

**Working Paper
Volume 2022 Number 575**

Living Through a Pandemic: Competing Covid-19 Narratives in Rural Zimbabwe

**Iyleen Judy Bwerinofa, Jacob Mahenehene,
Makiwa Manaka, Bulisiwe Mulotshwa,
Felix Murimbarimba, Moses Mutoko, Vincent Sarayi
and Ian Scoones**

August 2022

The Institute of Development Studies (IDS) delivers world-class research, learning and teaching that transforms the knowledge, action and leadership needed for more equitable and sustainable development globally.



© Institute of Development Studies 2022

Working Paper Volume 2022 Number 575

Living Through a Pandemic: Competing Covid-19 Narratives in Rural Zimbabwe

Ilyeen Judy Bwerinofa, Jacob Mahenehene, Makiwa Manaka, Bulisiwe Mlotshwa, Felix Murimbarimba, Moses Mutoko, Vincent Sarayi and Ian Scoones
August 2022

First published by the Institute of Development Studies in August 2022

ISSN: 2040-0209 ISBN: 978-1-80470-020-4

DOI: [10.19088/IDS.2022.058](https://doi.org/10.19088/IDS.2022.058)

Author ORCID ID: Ian Scoones [0000-0001-8547-4464](https://orcid.org/0000-0001-8547-4464)

Author Google Scholar: [Ian Scoones](#)

Suggested citation: Bwerinofa, I.J.; Mahenehene, J.; Manaka, M.; Mlotshwa, B.; Murimbarimba, F.; Mutoko, M.; Sarayi, V. and Scoones, I. (2022) *Living Through a Pandemic: Competing Covid-19 Narratives in Rural Zimbabwe*, IDS Working Paper 575, Brighton: Institute of Development Studies, DOI: [10.19088/IDS.2022.058](https://doi.org/10.19088/IDS.2022.058)

A catalogue record for this publication is available from the British Library.

The work was in part supported by the Economic and Social Research Council (ESRC) STEPS Centre (Social, Technological and Environmental Pathways to Sustainability) and the UK Foreign, Commonwealth & Development Office (FCDO)-supported Agricultural Policy Research in Africa programme. The opinions expressed are those of the authors and do not necessarily reflect the views or policies of IDS, ESRC or the UK government.



This is an Open Access paper distributed under the terms of the [Creative Commons Attribution 4.0 International licence](#) (CC BY), which permits unrestricted use, distribution, and reproduction in any medium, provided the original authors and source are credited and any modifications or adaptations are indicated.

Available from:

Institute of Development Studies, Library Road

Brighton, BN1 9RE, United Kingdom

+44 (0)1273 915637

ids.ac.uk

IDS is a charitable company limited by guarantee and registered in England

Charity Registration Number 306371

Charitable Company Number 877338

Working Paper
Volume 2022 Number 575

Living Through a Pandemic: Competing Covid-19 Narratives in Rural Zimbabwe

**Iyleen Judy Bwerinofa, Jacob Mahenehene,
Makiwa Manaka, Bulisiwe Mulotshwa,
Felix Murimbarimba, Moses Mutoko, Vincent Sarayi
and Ian Scoones**

August 2022

Living Through a Pandemic: Competing Covid-19 Narratives in Rural Zimbabwe

**Ilyeen Judy Bwerinofa, Jacob Mahenehene, Makiwa Manaka,
Bulisiwe Mulotshwa, Felix Murimbarimba, Moses Mutoko, Vincent Sarayi
and Ian Scoones**
August 2022

Summary

Through a real time analysis of the Covid-19 pandemic across rural Zimbabwe, this Working Paper explores the competing narratives that framed responses and their politics. Based on 20 moments of reflection over two years, together with ongoing document and media analysis and an intensive period of qualitative interviewing, a complex, dynamic story of the pandemic ‘drama’ emerges, which contrasts with snapshot perspectives. Across the period, a science-led public health narrative intersects with a security and control narrative promoted by the state and is countered by a citizens’ narrative that emphasises autonomy, independence, and local innovation. The politics of this contestation over narratives about appropriate pandemic responses are examined over three periods – reflecting different waves of infection – and in relation to two conjunctures – an early, strict lockdown and the rollout of vaccines. Different narratives gain ascendancy and overlap at different times, but a local citizen-led narrative emerges strongly in the context of heavy-handed lockdowns, inadequate state capacity, and struggles around rural livelihoods. The pandemic has reshaped relationships between the state and citizens in important ways, with self-reliance rooted in local resilience central to local pandemic responses.

Keywords

Covid-19; narratives; lockdown; vaccines; resilience; Zimbabwe.

Authors

Ilyeen Judy Bwerinofa, Jacob Mahenehene, Makiwa Manaka, Bulisiwe Mulotshwa, Felix Murimbarimba, Moses Mutoko and Vincent Sarayi are extension workers and farmers living across Zimbabwe.

Ian Scoones is a professor at the Institute of Development Studies at the University of Sussex. He has worked on land and agrarian and environmental change in Zimbabwe since 1985. His blog zimbabweland.wordpress.com has been running since 2011.

Contents

Acknowledgements	6
<hr/>	
1. Introduction	7
<hr/>	
2. Learning in a pandemic: real time reflections	10
<hr/>	
3. The changing social and political life of the pandemic: a brief chronology	13
3.1 Act I: Fear and lockdowns	13
3.2 Act II: A ‘rich people’s’ disease?	15
3.3 Act III: Omicron sweeps the country	18
4. Competing narratives	20
<hr/>	
5. Pandemic politics	22
5.1 Case 1: Lockdown	22
5.2 Case 2: Vaccines	23
6. Conclusion	27
<hr/>	
References	29
<hr/>	
Figures	
Figure 2.1 Map of study sites	11
Figure 3.1 Daily new confirmed cases of Covid-19 in Zimbabwe	13

Acknowledgements

This Working Paper was produced as part of ongoing work on land and agrarian change in Zimbabwe. All authors have been involved in collecting empirical material and conducting interviews. Felix Murimbarimba led the fieldwork team and liaised with Ian Scoones, who in turn drafted the paper. All authors have been involved in reviewing and approving its content. The work was in part supported by the Economic and Social Research Council (ESRC) STEPS Centre (Social, Technological and Environmental Pathways to Sustainability) and the UK Foreign, Commonwealth & Development Office (FCDO)-supported Agricultural Policy Research in Africa programme. Thanks are due to Hayley MacGregor for valuable comments on an early version. This paper draws on an overview of 20 blogposts produced over two years and published on [Zimbabweland](#) and an overview produced as part of a blog compilation book published online and distributed across the field sites: *Learning in a Pandemic: Reflections on COVID-19 in Rural Zimbabwe* (2022, Institute of Development Studies) ([high resolution download](#); [low resolution download](#)).

1. Introduction

The Covid-19 pandemic unfolded across several waves in rural Zimbabwe. Each was different, throwing up new debates about how to respond and so new political contestations between actors. This Working Paper reports on two years of real time reflection across seven sites in Zimbabwe, exploring the competing narratives about the pandemic and associated politics at play. For the waves of Covid-19 were not just about the incidence of the Sars-Cov-2 virus and its effects on human health, but about how people saw the virus, responded to public health measures, and managed their livelihoods.

Strikingly different views emerged over time that played out in the pandemic drama, involving different actors competing over contested narratives. In this paper we contrast a science-focused public health narrative, promoted by doctors and other health workers and backed by international agencies; a state-led security narrative that adopted elements of the public health perspective but insisted on extended and strictly imposed lockdowns; and a citizens' narrative that emphasised autonomy and independence and the need for self-reliance to pursue rural livelihoods. As we discuss, all these narratives overlapped and each gained prominence at different times in our study sites. Over time, there was no single view, as there was no single pandemic event. Looking across time therefore reveals important dynamics not revealed in snapshot assessments; a real time reflection instead emphasises how narratives, actors, and interests continuously interact, with hugely varied outcomes.

In focusing on the narrative politics of the pandemic, we highlight how political contestations changed. At one time, people backed the state and its insistence on lockdowns, at another they embraced the vaccine rollout, while at others they questioned or actively resisted both, offering alternative views that were rooted in their everyday livelihood concerns of food provisioning, marketing, and trading. There is no single story that emerges, but a set of competing scripts in an unfolding drama (Rosenburg 1992), with major implications for how we understand the relationship between people, disease, and politics. Pandemics are always co-constructed with social and political histories (Honigsbaum 2020) and rooted in particular political contexts (de Waal 2021), with the biological and social pandemic intertwined. Vargha and Greene (2021) argue that 'The social lives of epidemics show them to be not just natural phenomena but also narrative ones: deeply shaped by the stories we tell about their beginnings, their middles, their ends'. By emphasising the competing pandemic narratives – and so the process of debate and contestation over time – we highlight how it is important to see a pandemic as a process not an event, as an unfolding political drama involving many actors and with variegated consequences.

While pandemics formally begin and end with the emergence or disappearance of a disease across multiple countries, they have important pre-histories and unknown futures. Pandemics are often said to offer a window on society, and in this paper we show how this was the case in Zimbabwe. Pandemics emerge in particular social, economic, and political settings, with existing inequalities, forms of association and alliance, and political relations of trust and accountability that all affect how people respond and how external interventions land. Understanding these prior conditions is essential for any analysis of pandemic outcomes. And by looking at how these social and political relations change through a pandemic, we may get a glimpse as to how the pandemic not only transforms people's individual health and wellbeing, but also wider society.

By reflecting on different narratives, we explore the conflicts, tensions, and accommodations that emerged between different framings amongst diverse actors. Narratives offer simplified storylines, pushed by different actors; they are embedded in different social relations and networks, and, in turn, reflect certain positions and interests (Keeley and Scoones 2003). In addition to examining how the pandemic was represented amongst government officials, medical professionals, politicians, and the media, we have focused on how these have been reflected in debates in rural areas across the country, and how this has influenced debates about lockdowns, vaccines, and quarantines, among other public health measures.

There has been much written on the Covid-19 pandemic in Africa (e.g., Ardnt *et al.* 2020; Njenga *et al.* 2020; Musa *et al.* 2021), including in Zimbabwe (e.g., MacWorth-Young *et al.* 2021; Mutyasira 2021; Mhlanga and Ndhlovu 2020; Murewanhema and Makurumbizde 2020; Matsungu *et al.* 2020), but much of this has been quite general or focused on cases that do not engage with rural livelihoods. Some more anthropological contributions have usefully delved into the cultural contexts for the pandemic responses (e.g., Higgins *et al.* 2020; Parker *et al.* 2020), while others have looked at how livelihoods have been affected by multiple factors, and wider structural inequalities (MacGregor *et al.* 2022; Kirk *et al.* 2021). Still others have puzzled over the question of why, over much of the pandemic, the case rates and mortalities from Covid-19 have remained relatively low across most of Africa, certainly by comparison to Europe and North America, where health services and 'pandemic preparedness' systems were so much more developed (Nordling 2020; Oppong 2020).

Some studies have examined rural impacts, especially emphasising impacts on value chains and food security (Béné *et al.* 2020; Swinnen and McDermott 2020), while others have assessed wider economic impacts, especially of lockdowns (Teachout and Zipfel 2020; de Waal and Richards 2020). However, across the burgeoning literature there are very few instances that have offered a real time look at how the pandemic has unfolded in rural settings, since most

studies have been single (sometimes repeat) snapshots of a very fast-moving situation based on phone surveys and remote assessments.

By tracing how narratives changed over time also allows us to look at an African setting where, in certain periods, disease and death were directly experienced, while at other times the disease seemed not to impinge at all. Looking across time also allows us to gain a sense of the social and political life of the pandemic, and the way different narratives have competed. Taking a longitudinal approach, we hope therefore to offer a wider reflection on the implications of and lessons from the Covid-19 pandemic in rural Africa, and Zimbabwe in particular.

2. Learning in a pandemic: real time reflections

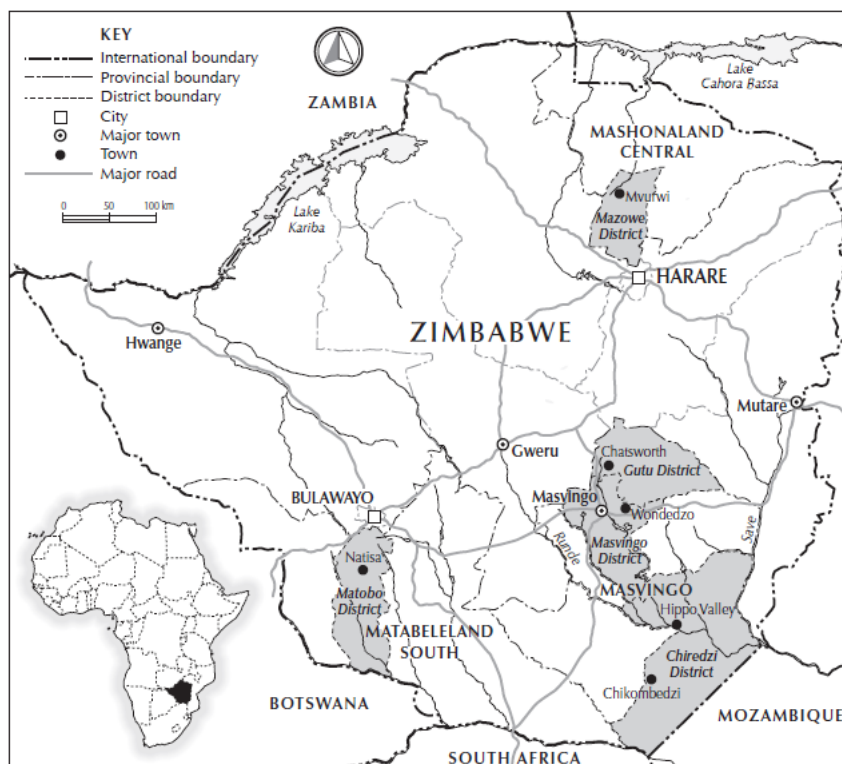
As a research team who have worked on land, agriculture, and livelihoods over many years (Scoones *et al.* 2010), we were able to engage with the pandemic in particular ways. We knew the field sites and the people living in them well given our past research activities and all but one of our team lived in one of the sites throughout the pandemic, and so could report on intimately observed, sometimes personal, experiences, as well as interviews they undertook. Our methodology evolved over time but settled into a pattern. Around once a month, the Zimbabwe-based team lead 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 2.1). Team members would reflect on what they had seen and learned in a very open-ended way, identifying themes from this experience. Over the period several hundred interviews and informal encounters took place. Most were not formally recorded but were central to the discussions each month.

The information was then collated in conversation with [anonymised], who was based in the UK, and he would write up the findings in a blogpost, published on *ZimbabweLand*, as well as in other venues including national newspapers and other blogs, combining field material with reflection from social media, newspapers, and government documents.¹ These generated commentary from others, helping us hone our explorations in the following month. Since March 2020, a total of 20 blogs have been published, providing important moments for reflection. A book including all blogs and an opening essay has been produced for sharing in the field study sites (see *Learning in a Pandemic: Reflections on COVID-19 in Rural Zimbabwe*). Through this process, particular themes emerged – such as the effect of lockdowns on women and youth for example – and discussions each month identified further themes that might be probed further before reporting again. These verbal reports were complemented by photographs that team members shared on WhatsApp. These highlighted issues that seemed important to team members, and together offer an interesting photo-documentation of the pandemic's twists and turns, offering new angles and insights. A selection of the photos appear in the blogposts and compilation book, offering a visual addition to the written documentation. Our monthly reflections were complemented by an intense period of field interviewing in five of our sites during February 2022 where 16 extended interviews (involving 20 individuals, with half of the interviewees being men and half women) were recorded, with

¹ [ZimbabweLand Covid-19](#).

excerpts included in the text below. We selected key informants, many of whom had contributed to our discussions across the two years, mostly farmers plus six health professionals from four sites. This helped triangulate with our earlier information, but also created an opportunity for participants to reflect back upon the period.

Figure 2.1 Map of study sites



Source: Authors' own, drawn by John Hall.

We did not have a fixed set of interview questions, nor even a formal checklist, but left it open for all team members to spot trends and identify particular stories. It was a form of immersed participant engagement but linked to a process of systematic reflection and recording in real time. Very soon, just as the villagers we were discussing with regularly, the team became quite practised field epidemiologists, despite our original training in agriculture and rural development. This was important as official reporting of disease prevalence was very patchy, especially in rural areas.

It was the connection between health issues and changes in rural life and economy that became the central theme of our extended conversations. We were not just interested in the public health issues, nor the particularities of medical responses or treatments, but on the intersection with rural livelihoods and economies, and how the pandemic affected people's day-to-day existence as farmers, traders, miners, labourers and so on. In other words, we became

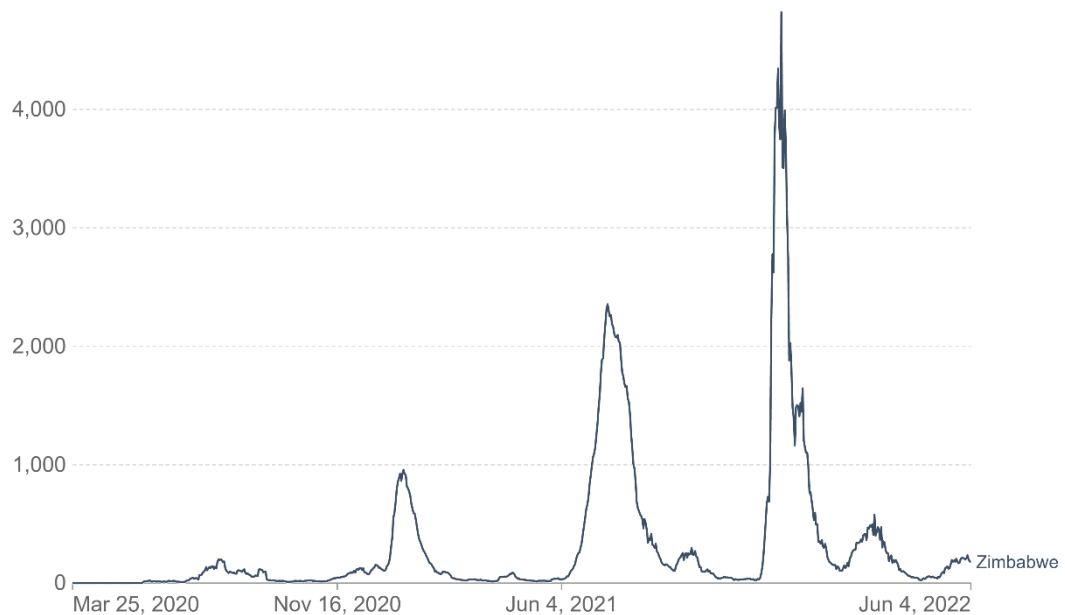
interested in how the pandemic reshaped daily life and so had impacts on wider agrarian dynamics, a theme rarely addressed in the existing literature on pandemic impacts on agriculture and food security in Zimbabwe (cf. Tom 2021).

By also keeping up with news reports, policy announcements, and the host of commentary on social media and the internet, we were able to contrast the narratives we were hearing in the field sites – the storylines about the pandemic, with beginnings around origins, middles about causes, and ends about implications and solutions – with those being offered by public health officials and the government. It was this intersection of narratives – which changed over time – that help reveal a nuanced understanding of the changing social and political dynamics of the pandemic across multiple sites in rural Zimbabwe. Through reflecting on local reactions to official pronouncements – whether requirements for lockdowns, public health and sanitation measures, vaccination campaigns, or official data on disease prevalence – we were able to explore how people made sense of the competing versions of the pandemic through their everyday lives, whether through disputing, ridiculing, or accommodating the official narratives, and how this changed over two years from March 2020.

3. The changing social and political life of the pandemic: a brief chronology

Since early 2020, the pandemic has changed dramatically; not only in terms of the disease through different variants (see Figure 3.1), but in terms of its social and political implications on the ground. In this section, we offer a condensed chronological picture – in three ‘Acts’, with a variety of ‘scenes’ within – of the unfolding drama of the pandemic from the grounded perspective of our field study sites, indicating how different narratives emerged and also receded.

Figure 3.1 Daily new confirmed cases of Covid-19 in Zimbabwe



Note: Seven-day rolling average. Due to limited testing, the number of confirmed cases is lower than the true number of infections.

Source: Our World in Data, Johns Hopkins University CSSE Covid-19 Data, [CC BY 4.0](#).

3.1 Act I: Fear and lockdowns

In early 2020 as Covid-19 spread around the world, from China to Italy to the UK, rural Zimbabweans looked on in horror as the news channels were filled with scenes from hospitals and locked down cities. It seemed a world away, although as the pandemic progressed, direct news from relatives in the diaspora quickly

made it very real. Was it coming here? Were we going to suffer the same? Fear was tangible, and with knowledge of the parlous state of the health services, everyone feared the worst. With doctors and nurses on strike, reputedly only 16 ventilators in the whole country and the government with few resources, it was not looking good. The international commentaries on the pending disaster in Africa did not make the mood any better.

The first case of Sars-Cov-2 was identified in a traveller from the UK in Zimbabwe on 20 March. The government was quick to act and imposed the first 21-day lockdown from 30 March 2020 in line with World Health Organization (WHO) recommendations. In these early days, people we talked to were worried: a deadly, invisible virus might kill in large numbers. People had experienced HIV, but this seemed different, more frightening because it was unknown, and no one knew how it spread. TV images created genuine fear, and people accepted the government's edicts to follow quarantine and lockdown measures, take up sanitary protocols, and reduce the spread. As MM commented, 'At first everyone was scared. It was a disease we didn't know'.² Another informant recalled, 'We knew it was serious, there were no planes in the sky, the skies were silent'.³

Despite some dismissing the threat as something only befalling a heathen West, overall, a science-led rationalism initially led the debate, reinforced by stark warnings from the WHO and others, and added to by stories from relatives in the UK and elsewhere. Messages from the president and the then health minister were delivered in grim tones, and in the rural areas people followed the recommendations of the village health workers, nurses, and doctors. It was a scary time, in the midst of uncertainty, although at this stage people were prepared to believe the officials, as at least they offered some assurance in the face of an unknown threat.

Despite the fact that there was no major spread of disease, the lockdowns persisted with new curfew arrangements instituted from 21 July. It was impossible to market crops, and many rotted in the fields or at home. You could not go to town, and if so it was expensive and involved much hassle. Roadblocks were everywhere, restricting movements, endlessly checking permits and papers. People complained bitterly, commenting 'These restrictions have made us poorer'; 'Lockdown is a deadly disease';⁴ or 'We cannot afford blanket restrictions, we cannot live like that'.⁵

The full power of the state, involving the array of security services, was being exerted in the name of public health, but many saw other motives at play, with

² Interview, MM, Wondedzo, 8 February 2022.

³ Interview, Chatsworth clinic, 11 February 2022.

⁴ Mrs S, Sanangwi, Wondedzo, 9 February 2022.

⁵ Mrs M, Lonely A, Chatsworth, 11 February 2022.

those in power able to accumulate through the pandemic, directly benefiting from the restrictions. As Mrs S argued,

*These restrictions are cooked up by the elite. The rich can get round them; they just pay the bribe. The influential people can move freely and do their business. It made them richer, and they milk us when selling us our supplies. The politicians are out to control us, so they get more money.*⁶

Others agreed, 'Lockdowns only benefit some people. Why are there only some buses on the road, who owns them?'⁷ In a gold rush area, someone else observed, 'The security forces came, and to gain ground in their deals, they insisted everyone wear masks. This allowed them to have control'.⁸ Another commented, 'Lockdowns are all about the desire to control people. It's about politics, about punishment'.⁹ Discourses of control versus freedom were common: 'We are being forced and oppressed. We fought the war of liberation, and now is the time to enjoy our freedom. We can't have these lockdowns and masks!'¹⁰ A very direct politicisation of the debate emerged in this period and has persisted.

Despite its justification in terms of executing public health measures, this authoritarian response seemed out of kilter with experience on the ground. People were not ill, let alone dying. The strains of the lockdowns were being felt on people's livelihoods, as agricultural incomes collapsed. Other options were sought out, but diversification also involved a resort to crime and petty theft for some. Others were desperate and bored and resorted to drug taking. With kids out of school, parents were at their wits end: 'When schools were shut, we were failing to control our children. They had so much time on their hands. Drinking, smoking. Some became thieves. There were many unwanted pregnancies. Evil things were created by the Covid pandemic'.¹¹ Another informant put it succinctly, 'Covid betrayed our children'.¹² There was a sense that things were falling apart, and people were worried.

3.2 Act II: A 'rich people's' disease?

By the latter part of 2020 and into early 2021, the lockdowns had almost become a way of life. Sometimes they were level 2, sometimes level 4, but people had found ways round many of the restrictions. They had to. It meant paying off the

⁶ Mrs S, Sanangwi, Wondedzo, 9 February 2022.

⁷ Pastor G, Chikombedzi, 17 February 2022.

⁸ Mr M, Wondedzo, 8 February 2022.

⁹ Discussion, Chatsworth, 11 February 2022.

¹⁰ SM and AB, Edenvale, Chikombedzi, 17 February 2022.

¹¹ Mr and Ms HM, Chikombedzi, 18 February 2022.

¹² Mrs C, Chikombedzi, 18 February 2022.

police at roadblocks, paying sweeteners to truck drivers to transport goods, and switching to mobile, night markets to dodge the authorities. As MM commented,

*The lockdown affected our markets, we were banned from moving. So many tomatoes rotted. You needed letters to go to Harare, but you end up going late as there were no permits. We had no money to bribe at the roadblock. We could only bribe with tomatoes!*¹³

In this period infection rates began to pick up, especially in the urban areas amongst the mobile elite. Nevertheless, the pandemic seemed far away, but it was getting closer. Relatives were getting sick in South Africa, and some died with bodies being returned. This was the first time that the disease became very real, with death, loss, and grief central to the local experience, even if those who died did so elsewhere. As Mr M explained, 'There were more deaths, people began really to fear this disease. At first it was just Harare, but people from towns ran away and came here. You are safer from the disease here compared to town'.¹⁴

Following the Christmas and New Year holidays, the news became full of cases of high-profile deaths of Zimbabwean businesspeople and politicians (including four cabinet ministers within the first few weeks of the year) (*Independent* 2021). Covid-19 had been seen as a rich person's disease (Zimbabwe 2021), something affecting 'chefs' in Harare, or those in South Africa; however, as migrants began to return from South Africa in larger numbers as the economy there declined, there was a sense that maybe the pandemic would affect the rural areas soon. People were wary. Returnees from South Africa were regarded with suspicion, often shunned. As MM recalled, 'People ran away from visitors from South Africa. They feared the disease'.¹⁵ The stigma of the diseased recalled the early years of the HIV/AIDS pandemic.

Although new lockdown measures had been introduced on 2 January 2021, by this time there was a growing confidence in local treatments and response strategies, and the importance of independence and autonomy, and the rejection of lockdowns was emphasised repeatedly across our study sites. As EHT commented, 'People were suffering from hunger due to lockdowns, not the disease'.¹⁶ There was a sense that you had to do something: 'If you just sit here, you will die of hunger'.¹⁷ The state did not have the capacity to do anything, people said, and in any case it was distant and corrupt; a view reinforced by various procurement scandals around protective equipment (Reuters 2020). There was a sense of fatalism about the capacity of external assistance to make

¹³ MM, Pembi Chase, Mvurwi, 24 February 2022.

¹⁴ Mr M, Hariana, Mvurwi, 21 February 2022.

¹⁵ MM, Hariana, Mvurwi, 21 February 2022.

¹⁶ EHT, Claire Farm, Chatsworth, 11 February 2022.

¹⁷ MM, Hariana, Mvurwi, 21 February 2022.

a difference, and indeed how appropriate the global recommendations were. One informant observed, ‘these international recommendations may be good in Britain, but not here. WHO was prescribing for who? Zimbabwe feared more sanctions if it didn’t follow. There were bigger politics at play; everything was ordered from outside’.¹⁸

In mid-February 2021, the first vaccines arrived from China, with much fanfare (Yuliang 2021). The Vice President, now also health minister, Constantino Chiwenga, hailed the generosity of the Chinese, and vaccine uptake was encouraged, initially for ‘frontline’ workers. Just as in the West and China, vaccines were going to be the solution to what was still felt to be the inevitable wave of disease and death that was central to the state-led narrative. Despite the health system’s terrible state, the vaccine programme was in many ways impressive. There was much hesitancy and some resistance, but for a period Zimbabwe’s vaccine uptake outstripped that of South Africa, especially in the period from late June 2021 when the Delta variant hit Zimbabwe for the first time.

Particularly during July and August 2021, the disease really affected the rural areas. This was clearly no longer a disease of the urban rich, it affected everyone. Across our sites there were multiple deaths, and the Delta variant quickly spread through social gatherings, whether funerals or markets. There was genuine fear, and many took up the vaccine offer as a result, with large queues forming outside clinics. As Dr K explained, ‘What pushes people to take up the vaccine is seeing death. In this period, we had up to 3,000 people being vaccinated a day at the hospital’.¹⁹ In people’s minds, this was the worst encounter with the disease, and where the lack of health-care facilities – often involving long walks to nearby centres – was felt most acutely. But, nevertheless, mortalities remained quite low. In discussions across our sites, most observed that there were no or only very few deaths due to Covid-19. Even in the clinics and hospitals we visited in February 2022, health workers reported limited deaths. The highest was 35 recorded over two weeks in Mvurwi hospital, but this was taking patients from a huge area across a province. In many cases deaths arose because of late presentation and difficulties in getting to hospital.

For many in the rural areas the Covid-19 virus was not such an issue, even in this peak period. Some dismissed it completely – highlighting instead the terrible losses of cattle due to what was dubbed locally as ‘cattle Covid’ (January disease or theileriosis): ‘I haven’t heard of anyone dying of Covid. Cattle Covid I’ve seen – you hear from everyone around here. What is this human Covid?’²⁰ Mrs K asked rhetorically. The pandemic was thus intertwined with other, often

¹⁸ EHT, Claire Farm, Chatsworth, 11 February 2022.

¹⁹ Dr K, Mvurwi hospital, 24 February 2022.

²⁰ Mrs K, Hariana, Mvurwi, 21 February 2022.

more pressing, concerns of agricultural production, marketing, off-farm work, and everyday survival.

Nevertheless, across our sites everyone had learned through family networks and WhatsApp groups about local treatments. There had been much experimenting and innovation going on, and a growth of local businesses involved in selling herbs and other treatments. The plant *Zumbani/Umsuzwane* (*Lippia javanica*) was in particularly high demand as it was used for steaming and infusions. There was also demand for lemons, garlic, onions, and other indigenous herbs. *Zumbani* collectors descended on rural areas to harvest it and sell in towns and cars lined roads selling the herb from their boots. As EH commented, 'There was a lot of experimenting going on in the farms. I grow lots of garlic now, more spiny cucumber and plenty of lemons. All are in high demand for Covid treatments. Even those in town are now planting'.²¹ Everyone from doctors in hospitals to rural farmers in the remotest of our study sites had a stock of local medicines in their homes.

By October 2021, the Delta wave had largely subsided, and people returned to a semblance of normality as lockdown measures were reduced again. As people got on with their lives, the few months of dread and fear were largely forgotten. Yet there was more confidence, brought through experimentation and learning about treatments. As MM commented, 'By then we had the experience; it's a learning curve. We now know the disease'.²² Others argued in terms of 'living with' Covid:

*We want to live with Covid, just as we now do with HIV/AIDS. We can use herbal medicines and avoid the hospital. We have always had diseases, but now they have names. We will grow old living diseases, just as we always have.*²³

Some also pointed to the greater physical resilience of rural farmers, compared to town dwellers, the rich and 'whites': 'The disease is associated with white people with money in foreign countries. It targets rich people. Working hard in the fields is the best medicine against Covid. You sweat!'²⁴

3.3 Act III: Omicron sweeps the country

The lull once again was disrupted at the end of 2021 as the Omicron variant wave swept across southern Africa. As a milder variant and with a barrage of local treatments now well established, there was a surprising confidence in dealing with the new wave, even though lockdown measures were once again

²¹ EH, Claire Farm, Chatsworth, 11 February 2022.

²² MM, Wondedzo, 8 February 2022.

²³ AB, Edenvale, Chikobedzi, 17 February 2022.

²⁴ Mrs M, Chikombedzi, 17 February 2022.

introduced in early December and extended later in the month. News quickly spread about how it was different, requiring different treatments, and the WhatsApp groups were full of advice as it spread over a week or two from our sites in the far south on the border with South Africa to elsewhere in the country. As EHT recalled, 'Knowledge spreads fast. I am connected to three to five WhatsApp groups, all discussing Covid. There were so many messages!'²⁵ But such information has to be filtered, as Mrs M explained, 'The WhatsApp groups tell us everything, but you don't know who to believe. We rely on each other to experiment with and test treatments'.²⁶ By this time, there was also a general awareness of co-morbidity risks (notably diabetes and high blood pressure) and the particular vulnerabilities of older people, which meant responses could be tailored locally.

The lockdown was not taken terribly seriously and even those enforcing it seemed more half-hearted. It was the summer holidays and the festive season and people just had to get on with their lives. As the wave subsided, farmers had to attend to their fields and ensure that they made the most of the season, and Covid-19 became a lesser concern compared with how to plough without animals that had died due to January disease during 2021. People questioned the state's focus on Covid-19 when there were more pressing issues at hand that were not getting attention or resources.

²⁵ EHT, Claire Farm, Chatsworth, 11 February 2022.

²⁶ Mrs M, Lonely A, Chatsworth, 11 February 2022.

4. Competing narratives

Across the two years of our study there have therefore been a number of phases – denoted here as Acts in the drama – partly generated by the peaks and troughs of viral and case incidence (Figure 3.1), but also affected by people's attitudes and responses to state imposition and public health measures. Three competing, although overlapping, narratives can be observed: a science-led technocratic narrative; a state-led control narrative; and a citizens' narrative focused on independence and autonomy.

The science-led narrative has been important throughout and has guided much government policy. The government followed WHO guidelines on lockdowns assiduously and promoted the vaccine campaign vigorously. Despite many health workers being in dispute with the government over pay and conditions, and indeed on strike for periods, their voice was often coincident with the pronouncements from government.

The lockdown policy was not always just to do with public health, even though health professionals and most of the rural population in our sites backed the first lockdown. Asserting control over the population through lockdowns, involving numerous arrests, surveillance, and restrictions on movements, was, many thought, a reflection of the authoritarian tendencies of the militarised state and ruling party, and an excuse for suppressing dissent and opposition. With the new health minister being a retired general and the former head of the national army, it is perhaps not surprising that a militarised response followed. As lockdowns continued, some surmised that the reason for them had switched to a largely political motivation, as protests were banned on public health grounds. The pattern of mixing of state-focused narratives of control and public health narratives of disease management has been seen widely, especially in more authoritarian states where trust is low and state capacity weak or threatened (Luckham and Carter 2022).

Such assertive scientific-technocratic and state-control narratives did not always gain the upper-hand, however. Zimbabweans are long practised at resisting imposition by the state, knowing that there are limits to its capacity and that there are ways of avoiding if not confronting. Jokes, songs, Internet memes, and other routes to subtle resistance make life more possible.²⁷ Such 'weapons of the weak' (cf. Scott 2008) of course can – as our informants repeatedly emphasised – also add to the costs of life – paying bribes, dodging roadblocks, marketing at night and so on. But none of this is new, and the pandemic just added another

²⁷ See for example, a video from the comedian, VaMayaya: [VaMayaya On Kupinda Mutown](#).

layer to the challenging navigation of everyday encounters with authority in Zimbabwe.

In our brief chronology above, we have highlighted how periods of lockdown and intense state control were interspersed with periods of relative 'normality'. These periods represented continuity with the ongoing everyday engagement with an often predatory, corrupt, and inconsistent state. The pandemic was layered on a long period of economic and political uncertainty for much of the past 20 years, where daily rural life has been a constant struggle in the face of currency fluctuations, hyperinflation, shortages of key goods, combined with often arbitrary state interventions, sometimes violence. In such situations, there is no option but to get by and get on – what is termed '*débrouillardise*' in the Democratic Republic of Congo, a sense of culturally rooted resourcefulness that allows people to survive in difficult circumstances (Wild-Wood 2007).

What came out strongly across the two years of observation and discussion, and again in our follow-up interviews, was a resigned resilience as people struggled to carve out a way of living independently to survive. This 'citizens' narrative' was centred on low expectations of external support and the need to develop autonomous and independent solutions. In our discussions, there was a sense that, if the state would not provide and probably only disrupt and if livelihoods are to continue even with the presence of a disease, then local solutions, experimentation and innovation, combined with collective action and solidarities, were essential.

5. Pandemic politics

Across the two years of our study, there were particular moments when the technocratic, state and citizen narratives collided. These conjunctures provide important insights into the contours of politics during the pandemic. Many could be chosen, but here we will illustrate with two: the mid-2020 lockdown and the arrival of vaccines.

5.1 Case 1: Lockdown

On 21 July 2020 a stringent lockdown was imposed, extending earlier measures. Lockdowns hit people hard, as the markets were closed, transport restricted, and curfews imposed. It was heavily enforced, with police setting up roadblocks at seemingly every corner. No one could move without a permit, but such permits had to be issued by officials, either village leaders or the police themselves. Authorities were allowed to issue spot fines for breaches of the rules, but many did not know what these even were. Many in our study areas were stuck in their villages, unable to market produce or purchase items in town. Mrs M complained, 'We had grown our crops, but we couldn't go to the markets. It brought terrible problems. Lockdown was a real thorn. My tuckshop sales went down, and I couldn't restock. You could travel illegally, but it was risky'.²⁸ At the same time, remittances had declined as the Covid-19 virus had struck both South Africa and further afield, including the UK, as people had lost jobs or been put on extended leave. Many businesses that farmers in our study areas rely on for provisions had shut up shop. And the new forms of marketing and other arrangements that got round the restrictions were only just beginning to emerge.

With Covid-19 rates not really surging at this point, many surmised that the restrictions were being deployed by the state in advance of planned protests by the opposition movements on 31 July 2020. Focusing on state corruption and poverty, the protests were not specifically focused on Covid-19 restrictions, but the state was quick to use these to restrict gatherings of any sort (Shumba *et al.* 2020). In the end, the predicted protests did not materialise. Whether this was because of state repression or because people had other survival needs on their minds cannot be known, but it was clear that the tightening of restrictions was related, as they were noticeably eased once the date had passed.

The heightened restrictions and the extreme challenges and complexity of daily life took its toll, and the critique of the government heightened in this period, with the positive views about the state's strong action taken early on waning. This was reinforced by the scandals around procurement of personal protective

²⁸ Mrs M, Lonely A, Chatsworth, 11 February 2022.

equipment (PPE) and the sense that the rich were benefiting from lockdowns, while ordinary people suffered. As Mr M put it, 'The elites are benefiting from the lockdowns. They're the only ones allowed to move freely. We are suffocating while they move. Those with a better life are going higher and higher; they are stepping on top of us'.²⁹

5.2 Case 2: Vaccines

The second moment that highlights the tension over competing narratives was in February 2021 when the first vaccines arrived on a plane from China, with great fanfare (Yuliang 2021). This was a symbolic moment, with the Vice President triumphantly meeting the plane at Harare airport, together with multiple assembled officials. The Chinese ambassador was on hand for a speech, and Chinese–Zimbabwean diplomatic relations were further cemented. This was a snub to the West, whose vaccines were shunned and a victory for Chinese soft power in Africa. What concessions were extracted for Zimbabwe's stance is unknown, but the strong position of the state against Western sanctions and in favour of 'looking East' for help was highlighted. A vigorous vaccine campaign ensued, with frontline workers, including doctors, nurses, teachers, and extension workers, targeted first.

As elsewhere in the world, an intense debate about vaccine efficacy and risks ensued (Leach *et al.* 2022). This took a particular twist in Zimbabwe because of the initially exclusive Chinese supply. Did the vaccines work? Were they shoddy like other Chinese goods? What has the government sold off to get the vaccines? Why should we trust the government or the Chinese? The villages in our study areas were full of discussion, with some of it blatantly racist and anti-Chinese, and many were reluctant to try out the vaccines when they were offered. Even health workers admitted that they were initially sceptical: 'When the vaccines were introduced, we were scared of them. Some messages on WhatsApp were really negative. It was the rapid development that we were worried about. There were a lot of questions'.³⁰

Vaccine hesitancy is often correlated with trust in authority, and in Zimbabwe trust is extremely low. Some waited to see if other relatives or friends got sick from their shot, while others simply refused. There were, as elsewhere, many reasons for refusal, ranging from religious prohibition to well-argued positions on relative risks given past conditions. And, many argued that, unlike in Europe, we do not have many cases and very few deaths were recorded, so why bother take the risk? In any case, there are more pressing livelihood issues to attend to.

²⁹ Mr M, Hariana, Mvurwi, 21 February 2022.

³⁰ Discussion, Chatsworth clinic, 11 February 2022.

Despite the appeals from the medical profession hesitancy remained. This was later tackled by the imposition of vaccine mandates for frontline staff, with those refusing being put on unpaid leave. This had a contrary effect, as many felt that the mandate was unjustified and inappropriate. Only when the rates increased dramatically, especially with the Delta wave, did more people come forward, as fear of illness and death increased. With trust so low in the state – and its alliance with the Chinese – even the usual trust in doctors did not cut through until genuine fear set in. By 28 April 2022 only 24.3 per cent of the total population had been fully vaccinated, and by this stage uptake reflected choice rather than access or supply issues. Thus, tensions within the public health narrative were observed, with changes over time as distrust in the origins of the vaccine and its politics were challenged by more immediate health concerns.

Both these moments therefore saw contests between a public health narrative – pushed by the Ministry of Health and independent medical professionals – urging caution and protection; a state narrative – also promoted through the Ministry of Health but supported by the president and other leading politicians – backing the science but imposing a heavy measure of control; and a citizen narrative focusing on the importance of everyday livelihoods and finally survival and questioning the authority of the state and the appropriateness of imposed public health measures.

The politics of pandemics reshape social life, defining what people can and cannot do through lockdown laws, curfews, movement restrictions, and vaccine mandates. Whether these public health edicts are accepted depends on trust in authority, and in Zimbabwe this is extremely low. When people do make choices – for example around personal hygiene, physical distancing, joining gatherings and so on – it is through their own judgements, mostly not because the state says so. As in many settings, the state adopted the ‘martial script’ of public health (de Waal 2021) and took it to extremes, making use of the health emergency to control people and impose authority, as well providing opportunities for accumulation by elites, including politicians and their allies.

As an authoritarian, militarised regime, the Zimbabwean state does not need the pretext of public health to impose its power, but it certainly helps. Yet, such forms of control are resisted, often quietly and in ways that do not cause confrontation. Rural gossip has continuously been full of condemnations of corrupt ministers and party-linked businesspeople and a repeated refrain about the problems of a corrupt police force. That this is not mobilised into organised resistance is a reflection of the powerlessness and disillusionment of people today. As Mrs T put it, ‘People want freedom. We can’t get bogged down forever, we’ve got to feed our families’.³¹ The expectations of the state are so low that when something happens, like a strong reaction to the initial outbreaks, people are surprised;

³¹ Mrs T, discussion, Chatsworth, 11 February 2022.

meanwhile others took pride in the fact that Zimbabwe was powering ahead with the vaccine programme, outcompeting South Africa at first.

As Chigudu (2020) observed for the 2008 cholera outbreak in urban Zimbabwe, a public health crisis can forge new political subjectivities, and so recast the relationships between the state and citizens. The failure of the state to provide safety and security in the face of cholera, as had come to be expected of a modernising 'developmental' post-independence state, created a sense of abandonment and 'disposability', with the state seemingly disinterested in the fate of its population, he argues. There were echoes of this pattern during the Covid-19 pandemic, with the rejection of state (and public health) authority by some, but the reaction was more nuanced over time. The state got high approval ratings during early 2021, with ZANU-PF coming out in the Afrobarometer survey as the most popular political party to the surprise of many (Newsday 2021). Some thought that this reflected a solid, if inadequate, response to the initial pandemic outbreak. Over the course of the pandemic, many did not blame the state for inadequate responses as they expected little, with the health-care system and other support having been effectively absent in our study areas for nearly two decades. As expectations decline, the vehemence of blame and the intensity of anger subsides it seems.

The relationships between the state and citizens are also different in rural areas. The structural inequalities in access to health care are well established, largely consistent from the colonial era, and rural dwellers do not expect any different. The experience of the health clinic being a long walk away, it usually lacking medicines, and maybe with few qualified staff present is not new. Nevertheless, the state – and the ruling party – remains surprisingly present in the rural areas, with extension officers, traditional leaders and party cadres deeply involved in local administration and development. Of course, subsidies, handouts, and land allocations are always incredibly political and central to the exerting of state and party patronage, but as long as they provide benefits, people are somehow willing to distinguish local actions from what they see as the distant state, where critique of rich, corrupt politicians dominates the discourse. These are complex political subjectivities therefore and they have changed over the course of the pandemic.

Neither the state nor the ruling party is uniform. People are able to distinguish between a state-employed nurse and a corrupt politician on the make. Some even feel sorry for the police – after all they are someone's son or daughter, often known locally – as they know they are not paid well and have to make ends meet by taking money at roadblocks. Instead, anger is directed more at the system and the wider level of incompetence and corruption, with blame directed at remote politicians. Health professionals at the clinics work under incredibly tough conditions, with limited pay, and the service they offer is usually hugely

appreciated. And this extends to rural teachers, extension officers, village health workers and so on. The technocrats at the centre of the state machinery are therefore distinguished and appreciated. Despite the conditions, Zimbabwe's civil servants show an extraordinary, committed professionalism, and so are not necessarily blamed for the failings of the state.

As noted earlier, pandemics offer a window on society and its politics, and this is certainly the case for Zimbabwe. The periods of strong state action – early preventive action and vaccine deliveries, for example – were seen positively, perhaps a reflection of a yearning for an idealised past from soon after independence when the state did actually deliver and could be trusted. Yet during the last few years, the expectations were not high, and people were quick to condemn procurement corruption and heavy-handed lockdowns. With trust low and capacity extremely limited, the attempt to impose a technocratic public health solution foundered, and people sought ways around what they saw as unnecessary restrictions, generating a 'citizens' narrative' centred on autonomy, independence and self-reliance, along with a certain pride in rediscovering local treatments, and so generating a local resilience, based on shared, collective knowledge and innovation. As Mrs C put it, 'Through these corona times, we've learned about our local medicines. We'd lost these ideas. Even in South Africa they want hear about our treatments!'³²

³² Mrs C, Chikombedzi, 17 February 2022.

6. Conclusion

By the end of April 2022, there had been around 250,000 confirmed cases and about 5,500 registered deaths from the Covid-19 virus in Zimbabwe (Ritchie *et al.* 2022). This is of course a huge underestimate but, compared to the trauma of HIV/AIDS or even the regular mortalities from malaria, Covid-19 has had much less direct impact overall (WHO 2022). Indeed, as many commented across our sites, it was more the lockdowns than the disease that caused people hardship and suffering.

However, impacts have been varied, both over time and between different sites and among different people, so general conclusions must be qualified. There were times when the virus struck fear and panic into the population and people sought guidance and support from an otherwise untrusted state and a weak public health system. At other times, the state's impositions in the name of public health, and through an authoritarian, sometimes militarised response, was seen as too excessive, and people found ways to avoid and resist, usually quietly and surreptitiously. The pandemic's narrative storyline is therefore neither linear nor straightforward, as at different moments certain narratives were more prominent, and indeed people held elements of the narratives simultaneously, even if they are in tension.

There have been twists and turns, abrupt moments, conflicting conjunctures, and all the time people have had to navigate these as the drama unfolded. As we have discussed, competing narratives jostled with each other for dominance – technocratic public health and the value of science, authoritarian state control and citizen flexibility, adaptability, and innovation as routes to survival. None were dominant all the time and in the eyes of all players, and the vagaries of politics as played out on global, national, and local stages had an important but varying effect.

Rather than simple assessments based on snapshot surveys or generalised overviews, our longitudinal, real time study, based on engaged, embedded observation across multiple sites, has revealed a complex story with no singular interpretation. Arguments for state oppression and abandonment applies at some moments, but not at others. Meanwhile a narrative centred on an independent, autonomous response, based on local knowledge, skills and experience may apply at other times, even though reliance on formal health care remained essential. All are coincident, affecting a shifting set of subjectivities constructed through a dynamic pandemic politics.

During the HIV/AIDS pandemic, public health officials recognised the co-constitution of disease responses and politics in the slogan, 'Know your epidemic, know your response, and act on its politics' (de Waal 2021). This could

equally apply to the Covid-19 pandemic in rural Zimbabwe. People began to know the epidemic, developing ways of responding both to the disease and importantly to the lockdowns and this meant acting on the politics of the pandemic, sometimes working with state efforts, sometimes resisting them, sometimes working completely outside them.

When the pandemic first emerged in Zimbabwe in March 2020, it arrived in a setting of economic and political uncertainty. Our rural sites were very different to urban settings where much of the commentary and analysis has emerged from to date. As our real time engagement shows, the rural areas have experienced the pandemic in very different ways, with competing narratives playing out over time. As Vargha and Greene (2021) argue, ‘epidemics colonise our social lives and force us to learn to live with them, in some way or another, for the foreseeable future’.

In rural Zimbabwe, the experience of the Covid-19 pandemic has generated a range of immediate and often highly innovative responses to the unfolding drama, but it has also resulted in some deeper changes, in relation to people’s perspectives on the state and its authority, the role of science and public health and the importance of autonomy and independence to allow flexibility in the face of uncertainty, when other options are not available. The knowledges, relationships and networks built during the pandemic – particularly centred around local treatment responses – have generated an active, embedded resilience, which in the future may become important as new crises arise, as they inevitably will.

References

- Arndt, C. *et al.* (2020) '**Covid-19 Lockdowns, Income Distribution, and Food Security: An Analysis for South Africa**', *Global Food Security* 26: 100410, DOI: 10.1016/j.gfs.2020.100410 (accessed 2 August 2022)
- Béné, C. *et al.* (2021) '**Global Assessment of the Impacts of COVID-19 on Food Security**', *Global Food Security* 31: 100575, DOI: 10.1016/j.gfs.2021.100575 (accessed 2 August 2022)
- Chigudu, S. (2020) *The Political Life of an Epidemic: Cholera, Crisis and Citizenship in Zimbabwe*, Cambridge: Cambridge University Press
- de Waal, A. (2021) *New Pandemics, Old Politics: Two Hundred Years of War on Disease and Its Alternatives*, Hoboken NJ: John Wiley & Sons
- de Waal, A. and Richards, P. (2020) '**Coronavirus: Why Lockdowns May Not Be the Answer in Africa**', *BBC News*, 15 April (accessed 2 August 2022)
- Higgins, R.; Martin, E. and Vesperi, M.D. (2020) *An Anthropology of the COVID-19 Pandemic*, Abingdon: Taylor & Francis
- Honigsbaum, M. (2020) *The Pandemic Century: A History of Global Contagion from the Spanish Flu to Covid-19*, New York NY: Random House
- Independent* (2021) '**Fourth Zimbabwean Cabinet Member Dies of COVID-19 in Surge**', 24 January (accessed 2 August 2022)
- Kirk, T. *et al.* (2021) '**Crisis Responses, Opportunity, and Public Authority During Covid-19's First Wave in Uganda, the Democratic Republic of Congo, and South Sudan**', *Disasters* 45.S1: S195–S215, DOI: 10.1111/disa.12513 (accessed 2 August 2022)
- Leach, M. *et al.* (2022) '**Vaccine Anxieties, Vaccine Preparedness: Perspectives from Africa in a Covid-19 Era**', *Social Science and Medicine* 298: 114826, DOI: 10.1016/j.socscimed.2022.114826 (accessed 2 August 2022)
- Luckham, R. and Carter, B. (2022) *Building Back Better from Covid-19? What Follows for Peace, Governance and Equality*, Topic Paper, Bern: SDC Governance Network
- MacGregor, H. *et al.* (2022) '**Negotiating Intersecting Precarities: COVID-19, Pandemic Preparedness and Response in Africa**', *Medical Anthropology* 41.1: 19–33, DOI: 10.1080/01459740.2021.2015591 (accessed 2 August 2022)
- Mackworth-Young, C.R.S. (2021) '**Community Perspectives on the COVID-19 Response, Zimbabwe**', *Bulletin of the World Health Organization* 99.2: 85–91, DOI: 10.2471/BLT.20.260224 (accessed 2 August 2022)
- Matsungu, T.M. and Chopera, P. (2020) '**Effect of the COVID-19-Induced Lockdown on Nutrition, Health and Lifestyle Patterns Among Adults in Zimbabwe**', *BMJ Nutrition, Prevention and Health* 3.2: 205–12, DOI: 10.1136/bmjnph-2020-000124 (accessed 2 August 2022)
- Murewanhema, G. and Makurumidze, R. (2020) 'Essential Health Services Delivery in Zimbabwe During the COVID-19 Pandemic: Perspectives and Recommendations', *Pan African Medical Journal* 35.2: 143
- Musa, H.H. *et al.* (2021) '**Addressing Africa's Pandemic Puzzle: Perspectives on COVID-19 Transmission and Mortality in Sub-Saharan Africa**', *International Journal of Infectious Diseases* 102: 483–88, DOI: 10.1016/j.ijid.2020.09.1456 (accessed 2 August 2022)
- Mutyasira, V. (2021) *A Multi-Phase Assessment of the Effects of COVID-19 on Food Systems and Rural Livelihoods in Zimbabwe*, APRA COVID-19 Country Report, Brighton: Future Agricultures Consortium, DOI: 10.19088/APRA.2021.034 (accessed 2 August 2022)
- Newsday (2021) '**Scent of Polls as New Parties Emerge**', 28 December (accessed 2 August 2022)
- Njenga, M.K. *et al.* (2020) 'Why is There Low Morbidity and Mortality of COVID-19 in Africa?', *American Journal of Tropical Medicine and Hygiene* 103.2: 564–69, DOI: 10.4269/ajtmh.20-0474 (accessed 2 August 2022)
- Nordling, L. (2020) 'Africa's Pandemic Puzzle: Why So Few Cases and Deaths?', *American Association for the Advancement of Science* 369.6505: 756–57

- Oppong, J.R. (2020) **'The African COVID-19 Anomaly'**, *African Geographical Review* 39.3: 282–88, DOI: 10.1080/19376812.2020.1794918 (accessed 2 August 2022)
- Parker, M.; MacGregor, H. and Akello, G. (2020) **'COVID-19, Public Authority and Enforcement'**, *Medical Anthropology* 39.8: 666–70, DOI: 10.1080/01459740.2020.1822833 (accessed 2 August 2022)
- Reuters (2020) **'Zimbabwe's Health Minister, Accused of Corruption, Sacked: Statement'**, 7 July (accessed 2 August 2022)
- Ritchie, H. et al. (2022) **Zimbabwe: Coronavirus Pandemic Country Profile**, Our World in Data (accessed 2 August 2022)
- Rosenberg, C.E. (1992) *Explaining Epidemics*, Cambridge: Cambridge University Press
- Scoones, I. et al. (2010) *Zimbabwe's Land Reform: Myths & Realities*, Oxford: James Currey
- Scott, J.C. (2008) *Weapons of the Weak: Everyday Forms of Peasant Resistance*, New Haven CT: Yale University Press
- Shumba, K.; Nyamaruze, P.; Nyambuya, V.P. and Meyer-Weitz, A. (2020) 'Politicising the COVID-19 Pandemic in Zimbabwe: Implications for Public Health and Governance', *African Journal of Governance and Development* 9.1: 270–86
- Swinnen, J. and McDermott, J. (eds) (2020) **'COVID-19 and Global Food Security'**, *Euro Choices* 19.3: 26–33, DOI: 10.1111/1746-692X.12288 (accessed 2 August 2022)
- Teachout, M. and Zipfel, C. (2020) *The Economic Impact of COVID-19 Lockdowns in Sub-Saharan Africa*, London: International Growth Centre
- Tom, T. (2021) **'COVID-19, Lockdown and Peasants in Zimbabwe'**, *Journal of Peasant Studies* 48.5: 934–54, DOI: 10.1080/03066150.2021.1933455 (accessed 2 August 2022)
- Vargha, D. and Greene, J.A. (eds) (2020) **'Ends of Epidemics'**, *Boston Review*, 30 June (accessed 2 August 2022)
- WHO (2022) **'Over Two-Thirds of Africans Exposed to Virus which Causes COVID-19: WHO Study'**, *WHO Africa*, 7 April (accessed 2 August 2022)
- Wild-Wood, E. (2007) **'"Se Débrouiller" or the Art of Serendipity in Historical Research'**, *History in Africa* 34: 367–81, DOI: 10.1353/hia.2007.0024 (accessed 2 August 2022)
- Yuliang, Z. (2021) **'Zimbabwe Receives its First Batch of COVID-19 Vaccines from China'**, *Xinhua*, 15 February (accessed 2 August 2022)
- ZimbabweLand (2021) **'The Rich People's Virus? Latest Reflections from Zimbabwe'**, *ZimbabweLand*, 8 February (accessed 2 August 2022)



Delivering world-class research, learning and teaching that transforms the knowledge, action and leadership needed for more equitable and sustainable development globally.

Institute of Development Studies
Library Road
Brighton, BN1 9RE
United Kingdom
+44 (0)1273 606261
ids.ac.uk

Charity Registration Number 306371
Charitable Company Number 877338
© Institute of Development Studies 2022