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The Trilogy of the Coronavirus Disease, Religion, and The Health of African Women

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Abstract

The article discusses the trilogy of the Coronavirus disease, religion, and the health of African women. The aim of the article is to interrogate how the Coronavirus disease affected the health of African women and deteriorated their general well-being due to the prevailing religious-based gender inequalities. A qualitative research methodology was employed, namely interviews and literature review. The article argues that the COVID-19 pandemic revealed a gender bias against women because it amplified already existing gender inequalities and inequities which increased their vulnerabilities; affecting their health and general well-being in the following five areas: (1) gender disproportions; (2) domestic violence; (3) the well-being of women's sexuality; (4) women's hospitality; and (5) women's mental health. These issues are detrimental to women's well-being, and they negatively impact their socio-economic participation in society. Thus, the intersectionalities of African women's health, religion, and the Coronavirus disease entails the inclusion of women in pandemic responses. The article proffers two main implications. Firstly, the inclusion and centring of women in the formulation of COVID-19 preparedness and response plans. The pandemic responses should be gender-conscious by recognising the multiplicity of their effect on both men and women; subsequently, leading to the formulation of tailor-made responses which address the unique needs of women. Secondly, pandemic responses should address how women are disenfranchised in the hospitality sector. This implies that women's economic empowerment (WEE) has enormous potential to eradicate gender disparities and create a viable and sustainable future for girls and women.

Key words: *COVID-19, Gender, Health, pandemic, Religion, Women.*

1.0 Introduction

The article discusses the trilogy of the Coronavirus disease, religion, and health of African women. The article aims to interrogate how the Coronavirus disease affected the health of African women and deteriorated their general well-being due to the prevailing gender inequalities. A qualitative research methodology was employed, namely, literature review and interviews. The argument proffered is that the Coronavirus disease revealed a gender bias against women because it amplified

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already existing gender inequalities and inequities which increased their vulnerabilities; affecting their health and general well-being. Thus, the article calls for a formulation of an effective and equitable pandemic response based on a proper understanding of the influence of gender dynamics on how the Coronavirus disease, particularly, affected women.

In pursuit of the aim of the study, the article discusses the following themes: (1) the Coronavirus disease, religion, and health of African women; (2) gender disproportions; (3) domestic violence; (4) the well-being of women's sexuality; (5) women's hospitality; and (6) women's psychological well-being.

1.1 The Coronavirus Disease, Religion, and the Health of African Women

The Coronavirus disease heightened the intersectionalities of religion and the health of African women because of the unprecedented global disruption, untold suffering, deaths, and socio-economic turmoil (Mawerenga & Knoetze, 2022:2792). Velavan and Meyer (2020: 278) contend that the deadly effect of the Coronavirus disease was noticeable when the outbreak was initially reported in Wuhan, Hubei province, mainland China in December 2019. Davis, Lembo, Laurie et al. (2022:34) argue that the Coronavirus disease endangered the entire world as it exposed the inadequacies of biomedicine and the public health delivery systems and put into the limelight the frailty and helplessness of human beings, particularly African women.

Religion became a significant lens for perceiving and processing the meaning of life under the existential threat to life and wholeness which was stimulated by the Coronavirus disease. In this case, religion was a treasured resource which informed people's daily navigation of life, confirming the claim that African religiosity and spirituality determining factors for human existence in Africa (Platvoet & van Rinsum, 2003:123). Mbiti (1990) states that Africans are notoriously religious, and their spirituality and religiosity cannot be separated from them even during pandemics. A woman who participated in the study commented that:

> My whole life revolves around religion, and I used religion ***to*** make sense of the untold suffering and deaths caused by the corona virus disease and navigate daily obstacles. Religion provided encouragement, hope, faith, comfort, refuge, and resilience during the perilous times of the Pandemic.

Sibanda, Muyambo, and Chitando (2022:4) affirm that the connection between religion and the healthiness of African women during the Coronavirus disease either positively or negatively influenced the political and public health spheres. For instance, while most countries in Africa complied with the Coronavirus prevention measures as stipulated by the World Health Organization (WHO), Tanzania alarmed the entire world by declaring itself *"a COVID-19 free country in June 2020"* (Mtani and Ngohengo, 2023:1). The Tanzanian government encouraged people to use steam therapy, traditional medicine made of herbs such as ginger and lemon, and prayers as remedies for the Coronavirus disease (Shagembe, Kinanda, Senga et al. (2022:135). The former president of Tanzania, John Pombe Magufuli, downplayed the severity of the COVID-19 pandemic claiming that *"Coronavirus, which is a devil, cannot survive in the body of Christ... It will burn instantly"* (Hamisi et al., 2023:2).

Mtani and Ngohengo (2023:5-6) document a fivefold response by former president Magufuli to the Coronavirus disease. Firstly, he questioned the validity and reliability of the Coronavirus testing and later fired the Director of Tanzania's National Health Laboratory who was supervising the tests. He claimed that the imported test kits were flawed because they had produced positive results on non-human samples such as a pawpaw and a goat. Secondly, he also fired Faustine Ndungile, the country's former deputy health minister for advising against the use of steam therapy and herbal remedies. Thirdly, he reversed the closure of schools and universities by ordering the

resumption of educational and sporting activities in the country. Fourthly, he spoke against social distancing and the wearing of masks. Fifthly, he dismissed accusations of his government's mishandling of the COVID-19 response and claimed that faith, not fear, will win over the pandemic. Hence, Magufuli's pragmatic and popular rejoinder to the deadly disease was nuanced with religious connotations; subsequently, endangering Tanzania's public health, with a particular emphasis on women's health due to the prevailing gender inequities and socio-cultural disparities (Simba and Ngcobo, 2020: 570666).

African women's religiosity and spirituality were also affected when most African governments introduced several preventative measures to mitigate the spread of the Coronavirus (Isiko, 2020:77). Mawerenga (2021) lists the following preventative measures:

> "The closure of international airports; closing ground crossing points for passengers with the exception of cargo drivers; closure of schools and other *high* congregation points; freezing of public and private transport; outlawing all mass gathering events; outlawing and restrictions on religious gatherings; overnight curfew; and nationwide lockdowns" (p. 60).

Manyonganise (2022:232) argues that the closure of religious spaces such as churches, mosques, and other religious places of worship had a threefold negative effect on women. Firstly, women form most of the faith communities in Africa and the COVID-19 restrictions to physical spaces of worship diluted the significance of the religiosity and spirituality associated with these sacred spaces. Secondly, women were deprived of the opportunity to offload their burdens in the religious spaces where they get spiritual and psycho-social support. Thirdly, women were deprived of hearing sermons which provided religious edification and guidance for their lives (Oduyoye, 2001; Longwe, 2019).

The fore-going discussion has ecclesiological implications for women's religiosity and spirituality in view of the COVID-19 preventative measures which were implemented in most African countries. Pillay (2020: 17) gives a fourfold observation. Firstly, women had to grapple with the meaning of the church (the body of Christ) without physically going to church (a place of worship or a building). Secondly, women had to re-think the possibility of being and doing church without its obvious visibility. Thirdly, women had to appropriate the meaning and praxis of the invisible church. Fourthly, women had to re-imagine the idea of a fellowship or community (*koinonia*). Mawerenga (2021:69) argues that some churches employed virtual or digital ways to continue with their core ministerial activities using Zoom, Google Hangouts, Microsoft Teams, WebEx, WhatsApp, You Tube, TV, Radio, etc. However, for most women in African societies access to internet connectivity was a big challenge to maintain the viability and sustainability of an ecclesiological virtual community (Magezi, 2022).

Hankela (2015:366) highlights that the communitarian aspect of the church as a congregation of believers corresponds with *Ubuntu* which champions an African communitarian way of life. Chisale (2018:3) avers that *Ubuntu* expresses African interconnectedness, interdependence, community participation, and an all-embracing humanisation. Thus, the COVID-19 pandemic's restrictions disrupted African communal life by affecting people's gatherings in community events such as public worship, traditional initiation ceremonies, weddings, funerals, etc. (Mawerenga, 2021:60).

Mawerenga and Knoetze (2022: 2792) argue that African women's health was jeopardised by misleading theologies which were used to explain the meaning of the Coronavirus disease in several ways. Firstly, some religious leaders in Malawi defied the COVID-19 restrictions which limited religious gatherings to ten people only. They argued that they will maintain their church capacity to one hundred while observing the other preventative measures such as social distancing, hand

washing with soap or sanitiser, and putting on face masks (Chilanga, Dzimbiri, Mwanjawala et al., 2022: 3). Secondly, some religious leaders in Africa peddled anti-vaccine hesitancy; thereby, stifling the vaccination drive by the World Health Organisation (WHO) and the African governments' initiatives (Dzinamarira, Nachipo, Phiri et.al., 2021:250). Thirdly, the construction of misleading theologies purporting that the COVID-19 pandemic signifies the fulfilment of eschatological events such as the end of the world, and a misreading and misinterpretation of Revelation 13:8 which wrongly identified the COVID-19 vaccination with the beast's stamp (666) (Mawerenga and Knoetze, 2022: 2792). Accordingly, these misleading theologies negatively impacted African women's health by increasing their risk of infection. Also, women's overall health-seeking behaviour, access to vaccines, and treatment were hindered because of the propagation of false theologies.

Writing at the peak of the plague of the HIV/AIDS pandemic on the African continent, Circle theologians, Phiri, and Nadar (2006:9) explain the connectivity of women's health and religion in the context of HIV/AIDS. Religion has a holistic influence on women in the pursuit of wholeness which embraces the spiritual, physical, emotional, economic, and psycho-social domains of life. Religion also has various resources that enhance women's health and fullness of life. Women are also informed by their religio-cultural heritage to engage in health-care provision in times of pandemics, peace, and conflict.

Therefore, the discourses concerning the healthiness of African women, their religion, and the Coronavirus disease provide a framework which helps us to retrieve lessons by hindsight from past pandemics and construct lessons by foresight for both present and future pandemics. Even so, focusing on the inclusion of African women's health and its subsequent re-positioning to the centre in the way African states respond to pandemics.

2.0 Methodology

The study employed a qualitative research methodology, namely, a literature review and interviews. Firstly, the author acknowledges the difficulties associated with conducting qualitative research during the time of the Coronavirus disease because the preventative measures constrained both researchers and participants of the study (Rahman, Tuckerman, Vorley, et al., 2021).

Secondly, primary data was also collected from six Focus Group Discussions conducted in Malawi. Ten people comprising five women and five men participated in each Focus Group Discussion in the following five districts: Lilongwe, Zomba, Blantyre, Phalombe, and Chikhwawa. The researcher created a free, open, and relaxed environment during the interviews that enabled maximum engagement from participants. The participants freely narrated their personal attitudes and perspectives concerning the Coronavirus disease, vaccine equity and distribution, main constraints and prospects, and lessons learnt that can inform us in developing public health responses that are inclusive of women. The interviews were recorded and later transcribed.

Thirdly, a multi-disciplinary literature review was conducted on the topic under investigation. This enabled the researcher to underpin the discussion with relevant theoretical and conceptual frameworks. It was also useful in identifying knowledge gaps that could be filled by the present study.

The data collected for the study were mainly qualitative and this demanded the employment of a thematic data analysis (Chandra & Shang, 2019:91). The collected data was then subjected to a process of transcription and translation from Chichewa into English. This was followed by the coding and identification of emerging themes, which were finally interpreted accordingly.

3.0 Discussion of Research Findings

The article sought to interrogate how the Coronavirus disease affected the healthiness of African women and deteriorated their general well-being due to the prevailing gender inequalities. The aim of the study was achieved by analysing five thematic areas: (1) gender disproportions; (2) gender

violence; (3) the well-being of women's sexuality; (4) women's hospitality (care-giving role); and (5) women's mental health.

3.1 Gender Disproportions

Simba and Ngcobo (2020: 570666) observe that pandemics entrench already existing gender disparities, subsequently, marginalising women's health. Kalinowski, Wurtz, Baird et al. (2022: 100140) argue that pandemics create and compound various inequalities which amplify vulnerabilities for women and girls. Baniol, McIsaac, Xu et al. (2019:1) state that gender disparities are further heightened because globally approximately 70% of the healthcare and social services employees are women; thus, broadening their risk of infection when responding to a pandemic. For instance, in the early stages of the development of the Coronavirus disease in the Hubei Province, in mainland China, it was reported that women comprised more than 90% of the healthcare labour force (Mo, Deng, Zhang et al. 2020: 1002). Hence, this development led to a twofold gendered impact on women health care workers who were making a frontline response to the Coronavirus disease. Firstly, women who lacked personal protective equipment (PPE) had a higher risk of infection (Jain, 2020). Secondly, women were highly susceptible to developing psychological issues such as depression, distress, nervousness, sleeplessness, etc. (da Silva and Neto, 2021:110057). This can be exemplified by the cry of a female nurse who was assigned to work in the COVID-19 isolation centre. She lamented:

> I was so much afraid when I was assigned to work in the COVID-19 isolation centre. Although I was wearing full personal protective equipment [PPE] I was very much anxious and worried about contracting COVID-19. I was just wondering if I had not been infected with the corona virus. A mere coughing or sneezing heightened the fear and distress of being infected with COVID-19.

Ahinkora, Hagan Jr., Ameyaw et al. (2021: 686984) intimate that the pandemic disclosed unequal gender roles and household inequalities in Africa. Haynes (2020) argues that one of the global barriers against women's socio-economic development is the burden of household care, which in most cases is characterised by unpaid labour. Sevilla, Phimister, Krutikova et al. (2020) acknowledge the universal effect of preventative measures against the spread of the Coronavirus disease such as the closing of schools, loss of employment, and working from home to avoid movement and contact with other people. Nonetheless, mothers bore the brunt of multiple tasks, e.g. formal or informal work, household work, and caring for children in comparison to their male partners. Ahinkora, Hagan Jr., Ameyaw et al. (2021: 686984) argue that young girls and women have an increased load of household and childcare responsibilities due to patriarchal biases which traditionally favour the male gender to the detriment of the female gender. Moreover, traditional hospitality roles placed upon girls and women may increase the care workload for the elderly, the unwell, relatives, and other vulnerable people in African society (Ayittey, Dhar, Anani et al., 2020:1210).

Parry and Gordon (2021: 797) argue that the connection between gender disparities and the Coronavirus disease also highlighted the plight of female-headed households in Africa. Wanjala (2021:1657) identifies an interplay of five factors between poverty and gender, subsequently, leading to an increase of poverty levels in women-headed family units more than those of their male counterparts. Firstly, women are trapped in a vicious cycle of extreme poverty because they are primarily involved in doing care work without pay. Secondly, women face many barriers in accessing wealth and capital in comparison to men. Thirdly, women are engaged in fewer income-generating activities as compared to men. Fourthly, women constitute most people who lack access to skills development initiatives; hence, they end up working as non-skilled labourers, with very

little income. Fifthly, women have a high probability of being occupied with part-time jobs because they devote most of their time towards voluntary care work. According to Kassen (2020), Nkosazana Dhlamini Zuma said that research findings had demonstrated that the lockdown contributed to poverty for African women. Commenting during the launch of a report entitled *"The Socio-Economic Impact Assessment of COVID-19 in South Africa,"* she said:

> Households headed by casually employed, Black African women, who had not completed secondary education, had a 73.5% chance of falling into poverty due to the Coronavirus lockdown (p.1).

Lepule (2020:1) narrates that women's predicament was heightened by the failure of some men to pay for their *"child maintenance"* during the Coronavirus disease, rendering mothers more vulnerable to poverty.

The Coronavirus disease put the world to be at the brink of a hunger pandemics (WFP, 2020:1). Simba and Ngcobo (2020: 570666) explain that girls and women were more likely to be affected by the hunger induced by the COVID-19 pandemics because statistics show that they comprise 60% of people who are food insecure in the world. Mahuku, Yihun, Deering et al., (2020:1) observe that lack of food at home sometimes causes women to sacrifice the available food for other members of the household and visitors. Unfortunately, this exposes women to malnutrition and vulnerability to various diseases. Thus, the Coronavirus disease was not gender blind, but necessitated a gendered response, particularly addressing its multi-faceted impact on girls and women (De Paz, Muller, Munoz et al., 2020:1).

3.2 Gender-Based Violence (GBV)

According to a report entitled *COVID-19 and Ending Violence Against Women and Girls*, the Coronavirus disease contributed to an increase in gender-based violence (UN Women, 2020:1). Gender-based violence (GBV) intensified because of "mandatory lockdowns, quarantine, and self-isolation, where security, health, and money worries heighten tensions and strains are accentuated by cramped and confined living conditions" (UN Women, 2020:1). Moreira et al. (2020:101606) argue that the Coronavirus disease precipitated intimate partner violence (IPV) culminating into a twofold projection. Firstly, instigating thirty-one million new cases of IPV by the end of 2020. Secondly, hampering the progress made towards the elimination of IPV with a one-third reduction by 2030 (Manyonganise, 2022: 234).

Leburu-Masigo and Kgadima (2020:16618) highlight the double effect of the lockdown restrictions on women and girls. Firstly, most women were confined to the home environment together with the perpetrators of abuse. Secondly, it brought a lack of access to people and hampered their use of available mechanisms or systems of victim support resources. Ansah et al. (2023:2) mention that IPV increased due to a combination of factors such as the prevailing anticipation of gender role performance, restraints associated with the lockdown, loss of employment and other income-generating activities, and mobility limitations. Joska, Andersen, Rabie, et al. (2020:2751) provide evidence of the severity of IPV in the first week of the lockdown in South Africa culminating in the 87,000 reported cases of violence against girls and women. Makhulu et al. (2020) add that the Coronavirus disease further compounded other types of violence against girls and women such as murder, bantering, manhandling, slapping, psychological, and sexual violence. A woman who was a victim of gender-based violence explained her ordeal:

Nakyazze (2020:92) argues that isolation and social distancing measures have compromised the support network for IPV victims creating a triple challenge of getting help, escaping, and finding safety. Kumar (2020) avers that before the COVID-19 pandemic,

> My experience is that GBV was heightened because of the duration in which we were confined together with my spouse during the lockdown. So, my partner was observing me closely, listening to my phone conversations, and always searching my social media chats. There was a lot of suspicion and jealousy which eventually boiled down to fights.

Nakyazze (2020:92) argues that isolation and social distancing measures have compromised the support network for IPV victims creating a triple challenge of getting help, escaping, and finding safety. Kumar (2020) avers that before the COVID-19 pandemic,

> a victim had at least four options for escaping a violent situation by seeking refuge at a neighbour's, family member's or friend's home or by reporting the incident to the authorities (p.192).

Thus, the safety networks of most women were greatly compromised, thereby leaving them trapped in a vicious cycle of domestic violence (Abrahamson, 2020). The WHO (2020:1) reported that victims of IPV had reduced access to vital resources, including those that maintain sexuality healthiness for violated African women. Moreover, we should bear in mind that any delay in providing treatment to sexually harassed women can inflict an irreversible health hazard in their lives.

Nyangweso and Olupona (2019:12) argue that pre-existing risks of IPV rooted in African religio-cultural practices affected women's general well-being during the epidemic. Leburu-Masigo and Kgadima (2020:16618) observe that containment measures against the spread of the Coronavirus restrained the availability of GBV amenities; thereby, affecting women's general well-being. According to a UNICEF (2020) report, the epidemic created a shadow and silent plague of general sexual violence against femininity and womanhood (UNICEF, 2020). Muluneh, Stulz, Francis, and Agho (2020:903) assert that GBV during the COVID-19 pandemic should be considered as a silent epidemic because victims rarely report their ordeal due to multi-faced barriers. Some of the factors that prohibit women from reporting GBV are apparent lack of law enforcement action, negative socio-cultural attitudes concerning GBV, fear of retaliations, disgrace, and humiliation, ignorance regarding the availability of victim support services, monetary constraints, and the negative influence of religious-cultural beliefs and practices.

Rajah and Osborn (2022:1373) add that women fail to report GBV because of their desire to protect the sacredness of the family unit and the home in line with African traditional religion and socio-cultural norms. This implies the privacy of GBV, which necessitates limited outside intervention. In some cases, the affected individuals can solicit the help of traditional mediators, who unfortunately condone GBV as normal in African society.

3.3 Sexual and Reproductive Health (SRH)

Ahonsi (2020:22) argues that issues related to women's sexuality well-being were compounded during the Coronavirus disease in Africa because of two reasons. Firstly, most of the COVID-19 responses in Africa prioritised the containment and mitigation of the Pandemic's impact leaving behind SRH issues. Secondly, the management of the consequences of SRH-related behaviours such as prenatal care, sexually transmitted pathogens, sexual harassment, and GBV was greatly compromised at the time of the epidemic.

Afolalu, Anuforo, Odetayo et al. (2021:23) assert that the COVID-19 pandemic presented unique challenges for womanhood, especially around menstrual hygiene management (MHM). Kuhlmann, Henry and Wall (2017:356) relate that most girls and women faced a triple challenge in their effort to maintain good MHM during the pandemic e.g. the use of good menstrual hygiene products, how often to use them, and when to change these products? Rheinländer and Wachira (2015:1) write that women utilise various menstrual cleanliness kits i.e. sanitary pads, tampons, clothes, toilet tissue or articles, menstrual cups, and leaves to retain menstrual blood and maintain domestic hygiene. Asumah, et al (2022) mention that the unavailability of basic menstrual hygiene kits to women promotes unhygienic practices e.g. the use of articles, old clothes, socks, and dried leaves to collect menstrual blood and deal with their periods. Ajari (2020: em0045) argues that the use of unhygienic menstrual products aggravates the risk for urinary tract infections and bacterial vaginosis, vaginal itching, and white or green discharge. Odey, Amusile, Oghenetejiri, et al. (2021: 100196) highlight that the Coronavirus disease compounded the lack of access to proper MHM, thereby, compromising women's dignity, nobility, and prosperity.

Eghtessadi, Mukandavire, and Mutenherwa (2020:286) argue that the Coronavirus disease produced an increase in unintended pregnancies. Wadekar (2020) reports that thousands of adolescent girls became pregnant in Kenya during the lockdown period. According to the MSF (2020) report, SRH care options were reduced for many pregnant women due to the closure of health centres and the re-allocation of healthcare providers to combat the epidemic. The UNFPA (2021) anticipated that lack of access to SRH services will force young girls into early marriages with an alarming estimation of about thirteen million victims from 2020-2030. Eghtessadi, Mukandavire, and Mutenherwa (2020:286) highlight that access to HIV medicines by female patients of HIV/AIDS and the administration of pre-exposure prophylaxis (PrEP) for female sex workers were affected at the time of the COVID-19 pandemic.

Adams, Adams, and Koki (2021:86) note that water and hygiene insecurity heightened the epidemic's toll on girls and women. Lack of access to water, sanitation, and hygiene (WASH), complicated by the epidemic deteriorated women's menstrual hygiene. Stoler, Miller, Brewis et al. (2021: 113715) argue that the lack of access to clean and portable water for most African women based in rural areas was deepened by the rigorous handwashing with water and soap as one of the precautionary measures against the spread of the Coronavirus. This was further compounded using water in maintaining women's menstrual hygiene (Adams, Adams, and Koki, 2021:86). A woman narrated her experience of maintaining menstrual hygiene when her area faced acute water shortage during the COVID-19 pandemic,

> I faced challenges in maintaining my menstrual hygiene because there were constant acute water shortages in my area, and it took a long time for the Water Board to fix the problem. Thus, I used the little water that I had for cooking and completely neglected bathing, and this greatly affected my self-confidence because I continually felt that I was unclean.

According to a brief by UNICEF (2020), the COVID-19 pandemic affected menstrual hygiene management and period poverty; consequently, impeding progress towards the advancement of dignity for womanhood,

> An estimated 1.8 billion girls, women, and gender non-binary persons menstruate, yet millions of menstruators across the world cannot manage their monthly cycle in a dignified, healthy way. Even in the best of times, gender inequality, discriminatory social norms, cultural taboos, poverty, and lack of basic services often cause menstrual health and hygiene needs to go unmet. In emergencies, these deprivations can be exacerbated. The result is far-reaching negative impacts on the lives of those who menstruate restricting mobility, freedom, and choices; reducing participation in school, work, and community life; compromising safety; and causing stress and anxiety (UNICEF, 2020:1-2).

3.4 Women's Hospitality as Care Givers

Kanyoro (1996:149) avers that it is imperative to understand the religious and socio-cultural norms that shape the discourse of hospitality for African women. This helps us in recognising the different patterns of exposure to COVID-19 between men and women (Spagnolo, Manson, and Joffe, 2020:385). Turquet and Koissy-Kpein (2020) claim that the Coronavirus disease presented a unique care predicament which highlighted the feminisation of global health care. In this case, women invested a lot of time in doing both paid and unpaid care activities to daily negotiate with the disruptions of life brought about by the pandemic. De Paz, Muller, Munoz et al. (2020) argue that the global paid care work is characterised by imbalances which indicate that women make up two-thirds of the global care-workers. Tarquet and Koissy-Kpein (2020) write that women are also burdened by unpaid domestic care work in numerous homes globally; consequently, their workload increased. In some cases, older women cared for their sick partners, children, and grandchildren. Moreover, the lockdown measures increased the burden of home-based care for school-going children (Govender et al. 2020:504). In some scenarios, women were engaged in a twofold role of caregiving both at home and at work; thereby, rendering them more vulnerable to infection (Gausman and Langer, 2020:456). A woman who provided home-based care for her sick husband narrated her experience,

> It was not easy for me since I had to provide hospice care for my husband. We had to be sleeping in separate bedrooms and I was only leaving food on his door. I was constantly afraid of being infected while caring for him. It pained me because it took us about 6 hours before we discovered that he had died of COVID-19-related issues.

Gausman and Langer (2020:456) insinuate that women are over-represented in the frontline healthcare profession, and this subsequently raised their risk of infection, morbidity, and death based on their occupation. Mo, Deng, Zhang et al. (2020:1002) illustrate that female health-care workers faced at least three additional challenges in Wuhan, China. Firstly, if a female nurse was pregnant, there was a higher risk of infection for both the mother and her foetus. Secondly, women's movements were restricted by the wearing of personal protective equipment (PPE), and this affected movements such as going to the toilet and eating. Thirdly, female frontline healthcare workers who were on duty while menstruating felt uncomfortable and unable to regularly change their menstrual kits (Chang, 2020:803).

Oduyoye (2001) argues that the association of hospitality with African women is deeply rooted in African traditional religion and socio-cultural values. In other words, hospitality is

definitive of African women and constitutes a moral criterion for judging whether a particular African woman has humanity (*Ubuntu*) (Magezi and Khlopa, 2021:4). However, Oduyoye (2001) acknowledges the oppressive and dehumanising aspect of hospitality for African women by noting that a spirit of injustice affects the practise of hospitality in Africa. Phiri (2004:422) illustrates women's traditional burden of caregiving was put in the spotlight in Africa because of the HIV/AIDS pandemic. She notes that:

> the HIV/AIDS pandemic has increased women's workload, as AIDS patients require home-based care for a long time. Women have sacrificed their health, jobs, and time to nurse their dying relatives, children, and husbands in the name of African hospitality" (p.15).

Therefore, various calls have been made for the emancipation of African women from oppressive kinds of hospitality that encourage self-sacrifice while neglecting their own general well-being (Siwila, 2005:59).

3.5 Women's Mental Health

Mental health refers to:

> a state of well-being in which the individual realizes their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community (Edwards, et al., 2021:4).

Ojeahere et.al (2020: 100147) observe that the COVID-19 pandemic was initially considered to be affecting organs and tissues that assist in the breathing processes (respiratory system) such as the airwaves and lungs. However, research has demonstrated its effect on the nervous system (Mukerji and Solomon, 2021). A correlation has been established between COVID-19 disease and some mental health issues such as despair, nervousness, fear, lunacy, and disorientation. In addition, COVID-19 could either worsen previous psychological well-being issues or generate new psychiatric disorders (Giorgi et al., 2020:7875).

Wang, Pan, Wan et al. (2020:1729) explain that studies from China, conducted at the beginning phase of the Coronavirus disease, revealed that most women reported mental health symptoms such as worry, dejection, tension, distress, phobias, insomnia, and general psychiatric unwellness. Hao, Tan, Jiang et al. (2020:100) report that pre-existing bleakness and nervousness syndromes and GBV intensify in times of epidemics (Campbell, 2020: 100089). Almeida, Shrestha, Stojanac, et al. (2020:741) explain that certain epidemic-associated stressors uniquely affect women because of their procreative performance at various stages of life. For instance, women with the following reproductive conditions such as miscarriage, pregnancy, and postpartum depression had a higher propensity for developing psychological issues. Brooks, Weston, and Greenberg (2020:28) write that mental health problems can be heightened in pregnant women because of worries regarding their own general well-being in addition to the health of the foetus. This creates fear of the unknown and feelings of uncertainty regarding pregnancy and childbirth. Sedri, Zgueb, Ouanes et al. (2020:750) identify several mental health factors associated with the Coronavirus disease e.g. moodiness, helplessness, tenseness, dispiriting, nightmares, and general fear. A woman who experienced severe mental health problems narrated her nightmare,

> When I tested positive for COVID-19, I got distressed and couldn't concentrate on anything. I was in despair and concluded that I was going to die. I was moved from the isolation centre to the ICU and was helpless in the shadow of death. Fortunately, I recovered and was discharged but it took time for me to have mental-health stability. I was psychologically deranged and failed to cope with family and friends.

Banerjee (2020) argues that the global disruption caused by the epidemic created a psychological dilemma for women, rendering them vulnerable to loneliness, fear, panic, apprehension, and mass hysteria due to dysfunctional social relationships at the family and community levels. Grief for loved ones, bereavement, and isolation as a social distancing measure kept most women segregated from their loved ones and inhibited access to social support networks inevitably causing fear. Şimşir, Koç, Seki, and Griffiths (2022:515) establish a link between fear concerning the Coronavirus disease and psychiatric issues. Fear was singled out as one of the drivers of the contemporary mental health system. For example, fear of getting infected and being admitted to the intensive care unit (ICU), hospitalisation in the COVID-wards, loss of employment and income-generating activities, and fear of eventual demise (Rwafa-Ponela, Price, Nyatela et al., 2022:9217). Additionally, fear and uncertainty were heightened because of people's inability to visit family and churches during the lockdowns.

Restrictions on funeral gatherings and burial rites presented a big challenge in African society. Failure to conduct funeral ceremonies and accord proper burial rites according to African religio-cultural beliefs and practices contributed to mental health issues such as feelings of deep sadness, loss, distress, and guilt (Rwafa-Ponela, Price, Nyatela et.al., 2022:9217).

Semo and Frissa (2020:713) claim that African women's susceptibility to mental health issues was due to the following four factors. Firstly, the direct effect of the Coronavirus disease, especially near-death experiences. Secondly, stress is based on the news concerning high death rates of COVID-19 patients and the highly exposed frontline healthcare workers. Thirdly, the loss of loved ones, parents, guardians, workmates, or friends and the associated stigma and discrimination among survivors and affected families. Fourthly, uncertainty, stress, and fear, emanating from the loss of jobs and livelihoods, caused mental health problems for African women. Posel, Oyenubi, and Kollamparambil (2021: e0249352) argue that loss of employment and income-generating activities aggravated mental health issues. For instance, an estimation of approximately 2.8 million adults in South Africa lost their jobs from February to April 2020 when the lockdown was implemented. Subsequently, this loss of employment and other income-generating activities implies a reduced participation in the economic sphere; leading to raised depressive symptoms among South Africans.

4.0 Conclusion

The article has discussed the trilogy of the Coronavirus disease, religion, and health of African women. It has demonstrated how the Coronavirus disease affected the healthiness of African women and deteriorated their general well-being due to the prevailing religious-based gender inequalities in the following areas: gender disproportions, violence against women and girls, sexuality wellness for women, women's hospitality, and the psychological well-being of women. This article has highlighted that religion provides systemic and institutionalised influence that shapes gender discourses either positively or negatively in African society. Religion can be positively used as a tool for societal transformation. Hence, the religious variable should be seriously considered when dealing with the effect of pandemics such as the Coronavirus disease and other future pandemics on the general well-being of women.

The trilogy of African women's health, religion, and the COVID-19 pandemic proffers three main implications. Firstly, the urgency for initiating gender-sensitive conversations that intersect

the broader themes of African women's health, religion, and pandemics. Secondly, the inclusion of women and their various organisations in the formulation of a woman-centric pandemic response. This process should be informed by women's frontline engagement at home, work, and the community, based on their religious and social-cultural prescription of caregiving roles. In so doing, Pandemic responses will amplify the voices of womanhood and femininity and provide women agency in effectively combatting pandemics. Thirdly, pandemic responses should address the problems that prejudice women in their engagement with global care work. This entails the formulation and implementation of deliberate socio-economic policies which create pathways to African feminism and development. Thus, women's economic empowerment (WEE) has enormous potential to eradicate gender disparities and create a viable and sustainable development for all people.

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