannot see how it’s weighed and graded because of the coronavirus restrictions, so farmers are easily ripped off. This is disastrous as these days payments are only in part in forex, so you don’t get much for your crop. Alternatively, you can take your tobacco to the auction floors yourself if you’ve got a truck, but you may have to queue for days, and they will not let you on the floor because of the virus. So there is always cheating, and you get a bad deal. Marketing for farmers is a big challenge due to COVID-19.

IT’S BETTER IN THE RURAL AREAS

There is massive urban to rural migration right now. Many people in town are really suffering. They have lost jobs, there’s no food, rents are getting hiked and there is huge inflation on everything. Some say it’s 700 percent! Many have come home to the rural areas. This is particularly those who were relying on informal activities, including vendors, sex workers and other informal jobs in town. The rural areas are now full of those coming back to their rural homes. Here rent is free, and you can grow food, even if only a small garden. And relatives know them, and will help out. It’s a much better situation. Some are wondering if they will ever go back to town.

RETURNES FROM SOUTH AFRICA ARE FEARED AND STIGMATISED

There are thousands coming back from other countries – mostly from South Africa, but also other countries in the region, such as Botswana, Zambia, Mozambique, Tanzania and so on. And also from the UK, Australia, parts of Asia. There are so many. People are saying why did you leave if you come back when things are tough out there? They left because of Zimbabwe’s problems, but now they’re running away from hunger and disease in South Africa. The rise in reported cases has almost all been from returnees from South Africa and other countries. They have lost jobs and have no means of survival, as the ‘social protection’ measures in those places do not cover
migrants, especially if you don’t have the right papers. When they cross the border into Zimbabwe, they are supposed to be put in a quarantine centre, but some may escape. These places are not good, and if you don’t have the virus you might catch it there! People are complaining seriously about these centres, as they are not well run. If you escape the police can chase you, and now they are confiscating passports and ID cards. If you don’t have the virus after eight days you can be transferred to an isolation centre, which are better. Less like prison. You can even pay for something better, as hotels are being used. Or you are sometimes allowed to self-isolate at a rural home under the supervision of a kraalhead. Those returnees from South Africa are seen as diseased and dangerous in the villages. People run away from them. There is so much stigma and fear. Those who dodged the quarantine camps, perhaps coming over an illegal crossing, are sometimes smoked out by locals, and reported. People really fear the returnees. We see this unknown virus in them.

**COMMUNITY RELATIONS ARE GETTING STRAINED**

COVID-19 is really straining relations. Social gatherings are restricted, and you have to get a permit. You can have up to 50 people for a church service or a funeral for example. But people cannot travel far to weddings, funerals and so on, so families are not keeping in touch at these important moments. With returnees coming back, they may be hidden from others for fear of them being exposed. This is causing problems within villages, where everyone knows everyone. But there are ways of bringing people together too. There has been a big rise in savings clubs to assist with people buying groceries. People now realise that saving is important so as to cushion you from a shock like this that just comes from nowhere. There’s also been a growth of burial societies, as the main funeral companies are no longer working. So people do help each other out in the villages particularly, making the rural a better place to stay right now. There are also quite a few projects and forms of assistance, which seems to be more common in the rural areas. This can come from government – including the First Lady’s projects – or through churches, NGOs, even companies. But the lockdown is certainly causing many frustrations for sure. You can see this especially in the locations but also in the rural areas. People want to socialise; they want to go for a drink and meet people. So you see lots of people hanging around in the urban and rural townships, especially where there are illegal bottle stores and shebeens. Drugs are a problem too, and this is causing conflicts between people, and sometimes the outbreak of fights. The police will round people up, hand out fines, but people will not obey; they are frustrated with lockdown life.
SHARING INFORMATION AND COUNTERING FAKE NEWS

There’s so much fake news circulating about COVID-19, especially on social media, WhatsApp groups and so on. Some are now saying that after so many months it doesn’t kill Africans. Some say that there is a cure already found. Others argue that it is all a plot by foreigners. Some of us look at the international media and know that these things are not true, but gossip and rumour travel fast, and it’s amazing what people believe! The government is publishing official information. They’ve printed books in all 16 local languages, and they also use radio, TV and the state newspapers. There are phone and text messages from the government too. And they publish the data by province each day, so you can find out how things are changing. The rise in cases from returnees especially from South Africa is certainly worrying people and adding to the stigmatisation of those who come back. So yes people know it’s dangerous. They see it next door in South Africa. Relatives tell them how bad it is in the UK and Europe too. Although we haven’t seen deaths, we realise that controlling it is important, so overall people still back the government, as we don’t want it here like it is in South Africa.
POLITICAL TENSIONS

We hear that there are some in power who are benefiting from tenders due to COVID-19. We know the chefs are corrupt. There are others profiting too, but that’s not bad. For example, there are businesspeople who are making and selling PPE and sanitisers. There are lots of small COVID businesses around. Farmers are even buying this stuff, including face masks and sanitiser so they can move around and trade safely. Some shop owners are even buying temperature testing kits costing US$100 or more. Emergencies always provide opportunities for some. However, some of the police and security forces are taking advantage. There were rumours of mass mobilisation by the opposition recently, and then the road blocks became harsher. Some were targeted, and there was reportedly some violence in some places. We heard the news of the shocking attacks on MDC people too. We don’t know how bad things are elsewhere, as where we stay in the rural areas there is less conflict. This seems to be in Harare and places like that. But we can see the tensions and we see the results in the movement restrictions and the massive presence of security people everywhere. But the police were more heavy-handed in the earlier lockdown period, and it’s eased a bit now, although if you are found in the wrong place at the wrong time, you will be in big trouble. It is lockdown with force, but people must violate the rules because they are starving. They see the rationale for the lockdown, but they just cannot always comply.

1 https://zimbabweland.wordpress.com/2020/04/27/2991/
COVID-19 has taken hold in Zimbabwe with a significant growth in community transmission observed in the past weeks. On July 24th, the total reported cases were 2296, with 32 deaths. This is likely the tip of a much bigger iceberg given under-reporting and limiting testing. President Mnangagwa has re-imposed a strict lockdown in response, including a dawn to dusk curfew, further limits on movements and restrictions on transport and business.

The relative easing of COVID-19 measures over the past weeks was clearly premature given the huge flow of infections from South Africa via
returnees coming home. In the last blog on the pandemic in Zimbabwe we discussed this mass migration of those who had lost their jobs or had become ill in what is now one of the major foci of COVID-19 in the world. Zimbabwe’s close proximity to South Africa is proving highly risky.

This is the third update from our field sites across the country, each focusing on how COVID-19 is affecting rural areas (see previous blogs here from 27 April and here from 15 June). Reports from all sites were relayed to me in a long phone conversation over the weekend. As the effects of lockdown have combined with an already deteriorating economy, the situation in Zimbabwe is bad. To survive people are resorting to a range of informal and sometimes illegal activities. The common view is that it’s better to risk COVID-19 in the future than die of hunger now.

**THE SMUGGLING ECONOMY**

Our colleagues in Mwenezi, Chiredzi and Matabeleland South in particular highlighted the massive growth in smuggling of goods, cash and people across the border from South Africa, and the implications for the spread of the virus. With restrictions on border crossing and the banning of private transport, the demand for goods has heightened and with this there have been massive hikes in prices.

A widespread network of smugglers, sometimes with the direct involvement of security forces and customs officials on both sides of the border, has emerged. Links are made to shop owners in Musina in South Africa who transport goods to the border and link up with traders and transporters who move them throughout Zimbabwe. Paying off officials adds to the cost, but the result is that a range of goods – groceries, clothes, agri-chemicals and more – are supplied throughout Zimbabwe.

With some shops closed and others operating with shorter business hours and less stock, suppliers sell on to mobile shops that move around rural areas and locations/townships in urban areas. Much activity happens at night to avoid the authorities who restrict vending or may impose arbitrary fines. These are elaborate value chains, with many connections, and with people at every stage demanding a cut. The consumer inevitably suffers as prices go up and up, inflated further by the collapsing value of the local currency. Government and local councils also lose out as the taxes, customs duties and rates that are normally paid are lost. This huge trade is largely illegal, and many cross at secret points in the highly porous border.

This massive informalisation of the economy extends to how the supply of cash is dealt with. In the past, remittances from relatives in South Africa and elsewhere were usually paid through standard agents – like Mukuru,
Western Union and so on – based in towns and cities. While still mostly operating, they no longer can be reached by many due to restrictions on access to town centres. This has become worse with the limitation of opening hours for businesses and the recent curfew.

This means that the lifeline of remittance cash in the absence of jobs has to be sought through new routes. Here the traders who illegally transport goods across the border also assist. Zimbabweans with South African bank accounts can receive and then withdraw large amounts of cash and send it via traders, lorry drivers and others to relatives on the other side of the border. Those moving the cash take a proportion for the service – up to 30% – but ensure that relatives’ money reaches their kin in Zimbabwe to keep them alive.

**MASS MIGRATIONS OF PEOPLE AND VIRUSES**

The movement of people from South Africa (as well as the UK, Botswana and other neighbouring countries) resulted in the establishment of the virus in Zimbabwe. A month back nearly all cases were imported, but now community transmission exceeds these in the reported statistics. The migration of people with the virus across a region that has long relied on labour migration is one of the major stories of the pandemic in southern Africa.

When the pandemic first struck, the South African government built a massive (and very expensive) new fence along the border with Zimbabwe,6 notionally aimed at stopping Zimbabweans flooding into South Africa as the economy collapsed further, and so spreading the virus. But it was movement in the other direction that has driven the pandemic, with many Zimbabweans in South Africa losing jobs and fleeing poverty to be with their families back home. Excluded from social security measures, the migrant populations in South Africa not only suffer xenophobic attacks but now viral infection.7

Those who return with the virus are often smuggled across the border with goods in lorries and trucks, hiding from the authorities. Illegal crossings are used to dodge the requirements to go to quarantine centres that have become notorious places, rumoured to spread disease through unsanitary conditions. Alongside normal returnees have been criminals who have been deported back to Zimbabwe, often returning to crime in the process. Returnees who arrive back in rural villages across Zimbabwe are often hidden from authorities and neighbours, and are sometimes protected by local officials and traditional leaders if well connected. It is no surprise that the pandemic has established itself in Zimbabwe.
VOLATILE MARKETS: CHALLENGES FOR AGRICULTURAL PRODUCERS

As discussed in previous blogs, agricultural producers have been hit hard by the pandemic, notably through the restriction of movement and constrained access to markets. As the economy continues to implode, demand also drops. The horticultural producers from our research sites that surround Masvingo for example have cut their production by 40% and shifted to local drying and processing of vegetables as contracts with supermarkets and other traders have ceased. This has affected all household economies, as especially in the dry season (which it is now) income from horticultural production is vital.

Farmers are much better off than their counterparts living in the town, however. As our team reports, in all parts of the country those without land and some form of agricultural production are suffering badly. Hunger is really stalking the townships in all parts of the country. Farmers who have reduced production have had to diversify livelihood activities, switching to trading in particular; as our colleagues point out, nearly every household has someone trading in the informal COVID economy.

Due to the loss of value of the Zimbabwe dollar, now trading against the US dollar on the black market at over Z$120 per US dollar, many have adopted
barter trade arrangements, informalising exchange yet further. This operates across international borders as well as within the country.

In rural areas, for example, farmers exchange grain, groundnuts, nyimo and other products for groceries supplied by mobile traders. In the sugar-growing areas, workers for the estates or A2 farmers who are able to buy 20kg of sugar per month at a reduced rate as part of their employment package, trade this for a range of goods. Sugar is an especially valuable currency as it holds its value well and is in constant demand. For farmers, agricultural products are fast replacing cash as a medium for exchange in the informalised COVID economy.

It is tobacco marketing season in our site in Mvurwi at the moment, and this is a rare focus of vibrant economic activity. Mvurwi town is a hive of activity with five auction floors now competing for trade. Payments are made half in US dollars and half in local currency, and although not as profitable as in the past, the tobacco sales are providing much-needed income in the area. However, as our colleague in Mvurwi notes, the crowded scenes in the marketing areas and in the transport hubs do not result in public health compliance. Tobacco marketing, like the increasingly large church gatherings and major funerals,⁹ are feared as foci for infection. The police intervene and occasionally arrest people (sometimes in large numbers) for
contraventions, but the next day things look much the same. Maintaining public health while continuing with economic activity is a tough balance.

**PANDEMIC POLITICS IN A FAILING STATE**

**Zimbabwe** in many respects has followed the WHO global recommendations on COVID-19 very assiduously. Interventions were early, movements have been restricted, masks are compulsory in public places and on transport, advice is to wash hands regularly and stay at home and so on. But these regulations just cannot work when people are starving, in desperate need of income. They cannot work either when the health services on which such measures rely are woefully inadequate or when health workers are hugely underpaid. Today nurses are on strike demanding better conditions, and in hospitals it is trainee nurses who are on the frontline, many now contracting the virus.

Without a functioning state that can provide security – through safety nets and support for livelihoods – and pay health workers and guarantee their safety, public health measures are quickly abandoned. Add to this the growing distrust of the state, and the likelihood of people following government edicts declines yet further.

At the beginning of the outbreak, when it seemed that this was a problem for others elsewhere, there was a sense of joint commitment: coming together to address something threatening and unknown. With the virus spreading fast and with the lockdown measures having decimated livelihoods this collective sense of purpose has gone.

Our colleagues report that, across the country, opportunistic crime has risen, along with gender-based violence. In all our sites, there is a palpable sense of frustration and tension; a sense of being left alone, abandoned by the state.

Trust in authority has been undermined too, and this has been massively exacerbated by the way the government and ruling party have acted. The scandal over corrupt procurement of PPE and other COVID-related materials that saw the Health Minister fired, charged (and then given bail) has enraged many. The heavy-handed tactics of the security forces – both the army and police – has generated resentments, as the informal trade that is the Zimbabwean economy has to pay off security officials at every turn, with bribes just adding to costs of an already expensive life. That the state is clamping down on opposition activists and journalists who are exposing corruption and restricting protests against the state is just further justification for a growing disquiet.
Rather than the sense of national collective effort in the face of crisis, it seems that everyone is on their own in the struggle to survive the virus.

**WHAT NEXT?**

The next weeks will be crucial ones in Zimbabwe. Will the virus continue to spread resulting in the scale of death and suffering now being seen in South Africa? Or will the measures being imposed now contain it? Will the resentments that have built up over the failure of the state – alongside scandals of corruption – result in strikes and protests that some have called for? Or will most Zimbabweans just continue to suffer; just about surviving and innovating continuously in response to the fast-changing economic, political and epidemiological conditions?
Reflections on COVID-19 in Rural Zimbabwe

2 https://twitter.com/edmnangagwa/status/1285955119620730881?s=12
5 https://zimbabweland.wordpress.com/2020/03/02/zimbabwes-economy-goes-from-bad-to-worse/
9 https://www.herald.co.zw/police-disperse-5-000-sect-members/
10 https://www.bbc.co.uk/news/world-africa-53462259
11 https://www.newsday.co.zw/2020/07/200-nurses-doctors-contract-covid-19/
14 https://twitter.com/unhumanrights/status/1286610858026598401?s=12
SEPTEMBER 7 2020

INNOVATION IN THE PANDEMIC: AN UPDATE FROM ZIMBABWE

The latest long discussion on responses to COVID-19 in our rural study areas across the country took place on 5 September. Check out the earlier updates from 27 July, 15 June and 27 April. The pandemic continues to take a hold in Zimbabwe, and the case numbers are rising (total 6837 reported cases and 206 deaths on September 4), although the rapidity and extent of spread is not as feared – so far at least. As one of my colleagues put it, “we are still the survivors of COVID-19”. That said, the impact of the lockdown measures is far-reaching, but since it’s now gone on for so long, people are
(by necessity) adapting, and finding new ways of responding. What was striking about this conversation was the array of innovations happening.

**RURAL AND URBAN CONNECTIONS**

The relationship between town and countryside has been transformed by the lockdown measures. In the past there were frequent visits between rural and urban homes, with people being able to respond immediately to a crisis or just go and visit for a weekend. Now movement requires an exemption letter issued by the police. “You very frequently have to lie”, one of our colleagues noted, “saying you have a sick relative or that there is a funeral; otherwise permission is not granted”. The comedian VaMayaya captured it well in a recent video.¹ The inconvenience and hassle is evident, as villagers try and bluff their way past the police officer.

The restrictions have a big impact when flows of agricultural labour are curtailed. For example, in our sugar-growing site in Hippo Valley, it’s cane cutting season and usually migrant labourers come for short periods, but this year they either haven’t come or they are failing to get back home, causing tensions and family disputes. The lack of labour is also pushing up hiring costs for producers and the resettled farmers are now competing with the estate. Fortunately more resettlement A2 farmers are on their farms these days, especially since lockdown, as the management of labour is increasingly demanding.

**THE IMPORTANCE OF ‘HOME’**

There are large numbers of people who have moved from towns in Zimbabwe back to their rural homes. Some have been away for years and have to find new places to stay. But town has become difficult to live in – there are few jobs and many have lost them since lockdown, prices are high, rents are prohibitive and the lockdown restrictions are harsh. Many are finding sourcing food difficult. Drivers, company workers, civil servants, vendors, sex workers and others who have lost the means to make a livelihood have moved in droves to the rural areas. In all our sites, the population of villages has expanded massively. Added to these local migrations, there are those who have come from abroad, as we have commented on before. ‘Home’ in the rural areas is the social safety net that the state is unable to provide.

Those coming back have to make a living of course, and there has been an expansion of agricultural projects (poultry, horticulture etc.) as well as other farming activities, as land has been subdivided by relatives. In our Mvurwi site some of the returnees have signed up for tobacco contracts for
the coming season, acquiring grower numbers through relatives. Teachers no longer working in schools have set up private tuition arrangements in their homes, while mechanics and others are providing services once offered in urban areas. Vending has exploded, as former civil servants and others try and raise money through new businesses and, in some areas such as Matobo and Mvurwi, small-scale artisanal mining provides sources of income for those who once populated offices and factories in town.

**FOOD FLOWS**

The last few seasons have been poor in Zimbabwe and there are many areas this year in food deficit. Getting food to the right place when movement is restricted is a challenge. Responding to this has been a massive growth in private transport networks that facilitate the flow of food. There are food relief efforts by government and NGOs, but this is far
more significant overall. Relatives with surplus in A1 resettlement farms will often take food to their kin in town in cars, where food is expensive and scarce. Those with significant volumes will sell on maize to traders who will take it to sell to traders in town markets. In local areas where there are patchy food deficits, people must scout around to check out which areas have food so links can be made, and food moved. It’s not like the past when people were always moving; in the COVID time people must actively seek out food and organise to get hold of it.

Some food is transported in larger quantities, with large 20 tonne trucks moving from Gokwe and northern Zimbabwe, for example, where food is plentiful to markets in the south of the country. The larger operations are well capitalised and organised, with ways of dealing with the movement restrictions through connections and payment to officials. Some operators control the whole supply chain, and move food to stores in urban areas where grinding mills are installed and direct sales organised. Other, more informal arrangements must deal with permits and road blocks, often having to pay off the police. Just as with the transport of groceries on trucks from South Africa discussed in an earlier blog, even though there are challenges, food does get through.
Despite the restrictions, the movement back-and-forth between town and the rural areas continues, and is essential for assuring food security and providing much needed goods. Much exchange is in the form of barter, as groceries (cooking oil, sugar, rice) and clothes are brought by people from town are exchanged with maize and other crops. Urban markets for food and other agricultural products are complemented by a huge growth of urban farming and gardening. As noted in a previous blog, nearly everyone is a gardener now.4

Within rural areas such as our food insecure sites in the lowveld and Matabeleland South, some can exchange dried mopane worms, for example, with those who have grain nearby. It as a mostly informal system but complemented increasingly by larger operations. It is far more effective than the cumbersome and politicised food relief systems of government, UN agencies and NGOs. As ever with food supply, even in a drought year like now, it’s about timely supply and access rather than overall availability, as is too often assumed in the ‘food crisis’ narratives about Zimbabwe.

**LOCALISING VALUE CHAINS: CARS ARE THE NEW MINI-MARKETS**

Our team has been visiting local shops and supermarkets from Chikombedzi to Masvingo, Mvurwi and Kezi-Maphisa, and a common pattern is emerging. Retailers are increasingly sourcing locally. They complain that volumes are insufficient, quality is variable and the range of products is limited, but with restrictions on supply, including from South Africa, supermarket buyers are making use of local production. This is good
news for horticulture, poultry and other suppliers in the rural areas who are receiving a COVID-19 dividend, despite the other travails.

This applies to other shops too. As stock cannot be sourced, local suppliers are turned to. The trend of South African ‘supermarketisation’ is being reversed due to an informal import substitution policy enforced by a virus. Of course, not all products can be substituted and there are shortages of key elements for manufacturing processes. This is having knock-on effects for example in feed supplies, fertiliser manufacture, herbicide provision and spare parts of different sorts. This has definitely having a negative impact on farmers, as prices hike with increasing scarcity.

Shops in town are shifting their focus too. One hardware store in Masvingo, for example, was failing to stock goods and applied for a grocery trading license and is now shifted to supplying locally sourced groceries. But commerce is now not just through shops, as their opening hours are restricted by lockdown measures. The provision of groceries, grain, vegetables and a whole host of products is increasingly being done by local, mobile traders, frequently operating out of their own cars.

Mrs V. lives in Mucheke, a high-density suburb in Masvingo, she formerly has a stand at the KuTrain market in town. But this was closed for renovation due to lockdown and she instead took up trading from her car. “I don’t dream of going back to the kuTrain market”, she says, “I start at 3pm when shops are closing down and park at strategic points in the location and sell until the evening. It’s good business. I source products from local...
farmers, including those who have plots near Great Zimbabwe, and get groceries from truckers who come from South Africa”. Cars are the new ‘mini-markets’ and business is booming. All this is restructuring the economy towards more localised value chains that a greater diversity of people can benefit from, including farmers.

**WORKING FROM HOME**

Many formal places of work have closed and to make a living people must now work from home. It’s impossible to travel to work due to movement restrictions and those who are self-employed have shut up shop as rents and rates are high. Moving businesses to home during lockdown made total sense, and they are thriving. There are welding operations happening in living rooms, tailoring businesses in garages, bakeries in people’s kitchens, beer brewing in yards... along with hair salons, photocopy/printing businesses, brick-making and so on. The list is endless.

Working from home takes on a different meaning in Zimbabwe, whether in the townships or in the rural areas. Of course much of this activity is illegal, flouting health and safety rules and avoiding taxes, but as one person running a home business argued, “What can I do? I have to survive! We are learning new skills for survival!”
FINANCE IN THE COVID ECONOMY

With Zimbabwe’s economy in a mess, and currency swings a daily occurrence, navigating finance in business and agriculture is a challenge. The new Reserve Bank auction system, and the control measures that have limited exchanges, agents and cash withdrawals has, it seems, brought some more stability of late. The official and parallel exchange rate is now closer, and the queues at shops, fuel stations and so on have reduced, as the opportunity for hoarding and speculation, and gaming the system has reduced. More commodities are now available in large part due to the new supply systems that have evolved in recent months. Instead, as one of my colleagues observed, “the queues you see today are waiting for sanitiser and temperature checks at shops”.

With inflation high and the local currency weak, the economy has by default re-dollarised, but the underlying fragility remains. All this is good for producers and consumers, but not everyone. Our team interviewed a money changer in Mvurwi, once a sight on every street corner: “I used to make US$500 per month, but now I am lucky to get US$80. I used to enjoy good living, drinking every day. Now it’s tough”. As our colleague put it, “rather than see the well-known money changers in the bars braaing meat, they now go home with a bundle of vegetables like everyone else!”

ALTERNATIVE HEALTH SYSTEMS

With the near-collapse of the Zimbabwean public health system, and a series of rolling strikes by nurses and doctors who are poorly paid and badly treated, people are more and more reliant on alternative sources of health provision.

Sometimes this is through the family, with particular family members having knowledge about herbal remedies. There is a huge demand for particular herbs, tree roots as well as onions, ginger and lemons, which are seen as important in remedies. Not all of this is directed to COVID-19, but people are very aware of the need to boost immunity, stay healthy and have remedies at hand in case the virus strikes. Those supplying herbs or other agricultural products used as treatments have been experiencing a roaring trade in recent months.

The same is the case for prophets and other religious figures offering spiritual healing of different sorts, through banishing evil spirits and other causes of ailment. Large gatherings led by prophets from a variety of churches have attracted the attention of the authorities and some have been dispersed by the police. These days most are more organised, with
effective distancing and requirements to wear masks. COVID-19 has
definitely boosted the popularity of particular prophets across our study
sites, who now have big followings.

Professional herbalists have also become massively popular. These range
from the informal n'anga living in the village to Chinese/Indian herbalists to
those African, traditional herbalists who have surgeries and clinics that
spread between Zimbabwe, South Africa, Mozambique and Malawi. One
such surgery is in Masvingo. One of the herbalists explained: “We have
300-400 customers a day, and sell herbs as far afield as the UK. There is
huge demand. The clinics and hospitals don’t look after their patients, but
we can – whether you are young or old. We can visit people at home or they
come here. For COVID you must build strength to fight it and our herbs
really can help”.

As elsewhere in the world, Zimbabwe’s pandemic experience continues to
evolve, reflecting the very particular context of the country. Innovation,
adaptation and learning to cope with a fast-changing, challenging setting
are all important. We continue to monitor the situation across our sites
from all corners of the country, so look out for another update

1 https://m.youtube.com/watch?v=e3pFQe8yLNs
2 https://zimbabwelaland.wordpress.com/2019/12/09/why-is-there-food-
insecurity-in-zimbabwe/
3 https://zimbabwelaland.wordpress.com/2020/06/15/life-under-covid-19-
lockdown-in-zimbabwe-we-are-good-at-surviving-but-things-are-really-
tough/
4 https://zimbabwelaland.wordpress.com/2020/06/15/life-under-covid-19-
lockdown-in-zimbabwe-we-are-good-at-surviving-but-things-are-really-
tough/
“Know your epidemic, act on its politics” was a lesson learned in the HIV/AIDS pandemic. As Alex De Waal argued back in March, it’s just as important for COVID-19. The pandemic is playing out in very different ways in different places, yet the public health responses tend to be standardised and not adapted to context. What needs to be understood are both local responses and their politics.

Since the end of March (when the lockdown was first imposed in Zimbabwe), we have been tracking the coronavirus pandemic’s impact on diverse rural areas and linked small towns across the country (see our first blog (Surviving COVID-19 in a fragile state: why social resilience is essential) for early reflections from March 27. Since then, and based on reports from colleagues from Chikombedi in Mwenezi district; Matobo district in Matabeleland; Masvingo and Gutu districts and from Mvorwi in Mashonaland Central, we have produced so far four extended blogs based on compilations of field reports. Through some reflections on the past four blogs (links included below), this piece asks how can we get to ‘know the epidemic’ in Zimbabwe, exploring the implications for the response and wider politics?

APRIL 27 (COVID-19 LOCKDOWN IN ZIMBABWE: A DISASTER FOR FARMERS)¹

Three weeks into the lockdown and the effects on rural livelihoods were already being felt. Movement restrictions and the closing of markets were causing havoc. A heavy-handed response was being led by the police who ‘were everywhere’, stopping people moving. Rumours abounded about the origins of the virus and who it was affecting, and people feared going to
health centres. The fear was tangible and the unknown nature of the virus (compared to say HIV) was causing major anxiety. Many had seen on the TV or heard about from relatives the devastating consequences elsewhere, including in the UK and South Africa. The expectation was that this was going to happen in Zimbabwe, in a situation with far fewer resources and an extremely under-resourced health service. The fear galvanised a collective response, and at this stage collaboration between people, the state, churches and others was growing. There was a sense that this was something that had to be addressed together, and for Zimbabwe there was an unusual politics of unity and collaboration.

**JUNE 15 (COVID-19 LOCKDOWN IN ZIMBABWE: ‘WE ARE GOOD AT SURVIVING, BUT THINGS ARE REALLY TOUGH’)**

By mid-June the lockdown had been in place for about 10 weeks, and people were having to find ways to cope. Things were getting very difficult and consumer products and even food was scarce. By this stage transport of imported goods from South Africa was being facilitated (mostly illegally) by truckers. Traders of all sorts had emerged to supply both rural areas and townships; as someone put it, “we are all vendors now”. Agricultural
production had spread – “everyone is a gardener” – including in town. Avoiding reliance on wider value chains had become essential and production, trade and consumption links were increasingly localised across our study sites. With the drying up of remittance flows (as diaspora populations were also affected by COVID-19 job losses and economic contraction), a sense of self-reliance emerged. The large number or returnees from South Africa (who had lost jobs and had been denied social assistance) was by this stage putting a strain on local communities. They also brought the virus and it was from this stage that cases were not just imports from outside but began to be based on local community transmission, although still at a very low rate. Community tensions rose in this period, as concerns over livelihoods and infection increased, with new arrivals from South Africa often shunned and stigmatised. Political scandals around procurement of PPE and equipment reinforced the sense that people were on their own.

**JULY 27 (VIRAL POLITICS AND ECONOMICS IN ZIMBABWE)**

By the end of July, the informal economy – including a substantial growth of smuggling – had expanded further to provide alternatives. A new economy had emerged in order for people to survive. While really tough, people had begun to find ways around restrictions. In this period there had been an growth of movement of people – first back from South Africa and neighbouring countries as people lost their jobs and had no other forms of support, and then from urban areas within Zimbabwe back to the rural areas. The extreme challenges of living in town had hit hard and many felt that the only way to survive was to go ‘home’ to the rural areas, where at least there were family members to offer support, and the opportunity of a small plot of land to do gardening. This pattern continued through August into September, likely resulting in a massive flow of people (and viruses). Meanwhile, the wider political context shifted. With the prospects of opposition protests scheduled for the end of the month, the state and security forces were clamping down, using the COVID-19 regulations to restrict movements and gatherings. Some high-profile arrests had changed the political mood. While at the beginning of the pandemic, everyone was pulling together and the joint COVID committees involved all political parties, the churches, businesses and others, tensions were rising.
The most recent update again showed a shift in responses. The restrictions had relaxed a bit and the political tensions had eased somewhat. Although lockdowns were still being imposed along with movement restrictions, the way local economies had adapted over the previous months had meant that new supply chains had emerged. The shift from formal to informal marketing was complete and mobile shops from cars had become the dominant approach to retail selling. By this stage, people had given up on expectations that the state was going to provide, and many had turned to traditional healers, herbalists and prophets offering health care and support. While cases had not expanded massively, the threat of COVID-19 remained real, but new ways of coping had to be found. The failure of state provision, combined with the series of corruption scandals allegedly linked to those at the top, fed into a disappointment with political leadership and process. People were again on their own having to cope with the virus – and in particular the harsh lockdown measures that had been imposed. Many argued that it was not the virus that was killing them but the lockdown. There were of course always ways around the restrictions as life had to go on, whether involving selling things at night, moving through new routes or paying off police or security forces at road blocks. A sense of disconnection and disillusionment reigned, with a feeling that no-one else – and particularly the state – cared. This has generated a spirit of innovation
however, as people have found new ways to get products to market, provide goods and get round the restrictions.

The COVID-19 pandemic – and in particular the lockdown control measures – has resulted in changing economic responses, huge transformations of market arrangements and value chains, there have been large movements of people, and with the rapid expansion of informal economic activity there has been innovation on all fronts. At the same time, politics has shifted from a politics of collaboration to a politics of conflict and dissent to a politics of disillusionment. With the economic struggles for livelihoods deeply entwined with politics, we can expect further changes as the pandemic unfolds. We are continuing our informal monitoring – getting to ‘know the epidemic’ – across the sites, so look out for further updates in the coming weeks.

1 https://zimbabweland.wordpress.com/2020/04/27/2991/
I had another catch-up with colleagues in Zimbabwe recently, reflecting on the COVID-19 situation and its consequences across our sites in Masvingo, Gutu, Mwenezi, Matobo and Mvurwi. This is now the fifth update since March/April (see summary so far here). The pandemic has not proceeded as some feared in Zimbabwe, and recorded case numbers (at 8471 on November 6) and deaths (at 250) are
still low. There is much speculation about how and why the pandemic took a different course across Africa, and in future blogs we will explore some of these hypotheses in relation to the Zimbabwe setting.

As colleagues mentioned during the call, “We really don’t know any cases where we live, even in the hospitals and clinics. We don’t see people sick with the virus so far”. What is feared is the return of migrants from South Africa plus visitors from Europe and the UK during the holiday season. “We hope the government will be strict. There are requirements for test certificates, but you know they can always be cheated.” The importance of flows of people from outside the country is certainly central to the COVID-19 story in Zimbabwe, as we have discussed in previous blogs.

Zimbabwe is still under partial lockdown, with road blocks and movement restrictions in place, even though curfews and business opening hour regulations have been relaxed. The police are very present, and particularly engaged in checking permits especially of cross-border traffic in towns like Masvingo. With the weather being very hot last week before the rains, it was commented that “many had given up wearing masks, and relied on the heat as a ‘natural sanitiser’”. As one colleague observed, “It’s difficult to continue protecting ourselves when we don’t see the impacts of the virus”.

DIVERSIFIED LIVELIHOODS

This blog focuses on the situation in the period since the last update on September 27, with a particular focus on the livelihood impacts of lockdown on women and young people. The standard approaches to raising funds to support families by women and young people have been insufficient, as COVID-19 restrictions have hit hard. Diversification beyond agriculture is key, offering new livelihood options. Below are some examples of occupations taken up during the pandemic in our sites, especially by women and young people, to support their livelihoods.

FRUIT AND VEG

Diversification of livelihoods has been vital, since traditional occupations for women and young people have been constrained during lockdown. For example, while vending remains important for women, cross-border trade that used to be a mainstay in the border areas such as Mwenezi and Matobo is no longer feasible. Some have diversified, so for example dry season sales of wild fruits has expanded along the roads near Gutu, as women and children harvest *matamba* and *mushuku*, both selling for a US dollar for a handful of fruit.
Similarly, gardening continues as a vital source of self-provisioning with major nutritional benefits. As we have reported before, nearly everyone is a gardener now, whether in town or the rural areas, although women and youth are the dominant gardeners it seems. However, the expansion of gardening, combined with restrictions on market (again discussed in earlier blogs) has resulted in local gluts, particularly during the recent dry season – which is the traditional focus for gardening activities. The result is that women in particular have had to innovate, and develop new ways of processing and storing vegetables and fruits to sustain income over a longer period across seasons, and through variable market conditions.

**GOLD AND AMETHYST**

Small-scale mining is an essential activity for young people, mostly men. However, over the past few months a surprising development has been the movement of women into mining activities. Our colleague in Matobo reckons perhaps a fifth of miners are now women. While the mining claim owners of course are by-and-large well-connected older men, who manage the claim through a system of sharing with a group of contractors, women and young people join syndicates and provide labour. Most mining is of gold and in these cases half is shared with the owner, while the rest is divided amongst the group who did the mining.

Gold mining has expanded massively in all sites, including a recent huge expansion around Masvingo town. One young man, RB, relayed his story:

> I had been a driver for three years, but I lost my job because of lockdown. The transport businesses just collapsed. My wife and kids went back to the rural home as I could not support them in town. But in the last six months I have started mining outside town. I work with a group of five and we share the ore, milling it locally. If you work hard you can earn US$1400 per month, even when giving half to the claim owner. I have bought a car and I have plans to buy a stand. My family came back two weeks ago and are with me now. Life is now good!

In Chikombedzi area in Mwenezi there has been a massive rush to mining sites where purple amethyst deposits have been found. Around a thousand people are living there, with markets developing for food, as well as services including transport, machinery hire and sex work. With amethyst quartz rocks being sold for about R1800 per kg, it has become a lucrative business.
BRICK-MAKING AND BUILDING

With the flood of migrants coming back from South Africa and neighbouring countries, as well as from urban areas across Zimbabwe, during the pandemic due to the loss of jobs, the demand for building in the rural areas has sky-rocketed. These dispersed COVID-19 ‘refugees’ have returned home, but need somewhere to live. This, in turn, has generated a big demand for local ‘farm bricks’, which are cured and sold on to builders. In Wondedzo, a thousand bricks were being sold for around US$25. Brick-making has become an important source of income during this past dry season for both women and youth, who take on different roles between digging, moulding and firing in kilns, with each kiln producing 5-10,000 bricks each time.

CHICKENS AND PIGS

Poultry is another area where women and youth have invested considerably in recent months as there has been a growth in demand for local supplies of poultry. In part this is because of the closure of butcheries and the difficulty of getting to town, and in part because local sources of meat have been hit hard by the mass mortalities of cattle due to ‘January disease’ during the past wet season. The abattoirs are also closed too; indeed one
near Masvingo has been converted into a gold milling plant reflecting the switch in livelihood activities.

Mrs C. based in Masvingo explains how she moved from having under 30 chickens to over 300:

I am a teacher, but my salary doesn’t pay. My husband who used to work on cross-border buses also lost his job due to COVID. I decided to expand my flock, buying up ‘road-runner’ indigenous chickens. I now have three breeds, two from a supplier of day-old chicks in Bulawayo and one from Mr M who supplies from a nearby growth point. I buy these for between 55 and 80 US cents per chick, along with some feed. These breeds though don’t need expensive feed and medicine, so I don’t have to go to town. I now make US$200 per month and am planning to expand further. I have already started a small piggery project to complement. I am thinking of quitting teaching, as this really pays.
BREAD AND BUNS

With access to town restricted and movement difficult, baking has become another big cottage industry in rural areas and urban locations, and an important income source for women. In Chatsworth in Gutu for example a government training course encouraged women to take this up, and baking at home of bread and buns has expanded massively since. Across our sites you can buy bread, buns and cakes from people’s homes, as local people have taken on the supply.

PIECE-WORK EMPLOYMENT

While conventional jobs are scarce, there have been other sources of employment emerging, even in the dry season when agricultural piece-work options are generally limited. In particular, hiring of labour for digging holes for the Pfumvudza programme (a major government-led initiative with donor support on conservation agriculture – watch out for blogs on the experience of this in the coming weeks) has become important in all our sites.6

Young people in particular have been able to benefit, with digging pits in one plot (39m x 16m) being charged at between US$5 at US$20 depending on the soil type and location, with payment in cash or kind (mostly soap and sugar). It is young men in particular who are benefiting from this, as older people often prefer to pay for the labour in order to get the free seeds and fertilisers.

MONEY MATTERS

Saving and circulating money is a big challenges, as access to towns has reduced. There has therefore been a big growth in various forms of ‘savings clubs’ in the past months across all sites, which particularly involve women. For example in Wondedzo area near Masvingo, 20 women pooled cash and members draw funds to finance projects, paying interest on the amount of around 20%. In Masvingo town meanwhile there are lots of such clubs, some church-based, some just amongst a group of individuals. One group involves six female civil servants, mostly teachers, who save 150 Rand every two weeks, and one member takes out the full amount each fortnight to fund activities.

Money for new activities is crucial; without employment and with banks closed or difficult to get to from rural areas or townships, then new forms of managing money becomes important. New regulations that restrict the amount of phone lines for mobile ecocash money transactions and the electronic transfer tax also dissuades people from using electronic means.
Instead very localised systems for saving and circulating cash – all in foreign exchange, either Rands or US dollars depending on the location – is the alternative.

And it’s women in particular who are the key players in this new savings and credit economy, as they in particular need funds for new projects to enhance their livelihoods.

**LOCKDOWN CHALLENGES**

As we have discussed in earlier blogs, lockdown has not all been plain-sailing. Not everyone is able to innovate, earn money and do better than before, as with RM the young miner and Mrs C the poultry producer introduced above.

Our colleagues report in particular the many tensions that have arisen within families. With relatives coming back from South Africa and elsewhere they have to be accommodated and supported. Extra mouths to feed and people to house in a time a crisis. While the COVID-19 migrant-return situation has not been widely reported, as people have dispersed to multiple homes across many locations, the absorption of many thousands of people into a poor, local, mostly rural economy has had a big impact economically and socially.
Those returning, used to working in big cities south of the Limpopo may not be happy with a new rural existence, something they escaped before. Among (mostly male) youth, both returnees and local residents, our colleagues reported a rise in drug taking, drinking and general depression. This has led to arguments and sometimes violence. A rise in pregnancies among young women and teenage marriages have also been reported. Boredom and lack of opportunity, along with an inability to travel, even move to the local town, play into a negative, potentially destructive, social dynamic affecting many young people.

Not all migrants have been able to return, however, and some have been trapped in South Africa, unable to move. In our study areas near the borders – Matobo and Mwenezi – in the past men would move back and forth between often temporary jobs in farms and mines in South Africa, or to Mozambique or Botswana. Today this flexible movement is no longer feasible. Men are locked in South Africa in particular, while women are locked down at home. Adulterous affairs among both men and women have expanded, resulting in arguments, occasional violence and many reported divorces.

**UNLOCKING OPPORTUNITIES DURING LOCKDOWN**

Despite the very clear lockdown challenges, the pattern seen across sites is one of innovative survival, and sometimes more. As one informant from Masvingo explained: “Lockdown has unlocked the entrepreneurial spirit! We can now earn good cash. I am not looking back!”

The transformations precipitated by COVID-19 lockdown have therefore not all been negative. As people have innovated to survive, new options have emerged, focused on new markets – whether building for returning migrants, supplying chickens or vegetables in the rural areas. With a shift to local production, short market/value chains and extending the range of activities – from mining to baking – the rural economy, and its connections to urban areas, has shifted significantly over the past seven months.

There is therefore a new COVID economy – and with this new social relations, with both opportunities and challenges. We will keep an eye on these developments over the coming months as the dry season moves (hopefully) into a rainy agricultural season, exploring whether these changes are temporary – a response to a crisis – or more long-term, shifting the terms, roles and incentives in economic activities over time, with new opportunities, especially for women and young people.
4 https://zimbabweland.wordpress.com/2014/01/27/zimbabwes-gold-rush-livelihoods-for-the-poor-or-a-patronage-economy-or-both/
6 https://www.herald.co.zw/new-farming-concept-unveiled/
CAN ZIMBABWE SURVIVE A SECOND WAVE OF COVID-19?

On January 2nd, Vice-President and Minister of Health, Constantino Chiwenga, announced another strict lockdown on the whole country. As in March, non-essential businesses are shut, travel is restricted and schools are closed. Everyone is urged to stay at home. In the last week, there have been a further 1342 cases, adding to the total of 14084 recorded. There have been a further 29 deaths too, including a number of high profile business people and politicians, adding to a cumulative total of 369.
Zimbabwe seems to be facing a second wave, driven by the new variant coronavirus from South Africa. I caught up with colleagues yesterday to hear about the current situation and to reflect on how has Zimbabwe fared since the first case was identified in March 2020 (see the ZimbabweLand COVID-19 blog series).

On the face of it, Zimbabwe like many other African countries outside South Africa and to some extent Nigeria, has been relatively spared the ravages of COVID-19 to date. The total (reported) cases and deaths remain low. Compared to the US, UK and much of the rest of Europe, where last week’s reported figures are a small fraction of what is happening each day in these countries, the figures seem to portray (relative) good news.

At the beginning of the pandemic, there was a wave of Afro-pessimism: Africa was going to be hard hit, and with poor health services and many co-morbidities the toll would be massive. This did not happen during the first wave of the pandemic. In fact, the richest, supposedly most ‘efficient’ countries on the planet suffered worse. Why is this?

**WHY SO FEW CASES?**

There are many theories out there, and no one really knows – uncertainties are everywhere. Some claimed it was the heat, but of course there are cold parts of Africa in some seasons and places, and hot places around the world have suffered terribly too, notably in Latin America. Some said it was because of widespread BCG tuberculosis vaccination, but the comparative data proved dodgy. Some said it was because of a young population demographic. This certainly helped, given the susceptibility of different age groups, but there are plenty of other places where a ‘young’ population was hit hard.

Certainly, African countries, including Zimbabwe, responded to the pandemic quickly and effectively in line with WHO recommendations, with national lockdowns, restrictions on movements and health campaigns. This was unlike Western nations where the response was sluggish, with an arrogance that they knew best. Clearly, they didn’t and coronavirus did not turn out to be like ‘flu as all the elaborate preparedness and contingency plans assumed.

The experience of past pandemics/epidemics has also probably helped in Africa. The AIDS pandemic taught African nations and peoples a lot of important lessons: know your epidemic, take it seriously and change behaviour to save lives. The same applied to Ebola in West Africa and of course SARS in southeast Asia. Such experiences shape cultures and practices, and citizens, experts and institutions learn lessons the hard way.
In the West, assuming that COVID-19 was ‘flu was fatal – literally, and resulting in hundreds of thousands of deaths in the US and Europe – but Western nations had not experienced the ravages of a serious pandemic for many years outside certain communities.

In some ways it may have been that poor health conditions actually helped. Acquired or pre-existing immunity through the frequent attack of multiple pathogens may have made certain people more able to fend off COVID-19. Noone knows this for sure, and plenty of poor and marginalised people have died, but it’s a hypothesis worth exploring, as many of the (recorded) deaths have been among middle class and richer people, where co-morbidities – being overweight, having diabetes etc. – are similar to those in the ‘healthy’ West.

The spatial pattern of cases also gives some clues. Cases in Zimbabwe, for example, are heavily concentrated in the larger urban centres, where poorer people live in crowded places and moving to jobs means travelling on crowded transport. The colonial design of racially-segregated cities has resulted in increased susceptibility to this type of respiratory disease, requiring new thinking in city planning.

The other foci of infection are on the borders, highlighting the impact of migration as a spreader of disease, especially from South Africa. With the new variant extending from the coastal areas of South Africa, the transfer of the virus through migrant populations moving back and forth, especially through the festive period, has already happened. Add to this the crowded conditions and long queues at the borders such as Beitbridge seen over the holidays, it has been a recipe for rapid spread.

UNDERSTANDING DISEASE CONTEXTS IN RURAL AREAS

However, there still remain very few (recorded) COVID-19 cases in any of our rural study areas, and few stories about people who have died. This is the case across the country – from Mvurwi to Chikombedzi – and the exceptions are in all instances a few imports from returning migrants, most common in Matobo. This is striking and contradicts the national narrative of growing infection.

We have been observing the local situation now for 9-10 months, and the pattern seems clear. Despite massive under-reporting due to an almost complete absence of testing, the rural areas seem to have been spared so far. As colleagues noted, “it may be that we have had the disease, but there are a range of ‘flus’ (respiratory diseases), and we know how to treat them with herbal medicines. Even the local village health workers are encouraging their use.”
We asked people in each of the study sites about why there were so few cases, and they consistently identified the activity patterns of people in rural areas. They live outside, there is ‘plenty of air’, they are not crowded together, as villages and homes are spaced out and people don’t move around so much – certainly compared to the ‘big bosses’ from Harare who seem to be suffering most. The moments when infection might happen included, according to their listing, funerals, markets, tobacco selling points, schools, indoor church services and beer parties where receptacles are shared. They also all pointed out that people are generally good at hygiene as this part of cultural practices for washing and cleaning, especially before eating.

As Paul Richards and Daniel Cohen point out on the *African Arguments* blog, understanding infection risk in context is essential, and this requires detailed insights into what people do where and why. In Africa it is not meat packing plants or care homes where concentrated transmissions occur, but in other settings. In order to shift behaviours and reduce infection, there is a need to know more about – for example – “the way infection hazard is shaped by key ceremonial activities in private spaces.” This means not just relying on the generic ‘science’ and projections from generalised models, or even the direct experiences of elite policymakers in large urban centres, but engaging with those who are confronting the disease, even if at this stage at very low levels. As they comment, it’s imperative to:

- Involve at-risk communities of all kinds in debate about how to manage the hazards associated with a second wave of the disease in Africa, based on diligent backward contact tracing undertaken while disease circulation remains relatively low.

The time to do this work is now.

Only with such engagement and supported by effective testing – as was the case with Ebola in West Africa – will people shift practices, perhaps in quite subtle ways, to prevent disease spreading. The blunt tool of lockdowns and generic health messaging may be increasingly ineffective in a second wave, and more attuned responses will be needed.

**DANGERS AT THE BORDERS**

As colleagues said, “people are fed up with lockdowns, they don’t know why they are happening”. In the last period, things had got back to a (sort of) normal. Or at least people had found ways of managing the restrictions. Businesses had been re-established, markets had reopened, people were moving about (even if paying bribes to the police at roadblocks), funerals
were being held with numbers way beyond the stipulated number, schools were open and mask wearing had become much more casual. The announcement of a new harsh lockdown has been met with dread. People remember the first major lockdown from late March, and cannot afford to return to that situation of extreme hardship.

But notes of caution also come from the border areas, especially in the last weeks. Over the festive period there have been a huge number of returnees from South Africa wanting to visit their relatives and rural homes. The massive queues at the border posts, with traffic jams of 20km or more have been widely reported. Traffic disruption has also occurred further away as police check for COVID test certificates among motorists and truckers.

As we have observed in previous blogs,8 migrants have invested in their rural homes during the pandemic, and have opened up fields, moving members of their families to these homes and away from towns in Zimbabwe or South Africa. Some villagers have been complaining that grazing areas are becoming short as so much land once fallow (and so available for grazing) has been ploughed this year, spurred on by the very
good rains. There is now more movement and mixing with migrants from elsewhere, and especially around holiday times.

With the main border posts highly congested, others have resorted to illegal crossings. The Limpopo is flowing due to plentiful rains and normal crossings on foot are not passable. Boat operators have sprung up using large inflatables, with crossings costing Rand 200 per head. Huge numbers of people cross each day – around 150 per boat – along with goods and supplies, and sometimes even vehicles. Soldiers and border security forces are paid off, and a lucrative transport business has emerged, alongside other activities including supplying food to travellers. These crossings are taken by those without the full paperwork and who cannot pay for the U$50 cost of a COVID test. No doubt viruses along with people and goods are being imported too.

**WHAT NEXT?**

To date, the rural areas of Zimbabwe have yet to experience the direct impact of the disease, and only the consequences of lockdowns. This may yet change. In the coming weeks, we will continue to monitor the situation in our study areas. How will they cope with the new lockdowns? Will the second wave hit the rural areas this time? What strategies are being used to respond locally, with they remain effective even with greater transmissibility of the virus? Before the next update report, next week the blog will look more broadly at the debate about lockdowns and their politics.

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1 https://zimbabweland.wordpress.com/2020/12/28/zimbabwelands-2020-wrap-up-2/
4 https://www.bbc.co.uk/news/world-africa-53998374
5 https://www.bmj.com/content/370/bmj.m3563
Last week, the blog looked at the COVID-19 situation in Zimbabwe. The situation continues to get worse. On 9 January, there were 20499 reported cases and 483 deaths – 6000 more cases and over 100 more deaths in just a week. It looks like the South African ‘new variant’ is taking hold. Another very severe lockdown was imposed on 2 January, with strict movement restrictions, many businesses closed and a curfew.

However, like many other African settings, as discussed last week, so far at least the rural areas in particular seem not to have significant coronavirus incidence, with reported cases concentrated in urban areas. So are widespread, national lockdowns justified? Should governments persist with the harsh lockdowns that are perhaps best designed for different Western, urban settings with different social and economic profiles?

This is a difficult one. We don’t know if the early action by African states – including Zimbabwe – prevented a massive early spread, and it would be foolhardy to experiment with releasing lockdowns to boost the economy if it resulted in a massive transmission of disease during a second wave. And especially so in settings where health systems are deeply inadequate.

The Swedish experiment of a light lockdown has faltered badly in recent months, and the haphazard approach of the UK government to pandemic control measures has resulted in a huge and unnecessary death rate, even with a top quality health service.

HARDSHIPS, BUT INNOVATIONS AND TRANSFORMATIONS

What then are the downsides of the current approach of strictly following international public health guidelines? As we have documented in the blog series since March last year, the impacts of lockdowns on rural populations
across our sites have been harsh. And the new lockdown in Zimbabwe is already biting hard.
This is a pattern seen across Africa as many studies have now shown. Reduced market access, lack of mobility for labour and work, school closures meaning kids don’t get an education… and so on. The story is now familiar. There have been many surveys of the impacts and the considerable costs of lockdowns. Lockdowns particularly hit those reliant on formal markets and those requiring mobility for their livelihoods.
Yet, as our field reports during 2020 have shown, in a largely informal economy, where exchanges are local, there has been an impressive resilience in rural areas and small towns in Zimbabwe so far. Without wanting to dismiss extreme hardships, falling perhaps especially on women and young people, the adaptations and innovations we saw over the past 9-10 months across our sites have been impressive.
Whether in terms of marketing, health care, off-farm income earning, trading or artisanal mining, a new array of new activities have sprung up so that people can survive during lockdowns. Compared to the formal phone surveys that many researchers are fond of, asking not just about what has changed from the status quo, and so highlighting the costs, we have also been asking what has emerged, highlighting innovations and opportunities too.

Our qualitative work across multiple sites in Zimbabwe shows not just how the existing agro-food and livelihood system suffered, but how it also was transformed – by necessity, and through skill and ingenuity. Reading back across our accounts from March 2020 onwards it is interesting how the tenor of the commentary changed: from negative impacts to positive opportunities,\(^6\) even in very tough circumstances.

**AUTHORITARIAN REACTIONS**

A common argument about the downsides of lockdowns is that they provide space for authoritarian states to exert control on restive populations under the guise of public health measures. The Crisis in Zimbabwe Coalition has recently produced a significant report (and video) on the shocking abuses that have occurred in Zimbabwe (and across SADC) over the past year,\(^7\) with heavy lockdowns and restrictions on movement seemingly being used as a pretext for arrests and violence, directed particularly against the opposition.

The ‘closing of civic space’ is very apparent in Zimbabwe,\(^8\) and was heightened especially in the build-up to the proposed 31 July uprising.\(^9\) While this never happened in the ways envisaged, the clamp-down was severe, affecting everyone, but especially journalists (arrested and imprisoned) and opposition leaders (sexually assaulted and imprisoned). This pattern continues, with new arrests during the past week, and some still imprisoned.

The argument in the Crisis Coalition reports is that lockdown measures were ‘excessive and disproportionate’,\(^10\) with state and security services using lockdowns to boost their control against rising opposition and internal faction fighting. It is implied that lockdowns should be released with ‘civic space’ restored. In other words, it is suggested that lockdowns are manipulated, becoming simply a political tool.

Many public health officials would however disagree, and especially now. With great hardship and without resources, they have been implementing the measures in good faith, with the genuine fear that the pandemic will take hold, and that only strict public health measures will hold it at bay.
Public freedoms are always curtailed in a health emergency for the greater, longer-term good, they argue. Lockdowns are therefore essential, even if private civic freedoms are curtailed.

**LOCKDOWN POLITICS**

This of course is a tension seen in many countries, with anti-lockdown protests in favour of ‘freedom’ a common occurrence. However, in Zimbabwe, the context is particular. A more sophisticated reflection on these tensions is necessary.

It is always about politics, and political assessment of trade-offs. In the UK, for example, the discussion has been about opening up to boost the economy and people’s jobs and livelihoods, while protecting health through a complex and confusing set of public health measures. In Zimbabwe, the state had similar concerns, as the already dire state of the economy was made worse by the pandemic, and fears of public unrest and opposition mobilisation were raised. Yet, actually, those economies with stricter public health measures have actually fared better economically over the pandemic, particularly in east and southeast Asia.

Lockdowns are of course no excuse for human rights abuses and illegal activities. These have been seen in many places, as the ‘emergency’ rhetoric of a pandemic provides the pretext for authoritarian measures, as well as corrupt practices. The rush to acquire personal protective equipment (PPE) at the beginning of the pandemic saw procurement practices abused massively across the world.

In Zimbabwe, media exposes resulted in the sacking of the health minister and fingers pointed to the very top, while in the UK the extent of involvement of senior politicians and associates in the Conservative party in getting favourable government contracts is only now becoming clear. This is now subject to a number of lawsuits, although still remarkably little mainstream media commentary, despite apparently extreme forms of corruption.

**PANDEMICS ARE WINDOWS ONTO SOCIETY**

A pandemic exposes the worst and best of any society, and Zimbabwe is no exception. The failure of governance, the abuse of power and the authoritarian approach to politics has been laid bare, along with the tragic lack of capacity in the health service and the neglect of key workers, notably doctors and nurses who have been underpaid for years. But, at the same time, the way public health workers have worked tirelessly across the country sharing messages about keeping a distance, washing hands and so
on has been impressive; in many cases involving people who are barely paid a living wage. The commitment of medical professionals is also amazing. Despite the terrible working conditions, they have insistently argued for solid public health measures and may have helped offset something worse. And, in response, the extraordinary resilience, as well as the improvisation, ingenuity and innovation, that people have shown over these months continues to impress.

Over the coming months, we will continue to monitor the situation across our Zimbabwe sites and report back via the blog, as the unpredictable life cycle of a pandemic reveals much about the struggles of daily life and the political, cultural, social and economic responses to adversity in rural settings, which remains the on-going focus of this blog.

1 https://zimbabweland.wordpress.com/2021/01/04/can-zimbabwe-survive-a-second-wave-of-covid-19/
7 https://e29cd76f-8594-426e-9cb7-fd978a7b2d51.filesusr.com/ugd/155e76_0756caf8672a4bcbb5b4993a1d2356ca.pdf
   https://www.youtube.com/watch?v=2kpOZq0FWP8
8 https://e29cd76f-8594-426e-9cb7-fd978a7b2d51.filesusr.com/ugd/155e76_ac13afeae49e42f197d7f6c1f183ae46.pdf
10 https://e29cd76f-8594-426e-9cb7-fd978a7b2d51.filesusr.com/ugd/155e76_0756caf8672a4bcbb5b4993a1d2356ca.pdf
12 https://zimbabweland.wordpress.com/2020/03/02/zimbabwes-economy-goes-from-bad-to-worse/
14 https://twitter.com/i/status/1320298145004269568
15 https://goodlawproject.org/news/special-procurement-channels/
THE RICH PEOPLE’S VIRUS? LATEST REFLECTIONS FROM ZIMBABWE

A few weeks back Oxfam released a major report, ‘The Inequality Virus,’ documenting the way COVID-19 has affected different populations and parts of the world. The now well-established impacts on the already-marginalised are presented, alongside how the rich have benefited. But the debate in Zimbabwe is currently rather different – people are wondering why the virus is hitting the urban rich and well-connected the most.
The last weeks have seen a massive spike in reported cases and deaths in Zimbabwe. The deaths of senior politicians, party officials and business people have been widely reported. It has provoked a level of concern, even panic, across the country, especially given the parlous state of the health care system.

Last weekend I caught up with the team who is monitoring the situation across our rural study sites – in Mvurwi, Gutu, Masvingo, Matobo, Chiredzi and Mwenezi areas. This is the tenth blog in a series (see here, here and here for updates since last March).

A DISEASE OF THE URBAN RICH AND POWERFUL?

In our rural study sites the experience of COVID-19 as a disease remains limited. Team members were able to report a few cases from each of the sites, with some deaths usually among older business people, but many of the funerals were of those coming back from towns or from South Africa. COVID-19 is still, it seems, not a rural disease – although of course, given the complete absence of testing in these areas, we cannot know for sure.

Over the past week or so, team members have been discussing why COVID-19 seems to be concentrated among the urban rich and powerful with locals in the rural areas where they live. Many explanations were offered. The rich move around more, they fly in planes, drive in cars; we barely move, especially with lockdown. The rich don’t do physical exercise, they move in cars; we walk everywhere – we have to, and do manual work. The rich work in offices and enclosed spaces; we are outside, in the clean air. The rich eat junk food, and have conditions like BP, diabetes and so on; we have fewer chronic conditions and get good food from our own local vegetables, which give immunity.

All this makes sense epidemiologically, but what was central to local narratives across sites was that local responses were not just passive – the consequences of being poor – but due to active choices about prevention and treatment. Unlike a few months ago, there is a tangible fear of the virus now. The news reports of the rich and influential dying despite their privilege, mean that people have to act to protect themselves.

LOCAL REMEDIES AND VACCINE ANXIETIES

There is today a booming market in local vegetables (such as Rudhe/Ulude and Mutsine/Umhlavangubo (Shona/Ndebele) – ‘weeds’ from fields mostly), as well as local medicines. Hot teas of many sorts – lemon and ginger, guava and eucalyptus, soaked onion – are combined with steaming using a variety of herbs. Herbs, roots and tree products such as Ndorani/
Intolwani, Rufauchimuka/Umafavuke, Zumbani/Umsuzwane and Chifumura are hot commodities, and lemons are reportedly selling for 20 bond notes a piece.

As people explained, they cannot get to town for conventional medicines, and in any case they have no money, so local approaches are better. They point to cases where people have recovered using such medicines. WhatsApp group messages are full of advice on local herbal medicines, and offers of their sale.

What then of the prospects of a vaccine? Here there is a raging debate across our sites. When asked, most people seemed highly sceptical. The Chinese have offered vaccines to the country (to be available free,[5] despite early confusion),[6] and this has been widely trailed in the press, as part of China’s effective vaccine diplomacy. While in time there will hopefully be allocations from COVAX, the central global facility too,[7] it’s the Chinese vaccine offer that seems to be generating the most debate.

Where does the scepticism come from? In part it emerges from (usually unfair and often racist) attitudes towards Chinese interventions in Zimbabwe and the quality of Chinese products, disparagingly referred to as ‘Zhing-Zhong’ – cheap, low quality products likely to break or be useless. People also worry that the state will force people to have the vaccine.

There are also rumours that vaccines cause infertility, make women grow beards and have other severe side-effects, potentially resulting in death. It is difficult to know where such rumours come from, but they are very real. I was sent a whole string of videos (mostly coming from anti-vaxxers and others in the US) by a friend who had received them from a church-based WhatsApp group. There are likely many similar ones circulating.

Amongst our informants across the study sites, there was a general unease about the rapidity of the vaccines’ development – pointing out of course that there is still no vaccine for HIV/AIDS after many years. There was also a sense that, among poor rural people, they have not been affected so far, and that the local medicines and remedies being used seem to be working so far.

As across the world, vaccine anxiety mixed with vaccine nationalism will be a big issue for Zimbabwe when vaccines finally come to the country.

**FARMERS’ LOCKDOWN STRUGGLES**

Combined with the flood of migrants from South Africa coming back over the festive period, there were many press reports of the elite partying unprotected and churches gathering in large numbers. The consequences
are now being felt with the current surge. For good reason, the government has clamped down on the strong advice of the medical professionals. Since Jan 2\textsuperscript{nd} there has been a strict ‘Tier 4’ lockdown across the country, recently extended for two weeks until the middle of February.\textsuperscript{9}

People report that this is the strictest lockdown yet, with severe movement restrictions, a curfew and business hours restricted from 8am to 3pm. Many arrests have been reported and once again there are accusations that the lockdown is being used to suppress political dissent.\textsuperscript{10} In the past, people could flout the rules or get round them – especially if you could bribe the police or were well-connected. Some are still able to get round the lockdown restrictions, but many fewer this time. There are shebeens (drinking places) that operate after dark, some transport operators that dodge the police road-blocks and a few churches still flout the rules, but for most the elaborate process of getting exemption letters is a daily struggle. One of our colleagues explained how he had to get an exemption letter locally in the township in Masvingo to get another exemption letter in town to travel to Chiredzi so he could look after his sugar farm. It’s not easy being a farmer at the moment.
The informal markets and many shops remain shut. Getting farm inputs is nearly impossible as movement restrictions and curfews mean many businesses have closed. Farmers cannot move their produce, and horticultural produce is rotting in the fields. Those who used to rely on vending of agricultural products at fixed locations have to move around or sell from home, with far reduced returns. Input supplies for farming have dried up – with fertiliser being absurdly expensive (up to US$40 per bag) and much in demand because of the heavy rains this year. The rains have resulted in livestock disease outbreaks, notably blackleg, but getting access to medicines is difficult because of movement restrictions, and cattle are dying in numbers. Despite it being a good season overall, especially on heavier soils, gaining the advantage of this is proving tough, both in terms of production and marketing.

With the good season, there are at least some early crops. Cucumbers, pumpkins, sweet reeds and early maize are already being consumed, along with the proliferation of local vegetables and wild fruits that have grown this year. This is a major help to many. Those who planted early look like they will get a decent crop in most of our sites, including those that are traditional ‘drought prone’. But late planted maize is currently looking weak and, with the lack of fertiliser and incessant rain, much of it is yellowing.
THE COVID BARTER ECONOMY

Even the COVID economy discussed in previous blogs is highly constrained at the moment. There is very little money circulating and people must get along with their own production and barter exchange. The growth of farming in town is dramatic – the outskirts of Masvingo are reported to be ‘one big farm’! Sugar beans or sweet potatoes with maize seem to be the favoured crops, and these will be keeping many people fed in the coming months.

Those who have some crops can exchange for other goods in their neighbourhoods. Barter is the basis for exchange without cash, and word is put out on the street or via the WhatsApp groups if things are available or needed. Goods are moved around the townships by a proliferation of push-carts, operated by many who have lost their jobs. And with the informal markets closed, selling has moved to people’s homes or mobile shops – in carts, wheelbarrows or cars – linking informal township-based wholesalers (who source for other towns or abroad) and a network of small-scale retailers and vendors.

As we have discussed before, there has been a massive growth of small-scale mining across our sites. In the last few weeks, two new areas have opened up near Masvingo and adjacent to our study sites, with now thousands of miners arriving in a new gold rush. Many underground mines
have been flooded with the heavy rains, and some are now dangerous, but mining continues in others, often with serious attendant dangers – not only of mine collapse, but also of COVID-19 infection.14

AN UNEQUAL DISEASE

COVID-19 is certainly an unequal disease, but in unpredictable ways. In Zimbabwe, it affects the rich and powerful disproportionately through illness and death and the poor through livelihood struggles during lockdown. How will the inequality virus’ evolution pan out over the coming months? Check out the blog for further updates.

3 https://www.theafricareport.com/62688/zimbabwe-covid-cases-dying-at-home-as-hospitals-reach-capacity/
If you didn’t know already, vaccines are political. And in southern Africa perhaps particularly so as the Chinese, Russians, Indians and the so-called international community through the COVAX facility jostle for position, each trying to show their benevolence towards Africa, reaping soft power diplomatic benefits in return.

In this context, the vaccine becomes the symbolic totem of a new form of political power. This competition between old and new powers has important implications for how public health and development more broadly are seen and responded to across Africa, including in Zimbabwe.
Vaccine nationalism and diplomatic competition however is raising concerns. These exist in Europe of course, perhaps especially around the British-Swedish AstraZeneca vaccine, which at different times has been cast as dangerous, ineffective or highly efficacious, depending on which politician or selective media commentary you listen to. These uncertainties of course feed into anxieties and contestations over different types of vaccines, some of which have a major commercial dimension. It’s predicted that those with a profit-making business mohttps://www.gavi.org/covax-facilitydel behind them – Pfizer, Moderna and the rest – will make huge profits over the coming years as the coronavirus settles into its endemic state across the world.2 Of course many Africans will not be vaccinated well into 2022,3 such is the inequality of vaccine distribution and access. Zimbabweans currently only have one vaccine being administered: the Sinopharm vaccine from China. Arriving through a coup of diplomacy on a specially chartered Air Zimbabwe flight, and met by the Chinese ambassador and the Constantino Chiwenga, Vice-President and health minister, it was a symbolic moment showered across the press.4
Other vaccines from China are expected (including Sinovax) along with the Indian vaccine, Covaxin and the Sputnik V vaccine from Russia. Nearly a million COVAX vaccines (AstraZeneca) are also expected as Zimbabwe (finally) signed up for a share, although the first deliveries to Africa from the international facility went to Ghana and Ivory Coast while nearby Malawi got a first shipment last week.

ZIMBABWE’S VACCINE ROLL-OUT: INTENSE DEBATE

With 200,000 Sinopharm doses delivered in the first batch, the Medicines Control Authority of Zimbabwe was quick to approve the vaccine, and the Ministry of Health presented a plan for delivery across three phases. Initially, following the symbolic injecting of the vice-president (the president and the rest of the cabinet it seems await the next batch), 34,000 ‘front-line’ workers were targeted. In Zimbabwe, the front-line is nurses and doctors, but also police and soldiers, who have been very present throughout the various lockdowns. Agricultural extension workers were supposed to be in this batch apparently, but have been relegated to the next phase, alongside teachers, college and university lecturers and those deemed vulnerable, including the elderly and some with particular health conditions. After these groups are vaccinated, the rest of the population will be offered vaccinations, which are free and not compulsory, with the aim of covering 60% of the population.

In all our sites bar one (and this is expected this week), the selection of frontline workers have been vaccinated. Not all took up the offers, with quite a few preferring to wait to see if there were any problems. Others were eager to get protection, while some feared that vaccinations were going to be used to restrict jobs in the health service – no jab, no job was the (actually unfounded) rumour. In our sites there were few side-effects commented on, and only a few nurses in one site who got a fever for a few days were mentioned. Sadly in one site someone died of a stroke following vaccination, although this was apparently due to high blood pressure rather than the inoculation.

With vaccinations underway, our team discussed with local people about their views. Many repeated the arguments that COVID-19 is not seen in the rural areas, so why bother get vaccinated. Others pointed to indigenous herbs and treatments that were proving sufficient. Rumours and strongly-stated viewpoints abound. Suspicion of China’s motives were presented: “China has economic and political interests in our country. They can now expand and exploit our resources”. Others observed that China “is known
for sub-standard goods. This makes us worried... We definitely don't rule out fake vaccines from China”. Some backed China – a war veteran from Mwenezi argued “We have a long relationship with China. It assisted us during the war of liberation. We have confidence in them, more than the West”.

Others shared more dramatic conspiracy theories circulating on social media: “COVID-19 is man-made; the vaccines alter our DNA and can kill us”. Others commented on the financial gains to be made: “This is about money. There are trillions to be made. How can we trust those companies?” Alongside the proliferation of stories on social media, a number of influential actors are adding to anxieties, despite the best efforts of government health services, with prophets, bishops and some churches urging people to avoid the vaccine.

Thus in the villages across our sites – from Mvurwi to Matobo – there is intense debate. As the vaccine rollout continues things may change, but
there seems to be widespread hesitancy right now, which is concerning medical doctors.\textsuperscript{13} Even amongst our team there are quite contrasting views. In part this emerges from the context. The rural areas have not suffered massive deaths from coronavirus; indeed in the past weeks the number of cases has declined significantly across the whole country and no cases were reported from our study sites. People in all sites once again emphasised the importance of local medicines, vegetables and herbs. Their popularity has resulted in some commercialisation of these products, with Tanganda, the famous Zimbabwean tea manufacturer, producing a new green tea line made from the popular COVID-19 treatment, \textit{Zumbani (Lippia javanica)}.\textsuperscript{14}

As team members commented, the shifts in behaviour over the past year around hygiene in particular have been impressive. As one commented, “you go to people’s houses and there’s hand sanitiser or soap to wash; even the kids will pull you up and ask if you’ve washed your hands!” The village health workers reinforce health messages, and continue to work on small allowances, but are widely respected in local communities. With schools opening soon again, school development committees have been mobilised to supply sanitisers and masks and parents have set up duty rotas to clean and sanitise classrooms.
Despite the lack of coronavirus, people have seen the potential risks through high-profile deaths and sickness (including of relatives) in towns and in the diaspora, in South Africa and the UK in particular. This has prompted local mobilisation and collective action in the absence of state support.

**LOCKDOWN EASING, BUT OTHER CHALLENGES**

In early March, the president eased the lockdown conditions.\(^1\) You can now move without permits between towns (although police are still at road blocks, extracting ‘fines’), and the massive price hikes that were seen in the last lockdown have reversed to some extent. There is more transport on the road and so greater competition among operators and now lower prices, which is in turn easing transport challenges for farmers who can bring their produce to towns to sell. Many suffered badly in the last lockdown as perishable crops just rotted at home, unable to be moved. Now things have improved, and there was a definitely more positive mood reported this month.

What has really struck people hard in this last period has been the tick disease of cattle known as January disease (theileriosis).\(^2\) People refer to this as ‘cattle COVID’, and it is hitting cattle herds really hard. Our team member from Mvurwi estimated that around 25 percent of all cattle have been lost. This collapse in a core asset will have long-term consequences, including damaging knock-on effects for ploughing next season. Tick grease has been supplied as part of government packages, but this is not easy to use given the density of ticks that have grown in number thanks to the heavy rains this season.

Lockdowns have meant that movement of animals is not possible, and people could not go to town to buy dipping chemicals, and even if farmers could get there they were in short supply. Standard government dipping has not been functioning effectively for a while, and the veterinary department has been overwhelmed and not been able to respond. In many ways, the impact of this cattle disease on people’s livelihoods is far greater than COVID-19, and it is being felt across our sites, with farmers selling animals for as little as US$60, and many have died.

We never expected to be reporting on the responses to COVID-19 a full year on, but this is now the eleventh report since our first post at the end of March 2020, and we will continue to monitor what happens across our sites in the coming weeks and months as vaccines become more common and the seasons shift from the wet to dry season, hopefully with a decline in tick diseases resulting along with a continued decline in COVID-19.
1 https://www.gavi.org/covax-facility
3 https://www.economist.com/graphic-detail/2021/01/28/vaccine-nationalism-means-that-poor-countries-will-be-left-behind
4 https://www.chinadaily.com.cn/a/202102/16/WS602a3f92a31024ad0baa9038.html
5 https://africa.cgtn.com/2021/02/04/mnangagwa-thanks-xi-jinping-for-supporting-zimbabwes-covid-19-fight/
10 https://zimbabweland.wordpress.com/2021/02/08/the-rich-peoples-virus-latest-reflections-from-zimbabwe/
12 https://zimbabweland.wordpress.com/2021/02/08/the-rich-peoples-virus-latest-reflections-from-zimbabwe/
14 https://www.africa-press.net/zimbabwe/all-news/tanganda-starts-selling-zumbani-tea
15 https://ewn.co.za/2021/03/01/emmerson-mnangagwa-relaxes-lockdown-in-zimbabwe
16 https://www.sundaymail.co.zw/january-disease-claims-1-000-cattle-in-mash-west
Half a million people have now been vaccinated in Zimbabwe, but this is still only 3.5% of the population. The Chinese Sinopharm vaccine has now been fully approved by the WHO for emergency use and Zimbabwe’s vaccination drive is in full swing. Even tourists from South Africa are taking advantage of vaccine availability for a fee. However, there have been hitches and hesitancy, and despite widespread adherence to basic hygiene/sanitisation measures, there is a general relaxation on social distancing and other COVID-19 prevention measures after so many months of restrictions.

It is perhaps not surprising that things have relaxed since the peak of the lockdown periods, given that case rates are low and recorded recoveries are high. The total number of cases recorded in Zimbabwe by 7 May was 38,403, while the number of registered deaths was 1,576. Compared to many other countries, this remains very low; although of course these are likely underestimates. And the effects of COVID-19 are very uneven geographically and socially too, with most cases and deaths recorded in Harare and Bulawayo and especially among relative elites. The rural areas where our team live and work remain largely unscathed by the virus.
RELAXED MEASURES, BUT LIVELIHOOD CHALLENGES REMAIN

In the rural areas, as our team reported in a conversation last week (this is the twelfth update in our COVID-19 blog series since March 2020),

6 coronavirus is not the major concern. It is a busy time due to harvesting after a good season and, with the seasons changing, many are complaining of colds and 'flus as the weather becomes colder. Livestock diseases continue to cause problems after the very wet periods, with the lumpy skin outbreak in Matabeleland causing havoc.

While there are fewer restrictions these days and no curfews, there’s still a lockdown and there are notional restrictions of business hours, although many do not observe these. Large gatherings remain banned, but there are
plenty of drinking spots where people gather in numbers. Many have returned to normal business, although transport remains limited as private operators remain restricted.

Despite the relaxation, the police are always ready to extract bribes, and moving about remains a hassle. Informal gatherings for beer drinking are regularly raided, but those hosting these often have made advance deals with the police or can pay them off. Movement across borders for trade is especially challenging as there are so many requirements for tests, certificates and loads of paperwork. There is a steady business in forgeries and bribing of officials is apparently commonplace; although there have been some arrests of truck drivers and others for flouting the regulations.

In the rural areas, while the harvest has been good the lack of other sources of income is a challenge. Many have started small agricultural projects – vegetable growing, selling of chickens and so on – and there has been a proliferation of small tuck-shops in everywhere from labour compounds to the smallest village settlement. As one farmer commented, “We used to go to town for shopping, but now there is no need, as everything is here!” With the good harvest and the surplus of agricultural produce in all our sites, farmers’ clubs have been revived to allow for collective selling and helping farmers to source inputs.

Remittances remain important across our sites but have declined, especially from South Africa and Botswana. Many who returned from there
during the COVID peak across the border have remained in rural Zimbabwe, unable to return. In our Matobo site in Matabeleland South migrants have become stuck, so have had to find other sources of income as they do not necessarily have their own fields. There has as a result been a massive increase in informal artisanal mining in the area, with many villagers profiting from selling food and renting out blankets for the filtration of sediment. This is mostly taken up by women who are making a steady profit, as apparently 600 Rand can be earned from a careful washing of each blanket rented to miners, retrieving the last bits of gold.

Schools remain open, but many are working with staggered attendance. This means kids attend only two or three days in the week, with the burden of extra care falling on women. Some have sought out places in boarding schools, as the regimes are stricter and a more complete education can be offered, but in the rural areas this is only possible for those who have got good harvests and income, and this is especially in the tobacco areas.

**VACCINE HESITANCY AND SUPPLY CHALLENGES**

After the high-profile arrival of the Chinese vaccine and the televised inoculation of senior political figures, the rollout has continued across the country. Initially the focus was on ‘front-line’ workers, mostly health workers, and then the elderly were focused on. Now a wider population can
get vaccinated, but the take-up is still patchy, a pattern repeated across Africa.¹⁰

As reported before, many are worried about the vaccine. They have heard of blood clots from vaccines in other parts of the world (mostly the UK), and fear the same will happen to them. This may after all be a plot by foreigners to kill Africans, some argue. People wonder why those who produce so many of these vaccines – such as India and Europe – have been so badly affected. Maybe these vaccines don’t work? And in any case, with so little COVID around, why bother, especially as our local herbs and medicines seem to work well. Some of the religiously inclined argue that the great pestilence of COVID is just a sign that the second coming of Christ is imminent, and we should not worry but celebrate. And of course the rounds of social media rumours reinforce concerns and worries for many.

In our sites there have been no reports of vaccine side-effects but uptake even amongst health workers has been below 50% so far. Of the others, it seems to be mostly women who have been coming forward, along with older people. However, getting a vaccine is not always straightforward. Supplies have been uneven, so clinics may have run out, and a clinic may be 20 kilometres walk away. Many feel that it is not worth the effort of going so far. The idea of mobile delivery like other health outreach was
recommended by some, arguing that this will get more to take the vaccine and the vaccines can be kept in cooler boxes for the day.

Across our sites, the availability, delivery and acceptance of vaccines is the highest in Hippo Valley. Here the major hospitals in Hippo Valley and Triangle are run by the sugar company, Tongaat Hullett. Workers on the estates, as well as contract farmers, have taken up the vaccine in droves. In part the supply is better, but some commented that they feared the company discriminating against them if they didn't have a shot. Either they might lose their job or they might not be able to get access to company services. On the estate, a different set of rules applies.\textsuperscript{11}

Across the country, including widely in the rural areas in all our sites, there is on-going promotion of vaccination and other mitigation measures by the government, some churches, NGOs and others, and overall the general understanding of the disease and its prevention is high. Contrary to the politicised narrative from the urban areas about the clampdown on civil society (which certainly has happened), by-and-large people think the government is doing the best it can – a finding echoed in a large survey mostly of urban dwellers in February.\textsuperscript{12}

While the official media pumps out health messages, people confront many other sources of information via Whatsapp, Facebook and so on. There are parallel messages, with people often getting confused or anxious, particularly around vaccines. Vaccine rumours abound, and it is difficult for most to sift fact from fiction. One rumour was set off in our Matobo site that the vaccine also prevented HIV/AIDS and there was a flood of people turning up at clinics until the rumour was dismissed. It is clear that HIV/AIDS still remains a much more live concern for many than COVID-19.

**LIFE CONTINUES, BUT FEARS ON THE HORIZON**

The big fear in Zimbabwe as elsewhere is the prospect of new variants. No-one wants to return to a full lockdown and as everywhere people have viewed the scenes from India with horror. The leaky borders, the dodgy certificates, the prospect of flows of refugees from the conflict in northern Mozambique and the opening up of international travel are all sources of concern. But meanwhile, people in our sites must get on with their livelihoods, generating a living in a challenging economy.\textsuperscript{13} There is a harvest to bring in and sell, gold to mine, vegetables to sell and livestock to look after. Rural life in Zimbabwe continues, despite the pandemic.

\textsuperscript{1} https://www.bbc.co.uk/news/world-asia-china-56967973
3 https://twitter.com/mohcczim/status/1390744775381372928?s=12
4 https://zimbabweland.wordpress.com/2021/02/08/the-rich-peoples-virus-latest-reflections-from-zimbabwe/
5 https://zimbabweland.wordpress.com/2021/01/04/can-zimbabwe-survive-a-second-wave-of-covid-19/
7 https://zimbabweland.wordpress.com/2021/01/11/lockdown-politics-reflections-from-zimbabwe/
9 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
11 https://zimbabweland.wordpress.com/2020/02/03/sugar-scandals-in-the-lowveld/
Zimbabwe’s COVID-19 situation looks uncertain, with localised outbreaks and a rise in infections south of the Limpopo in South Africa. On June 11 there were 191 new cases (including 82 that were reported late) and 3 deaths reported, making a cumulative total of 39,688 cases and 1,629 deaths and a current seven-day rolling average new case rate of 77 per day, with a discernible upward trend. Vaccination rates are increasing, but very slowly and somewhat chaotically with 691,251 vaccinated so far.¹
On June 12, Vice-President and health minister, Constantino Chiwenga, imposed new restrictions, with the banning of gatherings, the limiting of business hours, a stipulation that offices should only be half full and the prevention of moving to and from ‘hotspots’. This is a set-back as things had got largely back to ‘normal’ (whatever that is) in the previous weeks. Across our sites people had got back to work. It’s harvest season and markets have been open, with the selling of grains, tobacco, beans and horticulture happening across all sites. Meanwhile in the sugar estates it’s cane cutting season, with much activity and movement of people to provide temporary labour.

With so many people gathering at marketing points and traders, labourers and transporters, the fear was that these could become sites of infection, hence the recent move. Larger gatherings of churches, farmer field days, training events, funerals and so on were previously allowed if not exceeding 50 people, but are now either banned or have a reduction in permitted numbers. While these regulations were sometimes not kept to, as of last week our team report no major COVID-19 problems in any of our rural sites across the country, although the worry is that this may yet change.

The national pattern currently seems to be small, focused outbreaks that are dealt with by Ministry of Health ‘rapid response teams’ that operate in each of the provinces, coordinated through the district COVID-19 taskforces, which has membership from across sectors. The most recent such outbreak near our sites was at Bondolfi teachers’ college where there were a number of cases reported. Isolation and quarantining seem to have stopped further spread fortunately and all are now recovered.

Currently there are concerns in Kariba where the district taskforce has been targeting ‘houseboat gigs’ and shebeens where many gather to drink and are spreading infection. Last Saturday a lockdown was announced for Hurungwe and Kariba districts due to 40 new cases being identified, with movements in and out of the districts restricted and a process of contact tracing is ongoing. The fear of course is that such hotspots will spread.

**VARIANTS AND VACCINES**

Like other parts of the world, the concern is with the potential impact of new variants. So far there has been one outbreak of the Indian-origin delta variant in Kwekwe. Someone returning from India had infected a number of people and a local lockdown has occurred and been extended, again hopefully stopping further spread.
However, borders remain open, although restrictions and requirements for testing have been increased this last weekend. There is some testing, but also lots of reports of fake test certificates, with some in Mpilo hospital arrested, so it is difficult to see how the spread of variants, as elsewhere in the world, will be stopped, even if spread can be slowed.

The vaccination programme has run into difficulties with demand exceeding supply in some places, although the opposite in others. The ministry has admitted problems with distribution and administration. The main vaccines remain the Chinese Sinopharm and Sinovac shots (and some Indian ones too). Promises of others from Western aid programmes seem not to have been fulfilled as yet, while the Zimbabwe government has been showing caution around the US/Belgian Johnson and Johnson vaccine, perhaps part of the on-going tussle with Western powers. Meanwhile, as part of the continued frenzied vaccine diplomacy, the president received the first delivery of 25,000 Russian Sputnik V vaccine doses at the end of last week, donated by a diamond mining company. Vaccines clearly have important soft power.

Vaccine hesitancy remains, fuelled by much misinformation through the online media, Whatsapp messages and so on. But the big issue seems to be
delivery and the capacity of the over-stretched health service to delivery. The ministry correctly is keeping up with its regular vaccination programmes, and the current polio vaccination drive is occupying staff and taking them away from COVID-19 vaccination.

Our informants noted that they can arrive at a clinic and be turned away as the health staff are busy, even if there are COVID-19 vaccines there. Given the lack of incidence in our study areas, there is little urgency felt and many argue that local remedies – from local herbs and leaves to lemons, garlic and ginger – used for teas and steaming are sufficient. The cost of lemons apparently is soaring, and there are many new businesses packaging teas and juices to combat COVID-19.

**MARKETS ARE OPEN, BUSINESS IS BACK**

Unlike last year when the harvest season was very difficult, this year there has been much more opportunity. In Mvurwi tobacco marketing has been in full swing across a number of auction floors, and the trading companies are busy. Transporters are moving crops around and there has been a thriving business in the areas where people gather to market their crops, as prepared food is sold and groceries exchanged through a myriad of traders.
As of 12 June, this is now banned as vending in and around tobacco auction floors is prohibited and a maximum of two sellers per delivery is allowed. Maize and soybean marketing is underway too, but the government buyer – the Grain Marketing Board (GMB) – while offering higher prices has distant depots, pays in local currency (RTGS) and the cost of transportation is high. Instead, informal traders come to the farms, exchanging goods, notably groceries, for maize in particular. This means maize goes for USD 3 per bucket not the equivalent of USD 6.

While farmers complain about being ripped off, the provision of goods locally and the ease of marketing/transport is clearly beneficial. And the growth of informal trade provides jobs and sources of income for a whole range of people, especially women and younger people.

The cold season is traditionally a focus for horticultural production but some producers, particularly in Chatsworth-Gutu area, have been hit by frost, with large amounts of produce destroyed. In the same way, livestock have been affected by tick diseases this year, due to the plentiful rains. Despite it being the dry season now, this continues to be a problem in some
of our sites, and owners are selling off sick cattle before they die and so flooding the market and suppressing prices.

Despite these challenges, the marketing difficulties for farmers of the earlier COVID-19 lockdown periods have declined and all value chains for different crops are re-emerging, with vendors, traders, transporters and others all returning to support agriculture and the marketing of products across our sites.

However, the form, composition and location of these value chains are changing. Agricultural markets are now more localised, involve a greater diversity of people with exchange and barter being important and formal sales to outfits like the GMB on the decline. In time it may be that the more formal connections are re-established with the big players returning to dominate and control the market from farm sales to retail, but for now the COVID-19 shock seems to have reconfigured markets in favour of multiple, local players, with important effects on local economies, with value distributed across agricultural marketing chains.
SMALL TOWNS ARE BENEFITING

This explosion of local economic activity is seen especially in small towns. In the two previous blogs (here and here), and in our paper in the *European Journal of Development Research*, the implications of land reform on small town growth has been emphasised, based on work in Mvuruwi, Chatsworth and Maphisa over the past five years or so. This pattern has been accelerated by the effects of the pandemic.

With transport restricted by lockdowns and curfews and endless rent-seeking by the police on the roads, there has been a move to local marketing arrangements, often small-scale and involving informal, sometimes barter, arrangements. Women and young people without land are especially involved, and their improved spending power is seen in the rise of local retail outlets in small towns offering basic goods and groceries. While lockdowns affected the operation of food outlets and many other
businesses, as we have discussed many times in our blogs on COVID-19 impacts since March 2020, there has been a rebounding of activity; although with the recent announcement business hours are again restricted to 8am to 6pm, with all markets closing at 6pm and bottle stores two hours earlier.

Unlike larger businesses with a single operation, many of those involved in trade in small towns operate at a small scale and have other activities in play. Many business people in the small towns we’ve been researching had land reform farm plots and could diversify when their businesses were restricted, but now they’re very much back.

There are health restrictions in place – sanitisation and mask wearing is encouraged and large crowds are banned – but in the absence of cases and with the fear of COVID having receded from earlier periods, there is a much more lax attitude to restrictions in all our sites according to our team. This may not last if the spread of COVID-19 continues in South Africa, but for now small town business is thriving again.

The shortening of value chains and the focus on local economic activity is also reflected in investments by larger agricultural businesses. For example, in Mvurwi, an important centre for tobacco growing, tobacco companies have invested in new floors, with impressive new structures being built.

Since people couldn’t move during lockdown, they had to come nearer to the farmers. And the firms have clearly judged that this situation is permanent, with significant benefits for the efficiency of marketing and access to high quality tobacco leaf. There are now eight trading floors operating in the town, up from one earlier, ranging from the big players (ZLT, MTC, Boka) to newer companies (Boost Africa, Sub Sahara etc.). This move to local investment is reflected in the multiplication of banks in the town too. There are now six banks operating, where there were only three before. This allows farmers to gain finance, pay in sales receipts and manage their income much more easily, with the banks benefiting too.

Even in areas that don’t have such an intensive, cash-oriented commercial agriculture, there are other similar developments towards a localisation of the economy. For example, near Wondedzo, because people could not travel to Masvingo, Gweru or Harare to get seedlings for horticultural operations, a number of new business have emerged, based in the rural areas. Near Zimuto Mission, for example, Mrs Z has started producing seedlings, including of rape, cabbage, tomato and so on, with a vibrant local market. The same applies to Mr B’s business in Chatsworth, again supplying seedlings to the local horticultural market, replacing the mainstream suppliers, and making serious money by all accounts.
LOCALISING ECONOMIES

We are very far from a post-COVID situation in Zimbabwe, and must await a wider vaccination effort, with help from the world beyond China being essential. However, there are glimpses of what this might look like. The growth of informal markets, the localisation of economic activity, the expansion of rural-based businesses and the continued growth of small towns as centres of exchange and trade in rural settings are all central elements.

These are all features that have dominated Zimbabwe’s rural areas since land reform. Sometimes denigrated and dismissed as not the supposed ideal of what existed before, but maybe this transformation has been the basis for survival during the pandemic and provides the basis for an ongoing shift to a more flourishing, localised economy linked to agriculture into the future.

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JULY 12 2021

ZIMBABWE FACES A COVID-19 SURGE: WHAT IS HAPPENING IN THE RURAL AREAS?

The increase in COVID-19 cases in Zimbabwe has been significant in the weeks since our last blog.¹ This has been matched by an increase in recorded deaths. The government has responded with a new ‘level 4’ lockdown,² imposing a curfew, restricting business hours, limiting inter-city transport, requiring movement exemption permits, closing schools and educational institutions and banning all gatherings, except funerals where numbers are again restricted.

The national level data show an increasingly dangerous situation, but why now and how has it affected the rural areas? As we have reported in the
past, the incidence has been extremely low in most of our study sites, but this has changed somewhat recently, although few deaths have been recorded. Why this change?

**WHY IS THERE A SURGE NOW, INCLUDING IN THE RURAL AREAS?**

Informants across our study sites point to a number of factors.

- First it is winter and this is the cold and flu season when respiratory infections spread as people are more frequently inside and interacting in close proximity.

- Second, it has been marketing season when people have been travelling about, gathering at market places, interacting with itinerant buyers and going to auction floors in the tobacco areas. Indeed, it has been in the tobacco areas that the greatest spikes in infections have been noted, and people have speculated that buyers travelling from hotspots – such as Karoi – have brought new infections into areas.
Third, it has been the relaxation in measures, including the day-to-day practices of hygiene that have occurred. Certainly over the last months people had gone back to a (nearly) normal life, and abandoned wearing masks and had attended large gatherings of weddings, funerals and church services. These are now banned, but some churches are dismissive of the regulations and argue that the power of prayer in large gatherings should be recognised as a way of combating the disease, and many are still continuing.

Fourth, early foci for infections have been educational institutions, including Bondolfi mission, Morgenster and Great Zimbabwe University. Here students and staff have been infected and later isolated, but in places where there is residential accommodation such as teachers’ colleges and boarding schools, the virus can spread, and those moving to such establishments – as day pupils, as service providers or sometimes as church goers – can in turn spread the infection to their communities.

Fifth, the ease of movement from South Africa through illegal crossings improves in the dry season as the Limpopo has little water and the danger from crocodiles and hippos recedes. This is the period for mass movements, as people go and shop in South Africa.
and bring back goods. At the Chakwalakwala crossing people move daily in their thousands, even with cars and trucks crossing the sandy river bed. This has a focus for significant importation of disease, as South Africa’s surge is in full swing, increasing earlier than Zimbabwe’s.

- Sixth, the increase in dry season trade is linked to major markets in the south of the country. These bring people together over wide areas. These Bakosi markets are preferred to going to town as you can buy everything from iron sheets for roofing to a chicken for a meal, and everything else in between. Much comes from South Africa, but local produce is also sold and exchanged. Such large markets are also a focus for social events and much interactions. In the midst of a pandemic, they are clearly foci for infection, and have now been closed.

All these factors have combined in the last couple of months to fuel the pandemic in Zimbabwe, extending it to the rural areas.

**WHY DO DEATH RATES REMAIN LOW, AT LEAST FOR NOW?**

Yet despite this, the number of deaths in our study sites remain low. This remains an anomaly as vaccination rates and existing immunity from earlier infections rates are low.

When we discussed this, the team pointed to the difference between mortalities of those coming from South Africa (and indeed of South
Africans and Zimbabweans), pointing to different lifestyles, unhealthy diets of processed foods, co-morbidity factors (including being overweight, having diabetes and so on). Poverty, they argued, has kept us healthy!

In our study areas, burials have been occurring in cases where bodies have been returned home from South Africa. Cemeteries in Bulawayo for example are reported to be being under pressure. This may yet change, but there are some interesting hypotheses about what both results in infection and causes death.

Many informants across our sites point to local remedies as important in managing infection. While more people are getting the disease, its effects though far from pleasant are being addressed by local remedies. Mr Moses Mutoko from Wondedzo Extension in Masvingo district explained:

“In June my whole family was infected by an unknown ‘flu. It was persistent and heavy. We treated ourselves by steaming of a mix of Zumbani (a local herb), eucalyptus leaves and lemon, covering ourselves with a blanket for 15 minutes and sweating hard. We would also drink the mixture morning and night. We would also gargle several times a day with coarse salt and warm water and drink large amounts of water when we wake up and before we go to sleep to clean the body. We all recovered and are fine now. I have
shared this prescription with the community, and everyone has taken it up. We hope it will save people from the disease.”

People across our sites urge the government to take local treatments seriously and invest in research as well as promoting seemingly efficacious ones.

**VACCINE VIEWS**

The surge in infections across the country has put the vaccine programme in the spotlight. Earlier reluctance among some has turned to an increasing eagerness to be vaccinated. Currently approximately 6% of the population have had a first dose, but rates have slowed of late due to supply problems. The vaccines being offered remain only the Chinese, Russian and Indian vaccines with an offer via the African Union of Johnson and Johnson vaccines being rejected on the grounds that the infrastructure for delivery was not up to scratch.4

Many speculated that this was just politics being played out, with the Zimbabwe government snubbing the West. With the Chinese offering a further 2 million of their Sinovac shots,5 Zimbabwe may be able to play
politics, but it seems a risky strategy right now. This is especially so as
delivery is patchy, and the logistics not always streamlined with shortages
reported across our sites. Nevertheless, the government’s overall COVID-19
approach has met with approval, both from other countries in Africa, and
from the Zimbabwean population according to the Afrobarometer survey.
For a time Zimbabwe had been seen as a potential vaccine tourism
destination, with private clinics offering shots for US$70 or more, and
South African travel agencies offering pricey vaccination travel packages.
However, with current shortages, this has all stopped for now.
Meanwhile, companies such as Tongaat Hulett who run the huge sugar
estates are offering shots to workers, as there has been a local peak in
infections on the estates, with worker compounds closed down and put
into quarantine. Again, this is linked to the season and the greater
movement of people associated with cane cutting.
The discussion in our team and amongst informants across our sites
on vaccination continues. Many views are expressed:

- Some complain that agricultural extension workers are not treated
  as front-line workers and do not get priority on the vaccination lists
  like doctors and nurses, yet they have to have face-to-face contact
  on a regular basis and must travel over wider areas. These individuals
  are keen to get a shot but have failed so far.

- Others say that since deaths remain low and that the surge will likely
  abate after the marketing season and when the weather warms up,
  then they don’t mind and will wait for an more effective vaccine.
  They argue that these vaccines are not fully protective like the ones
  for measles, diphtheria and so on that Zimbabweans are very familiar
  with and many can name a case where someone vaccinated gets it
  again.

- There are some who argue that the situation is nothing like that
  experienced with AIDS when burials were happening daily and
  everyone was affected, and yet, they comment, we survived that
  without a vaccine and through changing behaviours and practices
  over time.

- Still others say it’s like any other severe ‘flu and we must learn to live
  with it, using local remedies. It’s clearly now endemic and it will be
  part of our winter experience forever.

Just like in discussions across the world, there are plenty of views, each
with their own evidence and case studies to share. Complexity, uncertainty
and contested interpretations of both science and experience remain the order of the day.

**LOCKDOWN RESPONSES**

The return of a lockdown is creating real concerns. The memories of the suffering from 2020 are fresh. This is especially challenging now as this is the main season for marketing horticultural products. Transporters can only start moving after 6am due to the curfew, meaning fresh, perishable products can only get to market late. And in the evening they want to move their transport out of town before 6pm for fear of getting vehicles impounded. This constrains the marketing day and for farmers reduces income.

In the past weeks, there has been an increase in direct contracting to local supermarkets, as markets have been closed down. This is only available to some and often means lower prices, even if a market is guaranteed. Wider business dependent on agriculture and dependent on farmers buying things are suffering as business hours and movement is restricted once again. It is back to the bad old days of 2020, with businesses laying off people or closing, and farmers suffering.
THE IMPORTANCE OF REAL-TIME REFLECTIONS

This is the fifteenth contribution to our real-time monitoring and reflection of the pandemic in rural Zimbabwe. It is far from a linear story and there are many contested views and diverse experiences. Without such in-depth, real-time information it is difficult to make an assessment, and so difficult to learn lessons. Lots of studies are emerging right now that offer definitive statements from snapshot and circumscribed surveys, including from rural Africa. What our tracking has shown is that these are inadequate. A fuller understanding of this pandemic in all its dimensions will only emerge in time, and we will continue our regular reflections, so watch out for the next blog in about a month.

3 https://zimbabweland.wordpress.com/2021/02/08/the-rich-peoples-virus-latest-reflections-from-zimbabwe/
4 https://allafrica.com/stories/202107050438.html
8 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
9 https://zimbabweland.wordpress.com/2020/04/27/2991/
COVID-19 SPREADS TO RURAL ZIMBABWE

The third COVID-19 wave has firmly arrived in Zimbabwe’s rural areas. This is no longer the ‘rich person’s disease’ of those based in town.¹ The number of cases and sadly deaths has surged across our rural study areas in the last month. This is a picture reflected across the country and indeed the region, with large increases since our last report.²
After being spared for so long, why are the rural areas only now being affected? This was the topic of the conversations in our research team this month. It is clear that the Delta variant is proving extremely dangerous. Having spread from a small isolated outbreak in Kwekwe just a few weeks ago and through imports from across the border in South Africa, it seems to be the dominant variant now. Highly infectious and easily transmissible, the fact that rural people don’t move much and work and live outside makes much less difference in the face of this variant it seems.

There have been deaths recorded in all our study sites in the past weeks, with others being buried in the area having died in South Africa or elsewhere in the region. Many others have contracted the disease and have been battling it at home while isolating. Some of the most vulnerable are the front-line workers who have frequent contact with people, while living in the rural areas. Nurses, health workers, agricultural extension workers, police and others have all be noted as people who have contracted COVID-19 in our sites in the last weeks, very often passing it on to others.

Mr FC is a 68 year old health worker and farmer in Wondedzo. He contracted the disease and went to the COVID quarantine centre. However, he was quickly discharged due to pressure on beds:
The doctor and nurses decided to send me home for self-isolation paving way for the ever in-coming COVID-19 victims. I was given different drugs by the nurses, but I supplemented these by taking herbal teas. My son used to bring lemons, garlic, onion and mutsviri herbal tea. I used to cut onion or garlic into pieces where I could place underneath my pillow. Crushed onion was used to massage my chest and nose. All my belongings at home were heavily disinfected and I was given my own room where I stayed alone. All the food was brought by my son. I was given light food like crushed potatoes, rice, porridge, beans and mincemeat as swallowing was not easy. In the end, on the 15th day, I felt better and there was then slow improvement until I returned to work, when I got the disease again as I am in contact with people. This time fortunately it was not so severe and we now know how to treat it.

VACCINE DEMAND AND COMPULSION
The demand for vaccination has risen significantly too as a result of the surge in disease and concerns about severe illness and death. Queues have been forming at vaccination centres in all our study sites, but demand far exceeds supply, and the many return home disappointed. While nationally
over 10% of the population have had one dose, there is much further to go even amongst the older, more vulnerable age groups.

Zimbabwe’s vaccine programme has been the envy of neighbouring countries, but it does remain heavily reliant on supplies from China (and to a lesser extent Russia and India). The J&J single dose vaccine is now (finally) approved locally, so maybe there will be an expansion of supply soon, but with China now experiencing new outbreaks some worry that politically-driven gifts of free vaccines to Zimbabwe will be less of a priority.

Despite claims that vaccination will always be voluntary there have been recent moves to make it compulsory among civil servants, with memos circulating across all departments requiring reporting of coverage. This has provoked quite a bit of debate, including within our team. Among those who have been hesitant about the vaccine, several commented that they will get it now as they need to keep the job. The old tension between public health and individual freedoms is once again being played out.

**LIMITED STATE CAPACITY: RELIANCE ON LOCAL INNOVATIONS**

This latest surge is both more severe and more widespread than before. The state, despite its best efforts, does not have the capacity to respond effectively. Health services are overwhelmed, funeral parlours are full, drugs are in short supply and vaccines insufficient. Whether via treatment or prevention, the response has to be centred on local people, their ingenuity and capacities. As we have mentioned in previous blogs, there has been a blossoming of innovation and entrepreneurship in response to the pandemic, particularly focusing on traditional remedies.

The now-famous Zumbani herbal tea is in huge demand, and those who collect it and process it are making good money. Diaspora Zimbabweans based in South Africa are sourcing it in large quantities as an effective remedy. Team members comment that they have abandoned Tanganda (black tea leaves) for herbal teas and remedies. A few months ago, they did not like them much, but now such teas are the preferred beverage several times a day. For those who get sick there is now a common health folklore about what the most effective treatments are.

This is shared through various routes. One of our informants swore by a video she had seen on WhatsApp from a Nigerian woman extolling the virtues of steaming and certain breathing exercises. Others listen to what neighbours have done and share locally. Even our research team, now known to be the contributors to these blogs – which are often shared
further through social media and in local newspapers – are asked for advice. “We are the new doctors!”, one quipped. While there is much misinformation on social media spread through rumours among relatives, neighbours and church members alike, there is also lots of useful advice. Sifting through this competing knowledge claims and making choices in the face of disease is a critical part of living with COVID-19 today.

Alongside traditional herbs and remedies, lemon, ginger, garlic and onion are the most common ingredients for local remedies and are used as teas, chest/body presses, inhalation steaming and so on. Mrs MC contracted COVID recently and explained:

I had two regimes, which is Zumbani mixed with lemon as tea taken twice a day, morning and afternoon. I also had ginger and garlic tea, which I took at sun down and late at night. I also used to chew raw onion regularly as means of opening the nasal system. I had learnt of these traditional medicines via social media, friends and relatives, I also learnt of the use of crushed onion wrapped in a transparent cloth, which then could be pressed against my chest whenever I go to sleep. It is now a habit in my family to take the traditional medicines all the time.
The demand for such products is massive. Mrs Kwangwa has a nursery in Masvingo in the compound of her husband’s National Railways of Zimbabwe house (see pictures). They started the project back in 2014 after she graduated from Masvingo Polytechnic with a certificate in agriculture. They have been growing vegetable seedlings, fruit trees, flowers and so on, with a wide market across the province and beyond. In COVID times they have shifted focus – and now the big crops are onions and lemon tree seedlings, with plans for expanding into garlic and ginger growing once they secure a bigger plot with more reliable water supplies. As we noted in earlier blogs, everyone is now a gardener, and Mrs Kwangwa commented that her customers have expanded. “COVID-19 has popularised agriculture – I now have doctors, engineers, teachers coming for seedlings as well as the normal farmers.” Everyone wants to buy products that can help them fight infections. It’s a profitable business and they bought a Nissan Sedan and a Mazda truck to transport water, leaf litter and seedlings, and they now employ three people.

If the world is going to live with COVID-19 (in its now many forms) forever, even with protections from vaccines and so on, then the sort of innovations and investments that Mrs Kwangwa has made will continue to be vital.
Research on new agricultural products and wild product harvesting and processing will be needed to support a longer-term strategy for responding to a seasonal, hopefully less virulent coronavirus into the future.

**DISEASE SPREADING EVENTS**

While traditional remedies help fight infection and treat disease, other behaviours may reduce transmission. People are now used to the idea of keeping a distance, wearing a mask, not going to large gatherings and so on, but it’s difficult to do this in normal life. Transport for example is rare because of restrictions and so people must resort to informal, illegal means. Such mushikashika transport is always packed, often with few measures to reduce infection. Cross-border movement is essential for many people’s businesses, especially in those study sites near the borders such as Chikombedzi and Matobo, but people have to pay the bribes to cross illegally so their business can survive. Different people commented: “It’s better to die of corona than hunger”; or “I have to carry on, I cannot let my business collapse. What will I do to survive?”; or “We just have to learn to live with this virus, we don’t have any other safety net”.

In our sites, our team (now all expert field epidemiologists too…) identified a number of spreader events. For example, one malaicha – an informal transporter of goods – became infected and spread the disease widely as a result of contacts made through his business. Equally, particular shebeens (illegal drinking places) have become a focus for outbreaks, as people gather in packed rooms, as the official bars and restaurants remain closed. Although church gatherings are officially banned and most churches comply, some – such as the Apostolic churches – resist and hold their (often huge) gatherings at night. It being winter, people huddle together and so become infected.

Perhaps the most risky gatherings are funerals. With more people being buried – sometimes several a week in a village – funerals bring together people from across the country as relatives gather to pay condolences. Village neighbours come to pay their respects and commiserate with the family. Viewing the body happens in closed spaces, within huts while the family sits nearby. With it being winter, more happens inside in closed spaces with limited ventilation, and no one knows if wood smoke disrupts the virus or makes you more susceptible. Funerals are of course important moments in any society, and are especially so in rural Zimbabwe and for the older (more vulnerable) generation. Children in the diaspora have been beseeching their parents to avoid funerals in their villages, but with little effect. How can you not attend, at least for a short time? The
traditions and rituals of passing are so significant that even a public health crisis cannot prevent them happening.

While official case numbers and deaths are thankfully declining in the last few days, this third wave has brought with it new challenges, especially in the rural areas where, for the first time, infection, severe disease and deaths are being seen on a much larger scale. There are many hypotheses as to why this is only happening now, but much must be to do with the Delta variant, which is effectively a new disease. The state is doing its best but can only do so much. As before, rural Zimbabweans are left to cope on their own, with important innovations supporting the struggle against the disease, both for now in the midst of the pandemic and likely into the future, as this is clearly not going to go away completely.

1 https://zimbabweland.wordpress.com/2021/02/08/the-rich-peoples-virus-latest-reflections-from-zimbabwe/
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11 https://zimbabweland.wordpress.com/2021/05/10/rural-livelihoods-in-the-pandemic-notes-from-zimbabwe/
13 https://bigsr.africa/pandemic-funerals-to-attend-or-not-to-attend/
THE POLITICS OF CONTROL IN ZIMBABWE’S COVID TIMES

The COVID-19 situation in Zimbabwe has improved since our last report, with infection rates and deaths declining in all areas. The alert level has been reduced to Level 2, with restrictions relaxed. At the same time, the vaccination drive has continued apace, with the government now mandating all civil servants to take a shot. So far just over 20 percent of the population has received at least one vaccine – mostly from China – although there are big variations across locations and age groups.
The period of Level 4 lockdown during the most recent wave has taken its toll. During this period, lasting up to 7th September, many businesses closed and most public institutions, including schools and colleges, were shut. This had a big effect on the local economy and many suffered badly. This included farmers across our sites, who complained bitterly that schools, colleges and other businesses they supplied food to were slow to open up after the shift to Level 2. This particularly affected horticulture farmers in Chatsworth and Wondedzo who rely on vegetable sales for livelihoods at this time of year, with large amounts of produce rotting.

**COVID CONTROVERSIES**

Controversies around COVID-19 continue to be central to discussions across our sites. COVID has become a symbol of control, a centre of power struggles and local politics; much more than just a disease.\(^3\) This has been especially evident around the vigorous vaccine campaign that the state has led.

Many, particularly younger people, still dismiss the disease: “It’s just a strong ‘flu”, one commented. “We have our own remedies for it, we don’t need the vaccines”. The view that COVID is being used by the state to control people is widespread. A number of younger informants observed that the vaccines may be used by the government, in alliance with foreign powers, to control the population, making people infertile. While conspiracy theories can be dismissed, their existence must be taken seriously as they reflect the politics of COVID times and the deep lack of trust many, perhaps especially younger people, have in authority.

Geopolitics comes into it too. “Why is this government accepting vaccines from unfriendly states like the US when they impose sanctions on us…. It seems very fishy”, one informant observed. Others argue that it’s odd to get a free vaccine from China when health centres have no other drugs “not even paracetamol, no basic drugs, no ambulances, yet these are all free and supplied by the government. We smell a rat… there is something not right…. What deals are being made about our future?” “It’s all about making money and controlling people”, one young person commented, “COVID is destroying our lives and economies”.

**TRUST AND THE POLITICS OF CONTROL**

All sorts of theories are debated, but the common theme is the little trust in the state and its solutions. Many see politicians capitalising on the COVID moment, recognising that elections are just around the corner. Other local leaders are using the requirement of the state to vaccinate to control their
populations, with chiefs and headmen threatening the withdrawal of food aid if people don’t get vaccinated. Vendors wanting to sell in local bakosi markets have to be vaccinated in some of our sites, again giving more powers to local leaders. Local officials keep lists of those vaccinated and not, creating new forms of local surveillance. Government departments have until 15 October to get their staff vaccinated, otherwise they must go on ‘unpaid leave’ until they do. All our team who work in the agricultural extension service have got vaccinated, for example.

Others resist the state vaccination efforts completely. For example, the Vapostori church followers refuse to take them. They say that COVID like other diseases is just punishment from God. It should not be resisted, and any requirement to stop praying in large groups should be resisted lest the Almighty is angered. God will answer and find a solution, they argue. Other churches, such as the Dutch Reformed, Roman Catholic and others, urge their followers to get vaccinated.

Among traditional religious leaders, such as the svikiro spirit mediums, there are a variety of opinions across our sites. Some argue that COVID reflects the anger of the ancestors for not following local customs and rules. They promote traditional practices for curing and healing, and some herbalists have joined others in prescribing herbal remedies for teas/infusions, gargling and steaming. The massive growth in demand for local treatments that arose especially during the most recent deadly wave has reinforced the power of herbalists and traditional healers within local communities.

Recourse to ‘tradition’ and the rejection of modern ways, around food in particular, is a common refrain. The argument that foods made from rukweza, mhunga (finger and pearl millet) and other traditional products give strength and help people resist the disease has been much repeated. This has strengthened the hand of traditional healers, mediums and some local leaders over their ‘modern’ replacements in local power struggles in a number of our sites.

There is a gender, generational and locational divide too. Women are getting vaccinated far more than men, according to those working in the local clinics across our sites. Older people too are much more likely to get vaccinated than the youth, as they have seen old people get sick and die. Parents complain that they cannot persuade their children to get vaccinated and follow the regulations on distancing, mask wearing and so on. Finally, those in town are more likely to sign up as they too have seen
the effects of the disease in recent waves – some even travelling to rural homes to get their shots as there is more availability of vaccine.

**CONTROLLING DAILY LIFE**

COVID times have created many tensions centred on the control over daily life. Tensions play out between the state and normal people; across generations, between youth and older people; within families, and between spouses; among colleagues who are civil servants; between church followers of different denominations, within villages and even within families; between the living and the spirit world; and between local leaders and their followers within rural areas. All these tensions are refracted through local politics.

While vaccination has often been the central, immediate focus, these tensions are therefore about much more; a window on contemporary rural society in Zimbabwe. These disputes are about the politics of control, over defining freedoms and limits and the role of the state and other authorities in relation to citizens. They are about faith and belief, interpretations of ‘tradition’ and ‘modernity’ and the trust in state authority and science. And they are about wider politics around which foreign powers can be trusted with people’s health and well-being.

We all know that the pandemic is political, but it now permeates all aspects of daily life in Zimbabwe’s rural areas.

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2 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
3 https://zimbabweland.wordpress.com/2021/01/11/lockdown-politics-reflections-from-zimbabwe/
NOVEMBER 29 2021

NEW COVID UNCERTAINTIES IN ZIMBABWE

The unfolding drama of the pandemic continues. With a new variant identified in the region (Omicron) thanks to the effective work of South African genomics monitoring, Zimbabwe has been subjected to international travel restrictions. However, despite the global concern about the potential spread of what may be a highly transmissible, immune-escaping variant, things on the ground feel very different. So far at least. After the sky-high infection rates and substantial deaths of a few months back, rates subsequently declined dramatically again. Will the new variant upset this? No-one knows of course.
Conversations with our team across our sites suggests that people have been getting back to ‘normal’ life, despite some remaining lockdown regulations. What does this new normal feel like? Some quotes from across our sites illustrate. “We are now not afraid, it’s not like the early days. We know how to prevent, treat and manage the disease”. “We have indigenous remedies at our disposal. We have made so many discoveries, and now know how to fight the pandemic”. This confidence may yet be shattered by the new variant, but for now a new version of normality seems to have settled in.

While people may wear masks on transport and mask wearing gets enforced during visits to town, the situation in the rural areas is much more lax. “These masks are far too hot in this season”, someone explained. Large gatherings have started again. Political rallies are the most noticeable as electioneering starts up already in advance of the 2023 vote. “It’s the politicians who are the biggest law-breakers”, someone noted. Churches, farmers’ fairs and so on are also being held, with few restrictions and little social distancing. Curfews too, people report, are barely acknowledged especially in the rural areas. It feels, at least on the surface, pretty normal, with people making judgements about risk not in fear but with knowledge about the trade-offs and consequences.
But of course such knowledge is not certain. All can be upset with a new variant, as it has been before. And the wider context has changed too through the pandemic as livelihood possibilities have been restructured and attitudes and practices towards health and disease have changed.

**LOCAL KNOWLEDGE AND INNOVATION**

People repeatedly mention their discoveries of local treatments that have given the confidence in the face of disease threats. “We have done so much research”, someone observed, “we really know the situation now”. As well as COVID-19, this applies to what people call ‘cattle COVID’ too (January disease) that has struck people’s herds in dramatic fashion, often resulting in greater impacts on livelihoods than coronavirus. “We have mixed grasses, *mutsvirri* ash and water, soaking overnight… and it works for cattle”. We are trying *mutsvirri* ash with lemon for humans too. Along with the many remedies from local herbs to boost immunity (such as *ndorani*) and for COVID treatment (like *zumbani*), as well as the range of mixes of garlic, onions, ginger and lemon, people have a battery of treatment meaning that for now they no longer worry about the disease as they once did.

Uptake of vaccines goes hand-in-hand, with supplies now good and queues small as people take up vaccine offers. This is far from universal and to date only 18.3% of the population have received two doses. But this combination of local systems of containment and disease management with external medical intervention is seen as efficacious, and the way forward for navigating on-going uncertainties.

As experience has increased with COVID, with different waves and different impacts on different groups of people, people’s local epidemiological knowledge has increased. The seasonality of the disease is often commented on (“now it’s hot, there’s much less disease, we are not inside”); the dangers of close proximity and crowded places is clear (“even though it’s hot, I wear my mask on the combi, but not around the town”); and the dangers to those who are already vulnerable is clear (“it’s the diabetes and the BP that’s the killer – we have to eat better and consume our indigenous foods”). The revival of debates about appropriate diet (millets, not processed maize, less meat and so on) has been part of the local conversation about the disease over time.

With this knowledge comes the ability to make choices. As people commented, “in the beginning we had so much conflicting information on WhatsApp, on the internet, from friends, we didn’t know who to believe”. 
Now people make judgements made on experience after 18 months of the twists and turns of the pandemic, taking account of local circumstances and not taking anything at face value.

Our conversations last week happened before the new variant was identified, and this of course presents a new uncertainty that may yet shatter local confidence, returning things to dark days of just a few months back. Such is the experience of the pandemic: continuous change, continuous uncertainty.

NEW LIVELIHOODS

No matter what a new variant throws at Zimbabwe’s rural population in the coming weeks, the pandemic has affected the structural conditions by which people remain healthy or become sick.

Due to repeated lockdowns and the parlous state of the Zimbabwean economy, people must make livelihoods in new ways. Many businesses have closed, jobs in town are scarce and people must increasingly rely on local provisioning, especially through agriculture. There are also many new opportunities that have emerged, which have been documented in this blog series before. In urban and peri-urban areas for example, the demand for COVID treatments is met by a proliferation of new gardens, growing key
ingredients. Ginger is now widely grown for example, and no longer imported from Mozambique or the Eastern Highlands. While transport has returned and farmers can move their crops to market, many have adopted new market networks, spreading risk and going for shorter transport distances, as the predatory police presence on the roads is still a problem (and a cost).\(^7\)

As we have documented before,\(^8\) many have returned to rural homes, seeking out a plot from a relative or a parent, when jobs have dried up in Zimbabwe’s cities or in South Africa. Agriculture, and especially in the land reform areas where there is more land available, is a vital source of resilience in pandemic context.

Some have taken up new agriculture-based business, switching from a town job to intensive horticultural irrigation for example, or in the case of women vendors in Chikombedzi moving into goat rearing and trade to South Africa on a huge scale. Time will tell whether this is a more permanent restructuring of the economy, but the shifts are significant and will be important for thinking about post-COVID recovery.
AUTONOMY AND RESILIENCE

Across the commentaries from our informants in all the sites, there is a great emphasis on autonomy, and how this brings resilience. People have learned and innovated on their own. They haven’t been reliant on the state or international donors. Indeed, they have not been able to provide – the government and party doesn’t care, the donors are not interested in Africa are frequent refrains. And the competition between the Chinese, Russians and Americans over vaccines and COVID response is seen from afar with disgust.

The emphasis in local commentaries is on local adaptation through experimentation and way of responding that is localised and seemingly effective. Knowledge is shared through local networks, through WhatsApp, but is sifted now more carefully as options are considered. As people confronted the information on a new variant this weekend, according to informants there was a mix of scepticism and stoicism, but equally a sense that people were on their own as before but now with the capacity to innovate and respond.
A POLITICS OF THE ‘NEW NORMAL’

These new social and economic patterns of the ‘new normal’ occasionally confront the emergency focused public health efforts from the state. The emergency mode is relinquished slowly, as it serves certain interests: both political control in a volatile context and also opportunities for corruption and enrichment as lockdown laws are enforced.

There is however a distinguishable shift in our informants’ attitudes in the last month or two. With the relief that the massive peak had passed, state-enforced public health is become less accepted. Before, public health was paramount, and people mostly accepted often quite top-down, heavy-handed state intervention. The government was getting high approval ratings. It was after all a crisis, and through the news from the UK or South Africa, people also knew how bad it could get and how limited the resources in Zimbabwe were to cope with it. “We saw it on the news, we were scared.”, someone commented.

Now with less fear and more grounded knowledge along with much more experience, there is a more circumspect view, with people prepared to make judgements about risk and assess trade-offs. In the end, basic survival and the sustaining of businesses and livelihoods is important. How the arrival of a new variant will affect the assessment of risk and collective responses is of course still unknown.

VACCINE MANDATES

These dilemmas reflect experiences elsewhere where the limits of state intervention are being tested. There are no mass protests as has been seen in Europe and other regions, but people are also asking where does public health stop and individual liberty start? A core focus of this debate is the vaccine mandate for civil servants. In one of our study sites, a district agricultural extension office lost a significant number of staff as they refused the vaccine due to their religious beliefs being members of one of the Apostolic churches. They were put on indefinite, unpaid leave, and so effectively fired.

This has caused reverberations among civil servants, in part because for some their workload has doubled, but also they are asking whether this is fair and just. Some labour unions are contesting the decisions in the courts arguing that the vaccine mandate is anti-constitutional. Others relay concerns that this is simply the exertion of authoritarian political control, linked to a surveillance state that has no concern for liberty.
UNCERTAINTIES ARE EVERYWHERE

If there is one thing that this pandemic has taught all of us it is that uncertainty is everywhere and we don’t know the future. But how uncertainties are navigated and how risks are perceived does change, and we have seen this clearly through our tracking of the pandemic in Zimbabwe since March 2020 (see the previous 20 odd blogs in this series). In the last months, there has been a tangible shift in ways people are going about their lives and how they see the disease. This may yet change if the new variant strikes hard as some fear.

However, for now at least and despite Omicron dominating the headlines, most people in our rural sites across the country currently don’t spend much time thinking about COVID, as the rains have come and it’s time to plant and get on with the agricultural season. There are always other uncertainties to contend with.

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1 https://www.ft.com/content/b8ca4536-07b2-463f-bb44-8159aaec89ab; https://twitter.com/Tuliodna/status/1463911554538160130?s=20
2 https://zimbabweland.wordpress.com/2019/07/01/responding-to-uncertainty-who-are-the-experts/
4 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
5 https://zimbabweland.wordpress.com/2021/01/04/can-zimbabwe-survive-a-second-wave-of-covid-19/
7 https://zimbabweland.wordpress.com/2021/01/04/can-zimbabwe-survive-a-second-wave-of-covid-19/
10 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
11 https://zimbabweland.wordpress.com/?s=covid
It was just a few weeks ago that our last report noted the arrival of a new variant identified in South Africa. In the interim Omicron has swept through the country. This initially resulted in panic, with a rush to get vaccinated and the government swiftly responding with further lockdown measures. As someone recalled, “it was like the world was about to come to an end”, so panicked were both officials and many in the population.

The rapid spread is reflected in the case data that is officially reported, but the real figures are massively higher. Across our rural sites, people report
that about 50-60% of villagers have been struck down by a virulent ’flu in the past weeks, suggesting massive under-reporting in official figures.

Just two weeks ago we were hearing reports of a ’flu in our site in Chikombedzi, in the far south of the country near the border with South Africa. On 5 December, our research team member reported via Whatsapp that many people in the villages had been coming down with ’flu, but no deaths were being recorded. Since then, the same reports have come from all sites as the variant has spread north and across the whole country.

However so far, just as observed in Guateng in South Africa, which has been the epicentre of the Omicron epidemic, there have been very few deaths. Indeed, in our last review across sites over this past weekend, no local deaths have been reported and the only COVID related burials have been of those who have died elsewhere – all in our Chatsworth site near Gutu, with four bodies returned from South Africa and one from Chiredzi.

Omicron seems to cause a debilitating flu, involving a severe headache, joint aches, body weakness and severe fatigue, together with a running nose. People say it’s like malaria, with hot and cold sweats. It is extremely transmissible and very often whole families are down with it together. Indeed one of our research team members has been suffering from it over the past week, but the whole family has now thankfully recovered. It affects all ages, and vaccinated and unvaccinated people are all affected.
However, recovery rates seems extremely good and it lasts about five days, slightly longer for older people.

**RAPID SPREAD, RAPID LEARNING**

While in the first days at the beginning of December people were seriously worried, as they have experienced the disease over the last couple of weeks and been able to treat its symptoms, people have become more relaxed. With such rapid spread, the learning cycle in this pandemic is speeding up. The remedies used in previous phases have all be deployed, but this time the focus on body aches and fatigue has meant new innovations. The long used medication from China called ‘Tsunami’ (an aromatic oil, as shown by Mr Mutoko from Mvurwi below) is in high demand, as it can be applied to joints and even drunk in a tea. Equally, onion compresses are widely used to help with body aches and cold symptoms.
While many have taken up the offer of vaccines (20% fully vaccinated, 27% with at least one dose), few think that this is enough. An interesting argument emerged in discussions across our sites about the importance of having lots of different responses so that new variants can be tackled on many fronts. A single response – just focusing on vaccines as the government is emphasising – is not enough, people argued: “You can be doubled vaxxed even have a booster and still get Omicron... the variant needs many things to fight”. “Treatment responses must be wide and varied and this must include local remedies”, was a wide consensus as expressed in one discussion.

The sharing of remedies and treatment responses has been as rapid as the spread. Those in the border areas near South Africa experienced it first, and shared information about symptoms and remedies to relatives and others elsewhere. WhatsApp messages and Facebook groups are full of advice on how to tackle Omicron. Each family and village has a different set of responses, but the sharing of options is widespread. There are many, diverse prongs of attack. And (so far) it seems to be working.
MAJOR DISRUPTIONS

With whole families out sick for a week, and with the rapid spread sometimes half a village at a time, this has seriously disrupted the beginning of the farming season. The rains have finally (it seems) come, with steady rain falling over the past days. This is the time to be in the fields to plough and plant, as timing is all. Omicron is causing havoc with farm labour and this may have knock on effects into the harvest. The need for labour for land preparation is heightened this year as many livestock have perished due to January disease (known as cattle COVID locally), and so draft power is scarce.

However, what is causing most disruption and what was the centre of people’s commentaries was the return of lockdowns. People are just fed up. They have no livelihood options, people are poor. Kids have been out of school for months and are really suffering. Social problems are building up. No one can face another round of lockdowns, especially with what appears to be a mild disease. And for this reason, very few are reporting sickness to clinics with the fear of being quarantined. As someone observed, “getting locked up is worse for you; you don’t have the support of your family, you cannot use your local remedies”.

THE POLITICS OF CONTROL

Perhaps more than in previous phases, or at least with a different accent, there is a political critique of the current response and a demand for
freedom and liberty,\(^2\) with an abandoning of a standard, centralised response to the pandemic. “We must learn to live with the disease, just as we have before with AIDS, and so many other diseases”, someone argued. “It’ll always be there, so we need vaccination alongside our own methods”, another said. “Who profits from this very standard way of responding – vaccines, vaccines, vaccines?”, someone asked rhetorically, answering: “it’s the big businesses who make a profit, and the governments who want our resources. A vaccine may be free, but it isn’t really”. People are very aware of the vaccine politics being played out in Africa and they don’t like it.\(^3\) In commentary across sites, there was a widespread critique of the top-down response to the pandemic:

It’s government, the WHO, corporations who are in control. The powerful. The messages come one-way from them to the masses. We are bombarded with messages and instructions, which require adherence without question. The restrictions of endless lockdowns were getting to many: “It’s just don’t, don’t, don’t; it’s terrible for us, we are trying to live. How can we live a life of lockdowns? We are not comfortable with this”.\(^4\) Another informant observed, “We are not scared now of this disease; the only challenge are the lockdowns. We are approaching Xmas, but we cannot do any business, we are stuck.”

Even those enforcing lockdowns are fed up. One police officer commented, “We are tired of this, but we have to enforce the law. We need a compromise”. Lockdowns, as we have discussed before, lead to businesses collapsing and people seeking other forms of income. Corruption and crime are rife. Civil servants have not been paid a living wage for years, so as someone observed “it’s no surprise that people steal and get involved in corrupt practices like the police….It’s the same with the rise in petty crime. People are desperate.”

**COLLABORATIVE APPROACHES**

So what’s the way out of this endless cycle? There were some interesting ideas expressed about ‘living with the disease’ in discussions in our sites during the last week:

We have to do this together. We cannot have government just saying do this, do that, the top-down control doesn’t work. We have to find a way to discuss. After all it’s us who must ultimately respond to the disease in our own localities.

A more collaborative approach, taking account of local needs and knowledges, was advocated:
We have our own ways of dealing with the pandemic, we don’t like being controlled. Those in charge don’t know what we do, let us do it. Yes, we need the vaccinations and the drugs from the clinics, but let’s recognise the many other responses. We have to work together.

This may be an important lesson for other countries too as a wider social contract emerges about how to deal with what inevitably will be an ongoing response to a disease (or now seemingly a variety of diseases), even as it settles towards an endemic state across the world, with inevitable new variants and new surprises in store.

2 https://zimbabwelands.wordpress.com/2021/01/11/lockdown-politics-reflections-from-zimbabwe/
3 https://zimbabwelands.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
OMICRON FOR CHRISTMAS: WHAT WAS THE EXPERIENCE IN RURAL ZIMBABWE?

The Omicron wave peaked in Zimbabwe just before Christmas. With people moving about for the festive season and large numbers coming back from South Africa and elsewhere for the holidays, the fear was that the spread would be dramatic, with devastating consequences. Border restrictions were maintained, curfews imposed and the lockdown was extended.

As we reported in our last blog on 20 December, many had already reported that the infection was proving relatively mild, a finding subsequently supported by hospital evidence from South Africa, the UK and Denmark. And, just as the spread of Omicron was dramatic and fast, its decline has similarly been sudden, although cases still persist. Across our sites in the last few weeks, multiple cases have been reported, but way down on the situation a few weeks back. No deaths have been recorded in our sites in the past weeks. A few of our agricultural extension colleagues went down with Omicron around Christmas, but they all isolated and quickly recovered.

A FESTIVE MOOD

Although Omicron presented more uncertainties to contend with for the holidays, people across our study areas reported that they were not going to be put off. People were in a festive mood, relatives had returned after a long gap and there were parties to be had. Many large gatherings were reported, including the return of large church services. In towns and business centres large crowds gathered, bars were open and there seemed
to be little social distancing, there was reduced mask wearing and people were sharing calabashes in communal drinking sessions.

The now familiar ‘bakosi’ markets were in full swing across our study sites, especially in locations further south. These sprawling open air markets usually operate once a week and sell everything from food to clothes to hardware and more. Huge numbers attend, perhaps several thousand at times, and of course are potentially major infection hot spots. But they also serve important economic and social functions: they are places to gather, to meet people, to exchange ideas and goods, and are now an essential part of rural economic life, and no matter what the potential risks people were not keeping away over the holidays.

Despite the caution of the public health authorities, the people were not going to let the virus get in the way of a holiday mood or the need for business. Fear had receded of COVID, perhaps because of the experiences
with Omicron in the previous weeks of relatives and others both in Zimbabwe and South Africa.

**CHANGING REMEDIES AND HOME TREATMENTS**

As we have reported *many times before*, local remedies and home treatments have become the way people have coped. People fear quarantining and forced isolation now more than the disease. Because Omicron presents differently – more ‘flu-like symptoms, with a combination of nose and throat congestion and a dry cough, rather than the impact on breathing and the chest as in previous waves – the treatments have changed.

The most recent, circulating widely on family Whatsapp groups, is a concoction of Coca-Cola and chilli, which is supposed to work wonders. Others reported include a mix of lemon, cooking oil and onion. And of course the full array of other herbal treatments we have discussed on this blog before. The important point is though that with an effectively new
disease in Omicron, with different symptoms, people have experimented, learned and shared new remedies – literally in a matter of weeks.

Nurses in clinics across our sites reported that it was a busy time over the holidays, but many were not coming to the clinics if they thought they had COVID as they feared quarantine. They would prefer to treat themselves at home, while self-isolating. Having a variety of treatments to hand people argue, is a more effective response. It seemed that the nurses (informally) agreed as they noted the problems in the public clinics.

**A PLURAL HEALTH SYSTEM: FOSTERING RESILIENCE**

Meanwhile, public health interventions continue focusing on vaccines. There was a big spike in vaccine take-up in the rural areas over the holiday period. This was apparently due to people coming home from town, and choosing mobile rural clinics over the urban ones where they normally live. The rural alternatives were quicker, easier and more accessible it seems.
Even diaspora relatives took up the opportunity, and many younger workers from town were persuading their parents and others to join them at the clinics.

During the pandemic a network of health professionals has emerged to support rural people’s response to the disease. These include of course the doctors, nurses, vaccinators and village health workers, part of the public health system, but the wider health system also includes herbalists (those with specialist knowledge of particular herbs), n’angas (spirit mediums with treatment powers), and family based health specialists (often individuals within a wider family recognised as especially knowledgeable). And supporting them there are the wide range of collectors of herbal products, those who process them and the vendors who sell them, often with street advice on how to prepare presses, teas or other concoctions.

A plural health system has therefore emerged, partly out of necessity as the public system is inadequate, but partly out of the need to respond in a
diversified way, recognising that many people have expertise in a fast-changing pandemic setting, and there is no one right way, especially as the virus changes. With such a plural system, innovation, learning and sharing can happen quickly and effectively. Some of the remedies may not work that well, but others might, and people will respond accordingly.

In March 2020, right at the beginning of the pandemic, in the first contribution of this now long series on COVID responses in rural Zimbabwe, we argued that rural Zimbabwe might offer some level of resilience, having been able to manage turbulence and uncertainty of different sorts for many years, despite the obvious ‘fragility’ of the state. Resilience is not a single property; it is relational based on how people, individually and together, respond to unfolding events. This requires flexibility, responsiveness and collective sharing. As we have seen now over nearly two years, these are all features that have been central to rural Zimbabwe’s (largely informal) pandemic response.
1 https://zimbabweland.wordpress.com/2021/12/20/omicron-sweeps-through-zimbabwe-how-are-people-responding/
2 https://www.ft.com/content/19065fba-025c-43fd-bd76-37234af97953
4 https://zimbabweland.wordpress.com/2021/03/15/vaccine-politics-in-zimbabwe/
HEALTH WORKERS ON THE FRONT-LINE: EXPERIENCES FROM RURAL ZIMBABWE

Since the beginning of the COVID-19 pandemic in 2020 (the first case recorded in Zimbabwe was on 20 March 2020), health professionals in clinics and hospitals have been on the front-line of Zimbabwe’s response. In the last few weeks, while reengaging with our field sites, we have visited a number of health facilities in our rural study areas across Zimbabwe and talked to health workers about their experiences. As our informants explained, the three waves of the pandemic in Zimbabwe have been quite different.
THE FEAR OF COVID: THE FIRST WAVE

At the beginning of the first wave from late March 2020, there was a deep fear of the unknown. Health workers were confronting a novel virus without protective equipment and no known treatment or preventive vaccination. People watched TV and saw the scenes from China and then Europe, looking in horror at what might be coming their way. Much commentary saw the parlous state of health systems in Africa and feared the worst. Certainly, our informants reflected on how they were all initially terrified, sometimes avoiding seeing or treating people for fear of contracting the virus, while later they learned how to respond to the disease, but with significant wider challenges.

Across Zimbabwe, the first wave saw limited cases and few deaths, and these were nearly all imported cases with deaths recorded in hospitals in Harare. One nurse, now based in the Lowveld, experienced this first-hand as he was a student the main hospital in Harare at the time. With qualified doctors and nurses on strike, students were asked to attend the COVID wards. Lack of PPE and no knowledge of how to treat patients meant that they had to improvise. The lack of ventilators in the country meant that any escalation of the pandemic would have been disastrous. Luckily, this did not happen. Whether the strict containment measures enforced through a harsh lockdown helped or it was other factors at play, no one knows, but the first wave came and went with only limited impact. In our sites, clinics
and hospitals instituted strict screening requirements for entry and with testing facilities emerging, there were requirements for widespread testing, especially of staff. This was initially resisted as everyone feared the virus. Being COVID positive was seen as a potential death sentence, and would result in enforced quarantining.

TENSIONS BETWEEN PUBLIC HEALTH MEASURES AND PUBLIC VIEWS: DILEMMAS IN THE SECOND WAVE

Vaccines became available from February 2021, but vaccination drives in our rural sites initially saw very limited uptake. Hesitancy emerged for a number of reasons. Low incidence meant that there didn’t seem a need. The misinformation from WhatsApp groups and social media was extreme, with all sorts dangers suggested from vaccination in general and from Chinese vaccines (the only ones initially available in Zimbabwe) in particular. Fears were also held by health workers, who were one of the first groups where vaccination was mandated. Many we interviewed admitted they delayed getting vaccinated until it was clear that the vaccines were safe.
This made their role in promoting the vaccination drive somewhat ambivalent; although this changed as vaccines became more widely accepted. By the time of the second wave from mid-2021, when deaths and more serious illness were experienced, the demand for vaccination increased dramatically, as did the effectiveness of delivery and supply in the rural areas.

By this time, health workers across our sites felt more prepared. There was better protective equipment available as well as testing facilities, and they were more accepting of vaccination as a strategy. Health workers had also become more relaxed about regular testing, and saw this now as an important preventive measure, protecting them and their patients. In this wave dominated by the Delta variant, there was however some sickness and death across our sites; although it remained limited COVID was definitely much more present in the rural areas than during the first wave. Reflections from health workers on this period were more about how systems were developed to test, trace and contain the disease. Given the small number of cases, this seemed to be remarkably effective. Who knows if there were other unrecorded cases elsewhere, but it seems that the timing of the wave in the dry season helped limit spread. By this stage, the lockdowns were increasingly being challenged by locals, as they were affecting livelihoods and businesses seriously. Health workers commented
on their importance for public health but recognised the challenge of implementing them when there was actually so little recorded COVID around.

These tensions between public health recommendations – strictly following government (and in turn WHO) regulations – and the negative impacts on everyday life became increasingly evident, as all our informants acknowledged. Lockdowns also had negative effects on wider health care. Transport restrictions (combined with fear of testing and then getting isolated) meant that many didn’t come to clinics or hospitals at all, or only late. This meant that there was an increase in complications around pregnancy and births for example. Those preferring to treat COVID at home with the growing array of indigenous herbal medicines available may equally have risked late treatment of malaria, which COVID was confused with. This likely had fatal consequences. Some informants even suggested that, particularly by the time of the third wave, which came in the malarial wet season, malaria deaths probably far exceeded mortalities from COVID, and may well have been exacerbated by COVID measures as people were late to test and get treatment.

And then there were all the other knock-on consequences of the lockdowns and the disruption of the economy. Mental health was mentioned,
including the problem of boredom of young people now unable to go to school. This resulted in increased substance abuse, as well as unwanted pregnancies amongst of very young girls. These wider health consequences of the pandemic (or at least the response to it) were mentioned frequently by health workers and villagers as major impacts (far more than the virus itself).

**THE EMERGENCE OF A PLURAL HEALTH SYSTEM: THE THIRD WAVE**

The third wave in December 2021-January 2022 was different again. As everyone recalled, Omicron presented as a bad ‘flu, but there were few hospitalisations (all from other conditions) and no directly attributable deaths. During this phase, the local treatments (steaming, herbal teas and other concoctions) had become part of daily life, for both treatment and prevention. These were seen as highly efficacious. Health workers admitted using them at home and with their families. Here the blurring between home life and treatment of health among the family and the official public health role became most apparent. As one nurse observed, I take off my uniform when I get home leave it until I go to work the next morning.

At home, health workers just like everyone else were engaging with a wider, plural health system, involving herbalists, healers, prophets, pastors, spirit mediums and traditional doctors, alongside their own medical
training. In the context of the uncertainty of a new disease – and one that seemed to be so different in each wave – this made absolute sense, and none of our informants found this contradictory or problematic. To protect themselves and their families they would follow whatever worked, usually hedging bets given prevailing uncertainty. In the clinics and hospitals, the protocols had not changed much from the first wave. At the clinics, paracetamol was administered along with antibiotic injections for severe cases to reduce co-infections, but for Omicron a different regime was required, and local remedies served the purpose well.

All the health workers we talked to had worked incredibly hard during the pandemic. Unlike in other parts of the world they did not have to deal with the horrors of massive sickness burdens and death, but they had to follow a set of complex measures of testing, masking, distancing and so on that made their jobs more difficult. And, with limited facilities and initially barely any protective equipment, the fear and stress that the initial concerns about how the pandemic would play out took its toll. They had to deal with the dilemmas of advocating testing and vaccines that initially they had their own concerns about. And they had to convince a public to follow a whole panoply of public health regulations associated with the pandemic, while still coming to clinics or hospitals with regular diseases. Masking became widespread but restricting gatherings, particularly of churches and political gatherings was more difficult. And as time went on, especially in the hot season, masks became an additional garment hung around the chin, and quickly put up over the nose and mouth if a police officer was near or a roadblock was approached. Lockdowns as containment measures for a disease that was only sporadically present and at very low levels presented a dilemma for many we discussed with. While accepted at the beginning in the face of deep uncertainty, later many were more circumspect of their value. Lockdowns, for example, meant that patients presented late if at all, increasing the acuteness of conditions and resulting in different health burdens and more challenges for health care.

Everyone we talked to agreed that, with the pandemic changing in form and severity, opportunities to ‘live with virus’ were increasing and the costs of some of the remaining public health measures probably exceeded their current value. Many lessons have been learned about how to respond to a pandemic in a rural setting, and importantly how public health has to be balanced with livelihood and economic needs, while being supported by local approaches to health care and treatment as part of a plural system. These will be important as health systems prepare for the inevitable next pandemic.
This booklet compiles 20 blogs, which originally appeared on www.zimbabweeland.wordpress.com. They document the COVID-19 pandemic in rural Zimbabwe between March 2020 and February 2022. The blogs emerged from discussions amongst field researchers based in sites across the country and together they offer a unique insight into the pandemic from a grounded, rural perspective.