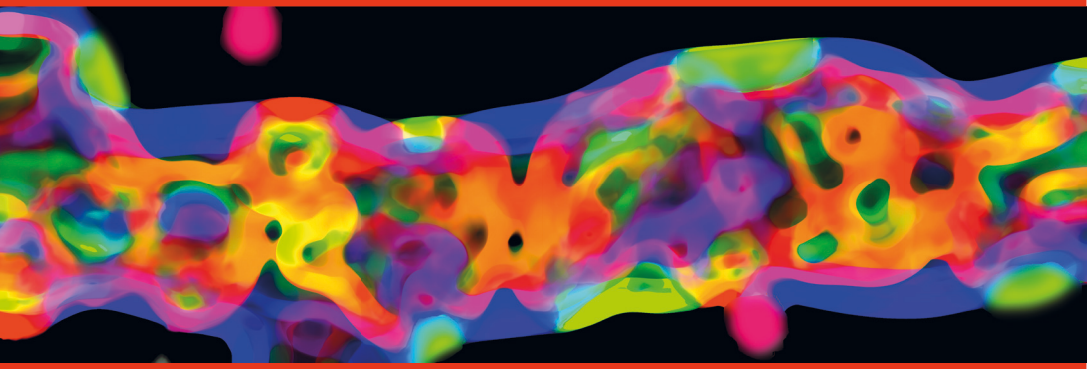
36 **BiAS - Bible in Africa Studies**
Exploring Religion in Africa 11

Molly Manyonganise (Ed.)

RELIGION AND HEALTH IN A COVID-19 CONTEXT

Experiences from Zimbabwe



University of Bamberg Press

36 Bible in Africa Studies

Études sur la Bible en Afrique
Bibel-in-Afrika-Studien

Exploring Religion in Africa 11

Bible in Africa Studies
Études sur la Bible en Afrique
Bibel-in-Afrika-Studien

Volume 36

Exploring Religion in Africa 11

edited by
Joachim Kügler,
Kudzai Biri, Ezra Chitando, Rosinah Gabaitse, Kathrin Gies,
Masiiwa R. Gunda, Johanna Stiebert, Lovemore Togarasei

University
of Bamberg
Press
2023

Religion and Health in a COVID-19 Context

Experiences from Zimbabwe

Edited by
Molly Manyonganise

University
of Bamberg
Press
2023

Bibliografische Information der Deutschen Nationalbibliothek
Die Deutsche Nationalbibliothek verzeichnet diese Publikation in der deutschen Nationalbibliografie; detaillierte bibliografische Daten sind im Internet über http://dnb.dnb.de/ abrufbar.

Umschlaggestaltung: University of Bamberg Press
Umschlaggraphik: Joachim Kügler
Deco-Graphiken: Joachim Kügler
Text-Formatierung: Irene Loch, Joachim Kügler

eISSN: 2750-0179 (Online)
eISBN: 978-3-86309-911-4 (Online)

URN: urn:nbn:de:bvb:473-irb-584228
DOI: https://doi.org/10.20378/irb-58422

CONTENT

Molly Manyonganise

1 Introduction by the Editor: Religion and Health in a COVID-19 Context in Zimbabwe

Introduction

The COVID-19 pandemic disrupted the socio-religious as well as the politico-economic spheres of nations around the world, Zimbabwe included. Sibanda, Chitando and Muyambo (2022:1) note that within a short period after its advent, COVID-19 became the world's most pressing emergency, exposing the limitations of bio-medicine and highlighting the vulnerability of human beings in different parts of the world. The impact of the pandemic across the world is visible, evidenced by the millions infected and that died. Ndlovu-Gatsheni succinctly describes the global COVID-19 situation when he says:

> One can say that COVID-19 has hit at the very center of planetary human entanglements, affecting both private and public lives. The modern world as we know it has been turned upside down. Closed borders and lockdowns have become part of the most immediate global response to curbing the spread of human infections by the virus, and within months, COVID-19 travelled along the global air and sea-lanes between China and Europe, and the USA and to the rest of the world. More than any other recent occurrence, the outbreak of COVID-19 has proved the point about the extent of global human entanglements and pushed home the necessity of finding humane ways of co-existing and sharing space on this earth between humans and other beings. (Ndlovu-Gatsheni 2020:367)

Ndlovu-Gatsheni's analysis correctly captures the intensity of the pandemic. What makes COVID-19 a pandemic of unimaginable proportions is how it ravaged countries in the Global North which tend "to associate pandemics with the Global South" (Sibanda, Muyambo & Chitando, 2022:1). Munyao (2022: xv) argues that the pandemic exposed the fragilities of societies specifically in the areas of human security, economy, social safety nets as well as the church in general. As such, scholars of religion have since begun to analyse the way the pandemic has affected religion and vice versa. For example, while religion has been seen to provide

some answers in the face of pandemics, it has shown that, it too, has been confounded by the nature and operation of the coronavirus.

Genealogies of pandemics reveal the centrality of religion as a critical resource in providing coping strategies, finding the meaning of life in threatening moments as well as explaining the origins of such calamities. Philips (2020:436) argues that the reliance on religion to make sense of and help mitigate a serious epidemic was evident throughout the world precisely during the Cholera epidemic, which started in India in 1817. He describes how the Hindus searched for an explanation beyond a traditional belief that local deities had been insulted and displeased by the villagers. The same happened during the Spanish flu. Philips (2020:438) explains how Buddhists, Hindus and a number of Africans looked to offended local deities or spirits as the source of the devastating pandemic. Muslims, on the other hand, saw it as the will of Allah and a serious test of their faith. It is instructive to note that in other times, religion can play an ambivalent role in people's responses to pandemics as shall be discussed later in this chapter. Munyao (2022) notes how at the peak of the HIV and AIDS pandemic, religions such as Christianity were chief culprits of perpetuating stigma and discrimination against those infected. As a result, religious leaders had to be challenged to promote pro-life attitudes as well as read sacred texts in life-giving ways. Hence, in a COVID-19 context, Sibanda, Muyambo & Chitando acknowledge the role different religions played in diverse African backgrounds, at times intersecting with politics while at the same time shaping the way in which people experienced and responded to the pandemic.

The global historical development of the pandemic has been captured by various scholars (see Murphy, 2020:495; Rashid & Yadar, 2020:1; Kaunda, Longkumer, Ross & Mombo, 2021) while several publications focusing on Africa can now be accessed (see Makamani, Nhemachena & Mutapuri, 2021; Machingura, Chazovachii & Mawere, 2021; Munyao, Muutuki, Musembi & Kaunga, 2022). As the pandemic ravaged nations, the role of religion in pandemic situations became clear. It is unfortunate that like in all pandemics, religion was considered critical in the response against COVID-19 a little late. The definition of frontline staff did not include religious leaders, yet for religions such as Christianity, church leaders are expected to journey with the sick, the dying and the bereaved. The closure of churches as part of lockdowns restricted church leaders from performing the accompaniment role. Governments and public health officials appear to have been oblivious to the influence that religion has in

pandemic situations. On 7 April 2020 (three months into the pandemic), the World Health Organisation (WHO) published a guide for religious leaders and faith communities. In it, the WHO acknowledged religious leaders, faith-based organisations and faith communities as critical to COVID-19 response because of their primary role as sources of support, comfort, guidance, direct health care and social service (WHO, 2020:1). It, therefore, encouraged them to follow the WHO regulations of physical distancing when they met for worship, clean their places of worship, to practice safe burials and adopt technology for worship among other expectations. In other words, the WHO was imploring faith communities and their leaders to compromise their religious practices in order to positively contribute to the mitigation of coronavirus transmission. However, within the Zimbabwean context, it became clear that as COVID-19 responses encountered religion and indigenous cultures, the long-held debate about the relationship between science and religion was reignited. I will analyse these encounters below.

COVID-19 and Culture Encounters: Reading 'Sacred Texts' in Pandemic Contexts

Religious institutions and communities of faith witnessed new dynamics as a result of the COVID-19 pandemic. This resulted in politicians and certain religious leaders religionising and politicising the pandemic to a point where attempts to explain it shifted from scientifically established truths into supernatural realms. For instance, the late Tanzanian President, John Magufuli downplayed the severity of the virus as he declared that prayer would defeat it. Hence, he refused to lock down churches and mosques in Tanzania arguing that these were places where the devil (COVID-19) would be defeated. In his opinion, COVID-19 could not survive in the body of Jesus and was going to be burned away (Kirby, Taru & Chimbidzikai (2020). In Zimbabwe, the defence minister interpreted the pandemic to be a punishment from God to Western nations who had put economic sanctions on Zimbabwe. Sibanda, Muyambo and Chitando (2022) argue that this shows the influence of religion in the public sphere. Such actions not only shaped how Zimbabweans responded to the pandemic, but also the way they received the COVID-19 vaccine.

This, therefore, calls for the interrogation of the way the sacred text shaped these responses in troubled times such as the COVID-19 context

in Zimbabwe. The use of the 'sacred text' in this case need not to be understood as the written text only but in oral terms as well. In other words, the study also interrogates how the 'Bible of culture' also played a significant role in the way Zimbabweans interpreted, explained and responded to the pandemic and how this eventually shaped vaccine uptake. The viciousness of the virus led to fundamentalist readings of the written Bible. Some New Pentecostal Movements (NPMs) in Zimbabwe appealed to the Book of Revelation in order to explain the pandemic. From this perspective, COVID-19 was a precursor of the end times. Hence, the COVID-19 vaccine was interpreted to be the 'Mark of the Beast' prophesied by John in Relevation 13. Such readings of the Bible resulted in some members of the NPMs and Apostolic sects shunning the vaccine. Their framing of the virus as a 'satanic virus' meant that it required spiritual solutions. White (2022) observes that as they addressed the effect of COVID-19, African Pentecostals resorted to the concept of deliverance from the bondage of Satan and evil forces, a view, which finds resonance in the African view of demonic attacks, and evil forces that perpetuate calamities. He further notes that some Pentecostals perceived the pandemic to be either an attack of the devil, the wrath of God due to sin or an action of God to call nations to repentance. In his analysis, "problematising COVID-19 and other pandemics in terms of supernatural evil, means that the responses to pandemics included the deployment of religious resources for supernatural intervention" (White, 2022: n.d). In Zimbabwe, most NPMs and AIC leaders told their congregants that prayer was enough to protect them from infection. For example, Emmanuel Makandiwa, founder of the United Family International Church (UFIC) in one of his sermons at his church in March 2020, told his congregants that whoever was hearing him pray against the COVID-19 pandemic that day would not die from it. Commenting on this claim by Makandiwa, Sande (2022) argues that it shows how African Pentecostal leaders [were] over-spiritualising pandemics. He contends that the problem of over-spiritualising pandemics is that it puts believers at risk by not encouraging them to act wisely. In the same vein, Kirby, Taru and Chimbidzikai (2020) accuse Makandiwa of preaching a message, which exemplifies a Pentecostal sense of exceptionalism, expressed in the claim of being 'in the world' but not 'of this world'. In their analysis, such a message instil a sense of complacency in his followers which might have been detrimental to their health as they desisted from following laid down public heath protocols during the pandemic.

There has been discussion on the link between COVID-19 and the increase in religiosity. Most religions believe that the occurrence of catastrophes point to a severance of relationship between humanity and the Supreme Being. For example, in Islam, Iqbal (2021) argues that the COVID-19 pandemic fits closely the description of calamities that are mentioned in the Quran. He avers that "the Ouran inform us that calamities of a global scale are consequences of human actions which in turn are a result of the degeneration of the collective consciousness of humanity" (2021:18) and from his perspective, COVID-19 was no exception. He notes how the demand for prayer rose significantly during the pandemic as also was noted by Bentzen (2020, 2021), which proves that the COVID-19 pandemic was a calamity intended to reconnect humanity with God. Within Zimbabwe, the government appealed to citizens to fast and pray against COVID-19. On 15 June 2020, a presidential national day of prayer and fasting was declared and a prayer meeting attended by government officials as well as church leaders was held at State House. At this meeting, the President, Emmerson Mnangagwa invoked 2 Chronicles 2:14 f and asked God to forgive the nation and show mercy towards it. He said:

> Forgive those who have worshipped idols and false gods. Forgive us for all the immorality and incleanliness. Forgive us for every act of injustice or corruption that has made the poor to suffer and the innocent to die.

As indicated in the above biblical text, he was calling on God to heal Zimbabwe of COVID-19. Mothoagae and Mavhandu-Mudzusi (2021) also note the increase in prayer by individuals during the COVID-19 pandemic in South Africa.

The WHO COVID-19 protocols challenged African religio-cultural beliefs and practices in a great way. The majority of chapters in this volume allude to how COVID-19 (re)configured how the Shona and other selected ethnic groups in Zimbabwe practised the ethic of Ubuntu specifically their communal nature as well as working together in times of crises. What was clear during the peak of the pandemic was the change in death and funerary rites that led to confrontations among relatives during a time when they were supposed to mourn together. At times, families of the deceased disregarded public health burial protocols leading to more people within families getting infected and at times succumbing to the virus. Hence, while scientific responses to the pandemic were widely publicised, most scholars have argued that they failed to take into cognisance the different social contexts of people. For example, while the concept of social

(physical) distancing is scientifically sound, within Africa it was shown to be very problematic not only in terms of one's economic status, but also in its difficulty to enforce culturally. It is highly probable that in coming up with such a very noble way of dealing with the pandemic, some religio-cultural beliefs and practices of different contexts were not taken into consideration. Hence, it is possible that as people continued to follow these beliefs and practices even in the face of death, it made the scientific response to the pandemic more difficult particularly in contexts such as Africa in general and Zimbabwe in particular. Asombang et al. (2020) have pointed out the difficulty of social distancing in Africa due to poverty while Medinilla, Byiers and Apiko (2020) as well as Manyonganise (2022) have argued that the socio-cultural set up of most African societies makes social distancing a luxury. In addition, Ndlovu-Gatsheni (2020) condemns the lockdowns that were enforced across Africa in general and Zimbabwe specifically. He characterises them as "knee-jerk responses and cut and paste versions from the Global North reactions to the pandemic with quite different implications for life, security, freedoms and economy in Africa" (2020:369). However, as people adapted to these new demands of WHO COVID-19 protocols, there is another possibility that we may notice, namely, that religious beliefs and practices (indigenous, Christian, Muslim, etc.) are not as compact/inflexible as scholars often assume. Thus, for example, Chitando (2013), "*Re-opening the Canon: The transformation of Shona indigenous religion in the face of HIV/AIDS in Zimbabwe*," shows how beliefs and practices were adjusted to fit the demands of the HIV and AIDS situation. Some of the chapters in this volume engage with the highlighted challenges and opportunities pertaining to the WHO protocols to mitigate the spread of COVID-19 particularly in Zimbabwe. For example, the adoption of Information Communication Technologies (ICTs) for church and funeral services has been highlighted as a positive development coming from the pandemic in the Zimbabwean context as may be applicable in other African contexts as well.

COVID-19 and Decolonial Discourses

In a COVID-19 context, Zimbabwe witnessed the resuscitation of not only the debate on science and religion, but also the geopolitics of knowledge between the Global North and the Global South. To start with, some African religious leaders like Pastor Chris Oyakhilome, founder of Christ Em-

bassy, Nigeria (who has a sizeable following in Zimbabwe) and Emmanuel Makandiwa among others tapped into colonial memory as they tried to explain the origins of the coronavirus. In their understanding, the virus was a new way devised by the West to wipe out Africans. Manyonganise and Biri (forthcoming) posit that present day prophets in Zimbabwe have been instrumental in presenting conspiracy theories about the pandemic being a Western invention intended to wipe out Africans as a way of paving a new wave of colonisation of African territories. Makandiwa actually blamed African leaders for failing to protect their people in the face of COVID-19 vaccination; a development, which he said, would lead to loss of territorial sovereignty. His is a call for Africa to come up with indigenous medical solutions rather than copy and paste Western solutions. In the same vein, Ndlovu-Gatsheni (2020:370), argues that the pandemic [provided] an opportunity for Africa in particular and the Global South in general not to look up to the Global North for salvation but to shift the geopolitics of knowledge by using African epistemologies of the Global South. Ndlovu-Gatsheni bemoans the way efforts and initiatives to deal with COVID-19 have remained stuck within complex global knowledge economy with creativity of Southern intellectuals and scientists silenced, marginalised and exposed. Yet in his opinion, Africa and the Global South have been facing major issues like epidemics and pandemics- hence, epistemologies of the Global South express knowledges emerging from these struggles making them relevant in confronting epidemics and pandemics (2020:372). A critical reading of the arguments being put forward by Makandiwa and Ndlovu-Gatsheni among many others shows that they are calling for the decolonisation of religion as well as concepts of knowledge production and its validation. Theirs is a demand for the provincialisation of Europe and its attendant allies. In other words, this is a call for Africa to treat Europe just as a part of the world and not 'the world'.

I have elsewhere made an analysis of the Madagascar initiative of coming up with an indigenous syrup for the treatment of COVID-19 and the support it received from some African leaders as a commendable effort in the right direction for Africa. However, the response of the WHO revealed the influence of the West in trivialising African epistemologies. Resnick (2022) calls the Madagascar effort 'dangerous and unproven [scientific] theory'. Hence, Rwodzi (2021:82) notes how the Madagascar issue ignited "widespread criticism, cynicism and outright outrage from some quarters while Chirimuuta and Chirimuuta (2021:34) lamented the doubts that were projected on the Madagascar medicine as evidence of the various

ways in which "the [Western] capitalist system would keep Africans out of the critical domains of life." Sibanda, Muyambo and Chitando (2022:14) perceive the Madagascar announcement (of having found a COVID-19 remedy) not only as an African ideology which had challenged the WHO of sustaining a colonial agenda by refusing to accept solutions from Africa, but also one that brought to the fore the politics of the centre versus the periphery. Yet in the face of no potential cure coupled with suspicion over the vaccines, most Zimbabweans resorted to indigenous medicine. It is unfortunate that some of the scholarship arising from Africa and elsewhere has not credited African Indigenous Knowledge Systems (AIKS) in their quest to explain why Africa was not hit as hard as some pessimists in the West had anticipated. Such silences invisibilise a critical component of how Africa weathered the COVID-19 storm. The silences also help the valorisation of Western perceptions, which have tried to explain the 'low' numbers of African COVID-19 deaths in ways that demean African countries' capacity to count the dead and the continent's unwillingness to release reliable data (Goncalves, 2021). Despite the denialism in the utility of AIKS during the pandemic, Sibanda, Muyambo and Chitando opine that "going forward, indigenous knowledge systems will continue to shape the responses of many Africans to pandemics", hence, they argue that "investing in greater understanding of the role of IKS among Africans from diverse backgrounds remains highly strategic" (2022:15). In doing this, African political leaders need to have the courage to push the decolonial process with the urgency that it requires.

COVID-19, Religion, and Gender

The COVID-19 pandemic has also reinforced certain gendered African religio-cultural perspectives. For example, it has become apparent that the pandemic affects women and men differently, with women suffering in a multiple of ways. Manyonganise (2022) has accused the COVID-19 pandemic of putting on the face of a woman. While she provides various ways in which the church in partic ular can be gender-sensitive and gender-competent in the face of this pandemic, it is noticeable that the gendered religious responses to the pandemic need further analysis. Scholarship on gender has shown how the pandemic increased the incidence of Gender-Based Violence (GBV) to the extent that GBV has been termed a 'shadow pandemic'. The increase in GBV cases during the pandemic has been

noted to be a global occurrence. African scholars have highlighted the intersections of religion and gender in a COVID-19 context (see Magezi & Manzanga, 2020; Mothoagae & Mavhandu-Mudzusi, 2021; Labeodan, Amenga-Etego, Stiebert & Aidoo, 2021; Manyonganise, 2022;). Some of these studies do not cast African women as perpetual victims in a pandemic context, but also reveal their agency and courage to navigate the impact of the pandemic by ensuring the health and safety of their families and communities.

As the world moved to technology, women were left behind due to their historical marginalisation in socio-economic as well as religio-political spheres. Lack of relevant technological gadgets meant that women lagged behind in conducting business online, staying in contact with loved ones during lockdowns and actively participate in online church services. In times where they had the gadgets, Manyonganise (2022) observes that the exorbitant cost of data was a barrier to most women who could not afford to purchase data bundles for internet connectivity while in other areas that are too remote, the internet connectivity itself was absent. Mothoagae and Mavhandu-Mudzusi (2021) note the same experience in the South African context. Hence, while noting that COVID-19 is a worldwide pandemic, Stiebert (2021:11) observes that it has particular severe consequences for the economically vulnerable and for women and girls. A cursory analysis of Manyonganise's (2022) study on the impact of COVID-19 on women in Zimbabwe shows how women's sexual reproductive health and rights suffered due to lockdowns and the increased presence of men in the home. She also highlights how girls in Zimbabwe became victims of child labour, sexual violence and child marriages which led to some of them failing to return to school after the lockdowns were lifted. It is, therefore, imperative that responses to pandemics factor in their gendered dimensions to ensure the safety of women from other dangers that they are exposed to in pandemic contexts.

Structure of the Book

The purpose of this book is to explore the intersections of religion and health in a COVID-19 context with a specific focus on Zimbabwe. Various scholars have examined the connection between religion and health (Koenig, MacCullough & Larsen, 2001; Koenig, 2012; Jawaid, 2014; Vanderweele, 2017; Manyonganise, 2020). With the menace of COVID-19 across cultures, focus is going to be placed on this pandemic and how it

has reshaped the discourse on the way religion interfaces with health. This book, therefore, seeks to make a valuable contribution to the body of knowledge by offering an incisive analysis of how the pandemic has shaped the way religion has contributed both positively and negatively to the discourses on health in Zimbabwe. It is envisaged that such an analysis is crucial in informing policy on the future relationship between science and religion I n public health both during this pandemic as well as in the post-pandemic era. Contributors to this volume dealt with the above raised issues in the following chapters. This chapter constitutes the first chapter and it provides the orientation of book.

In chapter two, Vengesai Chimininge examines how the COVID-19 pandemic took Zimbabweans on a journey back to indigenous cultural modes of healing. In the face of a challenged conventional health system, he shows how indigenous medicine became convenient tools in the hands of Zimbabweans as they sought to safeguard themselves from infection as well as heal their bodies when infected. Chimininge further discusses the contestations that arose between conventional and indigenous health practitioners on the efficacy of indigenous forms of healing. This has been a perennial debate, which is rooted in Western epistemologies trivialising African epistemologies. Chimininge blames African governments for failing to defend African epistemologies so that Africa can contribute to health discourses on the global stage as an equal partner.

A number of scholars has observed the deployment of Christian nationalism during the pandemic. Chapter three focuses on the deployment of Christian nationalism in Zimbabwe. In this chapter, Nomatter Sande and Clemence Makamure argue that in a pandemic context, some Christian leaders in Zimbabwe mostly those in AICs and NPMs sought to explain the pandemic as the sign of the end times. As the pandemic ravaged the country, some of them partnered with government in advancing public health messages, making a total break with their initial theologies of the end times.

In chapter four, Clemence Makamure interrogates claims by African Initiated Churches (AICs) specifically selected garmented Apostolic Churches in Harare urban and Domboshawa peri-urban, that in a COVID-19 context, prayers were enough to cushion them from infection. Such attitudes were influential in shaping their attitudes towards vaccine uptake. Makamure highlights how some AICs held on to the belief that the vaccine was the 'mark of the beast', hence not good for Christians. However, others were forthcoming in embracing the vaccines and AIC

leaders who were pro-vaccination actually encouraged their members to get the vaccines. He criticises death-giving theologies of some AICs that pits religion against science instead of complementing it. To this, he encourages government to ensure that such churches are not allowed to cause unnecessary deaths of their followers while at the same time being allowed to go scot-free. He challenges AICs to adopt both faith healing and conventional healing methods.

In chapter five, Silindiwe Zvingowanisei discusses pandemic responses of Muslims in Zimbabwe. Such a discussion is crucial as it inform us of how adherents of so-called 'minor' religions in Zimbabwe are contributing to national health responses in pandemic contexts. These discourses are often pushed to the periphery and the contribution of minor religions are subsumed in the discourses of major religions. Hence, their contributions are often made invisible. However, Zvingowanisei argues that Islam has always played a positive role in the domain of health in Zimbabwe through a number of Islamic organisations in Zimbabwe. She notes how Islam has been active in combating the spread of HIV as well as distributing Anti-Retroviral Treatment (ART) to those infected. She further argues that in the face of COVID-19 protocols instituted by the Zimbabwe following the WHO regulation, Muslims in Zimbabwe complied and like other religions such as Christianity also resorted to praying at home while suspending trips to Mecca for pilgrimage. Zvingowanisei concludes that Islam in Zimbabwe has the resources that can be deployed in response to future pandemics.

Lindah Tsara and Peter Masvotore, in chapter six, grapple with the racialisation of the COVID-19 Omicron variant, which was dubbed 'the virus from Africa'. They examine both the religionisation and politicisation of this COVID-19 variant and its implications for Zimbabwe. They accuse the western nations of playing the 'Big Brother' syndrome when dealing with Africa. In their analysis, the categorisation of the Omicron variant as an 'African virus' and the subsequent travel ban for Southern African countries, Zimbabwe included, had dire socio-economic consequences. Yet for them, such travel bans could not have been put in place if the variant had been discovered in a country in Europe or in the United States of America. On the whole, they conclude that the COVID-19 pandemic has been, on one hand, religionised as religious leaders sought to explain its origins and its intended goal while on the other hand, it has been politicised as big nations try to exercise power over 'weaker' nations. In this

case, the pandemic has entrenched inequalities in the socio-economic and religio-political spheres across the globe.

Chapter seven analyses the intersection of COVID-19, HIV, AIDS, Gender and Ethics. Bednicho Nyoni brings to the fore the moral dilemmas that the health personnel, employers and the general public have had to grapple with in the context of pandemics such as COVID-19, HIV and AIDS. For example, while the code of conduct in health stipulates patient confidentiality, for purposes of saving lives, such rights seem to have been suspended during the HIV, AIDS and the COVID-19 pandemic. Nyoni further discusses the gendered nature of these pandemics by showing how women and girls become the major victims. In the final analysis, he recommends the inclusion of vulnerable groups such as women, girls and people living with disabilities when policy formulation on pandemic responses is being done.

Tawanda Matutu examines the ethics of care during the COVID-19 pandemic by revisiting the African Philosophy of Ubuntu in chapter eight. He argues that the dire effects of the COVID-19 pandemic called for ethics of care, which are embedded in the Ubuntu philosophy, which calls for people to work together in times of crises. In his analysis, the public health protocols to combat the spread of the coronavirus worked against the concepts of friendliness and collectivism championed by Ubuntu. He, however, cautions us from priding ourselves with an ethic some of whose tenets exposes people to the dangers of infection in the name of fulfilling societal expectations. In pandemic contexts, Matutu encourages caution and the adoption of Gyekye's (2002) restricted communitarianism which empowers individuals to assert their rights to a reasonable extent, in this case, to ensure that they are safe themselves before they save others.

In chapter nine, Angeline Mavis Madongonda and Enna Sukutai Gudhlanga critisize the COVID-19 protocol of physical distancing particularly in an African context such as Zimbabwe. Their major concern is on the living conditions of most Zimbabweans who stay in deplorable conditions in Harare's high-density suburbs. In their analysis, this protocol ignored to consider people who live in over-crowded homes and suburbs as well as those whose livelihood depends on the informal sector. Hence, they condemn the one-size fits all responses that the Zimbabwean government instituted. In their recommendations, Madongonda and Gudhlanga urge government and public health officials to engage with community leaders in drafting response policies in pandemic contexts. Research

has established that trust in community leaders such as religious and traditional authorities is higher than that for formal state agencies in Africa (Resnick, 2022).

Molly Manyonganise, in chapter ten, further scrutinises the WHO protocol of social/physical distancing by focusing on how the pandemic altered African funerary rites particularly of the Shona people of Zimbabwe. She argues that the ban on travel resulted in most people who lost their loved ones during and due to the pandemic, mourning from a distance. In her analysis, this disrupted long held cultural traditions on how the Shona deal with death. For example, through embedding her study within the African ethic of Ubuntu, she contends that the COVID-19 protocol of physical distancing and the strict rule on funeral attendance challenged the Shona concept of togetherness espoused by the ethic. Furthermore, the way bodies of those who died due to coronavirus infection were treated meant that important death rituals could not be performed. She, however, suggests that in the face of a deadly pandemic, the use of ICTs can assist in bridging the gap between cultural dictates and public health protocols. From her point of view, ICTs can provide alternative ways of mourning.

In chapter eleven, Lovemore Togarasei investigates the impact of COVID-19 on Christians' handling of death. Studying the Karanga of Southern Zimbabwe and specifically engaging in an ethnographic study of one family which lost a son, Togarasei shows how COVID-19 made it difficult for church leaders to perform their expected duties in journeying with the sick, the dead and those in bereavement. What comes out clearly from his study is the way the pandemic challenged the church in Zimbabwe in the performance of its duties. Furthermore, he shows how people in rural Masvingo deployed biblical texts as a way of coping with the effects of the pandemic. Togarasei also brings out contestations that often arose between those who wanted to follow tradition and those who wanted to adhere to COVID-19 protocols in death situations. In most cases, such contestations resulted in tradition winning against public health laid down procedures of dealing with bodies whose cause of death was the coronavirus. Like Manyonganise, Togarasei recommends the use of ICTs in pandemic contexts so that the bereaving do not feel isolated, but notes that investment in ICTs needs to be done so that internet connectivity covers the whole country.

Enna Sukutai Gudhlanga and Angeline Mavis Madongonda, in chapter twelve, examine the responses of Zimbabweans in Harare to the government's regulation of mandatory face-masking. They highlight the

reasons behind resistance against face-masking. In their analysis, generally, Zimbabweans felt that most of the regulations were put in place to fool the public. In fact, they did not believe that the virus was real, but a creation of the Western countries. They questioned why in a pandemic context, Russia had the guts to start a war against Ukraine. The other contestation was why the government of Zimbabwe was allowing their party ZANU PF to hold rallies while forbidding the opposition Citizens Coalition for Change (CCC) to do the same. From their perspective, the whole COVID-19 thing was a hoax meant to disenfranchise other political parties. This is evidence to the distrust that part of the population in Zimbabwe had in government during the pandemic. Resnick (2022:183) argues that "distrust in national-level authorities leaves a critical void that imperils efforts to contain COVID-19." Gudhlanga and Madongonda also note that security agents mandated to ensure that people mask up were often the ones flouting the regulation. As a result, most Zimbabweans ended up putting on masks only when the police were around not out of conviction that it was for their safety. They also highlight how some AICs self-proclaimed prophets encouraged their followers not to mask up because their prayers were enough to protect them (see chapter 4 in this volume). Gudhlanga and Madongonda note that the unfair treatment of people by the government led to resistance against the use of face-masks among a plethora of others as "the public felt that the advice of scientific experts was being manipulated to advance political gains" (Resnick, 2022:184). Arguing from an Ubuntu perspective, they called for fairness so that people do not endanger their lives as well as those of others.

In chapter thirteen, Gift Masengwe focuses on COVID-19 and suffering bringing out the implications for pastoral care and counselling (PCC). He highlights the way the pandemic affected the services of pastors who were used to provide care and counselling to the sick and those in bereavement. Through a case study of the Church of Christ in Zimbabwe, Masengwe notes that the pandemic caused the suffering and deaths of a number of pastors. In such a case, he argues that in most cases pastors are expected to accompany their flock when in need, but at times they are also in need of accompaniment as in the COVID-19 context. In response to the lockdowns, Masengwe highlights how a Church of Christ in Zimbabwe congregation in Harare overcame the barriers to come up with ways that ensured that members were always connected through social media platforms. He, therefore, suggests that there is need to also focus on the welfare of the pastors while at the same time placing the needs of

the members at the centre. His point is that the suffering pastor is as important as the church member particularly in a pandemic context.

Bernard Pindukai Humbe (re)imagines spirituality in a pandemic context and beyond through the problematisation of the possibility of a sustained virtual church in chapter fourteen. Using AICs as case studies, Humbe argues that in the COVID-19 context, AICs posed a big challenge when it came to adhering to public health protocols. He notes that while some of the AICs followed the protocols, many others resisted and chose to hold their gatherings deep in the forests while neglecting to follow COVID-19 protocols. The lockdowns, however, forced some AICs to embrace technology and they started to offer spiritual services through social media platforms, precisely, prayers for healing. The challenge only arose where the spiritual service demanded the presence of both the church leader (prophet) and the patient. For those AICs which regard technology as evil, they resisted its use throughout the pandemic and they chose to flout COVID-19 protocols in order for them to meet. In his analysis, for many other Christian traditions in Zimbabwe such as mainline and Pentecostal churches, the possibility of a vibrant virtual church is possible because they are flexible. Most Pentecostal churches had been using technology in their services even before the pandemic and mainline churches quickly embraced technology when lockdowns were announced. While some AICs have come on board, a lot still remains to be done to convince those against the use of technology, so that in pandemic contexts, they continue to operate without jeopardizing their lives.

In chapter fifteen, Tenson Muyambo and Jane Tendere discuss the possibility of interfacing religion and science in a post-COVID-19 context. They argue that COVID-19 has forced humanity to rethink the relationship between science and religion. In their analysis, the debate on the relationship of science and religion is an academic one because Zimbabweans utilise anything that can save their lives. Muyambo and Tendere support the school of thought that deny that science and religion oppose each other, though they note that some religious believers are suspicious of science and also that in Zimbabwe, conforming to science appears to be forced by government during the COVID-19 pandemic. However, in Zimbabwe, people have always combined the use of science and religion whenever in need of both. Therefore, they conclude that even beyond the COVID-19 pandemic, science and religion will continue to interface not as enemies but complementary entities.

Conclusion

The intention of this chapter was to introduce the study and provide its orientation. It situated the study in discourses of religion and health in a COVID-19 context in Zimbabwe. It, therefore, highlighted the severe impact of the pandemic globally and specifically on Zimbabwe. The chapter engaged with the intersections of religion and health in a COVID-19 context in Zimbabwe. It showed how, as the pandemic encountered religion and culture, the latter influenced and shaped attitudes towards laid down public health responses to it. The fundamentalist readings of certain biblical texts was shown to have created negative attitudes towards vaccine uptake in followers of NPMs and AIC leaders. It further noted the various ways in which the pandemic altered African religio-cultural practices specifically pertaining to funerary rites. This resulted in contestations around the way religion and science relate in pandemic contexts. In fact, it pitted epistemologies of the Global North against those of the Global South. The chapter further discussed the gendered effects of the pandemic. Disaggregating the effects of the pandemic along gender lines assisted in showing the unique ways that women are affected by pandemics more than men do. As more research continues to be carried out on the effect of the pandemic on gender relations in Africa, it becomes imperative to also examine ways in which African masculinities were reconfigured in positive ways. This is critical in establishing Brief summaries of the focus of the chapters that make this study were also given in this chapter.

References

Asombang, A.W. et al. 2020. COVID-19 in Africa: The Nuances of Social distancing and Handwashing. *Medical Journal of Zambia*, 47(3):165-169.

Bentzen, J. 2020. Rising Religiosity as a Global Response to COVID-19. At https://cepr.org/voxeu/columns/rising-religiosity-global-response-covid-19-fear.

Bentzen, J.S. 2021. In crisis, we pray: Religiosity and the COVID-19 pandemic. *Journal of Economic Behaviour and Organisation*, 192:541-583.

Chitando, E. 2013. Re-opening the Canon: The transformation of Shona indigenous religion in the face of HIV/AIDS in Zimbabwe. In Adogame, A. et al. (eds). *Alternative Voices: A Plurality Approach for Religious Studies- Essays in Honour of Urlich Berber*, 195-210. Bristol: Vandenhoeck and Ruprecht.

Chirimuuta, C. & Chirimuuta, A. 2021. The Preparedness of Africans for the Fourth Industrial Revolution and for COVID-19. In Makamani, R., Nhemachena, A. & Mtapuri, O. (eds). *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 19-43. Mankon: Langaa.

Goncalves, B.A. 2021. Readings of the coloniality of power in the COVID-19 global dynamics: A brief reflection on Global South's socio-political location. S*ocial Sciences and Humanities Open*, 4:1-5.

Gyekye, K. 2002. Person and Community in African Thought. In Cotzee, P.H. & Roux, A.P (eds). *The African Philosophy Reader*, 317-337. New York: Routledge.

Iqbal, N. 2021. COVID-19 Pandemic: Perspective of the Holy Quran. *Journal of Asian and African Social Science and Humanities*, 7(1):16-25.

Jawaid, H. 2014. Impact of Spirituality on Health: What are the Evidences? *African Journal of Psychiatry*, 17(6):1-5.

Kaunda, C.J., Longkumer, A., Ross, K.R. & Mombo, E. (eds). 2021. *Christianity and COVID-19: Pathways for Faith*. London: Routledge.

Kirby, B., Taru, J. & Chimbidzikai, T. 2020. Pentecostals and the Spiritual War against Coronavirus in Africa. The Conversation at https://theconversation.com/ [Accessed 23 August 2021].

Koenig, H.G., McCullough, M.E. & Larsen, D.B. 2001. *Handbook of Religion and Health*. New York: Oxford Press.

Koenig, H. 2012. Religion, Spirituality and Health: The Research and Clinical Implications. *ISRN Psychiatry*, 8:1-33.

Machingura, F. Chazovachii, B. & Mawere, M. (eds). 2021. *COVID-19 and the Dialectics of Global Pandemics in Africa*, 253-278. Mankon: Langaa.

Magezi, V. & Manzanga, P. 2020. COVID-19 and intimate partner violence in Zimbabwe: Towards being church in situations of gender-based violence from a public pastoral care perspective. *In die Skriflig*, 54(1), a2658. https://doi.org/10.4102/ids.v54i1.2658.

Makamani, R., Nhemachena, A. & Mtapuri, O. (eds). 2021. *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*. Mankon: Langaa.

Manyonganise, M. 2020. Commoditising Health? Of Guesthouses and Spiritual/Faith Healing in Zimbabwe's New Pentecostal Movements. *Alternation Special Edition*, 30:257-277.

Manyonganise, M. 2022. 'When a pandemic wears the face of a woman': Intersections of religion and gender during the COVID-19 pandemic in Zimbabwe. In Sibanda, F., Muyambo, T. & Chitando, E. (eds.) *Religion and the COVID-19 pandemic in Southern Africa,* 232-243. New York: Routledge.

Manyonganise, M. and Biri, K. (forthcoming). Heading Towards the Mark of the Beast? Of Religion, Covid-19 and Vaccinations in Africa. Paper presented at the European Academy of Religion, University of Munster/Germany, 30 August to 02 September 2022.

Mothoagae, I.D. & Mavhandu-Mudzusi, A.H. 2021. The intersectionality of religion, race and gender at the time of COVID-19 pandemic: A South African Reflection. *Pharos Journal of Theology*. https://doi.org/10.46222/pharosjot.102.220.

Munyao, M. 2022. Introduction: Imagining of a Post-COVID-19 Church in Africa. In Munyao, M., Muutuki, J., Musembi, P. & Kaunga, D. (eds). 2022. *The African Church, and Security in Kenya*, xv-xxii. London: The Rowman and Littlefield Publishing Group.

Munyao, M., Muutuki, J., Musembi, P. & Kaunga, D. (eds). 2022. *The African Church, and Security in Kenya*. London: The Rowman and Littlefield Publishing Group.

Murphy, M.P.A. 2020. 'COVID-19 and emergency eLearning Consequences of the Securitisation of Higher education for post-pandemic pedagogy'. *Contemporary Security Policy*, 41(3):492-505.

Ndlovu-Gatsheni, S.J. 2020. Geopolitics Power and Knowledge in the COVID-19 Pandemic: Decolonial Reflections on a Global Crisis. *Journal of Developing Societies*, 36(4):366-389.

Philips, H. 2020. '17, '18, '19. Religion and Science in three pandemics, 1817, 1918, 2019. *Journal of Global History*, 15(3):434-443.

Rashid, S. & Yadar, S.S. 2020. 'Impact of COVID-19 Pandemic on Higher Education and Research'. *Indian Journal of Human Development*, 1-4.

Resnick, D. 2022. Trust in science and in government plays a crucial role in COVID-19 response. At https://ebrary.ifpri.org/ [Accessed 17 November 2022].

Rwodzi, A. 2021. COVID-19 and Southern Africa Development Community (SADC): A Litmus Test for Regional Solidarity. In Makamani, R., Nhemachena, A. & Mtapuri, O. (eds). *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 77-110. Mankon: Langaa.

Sande, N. 2021. Fluid Theologies: Shifts and Changes of African Pentecostalism. Journal for the Study of Religion, 34(2). http://dx.doi.org/10.17159/2413-3027/2021v34n2a4.

Sibanda, F., Muyambo, T. & Chitando, E. 2022. Introduction: Religion and Public Health in the Shadow of COVID-19 Pandemic in Southern Africa. In Sibanda, F., Muyambo, T. & Chitando, E. (eds). *Religion and the COVID-19 Pandemic in Southern Africa*, 1-24. London: Routledge.

Stiebert, J. 2021. Introduction. In Labeodan, H.A., Amenga-Etego, R., Stiebert, J. & Aidoo, M.S. (eds). *Covid-19*, 11-13. Bamberg: University of Bamberg Press.

Vanderweele, T.J. 2017. Religion and Health: A Synthesis. In Peetet, J.R. & Balbon, M.J. (eds). *Spirituality and Religion within the Culture of Medicine: From Evidence to Practice*. New York: Oxford University Press.

White, P. 2022. Pentecostal Spiritual in the context of faith and hope of gospel (prosperity preaching): African Pentecostal response to the COVID-19 Pandemic. *Dialog*, 1-8.

World Health Organisation. 2020. *Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19: Interim guidance*. Geneva: WHO, 07 April 2020.


Bias
era 11

Vengesai Chimininge

2 Going back to the Roots: Tapping into African Indigenous Knowledge Systems as a Response to COVID-19

Abstract

The coronavirus disease 2019 (COVID-19) pandemic has caused chaos around the world, taking its toll on human lives and economic activities. By May 2021, COVID-19 had infected over one hundred and sixty million people globally and killed more than three million, with the highest reported in North America, South America, and Europe in the first year, and the worst surge of the second year occurring in India. However, one of the great mysteries of the COVID-19 has been its relatively smaller impact on the African region, which endures high burdens of other infectious diseases such as HIV and AIDS. While Africa south of the Sahara is home to sixteen percent of the world's population, its share of reported COVID-19 cases is three percent of the global case count, more than a year after the first COVID-19 cases were diagnosed in China (Praag and Arnson, 2021). This low prevalent rate can be explained by underlying differences in the effectiveness and timing of control measures such as low rates of testing, under-reporting, or the use of African indigenous knowledge remedies. This study, therefore, explores the effectiveness of the African Indigenous Knowledge System (AIKS) in dealing with the COVID-19 pandemic in Zimbabwe. The paper adopts qualitative research methods. Data were collected through interview discussions (IDs), newspaper articles, and posters.

Keywords: African Indigenous Knowledge Systems, COVID-19, pandemic, roots, Zimbabwe

Introduction

The African continent has a rich repository of Indigenous Knowledge Systems (IKS) handed over from one generation to another. It is argued in this chapter that this form of knowledge can be harnessed in response to medical challenges caused by various pandemics in Africa. It is, however,

very unfortunate that African remedies that are a product of a constellation of indigenous beliefs and medical practices have not been accorded any recognition within the global medical epistemologies and ontologies (Mangombe et al., 2021). This is so because day and night national televisions, newspaper articles, and social media castigated the use of African Indigenous Knowledge Systems (AIKS) and are pejoratively labelled archaic, primitive, pseudoscientific, diabolic, and demonic. This negative perception is championed and perpetuated by forces of Western imperialism and neo-colonialism. For this reason, the use of AIKS in fighting against pandemics such as Ebola, HIV and AIDS, and the novel coronavirus disease (COVID-19) is shunned by Western scientists and their proxies residing in developing countries. However, the advent of COVID-19 witnessed a high level of utilisation of indigenous remedies in different parts of the world as people groped and stumbled in the darkness of failure of scientific medical systems (Mashego, 2021). It is this sad reality that propels this study to examine how Africa went back to its roots and tapped into IKS in response to the global COVID-19 pandemic. In doing so, the paper is divided into four major sections. The first part gives a situation analysis of COVID-19 in Africa. This is followed by an overview of how Africans respond to pandemics such as Ebola, HIV and AIDS. This helps us to understand some of the reasons why Africans are sceptical about the origins of these worldly pandemics and their impact on African societies. In this case, we pay special attention to the conspiracy theories about COVID-19. Finally yet importantly, the paper explores how Africans tapped into their IKS in response to COVID-19.

Research Methodology

The phenomenological design was used to explore the effectiveness of AIKS in response to COVID-19 pandemic. The research informants were people responsible for distributing African traditional medicine in urban and rural areas. The interview discussions were done after purposively selecting respondents from the source population. As a result, ten study participants were interviewed and their responses were recorded in a notebook. To complement data from interviews, observations were also used to glean data for this chapter. Then, data were presented and analysed using a thematic analysis. By making use of insights and analytic tools from sociological and phenomenological frameworks, the chapter examines and explains why and how Africans decided to go back to the roots by

tapping into their IKS in response to COVID-19 with special reference to the Zimbabwean experience.

COVID-19 in Africa: A Situation Analysis

In November 2019, a 55-year-old man from the Hubei province in China was diagnosed with a new disease caused by a new virus SARS-CoV-2. At the beginning of 2020, the coronavirus pandemic affected an enormous amount of people worldwide and it was declared a global pandemic by the World Health Organisation (WHO) on the 30th of January 2020. By the 11th of March 2020, COVID-19 had spread across the globe (WHO, 2020). Initially, the countries intensively affected by COVID-19 were Italy, the USA, Brazil and the UK (WHO, 2020). The pandemic further moved into the African continent

According to the WHO report (2021), as of December 31, 2020, African countries had reported 2 763 421 COVID-19 cases and 65 602 deaths, accounting for 3·4% of the 82 312 150 cases and 3·6% of the 1 798 994 deaths reported globally. Nine of the 55 African countries accounted for more than 82·6% (2 283 613) of reported cases. At the peak of the first wave in July 2020, the mean daily number of new cases was 18 273 in Africa (UNESCO, 2020).

On 3 July 2021, South Africa hit a record of 26000 cases of COVID-19, one of the highest new daily totals reported since the pandemic started. The country has been battling a deadly third wave of the pandemic, following previous peaks during the first and second waves between April and December 2020 (Mashego, 2021). As of July 19, 2021, South Africa had recorded 2.3 million cases and 67 000 deaths since the pandemic started according to the country director.

The introduction of the third wave in Zimbabwe was linked to an imported case found to be a SARS-CoV-2 infection with the delta variant. The third wave peaked in July 2021 with a corresponding cumulative increase in COVID-19 cases from approximately 38,000 to 120,000 in two months. Since the beginning of June 2021, Zimbabwe entered into a harsh third wave of the COVID-19 pandemic, which saw an increase in the cumulative number of cases from approximately 38000 to 120000 in just two months (Murewanhema and Mutsigiri-Murewanhema, 2021). In Zimbabwe, the Delta variant was reported to be responsible for 98% of the cases in the third wave.

The fourth wave according to Zibengwa (2022) was mainly due to the Omicron variant and had a positivity rate of approximately 35% on several days, signalling widespread community transmission. Data from the Ministry of Health and Child Care indicated that the highest number of daily recorded infections (4031, in December 2020) surpassed the previous record of 3,110 reached during the third wave of infections in July. As of 29 January 2022, Zimbabwe had recorded a total of 228,948 cases and 5,321 deaths, while having 216,028 recoveries and 7594 active cases (Zibengwa, 2022). Just like any other continent, the African responses to COVID-19 that were widely adopted at the beginning included strict lockdowns, bans on local and international travel, and prolonged school, college, and university closures. However, these measures have been perceived as doing more harm than good to the African population. What follows is a brief review of literature related to African response to worldly pandemics.

African Response to Pandemics: A Literature Review

A lot has been written and published on possible contributions of Indigenous Knowledge Systems (IKS) in fighting the pandemic across the globe, however, little has been done to provide perspectives from African indigenous knowledge systems. Most of the research carried out in Zimbabwe concentrated much on the use of African traditional medicine in fighting the COVID-19 pandemic and little was done to show how IKS can be used to decipher the symptoms, preventative and control measures as well as the management of COVID-19 cases. It is this gap that this paper seeks to cover.

A closer look at the history of endemic diseases, epidemics, and pandemics would reveal that Africa "has been active in biomedicine, exercising methods of appropriation and implementation that are as effective as those found in the modernised world" (Bernault, 2020:56). This entails that Africans have their own methods of detecting symptoms (diagnosis), prevention and treatment of various ailments which they have learned from their forefathers. Africa has experienced a wide range of pandemics and epidemics such as the plaque (1901-1907), polio (1917-2014), cholera (1970, the 1990s, 20s); Spanish Flu (1918-1919) Ebola, and HIV and AIDS which hit Africa hard from 1982 to this day, but she is resilient (Murewanhema and Mutsigiri-Murewanhema, 2021). In spite of the introduction of conventional medicinal interventions, Africa continued to use its condemned therapies in fighting against pandemics. According to Agozino

(2017), IKS offer low-cost approach with potentially high benefits. Agozino (2017) suggests that the efficacy of IKS within the conventional medical fraternity is generally not recognised since preference is given to the pharmaceutical products, which are believed to be the panacea to most health problems. However, IKS play important roles in health care among indigenous communities in Africa. This according to Borokini, et al. (2013) is due to their accessibility and affordability.

Agozino (2017) and Bernault (2020) highlight the immense contribution Africa has made to the discovery and treatment of many diseases such as malaria, smallpox, syphilis and tuberculosis among others. This contribution to the world's medical fraternity did, however, take place within an oppressive context and witnessed Africa being reduced to a laboratory for testing drugs as the indigenous knowledge and skills of healing were violently massacred, with indigenous medicinal practices and practitioners criminalised (Bernault, 2020).

According to Bernault (2020) the use of indigenous knowledge to meet primary health care needs in Africa goes as far back as the origins of the African communities. It became officially recognised around 1978 when the World Health Assembly announced the potential use of traditional medicine and urged member states to use traditional medical practices in primary health care (Agwaral, 1994). It is imperative to note that in Africa, inadequate healthcare systems, the unavailability and inability to access drugs, have made traditional herbal medicine popular (Zibengwa, 2022). However, it should be noted that Indigenous Knowledge Systems as utilised in primary health care settings have remained largely understudied in Zimbabwe.

The Madagascar issue is a typical example of how the Westerners have negatively looked at IKS as possible remedies to ailments. Commenting on the attitudes of modern health systems on IKS, Masoga and Shokane (2020) and Rugwiji (2019, 2008:102) postulated that "…the African way of dealing with ailments are perceived as evil and satanic." However, this chapter makes use of a plethora of ethno-medical testimonies by people who claim to have used IKS as remedies to curb COVID-19. It is important to note that Africans in general and Zimbabweans in particular could not wait for western medicines to be discovered to curb COVID-19. They hold their share in finding solutions to the pandemic by using IKS. This explains why Shoko (2007, 2011 and 2018) posits that health and wellbeing are of great primacy in the life of an African. As such, when the world

scenes were devastated with the death of millions, the Africans used IKS to ensure the safety to their health and life.

In this regard, the study argues that the use of Indigenous Knowledge Systems (IKS) as a resource can go a long way in dealing with the COVID-19 pandemic in Africa. According to Zibengwa et al., (2021) more than 80 percent of the people in Africa depend on traditional medicines to meet their health care needs. Mashego et al. (2021), observed that traditional medicine has played a huge role in providing primary health care services in Africa though it is under developed compared to Asian traditional medical systems. For him, it is vital for Africa to harness and develop the ever-present potential of indigenous health care systems in order to provide solutions to health challenges posed by the COVID-19 pandemic. Mangombe et al. (2021) discovered that the limited supply of COVID-19 vaccines and poor health systems across developing countries pushed people to use home remedies in response to COVID-19. Zibengwa, Mangiza and Muguti (2022) assert that as no cure for COVID-19 was found, the world could only rely on vaccines to contain its spread. What is disturbing though is that some of these vaccines have been received with much scepticism by some people. There have been various controversies, and conspiracy theories, pertaining to vaccines as there are suspicions that the availed vaccines will further spread the disease as a deliberate way of exterminating humanity. As such, some people are naturally hesitant to take the vaccines. Instead of taking the vaccines, some people have since turned to indigenous remedies based on Indigenous Knowledge Systems (IKS) in a bid to boost their immune systems, as well as to curb the effects brought by the COVID-19 pandemic. Despite the fact that some people in Africa in general, and Zimbabwe in particular, have turned to IKS, its efficacy has generated a lot of controversy due to the enduring nature of coloniality of power and knowledge, which has always denigrated African healing systems, and elevated western scientific medicines (Mangombe et al., 2021).

This being the case one can argue that the use of preventative vaccines and mechanisms such as national lockdowns, closure of borders, use of face masks, maintenance of physical distance, hand sanitization and use of medical equipment such as ventilators have been embraced to ease the spread of COVID-19 pandemic in many countries. However, such mechanisms have not brought any permanent solutions either, as some people, including those in Zimbabwe, remain sceptical about taking the COVID-19 jabs. Thus, dependency on donations of COVID-19 vaccines

from the developed countries also puts the continent's citizens at greater risk and in a condition of uncertainty.

Conspiracy Beliefs as a Way of Responding to the Pandemic

A conspiracy mentality is a generalized belief that powerful forces operate in secret to rule the world. This has been connected to both generalized distrust in science in general. Thus, people who endorse a conspiracy worldview are particularly unlikely to trust the expert recommendations aimed at reducing infection rates (Imhoff and Lamberty, 2020). This is relevant, as endorsement of conspiracy beliefs has been associated with an increased need for uniqueness both in correlational and experimental studies.

Past research shows that the increase of conspiracy theories during a pandemic is not a new phenomenon: Especially in times of crises, conspiracy thinking increases substantially (Douglas, 2021). For virtually all major events over the past decades were confronted with various conspiracy allegations that proposed an explanation involving plots hatched in secret by powerful agents instead. This is also true for major outbreaks of diseases. A misinformation campaign run by the Soviet Committee for State Security claimed HIV to be a biological weapon developed by the United States (O'Donoghue, Shava, and Zazu, 2019) and the widespread belief that AIDS is a conspiracy to kill black people had a direct impact on prevention behaviour. During the Zika virus outbreak 2015-2016, there were speculations that the virus was caused by genetically modified mosquitoes or used by the governments to kill people on purpose (Douglas, 2021). The current coronavirus crisis is an almost ideal breeding ground for conspiracy thinking, as there is no easily comprehensible mechanistic explanation of the disease, it is an event of massive scale, it affects people's life globally, and leaves them with lots of uncertainty. Such conspiracy beliefs might potentially even be palliative in giving people back at least a sense of control.

Tedros Adhanom Ghebreyesus, the Director General of the WHO, warned that the world is not just fighting an epidemic, but an infodemic as well. Fake news spreads faster and more easily than this virus, and is just as dangerous (WHO, 2020). A survey from mid-March 2020 conducted in the U.S. supported this notion: 42% of the US-Americans have

seen a lot or some news about the coronavirus outbreak that seemed completely made up (Douglas, 2021). This view shows that conspiracy theories began to emerge immediately after the first news of the COVID-19 outbreak. Many of these conspiracy theories stemmed from existing tensions within and between groups. For example, during the early stage of pandemic, some people believed that COVID-19 was deliberately manufactured by the Chinese to wage war on the USA. As the pandemic progressed in the US, other people believed that COVID-19 was a hoax or was exaggerated by left-wingers as part of a plot to derail Donald Trump's re-election campaign (Douglas, 2021). Recently, a vocal minority of 'anti-maskers' in Western countries have protested against what they view as a direct attack from powerful authorities on their civil liberties. These conspiracy theories were also rampant in Africa.

COVID-19 and Indigenous Knowledge System: The Zimbabwean Experience

Like any other African community, Zimbabwe has a constellation of beliefs, traditions, norms and practices that are anchored in the local, cultural and environmental conditions passed from generation to generation which could be used when communities have been struck by ailments of different types (Mapara, 2009). The Government of Zimbabwe (GoZ) launched the COVID-19 National Preparedness and Response Plan in March 2020 and subsequently declared the pandemic a state of disaster. With the support and guidance from the World Health Organisation (WHO), the government introduced measures aimed at curbing transmissions. The WHO Zimbabwe stratified the COVID-19 responses into eight pillars including surveillance, infection prevention and control, case management, ports of entry, risk communication and community engagement, laboratory, logistics, security, and coordination. Enforcement of these restrictive measures was done through coordination among various government arms such as the police, the military, the Ministry of Health and Childcare, port authorities, and local authorities.

Zimbabwe is characterised by a deteriorating health infrastructure and facilities, and a worsening epidemiological profile due to years of neglect (Dandara et al., 2021). This resulted in the country failing to provide enough medical services to those affected by COVID-19 pandemic. The importation of COVID-19 vaccines was piecemeal as the country largely

relies on donations from China, India and Russia (UNESCO, 2020). However, some sections of the society doubted the efficacy of the donated medicines and this created a scenario in which people were not sure whether they had to embrace the medicines or not. Faced with a situation in which the pandemic was rapidly spreading, a lack of confidence in the efficacy of donated vaccines due to conspiracy theories, traditional medicines found willing takers among ordinary Zimbabweans as they had been used to deal with epidemics of almost similar proportions in the past (Zibengwa et al., 2021). What follows is a data presentation and discussion on how IKS was used in the infection prevention and control; case management; and treatment of COVID-19 in Zimbabwe. To establish this, the researcher sought responses from 5 interviewees who are responsible for selling traditional herbs in the streets of Harare and another 5 in Chivi rural. For purposes of anonymity, these interviewees are given alpha-numerical codes UR1 to UR5 to those in Harare and RR6 to RR10 to those interviewed in Chivi rural. In this case, 'UR' stands for 'urban respondents' while 'RR' stands for 'rural respondents'. The interview questions sought to establish how IKS was used in the infection prevention and control of COVID-19; case management; and healing and treatment of COVID-19 in Zimbabwe.

Use of IKS on COVID-19 infection prevention and control

On the issue of symptoms, both rural and urban interviewees concurred that COVID-19 shares many characteristics with other respiratory diseases such as common flu, dry cough, fever, and shortness of breath. Interviewee UR1 stated that:

> ...Instead of reporting cases of COVID-19 to modern medical facilities, some urbanites flocked to their rural homes where use of traditional medicines was common.

Interviewee RR6 supported this view and indicated that:

> ...Rural homes also became a space for self-quarantining by those who suspected to have been infected by the COVID-19 virus wherein traditional medical remedies were taken for quick recovery.

This according to Shokane and Masoga (2020:26) and Chitsamatanga and Malinga (2021) entails that Africans use IKS to prevent and control the

spread of COVID-19 pandemic in a similar way they dealt with other respiratory diseases.

To prevent and control the spread of the infectious COVID-19, Interviewees ranging from RR6 to RR10 unanimously said that: in rural areas, disposable kitchen utensils made of clay and wood were encouraged to be used by those suspected to be septic of COVID-19 when served with food and drink. According to interviewee RR7, *"...all people were encouraged to wash their hands with warm water mixed with clean ashes (madota) and a piece of soap. Thus, ashes and soap were used as sanitizers in most households in rural Zimbabwe"*.

Use of IKS on COVID-19 management

Both rural and urban interviewees indicated that they were encouraged to use disposable utensils when serving food and drink to people with COVID-19 symptoms. For those who tested positive for COVID-19, food and drink were placed at a distance from the patient to avoid contact. According to interviewee RR8, this was *"a similar approach used by our forefathers during the outbreak of leprosy (maperembudzi)"*. However, interviewee RR10 asserted that. *"... in critical moments, relatives staying with COVID-19 patients were so vigilant to assist the patient with food and drink. They fed the patient in the open air rather than in a room."* This form of caregiving according to interviewee RR9 is a clear demonstration of *ubuntu* care ethics. People were advised to drink *(kugagura)* salt water instead of sugar-sweetened beverages. They were encouraged to limit or avoid alcoholic beverages. Interviewee RR9 postulated that,

> ...every member of society was encouraged to report to the village head about any visitor in the neighbourhood, this was used as a local security system to curb the spread of the virus from strangers. These visitors were allowed to stand outside the homestead and discuss their issues while maintaining physical distance.

In urban settlement, the interviewee UR2 indicated that citizens were encouraged to follow government protocol on COVID-19 in order to manage the spread of the virus. The researcher also observed that, every visitor in urban areas was supposed to produce quarantine certificate from government authority if coming from abroad for him or her to be received by other members of the society.

On the use of wearing face masks, all the interviewees UR1 to RR10 responded that this was an effective protective measure and as such it was welcomed by the majority of people especially during winter season. In addition to the surgical masks that were availed in different outlets in Zimbabwe, some people made use of homemade face masks as a management measure to reduce the spread of the virus. This was so because some people were sceptical about using the imported surgical masks. Again, these homemade face masks were reusable after washing them, hence they were cheaper as compared to the disposable surgical masks sold in retail outlets. A female interviewee RR6 indicated that, homemade face masks were increasing warmth especially when one is walking on a windy day. For her, *'... awa mamasiki anodziya uye anodzivirira dzihwamupengo, nokudaro gore rino vanhu vazhinji hatina kumbokosora nekuda kwemamasiki edu atakazvigadzirira.'* (facemasks are warm and protect us from COVID-19. This year many people were not affected by cough-like diseases because of the use of our homemade face masks).

However, the researcher discovered that there was a bit of resistance on wearing face masks during summer season especially in rural areas where social distance rule was very difficult to follow. Of interest to note is the fact that in Zimbabwe, summer seasons are very hot and dry and this is a period where the majority of people need to go out and prepare for the rain season. As a result, many people complained that face masks were making it difficult for them to breath due to hot weather. It was also noticed by the researcher that the majority of people in rural areas were of the opinion that COVID-19 was just but a winter disease, hence, there was no need to wear face masks in hot weather.

Use of IKS on COVID-19 treatment

Treatment of illness and disease in Zimbabwean traditional society is defined in terms of categories. In the first instance, serious illness and disease are treated by varied forms involving herbal treatment, extraction of disease-causing objects from a patient's body, and exorcism of undesirable spirits. In other instances, minor ailments are cured by medicinal treatment. Complementing this system of therapy, the indigenous people of Zimbabwe also subscribe to certain mechanisms of protection and prevention. These two forms of treatment have been summarised by

Olayiwola (1989:40) as chemotherapy, psychotherapy, soma therapy, metaphysic therapy and hydrotherapy. It should be noted, however, that out of these forms of healing and treatment techniques only the chemotherapy, somatherapy and hydrotherapy were prevalent in response to the COVID-19 pandemic in rural and urban Zimbabwe.

Chemotherapy

Out of need, necessity and convenience, the researcher discovered that in both urban and rural Zimbabwe, traditional herbs were oversubscribed as an alternative medicine used to cure COVID-19. In Harare Central Building District (CBD), the researcher discovered that there was a plethora of herbs packed in plastic bags and bottles sold by the road side. The interviewee UR3 who was selling African traditional medicine in Harare CBD listed different herbal remedies that were used during the peak of COVID-19 pandemic. For him, among the widely used herbs were the *Muvhinji* tree (Euclecrispa), *zumbani* shrub (Lippia javanica), *Muruguru* tree (Carisa edulis), ginger, garlic, onion, gumtree leaves and barks, guava barks and leaves and *Mukute* (Syzgiumcordotum) tree.

Tree barks, leaves, roots and shrubs are still being sold in the streets and the patients are advised to chew these frequently even if they do not have symptoms of COVID-19. Common to these herbs was the *zumbani* shrub which was used in the treatment of COVID-19. One interviewee UR3 narrates that: "The leaves and twigs of this shrub are boiled and the solution is taken for cough and cold alleviation. This *zumbani* syrup can be bottled and then used when the need arises". The researcher also observed that some people in rural areas were using dried *zumbani* leaves to make cigarettes and smoke it.

While there is no 'scientific proof' at the time of writing that *zumbani* can cure COVID-19, literature shows that some health experts believe that *zumbani's* respiratory healing properties may have provided relief in handling certain COVID-19 cases (Anadolu Agency, 2021). Informants in Chivi rural village, confirmed that many people with COVID-19 like symptoms 'miraculously' recovered from COVID-19 after taking the *Zumbani* syrup. *Zumbani* shrub is widely used in rural and urban Zimbabwe and some entrepreneurs are earning a living through selling it in neighbouring countries.

For interviewee RR3, "the *Muruguru* shrub's roots are extracted, soaked in water over night. The treated water is then consumed the following day in the morning and in the evening before going to bed until the illness has subsided". The interviewee further explains that "the *Mukute* tree's barks are extracted, soaked in water and administered in similar fashion to the *Muruguru* shrub". According to the interviewee RR5, these herbs had been traditionally used to treat coughs, chest pains, pneumonia and tuberculosis, and are now used to treat and heal COVID-19.

Pertaining to the effectiveness of these herbs, one informant RR2 testified that her grandfather who had COVID-19 symptoms recovered after taking the *zumbani* and *Muruguru* concoction. Interviewee UR4 testified that even doctors and nurses in the public and private clinics and hospitals encouraged people to use traditional remedies. Interviewee UR1 who sells these herbs in Harare CBD explained that some herbs such as the *Muvhinji* (Euclecrispa) have been used as an antibiotic since it also treats coughs and flu like symptoms.

Hydrotherapy

This study discovered that hydrotherapy was another common method used in the prevention and treatment of COVID-19 in both rural and urban Zimbabwe. This form of therapy includes the drinking of consecrated water to cure certain ailments and diseases, sprinkling of holy water on certain places to bring fortune and prosperity, and the use of streams for ritual bath with soap and sponges as prescribed by traditional healers and diviners. All the interviewees conducted for this study unanimously indicated that *kufukira/kunatira* (steaming) was one of the widely practised traditional practice by the local indigenous people in Zimbabwe. This involved inhaling steam from boiled water mixed with either *tanganda* tea or lemon or *zumbani* tea while one is covered with a blanket or cloth. Besides boiling *zumbani* in water, numerous other traditional herbal combinations were used in these *kufukira* sessions. All the interview informants confirmed that it was mandatory for family members to steam at least twice a day. This was mostly done in the morning and evening. However, the *kufikira* sessions were increased depending on the number of times that an individual left home and interacted with other people during the day. These *kufukira* concoctions were freely shared by people on social media such as WhatsApp and Facebook. This sharing of medical data was

a clear testimony that the indigenous people had confidence in the efficacy of their traditional herbal remedies.

Somatherapy

This form of therapy is mostly prescribed by the elderly, traditional healers, and diviners. These sacred practitioners in African societies prescribe some physical protective measures called *dumwa*. During a calamity or a disaster, sacred practitioners in many African societies can prescribe the chaining, tying of consecrated threads on wrists, necks and waists as protective measures against evil spirits. This is usually complimented by the use of physical objects like burning candles, burning of newspapers, consecrated oil, sponges, soaps, crosses, milk, salt, coffee and tanganda teas and *chifumuro* to ward off evil spirits and wash away bad destiny and command good fortunes (Chimininge, 2012). The researcher during his fieldwork observed that people who tested positive for COVID-19 in Zimbabwe were regarded as people with serious misfortunes (*munyama*) and the COVID-19 virus was regarded as a calamity caused by evil spirits. Through various media platforms people in rural and urban areas shared information that was used to conduct somatherapy. The *chifumuro* (exposer) derived from the Shona verb has the connotation of exposing or to shame (*kufumura*). According to Shoko (2007), the underlying conviction in the use of *chifumuro* plant is that it will expose the nature of the illness and disease and neutralise its effects upon the patient. This exposure restricts the aggressive nature of the illness so that it is effectively prevented from attacking any other member of the family. The *chifumuro* root according to Shoko (2007) is tied onto a fibre or a string prepared from the bark of a tree that the traditional diviner recommends after diagnosing the illness. This is then tied around the wrist, neck or waist. According to interviewee RR10, the string around the waist is called *dumwa* by the Shona. *Dumwa* means 'to send', that is, 'send to protect from the disease'. Thus, the medicine tied onto the string is thus both curative and preventive. Although *chifumuro* is limited to a specific disease, it acts as a safeguard against all forms of illness and diseases. In this case, *chifumuro* was used to protect people from the COVID-19 pandemic.

COVID-19 redefined African Identity

In light of the above discussion on the prevention and control; case management; treatment and cure of COVID-19 in Zimbabwe, it is clear that the people of Zimbabwe 'went back to their roots' and tapped from their IKS in response to the COVID-19 pandemic. The emergence of COVID-19 pushed most Africans to recognise the need of going back to their roots thereby redefining their African identity that have been obliterated by the advent of western medicine. In this case, a radical approach to our understanding of different forms of pandemics was taken into serious consideration by most African states. The emergence of COVID-19 as a world pandemic with no cure at the moment but relied on donated vaccines from America, Europe and Asia showed Africans that they are nothing without their culture. On this note, Chirimuuta and Chirimuuta (2021:19) posit that the African continent cannot afford to ignore the fourth Industrial Revolution and the various implications that it has to the developmental trajectory of its people. The duo noted that "...while it is good to acknowledge the advantaged position of continents such as Europe, Australia, USA among many others, it is high time Africans realise that the revolution at hand was never designed to benefit them, but the conglomerates, the global elite and the imperialists."

In support of this view, Kuhn (1970), Shokane and Masoga (2020) and Mukesi and Wabomba (2021) noted that the Western countries are not keen to embrace medical inventions from Africa, opting to cast a suspicious look and at times outright rejection of all African inventions. According to Mukesi and Wabomba (2021), the majority of African health systems rely on funding from multilateral organisations such as WHO and other development agencies to supplement their budgets. As a result, these African governments remain vulnerable to external influence which shun AIKS. The duo also observed that some African states do not support their own knowledge systems in human health, preferring to play second fiddle to Western medicine.

Basically, IKS have not been officially accommodated in the formal health systems of any country, let alone Zimbabwe. As a way of closing out IKS and promoting Western medicine, Western health professionals are quick to brush aside the use and efficacy of IKS within the medical fraternity (Murray and Chavhunduka, 1986). At one time through national television and radios, the Medicines Control Authority of Zimbabwe

(MCAZ) warned against the use of traditional medicines. For MCAZ, "African traditional medicines were posing a serious health risk to members of the public who were using them in place of the prescribed conventional medicines" (Shoko, 2018). Nonetheless, it is heartening to note that some innovation hubs, recently established by the government in the country's state universities are taking a leading role in carrying out research on the efficacy of some selected indigenous herbal remedies. This entails that, African survival in this world of change and competition should not be derivable from parroting the neo-imperialists but rather Africans need to advance the uniqueness of Africa in the medical fraternity and other facets of life.

As claimed by Chirimuuta and Chirimuuta (2021:30) Africans will then be better placed to curve their own spaces on the global terrain and claim their position on the global marketplace of ideas. For Africa to redefine its identity in the medical sector and other institutions, African countries should concentrate on inventing, researching and coming up with innovations that Sare peculiar to their situation rather than blindly attempting to fit in or to access what the neo-colonialists would have designed. It should be noted by every African that innovations from America, Europe and Asia are never and will never be intended to change their current attitude towards Africa, but to advance the neo-imperialist agenda. Mukesi and Wabomba (2021:45) argue that the stance taken by African countries behind Madagascar's invention of COVID-19 vaccine is laudable in redefining African identity. However, African countries need to do more to support each other and use their own AIKS in medical inventions and other sectors of life. In this case, deliberate efforts should be made by all stakeholders through public, private partnerships to preserve African indigenous knowledge systems which have proved to be very vital in fighting pandemics of different types since time immemorial. This according to Zivengwa et al. (2021) can be done through documentation of traditional medical knowledge by academics, and other research institutions. In redefining Africa and promoting its unique identity, the institution of traditional healers and diviners should also be promoted by African governments. Furthermore, concerted efforts should also be made by various stakeholders in Africa to protect biodiversity which is a ready source of medicine for traditional remedies since these were looked down upon by western scholars and missionaries and referred to them as 'witch doctors' (Shoko, 2018).

This view had already been supported by World Health Organisation (WHO) when it pointed out that the use of IKS in the medical fraternity is one of the surest alternative means to achieve total health care for the world's population (Maluleke, 2020). The WHO acknowledged at the height of the HIV and AIDS pandemic during the early years of the 21st century that, traditional medicines could be used to deal with its symptoms and also relieve pain, and opportunistic diseases, associated with it. The strong conviction is that if these medicines were used in the past, continuing to this very day, to treat various ailments, they could still be used successfully to treat COVID-19 (Chitungo, 2022). As such, the support by the African governments for IKS must be the first port of call. For this reason, Africa should take cognisance of the fact that the use of IKS becomes a necessity given the scenario where modern medicines are failing to treat COVID-19. Again, Western manufactured medicines are very expensive and beyond the reach of the majority of the African population. The scarcity of basic medicines in African hospitals and clinics at a time when the whole world is grappling with a pandemic should force African states to come up with home-grown solutions to medical challenges faced by the continent at large. This, in the end, makes health solutions derived from the use of IKS readily accessible in communities, affordable and effective. These remedies, as highlighted above, have the advantage that they are the most affordable and easily accessible source of prevention, management, and treatment of the COVID-19 pandemic, especially for poorly resourced countries like Zimbabwe. Of interest to note is the fact that health solutions anchored in the IKS are also more acceptable from a cultural point of view.

In order to redefine African identity, the school, college, and university curricula in African states should include the teaching of IKS in their syllabuses. Such a move will help to preserve and promote the use of IKS to posterity. Notwithstanding efforts currently on the ground, the African governments must avail more funding to public institutions such as universities, polytechnics, and state-owned research institutions to carry out research for the manufacturing of herbal medicines to meet local demand. This can also be done through partnering and patenting with international drug or vaccine manufacturing hubs.

Conclusion

COVID-19 has had a devastating impact on global communities, drastically affecting the population and the global economies. The African continent in general and Zimbabwe in particular, have not been spared by the wrath of the pandemic. In response to the COVID-19 crisis communities which used to shun African indigenous therapies including those from Mega churches, Pentecostal churches, Evangelical and African Indigenous churches resorted to African Indigenous Knowledge Systems as possible remedies to prevent and control, manage, cure, and treatment of COVID-19. In Zimbabwe, both urban and rural communities fell back on their African indigenous medicines and tried to salvage the little they could remember from the tradition's repositories to save humanity. The sad reality is that the indigenous knowledge of medicines and medical practices has been battered, castigated, and thrown to the doldrums of knowledge. The vehicle for this demonization and castigation of IKS is none other than western imperialism, industrialisation, and the influence of Christian teachings. This has been exacerbated by the death of the African elderly people who happened to be the repositories of the African knowledge systems. As such, African indigenous knowledge systems have generally been given a back seat in the global health fraternity because of the negative image that has been associated with them. The Zimbabwean government, however, took a positive stance when it professionalised traditional healers in 1980 through the formation of the Zimbabwe National Traditional Healers Association (ZINATHA). The move to secure their independence from the negative perception it had got from the colonial government shows the importance of the traditional healers and their practice in the lives of the people of Zimbabwe. This actually entailed the promotion of IKS. It should be concluded that the exclusion of ZINATHA from the modern medical field in Zimbabwe also means the exclusion of IKS from mainstream development and practices.

This paper discovered that Zimbabweans of all persuasions have never completely abandoned their confidence in IKS as they respond to various life problems and natural disasters as shown. As discussed in this paper, we have noticed that as the COVID-19 pandemic showed its sting on the world scene, Zimbabweans were quick to throw their face into the past and started to fish out IKS to prevent, manage and treat COVID-19. This demonstrated that, despite the modernisation of the Zimbabwean community, in times of crisis, Zimbabweans tend to go back to their roots for

sustainable solutions. Be that as it may, Africans need to find their roots, which they do in their community, among their people, and by doing so, they will be able to enrich the cultural soil out of which they were born. This simply means that to return to their roots is to find their meaning in all forms of life, be it in politics, economics, family, education, and above all health issues. In this case, Africa should acknowledge that there is only the present, and by going to the roots and their origins, the meaning of life in its various facets will be clearer. A lot of interventions are, therefore, required from different stakeholders as a way of promoting a cause that can be a saviour to the African population.

References

Agozino, B. 2017. Indigenous Knowledge Systems and Innovations in Malaria Control in Nigeria. *Journal of Immuno Virology*, 1-6.

Agwaral, A. 1994. Dismantling the Divide between Indigenous and Scientific Knowledge. Paper presented at a workshop on Political theory and Policy Analysis Blummington: Indiana University. https://dlc.dlib.indiana.edu [Accessed 30 May 2022].

Agrawal, A. 1995. Indigenous and scientific knowledge: some critical comments. Indigenous Knowledge and Development Monitor, 3(3):1-9. http://www.nuffic.nl/ciran/ikdm/3-3/articles/agrawal.html [Accessed 30 May 2022].

Barnhardt, R. and Kawagley, A.O. 2005. Indigenous Knowledge Systems and Alaska Native Ways of Knowing. *Anthropology and Education Quarterly*, 36(1):8-23.

Bernault, F. 2020. Some lessons from the History of Diseases in Africa. https://africanarguments.org/2020/06/some-lessons-from-the-history-of-epidemics-in-africa/ [Accessed 30 June 2022].

Borokini, T.I., Clement, M., Dickson, N.J., and Edagbo, D.E. 2013. Ethno-biological survey of traditional medicine practice for Gastro-intestinal tract infections in Oyo State, Nigeria. *Top class Journal of Herbal Medicine*; 2(6):131-139.

Chavunduka, G.L. 1999. *Christianity, African Religion and African Medicine* at https://repository.globethics.net [Accessed 06 February 2022].

Chimininge, V. 2012. The Ritual of Avenging Spirit: A Case Study of the Zion Christian Church of Samuel Mutendi in Zimbabwe, in *Theolgia Viatorum, Journal of Theology and Religion in Africa*, 36(1):42-58.

Chirimuuta, C. and Chirimuuta, A. 2021. "The Preparedness of Africans for the Fourth Industrial Revolution and for COVID-19". In Makamani, R., Nhemachena, A. and Mtapuri, O. (eds). *Global Capital's 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 19-43. Mankon: Langaa.

Chitungo, I. et al. 2022. "COVID-19 Response in Zimbabwe: The Need for a Paradigm Shift?" *COVID* 2, no. 7:895-906. https://doi.org/10.3390/covid2070065.

Douglas, K.M. 2021. COVID-19 Conspiracy Theories, Group Processes and Intergroup Relations 2021, Vol. 24(2):270–275.

Imhoff, R. & Lamberty, P. 2020. COVID-19 Related Conspiracy Theories and Pandemic Behaviour A bioweapon or a hoax? The link between distinct conspiracy beliefs about the Coronavirus disease (COVID-19) outbreak and pandemic behaviour. In Social and Legal Psychology, Johannes Gutenberg University, Mainz, Germany. Accepted for publication at Social Psychological and Personality Science (n.p).

Kuhn, T. 1970. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Maluleke, T. 2020. The social and cultural implications of COVID-19. *News24*. https:///www.news24.com/news24/columnist/guestcololumn/opinion-the-social-and-cultural-implications-of-COVID-19 [Accessed 29 March 2022].

Mangombe, K., Marufu, I., Milanzi, A., Moyo, S., Muza, C., Zanamwe, L. & Makurirofa, L. 2021. Informal Health Strategies: The Use of Traditional Home Remedies in the Fight against COVID-19 in Urban Harare, Zimbabwe. *Journal of Urban Systems and Innovations for Resilience in Zimbabwe,* 3(2):133-150.

Mashego, S.L., Maditsi, M.E., and Bhuda, M.T.A. 2021. Response to COVID-19: Perspectives from African Indigenous Knowledge Systems, Journal of Gender and Behaviour, 19(1):33-51.

Masoga, M.A. and Shokane, A.L. 2020. Socio-economic challenges faced by traditional healers in Limpopo Province of South Africa: Conversations from below. Alternative: The Sage.

Murewanhema, G. and Mutsigiri-Murewanhema, F. 2021. Drivers of the Third Wave of COVID-19 in Zimbabwe and Challenges for Control: Perspectives and Recommendations. *The Pan African Medical Journal*, 40-46.

Mukesi, M. and Wabomba, E. 2021. "Vaccinations in Africa: The Paradox of Human Rights and Human Experiments". In Makamani, R., Nhemachena, A. & Mtapuri, O. (eds). *Global Capital's 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 45-76. Mankon: Langaa.

Murray, L. and Chavhunduka, G.L. 1986. *The Professionalisation of African Medicine*. Manchester: Manchester University Press.

O 'Donoghue, R., Shava, S. & Zazu, C. 2020. (eds). *African Heritage Knowledge in the context of Social Innovation Learning contributions of the Regional Centres of Expertise on Education for Sustainable Development*. Pretoria: Institute of Advanced Studies.

Ogungbile, D.O. 1997. Meeting Point of Culture and Health: The Case of the Aladura Churches in Nigeria. *Nordic Journal of African Studies,* 6(1):98-111.

Praag, O.V. and Arnson, J. 2020. *A Crisis with a Crisis: Venezuela and COVID-19. Latin American Programme*. https://www.wilsoncenter.org [Accessed 12 March 2022].

Rugwiji, T. 2008. *Reading the Exodus Tradition from a Zimbabwean Perspective*. Unpublished Master of Arts Dissertation submitted to the University of South Africa, South Africa.

Rugwiji, T. 2019. 'Faith-based Healing and African Traditional Medicine in Zimbabwe: A Post-Colonial Perspective'. *Theologia Viatorum*, 43(1):1-10.

Shokane, A.L. and Masoga, M.A. 2020. An Afro-sensed perspective on decoloniality research methodologies. Research in Human Services Professions: South Africa.

Shoko, T. 2007. Karanga Indigenous Religion in Zimbabwe: Health and Well-Being, London: Routledge: doi.org/10.4324/9781315590905

Shoko, T. 2011. 'Shona Traditional Religion and Medical Practices: Methodological Approaches to Religious Phenomena'. *Africa Development*, 36(2):277-292.

Shoko, T. 2018. Traditional Herbal Medicine and Healing in Zimbabwe. *Journal of Traditional Medicine and Clinical Naturopathy*, 7(1): doi.org/10.4172/2573-4555.1000254.

United Nations Educational Scientific and Cultural Organisation (2020). Socio-economic and cultural impacts of COVID-19 on Africa, UNESCO responses: Executive summary. Retrieved from https://en.unesco.org/sites/default/files/stand_alone_executive_summary_fin_pdf [Accessed 30 April 2022].

World Health Organisation 2021. Regulatory updates on COVID-19. https://www.who.int/ [Accessed 24 April 2022].

Zibengwa, T., Mangiza, O. and Muguti, T. 2022. *Harnessing indigenous knowledge systems in managing COVID-19 pandemic in Zimbabwe*. Gweru: MSU Press.

Nomatter Sande & Clemence Makamure

3 Signs of the Times – Thinking Anew Christian Nationalism in Zimbabwe

Abstract

While the prevalence of modernity has altered religious ideologies in Zimbabwe, Christian proselytisation continues to grow. Religion and spirituality are distinctive traits providing meaning to the life of Zimbabweans. From an African Christian perspective, human life and all fundamental needs draw meaning from religious and spiritual convictions. Religion and spirituality permeate life's socio-political and economic issues. Although historically, there is an ambivalent relationship between church and state to solve the problems bedevilling Zimbabweans. However, the standstill of life in the world brought by the Coronavirus pandemic has opened new avenues for Christian nationalism. Through diverse conspiracy theories, Christian leaders have proffered explanations about the source, meaning, and solution(s) to the virus. A seemingly symbiotic relationship existed between the church and the state to deal with the coronavirus pandemic. The church used coronavirus as 'the signs of times', which has created room to redefine the intersection of religion, politics, and health. Besides exploring the new forms of religiosity created by the church to stay relevant during the pandemic, this paper analyses how the church's health solutions promote nationalism. This study used the de-secularization theory as a theoretical framework. The paper qualitatively analyses data from document analysis from social media, newspaper articles, news channels and text-based research. This paper concludes that the church's adaption to Coronavirus through creating churches without walls, virtual worships, online giving and spiritual prophetic healing declarations not only show that religion in Zimbabwe is not declining but continuing to surge and build the nation.

Keywords: Covid-19, de-secularization theory, new world order, conspiracy theories, politics, new religiosity.

Introduction

The relationship between the church and state has been historically regarded to be ambivalent as the two institutions thrive to solve the problems bedevilling humanity. With the advent of COVID-19 and the subsequent imposition of national lockdowns, banning of social gatherings and practicing of social distance, the relationship of the two institutions was at first strained because such moves were a blow pricking the heart of the church. The state seemed to be predicting an imminent death of religion. The severity of the pandemic and how it swept away life in various nations of the world had only one pointer that the world has now approached the end times. From evidence on the ground, the world was in a dilemma and the church was foreseeing doom on its existence. The echoes of biblical messages that the end of times will be announced by wars, conflict and untreatable diseases were coming to reality. Religious leaders from all divides were in a panic mode as nations went on to roll out vaccinations. This saw some of the religious leaders publicly confessing that they will not partake the vaccines since they were a mark of the beast. Such a mentality was pointing to the view that we have arrived at the end of the times because rumours were spreading that those not vaccinated would not be allowed to buy and even go out their nations. The words by governments which were meant to enforce people into accepting the vaccines were religiously interpreted to mean forcing people to accept the mark of the beast and were echoing the message of the book of Revelation in the bible. However, the standstill of life in the world brought by the COVID-19 pandemic opened new avenues for favourable relationship between the church and state. COVID-19 made the two to realise that they are core workers and not enemies. This chapter presents the role played by Christian nationalism in fostering the government efforts to contain the deadly disease. Efforts are made to explain in this chapter how the coming of the COVID-19 was first interpreted by the church as the end of the times and how the church took the government and science as enemies in their mission before realising the importance of the two in the service of the Church. The purpose of this chapter is to buttress the role played by Christian nationalism during the surge of COVID-19 in Zimbabwe.

Methodology

The study adopted the qualitative research paradigm which is relatively appropriate in exploring multifaceted religio- political behaviours and factors contributing to Christian nationalism in Zimbabwe. The qualitative research paradigm facilitated to comprehend variances in perceptions on the concept of Christian nationalism and offers exhaustive acquaintance of the innumerable eloquent factors that underlie the issue of the relationship between the church and state during the COVID-19 pandemic in Zimbabwe. The use of document analysis, social media, key informants including religious leaders and their followers allowed the researchers to capture imperative evidence from first hand informants. This research used the de-secularisation theory to understand how the pandemic has shaped the way religion has contributed both positively and negatively to the discourse on Christian nationalism in Zimbabwe. De-secularisation theory is defined as diverse of manifestations of the worldwide resurgence of religion (Berger, 1999). Put in other words, de-secularization is a counter-secularization showing the vitality of religion vis-à-vis global modernity (Reaves, 2012). De-secularization is a process of social change associated with religions' resurgence and their expanding societal influences. This then implies that de-secularization is defined as a process of counter-secularization (Kaprov, 2010:238). Secularization is generally considered as a multi-faceted social transformation in the course of which religion's influences on society decline. This being the case, therefore, it becomes logical to cogitate de-secularization as a process of social change that develops in the opposite direction (Kaprov, 2010:238). So, basically de-secularization is the revival of religious content in a variety of its symbolic subsystems, including the arts, philosophy, and literature, and in a decline of the standing of science relative to a resurgent role of religion in world-construction and world maintenance (Berger,1990:107). This research argues that the church's adaption to COVID-19 protocols through creating churches without walls, virtual worships, online giving and spiritual prophetic healing declarations clearly indicated that religion in Zimbabwe is not declining and is continuing to surge and play a significant role in nation-building. More so, Christians in Zimbabwe continue to find relevance in deadly situations which calls into practice the concept of Christian nationalism.

Conceptual Analysis

The major purpose of this chapter can only come to the fore if we first come to terms with the meaning of the concepts like nationalism, Christian nationalism and end times. This being the case, therefore, it suffices to analyse the terms before we delve into the issue of how Christian nationalism helped the state in fighting COVID-19.

Nationalism

The history of humanity is awash with people who are attached to their native soil, to the traditions of their parents, and to established territorial authorities. The concept of nationalism started to be popular in the 18th century and it became a recognised sentiment moulding public and private life (Yael, 2019). The American and French revolutions have been considered to be the first powerful manifestations of nationalism. In the early 19th century, nationalism spread to central Europe and from there, toward the middle of the century, to eastern and south-eastern Europe (Özkirimli, 2017). At the commencement of the 20th century, nationalism blossomed in Asia and Africa. This is the reason why the 19th century has been called the age of nationalism in Europe, while the 20th century witnessed the upsurge and brawl of powerful national movements in Asia and Africa. The term nationalism implies the identification of the state or nation with the people (Grosby, 2005).

Nationalism has also been defined as people's loyalty and devotion to a nation especially as expressed in the promotion of its culture and interests (Philip and Wollman, 2002). Yack (2012) defined nationalism as an ideology that emphasises loyalty, devotion, or allegiance to a nation or nation-state and holds that such obligations outweigh other individual or group interests. This implies that nationalism is a strong attachment to a particular country, or nation and is also called patriotism. Be that as it may, nationalism is erected around a shared language, religion, culture, or set of social values (Kuznicki, 2008). Thus, in essence there are three key types of nationalism which are language nationalism, religious nationalism and post-colonial nationalism. This implies that nationalism is all about the attitude that the members of a nation have when they care about their national identity, and the actions that the members of a nation take when seeking to achieve or sustain self-determination (Nielsen 1999:9).

Given the diverse definitions of nationalism it is not surprising, therefore, that during the COVID-19 pandemic, many citizens particularly Christians were very loyal to their country. People were feeling strongly about belonging to the nation and having a role to play to stop the spread of the pandemic. These feelings led to the creation of a new sense of Christian nationalism in Zimbabwe.

Christian Nationalism

The other term worth of analysing in this chapter is Christian nationalism. Christian nationalism is a cultural framework or a collection of myths, symbols, narratives, and value systems that seek to elevate an ethno-traditional, identitarian version of Christianity with civic culture (Gorski, 2017). Whitehead and Perry (2020) defined Christian nationalism as an ideology that idealises a fusion of civic life with Christian identity and culture. Christian nationalism is positively associated with identifying Christianity as the determinant factor of all activities in human life of any nation (Miscevic, 2010). Christian nationalism is also positively associated with believing that the nation is on the brink of moral decay and that God requires the faithful to help the nations to sustain the good (Whitehead and Perry, 2020:12). Christian nationalism is a cultural ideology that wants civic life to be permeated by a particular form of nationalist Christianity. This entails that Christian nationalists demand that their brand of Christianity be the sole source of moral authority for the nation and reject all competitors including science. Net of other factors, Christian nationalists significantly reject evolution and view scientists as hostile to faith, they respond incorrectly to scientific questions on topics that are religiously contentious and they hold anti-vaccine attitudes using pre-pandemic information (Whitehead and Perry, 2020).

Whitehead and Perry (2020) further stated that Christian nationalism had the second largest association with anti-vaccination attitudes and was the strongest predictor of believing that vaccines cause autism, that children are given too many vaccines and that vaccines do not help protect children. Rather, Christian nationalism from its history did not respond favorably to scientific recommendations regarding how to reduce the spread of COVID-19. Even before the pandemic, Christian nationalists expressed belief that as God's chosen people, Christians would be protected and privileged if they uphold their identity as a Christian nation and adhere to biblical principles (Kelly, 2015). Be that as it may, Christian nationalism is merely a heightened form of religious ethnocentrism' it is a

species of theological fancy dress dedicated to self-aggrandisement. It is a theological defence of Christian hegemony in politics (Breen and O'Neill (eds.), 2010).

Christian nationalism, or the synthesis of religious and national identities and goals, is a progressively striking aspect of nationalism. Instead of secular nationalism solely replacing religious identities and allegiances, Christian and national identities coexist and even reinforce each other. Christian nationalism has become a powerful force in buttressing popular religiosity and attitudes, empowers religious organisations in influencing policy across a wide range of domains, and shapes the patterns of inter- and intra-state violence (Grzymala-Busse, 2019). The implications of this research are that we should invest in better measures and operationalisation of Christian nationalism and reconsider the lucidities of state- and nation-building.

In Zimbabwe, Christian nationalism has become so powerful that it has shaped the very definition of legitimate citizenship, delineating the nation and privileging some political actors and visions in making public policy, obtaining electoral support, and building states. Rieffer (2003:225), defined Christian nationalism as the fusion of nationalism and religion such that they are inseparable. Greenfeld (1996:170), clearly stated that religion and nationalism are order-creating cultural systems. Brubaker (2011:4), avers that Christian nationalism is a form of social identification and modes of social organisation and segmentation. All what these scholars are implying is that Christian nationalism relies on religious identities and myths to define the nation and its goals. In turn, the term nationalism according to (Gellner, 1983:1), is the principle that holds that the political and the national unit should be congruent (Wald & Wilcox, 2006).

Spohn (2003:269) argued that despite the various forms of secularisation, religion remains a constitutive basis of national identity and nationalism. For him, religion and nationalism may coexist, either as separate projects or intertwined, with language and symbols borrowed from each other. Rather, there has been an inter-relationship between religion and nationalism from time immemorial. Religious doctrines, symbolic language, and narratives to nationalism have immensely shaped nationalistic perspectives for a long time (Brubaker, 2011:16). Smith (2008) argued that religious narratives and symbols justified and infused nationalist projects. More approximately, nationalism has roots not in religious decline but rather in moments of religious fervour and renewal (Zubrzycki, 2006:19; Calhoun, 1993; Gillis, 1994; Gorski, 2003; Marx, 2003). Typical examples

of tenacious coexistence of religious and secular nationalisms flourish in history of nation states. Religious doctrine and religious conflict can justify the exclusionary nationalism that allows elites to build both powerful states and compliant subjects (Marx, 2003). Religion, oriented around a fiery Protestantism, has been and is central to nationalism and national identity (Grzymala-Busse, 2015; Haselby, 2015; Kurth, 2007; McKenna, 2007; Morone, 2003).

Colley (1992) contends that the central element of nascent British identity was Protestantism and its intolerance of Catholicism as foreign and corrupt. Friedland (2001:129) has also posed that the national identities of Iran, Sri Lanka, India, Pakistan, Saudi Arabia, Israel, and Palestine are all suffused with religious narrative and myth, symbolism and ritual. This implies that the supremacy of religion to national identity remains both striking and robust, even when multiple denominations compete for allegiance. Nationalist projects further borrow religious language and symbols. Religious symbols and rhetoric have been superimposed on the mobilisation of nationalism by political entrepreneurs. Rather, religious beliefs are associated with new ethno-national projects, to which they have brought a feeling of historical continuity with the pre-colonial past. Religious symbols, banners and icons have appeared in mass political rallies, giving legitimacy to pro-independence movements and their leaders (Grzymala-Busse, 2015).

Religiosity defines the nation and nationalism reinforces religiosity, leading to unusually high rates of national identification with a given religion and high rates of religiosity itself. Religious nationalism, thus, enhances religiosity, which then helps to further consolidate the nation and its boundaries. Religion's durability, that is, its resistance to secular onslaught has reproduced a strengthening relationship between religion and nation. In almost every nation of the world, believers are not repressed, and religious organisations are not as easily abolished as trade unions, newspapers, political groups, and student organizations (Sahliyeh, 1990:13). Education and indoctrination within the family and religious community have also played a role in cementing the equation of nation with religion (Grzymala-Busse, 2015). Political entrepreneurs explicitly link religion and nationalism (Hibbard, 2010). Organized state campaigns can foster a godly nationalism, as in Indonesia (Menchik, 2014). Religious nationalism also lends itself to the influence of religious groups on public policy, especially when a specific church or denomination can claim the mantle of a representative of national interest (Grzymala-Busse, 2015,

2016). Religions have been enormously influential in shaping national policy debates and influencing the final outcomes of public policy areas that include education divorce, stem cell research, same-sex marriage and abortion rights. All this shows that Christian or religious nationalism has been at play from time immemorial. Rather, religion is a useful resource to national leaders. Since religion is a powerful source of identity and one that can unify a group and create loyalty to the national movement, national leaders try to draw on religion to create a cohesive public body. So, religious nationalism is the relationship of nationalism to a particular religious' belief, dogma, or affiliation. A shared religion can be seen to contribute to a sense of national unity, a common bond among the citizens of the nation. Another political aspect of religion is the support of a national identity, shared ethnicity, language, or culture. Hence, the influence of religion on politics is more ideological. In this chapter, Christian nationalism simply means the amalgamation of religious and national identities, goals and aims for a common cause.

The end times

The subject of "end times" is quite controversial in both religious studies and theology. The phrase refers to the events that will take place towards the second coming of Jesus Christ. The Bible teaches that before Jesus returns to establish His kingdom on earth, there will be a 7-year period known as the Tribulation or the Day of the Lord. Most Christians across the divide are convinced that we are now in that period of tribulation or end times. The bible has a list of corollary events associated with the signs of the end times or the tribulation period. Earthquakes, famines, and terrifying signs in the heavens are mentioned in Luke 21. Revelation 6:12-14, describes the 6th-seal judgment which will take place in the first half of the seven-year tribulation (violent earthquakes, cosmic signs in the heavens, and the uprooting of mountains and islands). The events of the end times according to Christian teachings would also include plagues and untreatable diseases. The other sign of the end times is the appearance of the man of lawlessness. In 2 Thessalonians 2:3, Paul speaks about the "man of lawlessness implying the coming of a world dictator. The other predictions signalling the end times include the coming of a false messiah who is also called the antichrist (1 John 2:18) and the appearance of the beast from the sea (Rev. 13:1-10). It is believed that Israel will sign a covenant with the future false messiah. Daniel 9:27 indicates that the

end times or the seven-year tribulation will begin when this future false messiah makes a treaty with the leadership of Israel. With the onset of the worldwide pandemic of the coronavirus, many Christian leaders linked COVID-19 pandemic with the Biblical signs of the "End Times." Specifically, some preachers pointed to the mentioning of "pestilence" and "plagues" in the book of Revelation as biblical evidence that the end was fulfilled by the advent of the coronavirus. So, the New Testament speaks of "great tribulation," an unprecedented time of global suffering at the end of the age, that is somehow related to the Second Coming of Christ. It speaks of war and violence, famine and persecution, suffering, tribulation and apostasy.

The Bible teaches that immediately after the tribulation of those days the sun will be darkened, and the moon will not give its light, and the stars will fall from the sky, and the powers of the heavens will be shaken. After all these the signs, the Son of Man will appear in the sky, and then all the tribes of the earth will mourn, and they will see the Son of Man coming on the clouds of the sky with power and great glory. (Matt 24:29-30; Mark 13:24-27). It is vital to note that Biblical interpreters see these passages differently in terms of the timing of these events. Interpreters also differ on whether or not God's people will even be around when this "tribulation" happens. COVID-19 presented Christians with a difficulty in finding spiritual answers and solutions and thus, they labelled it a sign of the end times. This was caused by the conviction that the events and the actual date of the second coming of Christ remain undisclosed to humanity and Jesus himself. Some prophets perceive the coronavirus as a spiritual issue rather than a medical or even scientific phenomenon.

Since the outbreak of the Covid-19 pandemic, several conspiracy theories were peddled on social media on its origin and cause. Two books fuelled the speculations and these are *The Eye of Darkness* (Koontz, 1996) and *End of Days* (Browne and Harrison, 2008). The two books gained instant popularity as the pandemic terrorised the nations. Both books predicted the outbreak of a flu-like pandemic around the year 2020 (Browne and Harrison, 2008). The *End of Days* details a number of calamities that were to plague the world in 2020 and beyond. The assumption was that the coronavirus fits the flu-like virus described in the book and hence, the end of times was imminent. The *Eye of Darkness* describes a Chinese scientist Li Chen who absconded to the United States with a diskette that contained key and perilous Chinese new biological weapon in the decade. The content in the diskette as narrated by the book, is called 'Wuhan 400'.

Interesting to note is the view that as these conspiracy theories continue to gain traction, some Christian leaders developed their own theories which dovetails into these popular but dubious narratives (Ibrahim, 2020). The generality of the perceptions zeroed in to the conclusion that the coronavirus is the mark of the end times.

The Advent of COVID-19 and the Church's perception

The advent of the coronavirus pandemic with its intense impact on the global village seems to have extremely slackened religious activities in the world. COVID-19, which was first discovered in December 2019 in Wuhan city in China, has recently become a global challenge to health, economic, social and religious systems. It has reshaped the Christians' focus and altered the existing status quo in the religious order — showing a new world with the unprecedented macro religious challenges. Given that the COVID-19 pandemic has rapidly encircled the globe and consequently affected almost all nations, it has been regarded as a pandemic which has engendered a shift of focus by the World Health Organisation (World Health Organisation, 2020). According to Gorbalenya et al. (2020), International Committee on Taxonomy of Viruses (ICTV) named it a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The policy measures and interventions adopted by governments as the pandemic surged, resulted in unavoidable religious downturn across the globe. While the measures of lockdown and social distance introduced by countries to curb the spread of the COVID-19 virus seemed to be necessary, the short-run downside effect was inevitable (McKibbin & Fernando, 2020). The COVID-19 virus did not only threaten human existence, but it also affected their spiritual belief. In order to tackle the further ill consequences of the pandemic, governments across the globe imposed travel bans, curfews and movement restrictions. Most countries closed their borders to foreign visitors to control its spread.

As the pandemic continued to heave, everyone in Zimbabwe and the world over was plunged into a period of uncertainties, despair and expectations. During this period, everyday activities such as selling and buying, schooling, religious gathering, footballing, clubbing among others ceased indefinitely. Voluntary and involuntary actions such as sneezing, coughing, loud laughing, talking and shaking of hands became strictly controlled (Forsu-Ankrah and Amoako- Gyampah, 2021). Adding to the list of restrictions was the need to constantly wash hands from every point of

entry or contact. This situation created uneasiness, and anxieties about when such restrictions and the virus would end.

It was during the period of uncertainties that Christians became expectant and remained in a period of waiting in anticipation of directions and solutions to the pandemic. The church and the nations could not find immediate solutions to the pandemic and this gripped people with fear (Fosu-Ankrah, 2020). Gripped with fear, panic and uncertainties, religious leaders started to see the danger in having their followers uninformed, unreached and not attending church services. Resultantly, they started to come up with alternatives, interpretations and ideologies which would safeguard the faith of their followers.

In Zimbabwe, some Pentecostal and white garmented church leaders interpreted COVID-19 as a spiritual blitz or retribution on humanity and thus, had to be addressed spiritually. It is interesting to note that in times of crisis like the COVID-19, religion and faith serves as a source of individual security and community resilience. However, the outbreak of COVID-19 in Zimbabwe created an amplified tension between Christian leaders and science as well as between the christian denominations. Whereas some Christian leaders made conscious efforts to align their church activities with advice by medical experts and governments to help curb the spread of the virus, others invoked religious ideology to confront the virus, assuring followers and devotees that faith offers adequate protection (Lichtenstein et al., 2020). Christian leaders from the Apostolic Church of Johane Masowe Wechishanu (JMC), Apostolic Church of St John (ACJ), African Apostolic church of Paul Mwazha (AAC), Independent African Church (IAC) and the Johane Marange African Apostolic Church (JMAAC) were encouraging their followers to pray for divine protection since we are in the end times. This entails that they considered the advent of the COVID-19 as a mark of the end of the times and that the parousia was indeed at hand.

One informant from the AAC said that *"chiporofita chakange chataura kuti kuguma kwenyika kwaapedyo. Nekudero pakauya korona takabva taudzwa kuti tishinge kunamata nokuti Nyika yaakuguma. munamato pamwe chete nekutsanya ndochete zvataiudzwa kuti zvichatiraramisa munguva yekupedzisira"* (the prophecy had already been proclaimed that the end of times has come. So by the advent of COVID-19, we were encouraged to be strong in prayer since the end of times had come. only prayers and fasting were the only solutions in such end times). The informants from the JMAAC were clear on noting that the end of the times have

come. One church leader said that *"Bhaibheri rakataura pachena wani kuti kana kuguma kwenyika kwosvika kuchava nezvirwere zxvisingarapike. Zvimwe zvacho takatozviona zvakaita seAIDS, asi apa kufa kuri kuita vanhu ndokutoguma kwenyika"* (the Bible has already proclaimed that at the end of times there will be untreatable diseases and some of them we have already witnessed them like AIDS. Now that with the rate people are dying we are in the end of times).

Samuel Mutendi of Zion Christian Church (ZCC) was quoted saying to his followers, "I want to assure you that you are in the secret place of the Highest God and, no virus can come near your dwelling'. For Mutendi, the basic things like washing of hands, keeping the environment clean and adhering to basic hygienic measures have been their day to day routine and them being spelt out now is a bit too late since his church has been doing it, hence were ready for the coming of the pandemic and his followers were accustomed to the measures. In a way, Mutendi was saying that by calling for the measures like washing of hands, sanitisation, social distancing among others, the government was indeed copying his church because that is what they are used to do on a daily basis. For him, each congregant has to be sprinkled with holy water and salt as they enter the church building for services. This implies that for the ZCC, accepting and adhering to COVID-19 protocols was not new, hence there was nothing wrong in following them religiously. He articulated that his church has to follow the dictates of the state since we are in the last days. He called his followers to remain pure, holy and prayerful because they are living in the last days. One of the leaders in the ZCC said that *Bhaibheri rinotaura kuti munhu haangararami nezvekudya chete asi neshoko rinobva kunamwari. Manje Mwari vazozviratidza simba ravo kupfurikidza nekuhunza chigwere chaakutituma kuvhara miromo. Ukavhura muromo nemhino uchida kudya wotofa. Ndokuguma kwenyikazve uku. Vanhu vangararama sei vasingadyi nekuti hapana kwatinosvika takavhara miromo yedu* (the Bible says that man cannot live by bread alone but by the word of God. Now God has showed his power through COVID-19 which is forcing us to mask up. When you unmask for eating you die. This is really the end of times because people cannot live without eating).

The generality of the AICs interpreted the coming of COVID-19 pandemic as the sign of the end of times. They were sure that the world was truly coming to an end. For them, the only option was to offer prayers of supplication for the forgiveness of sins. The AICs believed that the virus was from God and humanity were being punished for their sins. This is

the reason why they were encouraging their followers to pray for the protection of their lives.

Prophet Emmanuel Makandiwa, the founder and leader of the United Faith International Church (UFIC) in a sermon titled, 'Bible Politics, Technology and Plagues II', uploaded on YouTube affirms that COVID-19 emerged from the sea. For him, the disease is a demonic spirit on the rampage, and that nothing can stop it. YouTube video on November 2016 pictures Prophet Makandiwa claiming that:

> 'There is a deadly disease more dangerous than cancer or HIV originating from the sea. Thousands of people, if not millions, will die. There will be no cure. Only prayers will slow it down. It will be very fast and most people will seek God's intervention while some will insult him for the deadly disease. I said, it is a plague and it moves by air. There is a creature that I saw, it's the virus, faster than any disease known to man. It will make the educated people cry. It is a bird of the air because it moves by air. Covering your nose won't help because it can get into your ears, because it is a fowl air. (Christ TV, 2020a).

Makandiwa in his sermons on Covid-19, alluded to what he calls the 'mark of the beast' and cautions his congregation and followers against a 'microchip implant' in the vaccine (Makandiwa, 2020b).

Makandiwa further alleges that the outbreak of the coronavirus will usher in the creation of microchips implant to be implanted into human beings. He quoted Genesis 3 and Revelation 13 as his points of entry to this discussion. For him, the microchip is the handicraft of the beast and it is its final ploy to deceive mankind and to control the entire world. He said that the microchips would be pushed into the market through the activities of women. He added that "with 5G technology, information about individuals would not be hidden and he calls it the highest level of nakedness. He said that nations fight the 5G technology because it uncovers all individual secrets. All this implies that 'Prophet' Makandiwa was teaching that there is a direct link between the outbreak of COVID-19 and 5G technology (Christ TV, 2020b). In the sermon, Makandiwa highlighted the connection between politicians whom he dubbed serpents, pharmaceutical companies, and the technology industry whom he referred to as the agents of the beast in the outbreak of COVID-19. For him, the connection is meant to improvise a grand scheme to control the world through the pandemic.

Makandiwa alleged that 5G technology is championed by a satanic agent who will introduce a COVID-19 vaccine composed of microchip

which would to be implanted in people. Humanity therefore, will no longer have agency, and they would be manipulated into serving Satan instead of God. He further explained that the ban on religious gatherings was orchestrated to disrupt believers from getting together to pray as this would stop the agenda of the new world order. He then directs all believers to pray against the spirit of the new world order and to scatter the agenda of the anti-Christ. For this reason, Makandiwa vowed that he would go against the government when it imposes the vaccination exercise since he regarded it as accepting the mark of the beast (the microchip).

However, the interpretations of the Christian leaders on the COVID-19 changed as the pandemic continued to wage war on human lives. The government of Zimbabwe continued to extend the lockdown measures as it tried to contain the spread of the virus. The move by the government left the Church with limited options for its survival. The subsequent rolling of vaccinations and the pronouncement by the government that only the vaccinated would be allowed to board buses and attend church services made some church leaders to make a u- turn on their earlier ideologies and interpretations about the pandemic. The urge to congregate and the clearer understanding of the virus as more information was coming through discoveries and studies about the pandemic also contributed to the revisiting of some earlier thoughts by Christian leaders.

Christian nationalism on the prevention of COVID-19 in Zimbabwe

The spread of COVID-19 to all nations of the world made World Health Organisation (WHO) to come up with guidelines which all nations were to follow in order to help halt the spread of the disease. The following were the guidelines (WHO, 2020):

- People should avoid contact with anyone, especially if they have cold or flu-like symptoms by practising physical distancing of at least one metre.
- Cover mouth and nose when coughing or sneezing into your elbow or use a tissue and discard it into a bin with lid straight away.
- Avoid touching eyes, nose and mouth.
- Wash hands with water and soap regularly for at least 20 seconds.

Every nation was compelled to follow the guidelines, which were set by WHO. With the COVID-19 pandemic gathering momentum, in Zimbabwe there was need for political leaders to persuade the religious community to play an important role in responding to COVID-19. The government of Zimbabwe called for Days of National Prayers where political leaders conceded space to religious leaders to lead the nation in prayers of supplication and to mobilise their constituencies to respond to the pandemic (Chitando, 2021). Such programmes like national days of prayer helped in crafting a good rapport between Christian leaders and the government. There was a creation of a cordial relationship between the Church and the government. To further cement the cordial relationship with the church leaders, the government of Zimbabwe, gave them prominent positions at the meetings to respond to COVID-19, acknowledged their role in social transformation and sought to make them feel relevant and appreciated.

Equipped with authority from the government Christian leaders particularly from the mainline churches, started to uphold and promote the COVID-19 protocols that were being popularised and enforced by the government. In the connections between government and religious leaders, the zeal to prioritise the good of the Zimbabwean communities became the prime action. Thus, both the politicians and religious leaders became selfless and were keen to promote human security (Tarusarira and Chitando 2020) in the wake of a devastating pandemic. As a way of showing their allegiance to the national and WHO demands church leaders from the Pentecostal and mainline churches in Zimbabwe started to teach their followers to mask up, sanitise, practice social distance among other preventative measures to contain the spread of COVID-19.

To prevent the spread of the pandemic, churches were instructed to avoid gatherings. Church leaders had to embrace this call by the government and this ushered in a new christian nationalistic mentality. Instead of seeing the government as moving against the mandate of the church, the church leaders started to see it as a key player in the church's existence. It seems the church started to realise that the call by the government to observe COVID-19 related protocols made it to de-secularise. It was due to lockdowns, banning of gatherings, call for social and physical distancing that the church started to use the once regarded secular systems to hold their services. The church, thus, started to regard the government as a core- worker rather than an enemy. Christian leaders which include Makandiwa of UFIC, Mutendi of ZCC, David Masuka of Zion Apostolic

Church (ZAC), Jameson Andreas Shoko of Zion Apostolic Faith Mission (ZAFM), Amon Madawo of Apostolic Faith Mission in Zimbabwe (AFM), Cosam Chiyangwa of Apostolic Faith Mission of Zimbabwe (AFMoZ) started to embrace a new perception about the government and thus, they started to work alongside the government to help fight the COVID-19 pandemic. So, as COVID-19 infections continued to rise throughout Zimbabwe, many church leaders started to work in cohorts with political leaders to disseminate information about COVID-19 through various social media platforms. Religious institutions commenced to extremely cogitate the viability of intensifying the use of online preaching, prayers, giving and healing (Asamoah-Gyadu, 2015) in times of COVID-19. This was a rebirth of a new Christian nationalism. In this regard, the church was complementing both the public health and government protocols in COVID-19 infection prevention. Christian leaders complied with the government call to avoid gatherings by even banning their main gatherings like Easter, general conferences and even church services. So, by helping in promoting public health messages to mitigate the impact of COVID-19, religious leaders in Zimbabwe were contributing to the ideology of religion-state partnership which in itself shows Christian nationalism. In the same process, the issue of de-sacralising the relationship between church and state was also coming in.

Church leaders like Samuel Mutendi of ZCC considered the COVID-19 messages of frequent hand washing, sanitising and keeping social distance as God's own strategy of shielding humanity. Such a move was indicating a new wave in the relationship between church and state. Rather, the inherent conflict between religion and science was defused by the strands that were taken by the church. The preaching and dissemination of health related messages by religious leaders made many people to quickly embrace and implement them since it was coming from people they trust. Thus, for example, staying at home and not going to a religious gathering became a sign of obedience to a divine command, and not only accepting public health messages. In keeping with the dynamics of upholding COVID-19 protocols, many religious activities moved online (Chitando, 2021).

Christian Nationalism in the Management of COVID-19 in Zimbabwe

Due to Christian nationalism in the era of COVID-19, religion joined with science as people would "pray and wash" (VOA News 2020). Rather, instead of magnifying the conflict between faith and science, the theory of religion and science as dialogue partners became rampant in the mind of many Christian leaders and their members. Church leaders were also not restricting their followers to use traditional methods of fighting ailments which further show how nationalistic Christians had become in the era of COVID-19. So, instead of solely relying on biomedical strategies to manage COVID-19, attention was also given to the use of traditional medicines and remedies to understand, manage and reduce the impact of the pandemic (Dandara et al. 2020). Church leaders were encouraging their followers to practice isolation when any one has contracted the virus. The use of other remedies which were once taken to be traditional, primitive and devilish was another way Christians were using to manage the virus. All these practices were traditionally forbidden by the church but in the era of COVID-19 their use became accepted by the church.

However, even though some Christian leaders showed nationalism by taking heed to the call by government and were ready to work together the researcher of this paper concede that there were some religious leaders who refused to listen to government calls in the prevention and management of COVID-19. As noted earlier, some "ultra conservatives" within the AICs refused to put on masks, take medicines, quarantine and continued to have their open air meetings in different sections of the country. For instance, the JMAAC in Zimbabwe has been castigated for flouting COVID-19 gathering restrictions by holding their Festival at their national shrine in July 2021 (News Day 2021). The Apostolic Church of St John (ACJ) in Domboshava were reported to have not stopped gatherings in the whole of the national lockdown periods in Zimbabwe. "One of the participants during interviews said that, our leader is a man of faith, we never stopped gathering, neither did we wear face masks during the surge of COVI-19 but none of us got sick". Members from both the African Apostolic church of Paul Mwazha (AAC) and Independent African Church (IAC) clearly said that they never observed any of the COVID-19 protocols. in their own words they said *Isu hatina kana chimwe chatakatevedzera pazvinhu zvose zvatainzi itai kudziviira korona. kutenda kwako ndiko kunoraramisa kwete kufapfeka masiki nekugeza maoko* (We did not observe

any of the protocols that we were asked to observe because what protects one's life is faith).

One the same note members from the Apostolic Church of Johane Masowe Wechishanu (JMC) said *isu taiita zvataudzwa nemweya mutsvene. Muporofita akange audzwa kuti ape vanhu huchi, maremoni pamwe chete nekumwa mvura inopisa kana chirwere chedzihwa chauya kare kare. saka ndizvo zvataiita munguva yose yekorona uye hatina kurega kuenda kuchurch* (We were doing what the holy spirit had informed our prophet well before the coming of COVID-19. The prophet was given instructions to give people honey, lemon, and to let people drink warm water when a flu like pandemic struck the earth. We never stopped to go to church).

The behaviour of these churches was congruent to the underlying AIC ideological perception that biomedical approaches are part of the Western, colonial agenda and are morally wrong. Rather, as noted by Ndlovu-Gatsheni (2020), the resistance to follow WHO COVID-19 protocols and government dictates by some AICs must be located within the discourse of decoloniality. AICs in reality would vociferously oppose the tendency to associate indigenous practices and church gatherings with the spread of pandemics (Jaja et al. 2020). Therefore, as Dein (2021) stated, while many religious leaders, governments and communities were taking pivotal measures guided by public health systems such as halting congregational services and offering private and public spiritual guidance, others, were generating and circulating messianic and apocalyptic messages, which downplayed the value of public health guidance, and offering religious panaceas that were running contrary to good public health practice.

Even though there have been AICs and other church leadership who were not complying with the dictates of the government in trying to combat COVID-19, in a way they were observing WHO measures to mitigate the spread of the pandemic. The only difference was on the methods and mechanisms used. Like what some of the informants were saying, the use of honey, holy water for washing hands, drinking hot water, taking *Zumbani* and offering prayers for protection were indeed African methods of fighting against the spread of COVID-19. This being the case therefore, AICs were indeed observing COVID-19 containment measures from a different angle. In doing this, the AICs were showing nationalism in that they were reserving the lives of their followers.

Diagnosis of COVID-19 and Christian nationalism in Zimbabwe

COVID-19 clinical diagnosis has been mainly based on signs and symptoms evaluation and confirmed by nucleic acid amplification tests (NAAT). The RTPCR (Reverse Transcription Polymerase Chain Reaction) of nasopharyngeal or oropharyngeal swabs were basically used. PCR-based methods are simple, highly sensitive, and highly specific and, therefore, they are routinely and reliably capable of detecting coronavirus infection in patients. RT-PCR which is a gold-standard method to detect most coronaviruses, including SARS-CoV-2 was also used. Particularly, COVID-19 early infections' most common symptoms are fever, cough, and other respiratory issues. While these were basic diagnosis methods that were used from the onset of the pandemic, the church was not against it. The church leaders were encouraging their members with any symptoms of flu to go and get tested. Some of the church leaders like Amon Madawo of AFM had to make it compulsory for every pastor and their wives to be tested of COVID-19 fort nightly to safeguard the health of their congregants. One of the church members from the ZAOGA said that there is nothing wrong in being tested for COVID-19. He said "as leaders we need to make sure that we encourage our members to be diagnised of the virus so that we do not put our flocks at risk." A member of the AFM said that "as a pastor having routine diagnosis of the virus helps the church and my family because I visit many followers at their homes and I interact with a lot of people hence, the need to be tested regularly." However, while church leaders from Mainline churches and Pentecostal movements were encouraging their followers to be diagnosed of COVID-19, the AICS perceived it as accepting the worldly help.

Conclusion

This chapter has managed to argue that the advent of COVID-19 rejuvenated the relationship between religion and state hence, Christian nationalism. The church acted as the mouth piece of the government during the era of the COVID-19 in Zimbabwe. In a situation where there was seeming to be a conflict of interest between the church and the nation state, the church obeyed the dictates of the government and started to have churches without walls, virtual worship, online giving and spiritual prophetic healing declarations. The research argued that despite the various

forms of secularisation, religion remains a constitutive basis of national identity and nationalism. This chapter has argued that in Zimbabwe, COVID-19 has made it plainly conceivable to re-think Christian nationalism. The church had its own interpretations on the coming of the pandemic and they had to inform their adherents on the course of action. Some Christian traditions regarded the coming of COVID-19 as the sign of the end of times and hence, supplication prayers were viewed as the only solution. The chapter argued that religion and nationalism will continue to interface no matter the situation and that religion will never die a natural death even in the face of science and modernity since religion utilises science for its nationalistic benefits. The once perceived as secular has been de-secularised at the advent of COVID-19 and hence, religion still has life in the modern scientific society in Zimbabwe. The chapter argued that basic Christian nationalism in Zimbabwe was seen through how the church embraced the prevention, management and diagnosis methods in the mitigation of the spread of the pandemic.

References

Berger, P. L. 1990. *The Sacred Canopy: Elements of a Sociological Theory of Religion*. New York: Anchor Books.

Breen, K. and O'Neill, S. (eds.). 2010, *After the Nation? Critical Reflections on Nationalism and Postnationalism*, London: Palgrave Macmillan.

Brubaker, R. 2011. Religion and nationalism: Four approaches. *Nations and Nationalism*, 18(1):2-20.

Dandara, C., Dzobo, K. & Chirikure, S. (2020). COVID-19 Pandemic and Africa: From the situation in Zimbabwe to a case for precision herbal medicine. *OMICS A Journal of Integrative Biology*, 24:1-4.

Dieckoff, A. (ed.). 2004. *The Politics of Belonging: Nationalism, Liberalism, and Pluralism*, Lanham: Lexington.

Friedland, R. 2001. Religious nationalism and the problem of collective representation. *Annual Review of Sociology*, 27(1):125-152.

Gellner, E. 1983. *Nations and nationalism*. Ithaca/NY: Cornell University Press.

Gorski, P.S. 2003. *The disciplinary revolution: Calvinism and the rise of the state in early modern Europe*. Chicago/IL: University of Chicago Press.

Gorski, P. & Türkmen-Dervişoğlu, G. 2013. Religion, nationalism, and violence: An integrated approach. *Annual Review of Sociology*, 39:193-210.

Gorski, Philip N. 2017. "Why Evangelicals Voted for Trump: A Critical Cultural Sociology." *American Journal of Cultural Sociology*, 5(3):338-354.

Greenfeld, L. 1996. The modern religion? *Critical Review*, 10(2):169-191.

Grosby, S. 2005, *Nationalism: A Very Short Introduction*, Oxford: Oxford University Press.

Grzymala-Busse, A. 2016. The difficulty with doctrine: How religion can influence politics. *Government and Opposition*, 51(2):327-350.

Grzymala-Busse, A. 2012. Why comparative politics should take religion (more) seriously. *Annual Review of Political Science*, 15:421-442.

Grzymala-Busse, A. 2015. *Nations under God*. Princeton/NJ: Princeton University Press.

Haselby, S. 2015. *The origins of American religious nationalism*. Oxford/UK: Oxford University Press.

Karpov, V. 2010. De-secularization: A Conceptual Framework, in *Journal of Church and State*, 52(1):232-270.

Kelly, P. 2015. "Liberalism and Nationalism", in Wall, S. (ed). *The Cambridge Companion to Liberalism*, 329-352. Cambridge: Cambridge University Press.

Kurth, J. 2007. Religion and national identity in America and Europe. *Society*, 44(6):120-125.

Kuznicki, J. 2008. "Nationalism", in Hamowy, Ronald (ed.). *The Encyclopedia of Libertarianism*, 347-349. Thousand Oaks/CA: Sage, Cato Institute.

Lee, M.L.H., Xavier, M.S. & Lee, E.Y. 2021. 'A divine infection': A systematic review on the roles of religious communities during the early stage of COVID-19. *Journal of Religion and Health*, 866-919. https://doi.org/10.1007/s10943-021-01364-w.

Luhmann, N. 1977. *Funktion der Religion*, Frankfurt a.M.: Suhrkamp.

Lumbreras, S. & Oviedo, L. 2020. The pandemic and its influence on the relationship between science, religion and theology. *ESSAT News & Reviews*.

Malesevic, S. 2006. *Identity as Ideology: Understanding Ethnicity and Nationalism*. Cham: Palgrave Macmillan.

Malesevic, S. 2013. *Nation-States and Nationalisms: Organization, Ideology and Solidarity*. Cambridge: Polity Press.

Marx, A. 2003. *Faith in nation*. New York/NY: Oxford University Press.

McKenna, G. 2007. *The Puritan origins of American patriotism*. New Haven/CT: Yale University Press.

Muyambo, T., Sande, N. & Tendere, J. 2022. 'Wash and Pray': The nexus between African Christianity and Science in the context of COVID-19 in Zimbabwe. *Journal of Religion in Africa*, 52(3-4):348-373.

Smith, A. 2008. *The cultural foundations of nations: Hierarchy, covenant and republic*. Malden/MA: Blackwell.

Smith, Anthony D. 2010 [2001]. *Nationalism: Theory, Ideology, History* (2. ed.). Cambridge: Polity Press.

Smith, A.D. (2013). *The Nation Made Real: Art and National Identity in Western Europe, 1600-1850*. Oxford: Oxford University Press.

Spencer, P & Wollman, H. 2002. *Nationalism, A Critical Introduction*, London: Sage.

Spohn, W. 2003. Mulitple modernity, nationalism, and religion: A global perspective. *Current Sociology*, 51(3-4):265-286.

Yael, T. 2019. *Why Nationalism*, Princeton: Princeton University Press.

Wald, K., & Wilcox, C. 2006. Getting religion: Has political science rediscovered the faith factor? *American Political Science Review*, 100(4):523-529.

Yack, Bernard, 2012, *Nationalism and the Moral Psychology of Community*, Chicago: University of Chicago Press.

Zubrzycki, G. 2006. *The Crosses of Auschwitz*. Chicago/IL: University of Chicago Press.

Clemence Makamure

4 Prayers for Protection? A Critique of African Initiated Churches' Response to COVID-19 Vaccination in Zimbabwe

Abstract

The advent of COVID-19 and the subsequent array of fast-tracked vaccination against the disease gripped many people with fear and relief and the same time. Various perceptions emerged as people were in a dilemma as to how they should manage and put under control the pandemic. As the vaccinations were rolled out to people, different viewpoints erupted. The church also expressed its perceptions on the vaccines. The church had a myriad of reactions in so far as the rolling out of vaccinations was concerned. The mainline churches saw no problem in following the view and plan of the government. Some Pentecostal churches were treating it as accepting the mark of the beast. Other church denominations used quiet diplomacy on the issue of vaccination. Some African Initiated Churches opted for prayer rather than vaccines on the issue of COVID-19. It is light of this that this chapter intends to give a critique of the responses of African Initiated Churches to COVID-19 vaccination in Zimbabwe. The chapter uses the qualitative approach to glean the efficacy and non- efficacy of prayers for protection against the pandemic. Focus group discussions, personal observations, interviews and document analysis were used to glean data. The chapter focuses on how African Initiated Churches were placing importance on prayers for protection against the pandemic instead of embracing the COVID-19 vaccines that the nation was rolling out.

Keywords: African Initiated Churches, Church, COVID-19, Prayers, Protection, vaccination, Zimbabwe

Introduction

COVID-19 has left the global community devastated as it takes its toll on the population, leaving hundreds of thousands dead across the globe. The advent of COVID-19 was a nightmare to Zimbabweans in all circles of life. People were gripped with fear and pandemonium was the order of the day as the pandemic was spreading like veld fire to all corners of the nation.

The pandemic made people to seek all possible help and potential solutions from various facets of a rich repository of indigenous knowledge systems that have been handed over from generation to generation, since time immemorial. Rather, the crisis made communities to resort to all possible remedies to bail themselves out of the situation. The remedies that most people opted for are a product of a constellation of indigenous beliefs, which the medical practices and some religious traditions have not accorded any recognition within the global medical epistemologies. However, the advent of the novel COVID-19 has witnessed a high level of utilisation of indigenous traditional remedies as people grope and stumble in the dusk of dwindling medical systems. As the pandemic continued to surge, people from various walks of life started to keenly involve themselves in finding possible remedies to opiate the harshness of the disease. As a contribution to the fight against the COVID-19 pandemic, the Western communities came up with different COVID-19 vaccines which they recommended for use by every nation. It is this gloomy reality that propels this study on the responses of AICs to COVID-19 vaccination in Zimbabwe. The chapter attempts to nudge for the interrogation of the efficacy of prayer for protection in the face of COVID-19 that is threatening people's lives in Zimbabwe. The chapter, therefore, seeks to investigate the reliance on prayer by the AICs community in fighting against the pandemic in Zimbabwe.

Methodology

The study adopted the qualitative research design which is quite suitable in investigating complex socio- cultural behaviours and factors contributing to vaccination acceptance and hesitancy in the AICs in Zimbabwe. The qualitative research paradigm helped to capture and understand differences in perspectives among the different groups of AICs and provides in-depth knowledge of the various meaningful factors that underlie the importance given to prayers for protection. It also helped in understanding the context of the attitudes of AICs towards COVID-19 vaccination. The use of key informants including health-care workers and religious leaders and their followers allowed the researcher to capture important information from first hand sources. As a way to hide the real names of the informants, each participant was given a code from A to L. The phenomenological method was used as a dominant model in data collection and analysis. The method is occasionally known as the comparative

method to the study of religion (Chimininge & Makamure, 2021). According to Cox (1996), the phenomenological method requires the researcher to suspend or bracket previous ideas, thoughts, opinions, and beliefs of a community one is studying. This enables the researcher to observe the phenomena as they appear rather than as they are understood through opinions formed prior to observation. Academic theories about the nature, function, purpose or meaning of the phenomena under study must also be suspended or bracketed (Cox, 1996:26 cited in Chimininge & Makamure, 2021). This study applied *epoche*, empathy, describing and naming the phenomena in the collection, presentation and analyses of data on African Initiated Churches' response to COVID-19 vaccination in Zimbabwe. The phenomenological method is pensive with bringing to the fore differences and similarities between two or more entities, be it historical epochs, personalities, events or components (Chimininge & Makamure, 2021:156). Since the term AICs involves a large spectrum of churches, for the purposes of this study, focus is on garmented churches which are commonly referred to as Apostolic churches. These include the Apostolic Church of Johane Masowe Wechishanu (JMC), Apostolic Church of St John (ACJ), African Apostolic church of Paul Mwazha (AAC), Independent African Church (IAC) and the Johane Marange African Apostolic Church (JMAAC). The churches are scattered all over Zimbabwe but the study focuses on Harare urban and Domboshava peri-urban areas.

Defining African Initiated Churches

The meaning of the term African Initiated Churches (AICs) has been grappled with by many scholars of theology and religious studies. AICs have been accredited for being profoundly engrained in culture and socio-economic lives of Africans. Their perception of salvation is holistic as they conceive human growth and socio-economic attainment as part of God's salvation plan for humanity. The acronym AICs has attracted many different meanings, depending on the scholars' interests and opinions. A diversity of coinciding terms such as African Independent churches (Turner, 1979:92), African Indigenous churches, African Initiated churches, African International churches (Ter Haar, 1998) and more recently, African Instituted churches (Chitando, 2004), have been used by scholars. This implies that the 'I' in the acronym has been accorded different meanings. However, no matter what the 'I' stands for, the meaning

and subject matter remains the same (Mapuranga, 2013). In essence, the term African Initiated Churches refer to churches founded in Africa by Africans for them to worship in African ways (Mapuranga, 2013). Turner (1979:92) defined AICs as churches primarily founded in Africa by Africans for Africans. Mapuranga (2013), further articulates that AICs are bodies that have originated in Africa and have not depended on any religious group outside Africa for funding, leadership or control. Appia-Kubi cited by Olowola (2014) defines African Independent Churches as churches by Africans for Africans in [their] special African situations. They have all African membership as well as all African leadership. In this chapter the term AICs refers to Christian movements in Africa that have sought to make Christianity more relevant to the African context. They are churches in which the African worldviews, culture and spirituality found fulfilment in a Christian way. The term refers to all Christian churches, which were founded and are led by Africans in an African style of leadership and worship systems.

Sundkler (1948) made an attempt to typologically divide AICs into two distinct groups which are Ethiopian and Zionist Churches. In his typological understanding, Sundkler (1948) postulated that the Ethiopian Churches are those which retained the structures and practices of mission-derived churches while the Zionist Churches emphasised the role of the Holy Spirit and had a completely different outlook from the missionary oriented churches. Mapuranga (2013) categorised the AICs into three groups which are Ethiopian churches, Zionist churches and Apostolic churches. For her, the Ethiopian churches are those which have no claim to manifestations of the Holy Spirit. They reject European leadership and their belief is anchored on Psalms 68:31b, which says: "Let Ethiopia hasten to stretch her hands to God." Examples of such churches include the African Congregational Church by Rev Sengwayo, First Ethiopian churches *(Topia)* by Bishop Gavure and the African Reformed Church by Rev Sibambo (Mapuranga, 2013).

The Zionist type of AICs have their root in the Zionist movement in South Africa and Zion City, Illinois, in the United States of America (Anderson, 2001:16). They emphasise the activity of the Holy Spirit, healing, prophecy and abstention from various dietary obligations as stipulated in the book of Leviticus. In Zimbabwe, typical Zionist churches include the Zion Christian Church of Bishop Samuel Mutendi, the Zion Apostolic Church of Bishop David Masuka and the Zion Apostolic Faith Mission by Bishop Andreas Shoko.

The Apostolic churches emphasise the phenomenon of speaking in tongues, basing on the Acts account of Pentecost (Acts 2:1-13). This grouping can be further divided into white garment apostolic churches and Pentecostal churches. Typical examples of white garment churches include the Johane Marange African Apostolic Church (JMAAC), Johane Masowe WeChishanu (JMC), African Apostolic Church (AAC), Independent African Church (IAC) (Chimininge and Makamure, 2021:155). The white garment churches are also referred to as *Mapostori* or *Masowe* in the local language in Zimbabwe. The Pentecostal churches have their roots in the spiritual stimulus at the Azusa Street Revival in the United States of America (Onyinah, 2007:307). Typical examples of Pentecostal churches in Zimbabwe include Zimbabwe Assemblies of God Church (ZAOGA), Apostolic Faith Mission (AFM), Family of God (FOG), and the United Family International Church (UFIC) among others.

Spirituality, Faith healing and Modern Medicines in AICs

Africans of all divides have a deep spirituality in faith healing if they have converted to a particular religious' tradition. Kim and Moon (2021) defined spirituality as the relationship between a transcendent being and an individual or group that is seeking to find transcendental meaning. Spirituality is expressed through various methods, including nature, music, and artistic activities, but mostly it is expressed through religious activities. Meador and Koenig (2000) and Lucchetti et al. (2012) posit that spirituality is emerging as a tangible concept that directly interacts with human health. Kim (2013) opines that the World Health Organisation (WHO) includes spiritual well-being under the definition of human well-being. Recently, even in various academic fields such as medicine and psychology, research is recognising the importance of spirituality in the treatment of patients (Kang et al., 2021; Yoon et al., 2021; Yong et al., 2011). According to Koenig (2009), more than 90% of the world's population is involved in various forms of religious or spiritual practices which confirms that spirituality is an inseparable, major factor in human life. All this culminates to the view that spirituality is part and parcel of human life. Human activities, behaviour and perceptions are shaped in one way or the other by spirituality. Masuku (2021) states that the whole of African life is infiltrated by spirituality, which is based on African religiosity.

Bourdillon (1993) rightly articulates that Africans have an unbreakable spirituality in so far as they have beliefs in witchcraft (*kuroiwa*), demons (*madhimoni*), ghosts (*magoritoto*), alien spirits (*mashavi*), diseases or ancestral curses in form of misfortunes (*minyama* or *mamhepo*) such as poverty, unemployment and barrenness. When Africans feel threatened by any of the above at any given time, they seek spiritual intervention. This makes spirituality in faith healing to be a key expression in African Christianity. AICs believe in faith healing through prayers whenever they are sick or faced with problems which they believe to be caused by evil spirits. Anderson (2004) avers that faith healing and protection from evil are prominent practices in African Independent Churches. Anderson (2003) further points out that garmented churches practice gifts of the Spirit like healing, prophecy, and speaking in tongues. Kahl (2007) reiterated that faith healing involves prayers for the restoration of health for the sick, and includes anointing with oil. For Kahl (2007) deliverance denotes the exorcism aspects of the process of healing where evil spirits are perceived to be involved in crises. (Biri, 2012) argue that in African Christianity, when healing and deliverance take place, prosperity, in terms of abundant life in Christ and success in the material world follows the believer. Manyawu (2008) points out that AICs have more emphasis on faith healing through the laying of hands on the head of the sick. In the same vein, leaders in AICs are very much convinced that God has actually endowed them to foster physical healing to their followers as a proof of the validity of their preaching (Manyawu, 2008). This clearly indicates that AICs are strongly tied to the notion of healing, and for them there is no disease that is incurable.

Anderson (2003) clearly indicated that African Initiated Churches emphasise the active and manifest presence of the Spirit in the church. Through the use of faith healing, AICs have gone a long way towards meeting the physical, emotional, and spiritual needs of their followers. Prayers in AICs offer a solution to all of life's problems and prayers pave a way for people to cope with challenges that the world face. For AICs, the God who saves the soul also heals the body and provides answers to the fears and insecurities inherent in the African worldview (Anderson, 2003). God for AICs, forgives sin and is concerned about poverty, oppression, and liberation of humanity from any form afflictions and aliments. It is such kind of beliefs in AICs which make them give religious teachings to their adherents that emphasise prayers over the use of medicine. It is imperative to mention that for AICS especially of the white garment type,

the use of modern medicines is dangerous to human life because it can lead to death or diseases. They have more confidence in the use of the holy water and prayers to treat diseases. The belief was exacerbated by the racial discrimination during the colonial rule in Zimbabwe. During this time, the indigenous Africans had limited access to hospitals and modern health care. The traditional belief of consulting the divine healers when one is sick also cushioned the white garment churches' belief in prayers for protection and healing.

Gregson et al. (1999) note that most garmented churches regard themselves as a spirit type churches. This entails that the holy spirit is at the helm of their religious beliefs and practices. Mbiti (1973) posits that in AICs the belief in the Holy Spirit is a key in the sense that it works to nurture and restore good health and quality of life. For Mbiti, the Holy Spirit in AICs is regarded as the source of spiritual revelation, prophecy, healing and protection and that without it, there is no future for human life. The Holy Spirit aids as the divine potency that directs the church, and equips prophets and some church members with special healing powers. Mbiti (1973) further reiterates that the Holy Spirit works to ensure strict adherence to religious teachings and practices, and compliance with all normative values of the group. Imposition of penalties on those who violate church regulations and the belief system is a common practice in AICs. The beliefs, teachings and practices in AICs also incline to buttress belief in faith healing and strict adherence to the church's doctrines. The belief in the importance of the Holy Spirit and the power of prayers for protection makes the garmented churches to discourage their adherents from seeking help and medication from secular biomedical health services. It is against the garmented churches' dogma to seek medical help from modern medical services and practitioners. The belief on the 'non-efficacy' of modern medicines as compared to prayer when it comes to protection is derived from the belief that illness and diseases have spiritual and religious undertones, and that these are the primary cause(s) of illness and sickness (Musevenzi, 2017). Chakawa et al. (2010) indicate that garmented churches believe that their spiritual interventions have a spiritual competitive edge over secular, modern healthcare services. It is because of such beliefs that they strongly warn their adherents to religiously observe these beliefs, teachings and doctrine on matters pertaining to health. In the view of the garmented churches, the susceptibility to, and the severity of diseases, are subject to the Holy Spirit and one's faith. For them, death from sickness is the will of God. In some cases, they do not

accept that a person has died until they have tried to resuscitate the person using prayers and holy water (Musevenzi, 2017).

Due to the beliefs and practices of the garmented churches, modern medical services are regarded as 'heathen' and of the devil, and are also reckoned as practices which exalt human beings at the expense of God (Musevenzi, 2017). Garmented churches believe that sin leads to sickness and is caused by demonic or spiritual forces. Some garmented churches forbid the use of antiretroviral, contraceptives, family control pills and the use of condoms. This being the case therefore, the role of modern medical services is downplayed since for them, spiritually-related illness requires spiritual attention and treatment, that is, cleansing by the Holy Spirit, holy water or healing rituals which call for prayers for protection.

Museveni (2017) clearly pointed out that the spiritualisation of illness and disease is the main cause for members of the garmented churches to object the use of modern health facilities. Consulting them or using modern medicines is perceived to be in conflict with the things of the spirit. Rather as Museveni (2017) puts it, when a member of the garmented churches accesses modern medical treatment, it is a sign of insufficient faith or trust in God's healing power and intervention. Scholars like Chitando (2007) perceived the philosophy of faith healing as having disastrous consequences for women and children needing medical assistance. For Chitando, due to the churches' teachings and beliefs, members have had sad stories about preventable child deaths and deaths of pregnant mothers due to lack of knowledge of child diseases, mostly those that could have been easily prevented by vaccines. Those who get ill and are members of the garmented churches are quarantined and treated with special concoctions together with prayer. As a way to make the prayers more powerful, if the sick person is a child, the parents are forbidden to indulge in sex as it is believed that the child might die if they have sex. The whole system here is to ensure that both the parents and the person who would be praying for the sick should have more time to dedicate themselves to God in prayer for the healing. So, the avoidance of pleasure during that time implies sacrifice to expedite healing. Phiri (2008) rightfully notes that the anti-modern health teachings are prevalent in garmented churches and prayers are the most preferred mode of healing and protection against diseases and misfortunes. Ngoya (2021) proffered that African Initiated churches are well known for in healing diseases spiritually. For Noya (2021), controlling diseases and faith healing are important

aspects of change in AICs and various healing methods and prayer rituals are used to effectively administer healing.

From the discussion on spirituality, faith healing and modern medicines in AICs, it can be noted that AICs have a deep belief in faith healing. Even those which are Pentecostal in nature, call their followers for healing sessions at the end of every church service. Even though some would allow members to seek medical attention, their first port of call would be to pray for their members' healing and protection. Pentecostals would even continue to pour out prayers for the healing of their fellow sick member for the whole period that person would be ill. They even pay visits to the hospitals which in most cases would end with prayers for healing of the sick person.

The advent of COVID-19 and the reactions of AICs to vaccination

The advent of COVID-19 and the subsequent array of fast-tracked vaccination against the disease gripped many people with fear and relief at the same time. Various perceptions emerged as people were in a dilemma as to how they should manage and put the pandemic under control. Rather, COVID-19 left the global community stranded as it took its toll on the population, leaving hundreds of thousands dead across the globe. It has left the whole world devastated. For Africans, COVID-19 was a nightmare considering that there are other life-threatening ailments that they still have to battle with, which apparently are not heavily affecting other continents. More so, the lack of economic resources and technological advancement worsened the dilemma in African countries as the pandemic threatened their lives. Zimbabwe, like all other countries on the globe, has been hard-hit by the COVID-19 pandemic. In response to the crisis, communities resorted to all possible remedies to bail themselves out of the situation. The COVID-19 pandemic has forced its foot-prints on the health, economy and social well-being of people, globally. As nations try to combat the pandemic, national lockdowns were imposed and were successively reviewed, and periodically extended, with accompanying relaxed or tightened measures depending on the situation as infections were also worsening. Other mechanisms which governments imposed to ease the spread and venom of the COVID-19 pandemic included closure of borders, mandatory wearing of face masks, observance of social distance, compulsory hand sanitization, banning of all sorts of gatherings including

churches and funerals. As WHO (2020) reported, by the 11th of March 2020, the pandemic had cruised across the globe. The most hard hit countries include Italy, USA, Brazil and the UK (WHO, 2020). As the pandemic popped its nose onto the African soil, affecting Zimbabwe in the process, the nation like other countries, closed its schools on the 24th of March 2020, and by the 30th of March 2020, the country was under lockdown (Mangiza & Chakawa, 2021). The move by the government created a tense atmosphere and families were gripped with fear of the unknown. As the pandemic intensified, developed countries took advantage of their technological advancement to manufacture some personal protective equipment, and to fully equip their hospitals for their citizens (Zibengwa et al., 2021). At the same time, developing countries including Zimbabwe were thrown at crossroads as a result of weak economies and collapsed health delivery systems. The only option for Zimbabwe was to rely on developed countries' initiatives and look back into its tradition to look for possible flu related remedies like the use *Zumbani*, gum tree leaves, guava tree leaves, *kunatira* (steaming), drinking water with salt and many others. For this reason, the nation started to acquire vaccines and they made the vaccination mandatory.

As the vaccinations were rolled out to people, different viewpoints erupted as people were surprised by the nation's move. The church had also its own share of perception to the vaccination like any other human groupings in the country. The church had a myriad of reactions in so far as the rolling out of vaccinations was concerned. Some Pentecostal churches like Apostolic Faith Mission, United Family International and Zimbabwe Assemblies of God Africa were treating it as accepting the mark of the beast. Other church denominations used a quiet diplomacy on the issue of vaccination. The African Initiated Churches opted for prayer other than vaccines on the issue of COVID-19. Rather, the use of vaccines had no permanent solutions and the AICs remain skeptical about taking the jabs, and the COVID-19 virus continues to mutate into different variants. The augment of the government was that as no cure has been found for COVID-19, vaccines would curtail its spread. Various controversies, and conspiracy theories erupted as people thought that the vaccines will further spread the disease as a deliberate way of decimating humanity. As such, many people in general and the AICs in particular were logically hesitant to take the vaccines. Instead of taking the vaccines, some people turned to indigenous remedies based on Indigenous Knowledge Systems (IKS) in a bid to boost their immune systems, as well as to curb

the effects brought by the COVID-19 pandemic. The AICs had their own way of administering their prayers to equitably suit the move to curtail the spread of the pandemic.

As the pandemic continued to affect nations, leaving trails of death in most households, the AICs like Apostolic Church of St John in Domboshava used holy water to help stop the spread of the disease to its members. According to the interviews conducted with the members of the church, they did not even stop their church gatherings because they had strong belief in the prayers offered by their Bishop. According to one church member who chose not to be mentioned by name, the bishop would take water and pray for it and then let his followers drink it in their households. As they were gathering, they were not observing physical distancing, they were not using any sanitizer but most of them never felt sick. However, he admitted that they had an incident where the wife to the bishop had problems with breathing and within few days she passed away. Even though the church did not believe that she died of COVID-19, it seems the wife of the bishop exhibited COVID-19 symptoms as shown from the information gathered during the interviews. From the medical point of view, the move by the St John Apostolic church had detrimental effects to the followers. The fact that the wife of the Bishop passed away due to failure to breathe implied that she had contracted COVID-19. However, the church's belief in the non-efficacy of vaccinations in particular and modern medicines in general caused the members not to get tested and, hence, they were more vulnerable to the pandemic. It seems many people died due to the pandemic but since they were not tested, the deaths were considered to be natural. Furthermore, due to the secretive nature of this church, most of the deaths cannot be revealed even today because they fear criticism. There is need to further engage the church leaders and make awareness campaigns to educate the church members on the efficacy of modern medicines and also to mix faith healing and modern medicines in their belief system.

For the members of the Johane Masowe WeChishanu, prayers together with other locally made concoctions were used to help the members as the pandemic was continuously claiming many souls in Zimbabwe. According to informant A, the bishop with the help of prophets would take pure honey, mix it with lemon juice and cooking oil and give the mixture to the followers after saying out prayers. Interesting to note is the view that while the remedy is now used in the church set up, it has been used in the traditional circles to treat flu related ailments. This

means that AICs are roping in some of the traditional healing methods into their churches and it shows the Africanness of AICs. This remedy according to informant A was very helpful to the members of the church. The church did not observe any lockdown regulations and they claim that their bishop's prayers and the concoction helped them to survive the pandemic when it was striking the nation at most. For the members, only God can heal and their faith in him makes it possible. Informant C said in an interview that "we were not even wearing masks during our services because such a move shows lack of faith in the power of prayer and the healing ability of God. The Holy spirit is our guide through the prophets."

According to Informant B, the coming of COVID-19 was not a surprise to them. He said that just before the onset of COVID-19 in Zimbabwe in January 2020, congregants had been warned of this deadly epidemic which was going to befall the world and they were prayed for as well as given holy water and *nhombo* (*miteuro*) to protect congregants from this deadly pandemic. So, we had been forewarned and had been prayed for and got protected against the deadly epidemic. In his own words, he said that "*Mweya wakange watotaura chirwere chisati chaapo. saka takagara tanamatirwa*" (The Holy spirit had already told us well before the pandemic came and we were prayed for). This further shows how the Apostolic Church of Johane Masowe put emphasis on prayers for protection more than anything else. The prophets play a vital role in giving advice to the people on what shall befall them in the future and the possible remedy to the foreseen problem.

From a critical perspective, the members of the Johanne Masowe WeChishanu were more exposed to COVID-19 since the members were defying both governmental and WHO guidelines and protocols against the spread of COVID-19. Such moves had greater effects on the health and lives of the church members. Unexpected deaths and sickness could have befallen on innocent souls who were blindly following the church doctrine of rejecting vaccinations. Moreover, the use of locally made concoctions which are not scientifically approved is a threat to the lives and health of the followers. Education on health care delivery is essential to this church so as to incorporate the members into approved health care systems rather than exposing themselves to death due to religious beliefs.

The interviews conducted with the members of the African Apostolic Church of Johanne Marange (JMAAC) indicated that in their history, the church officially refuses medical treatment of any kind even in the most severe cases of injury or illness. For Informant H, the faithful shall live by

faith and faith would set them free from any kind of disease. The Johanne Marange Apostolic church compels its adherents to seek healing and protection from prayers and faith. They completely reject modern medicines at all odds. During the focus group discussion with the members of this church, Informant E said that every Christian should have faith in God and that faith will protect oneself from any kind of illness or misfortune (Field interview, 15 July 2022). It is their belief in the power of prayers which makes them to shun COVID-19 vaccines in favour of prayers. Informant D said that, "I have my own vaccine which is the holy prayer." The other one said that, "I was already vaccinated by the holy spirit through prayers from my bishop" (Field interview, 15 July 2022). Informant F stated that "there is nothing for me to fear even in the severest moments of COVID-19 because our God is able." The other respondent, Informant G argued that the vaccines are contaminated with the virus and they are meant to distort people's blood. "God created us perfect and as Christians we should have faith in him and remain perfect" she declared (Field interview, 15 July 2022). When asked if there were no people who died due to COVID-19 complications, Informant J vehemently said that flu is not a killer disease and no disease has power over those who pray seasonally (Field interview, 15 July 2022).

In the AAJCM faith-healing is the major teaching that new converts are taught. The church regard sickness itself and use of medical services (traditional or modern) as signs of weakness of faith (Gregson et al., 1999:188). *Mweya Mutsvene* (Holy Spirit) serves as the deific potency that guides the church, and equips prophets and some church members with special prophetic and healing powers. The importance that is highly placed on the power of prayers makes the church's position on non-use of modern medicines or seeking health services during the COVID-19 pandemic. Rather, vaccination was a 'no to them'. Gregson et al. (1999) postulated that religious teaching, practices, and church regulations profoundly shape health-seeking behavior in AICs. On the same note, Addai (1999) reiterated that religion influences attitudes and a wide range of behaviours such as reproductive behaviour, HIV preventive behaviour, and use of health services in the case of pandemics. For the members of the JMAAC, diseases and sicknesses have spiritual and religious undertones and thus call for the non-use of modern medical services or getting vaccinated (Gyimah et al., 2006:29-33). Gregson et al. (1999:187) further state that the Shona people in general, believe that spirits have both positive and negative influences on the health of the living and, hence, such does

not require modern medicines but the intervention of the Holy Spirit. It is vital to note that such kind of spiritualisation of sickness and diseases which is premised on religious beliefs, tends to influence the seeking of prayers for protection at the expense of vaccinations against COVID-19 in AICs. Rather, modern health facilities are perceived to be of no benefit to the things of the spirit in AICs. It is, therefore, not surprising that AICs religious beliefs, teaching, philosophical ideals, and church regulations have largely shaped their members' health-related behaviour, decisions to seek prayers for protection and choices about where to seek first consultation when ill (Gyimah et al., 2006). So, in AICs, health beliefs, perceived susceptibility, perceived threats, and the decision not to accepts vaccines in addressing COVID-19 related health challenges are largely determined by religious beliefs, teachings, philosophy, church regulations (formal or informal), and belief in faith-healing and the Holy Spirit (Gregson et al., 1999).

A critical analysis of JMAAC philosophy on faith-healing reveals that its unquestionable acceptance and submission to the power of prayers for protection may have disastrous consequences for its members. The tragic and unnecessary deaths of people due to religious beliefs and parental behaviour that are anti-modern medical services cannot be ignored. We cannot ignore the unfortunate, pervasive anecdotes and sad stories of preventable deaths in communities, and the lack of knowledge of pandemics that could be easily prevented by vaccines as well as risks to non-medicine treatment of people. Prayers have to be administered together with vaccines in the case of COVID 19 since no cure has been found. Moreso, dodging vaccination is a threat to others who are not even part or members of the church.

The "artificial" contradiction between belief in faith-healing at the expense of using modern medical health care requires reappraisal. Engagement is required between the AICs and medical practitioners so as to create a common ground that nurtures and educate the faith communities on the importance and efficacy of vaccination on the verge of pandemics. Rather, there is need to increase AICs' capacity to solve health challenges and reduce rates of morbidity and mortality through adaptive theology, doctrinal arguments, and social teachings (UNICEF, 2011). This can be achieved through "engaged theology" and constructive platforms that enable AICs to learn and change as well as foster ties with formal health providers (Blanchard et al., 2008; Chitando, 2007). The reformation process has to be elicited by active AICs involvement and development of social stimulus patterns that focus on cultivating progressive thinking and

change among the members and instilling new values on religion and health. It is important, therefore, to build network ties between modern health care givers and AICs leaders to enable internal conversations about health and socio-cultural underpinnings related to COVID-19.

The African Apostolic Church of Paul Mwazha presented a different scenario on the use of vaccines at the advent of COVID-19. The church members during the face-to-face interviews clearly admitted that their leaders encouraged them to get vaccinated against COVID-19. The church is semi-conservative in that it uses both faith-healing and modern medicines. Most members were claiming to have been vaccinated together with their children and they said that they use of modern health facilities without any victimisation from the church leaders.

The interviewees highlighted that Paul Mwazha, the founder, personally encourages his followers to use modern health services and get COVID-19 vaccines while believing in faith-healing. The respondents from African Apostolic Church of Paul Mwazha clearly conveyed their willingness to get vaccinated for COVID-19 and any other disease but faith-healing and receiving prayers for protection is also part of their belief. Rather, the respondents stated that they are more inclined to using spiritual healing methods concomitantly with modern health services. Whilst Paul Mwazha allowed his followers to accept COVID-19 vaccinations and other modern treatment methods, it also seems that spiritual healing methods is their first anchorage of call when struck by any ailment.

The Independent Apostolic Church (IAC) showed a variability of teaching, practices, doctrine, and regulation against vaccinations not only for COVID-19 but all sorts of vaccinations and the use of modern medicines when hit by ailments. The IAC strongly believe in faith healing, *Mweya* (Holy Spirit), and supremacy of trusting God for healing instead of putting faith in the medical health care system. Interestingly, Informant K postulated that those who use both faith-healing rituals and modern medical services and biomedicines are of low faith. For Informant L, a true Christian should not consult heathen services because they would defile one's Christian life and faith. The findings from the IAC indicated that as a way of refraining their members from consulting worldly practitioners the church has set aside prophets, midwives and elderly women with the responsibility of delivering pregnant women and providing both antenatal and postnatal care. There are also prayer sessions at the end of each church gathering where the sick people are called for healing and the members are free to consult the prophets for protection prayers at any

time. This implies that the belief in Mweya has a superseding influence in health seeking behavior of the garmented churches and it strongly shaped their attitude and behavior towards vaccination in the COVID-19 era.

Due to the emphases on faith healing and strict adherence to church beliefs and practices, the followers of IAC are not allowed to access the COVID-19 vaccines and they still pray for their followers so that they would not fall victim to the pandemic. During the focus group interviews, most members from the IAC were saying that they know that violating church doctrine or regulations on accessing vaccines attract social sanctions, which include confession, shaming by being asked not to wear church regalia or "*kubvisiswa gamenzi*", or re-baptism (*kujorodwa*). Informant L said that it is because of these sanctions that they do not dream of being vaccinated since their leaders have already prayed for them and they feel secure under the covering of the prayers they received. However, it seems as a way to refrain followers from being vaccinated, the leaders of IAC are using militaristic-type of discipline to instill strict adherence to the norms, values, and leaders' instructions. This implies that the followers have no choice but to follow what their leaders tell them to do in so far as COVID-19 vaccinations are concerned.

It was also observed during the face-to-face interviews that there is a semi-conservative and liberal groups of garmented churches with ambiguous teachings and church doctrine in so far as the issue of vaccination is concerned. This group does not openly condemn or encourage their members to get vaccinated but they emphasise that members should first seek spiritual counsel and faith-healing before consulting or utilise modern healthcare services. This implies that the Holy Spirit (*Mweya*) is a central spiritual force in the beliefs and faith-healing of the garmented churches, and is believed to foretell and forewarn the members about any looming disease outbreak, tragedy, complications as well as how to treat illnesses using prayer rituals. The prophets and or any church members endowed with special healing and prophetic powers have the rights to pray for the sick. So, at the advent of the COVID-19 pandemic, healing rituals and "spirit-filled members" with special healing powers and delivery skills were offering an alternative health system to the conventional healthcare system. Faith-healing, healing rituals, prayers, the use of sanctified (holy) water, sanctified stones *(matombo akayereswa),* and the use of "apostolic concoctions" were used instead of vaccinations to prevent members from contracting the disease. In their day-to-day belief, prayers have the power to heal or deliver healing, cleanse impurities or evil spirits, maintain good

health or restore it during sickness, and ensure improved quality of life. It is because of such a belief system that members were discouraged from vaccination as the COVID-19 pandemic was causing mayhem in Zimbabwe. It can, thus, be safely said that the "apostolic healthcare system" which include faith-healing and prayers for protection occupy a special place in the lives of the Apostolic churches, and members expressed strong faith in prayers for protection over vaccination in this era of COVID-19.

This study has demonstrated that AICs, which have been referred to as garmented churches articulate certain religious and behavioral norms that essentially shaped health behaviours and perceptions of their followers towards the COVID-19 vaccinations. The religious leaders in AICs robustly communicate teachings, beliefs and doctrine to the members, and have means to enforce adherence to religiously observe these teachings and practices. The pervasiveness of the AICs' healthcare system of faith-healing, healing rituals, and faith in prayers for protection aid to build and reinforce attachment to it such that there is limited incentive to explore fully modern healthcare services. It is, therefore, not surprising that across all AICs members interviewed in this study, the general consensus was that one's dependence on vaccines and modern medicines at the advent of COVID-19 reflected a weak faith. AICs vehemently accentuate faith in their teachings, which eventually influenced decisions about health-seeking options in the era of COVID-19. The study observed that AICs can be grouped into two groups in so far as their reactions to vaccination is concerned. On the one hand, there are those who strongly state that COVID-19 vaccination distorts one's faith. On the other hand, we have those who are semi-conservative. They believe that there is nothing wrong with accepting COVID-19 vaccinations but faith-healing is the first port of call.

Conclusion

The chapter intended to examine the responses of AICs in Zimbabwe to the COVID-19 pandemic. It, therefore, highlighted the attitudes of some AICs to the public health as well as government regulations to mitigate the spread of the coronavirus. From interviews carried out with AIC leaders and members in Harare and Domboshava, the chapter established that the majority of these churches implored their members to depend on prayer in order to be protected from infection by the coronavirus. The

chapter also showed the centrality of faith-healing in these churches even in the face of deadly virus such as COVID-19. In those AICs that encouraged their members to follow the public health protocols, they also emphasised that faith-healing had to be sought before conventional health treatment. In the final analysis, the chapter established that the suspicion towards conventional health systems held by AICs led to unnecessary loss of life. Hence, the chapter called for critical engagement between the government and AICs so that in the event of future pandemics, lives of AIC members are not lost when they could be saved.

References

Anderson, A. 2001. *African Reformation: African Initiated Christianity in the 20th Century*. Trenton: Africa World Press.

Anderson, A. 2000. Zion and Pentecost: The Spirituality and Experience of Pentecostal and Zionist/Apostolic Churches in South Africa. *African Initiatives in Christian Mission, Vol. 6.* Pretoria: University of South Africa Press.

Barrett, D.B. 1968. *Schism and Renewal in Africa: An Analysis of Six Thousand Contemporary Religious Movements*. Nairobi: Oxford University Press.

Blanchard, T.C., Bartkowski, J.P., Matthews, T.L & Kerley, K.R. 2008. Faith, Morality and Mortality: The Ecological Impact of Religion on Population Health. *Social Forces,* 86(4):1591-1620.

Bourdillon, M.F.C. 1976. *The Shona Peoples: An Ethnography of Contemporary Shona, with Special Reference to their Religion*. Gweru: Mambo Press.

Byaruhanga, C. 2015. *The History and Theology of the Ecumenical Movement in East Africa*. Kampala: Fountain Publishers.

Campbell, C. 2010. What More in The Name of God? Theologies and Theodices of Faith Healing. *Kennedy Institute of Ethics Journal,* 20(1):1-25.

Chakawa, J. 2010. Church in Marange Area of Zimbabwe. *Zimbabwe Social Science Review* 1,2.

Chitando, E. 2007. *Living with Hope: African Churches and HIV/AIDS*. Geneva: WCC Publications.

Daneel, M. L. 1987. *Quest for Belonging: Introduction to a Study of African Independent Churches*. Gweru: Mambo Press.

Daneel, M.L. 1971. *Old and New in Southern Shona Independent Churches, Vol. 1: Background and Rise of the Major Movements*. The Hague: Morton.

Gregson, S., Zhuwau, T., Anderson, R.M. and Chandiwana, S.K. 1999. Apostles and Zionists: The Influence of Religion on Demographic Change in Rural Zimbabwe. *Population Studies,* 53(2):179-93.

Gyimah, S.O., Takyi, B.K. and Addai, I. 2006. Challenges to the Reproductive-Health Needs of African Women: On Religion and Maternal Health Utilization in Ghana. *Social Science & Medicine,* 62:2930-44.

Hastings, A. 1979. *History of Africa Christianity 1950-1975*. Cambridge: Cambridge University Press.

Heaton, T.B. 2010. Does Religion Influence Fertility in Developing Countries? *Population Research Policy Review,* DOI 10.1007/s11113-010-9196-8.

Kang, K., Shin-Jeong, K., Do-Bong, K., Park, M., Yoon, S., Young-Sim Choi, and Kho, S. 2021. A Meaning-Centered Spiritual Care Training Program for Hospice Palliative Care Teams in South Korea: Development and Preliminary Evaluation. *BMC Palliative Care,* 20:30-41.

Kim, Do-Hoon, and Yoo-Sun Moon. 2021. Religion/ Spirituality and Mental Health: Explore Clinical Applications Through Article Review. *Journal of Korean Association Social Psychiatry,* 26:23-39.

Kim, Keun-Hyang. 2013. 'The considerations for application of spirituality in the mental health field'. *Korean Journal of Psychology,* 32:213-229.

Koenig, Harold G. 2009. 'Research on Religion, Spirituality, and Mental Health: A Review'. *The Canadian Journal of Psychiatry,* 54:283-291.

Lucchetti, G. et al. 2012. Spirituality and health in the curricula of medical schools in Brazil. *BMC Med Educ,* 12:78-93.

Maguranyanga, B. 2011. *Apostolic religion, health and utilization of maternal and child health services in Zimbabwe*. New York City: UNICEF.

Makamure, C. & Chimininge, V. 2021. Leadership Succession Practices in African Independent Churches in Zimbabwe: The Case of Zion Apostolic Faith Mission Church (ZAFM). In Bostic, J.R., Mothoagae, I.D. & Tucker-Worgs, T. (eds.). *Black Religious Landscaping in Africa and the United States,* 139-154. New York: Peter Lang.

Machekanyanga, Z., Ndiaye, S., Gerede, R., Chindedza, K., Chigodo, C., Shibeshi, M.E., et al. 2017. 'Qualitative assessment of vaccination hesitancy among members of the apostolic church of Zimbabwe: A case study'. *Journal of Religion and Health,* doi: 10.1007/s10943-017-0428-.

Masuku, Mnyalaza T. 2021. *African Initiated Churches as interlocutors of African spirituality of liberation against colonial spirituality of the empire*. University of South Africa: Pretoria.

Ngoya, A.J. 2021. The Historical Role of African Churches in the Healing Systems in Mbeya Region from the 1980s to the Present. *Journal of Religion in Africa*, 49(2):162-180. https://doi.org/10.1163/15700666-12340164.

Pomerai, K.W., Mudyiradima, R.F., Gombe, N.T. 2012. Measles outbreak investigation in Zaka, Masvingo Province, Zimbabwe. *BMC,* 5:687.

Sundkler, Bengt G.M. 1961. *Bantu Prophets in South Africa*. London: International African Institute.

Yong, J., Juhu, K., Park, J., Imsun, S., and Swinton, J. 2011. Effects of a Spirituality Training Program on the Spiritual and Psychosocial Well-Being of Hospital Middle Manager Nurses in Korea. *The Journal of Continuing Education in Nursing,* 42:280-288.

Yoon, H., Lee, E. and Kim, K. 2021. Relationship between Sub-factors of Religiousness/Spirituality and Mental Health. *Journal of the Korean Society for Wellness,* 16:238-245. Available online: http://www.riss.kr/link?id=A107287752 [accessed 27 July 2022].

Silindiwe Zvingowanisei

5 COVID-19 in Zimbabwe: An Islamic Response to the Pandemic

Abstract

The chapter seeks to investigate the place of religion in the context of the COVID-19 pandemic in Zimbabwe. Using the concept of religion in relation to Islam, it explores the Islamic response to the COVID-19 pandemic in the country. This is inevitable in a context with a multi-religious landscape, which implies that people's contribution to public health message was, by and large, shaped by religious beliefs and the response of religious actors. Yet, despite the fact that Zimbabwe is a multi-religious society, it has been a common practice to regard the dominant religion, Christianity, as the only key development agent that the Zimbabwean government could work with in the fight against the COVID-19 pandemic. In this way, minority religions such as Islam are excluded in development initiatives for health. Utilising a qualitative phenomenological research design, the chapter foregrounds the role of the Islamic community in promoting public health and human well-being during the COVID-19 pandemic through their cultural identity and other religious resources. As COVID-19 takes a downward curve, the chapter advocates for the inclusion of minority religions such as Islam in post-COVID-19 recovery initiatives and in any other future pandemics.

Keywords: COVID-19, Islamic Response, Pandemic, Zimbabwe

Introduction

The novel coronavirus that causes the COVID-19 pandemic which was first reported in Wuhan City, Hubei province, China in December 2019 and in Zimbabwe in March 2020 affected all spheres of life including religious communities. This unprecedented health phenomenon was declared a pandemic by the World Health Organisation as it affected societies at their core (WHO 2020). In Zimbabwe, while the intersection between religion and the pandemic attracted media attention, the religion and public health interface continued to receive limited scholarly attention. This is despite the fact that religion manifested its presence in public

health not only as a provider of healthcare, but also as part of the emergency response team. This chapter interrogates the place of religion in the context of the COVID-19 pandemic in Zimbabwe. The chapter examines the Islamic response to the COVID-19 crisis in Zimbabwe. This was inevitable in a context with a multi-religious landscape, which implied that people's contribution to public health messaging was largely shaped by religious beliefs and the response of religious actors. Given that COVID-19 is a novel pandemic, the chapter seeks not only to contribute to the religion and public health discourse in Zimbabwean scholarship that has been preoccupied with other pandemics such as HIV and AIDS, but also to take stock of religion's complex role during pandemics and consequent contribution during a crisis. Cognisance of the fact that different religions were involved in the fight against COVID-19, the intersection of religion and public health in Zimbabwe during the COVID-19 pandemic is deliberately situated in the setting of Islam. This is because although Christianity remains the dominant religion in Zimbabwe, the religious landscape in Zimbabwe is multi-religious, with representation of other religions including *interalia* Islam, African Indigenous Religions, Rastafarianism, Baha'I Faith and Hinduism among others, which account for smaller percentages in terms of following. As Maposa *et al*. (2016:127) rightly observed, "Zimbabwe is a multi-religious society where living religions like Christianity, Islam, Hinduism and African Traditional Religion co-exist." According to Chitando (2003:123), "a multi-religious society occurs when some people living in a pluralistic environment consciously and deliberately undertake to deal with the existence of the other." The context of co-existence among different religions in the country helped in the fight against COVID-19 as the religions deployed their respective religious resources in response to the pandemic. However, while scholarly literature on the nexus between religion and public health in Zimbabwe has mainly focused on Christianity, there is a dearth of research on minority religions. This chapter explores this neglected dimension of religion and public health, focusing on Islam.

Research Methodology

The chapter utilised a qualitative phenomenological research design that provided a description of the lived experiences of participants from an insider perspective. The study corroborated insights from the phenomeno-

logical and historical approaches to describe and analyse data. The historical method involves hermeneutics and is important in tracing the origins, development and impact of the COVID-19 pandemic and to bring out how the Muslim community perceived the disease in Zimbabwe. The study used the phenomenological principles such as *epoche* (bracketing out), descriptive accuracy, *eidetic* intuition (establishing the meaning), empathy and comparison (Cox 1996). The two approaches were used in a complimentary way. The chapter is based on a study conducted among Muslims in Zimbabwe. In order to collect data, the study conducted unstructured in-depth personal interviews with thirteen purposively sampled information-rich African Muslims in Zimbabwe. Of the thirteen study participants six were female and seven were male and they were all located in Harare. The interviews were significant in understanding Islamic responses to the COVID-19 pandemic in Zimbabwe.

Religion and Pandemics: A Review of Existing Literature

The chapter situates the Islamic responses to COVID-19 in discourses of religion and pandemics. This scholarship has partly engaged with the role of religious actors in curbing pandemics. For instance, Chitando (2009)'s book *Troubled but Not Destroyed*: *African Theology in Dialogue with HIV and AIDS* emerged from the conviction that African Theology can stir African churches and communities to provide effective responses to HIV and AIDS. Where Afro-pessimists are writing off Africa – due to AIDS, corruption, ethnic wars, and other challenges – the book contends that Africa will, as always, stubbornly refuse to die. Where one will in all honesty concede that Africa is indeed troubled, one must also celebrate the fact that it is not destroyed.

Similarly, with reference to the HIV and AIDS pandemic, Mapuranga (2009) highlights the effects of the pandemic on the traditional Ndau women in Chipinge District in Zimbabwe. She argues that while there are some negative aspects of Ndau traditional religion which have helped to spread HIV among women, the same women have played a key role on the overall response to the HIV and AIDS pandemic.

In the case of the Ebola outbreak, which profoundly disturbed three West African countries (Guinea, Liberia and Sierra Leone) in 2014-15, Marshall *et al*. (2015) posited that religious beliefs and practices shaped (positively and negatively) ways of caring for the sick, patterns of stigma,

and gender roles and affirmed that throughout the crisis, religious institutions provided services including health, education and social support.

In the same line of thinking, with reference to Ebola, Jansen (2019) concluded that the unified voice and collective action from faith leaders around infection prevention activities decreased the fear and stigma about Ebola. He observed that the Muslim and Christian faith leaders drew lessons from their own Quranic and Biblical texts respectively to support the recommended infection control and prevention measures for Ebola.

With regard to COVID-19, emerging scholarship has also been centred on religion's role in spreading the pandemic. For instance, Jaja *et al.* (2020) while focussing on social distancing, examines how religion, culture and funeral rites undermined the efforts to curb COVID-19 in South Africa.

Emerging scholarship on religion and COVID-19 has also focused on the positive responses of religion through the use of the media in addressing the pandemic. For instance, scholars in different contexts such as Zambia (Mwale *et al.* 2022), Nigeria (Aluko 2020), South Korea (Wildman 2020) and the Philippines (de Castillo *et al.* 2020) concluded that most religious groups were innovating in response to demands of social distancing by conducting online services, including disseminating practical health information, and offering urgent financial help in the wake of rapidly degrading economic conditions.

Sipeyiye (2022) analysed the indigenous religious resources deployed by the Ndau people in coping with the COVID-19 in Chipinge District in Zimbabwe. He concluded that indigenous people's belief systems are both a source of their resilience and can also pose a threat in preventing and containing the COVID-19 pandemic.

While acknowledging the complex and ambivalent role of religion during pandemics, the foregoing studies affirm how pandemics can be positively or negatively shaped by religion and religious actors in different contexts. However, there has been limited work on the responses of Islam as a religion to COVID-19 in Zimbabwean context. This chapter, therefore, seeks to contribute to emerging scholarship on religion and COVID-19 with specific reference to Islam.

Islamic Religious Actors and public health in pre-COVID-19 Zimbabwe

The participation of Islamic religious actors to public health was not new in Zimbabwe. Apart from religious institutions, forming the bulk of the health delivery systems as part of national health service delivery, the Islamic umbrella body in Zimbabwe, the Supreme Council of Islamic Affairs in Zimbabwe, has often collaborated with other religious umbrella bodies on different fronts in health related ventures. For instance, in the wake of HIV and AIDS, the Supreme Council of Islamic Affairs joined hands with umbrella bodies of other religions such as the Zimbabwe Council of Churches (ZCC) in the fight against the pandemic.

The Alkauther Aids Foundation which was formed in 2007, is a good example of the Muslim organisations which work in collaboration with other religions in Zimbabwe. The organisation has its headquarters in Mutare. The director of the Organisation is Mustafa Wasile. The main aim of the organisation is to provide treatment and nutritional support to Muslims living with HIV and AIDS in Zimbabwe. It encourages people to disclose their status as a way of eradicating stigma and discrimination. Thus, the organisation established support groups of Muslims living with HIV and AIDS and it has assisted by providing anti-retroviral drugs (ARVs) to Muslims in need of them. It has, therefore, complimented the efforts of the Zimbabwean government in public health service delivery through access to care and treatment. The organisation also deals with advocacy on HIV and AIDS issues, awareness programs, counselling and home-based care. More so, it engages in self-help projects in order to improve the quality of life of both the infected and affected (Maposa *et al.* 2016). This Islamic organisation networks with the National AIDS Council of Zimbabwe (NACZ). With such existing institutional structures like the Supreme Council of Islamic Affairs in Zimbabwe and the Alkauther AIDS Foundation already dealing with the HIV and AIDS pandemic, the chapter observes that Islam in Zimbabwe was well-placed to deal with the COVID-19 pandemic.

A key Muslim practice which has helped a lot to curb the spread of HIV is male circumcision. Every Muslim man is supposed to be circumcised. Male circumcision involves removing the foreskin. Scientific research has shown that male circumcision reduces by up to 60% a man's risk of becoming infected with HIV during heterosexual intercourse

(Anita 2014). Muslims have always utilised this religious resource to reduce HIV infection. This resonates well with Chiwara (2013) who postulated that Muslims have always advocated and brought an awareness of circumcision as a measure that reduces HIV infection. It was against this backdrop that the Zimbabwean government acknowledged the efficacy of circumcision in containing the spread of HIV. Muslims through the Supreme Council of Islamic Affairs in Zimbabwe headed by Sheikh Duwa, have been part of the team that is helping to conscientise the people about the merits of circumcision.

Traditionally, Muslim boys attend the male circumcision rite called *murundu* (Gumbo 2020). Magesa (1997) observes that traditionally, Muslims who wanted to be circumcised were physically removed from the mainstream society and sent to secluded places where they had practically no contact with people from their community. For instance, among the Muslims in Mberengwa District, *murundu* (circumcision) takes place in a forest in the mountain called Dumbwi, where they camp for about two months, normally in winter (Mrs Badge, interview, 2022)[1]. Muslims associate circumcision with hygiene. This, therefore, means Muslims in Zimbabwe were well-placed to respond to COVID-19 through the call to practise hygiene to thwart the spread of the pandemic. In addition, the practice of physical isolation during *murundu* also meant that Muslims had no problems implementing the COVID-19 containing measures such as lockdowns, social (physical) distancing and self-quarantine, as they were already part of their religious practices.

While Muslim boys attend male circumcision rite, their girl counterparts attend *Komba* (girl's initiation rite), a practice which is widely respected among the indigenous Muslims in Mberengwa. The practice requires that young girls of 13 to 16, be sent for initiation schooling outside the villages with old women (Gumbo 2020). A major component of the school curriculum is that the girls are taught how to handle their menstrual periods. In other words, they are taught hygiene. Like the boys, *Komba* girls are supposed to remain in those secluded places until the end of the school calendar, whereupon they return to the community for graduation. As in the case of the boys, the teachings on hygiene and the practice of physical isolation from the rest of the community were used by Muslim women as coping measures in response to the COVID-19 pandemic.

[1] All the names of the participants used in this chapter are pseudonames.

Muslims in Zimbabwe were also key actors during national epidemics like cholera. In 2008, Zimbabwe was hard-hit by a crippling cholera epidemic, which began in Chitungwiza (a town located about 35 kilometres south-east of Harare). The disease subsequently spread countrywide. Cholera is a highly infectious disease spread through poor sanitation, contaminated water sources and infected food by *bacterium vibrio cholera* (Cholera Country Profile, WHO 2009). An assessment carried out by the Crisis in Zimbabwe Coalition (2008) attributed the cholera outbreak to a direct result of Operation Murambatsvina launched by the Zimbabwean government in 2005. Operation Murambatsvina, according to Chiwara (2013) left many people homeless, without access to food, water and sanitation or healthcare. Similarly, Manyonganise (2013:146) notes that "in this operation, government demolished all perceived "illegal" structures and the United Nations Report compiled by Anna Kajumulo Tibaijuka estimated that about 700000 people were affected by this operation." Fenga (2018) opines that apart from Operation Murambatsvina the cholera outbreak was also due to a crumbling health-sector, erratic urban water supplies or no supplies at all, power outages and shortage of chemicals to treat the water. Harare was the most affected due to the big population in the city.

The Islamic community responded to the cholera epidemic through the Islamic Organisation called The Direct AID: Africa Muslim Agency of Zimbabwe, by drilling boreholes in many areas in and out of Harare in order to provide safe water for the people. The organisation drilled boreholes at Budiriro High School, Seke 5 High School in Chitungwiza, Dzivarasekwa Muslim community, Nyabira High School in Darwendale, Dorowa Community Centre, Mvurwi, Hatcliffe Clinic and Chinyika Clinic in Gutu. This was in keeping with the Muslim belief that health is a fundamental human right (Chiwara 2013). This fundamental belief was at the centre of the Islamic response to the COVID-19 pandemic in Zimbabwe as will be demonstrated below.

With a background of engagement in pandemics and epidemics, it became imperative to understand the Islamic response to the COVID-19 pandemic. The chapter unfolds by situating the Islamic responses in existing scholarships before exploring the responses of the Muslims to the pandemic.

Islamic responses to the COVID-19 pandemic in Zimbabwe

A number of precautionary and intervention strategies were implemented in response to the COVID-19 pandemic in Zimbabwe as will be explored below.

Suspending public physical worship

When COVID-19 announced its presence in Zimbabwe in March 2020, the Zimbabwean government swiftly responded by instituting a raft of measures which were meant to curb the spread of the virus, including lockdowns. Mosques, churches, masjids and other collective worship places were placed out of bounce by the successive government statutory instruments meant to legalise the lockdowns. Muslims complied with these preventive measures as also informed by the Ministry of Health and WHO guidelines on the pandemic. They suspended public physical mosque and *masjids* (houses of prayer) gatherings and instead met in their homes for worship. Thus, homes were turned into temporary mosques and masjids (Dube 2022).

The following extracts from participants illustrate this:

> With the advent of the coronavirus, we closed all mosques and masjids and started praying at home." (Sheikh Salim, interview, 2022).
> COVID-19 was a reality and it was killing. So during the days of the pandemic mosques decided to cancel Friday prayers and Quran classes. (Imam Sadiki, interview, 2022)
> The closure of mosques and *masjids* was a challenge to our prayers. It was a very difficult time as we had never had such an experience since we were born. Mosques and *masjids* had always been open places for worship. However, it was for the benefit of everyone. We Muslims are law-abiding citizens and we tried our best to adhere to the lockdown rules. (Sheikh Phiri, interview, 2022)

Muslims in Zimbabwe did not have any problems complying with the lockdown rules. This was because the idea of lockdown was long prescribed by Prophet Muhammad as noted in the *hadith* above that if any pandemic may appear in a land, do not go there, and if you are in that land, do not escape from it (and spread elsewhere). This was confirmed by one participant who said:

> "We had no problems with COVID-19 because Islam taught us about such diseases as our beloved Prophet Muhammad said that if such disease happens, you are not allowed to leave the city or any place you are in. So we already knew how to respond." (Yoshua, interview, 2022)

Self-quarantine

Apart from the general lockdown and barring of public gatherings at churches, mosques, *masjids* and other public gathering places, the government also recommended self-quarantine at home as a COVID-19 containment measure. Muslims also complied with this measure and those who tested positive to the coronavirus had to self-quarantine within the home. Islamic self-quarantine was also guided by Prophet Muhammad's recommendation about not leaving a city in the case of infection by a disease. Islam is one of the Abrahamic religions apart from Judaism and Christianity. It considers the Bible as a Holy Book and believes in the Biblical prophets. The idea of lockdown and self-quarantine are also found in the Biblical text from the book of Isaiah 26:20 which says, "Come my people, enter your inner chambers, and shut your doors behind you, hide yourselves for a while, until the wrath is past." Thus, for Muslims the lockdown and self-quarantine were not only secular measures but also divine laws which warranted total obedience.

However, the Islamic response to the COVID-19 pandemic also entailed the promotion of family health as they were locked down in their homes. The lockdown at home facilitated adaptation to the disease or the restrictions resulting from it. This was really necessary considering the fear and uncertainty that had gripped all and sundry in addition to situations where some family members got infected. It was in such situations that the Muslims interpreted their concept of family health and applied the WHO theme of 'Health Begins at Home', discussed above, by caring for their loved ones who would be in self-quarantine. As one participant put it:

> If any member of the family got infected by the coronavirus, we would attach one person with them, to take care of them like bathing, food and so forth, and with protective equipment such as gloves and masks because in Islam we live as family and do not leave any person behind. (Mrs Sarifu, interview, 2022)

Social (physical) distancing

Social (physical) distancing was also one of the many containment measures introduced by the Zimbabwean government. Since it is agreed that the coronavirus does not move but it is moved from one locality to another by human beings, physical distancing which is a method to minimise crowd interactions and prevent the spread of disease within groups of people (Aslam 2020), is viewed as reducing the rate at which infection takes place. This is a common practice, which has been carried out over generations. Globally 50-100 million succumbed to the 1918 influenza pandemic. Although social distancing was not implemented back in 1918, the majority of the population took reactive social distancing measures that made it possible to escape the disease outbreak (Aslam 2020). This behavioural practice followed by several millions led to the pandemic limiting the damage after World War 1 in several European countries. With this in mind, many governments, including the Zimbabwean government at the advice and direction of WHO, regulated social distancing which ranged from one to two metres. This recommended distance was believed to curb the transmission of the coronavirus from one person, who could be infected, to another (Muyambo 2022).

In compliance, Muslims in Zimbabwe also acted to promote public health protocols through social distancing and avoiding large gatherings, particularly at mosques and *masjids* to prevent the spread of the disease. As one participant noted:

> During the COVID-19 period, our leaders, the sheikhs and imams told us to close all mosques and *masjids* to implement the social distancing rule stipulated by our government. (Musa, interview, 2022)

In addition to closing all mosques and *masjids*, the Islamic community in Zimbabwe also responded to the COVID-19 pandemic by celebrating Ramadan in individual households (*ummah*). This resonates well with Shaban (2020) who observed that the 2020 edition of Ramadan was celebrated in homes despite it being the Muslim annual season of worship, comradeship and relationship. In concurrence, Picciaredda (2020) notes that Muslims experienced the first Ramadan without public ceremony between 23 April and 23 May 2020. In the 2020 Ramadan edition, Muslims also cancelled the communal *ifar*, which ended fasting in the evening, pulling together huge crowds to share meals together. Since the inception of Islam, this comradeship had been an indelible mark of Ramadan. On this note one Sheikh participant said:

> In 2020, we celebrated Ramadan in our homes and not in mosques as is the traditional practice. Especially *ifar*, the feast to break the fast of Ramadan where we gather together in large groups in the mosque and partake food together. (Sheikh Zhou, interview, 2022)

According to the Sheikh, Muslims generally increased mosque attendance during Ramadan to do marathon prayers known as *taraweeh* and *qiyam*. Such attendance gained momentum in the last ten days as they spent consecutive days and nights at mosques for the *I'tikaf* prayers. Against this backdrop, the Sheikh further intimated that:

> As Muslims we missed these acts of comradeship. However, we had to do this in obedience to our religious and Quranic rules which forbids the deliberate promotion of pandemic diseases such as COVID-19. (Sheikh Zhou, interview, 2022)

The study also revealed that apart from the cancellation of the 2020 edition of *ifar*, the Islamic community in Zimbabwe also responded to the COVID-19 pandemic by cancelling the minor (*umrah*) and major (*hajj*) pilgrimages to Mecca, in their endeavours aimed at curbing the spread of the disease. The *umrah* normally runs throughout the year while the hajj takes place in Dhu al-Nijjah (Abdalati 1998). The shrine in Mecca draws millions of Muslim pilgrims from all parts of the globe. In this case, the Muslims were also guided by Prophet Muhammad's advice on what to do in the event of a pandemic breaking out in another city or their own city. Given that COVID-19 was a global pandemic which had broken out in both Arabia and Zimbabwe, the Muslims, therefore, decided not to go to Mecca and not to leave Zimbabwe. These findings were confirmed by one of the participants who said:

> Due to COVID-19, in 2020 we cancelled the *umrah* and *hajj* to Mecca so that we would not infect others, nor be infected. Since COVID-19 was a global pandemic which affected both Mecca and Zimbabwe we referred to the rule which we were given by our beloved Prophet Muhammad neither to enter a city (Mecca) nor leave one's area (Zimbabwe) where the disease had broken out. (Imam Sadiki, interview, 2022)

To this extent, the Islamic community in Zimbabwe reasoned that since the COVID-19 pandemic is a contagious disease, social distancing was imperative to roll back the virus. However, the study also revealed that, to some extent, the Muslims had challenges in implementing social distancing, particularly at home. This is because Muslims live a communalistic life. They embrace each other, live, eat and sleep as family, in some cases

using the same utensils or the same blankets. Thus, the call to implement social distancing created serious challenges for them at home.

Islamic funeral rites

The challenge of implementing social distancing among the Islamic community in Zimbabwe manifested itself most in their funeral rites. In Zimbabwe, COVID-19 containment measures sought to limit the number of mourners to forestall the possibility of virus spread due to congestion. However, the study revealed that Muslims, just like their Christian and African indigenous counterparts in Zimbabwe demonstrated a blatant disregard for the personal and collective safety measures in their funeral rites.

A case in point was the funeral service of Mitchelle (Moana) Amuli which drew headlines in November 2020. Moana was a socialite of repute, with estranged parents – a Muslim and Christian father and mother, respectively. After her death in a road traffic accident, each parent claimed her body intending to bury it according to their respective traditions. After deliberations which even included the High Court, it was finally agreed that the body would pass through the mother's Christian home in transit for burial at the father's Islamic home (Kafe 2020). Although the government had limited funeral attendance to a hundred mourners with face masks and maintaining social distancing, a few hundred mourners gathered at Moana's funeral ceremony, as many mourners also violated the COVID-19 containment measures of both face masks and social distancing (Mandivengerei 2020).

Paradoxically, this was happening at a time when improperly handled funeral rites had led to the inadvertent spread of COVID-19 in other countries. For instance, as noted above, Jaja *et al.* (2020), while focusing on social distancing, examined how religion, culture and burial ceremonies undermined the efforts to curb COVID-19 in South Africa. They observed that during funeral rites, social distancing was not necessarily followed while cultural practices (such as those relating to washing of hands in the basin after the funeral) presented an opportunity for guests to contract the virus. In the Zimbabwean context, although religious leaders had been at the forefront encouraging compliance with the rules, adherents were not always meticulous in following the rules; thereby putting themselves and others at the risk of infection by the coronavirus. Commenting on the issue of the Islamic funerals, one of the female participants had this to say:

> We are Africans. Our practice of *Hunhu/Ubuntu* is that we should mourn with those who mourn. When someone has lost a loved one, the whole community is supposed to stand with them in solidarity in their time of bereavement. We cannot abandon this noble practice. (Mrs Makore, interview, 2022)

Cleanliness/ Hygiene

The Islamic community in Zimbabwe also responded to the COVID-19 pandemic through practising a high level of cleanliness/hygiene. Participants highlighted the fact that the issue of hygiene was central to Islamic teachings which stress the significance of cleanliness. Muslims must maintain cleanliness before regularly scheduled prayers, the *Salaat*, which takes place throughout the day. In Islam, religious teachings and practices play an important role in promoting hygiene practices, including frequent hand-washing. Below are some of the extracts from participants:

> One thing I like about Islam is its emphasis on cleanliness. This is within our communities and we wash five times a day for prayer. (Mrs Hove, interview, 2022)
>
> As Muslims we had always practised hygiene. One of the five pillars of Islam is prayer. As Muslims we pray 5 times a day facing Mecca. Before each prayer, we should first wash our face, hands and feet. Hygiene is our way of life. Thus, during the COVID-19 period, we had no problems in implementing the call for hand-washing. Besides, cleanliness is enjoined in the Quran while Prophet Muhammad taught us that cleanliness is half the faith. (Fatima, interview, 2022)

These Islamic hygiene standards show that Muslims have been pacesetters in this regard. These practices proved handy in their response to the COVID-19 pandemic.

Interviews with participants also revealed that apart from social distancing, the issue of hygiene was also a major consideration behind the cancellation of the *umrah* and *hajj* to Mecca in 2020. The cancellation was not just in line with the theory of the spread of COVID-19 through human contact, "respiratory droplets and contact with contaminated surfaces" (WHO 2020:1), but had a concrete foundation in the research works surrounding early pilgrims to Qom and Mashhad (Barmania *et al*. 2021). The Shia shrines in Iran and Iraq, which ordinarily drew millions of pilgrims, were eventually closed due to such research works. As one participant, a Sheikh noted:

> I am a Shia Muslim and I have been to Qom in Iran on many occasions. In Qom we kiss the walls of shrines where our religious figures such as Ayatola Khomeini were buried, which often bred diseases in ordinary times. We, therefore, thought the situation would be worse with the more infectious coronavirus. (Sheikh Phiri, interview, 2022)

The practice of kissing and the sheer numbers of millions of pilgrims from across the globe to Mecca, led to *hajj* cancellation in 2020 not only in Zimbabwe but worldwide. Another participant imam said:

> I have been on pilgrimage (hajj) to Mecca. Hajj is one of the five pillars of Islam. In Mecca, those nearest to the Kaabah kiss the black meteorite during hajj circumambulations. This would, therefore, be very risky during the COVID-19 pandemic. (Sheikh Neza, interview, 2022)

Islamic Halal food

The study established that the Islamic community in Zimbabwe sought to promote health through halal food. For Muslims, good health is considered the greatest blessing and gift God has given humankind. Halal is an Arabic term which means permissible. In Islam terms, it means permissible according to the rules of Islam. The opposite of halal is Haram or sometimes referred to as non-Halal. This refers to anything considered unlawful under Islamic teachings. Halal food is all food that is permissible to eat according to the teachings of Islam. This is essentially any food that does not fall into the category of haram (or forbidden). In Islam, all foods and beverages are halal except for those that were explicitly forbidden in the Quran. Muslims in Zimbabwe accept the Quran to be the book of perfect direction and bearing for humankind and believe the Quran to be the last disclosure of God. God says in the Quran:

> Eat what is lawful (Halal) and wholesome (Tayyib) on the earth (Quran 2:168).
> O mankind, eat from whatever is on earth [that is] lawful and good and do not follow the footsteps of Satan. Indeed, he is to you a clear enemy (Quran 2:168).

The study established the efficacy of halal food in the Islamic response to the COVID-19 pandemic in Zimbabwe. Halal food include natural foods and a lot of vegetables and fruits. Muslims in Zimbabwe rely on traditional halal food which is not only highly nutritious but also has a lot of medicinal value.

The traditional halal food proved very effective in the Islamic response to the COVID-19 pandemic. This was confirmed by two female participants who said:

> We live on a healthy and nutritious diet which helped to fight the COVID-19 pandemic. We drank *zumbani* tea, ginger tea, garlic tea and *moringa* tea. For relish, we ate natural vegetables such as blackjack, *nyevhe*, pigweed and mushroom. African loquats and figs served as fruits. (Mrs Zhou, interview, 2022)
>
> During the COVID-19 pandemic, we had no problems on issues of diet because the Quran had already taught us about what is lawful and healthy food. For example, the Quran says we should eat of the good things which Allah provided for our sustenance. (Mrs Hove, interview, 2022)

For meat and poultry to be halal, it must be slaughtered according to Islamic dietary laws (*Zabihah*). The issue of hygiene is again a major consideration in the Islamic slaughter of animals. Muslims in Zimbabwe believe that the Islamic slaughter drains most of the animal's blood. As it is known, blood carries all the bacteria and any harmful toxins in the body of the animal. Sometimes, these toxins are not released when boiling or cooking the meat. According to Muslims, it is, therefore, important to get rid of all the blood before one eats the meat. Muslims in Zimbabwe, therefore, utilised halal food in the fight against the COVID-19 pandemic.

Islamic herbal remedies

The Islamic participants in Zimbabwe highlighted the importance of indigenous natural herbs to promote good health. The participants affirmed the centrality and vitality of herbal healing in the context of the COVID-19 pandemic. Top on the list of indigenous herbs used by Muslims in Zimbabwe were *zumbani/mushani* and *tsangamidzi* (ginger). These herbs were used to steam as a precautionary measure or for managing the infected, on a regular basis. The herbs help to clear the bronchitis and breathing system. For Muslims, therefore, steaming and bathing could keep the coronavirus at bay because of the high temperatures and the herbal therapy. In the case of ginger, the herb could also be chewed to treat flue and coughs. Since COVID-19 had flue-like symptoms, the herb, therefore, proved handy in combating the pandemic. The utilisation of natural remedies was confirmed by all participants as extracts below illustrate:

> During the coronavirus, *zumbani* and ginger were very helpful. My husband was infected by the coronavirus, and he went into self-quarantine

> where for two weeks, he used *zumbani* for steaming and bathing as well as chewing ginger." (Mrs Makore, interview, 2022)

In light of this analysis, it is clear that natural herbs were pivotal in the Islamic response to the COVID-19 pandemic in Zimbabwe.

Physical Activity

Regular physical exercise was also a major strategy used in the Islamic response to the COVID-19 pandemic apart from a healthy lifestyle characterised by halal food and diet. Participants indicated that the Islamic daily performance of five prayers was itself a form of exercise which helped in the fight against COVID-19. This resonates well with Fatimah *et al*. (2008) who postulated that its prescribed movements involve all the muscles and joints of the body, and exercising the concentration of the mind. On this note one participant had this to say:

> Since mosques and masjids were closed because of the lockdown, we prayed at home. In Islam prayer helps to strengthen the body because we pray with different body positions such as standing, walking, squatting or lying down. The Quran also teaches that Allah likes strong believers. Physical exercise, therefore, helped us not to fall sick from COVID-19. (Musa, interview, 2022)

From this mitigation measure, one cannot miss the positive Islamic response to the COVID-19 pandemic in Zimbabwe through physical exercise.

COVID-19 and Islamic environmentalism

Islamic communities are super environmentalists informed by the Islamic concepts of *Tawhid, Khalifa and Al Mizah* which all points to harmony between humanity and nature. In this way Muslims in Zimbabwe are convinced that the global lockdowns and quarantine made the global environment to reset and improve in health. *Tawhid* (unity of Allah) is the relation of humanity to the creator (Mawil 2013). Thus, all things were created by Allah and they are supposed to live in harmony which means humanity has no mandate to exploit the environment. According to one participant:

> Everything was created by the Creator including human beings and all other creation. Thus, humanity has no power over creation and the destruction of nature is unlawful. However, we believe that because of the lockdown, nature had time to gain strength and get healthy. For example,

> with the closure of industries, water in rivers, lakes and seas and oceans rested from being polluted while air got more fresh with the ban on air travel. (Sheikh Neza, interview, 2022)

Linked to *Tawhid* is the concept of *khalifa* or stewardship. Muslims believe that when Allah created everything on earth, he gave humanity a responsibility to look after the environment which means nursing rather than destroying it. The Quran declares that human beings are stewards of Allah's creation. For instance, Quran 2:30 says, "Behold, the Lord said to the angels; "I will create a vicegerent on earth." On this note another participant said, "The Quran says one of our duties is to look after Allah's creation and not destroy it." The COVID-19 related lockdown helped in the sustenance of nature.

Al Mizan is another fundamental Islamic environmental concept which says that each form of creation is meant for a purpose on earth (Khalid 2002). Each form of creation is meant to balance the universe. It is often said that the universe is one of the amazing creations by Allah. In emphasising the importance of every form of creation, one of the participants said this, "Everything that was created by Allah was created for a purpose, and thus, is supposed to be conserved."

Muslims argue that while modernisation has to some extent improved the standard of living, it is also affecting the health of the environment (Hamid 1989). Lately, in the Zimbabwean context, we have been tested with various natural disasters including *interalia* climate change, cyclones, droughts, flash floods and pollution of air. These disasters are to a certain extent, due to anthropogenic sources such as deforestation and uncontrolled open burning, not due to natural causes alone. The Islamic concern is on what steps can be taken to restore the health of the natural environment for the sake of the present and future generations. According to Quran 30:41:

> "Mischief and disaster on land and sea has appeared because of what was done by the hand of man, that He may make them taste a part of the reward of the bad deeds they have done."

From the above analysis one cannot miss the point that Muslims are environmentally friendly. They promote a healthy environment with green trees, unpolluted water and fresh air. While Muslims forbid deforestation, afforestation is regarded as an act of worship. The Islamic faith, therefore, calls for the conservation of natural resources. Muslims believe that wastefulness of the natural environment is a major contributing factor to our

present lives like global warming, climate change and the extinction of natural resources. Furthermore, the green colour is important to Islam as it presents a profound sense of the values of nature for God and the people. Muslims also believe that green is the colour of the clothes which people will be putting on in the next world as a reward for those who would have obeyed the laws of God (Hamid 1989).

During the COVID-19 pandemic, Muslims in Zimbabwe were guided by these positive Islamic attitudes to the environment. As one participant stated, "As a human being one's relationship to the environment is not based on one's immediate want and needs but is shaped by one's consciousness of the needs of the future generations. This was stressed by Prophet Muhammad when he said, "If the hour of death is imminent and anyone of you has a palm shoot in his hand and is able to plant it before the hour strikes, he should do so and he will be rewarded for that action.

This *hadith* shows that in Islam improving the quality of this life for others brings several rewards both to the doer of good and those who benefit from his action. It also shows that it is never too late in one's life to do good and that there is a close connection between this world and the hereafter.

Conclusion

The chapter explored the Islamic responses to the COVID-19 pandemic in Zimbabwe. As the chapter has demonstrated, the Islamic communities in Zimbabwe are a force to reckon with in the quest for health and well-being in response to the COVID-19 pandemic and the development agenda through their cultural identities. Islamic cultural identities such as halal food, cleanliness or hygiene, holistic natural herbalism and environmentalism as well as spiritual and physically balanced lives engender creative and unique parameters that foster public health and human wellness in Zimbabwe. As the COVID-19 pandemic takes a downward curve, the chapter concludes by making a clarion call to the Zimbabwean government, policymakers, the international community and all stakeholders to include Islam in post-COVID-19 recovery initiatives and in any other future pandemics.

References

Aluko, Oluwasegun Peter. 2020. COVID-19 Pandemic in Nigeria: The Response of the Christian Church. *African Journal of Biology and Medical Research* 3(2):111-125.

Aslam, F. 2020. *COVID-19 and the importance of social distancing*. www.preprints.org. [Accessed 22 August 2022].

Chitando, E. 2003. Christianity in a Pluralistic Context: Religious Challenges in Zimbabwe. In J.L. Cox and G. ter Haar (eds). *Uniquely African? African Christian Identity from Cultural and Historical Perspectives*, 109-130. Trenton: Africa World Press, Inc.

Chitando, E. 2009. *Troubled But Not Destroyed: African Theology in Dialogue with HIV and AIDS*. Geneva: World Council of Churches.

Chiwara, A. 2013. Islam and Social Activism in Zimbabwe: A Phenomenological Investigation. In Ezra Chitando, *Prayers and Players: Religion and Politics in Zimbabwe*. Harare: SAPES Books.

Cox, J.L. 1996. *Expressing the Sacred: An Introduction to the Phenomenology of Religion*. Harare: University of Zimbabwe Press.

Del Castillo, Fides A., Hazel T. Biana, and Jeremiah Joven B. Joaquin. 2020. ChurchInAction: The Role of Religious Interventions in Times of COVID-19. *Journal of Public Health,* 42(3):633-634.

Dube, E. 2022. The influence of health perceptions on Zimbabwe Muslim responses to COVID-19 restrictions over Ramadan, pilgrimages and funeral rites in 2020. In Fortune Sibanda, Tenson Muyambo and Ezra Chitando, *Religion and the COVID-19 Pandemic in Southern Africa*, 202-212. London: Routledge.

Fatimah, I., Wan Abu Bakar WA. & Ng SC. 2008. *Solat: Kebaikan dari Perspektif Sains*. Kuala Lumpur: Universiti Malaya.

Hamid, A. 1989. *Islam the Natural Way*. London: Mels.

Jaja, Ishmael Festus, Madubuike Umunna Anyanwu, and Chinwe-Juliana Iwu Jaja. 2020. Social Distancing: How Religion, Culture and Burial Ceremony Undermine the Effort to Curb COVID-19 in South Africa. *Emerging Microbes & Infections,* 9(1):1077-1079.

Jansen, Perry. 2019. The Role of Faith-Based Organizations and Faith Leaders in the 2014-2016 Ebola Epidemic in Liberia. *Christian Journal for Global Health,* 6(1):70-78.

Kafe, E. 2020. 'Moana fnally rests', *The Sunday Mai,l* 29 November 2020.

Khalid, F.M. 2002. *Islam and Environment*. Chichester: John Wiley and Sons.

Magesa, L. 1997. *African Religion*: *The Moral Traditions of Abundant Life*. Nairobi: Paulines Publications Africa.

Mandivengerei, P. 2020. Zimbabwe: Mourners defy covid-19 regulations to bury Moana. *AllAfrica,* 29 November 2020, viewed 22 August 2022, from https://allafrica. com/stories/202011300356.html.

Manyonganise, M. 2013. The Zimbabwe We Wat Document: A Critique of the Ecumenical Response to the Zimbabwean Political Crisis. In Ezra Chitando, *Prayers and Players: Religion and Politics in Zimbabwe*, 143-157. Harare: SAPES Books.

Maposa, R. Sibanda, F. and Kwaramba, J. 2016. Linking Theology of Inter-Faith Dialogue and Humanitarian Service. In Musa Shojakhani, *Interreligious Dialogues in Zimbabwe*. Alhoda International Publishing.

Mapuranga, T.P. 2009. A Phenomenological Investigation into the Effects of Traditional Beliefs and Practices on Women and HIV/AIDS, With Special Reference to Chipinge District, Zimbabwe. Unpublished PhD thesis, University of Zimbabwe.

Marshall, Katherine, and Sally Smith. 2015. Religion and Ebola: Learning from Experience. *The Lancet,* 386(10005): e24-e25.

Mawil, I.D. 2013. Islam and the Environment: Towards an Islamic Ecumenical View. *Quranic: International Journal of Quranic Research*, 5(2):33-52.

Muyambo, T. 2022. Social distancing in the context of COVID-19 in Zimbabwe Perspectives from Ndau religious indigenous knowledge systems. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 Pandemic in Southern Africa*, 37-51. London: Routledge.

Mwale, N. & Chita, J. 2022. Standing together in faith through the time of COVID-19: The responses of Church umbrella bodies in Zambia. In F. Sibanda, T. Muyambo & E. Chitando (eds), *Religion and the COVID-19 Pandemic in Southern Africa*, 155-171. London: Routledge.

Picciaredda, S. 2020. 'Religions, Africa and COVID-19'. In P. Consorti (ed.), *Law, Religion and Covid-19 Emergency,* 109-118. DiReSom: Pisa.

Shaban, A.R.A. 2020. 'Ramadan 2020: Muslims Straiten rows for the locked down fasting', *Africa News*, 21 March 2020, viewed 10 August 2022 from http://www.africanews.

Sipeyiye, M. 2022. Coping with the coronavirus (COVID-19). Resources from Ndau indigenous religion. In F. Sibanda, T. Muyambo & E. Chitando (eds), *Religion and the COVID-19 Pandemic in Southern Africa*, 52-71. London: Routledge.

WHO, 2020. Coronavirus disease 2019 (COVID-19). Situation Report – 51. Retrieved from https://www.who.int/docs/default-source/coronavirus/situationreports/20200225-sitrep-36-covid-19.pdf?sfvrsn=2791b4e0_2 [Accessed 20 August 2022].

Lindah Tsara & Peter Masvotore

6 The Virus from Africa? The Religionization and Politicization of the COVID-19 Pandemic: Implications for Zimbabwe

Abstract

COVID-19 has caused a lot of havoc since its inception in December 2019, first in China and some parts of the world and in 2020 in Zimbabwe in particular. Due to the outbreak of this pandemic, the government introduced vaccination response to mitigating the spread as well as effects of the virus. It is expected that every adult of 16 years and above was subject to voluntary vaccination. This voluntary vaccination only excluded those who are pregnant and those breastfeeding. The reasons for not vaccinating the pregnant were not clearly highlighted. Conspiracy theories pertaining the effects of vaccines were and continue to be circulated online. Hence, this study seeks to establish the perceived effects of vaccines on sexual reproductive health as well as how the subtle force on people getting vaccinated is an infringement on their sexual reproductive rights. The focus of the paper is on finding out the link between COVID-19 vaccine hesitancy in Zimbabwe and sexual reproductive health and rights. In doing this, the study grapples with the following questions: 1. What are the reasons for vaccine hesitancy in Zimbabwe? 2. Why were the pregnant and breastfeeding in particular not being vaccinated? 3. How are some Zimbabweans perceiving vaccination in relation to their sexual and reproductive health and rights? 4. What religio-cultural beliefs and practices inform these perceptions? This chapter makes use of purposive sampling interviews and secondary sources. The chapter concluded that there are many reasons for low uptake of COVID-19 vaccine which include religious, health and political.

***Keywords*:** COVID-19, Sexual reproductive health and rights, vaccine hesitancy, Zimbabwe

Introduction

Omicron seems to be a politically contentious variant of the COVID-19 virus. The emerging reactions from the Global North about the omicron variant targeted at Africa are not backed by scientific evidence (Dakuku, 2021). Instead, the Western countries who are neo-colonialist demonstrate the existing ideology that often depicts Africa badly. Western countries' fear of doom coming from Africa fuels their overreaction. Europe and its powerful allies acted as if they are the exact representations and sole source of knowledge forgetting that Africa from time immemorial had indigenous knowledge systems that produced results which the world can tap on for its survival strategies. It is surprising to note that the spread and impact of COVID-19 particularly the Omicron variant was regarded as a phenomenal task for Africa and African governments. It was even more challenging when Western countries and their allies deliberately conspired to allow politics and economic nationalism, instead of science, to define the global response to a virus that Africa knows little about. Scientifically the origin, transmission and severity of the coronavirus, in all its manifestations, are still matters of contention among experts (WHO, 2020). From the day South African medical scientists raised the alarm about discovering the Omicron variant of the coronavirus, the Western world came out in full force to display its racist diplomacy against Africa. Critical thinking and scientific inquiry were discarded, and the new variant was inappropriately dubbed the "African virus".

The COVID-19 pandemic that wreaked havoc in most parts of the world from 2020 demonstrated that it was no longer a health issue only but a political and religious pandemic that calls for scholarly attention. African scholars have expressed dismay at the move by the United States of America, the European Union, the United Kingdom and other countries to block flights from several African countries following the sequencing of a new, potentially more transmissible variant of COVID-19. This had various mutations, which the Western countries has termed the virus from Africa since these variants are first discovered in Africa. Using a religio-political analysis lens to view the implications of the new variant of the fourth wave called Omicron, this chapter examines the origins of this variant and how the issue of COVID-19 as a whole has been interpreted from Africa and Zimbabwe in particular following responses from both politically and various Christians/religious formations. Furthermore, it

traces the reasons for punitive action by European countries to block African countries to enter into their territory. The chapter concludes by looking at the implications for Zimbabwe and suggests a way forward.

Definition of some concepts

It is prudent at this point to draw the readers to an understanding of this vicious virus code named COVID-19. WHO publicized that COVID-19 is the authorized name of the pandemic (WHO, 2019) WHO chief Tedros Adhanom Ghebreyesus further elucidated that,

> CO stands for corona
> VI stands for virus
> D stands for disease,
> While 19 is for when the outbreak was first identified
> on 31 December 2019 (WHO, 2019).

The name had been preferred to circumvent a direct mention to a particular geographical locality (e.g. China), mammal species or crowd of citizens, in line with global advices for naming meant to prevent stigmatization (Taylor-Coleman, 2020). According to WHO (2019), COVID-19 is a transmissible sickness caused by Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2). This type of illness was first discovered in December 2019 in Wuhan, a city in China that is located in the Hubei region. This pandemic spread internationally without exception (Hui et al., 2020; WHO, 2019). Additionally; the known Common symptoms include fever, cough and shortness of breath. Other symptoms may include fatigue, muscle pain, diarrhea, sore throat, loss of smell and abdominal pain. These and other symptoms may appear between two to fourteen days after exposure based on the incubation period of MERS- 225 COV viruses (Centre for Disease Control and Prevention (CDC, 2020a; WHO, 2019).

The new variant first discovered in South Africa is called Omicron SARS-CoV-2 B.1.1.529 (Chantel, Martinez & Ives, 2021). Scientists in South Africa identified the new variant with mutations that marked a big jump in evolution. According to Tulio de Oliveira the director of the Kwazulu -Natal research and innovation sequencing platform the B1.1.529 variant had a very unusual collection of mutations with more than 30 mutations in the spike protein alone (New York Times, 2022). The new variant Omicron had 10 mutations in comparison with Beta variant that has three mutations, the Delta variant had two mutations. Furthermore, the new variant was largely detected among young people, the cohort that also

had the lowest vaccination rate in South Africa. Just over a quarter of those aged between 18 and 34 in South Africa had been vaccinated as reiterated by Dr. Joe Phaahla, the country's Minister of health. This pressed a panic button to the whole world and nations reacted in different ways that also raised more questions than answers and stimulated debate among scholars.

Religion[1] and epidemics

Religious beliefs have always been a primary lens through which people have viewed and understood the experience of epidemic diseases. Religion entails the cultural practices and beliefs that have as their goal a relationship and communication between human beings and those (usually) unseen spiritual entities or forces that are believed to affect their lives (Westerlund, 2006). As anthropologists have noted, the dominant motif of a religion and its fundamental characteristics is often most clearly revealed in the ways in which it explains misfortune and sickness and by the steps recommended to avert them (Louise, 2008:597).

The most important role that religion plays in relation to epidemics is to explain what is happening in ways that make sense to a specific society and particular culture. Frequently, such explanations are in two dimensions which are firstly, looking upward to the supernatural realm and secondly, looking outward (or perhaps better, inward) to contemporary society (Bryne, 2008:596). Furthermore, epidemics are mostly understood as having been directed to the world by supernatural forces that are linked to one or many gods, demons, or spirits of the dead. In most cases, these heavenly beings are not seen as acting randomly, but as responding to particular human actions that offended them (Westerlund, 2006).

Pandemic diseases represent the world out of joint, a disastrous upset of the expected cosmic harmony. Religion aims to identify the causes, redress the problem, and restore good relations between heaven and earth. To do this, adherents draw on specially designated human intermediaries. These men and women be they priests, chanters, oracles, diviners, seers, prophets, soothsayers, exorcists, and other specialists are attributed with special skills and status that enable them to clarify the wishes of the supernatural powers and identify the human failings responsible. From

[1] Although the word religion is a compound name representing different types of religions, however, the focus of this chapter is limited to the Judeo-Christian religion due to space and time to cover all religions.

these individuals, too, would often come specific recommendations for remedial devotional and ritual action.

The history of humanity has always been characterized by pandemics. In the Old Testament, we learn that the deliverance of the Israelites from Egypt was possible after a series of pandemics and disasters that rocked Egypt (Exodus 7:20-10:13). While the term 'pandemic' is modern and was never used in the Scriptures, Hebrew and Greek words for pestilence and plagues are recorded at least 127 times in the Bible (Rosenberg, 2020). Gusha (2020) argues that since 165AD to 2015, pandemics have been killing people with the worst death caused by the Plague of Justinian (Byzantine) Empire around 541-542 CE that claimed ten percent of the world's population, followed by HIV and AIDS, a global pandemic that claimed over thirty -five million people, third was the American Plague of the sixteenth century that claimed ninety percent of the indigenous population (Gusha, 2020). From the arguments raised by Rosenberg (2020) and Gusha (2020), COVID-19 is one of the pandemics that humanity has experienced leading to the closure of the chapels, mosques, sanctuaries, shrines and temples across the world that fundamentally changed the way of being ecclesia, from being a Centre of healing to a platform of contamination and infection (Masvotore, 2021).

Pandemics, epidemics, and infectious diseases have long been the fatal challenges to human survival, greatly surpassing wars, accidents, and chronic diseases as a cause of mortality. They have been recorded in history books and have been knit into the fabric of religious cultures: examples include the Pharaonic "plagues" of the Old Testament and the many later "plagues" of ancient Greece and Rome (Louise, 2008:594). Be that as it may, much about viral diseases has transformed in the modern era, with the accessibility of vaccines, disinfectant therapy and other interventions; however, much remains unearthed and needs researchers to continue digging deeper for answers especially in the case of COVID-19. We still face the unpredictable appearance of new diseases such as COVID-19 appearing in different variants that goes through stages of mutations. The case in point was the new variant Omicron that invited different reactions and interpretation from both health and political practitioners.

Foucault (1977:166) identified what he called politics of health, where medical fraternity is infiltrated and draws its support from structures of power to downplay other forms of healing that are not scientifically proven (Masvotore, 2020:229). Furthermore,

> There is also the growth of a medical market in the form of private clienteles, the leeway of a network of personnel offering qualified medical attention, the development of individual and family demand for health care, the emergence of a clinical medicine strongly centered on individual examination, diagnosis and therapy, the explicitly moral and scientific (Foucault, 1977:167).

In this case, universal bodies such as WHO are seen to control the operations and sidelining faith healers whom they see as dump, but surprisingly people flock to them in numbers. From an analytical point of view, one can deduce that there is an issue of contested truth where there is imposition of Western knowledge and rules about evidence that is scientific.

This leads us to the Foucault's idea of the care of the identity where scientific practitioners are unconvinced of customary medicinal approaches centered on sciences of the personality, the psy-sciences, as Rose and Miller (1992) explained them, as well as their allied qualified specialists. Furthermore, Randal and Munro said:

> A joint journey led by the sufferer, where the self and other accept the account of suffering and the challenge of finding a way out of social isolation. Both the doctor and patient are seen as equals. In this case the idea of healing or care is rooted in a relation of mutual equality rather than of expert authority, and it is grounded upon willingness to share and accept the narrative of the other (Randal & Munro, 2010:26-27).

It is apparent that a major fraction of African sick people go for faith healing as a first preference in diverse cultures as well as believing in its efficacy (Puckree, 2002:247). Patients in sub-Saharan Africa, Zimbabwe in particular hunt for the cure of faith healers for every type of diseases including societal and psychosomatic matters. On the other hand, Masiiwa, Moyo, and Mujuru (2018) state that some prophets focus on handling particular health challenges and in case of emergency, they advise patients to seek formal health care facilities for treatment.

Critically the question being asked today is: has the COVID-19 pandemic created the ending of faith healing traditions in the globe, specifically in Africa and Zimbabwe in particular? This question has become necessary among scholars because a few days, weeks, months and years ago traditional and Christian faith healing declarations have been widespread. These claims included curing persons who suffer from different kinds of sickness, the sightless, lame or those with HIV and AIDS. Shockingly, subsequent to the COVID-19 catastrophe, practitioners and organizations that allege to have power over faith healing have retreated back to

the trenches (Masvotore, 2020:229). Some practitioners such as a Nigerian faith healer (Kungleo) said that he wanted to go to China to tear down the disease. According to Kungleo in a video that went viral, he declared that, "the critics, who are questioning God's power and ability to heal coronavirus, should bring patients of said disease for healing as proof that God is still the greatest physician." This was after the prophet had vowed to go to China to destroy Coronavirus personally using prophetic means (Kingleo, 2020).

Nevertheless, from the time when the disease was recognized in Nigeria, no one has heard from the seer of God including other highly praised faith practitioners in Zimbabwe and across Africa. Furthermore, they have been so silent and have declined to make any further claim to heal any infected human being. The questions to ask are; why? What has gone wrong? Could the reason be that faith healing is not effective anymore? Or else that faith healing is not applicable to coronavirus? As already indicated elsewhere in this chapter these and other questions can be answered by viewing the silence of faith healers not as a surprise but as issues embedded in politics of knowledge as demonstrated by Foucault (1977). The same developments where religious organizations were silenced giving priority to scientific medicine that took place during the nineteenth century are repeating. This is substantiated by Foucault when he indicated that:

> The progressive emplacement of what was to become the great medical edifice of the nineteenth century, cannot be divorced from the concurrent organization of a politics of health, the consideration of disease as a political and economic problem for social collectivizes which they must seek to resolve as a matter of overall policy (1977:166).

He further observes that:

> Medicine, as a general technique of health even more than as a service to the sick or an art of cures, assumes an increasingly important place in the administrative system and the machinery of power, a role which is constantly widened and strengthened throughout since the beginning of COVID-19. The doctor wins a footing within the different instances of social power (Foucault, 1977:176).

In Zimbabwe prophets such as Makandiwa divided Zimbabweans after contradicting himself on COVID-19 by backtracking on COVID-19 vaccines as he urges loyalists to get vaccinated. Throughout the COVID-19 pandemic, some conspiracy theorists in Christendom have interpreted

masks and vaccines as the mark of the beast. According to the Staff reporter of the Zimbabwean mail (2021) Makandiwa climbed down from his cautionary message that discouraged the inoculation. This was done after the call by the Zimbabwean President, Emmerson Munangagwa for religious leaders to support the vaccination programme. This indicates the political muscle that downplays religion. At the advent of COVID-19, all religious leaders were not considered to be front-line workers by most governments. It was only until the time the government hit a brick wall in calling for vaccination, that governments particularly in Zimbabwe realized that they need religious leaders to be at the forefront. This is because religion plays a crucial role in community development especially in Africa where most communities give spiritual or religious explanation to almost every natural disaster. Religious leaders command a greater following sometimes more than politicians or government and are found almost everywhere.

Race and epidemics

Race is among the most contentious factor used for understanding and tracking diseases in human populations. The classification of human groups under racial labels is largely a cultural creation and does not strictly correspond with biology (Byrne, 2008:588). For Alchon (2003) epidemic disease factors previously thought to be related to race are now known to be caused by cultural behaviors, socio-economic conditions, and environmental factors. However, race has been, and continues to be, used for scientific, political, religious, social, and cultural classification of human populations (LaVeist, 2002).

In other historical cases, the assignment of particular diseases to particular human groups, as defined by their "race," does not correlate with any biological explanation (Byrne, 2008:599). For instance, when the Black Death struck Europe in the fourteenth century, terrified Christians used ethnicity and religion to explain the origin of the disease (Humphreys, 2007). Further to that:

> Though defended by royal and religious authorities, Jews in many parts of Europe were accused of "poisoning" "Christian" water supplies to initiate the waves of pestilence over European cities. Because of these claims, mobs murdered hundreds of Jews, while local magistrates imprisoned and exiled others during the plague epidemics of the fourteenth centuries. In Spain the concept of "purity of blood" (limpieza de sangre) reinforced the

> intolerance for Jews that led to their expulsion in the late fifteenth century (Byrne, 2008:599).

The association of race with epidemics has a long history. However, it was not until the nineteenth century, with the work of the German naturalist J. F. Blumenbach (1752-1840), that race achieved its current status in the categorization of human groups (Hogan, 2001). Nevertheless, a nuanced scrutiny of the history of epidemic diseases demonstrates that rather than being conclusive, race is a temporal and unsolidified category, one that is not objective and does not relate to biological characteristics that determine susceptibility to disease (Byrne, 2008). Although it is undeniable that differences in immune responses have been responsible for the behavior of epidemic diseases around the globe, such differences are the result of cultural patterns or geographical location and not racial characteristics. This shows that Western countries made an error to dub the Omicron variant an African virus without scientific proof. Rather it became more politically generated as a biological weapon of war.

Politicization of COVID-19 and its implications to Zimbabwe

History is key to any suspicious development or allegation levelled against any country. According to Byrne (2008:53) South Africa's minority white government [was] historically known of having a modest programme to develop biological and chemical weapons for non-battlefield use, such as assassination and special forces use. Although this was voluntarily ended when the black majority government came to power in 1994, the scientific discovery of Omicron variant could have raised memories of Western countries about the ability of South Africa to develop biological weapons. Leitenburg (2004) avers that:

> Several other countries are suspected by Western intelligence agencies of trying to develop biological weapons, but the available evidence is quite weak, and it remains to be seen if any of these suspicions are true. In addition to suspicions that some countries may be trying to develop biological weapons, there have been periodic accusations that some countries have actually used them.

Politics indeed plays a role in health affairs, but it should not define the response to an epidemic requiring an evidence-based mechanism of con-

tainment. Viruses do not know colour, creed, nationality, or race. As revealed by COVID-19, humans across all strata and genealogies are exposed to this deadly disease. As such, drawing out a continent or group to target and discriminate against it is a folly taken too far (Dakuku, 2021).

On November 26 2021, the WHO labelled Omicron a "variant of concern", the fifth version (Alpha, Beta, Gamma, and Delta having come before it) of the virus to be thus marked out (WHO, 2021). Omicron generated quite a stir globally and put Southern Africa in the middle of it all. There were earlier predictions that the coronavirus would continue to mutate, and so this did not come to public health experts as a surprise. What may have caused the uproar was the West's response to the new variant. When South Africa broadcasted this new variant, the West recoiled back to its isolationist and xenophobic mode, and Southern Africa became a target of condemnation and judgement. The description and actions of Western countries directly labelled Africa's dominant historical 'story' as unsafe place with exotic diseases that threaten other parts of the world (Dakuku, 2021). Generally, one could have expected that the Global North community should praise South Africa for its timeous openness and scientific prowess for working hard to identify this new variant. Instead, the West was quick to close down the world on South Africa and Southern African countries, an action fueled by self-destructive nationalism.

This reaction can be interpreted as being instigated by political motives that are aimed at isolating Africa from the world and furthering the suffering of Africans economically. Thus, some African leaders the likes of South African President, Cyril Ramaphosa and Senegalese president, Macky Sall, did not hide their unhappiness at the opening of the 7th edition of the Dakar International Forum on Peace and Security in Africa to the actions of the West by saying:

> When South Africa scientists discovered, as President Macky Sall was saying, Omicron, the new variant they immediately took on the responsibility of informing the world, ... that a new variant has come through. And what is the result? The Northern countries impose a ban to punish the excellence that comes from Africa... They basically said we will not allow you to travel around but lo and behold, Omicron is spreading all over the world (Redaction Africa news, 2021).

Macky Sall further called for unity amongst world leaders at a time like this, in order to fight the pandemic by saying:

> We must continue to work together in solidarity. This pandemic, which is affecting all our countries, must bring us together on the side of solidarity

> in our response instead of adding a new divide between rich and poor countries (Redaction Africa news, 2021).

The two leaders accused the Western countries of giving only the crumbs to poor nations in their distribution of the vaccines. The fact that the comments are uttered at a forum of peace and security for African leaders demonstrates that the reaction by Western countries to bar South Africa and other African countries needed a political solution and African governments needed to come together and rebuke actions of the West.

Reacting to the same aspect of the variant, WHO's Executive Director posited that:

> It is really important that there are no knee jerk responses here, especially with relation to South Africa. South Africa is picking up interesting and important information for which we are doing the proper risk assessment and risk management. We have seen in the past that when there is any mention of a variant then everyone is closing borders and restricting travel. It is really important that we remain open and focused on characterizing the problem, not punishing countries for doing outstanding scientific work and being open and transparent about what they are seeing in Africa and what they are finding (Dakuku, 2021).

Furthermore, Guardian News reported that Dutch health authorities had announced that they had found the new Omicron variant of coronavirus in cases dating back eleven days before South Africa's announcement, indicating that it was already spreading in Western Europe before the first cases in Southern Africa were identified. Also, in many European, North American, and Asian countries, Omicron was seen in numbers sizeable enough to be of concern, but the reaction that followed did not target these countries but only African countries (Dall and Davies, 2021).

While the Western countries referred to the Omicron variant as the African virus, Zimbabwe's defense minister described the coronavirus as God's way of punishing the United States of America and other Western countries for imposing sanctions on Zimbabwe. Oppah Muchinguri, the defense minister, appeared to mock Western nations while addressing a group of ruling party supporters in Chinhoyi (a town in Zimbabwe's Mashonakand West province, when she said:

> This coronavirus that has come are sanctions against the countries that have imposed sanctions on us. God is punishing them now and they are staying indoors now while their economy is screaming like what they did to ours by imposing sanctions on us. Donald Trump should know that he

> is not God. They must face the consequences of coronavirus so that they also feel the pain (Mutsaka, 2021).

She also accused China of creating the virus. However, public health experts in Zimbabwe condemned these remarks which accused China of botched "experiments" as responsible for the outbreak of the coronavirus pandemic ravaging the world. President Emmerson Mnangagwa's government distanced itself from the accusations made in a tearful interview as the defense minister mourned a fellow minister lost to COVID-19. The move to distance itself from the utterances could have been done out of fear of direct political challenge to a sovereign state and China being one of the economic stable giants in the world, Zimbabwe could be isolated from foreign trade and partnership with its ally.

More so, the defense minister Muchinguri also said she would only take a COVID-19 vaccine if it is developed in Zimbabwe (Mutsaka, 2021). This agitated the deputy ambassador to Zimbabwe, Zhao Baogang who said:

> The embassy would only comment on the accusations by Defense Minister Oppah Muchinguri in the coming week after reaching Beijing as it was a "sensitive issue" (Mutsaka, 2021).

The reference to the matter being a sensitive issue proves that it was no longer a health matter but had degenerated into a political accusation that could avert a potential diplomatic fallout of Zimbabwe with China. Nevertheless, Zimbabwe's ministry of foreign affairs, distanced Harare from Muchinguri's remarks on the origins of the coronavirus disease. Constance Chemwayi, foreign affairs spokeswoman, said:

> Muchinguri's sentiments did not reflect the position of the government of Zimbabwe. Zimbabwe and China enjoy excellent relations. The government does not hold the Chinese government responsible for the emergence and spread of the coronavirus that has affected every global citizen. The government appreciates that China has exercised global leadership in efforts to find both the cause and a solution to the pandemic (Mutsaka, 2021).

As one ponders upon the developments that took place around the accusations and counter labeling on COVID-19 between the Western countries and Africa, one can conclude that, the statements, so far, from the West have all the trappings of intellectual and scientific incoherence. Once Africa is involved, the West suspends logical reasoning backed by scientific evidence and wears the cap of self-protectionism, discrimination, and fearmongering to paint Africa in a bad light (Dakuku, 2021). The

West acts as if when a variant is linked to a place it is detected first in, it must create many stigmas, and they (a healthy privileged population) have the right to blame someone. It is imperative to highlight that when a new variant is detected in a specific place, it does not mean it originated there; it may simply imply that professionals in the health area there did a good job and noticed it before anybody else. This knee jerk response of clamping down on some countries where omicron was found (many countries outside of Africa where scientists found it had not received the same level of punishment that African countries did) and shutting down flights from these countries were only justified due to the idea of stopping or delaying Omicron from reaching these countries.

The pertinent question at this point is, why is Africa targeted? Why are Africans enraged about the barrage of bans from the West? We must note with great emphasis that in 2020 when COVID-19 left Wuhan, it first infected many people in the U.S. and Europe before it reached Africa. However, African countries did not discriminate against those Western countries, nor did they ban flights from them in a knee jerk reaction, as these countries were doing now. Africans saw thousands of people infected in the West who died from COVID-19, but they did not discriminate or target the West for ridicule. Why is the West doing this to Africa now? This is only an extension of the dialogue of the imbalance between Africa and the West. Unfortunately, what ought to be a scientific debate has been overwhelmed by racist diplomacy and economic nationalism.

The response of the West in this issue of Omicron is indirectly related to how they have handled vaccination in poorer countries. They are yet to show real commitment to the vaccination in Africa and other developing countries generally. This has resulted in a threatening disparity. This wide gap between vaccination rates in the West, put at 70 per cent of the population, against the less than 7 per cent for Africa, is a reason for unchecked isolationism (Dakuku, 2021). Part of the protectionist policies was in shutting out Africa from the rest of the world, starting with air travel. Some countries banned flights from Southern Africa from coming to Europe, and other African countries were added later. The case of Zimbabwe being on the list, with its insignificant number of omicron cases, is unjustified. The Western countries have now rushed for a booster jab to prevent effects of Omicron variant and neglecting millions of Africans who have not yet received the first jab. This disparity between the haves and have not has been widening.

One can only imagine, given this approach, that had the first COVID-19 virus first identified in China last year originated in Africa, it is now clear that 'the world would have locked Africa up and thrown the keys away'. There would have been no urgency to develop vaccines because Africa would have been nonessential. This virus was already in three continents, and nobody locked away Belgium, Denmark or Israel. Why is the West locking away Africa? Politics played the major matrix than health concerns, hence, the need for academic introspection.

The Implication for Zimbabwe and Conclusion

The implications of this locking of Africa and Zimbabwe in particular were huge. There were psychological implications related to the emotional impact of Africans in general and Zimbabweans especially feeling discriminated against. There were also economic and social consequences due to the travel ban. The loss in productivity and revenue to businesses in the aviation and allied industries in Africa and specifically Zimbabwe within the period of the ban affected the economy. Given the timing of this ban, many Zimbabwean families abroad that had planned to travel back to the country to celebrate Christmas with their families had to call off their travel plans.

Perhaps, if the government had been challenging this hatred, as it did during the Mugabe era Zimbabwe would have gotten more respect. Dakuku (2021) avers that, nothing stops developing countries from engaging with the West more challengingly, if they act mockingly towards them. There is a need for mutual respect from all countries and continents, devoid of patriarchal sentiments and tendencies bordering on ideological apartheid and unnecessary supremacy inclinations that reflects a big brother syndrome. Omicron appears to have been a politically divisive variant of the COVID-19 virus. As indicated elsewhere in the chapter, the negative reactions about the Omicron variant targeted at Africa were not backed by scientific evidence. Instead, they reify the existing ideology that often depicts Africa badly. Western countries' fear of doom coming from Africa fuels their overreaction. Europe and its powerful allies acted as if they are the exact representations of overbearing patriarchy, they exploit, and use Africa as a resource base, whilst condemning it as a hell on earth (Dakuku, 2021).

The COVID-19 crisis is not about to end. There may be other mutations with even stranger names in the near future. Yet, one thing is clear:

The gains of globalization may be eroded by the history of this virus. Both the West and Africa stand to lose. China's interests will advance, as it keeps dealing with the virus as a scientific and economic challenge with hidden benefits. Africa must rise and seek collaborations and cooperation, instead of looking up to the West for salvation.

In conclusion, the discriminatory treatment of Africa should spur a renewed sense of Pan-Africanism and bring all African countries together to work for their collective good. Reliance on the West to solve Africa's problems reifies Africa's perception as a problem continent and the affiliated fear that goes with those negative sentiments about Africa that persists in the West. Africa has allowed the West to tell its story for too long, and it is time Africa takes back control of its narrative and engage with the world on better terms. Sometimes, it is difficult to blame the West for their knee jerk reactions to African issues. It comes from their existing perceptions of Africa as a corrupt haven, where poverty and disease are ravaging the continent that cannot help itself. Although this perception is not entirely accurate, Africa still engages from weak and needy positions with the world.

References

Alchón, S.A. 2003. *A Pest in the Land: New World Epidemics in a Global Perspective*. Albuquerque: University of New Mexico Press.

Bryne, J.P. (ed.). 2008. *Encyclopedia of Pestilence, Pandemics, and Plagues*. London: Greenwood Press.

CDC, 2020. 'How COVID-19 spreads', Centres for Disease Control and Prevention. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/prevent-gettingsick/how-covid-spreads.html [Accessed 6 June 2022].

Chuntel, L; Martinez, A.R. & Ives, M. 2021. South Africa detects a new variant, prompting new international travel restrictions. https://clubofmozambique.com>news [Accessed 6 June 2022].

Dakuku, P. 2021. Omicron: How politics infested a virus. The Cable news and views unlimited. www.the cable.ng [Accessed 6 June 2022].

Dall, N. & Davies, L. 2021. South Africa accuses UK and others of knee-jerk reaction to new variant, https://www.africanews.com>south [Accessed 7 June 2022].

Foucault, M. 1977. *Power/Knowledge selected interviews and other writings 1972-1977*. New York: Pantheon Book.

Gusha, I.S. 2020. 'Covid-19 and the politics of identity. Unpublished paper presented to the Zimbabwe Council of Churches E-leaning Platform', 16 May.

Hogan, K. 2001. *Women Take Care: Gender, Race, and the Culture of AIDS*. Ithaca: Cornell University Press.

Hui, D.S., Azhar, E., Madani, T.A., Ntoumi, F., Kock, R., & Dar, O. 2020. 'The continuing 2019-nCoV epidemic threat of novel coronavirus to global health: The latest 2019 novel coronavirus outbreak in Wuhan, China', *International Journal of Infectious Diseases*, 91:264-266. doi: 10.1016/j.ijid.2020.01.009. PMID 31953166.

Humphreys, M. 2007. *Intensely human: The health of the black soldier in the American Civil War*. Baltimore: Johns Hopkins University Press.

Kingleo, D.E. 2020. 'Major Prophet challenge critics to bring coronavirus patients for Healing', *YouTube channel Possibility TV*. Retrieved from https://iharare.com>local.

LaVeist, T.A. (ed.). 2002. *Race, ethnicity, and health: A public health reader*. Hoboken/NJ: Jossey Bass.

Leitenberg, M. 2004. *The problem of biological weapons*. Stockholm: Swedish National Defense College.

Louise, M. 2006. Religion and epidemics. In J.P. Bryne (ed.). 2008. *Encyclopedia of Pestilence, Pandemics, and Plagues*. London: Greenwood Press.

Masiiwa, G., Moyo, F. & Mujuru, L. 2018. 'Zimbabwe's ban of faith healing broadcasts gets Mixed reviews'. At https://globalpressjournal.com/africa/zimbabwe/zimbabwes-banfaith-healing-broadcasts-gets-mixed-reviews/ [Accessed 7 June 2022].

Masvotore, P. 2020. The healing practitioner has retreated back to the trenches: Healing and Spirituality during COVID-19. In R. Makamani, A. Nhemachena, and O. Mtapuri, *Global Capital's 21st Century Repositioning Between COVID-19 and the Fourth Industrial Revolution on Africa*, 221-243. Mankon: Langaa.

Mutsaka, F. 2020. Zimbabwe official says coronavirus punishes US for sanctions. https://apnews.com [Accessed 7 June 2022].

New York Times, 2021. 06 December 2021.

Puckree, T., Mkhize, M., Mgobhozi, Z. and Lin, J. 2002. 'African traditional healers: What health care professionals need to know.' *Intern J Rehab Res*, 25:247-251.

Randall, J. & Munro, I. 2010. Institutional logics and contradictions: Competing and collaborating logics in a forum of medical and voluntary practitioners, *Journal of change management,* 10(1):23-39.

Rosenberg, D. 2020. 'The air movement group'. At https://www.rosenberg-gmbh.com/en/infocenter/news/349-covid19-update-06112020 [Accessed 8 June 2022].

Rose, N. & Miller, P. 1992. Political power beyond the state: Problematics of government. *The British Journal of Sociology,* 43(2):173-205.

Staff Reporter, 2021. Makandiwa backtracks on Covid vaccines urges loyalists to get vaccinated. *The Zimbabwean mail*. https://www.thezimbabwemail.com [Accessed 8 June 2022].

Taylor-Coleman, J. 2020. 'How the new coronavirus will finally get a proper name', *BBC News*. At bbc.com/news/world-asia-china-51371770 [Accessed 9 June 2022].

Washington, H.A. 2006. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday.

Watts, S.J. 1997. *Epidemics and History: Disease, Power, and Imperialism*. New Haven/CT: Yale University Press.

Westerlund, D. 2006. *African Indigenous Religions and Disease Causation: From Spiritual Beings to Living Humans*. Leiden: Brill.

WHO, 2019. 'Naming the coronavirus disease (COVID-19) and the virus that causes it', World Health Organization. At https://www.who.int/emergencies/diseases/novel-coronavirus2019/technical-guidance/naming-the-coronavirus-disease- (covid-2019)-and-the-virus-that-causes-it [Accessed 9 June 2022].

WHO, 2020. 'COVID-19 advice for public', World Health Organization. Retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus2019/advice-for-public/ [Accessed 9 June 2022].

Bednicho Nyoni

7 COVID-19 in Zimbabwe: An Analysis of its Intersection With HIV, Gender And Ethics

Abstract

COVID-19 is a global pandemic that has send out shivers and quivers to all countries of the world, including the so-called First World Economies. Everyone is affected by COVID-19, but the impact is direct and indirect to public health emergencies and disproportionally on the most vulnerable. However, beyond health outcomes the wider impacts of the pandemic, including increased burdens of care giving, disrupted livelihoods, increased malnutrition and an increase in violence, have significantly and disproportionately affect women and girls in Zimbabwe. This chapter's objectives are to discuss key considerations on the public health response to the pandemic and its intersection with ethics in Zimbabwe. This chapter uses the qualitative research methodology of reviewing existing data through a desk research analysis method. The findings are that COVID-19 has severely affected women than men and has attracted dilemmas in the context of ethics in Zimbabwe.

Keywords: AIDS, COVID-19, HIV, Women, Girls, Zimbabwe, Ethics, Dilemmas Public Health

Introduction

On January 30, 2020, the Director General of the World Health Organization declared the outbreak of the corona-virus pandemic (COVID-19) as a Public Health Emergency of International Concern. With its alleged genesis in December 2019 in the 11 million populated Wuhan City of China, the historic COVID-19, unlike other pandemics of the past such as Ebola (of 1976 and 2014) and Spanish Flu (of 1918), has had its epicenters in the East, before shifting to Europe, the United States of America and last but least Africa. This was very unusual, as historically Africa has been scornfully known as the genesis and epicenter of diseases, among other horrors. Globally, hundreds of thousands of people have been infected and

thousands lost their lives (WHO, 2020). In Zimbabwe, the first case was recorded on March 20, 2020. Since then, the number of cases has been rising steadily but these days they are too low. Though the outbreak was still evolving in Zimbabwe, the potential impact of intense community transmission remains high. "The pandemic is the highest health crisis facing the world today and its social and economic impact are threatening to undermine development gains and progress towards the Sustainable Development Goals (SDGs)" (WHO, 2020). In Africa, the COVID-19 pandemic is evolving against the backdrop of a difficult macro-economic environment, climate shocks efforts to save lives, protect people, and rebuild better, alongside the health response and humanitarian response.

The number of confirmed COVID-19 cases in Africa was relatively low until mid-April 2020, but it should be noted that levels of testing to date have been very limited in Africa. However, South Africa is the highest in COVID-19 cases compared to other countries in the continent. CARE International says that in response, African governments imposed lockdowns and curfews requiring self-quarantine and restricting gatherings and movement of people. Although critical in slowing the spread of the pandemic, these measures can themselves impose significant social and economic costs, especially for millions of people in Africa living in urban slums, informal settlements or overcrowded refugee camps, often with poor access to health care, clean water and sanitation (CARE International, 2020).

Furthermore, the African continent includes remote and rural areas where both access to health services and basic information about the disease and means of prevention is limited. While preparedness and response to previous epidemics such as Ebola provides a strong foundation for some countries such as the Democratic Republic of Congo, to tackle the spread of COVID-19, most countries in Africa have little or no prior experience in response to such a pandemic (WHO Africa, 2022). WHO Africa notes that, beyond health outcomes, the wider impacts of the pandemic, including increased burdens of care giving, disrupted livelihoods, increased malnutrition and an increase in violence, will significantly and disproportionately affect women and girls (WHO Africa, 2022).

Methodology

The chapter used a qualitative research methodology of reviewing existing data through a desk research analysis method. According to Creswell

(2009) a desk study is collecting data without fieldwork. It can further be defined as secondary analysis which means "an analysis of an existing data which presents interpretations, conclusions or knowledge additional to, or different from, those presented in the first report on the inquiry as a whole and its main result" (Hakim, 1982:1).

Contextually this chapter used the term 'desk research' in a wider spectrum to embrace all information gathered without the involvement of a field survey. The use of this method employs gathering data from libraries and the internet. Additionally, desk study analysis is examination of information that was assembled by somebody else intended for a different main purpose (Masvotore & Tsara, 2019). The use of existing information presents a feasible alternative for the researcher who could have inadequate resources and time for fieldwork. Desk study analysis is a pragmatic method that utilizes similar fundamental research ideology as studies using primary data and has rules to be pursued just as any research method. In as much as secondary data scrutiny is further defined as a logical research method, however, not many frameworks are obtainable to direct researchers as they carry out desk research data analysis (Andrews et al., 2012; Smith et al., 2011).

In this chapter, the researcher conducted the research through accessing sources from the internet, news articles, published books, articles and journals based on the lockdown as indicated elsewhere. In a bid to fill in these gaps, the study made use of published materials from World Health Organisation (WHO) on COVID-19 and information from published sources, for a cautious deep in thought assessment and decisive appraisal of the data as a mitigating measure to avoid most limitations of desk research methodology (Boslaugh, 2007; Dale et al., 1988; Kiecolt & Nathan, 1985).

COVID-19, HIV and African Ethical Dilemmas

African ethics signifies a set of values, which a person, rooted in Africa, ought to maintain for making correct judgments and for interpreting life experiences. There are a number of moral and ethical problems in the African context. These include COVID-19, HIV and AIDS, corruption, the individual and the community, female genital mutilation, rape, abortion, widow inheritance, homosexuality, and land issues. In this section, we focus on two selected moral and ethical issues around HIV and AIDS as well as the COVID-19 pandemic. COVID-19 coupled with HIV and AIDS have become two of the most debilitating ailments affecting every sector

of life in many countries in Africa in the 21st century. In addition to their taking many lives and causing much suffering, they have impacted negatively on socio-economic development in many countries by undermining many efforts towards economic growth, poverty alleviation, and better quality of life. Their effects in the region cannot be underestimated. For instance, they can cause a reduction in production due to reduction in human resources, can lead to an increased cost of health care, and leave behind many orphans. In dealing with these challenges, one cannot avoid making some ethical decisions. Southern Africa is the region most affected by COVID-19 and HIV worldwide with HIV prevalence rates peaking between 10 and 40% of the adult population (WHO, 2021). According to WHO, as of 7 July 2021, there have been 493 131 cases of COVID-19 and 11 643 deaths reported from the African continent – a 25% increase in cases and 18% increase in deaths. WHO worked closely with Ministries of Health and other partners in the African region to support the strengthening of essential health services in managing the COVID-19 pandemic. WHO continued to advise and support countries to strengthen both emergency and routine health services and to maintain influenza surveillance and other disease control strategies (WHO, 2021). As countries began to reopen borders and resume air travel, including commercial flights, WHO urged governments to take effective measures, including entry and exit screenings and the practising of hand hygiene, cough etiquette and physical distancing measures, to mitigate the risk of a surge in COVID-19 transmission due to the resumption of commercial flights and airport operations (WHO, 2021).

According to UNAIDS Report on the global HIV and AIDS epidemic (2004), the approximate percentages of HIV prevalence rates for adult population (15-49) in some African countries are: Botswana 37.3%, Zimbabwe 24.6%, South Africa 21.5%, Zambia 16.5%, Malawi 14.2%, and Mozambique 12.2%. These figures show that HIV and AIDS is a significant problem in the region despite declining trends in some countries like Zimbabwe. In Zimbabwe, for example, HIV prevalence rate peaked around 1997 at 26.5 % in the adult population and declined to 14.3 % in 2009 (MoHCC, 2010). This decline has been attributed to changes in sexual behaviour since 1999 in which fewer young people have casual or multiple sex partners and many young people use condoms with non-regular partners.

There are some specific practices in Africa that facilitate the spread of the COVID-19 as well as HIV and AIDS pandemic and give rise to several

ethical dilemmas when one attempts to overcome them. These practices, either directly facilitate the spread of COVID-19 as well as HIV and AIDS infections, or indirectly frustrate the efforts to control the spread of infections and caring for the infected and affected people. The subsequent issues bring to light some of these practices, and show how ethical knowledge is relevant in addressing the moral issues involved.

Stigmatisation

The first problematic practice is discrimination against COVID-19 as well as HIV and AIDS victims (women and men) by some members of the family and the public, which lead to a serious stigmatisation on the side of the victims. Stigmatisation undermines the dignity of the victims. Most people who are infected by both aforesaid ailments experience a lot of segregation in various ways. Some victims have lost their jobs; some cannot be hired to work in some businesses based on their COVID-19 positive status, while others have been deserted by their close relatives and friends. Lack of understanding of the way COVID-19 as well as HIV and AIDS is caused and spreads, scares people and makes them too naïve to believe that if they share things like kitchen utensils, catering utensils and toiletries with the victims in the case of HIV and AIDS, they will contract the disease. Other people hold a rather more naïve belief that even shaking hands may transmit HIV infections. Additionally, is a mistaken notion that COVID-19 as well as HIV and AIDS are punishment from God due to humans' evilness in the context of COVID-19 and promiscuity and or consumption of illegal drugs in the context of HIV, respectively. Absorbed in this false view, some people feel justified in segregating against COVID-19 and AIDS patients arguing that they ought to carry responsibility of their reckless habits without bothering others. This harsh treatment exemplify stigma among COVID-19 as well as HIV and AIDS victims. Stigma causes severe psychological and physical suffering on patients and hastens the deterioration rate of their health (Bilton et al., 2002).

Stigmatisation raises a big moral dilemma as it frustrates the whole understanding of human dignity. It raises the question, whether, the dignity of a person varnishes when she or he falls sick or not. The basic question is whether relatives and close friends, have no moral obligation to take care of HIV and AIDS victims irrespective of the way one may have contracted the disease. Likewise, stigmatisation evokes another question of whether it is morally right for an employer to retrench her or his employee once she or he happens to contract COVID-19 and HIV infections

even when the employee is still capable of carrying his or her contractual obligations after being negative in case of COVID-19. On one hand, reasons like efficiency, effectiveness of employees, and the returns on the employer's costs of hiring and training his/her employees, provides ground for why employers should terminate contracts of employees who contract COVID-19 and HIV infections. On the other hand, there are reasons for maintaining employees with HIV and AIDS positive status (Bilton et al., (2002) for such victims need love and care, and as sick persons, it is their right to be cared for first by those whom they are working and living with.

This dilemma leads to the conflict of rights and responsibility. For example, do relatives, employers, and friends have a moral 'obligation' to care for their COVID-19 and HIV victims? That is, do the victims have a 'right' to be cared for by those who are well, irrespective of how they contracted the disease? A reconciliation of such clashing views underscores an application of ethical norms since it is inevitable to make informed and balanced decisions on how to take care of COVID-19 as well as HIV and AIDS victims without application of ethical knowledge. It is important to appreciate that God has control over human life; God grants the sanctity of life; one cannot determine the beginning of life neither can one determine its end. Therefore, life should be nurtured and protected to its natural end. While suffering is not a value in itself, it does not diminish human dignity for human value comes not from what a person has, but from what a person is (Filibeck, 1993).

False Confidentiality

Second, an attempt to avoid stigmatisation in many parts of Africa, somewhat yields to a sense of false confidentiality and exacerbates the COVID-19 as well as HIV and AIDS problems. When a person dies of COVID-19 or HIV, for instance, it is very common for the relatives to give a false explanation for the cause of the death. For example, while fully aware that their relative died of COVID-19 or AIDS, they can say that he or she died of typhoid. The reason behind is that they are trying to avoid stigma, a negative feeling that their relative died of a shameful disease. The ethical problem here is that hiding the truth about COVID-19 or HIV and AIDS under the pretext of confidentiality causes more harm because some people will keep thinking that COVID-19 or HIV and AIDS is a predicament for 'others' and they are exempt. Furthermore, if the relative died from COVID-19 it means all her/his contacts should be stigmatized

and eventually quarantined, hence, most relatives would prefer to lie (if the person is buried without being tested by health workers or physicians through the Ministry of Health and Child Care). This is false confidentiality that attracts African ethical dilemma.

Hiding the truth that COVID-19 or HIV and AIDS kills indiscriminately, is unethical because that does not raise people's awareness to change their life style, especially their sexual habits in the context of HIV. The moral dilemma is whether the relatives and physicians should maintain the confidentiality on information about COVID-19 or AIDS victims, and risk more lives, or breach confidentiality for the sake of inherent value of life. Such dilemmas are also found on similar issues like whether it is ethical to perform mandatory COVID-19 or HIV test on patients, and whether in the event of positive findings, their contacts or partners ought to be informed irrespective of the patient's consent. Although ethical knowledge may not provide us with precise ways of dealing with such dilemmas, still it is a means of making informed and balanced decisions.

Most Africans may appeal to forces such as witchcraft and superstition when they contract COVID-19 or HIV or when their relatives or friends are infected. The practice of blaming witchcraft for the cause of illness, for example, is common in some African cultures; yet there is no causal link between witchcraft, COVID-19 and HIV. Such attitude and false belief concerning illness of individuals may cause others not to change their behaviour making them more vulnerable to COVID-19 or HIV. Thus, there is a need to constantly prick the conscience of the population in order to honestly raise the level of COVID-19 as well as HIV and AIDS awareness among the people of Africa. This may lead to changes in attitude and behaviour in an effort to combat the spread and effects of the pandemics.

Cultural Practices

Third, some cultural practices in African tradition such as widow inheritance, polygamy, and male supremacy create dilemmas in HIV and AIDS pandemics. An example is the practice of widow inheritance and the polygamous behaviour among some African ethnic groups. Some cultural groups hold a belief that in the event of death of a husband, a relative of the deceased must inherit the widow. In this case, what if either COVID-19 or HIV is still dormant inside the widow? In many cases, no clinical examination is carried out to ascertain if the death was not due to

COVID-19 or HIV infections, especially in deep rural areas, and if the widow's COVID-19 or HIV status allows her for re-marry. As a result, if the husband died of COVID-19 or HIV infections, and he had infected the widow, then the infections are easily carried across not only to the inheritor but also to the inheritor's formal wife. Therefore, even if they have to re-marry, it is crucial that they undergo COVID-19 and HIV test in order to make informed decisions. Akin to the practice of widow inheritance, is the fact that some African cultures are still at home with polygamy and cohabitation behaviour. Polygamy and cohabitation practices are condemned because they promote reckless sexual behavior as well as compromise social distance, and hasten the transmission of COVID-19 or HIV infection. There are other practices and behaviours within African cultures like traditional circumcision, female genital mutilation, and vigil traditional dances that expose people to some possibilities of contracting HIV infection.

An attempt to limit both polygamy and widow inheritance practices in order to curb the spread of COVID-19 as well as HIV infections touches a controversial issue of freedom and human rights, making the whole attempt ethically alarming. According to Tauer (1988), the international declaration of human rights shows that any individual is entitled to: (**i**) the right of personal privacy and confidentiality regarding medical and sexual information; (**ii**) the right to free movement within one's country and to associate where and how one chooses; and (**iii**) the right to pursue one's economic good, without limitation based on irrelevant grounds for example, sex and sexual preference. The real ethical dilemma here is whether COVID-19 or HIV and AIDS control programmes in Africa should observe these rights and risks losing more lives or rather trespass them and defend life. This dilemma again presents us with rights and duties at odds. An ideal decision in this matter presupposes an application of ethical norms (Tauer, 1988). Thus, there is a need to try to reconcile rights and duties.

Another ethical dilemma is the question of male supremacy. Among some African ethnic groups, women are expected to express a high sense of submission to men. As a result, most married women have no active voice before their husbands. They are not free to protest effectively against various forms of oppression exercised by their husbands. They have to carry out and fulfill the wishes of their husbands irrespective of their own wish. In such cultures, women who try to criticize their husbands are taken to be disobedient, and they risk divorce and humiliation. This kind

of male supremacy, which finds grips on culture, has negative implications on the fight against the spread of COVID-19 or HIV and AIDS infections. It reinforces 'blind female docility', and hence, puts off any effort to challenge those husbands who engage in extra marital affairs. Although this practice exposes even faithful wives to HIV infection, still some African cultures ignore this problem by affirming male supremacy while undermining women's right to protection of life. Moreover, in the event of unfaithfulness in marriage in the context of HIV, as we have just seen, the ethical dilemma is whether such a wife still has the moral duty to honour her wedding promises, remains married and jeopardize her life owing to the reckless behaviour of her husband, or to be morally free to break away. In contrast, does the husband have a right to claim compensation in case of divorce? This complicates the situation even further.

Funerals

African ethics is embedded with communalism. If everything that exists is in an organic relation to everything else that exists, then the same applies to how human beings interact. People are not individuals, living in a state of independence, but part of a community, living in relationships and interdependence. In contrast to the Western approach, one does not claim personal rights and freedoms but rather fulfills one's communal obligations and duties. Van der Walt (1991) lists some forty characteristics of African communalism that contrast with Western individualism. These characteristics can be summarized in terms of communal self-respect, interdependence, survival of the community, group assurance, cooperation and harmony, affiliation and shared duties. This concept of community is not restricted to the community of human beings alone, but embraces a communal attitude to the world of the spirits and ancestors as well as to the world of nature.

Furthermore, African ethics embraces communalism in relation to fellow human beings. A traditional African community consisted of clans with different histories, emblems and taboos and also their sub-clans and kindred (lineage system). Villages were occupied by fairly well localized kindred, although some might include people who did not belong to the principal group in the village. At the next level of organization was the household, which consisted of a small social group of parents and children.

This system of relationships has been seriously disrupted by the sudden appearance of COVID-19, compounded by HIV and AIDS. There is

African ethical dilemma when it comes to attending a funeral in a village or community or location. African traditional societies and communities as well as villages were used to attend funerals in their numbers and could easily comfort the deceased's family members without distancing themselves from each other. This communalism was disrupted in March 2020 when most African governments announced lockdowns and implementing all rules and regulations set by the World Health Organizations (WHO). Funerals are sacred in Africa and everyone in the community or village must attend to show solidarity and grieving together with the deceased's family and relatives. The African ethical dilemma came when attending a funeral since it allowed a few selected numbers of people from family, relatives and friends, when mourners were not allowed to stay overnight outside their home, when there were requirements to wear face coverings in indoor places of worship and burial grounds, when there was need for physical distance of at least two meters apart from each person and when there are requirements to self-isolate for 14 days for those with symptoms of COVID-19. Furthermore, the COVID-19 pandemic disrupted many aspects of daily lives, such as general movement to shops and towns as well as visiting friends and relatives, but its impacts are especially acute for working people who lost their jobs, to this end they are struggling to feed their families. Although, these restrictions were to save life, the new normal brought by COVID-19 jeopardized African ethics that is embedded within Ubuntu and communalism.

Another barrier involves adopting recommended public health strategies, such as social distancing and washing hands. Hence, frequent handwashing is not always feasible for people with certain types of physical disabilities. The last issue is equitable access to health care for people with disability, since it is a long-standing barrier worsened by COVID-19. This ranges from getting a coronavirus test to being prioritized in access to health services.

Gender Roles and Responsibilities in the Context of COVID-19

The majority of health workers are women and that put them at the highest risk. Most of them are also parents and care givers to family members. They continued to carry the burden of care, which is already disproportionally high in normal times. In fact, this put women under considerable stress. According to (UNFPA, 2020: n.d),

> in Africa, women carry out at least 3.4 times more unpaid care work than men. The prevalence of these harmful social and gender inequalities mean that the COVID-19 crisis increased women's unpaid care and domestic work. The most Profile of unpaid care work in Africa is that of a woman between 15-54 years old with few economic resources, several children, a low level of education, and often, health problems or disabilities who simultaneously works for pay or profit in the informal economic and receive little or no formal care support.

It is important to note that, women are also responsible for caring for the sick, the elderly and the orphaned. COVID-19 and HIV prevalence, especially in East and Southern Africa, has resulted in orphaned children mostly cared for by grandmothers. In addition, most of the African countries announced country-wide temporary closure of schools. According to African Development Bank Group (2015) increased child care is expected to further stretch women's existing household and community burdens. It further notes the way Africa displays how the COVID-19 outbreak places a three-fold care giver burden on women and girls. For example, they are responsible for household-level disease prevention and response effort, at greater risk of infection, and subject to emotional, physical, and socio-economic harm. This being the case, women and girls are always at the receiving end of negative effects in any society throughout the continent of African and beyond.

COVID-19 and Women's Economic Empowerment

The COVID-19 pandemic and measures taken by governments to suppress it is likely to have a significant and sustained negative impact on the economics of the countries in Africa. Even in a best-case scenario growth domestic product (GDP) growth is expected to be reduced by half, pushing close to 27 million people into extreme poverty (UNSTATS, 2020). This impact will fall disproportionally on women and girls. Across Africa, women are less likely to have access to and control over productive costs and resources such as land. In CARE's rapid gender analysis following Cyclone Idai in Mozambique and Zimbabwe in 2019, all women respondents stated that they did not own the land they worked on (CARE International, 2020). More so, if their husbands died, women told CARE that the land would pass to his family and may face eviction resulting in disempowerment (CARE International, 2020). Women face widespread discrimination in the distribution of other services and opportunities, such

as credit, training, employment opportunities, mobility, climate and market information services, inputs and technologies. The roles and rules in producing, processing (including cooking) and marketing food is often divided along gender lines and continued imbalance in gender relations perpetuate cycles of poverty for women and girls. Furthermore, the impact of COVID-19 on education is the most severe in countries that already have poor learning outcomes, high dropout rates and low resilience to shock, further widening the gender gap. Dropouts' rates are higher among girls than boys due to pregnancy and child marriages, a situation likely to worsen due to school closures. Closure of schools in Africa, for example in some areas in Zimbabwe, has not only affected children's access to education, but also to food.

Recommendations

The study recommends the following:

- Women and girls in Africa have limited access to information and low literacy rates and should, therefore be consulted in the design of awareness materials, methods of communication and imagery should be gender sensitive.
- Public health actors and governments should ensure systematic, meaningful engagement of women, adolescent girls and people with disabilities in all COVID-19 as well as HIV and AIDS decision-making on preparedness and response at the national, provincial and community levels, including within their own structures, to ensure efforts and responses are not further discriminating and excluding those most at risk.
- Governments and local authorities should ensure that policy decisions related to COVID-19, in particular those on restricted movement, are gender sensitive and do not disproportionately compromise women's access to health, water, sanitation and hygiene (WASH) as well as sexual and reproductive health and rights (SRHR) services or compromise their food security and nutrition in the case of HIV and AIDS.

Conclusion

COVID-19, HIV and AIDS in Africa in general and Zimbabwe in particular, is a public health crisis, but one compounded with complex socio-economic and political challenges and inequalities, particularly around gender. Lack of resources, limited health services, large vulnerable populations and low economic capacity means the impact will be profound. The outbreaks affect women and girls in Africa in significant ways, education, food security and nutrition, livelihoods and safety and protection. Women are the primary care givers in the family and are also the key frontline responders in the health care system, placing them at increased risk of exposure to infection. The outbreak of COVID-19 also burdens women by adding their existing gendered household and community roles.

It is evident from the discussion above that COVID-19, HIV and AIDS pandemics have brought more African ethical dilemmas in relation to gender. Providing essential maternal, sexual and reproductive health services during the emergency and strengthening protection is crucial. Interventions must seek to identify the needs of the most vulnerable, that is, women and girls and ensure their representation and participation in the response process. Engaging men and boys during the COVID-19 response is crucial to mitigate unhealthy masculine behavior and support positive male and female roles in the crisis.

References

African Development Bank Group 2015. *Empowering African Women: An Agenda for Action: Africa Gender Equality*. https://www.afdb.org/fileadmin/uploads/afdb/documents/publications/africangenderequality [Accessed 11 April 2022].

Bilton, T. et al. 2002. *Introductory Sociology*. 4th Ed. London: Palgrave Macmillan.

CARE International. 2020. *Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings*. March, 2020. https://unstats.un.org/unsd/genderstatsmanual/print.aspx?Page=Refugees-and-intrenally-dispalaced-persons [Accessed 11 April 2022].

COVID-19 Food Security Alert. 2020. 30 March 2020. https://reliefweb.int/sites/reliefweb.int/files/resources [Accessed 12 April 2022].

COVID-19 Lockdown. 2022. GBV: https://www.power987.co.za/news/COVID-19 [Accessed 11 April 2022].

Filibeck, G. 1993. *Human Rights in the Teaching of the Church: From John XXIII to John Paul II*. Vatican City: Libreria Editrice Vaticana, 1993.

Gender Statistics Manual: https://unstats.un.org/unsd/genderstatmanual/print.aspx?page=refugges-and-internally-displaced-persons [Accessed 20 May 2022].

Girls not Brides. 2015. https://www.girlsnotbrides.org/wp-content/uploads.2015/02/child-marriage-in-africa-a-brief-by-girls-not-brides-pdf.

Government of Zimbabwe. 2010. Ministry of Health and Child Welfare, 2010.

Odhiambo, A. 2020. Tackling Kenya's Domestic violence Amid COVID-19 Crisis. *Human Rights Watch*, 08 April 2020.

Tackling Kenya's Domestic Violence Amid COVID-19 Crisis 2020. https://www.hrw.org/news/2020/04/08/tackling-kenyas-domestic-violence-amid-COVID-19-crisis [Accessed 10 June 2022].

Tauer, Carol. 1988. "AIDS and Human Rights: An international Perspective". In C. Pierce & D. Vandeveer (eds). *AIDS: Ethics and Public Policy*, 154-169. California: Wadsworth.

UNFPA. 2020. *COVID-19 Preparedness and Response*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19 [Accessed 18 June 2022].

UNFPA. 2020. *COVID-19 Preparedness and Response: UNFPA Interim Technical Brief Gender Equality and Addressing Gender-Based Violence (GBV) and Coronavirus prevention, protection and response*, 23 March 2020.

UNICEF. 2021. Child Marriage: Latest Trends and future prospects https://data.unicef.org/resources/dataexplorer/unicef. [Accessed 15 June 2022].

van Der Walt, B. J. (ed.). *1991. Cultural Diversity in Africa: Embarrassment or Opportunity*. Potchefstroom: IRS.

World Food Programme: https://africanlin.org/article/20190718/human-trafficking-reports-show-sub-saharan-africa-global-player [Accessed 10 July 2022].

World Health Organization. 2022. *Africa concerned as COVID-19 cases accelerate in Africa*. https://www.afro.who.int/news/who-concerned-COVID-19-cases-acelerate-africa [Accessed 9 July 2022].

World Health Organization Africa. 2022. https://www.afro.who.int/news/who-concerned-COVID-19-cases-acelerate-africa [Accessed 15 June 2022].

World Health Organization. 2022. Africa WHO concerned as COVID-19 Cases Accelerate in Africa (02 June 2022).

Tawanda Matutu

8 COVID-19 AND THE ETHICS OF CARE: REVISITING UBUNTU PHILOSOPHY

Abstract

The effects and management of the COVID-19 pandemic have brought Care ethics and Ubuntu philosophy into academic speculation. With the absence of cure for the pandemic, the World Health Organisation (WHO) promulgated a number of mitigation and containment measures such as social and physical distancing, washing of hands and wearing of masks. At the same time, the devastating effects of this invisible enemy called for the ethics of care. Care ethics is defined by character traits that include care, sympathy, compassion, trust, fidelity, love, and friendliness. These traits resonate well with the philosophy of Ubuntu which is anchored on the maxim '*umuntu ngumuntu ngabanye*'. The maxim emphasizes the pre-eminence of collectivism over individualism. It is this collectivism that defines humanness. However, the COVID-19 containment measures such as social and physical distancing, seem to be in apparent conflict with the main tenets of Care Ethics and the philosophy of Ubuntu. The measures do not seem to promote friendliness and collectivism. This paper, therefore, aims to explore the ways of harmonizing the philosophy of Ubuntu and care ethics with the protocols in the management of COVID-19. Data for the paper were gathered mainly through document analysis, that is, published books and newspaper articles as well as interviews, mostly, with people who have been affected, directly or otherwise, by the pandemic with respect to Ubuntu and care ethics. The paper also made use of relevant literature such as newspaper articles.

Keywords: care ethics, COVID-19, management, philosophy, Ubuntu

Introduction

Issues surrounding the COVID-19 pandemic have ignited the need to revisit the philosophy of Ubuntu. This need emanated from the seeming conflict that exist between COVID-19 control measures and the traits of Ubuntu. Ubuntu is largely a communitarian philosophy, which thrives on human relations. The measures, which include physical distancing, that

is the minimization of social gatherings, essentially meant the closure of the space to practice Ubuntu. In African societies, people regard issues of sickness and death as communal rather than individual affairs. As such, it is outside the realm of Africanness to fail to care for the sick for whatever reason. The restrictions placed around access to COVID-19 patients have rendered the philosophy of Ubuntu almost null and void since the care rendered to patients is perceived as vehicles in the spreading of the virus. However, at the same time, the patients required great care since the severity of the disease could sometimes be so dire that maximum care would be necessary if the patients were to have any chances of survival. Ubuntu care extends beyond just visiting the sick and calls for care, interdependence, reciprocation and communality. However, with the advent of COVID-19, all these values were perceived to be contributory factors to the spread of the disease. This chapter examines the concept of Ubuntu in general before unpacking the inherent nexus of Ubuntu and care. This is followed by an analysis of the opportunities and challenges presented by Ubuntu and care ethics in the face of COVID-19. Finally, the chapter proceeds to show the need to re-visit Ubuntu. The chapter attempts to answer the following questions: What is the link between Ubuntu Philosophy and Care ethics? What are the challenges and opportunities raised by the ethics of care in the face of COVID-19? How can the various aspects of Ubuntu be re-visited to align the philosophy with the COVID-19 induced new normal? The research employed the qualitative research methodology. Data for the paper were gathered mainly through document analysis, that is, published books and newspaper articles as well as interviews. Ten people were selected for interviews. Of these ten, five are from Harare and five were from the rural area, Ward 2, Mwenezi district. The Interviewees were coded as Interviewee A-Interviewee J for the sake of identity protection in line with research ethics. Interviewee A-E are from Mwenezi while F-J are from Harare.

The Concept of Ubuntu

It is imperative that an analysis of the concept of Ubuntu be considered first and foremost in this chapter. This helps to clear the ground for the whole discussion. Ubuntu is a term derived from the Bantu-Nguni languages of Zulu, Xhosa, Swati, and Ndebele (Samkange, 1980). The term is the equivalent of the Shona *hunhu* and can be described as a social philosophy (Samkange, 1980). It embraces a spirit of caring and community,

harmony and hospitality, respect and responsiveness (Mangaliso, 2001). It can further be described as the capacity for compassion, reciprocity and dignity. The hallmarks of Ubuntu are harmony and continuity. It is about understanding what it means to be connected to one another. The concept expresses an African view of the world which is anchored in its own culture and society and this notion is unique and thus difficult to define in a Western context. At the heart of Ubuntu is the relationship with others. Ubuntu encourages humanness and recognises the sanctity of human life. No individual is more sacred than another. The respect of another's basic humanity is absolute.

The African community has been traditionally built on strong relationships, participation, social responsibility and interdependence. Ubuntu inspires individuals to expose themselves to others and to encounter the difference of their humanness to inform and enrich their own. The typifying phrase is '*umuntu ngumuntu ngabanye'* or '*Umuntu ngumuntu ngabantu'*. Literally translated, this means "A person is a person through other persons" (Mulaudzi & Peu, 2014; Mulaudzi, Libster & Phiri, 2009). Another catchy phrase is "I am, because we are" (Metz, 2019) which Van der Merwe (1996) has translated as "To be is to affirm one's humanity by recognising the humanity of others in its infinite variety of content and form."

Ubuntu respects the particularities of the beliefs and practices of others. This is well illustrated by another common expression, *ungumuntu*. It is translated as "he or she is a person," implying that the person has humaneness. This illustrates that the collective is more important than the individual. For postcolonial southern Africans of all ethnicities and cultures, Ubuntu recognises the genuine otherness of all people (Louw, 2001). In other words, the diversity of people, languages, histories, and cultures must be recognised and acknowledged. Another critical aspect of Ubuntu as a social philosophy is its emphasis on the importance of agreement or consensus.

Ubuntu captures the Africans' shared vision. The interdependence of human beings on each other conceptualises Ubuntu as a communal enterprise. This points to Ubuntu as similar to an unbroken circle where everything is connected in harmony and in the 'interpersonal network of life' (Shutte, 2001; Sindima, 1995). Sindima (1995) conceptualises Ubuntu as a web that 'provides a basic framework of the interpretation of the world'. In the 'web of life, there is interdependence and interconnection of ethical relations. The quest for a holistic well-being is a common thread

that neatly weaves through the existence of humanity. The theory of Ubuntu emphasises the humanity of other African persons as ends in themselves, which then extends also to other people of other races.

The Nexus between Ubuntu and Care

An elaboration of the connection between Ubuntu and care ethics is prudent as it helps to clarify why the difficulty to implement care ethics in COVID-19 context should result in the re-visiting of Ubuntu philosophy. As already alluded to in the preceding discussion, the connection between Ubuntu and care is more than a necessary one. In fact, there can be no Ubuntu without care and the reverse is true as well. All the tenets of Ubuntu which include participation, interdependence, compassion, hospitality, reciprocity, harmony, respect, communality, consensus and relationships cannot exist without care. Held (2005) defines care as a practice and a value that is extended by considerate persons who are not only motivated to care and participate in effective practices of care but are compelled by moral salience of attending to and meeting the needs of the particular others for whom they take responsibility. This aspect of striving to meet the needs of others is a salient feature of Ubuntu. Therefore, care ethics is ingrained in Ubuntu. The two can safely be conflated.

Care ethics refers to the practice of caring for the other. This practice requires the very forms of Ubuntu- hospitality, compassion, communality etcetera. These aspects are crucial in taking care of the sick and the need. Ubuntu's emphasis on relationships may usefully be applied to the care for the sick. Like in extended families, it may be more appropriate to create an environment where people feel close and able to interfere in other people's lives if they feel that would benefit that person (Maruyama, 2004).

The interdependence and interconnection fostered by Ubuntu entail that communities embrace the values of the African worldview of humanness, caring, sharing, respect, compassion and associated values (Broodryk, 2002). In the context of Ubuntu, care is more of an action, where people practically and physically interdepend on each other. In cases of illness or death, community members are required to actively take part and their participation is expected to be reciprocated. This is well conceptualised by one of Lartey's three basic principles of interculturality authentic participation that is undertaken 'upon mutual concern for the integrity of the other' (Lartey 2003). According to Berinyuu (1988) in Africa life is a liturgy of celebration for the victims and sacrifices of others. The ontological and

epistemological foundations of caring and well-being are very critical to Ubuntu. Cornell and Van Marle (2015) are of the view that the ontological understanding of Ubuntu describes how human beings are intertwined. Epistemologically, Cornell and Van Marle (2015) opine that the being of the human also constitutes how we see the world; for this intertwinement is inherently ethical. When we see the world, we epistemologically understand it through an inherent ethicality that is in our human being with inescapable obligations.

Ubuntu embraces welcoming travelers, strangers and any visitors. This is depicted and influenced by particular sayings such as the Shona saying; *mwana wehama haanzi wavingei* [The presence of your relative in your home should not be questioned] and *mweni haapedzi dura* [a visitor does not deplete the granary] and the Nguni saying *isisu somhambi asingani singangenso yenyoni* [a traveler's stomach is as small as a bird's kidney]. As such, among most African ethnic groups, travelers are welcomed and given the cooling drink usually water or mahewu and a place to rest until they were ready to continue with their journey.

Ubuntu focuses on a set of character traits that people greatly value in close personal relationships. These character traits include care, sympathy, compassion, trust, fidelity, love, and friendliness (Beauchamp and Norman, 1993). Ethics of care is a relatively new body of normative ethical theories that is closely related to virtue ethics. It is a disposition-based ethical theory – it develops some of the themes in virtue ethics about the importance of character. However, the ethics of care focuses on a list of character traits that people greatly value in close personal relationships. The distinctive features of this theory are a concern with relationships as opposed to individuals; responsiveness to the particular needs of others; and a commitment to their well-being (Beauchamp and Norman, 1993).

The ethics of care offers a fundamental re-thinking of the moral universe. The terms of social cooperation, especially in families and in communal decision-making, are unchosen, intimate and among unequals. This is in contrast with the contractarian models like the Kantian and utilitarian ethics which fail to appreciate, for instance, that parents, relatives and health professionals, do not see their responsibilities to their children and patients in terms of contracts or universal rules, but rather in terms of care, needs, sustenance, and loving attachment. Human warmth, friendliness, and trust in responding to others cannot be brought under rules of behaviour (Beauchamp and Norman, 1993). Philosophical account of an ethics of care "does not recommend that we discard categories

of obligation, but that we make room for an ethic of love and trust including an account of human bonding and friendship" (Beauchamp and Childress, 2001). These accounts criticise the traditional liberal theory and its emphasis on impartiality and universality by claiming that, the impartiality and the 'standpoint of detached fairness' advocated by liberal theories of justice, overlook, for example, the moral role of attachment to those close to us. Speaking from the perspective of medical ethics, "the care perspective is especially meaningful for roles such as parent, friend, physician, and nurse, in which contextual response, attentiveness to subtle clues, and the deepening of special relationships are likely to be more momentous morally than impartial treatment" (Beauchamp and Childress, 2001).

Ubuntu stresses that we should care, that caring is a moral quality and that we should encourage conditions which create care. Unlike consequentialist and deontological ethical theories which emphasise universal standards and impartiality, Ubuntu emphasise the importance of relationships. In fact, Ubuntu emphasises the argument that caring should be a foundation for ethical decision-making. The argument starts from the position that care is basic in human life; that all people want to be cared for. Thus, natural caring is a moral attitude, a longing for goodness that arises out of the experience or memory of being cared for (Flinders, 2001). On this basis, Noddings (2002) explores the notion of ethical caring as a state of being in relation, characterised by receptivity, relatedness and engrossment. The key to understanding the concept of caring is to appreciate the notion of caring for and caring about, as well as natural and ethical caring.

Ubuntu and Care in the Face of COVID-19: Challenges and Opportunities

The advent of COVID-19 has had both challenges and opportunities. The challenges experienced include the diminishment of the ethical ideal as manifested through the difficulty to practice beneficence and non-maleficence, handling of funeral processes and the requirement of physical distancing. However, the dire situation was not without its own opportunities. The opportunities have come in the form of innovations which could be designed as a coping mechanism. These include the use of technology, especially Information Communication Technology (ICT) as a means of closing the gap that had been created by COVID-19 control measures. The adoption of moderate communitarianism can also go a long way in minimizing the risks that Ubuntu poses in the face of the COVID-19 pandemic.

The Diminishment of the Ethical Ideal

COVID-19 led to what has been described as "a diminishment of the ethical ideal". A person's ethical ideal is diminished when he or she either chooses or is forced to act in a way that rejects his or her internal call to care Noddings (1984). According to Noddings (1984), people can deliberately or carelessly contribute to the diminishment of others' ethical ideals. They may do this by teaching people not to care, or by placing them in conditions that prevent them from being able to care. Noddings (1984) roots care ethics in the "attitude which expresses our earliest memories of being cared for and our growing store of memories of both caring and being cared for. She argues that all people have experiences of being cared for, and most have experiences of caring for others, that they intuitively recognize as good. Everyone, thus, implicitly acknowledges the morality of caring relations even if only among family or friends. Interviewees C and F concurred that COVID-19 restrictions inhibited their natural disposition to care for others. They viewed the restrictions as against human nature. Both the fear to contract the virus and the imposed restrictions acted as an impediment to the practice of care, thereby resulting in the diminishment of the ethical ideal. Therefore, to reject care is to reject the basic conditions of human development and sociability (Noddings, 1984).

COVID-19, Engrossment and the Particularity of Care

Noddings (1984) defines the term engrossment as thinking about someone in order to gain a greater understanding of him or her. Engrossment is, therefore, a necessity in the ethics of care. Noddings (1984) argues that the carer (one caring) must exhibit engrossment and motivational displacement, and the person who is cared for must respond in some way to the caring. Engrossment is necessary for caring because an individual's personal and physical situation must be understood before the one caring can determine the appropriateness of any action (Noddings, 1984). Noddings (1984) believes that caring requires some form of recognition from the cared-for that the one caring is, in fact, caring. When there is recognition of and response to the caring by the person cared for, then caring is completed in the other (Noddings, 1984). However, all this would be difficult in COVID-19 situations where the patient needed to be quarantined and physical access to the patient was restricted. Moreover, caring involves connection between the caregiver and the cared for and a degree of reciprocity meaning that both gain from the encounter in different ways, a

scenario very difficult to obtain in COVID-19 situations. In cases of COVID-19, engrossment becomes very risky to the caregiver. Engrossment is closely linked to the particularity of care in that both concepts require the caregiver to be physically close to the patient.

The particularity of care demonstrates the inevitability of human physical contact in care. Care ethics takes the concrete needs of particular individuals in specific circumstances as the starting point for what must be done. Noddings (1984) identifies care ethics as a superior moral orientation to impersonal theories of justice based upon principles and rules because it involves attending to the particular needs of concrete others. Caring involves stepping out of one's own personal frame of reference into others. When we care, we consider the other's point of view, his or her objective needs, and what he or she expects of us. Our attention, our mental engrossment is on the cared-for, not on ourselves. Our reasons for acting, then, have to do both with the other's wants and desires and with the objective elements of his problematic situation (Noddings, 1984). Such requirements have inevitably proved to be untenable in the face of COVID-19. Since most of the common practices of care such as hospital visits were suspended during the peak of COVID-19 infections, it was not possible to have human physical contact as the particularity of care supposes. The concrete needs of a patient could not be established whereas this is the starting point in care ethics. Care ethics places the particular needs of individuals at the foreground of moral action so that attention to their immediate human concerns take priority over abstract principles and programmes. Therefore, caring per se requires personal contact and varies according to individuals and situations. What is good for one individual may not be good for another. As such, caring cannot be taken as a model for general moral relations. It rather occurs in circles of intimates and friends who are engrossed in one another.

A person can, therefore, only care for so many particular others since each of these must be treated particularly without general rules or principles (Noddings, 1984). In articulating the importance of the particularity of care and challenging "universal principles," Beauchamp and Childress (2001) write:

> "We can produce rough generalizations about how caring physicians and nurses respond to patients, for example, but these generalisations will not be subtle enough to give helpful guidance for the next patient; each situation calls for a set of responses outside any generalization"

This would be a very accurate assessment of the COVID-19 situation whereby all patients would be placed in the same hospital ward no matter the severity of their symptoms and the particularity of their needs. For example, there are certain concrete needs that patients may require such as oxygen supplies and other medical supplements. This is a clear indication that COVID-19 made the practice of Care ethics almost impossible.

Both engrossment and the particularity of care endangers the caregiver in cases of COVID-19. This, therefore, suggests that vulnerable individuals such as those with underlying conditions should be exempted from participating in such processes. Society needs to respect the individual rights of such persons as they are at risk. The idea of reciprocity needs to be limited. It is normally expected that if others have assisted you to take care of the sick then you would also assist them in such circumstances. However, in the event that one is suffering from COVID-19 then there is need to limit the number of caregivers as a measure to minimize the spread of the disease. It should be understood that it would still be within the dictates of Ubuntu for someone to provide other forms of care which do not require physical presence.

Beneficence and Non-maleficence

The ethics of care have a strong emphasis on beneficence and non-maleficence. Beneficence premises on caregivers and the general public doing good to others, their patients, while non-maleficence concerns the avoidance or prevention of harm. In the case of the COVID-19 pandemic, caregivers are expected to treat and care for their patients and promote beneficence and non-maleficence. Meanwhile, in the case of health workers, their employers are expected to provide a safe environment through the provision of Personal Protective Equipment (PPE). In cases where the employer does not provide PPE as legally required by COVID-19 prescripts, both the health workers and patients' lives would be in danger. Such a situation renders health workers' beneficence difficult because the decision to "do good" entails the treatment and care to clients while endangering one's life and the lives of patients, colleagues, own family and even those mingled with in public spaces.

Although the core values embedded in Ubuntu, such as mutual respect, humanness, trust, honesty, cohesiveness, and solidarity, are commensurate with ethical principles that guide the nursing practice (Mulaudzi et al., 2018), the nature of the coronavirus makes it difficult for

these values to come into play. Interviewee J argued that although health workers were willing to attend to COVID-19 patients in line with the Hippocratic Oath, lack of essential provisions was their greatest hurdle. Interviewee C was also in agreement with J as she also noted that there is no way the health workers would risk their lives by attending to patients without the necessary protective clothing equipment.

Ubuntu provides a perspective to analyze the right to strike action regarding personal and community right-doing (Mangena, 2016). Ubuntu offers a starting point for negotiating the common good and social aspects of doing good. Ubuntu philosophy essentializes the virtues of respect because a person can only see the other through the value they allocate to respect. In the COVID-19 context, nurses as caregivers need to demonstrate their respect by wearing PPE to protect themselves and their patients to avoid further spread of the infection. Similarly, the State is obliged to reciprocate the respect shown by nurses and the value they bring to both the healthcare system and the nursing profession. As reflected in this scenario, solidarity and cohesion are two critical Ubuntu principles with a significant bearing on nursing ethics.

It is equally important to note that conversely, the decision by nurses not to protest also affects the extent of solidarity and patient advocacy in respect of providing and receiving essential treatment and care services in a safe environment (Desai et al., 2020). Due to the public's view of the rationality and justification of the non-strike actions by nurses during the COVID-19 pandemic, they subsequently generated and received overwhelming public support and solidarity (Tuohey, 2007). This public response is based on the value of respect for the common good and cohesive unity of purpose between the public and the nurses. Such a state of affairs epitomizes the value and respect that members of the same group(s) allocate to dialogue as a pivotal aspect of decision-making by consensus for the common good (Tuohey, 2007). Hence, while beneficence and non-maleficence are expected from caregivers, the nature of COVID-19 proved to be inhibitive to the practice of the same. In requires a revised notion of Ubuntu to understand and empathize with caregivers who almost always found themselves between a rock and a hard surface. A revised notion of Ubuntu needs to be able to consider the rights of the caregivers first before generalizing the situation.

Physical Distancing, Travel restrictions and their Effects on Communitarian Hospitality

Physical distancing proved to be one of the most effective measures of controlling the spread of an infectious disease. Given this fact, most countries-including Zimbabwe- instituted lockdowns and curfews meant to restrict human movement and interaction. Those who needed to travel for a distance of more than 20 km had to be in possession of a letter of exemption. Most of these letters were only given to those who worked in essential service provision, meaning that there was very little room for one to be able to visit a sick relative, yet Ubuntu calls upon all family members including members of the extended family to take care of the sick. On the other hand, travellers from other places especially from urban to rural communities were not very welcome. Most myths and conspiracy theories tended to associate COVID-19 with urban dwellers. This, therefore, means that even if someone could manage to travel to the rural areas to visit a sick relative, such a person would not be very welcome owing to the suspicion that he or she could be carrying the virus. Inversely, the other scenario would be that the very sick person could be the one suffering from COVID-19 and, hence, posing a health risk to potential caregivers. In this case, care giving would be extremely difficult since chances of getting infected would be very high. Moreover, Interviewee H said due to COVID-19 control measures hospital visits to COVID-19 wards were outlawed and this left COVID-19 patients in the care of health workers who would sometimes threaten to abandon the patients due to poor working conditions such as lack of Personal Protective Equipment.

In addition to physical distancing, COVID-19 restrictions also included the barning of travelling beyond a 20km radius. This meant that a combination of physical distancing and travel restrictions, coupled with the general dreading of the disease curtailed the practice of one of the pillars of Ubuntu that is hospitality. Hospitality is founded on the African notion of interdependence. African hospitality is grounded on the fact that no one is an island. Rather, each and every one is part of the whole community. African hospitality expresses the African sense of communality. That is, instead of, "I think, therefore, I exist" (*cogito ergo sum*) of the French Philosopher Rene Descartes, the African asserts "I am because we are," or "I am related, therefore, I am" (*cognatus ergo sum*) (Gathogo, 2008). This compares with Mbiti's summary of the philosophy underlying the African way of life, thus: "I am, because we are; and since we are, therefore

I am (Mbiti, 1967). African hospitality, therefore, places more emphasis on interdependence. As earlier indicated, many African proverbs express this communalistic approach to life. Essentially, as an individual one cannot do anything substantial. In fact, one needs others for advice, teaching, rebuke, correcting and training. One needs others, for example, to do business.

Interviewee D explained that the requirement for physical distancing, which outlawed social gatherings and compelled people to stay at home made it very difficult for some people to welcome visitors and strangers into their homes. He added that this entailed that hungry strangers could not be cared for since this would be somehow in contravention of laid down COVID-19 control measures. This again ruled out the communal sharing of food and in a way promoting the 'vice' of individualism. Similar sentiments were shared by Interviewee A who said in some communal areas in Zimbabwe, the traditional leadership would not allow visitors in their areas of jurisdiction, especially those from urban areas which were considered as hotspots. In most societies, the rearing and socialisation of children is not only a responsibility that is assumed by the children's biological parents, but it also involves other extended adult kin. These kin relationships have always been comprised of mothers, fathers, grandparents, siblings, and other extended kin such as aunts and uncles (Gayapersad A. et al., 2019). It should be noted that although Ubuntu thrives on human interactions, welcoming strangers and travelers in times of pandemics should either be avoided and done under very strict conditions to minimize contact with such people. It has always been emphasised that the COVID-19 requirement of physical distancing does not mean social distancing. As such, it is possible for people to be distanced physically but remaining socially connected. Interviewee A was of the view that there are various ways of being socially connected in the COVID-19 era. The use of social media platforms such as WhatsApp, Twitter and Facebook are one of the most common ways through which people have remained socially connected during lockdown.

COVID-19, Ubuntu and Funeral Processes

In African culture, especially Shona culture, whenever there is a death in the community people are required to pay condolences. Paying condolences literally means to hold hands [*kubata maoko*]. In most Zimbabwean cultures, as soon as death is announced friends and relatives pour into the

bereaved family's home. A typical funeral can attract as many as 500 people and can stretch for several days. There is a lot of singing and dancing in memory of the dead with mourners staying at the homestead until after the burial. COVID-19 control measures initially limited funeral attendees to 30, but in most remote areas the regulations were seldom adhered to. At most funerals people were not observing regulations to stop the spread of COVID-19 such as wearing of face masks, social distancing and washing of hands. There were even reports of shocking incidents where people coming from other areas to bury their relatives, who died of COVID-19, would demand to see their bodies contrary to advice by health authorities. There are cases where people were even arrested for opening coffins of their relatives who would have died of COVID-19 as they could not come to terms with the prohibition of body viewing.

Traditionally, Africans greet each other by shaking hands -- a practice that is more pronounced during funerals when mourners console each other. In the event of death in the community due to COVID-19 this practice has been severely challenged. Although most people have resorted to using clenched fists to greet each other, some still find it odd to do so and end up shacking hands. It is also a strong African practice that funeral attendees feed especially after the burial process. Failure to do so is socially frowned upon as it is perceived as an act of pride, egotism and superiority. Urging people to refrain from eating food at funeral gatherings is obviously something which Zimbabweans also find hard to do for fear that the same act may be reciprocated in the event of deaths at their own homes. In rural areas, people slaughter cattle and goats at funerals, which are at times prepared under poor hygienic conditions, exposing mourners to diseases during times of outbreaks. According to interviewee A, it is very difficult to shun food at funerals especially in rural areas where people slaughter cattle and goats at funerals since such relish is a rare delicacy. However, the interviewee noted that at times the food is prepared and served under very poor hygienic conditions, posing a great health risk to mourners during times of outbreaks. It is also interesting to note that in Africa, a funeral is more than mourning and burying the deceased. It is also an opportunity for relatives to meet their loved ones whom they would have for long separated with. It also functions as a platform to know each other as a funeral draws together people from various geographical and social locations. Attendees, therefore, take their time mixing and mingling. The implementation of COVID-19 control measures in such a situation may prove to be a mammoth task. However, it has to be understood

that paying condolences may not necessarily entail being physically present at the funeral wake. With the advancement in information communication technology, physical gatherings can be avoided as others may watch the process through live streaming. Such people may also make their contributions in the form of electronic money transfers. Those who might want to know each other may do so by way of exchanging electronic contact details. It should be noted that food consumption at funerals may be avoided without infringing any cultural norms and that should not be reciprocated where a funeral is not in any way linked to COVID-19 or any other infectious disease. Paying condolences should not be in the form of shaking hands. Interviewee B confided in this researcher that among the Ndebele people paying condolences is not about shaking hands with members of the deceased's family. The shaking of hands at funerals is restricted to very close members of that family. Even if fewer people would attend the funeral, other people could still go and pay their condolences later and this can be done on a staggered basis. Moreover, through the use of modern communication technologies, some people may view the funeral proceedings via social media platforms such as Facebook.

Washing and Sanitizing of Hands

As a prevention measure people are required to regularly wash their hands with soap and water or to use hand sanitizers. This would mean that if a visitor comes to one's house, they would need to make them wash their hands. Such a requirement may not sound well with Ubuntu philosophy because it is tantamount to accusing someone of uncleanliness, and therefore, unwelcome in the home. Ubuntu requires that any visitor be received into the home as they are. Interviewees E, G and H all opined that if a potentially infectious individual visits, the African understanding is that the ancestors and God would have allowed that to happen and therefore, they will either find a way to protect you or they will let you get infected for a valid reason. This is depicted in the proverb *Mudzimu wakupa chironda wati nhunzi dzikudye* (The ancestor who has given you a wound wants flies to eat you) meaning that if the ancestors allow a calamity to befall you, they want you to suffer. Thus, one challenge with care ethics is that it accords little importance to caring for oneself, except perhaps as a means to provide further care for others. Gilligan (1982) argues that there is something deficient in a wholly other regarding caring morality since a mature moral perspective involves concern for oneself and one's own well-being within relations of care. As such, the philosophy of

Ubuntu puts the health of an individual at risk just for the purposes of reinforcing traditional stereotypes of a good person. Getting in contact with a patient suffering from a highly infectious disease as a way of being indiscriminate may have adverse effects to the caregiver. Moreover, the enforcement of hand sanitizing to visitors should not be in any way seen as snobbery but rather as act of care. This shows that the philosophy of Ubuntu needs repackaging. In this instance, the society has to understand that disregarding COVID-19 control measures for communitarian expedience has more harm than good.

Moderate Communitarianism as a Pandemic-sensed Re-alignment of Ubuntu Philosophy

The challenges that have been presented in this chapter have made it inevitable for the suggestion that Ubuntu has to be re-packaged. It has always been noted that one of the shortfalls of Ubuntu has been its indiscriminate emphasis on communal interests at the expense of individual rights. As a result of that, it has been somehow difficult to control the spread of COVID-19. In fact, in a bid to practice Ubuntu, some people have ended up being exposed to this invisible enemy. The exposure has come through most of the traits of Ubuntu such as communality, hospitality, responsiveness, compassion and reciprocity.

The suggested adjustments to Ubuntu have essentially resulted in what the philosopher Kwame Gyekye (2002) termed *Moderate Communitarianism*. For a better understanding of Moderate Communitarianism there is need to first briefly unpack Communitarianism. Communitarianism is a theory that emphasizes the moral supremacy of the common good - the good of the community as a whole. According to Roberty Longely (2020) the basic theory of communitarianism is revealed largely through its supporters' scholarly criticism of liberalism as expressed by American political philosopher John Rawls in his 1971 work, "A Theory of Justice." In this seminal liberal essay, Rawls contends that justice in the context of any community is based exclusively on the inviolable natural rights of each individual, stating that "each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override." In other words, according to Rawlsian theory, a truly just society cannot exist when the well-being of the community comes at the cost of individual rights. A communitarian, thus, is someone who considers the

community to be of central importance. The rationale for this is that the individual is a social being and can only flourish in the community.

Communitarian scholars who only emphasize the supremacy of the community without recourse to the individual's individuality and the rights that come with it are categorized as radical communitarians. This includes scholars such as John Mbiti and Ifeanyi Menkiti. Radical communitarianism is, therefore, interpreted as a theory that upholds the irrelevance of individual rights within the structure of an intimate and harmonious interaction among community members (Bond, 1996). This version of communitarianism denies liberalism. Proponents of the theory contend that liberal rights are superfluous in a community characterized by shared values, where every member is already constituted by the community itself. No individual is created to be able to provide for himself or herself, all his or her needs. Therefore, the natural inability of the individual to personally meet all his or her economic needs, without external support, compels him or her to seek the fellowship of others. This position has led to this state of tension between the individual and the community and this tension escalates in times of pandemics such as COVID-19. This tension can only be resolved by taking into account that the human person is first an individual and then a communal being. The tension between the individual and the community can be resolved to a reasonable extent by moderate or restricted communitarianism, that is, a communitarianism that gives consideration to communal values as well as to the values of individuality, to social commitments, as well as to duties of self-attention. Thus, in times of pandemics such as COVID-19, an individual whose safety and health maybe under threat due to the need to fulfill some values of Ubuntu should be excused without any fears of being labelled a deviant.

Guided by assumptions about the dual features of the self with its implied dual responsibility, moderate communitarianism should be possible to deflate any serious tension between the self and its community in the era of COVID-19. Thus, Gyekye's idea seems promising enough since it takes into account the 'self-asserting I' as well as the 'all-embracing we' (2002). In that sense, moderate communitarianism ensures that even though the communal values continue to receive primacy, the individual is allowed to assert his rights to a reasonable extent. This means that issues such as group solidarity, communality, compassion and participation could be done moderately, that is, without compelling individual members to conform to certain requirements that may put them at risk of being infected with COVID-19.

Conclusion

This chapter examined the challenges that the philosophy of *Ubuntu* is facing in this era of the COVID-19 pandemic. An analysis of *Ubuntu* revealed some key features such as compassion, hospitality, communality and interdependence. These qualities were shown to be synonymous with the ethics of care. At face value, these features of *Ubuntu* appear to be indispensable in care in general and in caring for the sick in particular. However, the nature and devastating effects of COVID-19 has led to the introduction of the disease management and containment measures which resultantly rendered *Ubuntu* almost defunct. The measures curtailed most of the very salient values of *Ubuntu* including communality and interdependence. As such, this chapter argued for the need to make an adjustment to the scope of *Ubuntu* in order to balance between the need to practice care and the requirement to protect both caregivers and care receivers. The chapter viewed Gyekye's (2002) moderate or restricted communitarianism as a possible remedy to this quagmire.

References

Beauchamp, L.T. and Norman, E.B. (eds.) 1993. *Ethical Theory and Business*. 4th ed. New Jersey: Englewood.

Beauchamp, T.L. and Childress, J.F. 2001. *Principles of Biomedical Ethics*. 5th ed. Oxford University Press.

Desai, A., Lankford, C. & Schwartz, J. 2020. With crisis comes opportunity: Building ethical competencies in light of COVID-19. *Ethics & Behavior*, 30(6):401-413. https://doi.org/10.1080/10508422.2020.1762603

Elder, J.P. et al. 2014. Caregiver behavior change for child survival and development in low-and middle-income countries: an examination of the evidence. *J Health Commun*, 19(supp 1):25-66.

Flinders, D.J. 2001. 'Nel Noddings'. In Joy A. Palmer (ed.). *Fifty Modern Thinkers on Education. From Piaget to the Present*. London: Routledge.

Gathogo, J.M. 2008. Some Expressions of African Hospitality Today. *Scriptura*, 99:275-287.

Gayapersad, A. et al. 2019. The Production and Reproduction of Kinship in Charitable Children's Institutions in Uasin Gishu County, Kenya. *Child & Youth Care Forum*, 48(6):797-828.

Gilligan, C. 1982. *In a Different Voice: Psychological Theory and women's Development*. Cambridge: Harvard University Press.

Gyekye, K. 2002. Person and Community in African Thought. In P.H. Cotzee & A.P. Roux (eds.). *The African Philosophy Reader*, 317-337. New York: Routledge.

Held, V. 2005. *The Ethics of Care: Personal, Political, and Global*. New York: Oxford University Press.

Mangaliso, M.P. 2001. Building a competitive advantage from ubuntu: management lessons from South Africa. *The Academy of Management Executive*, Randburg.

Mangena, F. 2016. African ethics through Ubuntu: A postmodern exposition. *Journal of Pan African Studies*, 9(2):66-80.

Mulaudzi, F.M., Libster, M.M. & Phiri, S. 2009. Suggestions for creating a welcoming nursing community: Ubuntu, cultural diplomacy, and mentoring. *International Journal of Human Caring,* 13(2):45-51. https://doi.org/10.20467/1091-5710.13.2.45

Mulaudzi, F.M. & Peu, M.D. 2014. Communal child-rearing: The role of nurses in school health. *Curationis*, 37(1). Doi.10.4102/curationis.v37i1.1158.

Noddings, N. 1984. *Caring a Feminine Approach to Ethics and Moral Education*. Berkeley: University of California Press.

Noddings, N. 2002. *Starting at Home: Caring and Social Policy*. Berkeley: University of California Press.

Robert, L. 2020. What Is Communitarianism? Definition and Main Theorists. At https://www.thoughtco.com/communitarianism-definition-and-theories-5070063 [Accessed 5 September 2022].

Ramose, M.B. 1999. *African Philosophy through Ubuntu*. Harare: Mond Books.

Samkange, S. and Samkange, T. 1980. *Hunhuism or Ubuntuism: A Zimbabwe Indigenous Political Philosophy*. Harare: Graham Publishing.

Shutte, A. 2001. *Ubuntu*. Pietermaritzburg: Cluster Publications.

Sindima, H.J. 1995. *Africa's agenda: The legacy of liberalism and colonialism in the crisis of African values*. London: Greenwood Press.

Tuohey, J.F. 2007. A matrix for ethical decision making in a pandemic. The Oregon tool for emergency preparedness. *Health Progress*, 88(6):20-25.

Angeline Mavis Madongonda & Enna Sukutai Gudhlanga

9 Physical Distancing – Necessity or Luxury? Culture, Population Density and COVID-19 in Zimbabwean Society

Abstract

The period of COVID-19 has seen the proliferation of the pandemic the world over. Among mitigatory measures was physical distancing, initially named social distancing. However, in urban areas where population density is high in Zimbabwe, physical distancing becomes a luxury. Most Zimbabweans, particularly in urban areas live in high-density areas, almost squalid conditions. Zimbabweans are a hospitable lot whose familial ties are binding and this means the extended family (a significant number of people) can stay in one household. The economy does not help matters either with people being forced by circumstances to converge in large numbers in the community at any given time to irk out a living. This therefore presents a challenge where the World Health Organisation COVID-19 protocol of physical distancing appears to be offside. The protocol of physical distancing does not take into consideration population density of given areas, let alone the socio-economic and religio-cultural dimensions of any given society. This chapter is thus an exploration of the circumstances under which the average Zimbabwean must operate to survive. It also examines the traditional indigenous/ religious beliefs that uphold the spirit of *ubuntu* fostering communal existence *vis-à-vis* the COVID-19 pandemic. Informal interviews were conducted on how the average Zimbabwean fares on an average day and targeted informal traders ordinary Zimbabweans. A convenience sample of selected research participants was drawn from Harare's CBD area to examine the applicability of physical distancing in Zimbabwean society. The study revealed that for many living in the high-density areas, physical distancing is a luxury, as people tend to prioritise survival in a harsh economic climate ahead of the COVID-19 protocol of physical distancing first. This research is informed by *Ubuntu* theory where Shona religious beliefs frown at individualism and uphold teamwork despite the raging COVID-19 pandemic.

Keywords: physical distancing, culture, population density, COVID-19, Zimbabwe, Shona, Harare, Ubuntu, pandemic, mitigation

Introduction

This chapter focuses on the effectiveness of physical distancing as a mitigatory measure in combatting COVID-19 in Zimbabwe. It is premised on what we regard as a challenge to the average Zimbabwean, a challenge which needs serious attention and whose resolutions could see inclusive consideration of underprivileged communities. To a large extent world news and sadly what is assumed to be world-class research from the West tends to cover issues on the well-to-do and then cascade resolutions passed for their societies to the Global South irrespective of suitability of such resolutions. This is the case with some of the COVID-19 protocols, physical distancing to be precise. This study explores how effective the use of this strategy is in Zimbabwe and how cultural values and practices have been affected and appear to contradict control measures laid down by the World Health Organisation (WHO). The chapter, thus, interrogates the one-size fits all approach to the containment of COVID-19, which discounts the diversity of both the people as well as their circumstances. In this study, we analyse the findings of interviews conducted to find out how the Zimbabwean society has grappled with this phenomenon.

Background to the Study

Some infectious diseases need physical separation and minimized human contact and COVID-19 is no exception. History has proven how people with highly infectious diseases were separated from their communities. Quarantining is one such measure that was put in place to physically remove the infected ones from the healthy. The Bible has demonstrated God's emphasis on quarantining to the Israelites as a strategy to use should one become afflicted with a highly infectious disease such as leprosy (The Bible book of Leviticus Chapter 13, Verses 4, 5, 11, 21, 26, 31, 33, 50, 54). Muyambo (2020) has pointed out that quarantining and physical distancing have not been alien in Africa but part of *Ubuntu* to physically separate the sick from the healthy in a bid to protect them. He outlines several diseases that warranted physical distancing in Ndau culture among them being *maperembudzi* (leprosy), *manyembana* (chicken pox), *biripiri* (measles) and *mphezi* (scabies). Here in Zimbabwe a community that has acted as a quarantine centre is evident in Mutemwa village in Mutoko (The Mutemwa Leprosy Centre). The main objective of quarantining is to stop the spread of infection of otherwise deadly pandemics.

Instances of physical distancing have also been seen in other parts of the world where such infectious diseases such as Spanish flu, Ebola and the Bubonic plague demanded that infected ones be kept apart from the healthy ones to arrest the spread. Of note is the Spanish influenza of the early twentieth century (1918-19) which was said to be responsible for 50 million deaths across the globe (Taubenberger & Morens, 2006). Creative writers such as Elechi Amadi have documented such a pandemic in the novel *The Great Ponds* (1969). Similarly, Albert Camus has also demonstrated the devastating effect of the bubonic plague in his seminal novel *The Plague* (1947). Thus, the different measures of arresting the spread of infection have dated back since time immemorial and we are seeing a repeat with face mask wearing taking the centre stage which can be traced to the middle ages (Matuschek, Moll, Fangerau, Fischer, Zänker, van Griensven, Schneider, Kindgen-Milles, Knoefe, Lichtenberg, Tamaskovics, Djiepmo-Njanang, Budach, Corradini, Häussinger, Feldt, Jensen, Pelka, Orth, Peiper, Grebe, Maas, Bölke & Haussmann, 2020). Other pandemics such as the influenza of 1957-58 are a testimony of the prevalence and spread in social groupings such as schools (Pinkowski, 2021). Closure of such institutions was also done to mitigate the spread of the pandemic.

The WHO took similar measures in containing the COVID-19 pandemic. It became apparent that for the world to survive, such measures as "restrictions placed on physical mobility, staying indoors, washing hands, wearing masks and maintaining physical distance" (Lingam & Sapkal 2020:174) had to be adhered to. However, owing to deeply ingrained cultural beliefs and practices as well as prevailing economic conditions, there have been more challenges than solutions on the African soil and in Zimbabwe to be precise. Old habits and beliefs have made it difficult even for authorities to deal with corruption of the law enforcement agents exacerbating rather than providing reprieve against the spread of COVID-19.

Apart from this, Zimbabwe has had a flagging economy for more than two decades (Chirisa &Mundau, 2021) and this has resultantly affected the health delivery system. This eventually has left most Zimbabweans highly vulnerable to COVID-19. Not only do they have day-to-day economic and social challenges to grapple with, but also the threat of the pandemic and inaccessible medical facilities. The public hospitals that are at the disposal of most of the poor have been over-subscribed particularly at the peak of the pandemic. For a significant number, affordability is the greatest bar-

rier to access, hence, many during the pandemic had to deal with the infection at home. Noko (2020) makes this observation about the quandary the poor face considering the pandemic, "While optimists hope [the pandemic] will force us to rethink inequality and global access to healthcare, the realists believe the net effect of the pandemic will be to further entrench the divides that already exist." This is reflected in the way most of the poor struggled with following the laid down COVID-19 protocols which were a serious challenge as this chapter seeks to show. For the well to do, physical distancing is easily orchestrated but for the poor this is easier said than done.

Statement of the Problem

Despite all the measures instigated to control the virus, Zimbabwe amongst other developing nations had a myriad of challenges that could have seen the COVID-19 virus spiral out of control. Amongst these are the debilitating economic system and the squalid living conditions in numerous households not spacious enough to allow the desired physical distancing. To add to this, during the pandemic the use of the widely available public transport system in the form of smaller omnibuses, kombis, was suspended in a bid to contain the virus, thereby putting pressure on bigger buses which could not meet the demand on the large essential services commuters and the public at large. All this worked against the control measure of physical distancing.

Research Questions

This study was guided by the following questions:

- What is physical distancing?
- How have Zimbabweans living in highly congested areas grappled with the COVID-19 protocol of physical distancing?
- To what extent have people implemented physical distancing during social gatherings such as funerals?
- Is there a gendered dimension to physical distancing?

Methodology

This research is qualitative in design. The focus of this study is to analyse or decipher social issues, events, or practices, with the main purpose being to explore meanings, processes, reasons and explanations. One of the strengths of qualitative methods is their ability to generate rich and detailed data that leave participants' perspectives within the context of their behaviour (Flick, 2014). Research participants provide their own explanations and perspective in a participatory exchange with interviewers. Rahman (2017) has observed that the qualitative research approach produces the detailed description of participants' feelings, opinions, and experiences; and interprets the meanings of their actions. The interactive nature of qualitative research makes it easy for complex issues to be understood easily (Maxwell, 2012). Informal interviews were conducted on how the average Zimbabwean fares on an average day during the COVID-19 pandemic. A convenience sample of selected research participants was drawn from Harare's CBD area to examine the applicability of physical distancing in Zimbabwean society. The sample was reached after data saturation was achieved for the questions that were crafted for the interviews: Harare's CBD area was chosen as it is the epicentre of most activities of people from all suburbs in Harare and a place people from diverse walks of life converge for different motives. Participants who were selected for the study shared their own experiences regarding physical distancing. Data is presented in thematic form based on questions that demanded how people were physically distancing in their households, how they were managing social gatherings such as funerals amidst cultural beliefs that fostered camaraderie during times of bereavement, how women were faring in observing the protocol on physical distancing. Responses from the interviews are presented in coded format (P1-P14).

Theoretical Framework

Ubuntu (Ramose 1999) or *hunhu* (Samkange & Samkange, 1980) involves the communal spirit of empathy as well as physical presence to convey one's heartfelt sympathy or empathy to one's neighbor. It underlines the humanity, interdependence and interconnectedness of the individual and the community (Chigangaidze, Matanga & Nyatsuro, 2022; Chisale, 2022). Thus, in the context of a misfortune, African culture demands the physical presence of an individual in a bid to act in solidarity with either

the bereaved or the sick. Unfortunately, this spirit of *Ubuntu* which emphasized commiserating with the misfortunes of kith and kin through physical presence has persisted in the context of the highly contagious pandemic thereby covertly bringing into conflict principles that used to uphold numerous African communities and the COVID-19 protocols. In this chapter, we argue that despite what appears to be the fostering of the COVID-19 infections through the spirit of *ubuntu*, there are other ways in which the values of this philosophy were critical during the pandemic. To add to this, proponents of such arguments present their case basing it mainly on the physical separateness of individuals were supposed to exercise but not the harmony that people experienced when they shared home remedies to alleviate or even treat the symptoms of the virus. We, therefore, argue that despite possessing an area of challenges that need adjustments, good practices of watching out for one's nieghbour drawn from *Ubuntu* can be adopted, adjusted and utilised to work harmoniously with laid down COVID-19 protocols. According to U*buntu* philosopy "no person can exist in isolation" or 'I am because you are' (Ngomane, 2019:31). This *ubuntu* concept was adopted in this study in a bid to demonstrate that with the raging pandemic, previously good practices from the concept can be adversely affected and degenerate in essence. The way people from Zimbabwe have grappled with the pandemic might leave a few lessons for the world. The question we wish to tackle is how people fared in physically distancing and quarantining during the pandemic. To date, many are still baffled as to why COVID 19 did not have such a devastating effect on African soil despite the debilitating circumstances that fostered rather than alleviated the spread of the pandemic. This can only be explained by the same spirit of *Ubuntu* amongst the people whose respect and sanctity of life during pandemics exuded the much-needed emotional support and meant adhering to laid down protocols. However, the question that remains is for the populous Harare's suburbs and economically disadvantaged populace is; does the strategy of physical distancing work? Chirisa and Mundau (2021) have pointed out that the correlation between high population density and the pandemic makes dwellers of such places highly vulnerable, and the management of the virus almost impossible.

Social and Physical Distancing: Implications on the Spread of COVID-19

During the pandemic, the term social distancing was adopted and was a step taken by public health officials to stop or slow down the spread of the highly contagious pandemic. Complete lockdowns were enforced. This also meant that schools, public institutions, funerals, weddings among other social gatherings as well as business operations were suspended making people adopt a 'work from home' strategy. These measures were supposed to be well coordinated in order to minimise the rate at which the infection was being spread from one person to the other and from one area to the next. Bans on hospital visits meant the sick were also separated from their loved ones (Madongonda & Gudhlanga, 2021) and failure to attend a funeral of a loved one was not only taboo but unheard of (Madongonda & Gudhlanga, 2021; Humber, 2020) but became the order of the day.

Debates surrounding social distancing are abound and the term 'physical distancing' has itself evolved from initially being referred to as 'social distancing'and numerous scholars have referred to this phenomenon (Metha, 2020; Nyabadza, Chirove, Chukwu & Visaya, 2020; Peters, 2020). Over time, scholars have agreed that social distancing sent the wrong message which meant social isolation which extended to separation from one's own family and friends. The term social distance has also garnered negative connotations and insinuated cutting off all social ties including emotional distance with family and friends. This is understandable considering how COVID-19 was initially associated with fear and trepidation to the extent that the first reaction when one came into contact with the virus meant running to hide and those who learnt of COVID-19 infected individuals would panic and try to shy away from them. In other words, those who caught the virus were condemned to death or faced imminent rejection by their own. In Zimbabwe, even medical personnel were known to abandon known COVID-19 patients for fear of catching the virus (Moyo, 2020)). Their fear was exacerbated by lack of protective ware when handling the afflicted COVID-19 patients. The fear of COVID-19 can be paralled to the fear of HIV and AIDS when people were unaware of the virus and how it was transmitted. The same reaction can be attributed to early perceptions about the pandemic. The term social distance according to UNICEF (2020) is therefore misleading, highlighting a social and emotional disconnection, yet during the time of the pandemic people need to

stay socially and emotionally connected for their own wellbeing. This is in line with the concept of *Ubuntu* among Africans, emhasising the fact that one does not abandon their kith and kin because they got infected by a deadly virus. As shall be shown, this spirit has seen the people who practice *Ubuntu* facing challenges of getting infected and eventually succumbing for fear of abandoning sick relatives or failing to attend funerals. Lingam and Sapkal (2020:178) have highlighted the effects of the social distance when they observe "growing concerns expressed about the potential loss of solidarity, support and community that is required in such difficult circumstances leading to depressions, suicidal tendencies and intimate partner violence." Chisale (2022) aptly has stated that COVID-19, through promoting a privacy that is dangerous to vulnerable groups such as women and children, has disrupted *Ubuntu*.

Thus, the term physical distancing is more apt as it stipulates that physical distance from any two individuals staying at least a metre away from others to avoid the risk of spreading or catching the virus. The change from social to physical distance was, therefore, promulgated to emphasise that while physical distance is maintained, people should stay connected to family and loved ones (Gudhlanga & Madongonda, 2021). They should stay emotionally connected even over distance through such means as video calls, chats, phone calls, social media among others. It meant adopting what the world has come to understand as part of the new normal where most activities were and are still being done online including work as well as school. In this chapter, however, we argue that in Zimbabwe and other developing countries, while keeping physically separate as well as quarantining or self-isolating was the new normal and a necessity, it was a luxury owing to constricted space. Physical distance becomes the privilege of the well-to-do who can physically separate the sick and find alternative means such as extra rooms from which to nurse the sick. This shall be explored in greater detail in the coming sections. While the term physical distance has narrowed down to the distance between one and two metres, there have been other ways in which people have been keeping themselves physically separate to prevent passing on the virus as well as catching it. This has depended on whether one has been infected or suspects that they have caught the virus. The reverse was also true as people avoided contact with others even when they had not been exposed to the virus to keep themselves and loved ones safe.

Lockdowns, as mentioned before, were the most common and effective ways of slowing down and dealing with the spread of the virus

(Nkengasong & Mankoula, 2020; Kharroubi & Saleh, 2020; Yang, 2021). It was clear that location was important and identified COVID-19 hotspots were locked down first as well as places where there was the likelihood of large numbers and gatherings that were potentially super spreaders. However, the maxim by Jacinta Arden (Prime Minister of New Zealand) that 'act as if you have COVID-19' (cited by Peters, 2020) personalised the fight against the infection and was meant to keep people persistently on their guard against passing on the virus and thus, not catching it. However, in this chapter we question the feasibility of physical distancing when living in a populous city particularly in high density areas where most accomodation is shared by several people, if not families. This is exacerbated by the extended family which usually is part of the core household.

Physical Distancing in the High-Density Suburbs

In this study, the interviews conducted were done based on an informal interview guide that sought to establish if people were physically keeping their distance considering the pandemic. The study took into consideration lockdowns that were meant to keep people physically separated to mitigate the effects of the pandemic. The study interrogated whether it was feasible to observe physical distancing under lockdowns and after they were lifted. Purposively selected adults from different high-density suburbs were interviewed until data saturation was achieved. Harare's CBD provided a lucrative sample from informally employed adults who were selected using the snowballing sampling technique. From the city centre, interviews with research participants who hailed from such high-density areas as Tafara, Mufakose, Mabvuku, Budiriro, Hatcliff, Glen View, Epworth and Chitungwiza were conducted. On being asked how they had fared in terms of physical distancing, most of the responses pointed to there being limited physical distance particularly in the home and other closed spaces such public transportation vehicles and at funerals. Noko (2020: n.p) also confirms this when he asks this petinent question, "If you live in a township, make a living in the informal sector, or travel on a crowded bus, how do you self-quarantine?"

Research participants to the interview questions revealed being part of disadvantaged and particularly poverty-stricken communities means physical distance is a luxury. Lingam and Sapkal who cite the WHO (2008) concur with this and aptly state, "it is not diseases but social injustice that kills [sic] people" (2020:176). In a study drawn from India, Lingam and

Sapkal (2020) list the five key variables that potentially expose people to risk of contracting the virus: Access to drinking water, access to toilets, access to electricity, access to mobile phone and Internet and Income security. However, what is striking about some of the variables such as access to water is how, when placed in a dissimilar context, they differently impact on COVID-19 infection. Lingam and Sapkal also talk of unsafe drinking water which would raise co-morbidity rates yet in Zimbabwe it is the process of accessing the water that makes the difference. An elderly woman from Budiriro suburb bluntly put it,

> *Hakuna COVID-19 mwana, dai takapera kare kare. Nemashandisiro atinoita tambo yemugodhi unoti nguva yesocial distamce yamunotaura iyo tinoiwanepi.* (There is no COVID-19 child, otherwise it would have finished us off long back. With the way we use the rope for the well [for drawing water] do you think we get the time for social distance that you talk about?) (P2, 2022).

The old woman raised a valid point as the queues for water were the order of the day and the rope for manually drawing water as well as the borehole pump are utilised by everyone in the queue with little regard for sanitising one's hands. Even the boreholes sunk for the same purpose were oversubscribed. On being asked what she does to make sure she does not get the virus, she went on to say her mask offered much of the protection as well as the *zumbani* (indigenous herb) tea which is readily available in the bushes and forests in communities.

It appears, the issue of queues brought in another interesting variable to the pandemic. While elsewhere in the developed world, concern was transmission of disease in queues and stampedes over panic buying (Peters, 2020), in Zimbabwe the concept of stocking up was a myth with most households living beneath the poverty datum line. Queues manifested on basic needs such as water as cited above and the transport services. The latter mainly affected essential services workers- medical personnel, police, army among others during the lockdown. For them normal duties proceeded unabated and they had to grapple with the transport challenges as they had to work through the pandemic. The situation was exacerbated when lockdowns were lifted yet people were supposed to keep the strict physical distancing routine. This meant in queues for buses no physical distancing was observed with all commuters desperate to get home. One commuter pointed out,

> *Ko ndezvekuviga here kuti mabhazi hakuna. Sometimes kusvika kumba na 10pm nekumuka patema kunobata bhazi. Even bhazi rinenge rakazara hapana anoda kusara.* (Is it apparent that there are no buses, it is something

> that cannot be hidden. Sometimes you get home at 10pm only to wake up in the wee hours of the morning to catch the bus. Even when the bus is full, nobody wants to be left behind.) (P3, 2022).

Although busses were required to carry a stipulated number to encourage physical distancing this was just a myth as the queues leading to the bus meant people were tightly packed. Another commuter from Zengeza in Chitungwiza commented, "*Chakakosha kuenda kumba mwachewe, hakuna kusingafiwi* (What is important is getting home, nowhere do people not die) (P1, 2022). Apart from this, research participants revealed that evenings saw vehicles overloading as vehicle owners maximised on opportunities to make the sought-after dollar. Such challenges got worse after hours especially in the evening when the police were no longer manning roadblocks and spot checks on overloaded vehicles. Lorries offered a cheaper option, revealing that the cheaper the option the higher the risk of contracting COVID-19.

On being asked if people in their community complied with lockdowns rules, most of the interviewees said lockdowns were largely ignored in poor communities where some of the research participants revealed that they kept to their homes only when they were afraid of arrest by law enforcement agents who sometimes patrolled the streets. Without these patrols the research participants said they were more concerned about bread-and-butter issues. One research participant had this to say,

> *Kutaura chokwadi, hatina kumbobvira tanyatsovhara isu, takangochinja mashandiro phone ndooyakanga yaakushanda kuenda kune basa. Kana ndikagara kumba tinofa nenzara.* (To be frank, we never really closed, we simply changed the way we operated – we relied mainly on the phone to conduct business. If I stay at home, we starve.) (P6, 2022).

Lingham and Sapkal (2020:174) concur with this when they say,

> The present containment policies, while important to combat the disease and break the cycle of transmission, are likely to place many low-income households at the brink of hunger and starvation, a threat worse than the COVID-19, if not supported with necessary welfare measures" (Lingam & Sapkal, 2020:174).

Another research participant (P8) added,

> *My sister isu tine maroom three; vasikana 4 vanosheya bedroom one- vakomana vanorara mukitchen inova ndiyo dining vabereki mavo. Kana ndiwe paita COVID-19 tinodii kutongotambidzana. Mask iyoyo inongoshanda nekusimba*

> *kugeza maoko*. (My sister, we have three rooms four girls share one bedroom and the boys use the kitchen cum dining room and the parents the other room. Imagine getting COVID-19 in such a situation we simply pass it on to each other. We are sticking to wearing masks and washing hands.) (P8, 2022).

On being asked if they were physically distancing within the home including at funerals, a young man first laughed and then added

> "A*hhh ndokunge dzimba dziripoka. Kana pasina kutotswinyikidza muone room imomo ndoda kana kuchinaya heheheee.*" (As long as there is enough space. If not we all squeeze into that one room, imagine when it is raining.) (P7, 2022).

Further probing on what they would do after being in crowded places or living in shared accommodation, several of the research participants disclosed that they would use herbal remedies such as "*kunatira*" (steaming) using "*zumbani*". Other remedies the research participants claimed to have used included gaggling with warm water and salt and or chillis, drinking a cup of bicarbonate of soda every morning, drinking concoctions made from eucalyptus, guava leaves and lemon among others. Most of the research participants said they resorted to using social media in sharing the home remedies that they believe would keep COVID-19 at bay or alleviate its symptoms. However, despite admitting that physical distancing was a challenge, it was also apparent that all the research participants used other measures to protect themselves from COVID-19 infection. They all had masks dangling around their chins and we presumed they were pulled up at the sight of law enforcement agents (see Gudhlanga and Madongonda, forthcoming). They claimed to religiously adhere to the routine of either handwashing or sanitizing. One interviewee stated that the home remedies worked claiming,

> "*Hapana asina kurwara* COVID *muno, taingozvirapa*" (No one was spared by COVID-19, we treated ourselves.) (P1, 2022).

Lingam and Sapkal (2020:176) conclude by stating,

> "The combined influence of biological, environmental and a host of social– political– cultural determinants interplaying with the social markers produce differential health outcomes and inequities."

The risks associated with being poor in a pandemic are indeed numerous and under such circumstances, physical distancing is a luxury. In their own way people in such communities found ways of overcoming the risks they faced on a day-to-day basis.

Social Gatherings: Funerals and the gendered risk of COVID-19

Since it is the nature of Zimbabweans to express camaraderie in grief in the spirit of *Ubuntu,* we thought it worthwhile to zero in on funerals to find out how the research participants reacted to issues pertaining to social gatherings when faced with bereavement in their families. Almost all the research participants in the study were agreed that it is an abomination to keep away from the funeral of a close loved one as was the case during lockdowns. Yet funerals were declared potential coronavirus super spreaders and thus, restricted to several attendees. Humbe (2022) has cited a case of transmission and resultant casualties of the virus that occurred after attendance at one such funeral. Despite having this knowledge, only a few research participants said they would rather be at home to protect their families and those of their relatives at the funeral from catching the virus. One research participant aptly said he would rather bury one deceased than to end up burying multitudes and thus vowed to stay at home. Most of the research participants said they would try to attend. However, after the lifting of these stern lockdown measures, physical distancing was the alternative to prevent infections. Unfortunately, the relaxation of lockdowns was almost reflected in a similar complacency regarding physical distancing. Most of the research participants were agreed that not many observed physical distancing at funerals. One research participant had this to say,

> *Chinongova chirango icho. Vana sabhuku kumusha vanoedza kuti vanhu vaite social distancing asi havana simba seremapurisa rekusunga vanotyora mutemo uyu – voisa mabucket emvura kugedhi nekuti vanhu vapfeke mamask and kugara vakataramukana but chokwadi chaicho ndechekuti pachivanhu chedu, pachiradzwa paya vanhu vanorara vachiimbira mufi. Imba izere ende vazhinji vanenge vasina mamask.* (That is just routine procedure. The village heads in the rural try to ensure that people followed COVID-19 protocols but they are not empowered to enforce these protocols as does the police– they leave a bucket of water at the entrance of the homestead, wearing masks and observing physical distancing but the truth of the matter is, our culture stipulates that during the all-night vigil we must sing for the deceased. The house will be packed and almost everyone would be without masks.) (P1, 2022).

The study further revealed a blatant connection between gender and the risk of contracting COVID-19 from taking care of the sick and the actual

funeral. The gendered dimension of the issue of physical distancing reveals itself in women who must go out to fetch basic household goods water included. Additionally, accessible hospitals during the height of the pandemic were strained for most COVID-19 positive patients and these could not take in any more patients. Furthermore, most Zimbabweans could not afford the astronomical fees that were charged by private hospitals which were treating COVID-19, so they resorted to home-based care as well as handling COVID-19 patients who eventually died at home. This means that such care fell into the hands of female householders who would shoulder the burden of caring for the sick as well as attending to the deceased before they are ferried away. The routine was to have healthcare workers fumigating the home but efforts to quarantine the caregivers were never monitored and the people would come for the funeral in their numbers. While the world, however, has largely emphasised the effects of COVID-19 on frontline workers and considered them the most highly at risk, very little reference has been made to homebound women as caregivers of the sick in poor communities that do not have sophisticated healthcare facilities. Nor do we have statistics showing the effects of the pandemic according to gender. Manyonganise (2022) rightly captures this when she states that during times of crises, the hardest hit are women. From a medical perspective scholars such as Liu, Luo, Li, Zheng and Zhang (2021) have observed that physical distancing in the constricted indoor settings, including transportation modes, has challenges and actually raised the chances of catching the virus. They say "the one-size-fits-all 2-m physical distancing rule …is not applicable under some realistic indoor settings, and may rather increase transmission probability of diseases." Women as caregivers, often must work in proximity with the afflicted, thus, intensifying their chances of catching the virus.

One middle-aged lady had this say over the vulnerability of women during the COVID-19 pandemic during funerals;

> *Isu vana mai tine nhamo yekunzi rarai makarinda chitunha, hamusiyi mufi ari ega. Zvimwe zvitunha zvacho ndoozvinenge zvitori neCOVID-19 yacho sevaya vanofira mumba vasina kuenda kuchipara. Tinochengetwa naMwari.* (Us women have many challenges that include sitting out the all-night vigils in the same room with the deceased. It is unheard of to leave the deceased unattended. Some of the dead would have succumbed to COVID-19 especially those who die at home without going to the hospital. It is God who protects us.) (P11, 2022).

The same could be said of the few vendors who were interviewed, most of whom were women. One female vendor aptly captured it when she said,

> *Kutaura chokwadi handina kubasa kwandinoenda, zvese zvinoraramisa hazviwanikwe mumba saka zvephysical distance nequarantine ingano idzo; ndinoraramisa vana vangu sei ndikagara mumba? Even tikaita physical distance yacho ko mari yandipopihwa ini ndichipawo vanhu staff yangu yandinotengesa hazvibatise neCOVID here?* (Honestly speaking I have no formal job, what makes me survive is not found at home, so all this talk about physical distance and quarantine are myths; how would I fend for my family? We exchange money and merchandise, do they not transmit COVID.) (P9, 2022).

This vendor went on to say she regularly uses her sanitiser and wears her mask although we observed the mask was not properly worn. Unfortunately, she was also honest and disclosed that even if she had the symptoms, she would still come to work. Upon probing, she said all things being well, she would not want to risk herself and her family, she just had no choice. Most of the interviewees concurred that they did not really believe if COVID really existed or not, they felt that it was a disease which was created by superpowers to control weaker nations.

COVID-19 and *Ubuntu* Philosophy

Ubuntu philosophy in the context of a pandemic such as COVID-19 appears to contradict the purposes of COVID-19 protocols that were meant to slow down the spread of COVID-19. Although the strength of the philosophy lay in wholeness and unity of purpose, it was threatened by COVID-19 (Mulaudzi, Anokwuru, Du-Plessis & Lebese, 2022). This, however, does not mean the *Ubuntu* values were totally eradicated. A significant number of researchers agree that this spirit was not exterminated by COVID-19 (Chigangaidze, Matanga & Nyatsuro, 2022; Okyere-Manu & Morgan, 2022; Chisale, 2022). Scholars have highlighted how the effects of lockdowns have been alleviated by online interaction (Ahmad, 2022), not only for educational, business or information dissemination but for social support and human warmth in the context of *Ubuntu* (Makoe & Shantu-Phetla, 2019). However, others such as Ngomane (2019:32) have lamented the current technology driven world where everyone appears to be cubicled in the world of the computer; he says,

> lack of human contact is in direct contrast to the African way of life, where cooperation is vital to enduring hostile conditions. When you need to survive by living off the same land as your neighbour and working alongside them, collaboration is key.

Ponde-Mutsvedu and Chirongoma (2021) agree with Ngomane by stating that trying to circumvent the challenge of disrupted relationships due to COVID-19 through the use of ICTs brings in another new challenge of cyberbullying. It appears they believe that in the face of *Ubuntu*'s inclusive approach to human relationships in the face of challenges, technology, while it appears to create alternatives may actually widen that gap between individuals within the context of African beliefs and practices. To add to this, the Ponde-Mutsvedu and Chirongoma observe that among vulnerable communities, particularly rural communities and the poor, access to this technology is severely limited and at the same time discriminatory in terms of information access as well. Yet, despite these misgivings, one should not fail to observe that the spirit of *Ubuntu* has metamorphosised and using social media has become the new normal in the context of the COVID-19 pandemic as this study has shown, circumventing limited human and physical interaction (Ahmad, 2022).

The foregoing argument that *Ubuntu* has some few challenges in the context of COVID-19 is bound to set the adherents of traditional practices on a collision course with new ways of interacting on social media particularly where funerals are concerned during times of pandemics. While the belief in *Ubuntu* in this regard can appear to be contradicting the COVID-19 protocols, it is clear that it does not take away the merits of the philosophy. Zimbabweans have always acted as a community due to the communal nature of their existence and act in accordance to *Ubuntu* regarding abiding to laws and regulations. While they are hospitable and watch out for their neighbour, proponents of this philosophy should realise that it needs adjustments to take into consideration the period of pandemics such as COVID-19, where congregating in large numbers in support of a sick or deceased relative is no longer advisable. Being flexible removes the stigma and the pressure of being labelled anti-social or worse being ex-communicated from one's kith and kin.

Furthermore, technology used in an appropriate manner can extend the same ethos of *Ubuntu*. In line with this, Okyere-Manu and Morgan (2022) have stated that African ethics can remain relevant and be used to explore challenges effected by COVID-19. WHO ARE THESE? Okyere-Manu & Morgan emphasise the need to find new ways of demonstrating

solidarity and connectivity, as well as the importance of human relationships in the face of a pandemic. Ponde-Mutsvedu & Chirongoma (2022) and Muyambo (2022) concur with the later castigating rigid COVID-19 measures such as physical distancing and call for diverse measures including a return to indigenous knowledge systems not the "one size fits all" strategies. Mukesi and Wabomba (2021) have also criticised African governments for looking down upon their own knowledge systems instead of promoting them. These are more likely to be homegrown systems that are tailor-made for their own circumstances and cultures. It is unfortunate that African governments refrained from imitating the Madagascar model of the production of homegrown medical solutions, which can be drawn from our own indigenous knowledge systems (Mashego, Madotsi & Bhuda, 2021; Nhongo, 2020; Chigangaidze, Matanga, A. & Nyatsuro).

Way forward

Despite the adverse circumstances that could have worked against the welfare of the people particularly the poor, one then wonders how the pandemic did not have such a devastating effect on the populace. The study revealed that despite physical distancing being a necessity, it was a luxury to use physical distancing as a strategy owing to congestion in high density areas. With the low COVID-19 statistics in the country, it can only be safe to conclude that Zimbabwe, among other African nations, has more than been fortunate. An important factor that accounts for the low statistics is that the majority of Zimbabwe's population is rural based and indeed the households in such areas are naturally separate thereby underscoring the success of mitigation against the devastating effects of the pandemic as experienced elsewhere. The story of Africa's success in combatting the virus could also be explained by the swift actions of the governments before losing control to the rampaging virus. The temperate climate has also been factored in as a contributory element to the mitigation of the spread of the COVID-19 virus. This has been supported by statistics that demonstrated that colder climates have contributed immensely to the spread of the virus. Countries with extremely cold temperatures were affected, hence, their infections and mortality rates spiraled out of control.

For future reference we propose that with regards to combatting pandemics the following be considered:

- Measures to contain pandemics should be contexualised to take into cognisance a people's cultural values, beliefs and practices which can be drawn from their own indigenous knowledge systems.
- A combination of both control and monitoring measures should be put in place if another pandemic occurs.
- *Ubuntu* as a philosophy has its merits and focus should be on these as part of mitigatory measures. Most of the people be conscientised and thus adopt the altruistic values and principles of *Ubuntu* and desist from behavior that exposes others to the virus even when under serious threat.
- Governments should put in place mitigatory measures to alleviate the effects of the pandemic on most of the people who are economically disadvantaged as well as assist the vulnerable particularly caregivers.

Conclusion

It is apparent that despite the vulnerability of most Zimbabweans in the face of the COVID-19 pandemic, the worst of the pandemic is over. The study has revealed that in populous locations, physical distancing was a luxury and that numerous factors contributed to the vulnerability of the populace due to some extent, the communal nature of Zimbabwean society that could have resulted in a high mortality rate. The study has shown how the people in Zimbabwe, despite facing a crippled economic and healthcare system found their own strategies of surviving the raging pandemic. It demonstrated that survival and upholding the spirit of *Ubuntu* as reflected in traditional practices of mourning took precedence over contracting the virus. However, the study has also revealed that people were left with no choice but were forced into such situations that include unethical behavior such as flouting COVID-19 protocols. This left them vulnerable; should they have had a conducive environment availed to them, they would have effectively combatted the pandemic.

References

Primary Sources

P1 Field Interview, 28 February 2022, Fourth Street Bus Terminus, Harare CBD

P2 Field Interview, 01 March February 2022, Market Square Bus Terminus, Harare CBD

P3 Field Interview, 08 March 2022, Kurima House, Harare CBD

P4 Field Interview, 08 March 2022, Cameron St Bus Terminus, Harare CBD

P5 Field Interview, 12 March 2022, Corner Speke and Julius Nyerere, Harare CBD

P6 Field Interview, 15 March, 2022, Seke Rd Flyover, Harare CBD

P7 Field Interview, 24 March 2022, Corner Robert Mugabe and Julius Nyerere, Harare CBD

P8 Field Interview, 24 March 2022, Town House, Harare CBD

P9 Field Interview, 28 March 2022, Copacabana Bus Terminus, Harare CBD

P10 Field Interview, 28 March 2022, Copabana Bus Terminus, Harare CBD

P11 Field Interview, 31 March 2022, Corner Leopold Takawira and Nelson Mandela, Harare CBD

P12 Field Interview, 08 March 2022, Chinhoyi Street Flea Market, Harare CBD

P13 Field Interview, 26 March 2022, Kwame Nkrumak Mall, Harare CBD

P14 Field Interview, 28 March 2022, Cornerhouse, Harare CBD

Secondary Sources

Ahmad, A. 2022. Exploring the role of social media within Covid-19 prevention and mis/information on Facebook: A case study of the South Africa level 5 lockdown. ResearchSpace [Web Page] https://ukzn-dspace.ukzn.ac.za/handle/10413/20636 [Accessed 12 August 2022].

Amadi, E. 1969. *The Great Ponds*. London: Heinemann.

Camus, A. 1947. *The Plague*. London: Penguin Books.

Chigangaidze, R.K., Matanga, A.A. & Nyatsuro, T.R. 2022. Ubuntu Philosophy as a Humanistic–Existential Framework for the Fight Against the COVID-19 Pandemic. *Journal of Humanistic Psychology*, 62(3):319-333. https://doi.org/10.1177/00221678211044554

Chirisa, I. & Mundau, L. 2021. The impact and Imlications of COVID-19: Reflections on the Zimbabwean society. *Social Sciences & Humanities Open*, 4(1). http://doi.org/10.1016/j.ssaho.2021.100183

Chisale, S.S. 2022. "COVID-19 and Ubuntu Disruptions: Curbing the violence against Women and Girls with Disabilities through African Women's. Theology of Disability". *Journal of International Women's Studies:* 24(4), https://vc.bridgew.edu/jiws/vol24/iss4/3 .

Flick, U. 2014. *An introduction to qualitative research* (5th ed.). London: Sage Publications Ltd.

Gudhlanga, E.S. & Madongonda, A.M. 2020. Shona Culture and a New World Order: Fissures, Strategies and Mitigation in COVID-19 Era. In R. Makamani, A. Nhemachena & O. Mtapuri (eds). *Global Capital's 21st Century Repositioning: Between COVID-19 and 4th Industrial revolution on Africa*, 151-170. Mankon: Langaa.

Gudhlanga, E.S. & Madongonda, A.M. (Forthcoming). Who is Fooling who? Masking up and its implications on Zimbabwean society (Chapter in this volume).

Humbe, B.P. 2022. Living with COVID-19 in Zimbabwe: A religious and scientific healing response. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa*, 73-88. New York: Routledge.

Kharoubi, S. & Saleh, F. 2020. Are Lockdown Measures Effective Against COVID-19? Frontiers in Public Health [Webpage] https://doi.org/10.3389/fpubh.2020.549692

Lingam, L. & Sapkal, R.S. 2020. COVID-19, Physical Distancing and Social Inequalities: Are We all Really in this Together? *The International Journal of Community and Social Development* 2(2):173-190.

Liu, F., Luo, Z., Li, Y., Zheng, X., Zhang, C. & Qian, H. 2021. Revisiting physical distancing threshold in indoor environment using infection-risk-based modeling. *Environmental International 153*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8016632/pdf/main.pdf

Manyonganise, M. 2022. 'When a pandemic wears the face of a woman': Intersections of religion and gender during the COVID-19 pandemic in Zimbabwe. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa,* 232-243. New York: Routledge.

Mashego, S.L., Madotsi, M.E. & Bhuda. 2021. A Response to Covid-19: Perspectives from African Indigenous Knowledge Systems. *African Journals Online (AJOL)*, 19(1). https://www.ajol.info/index.php/gab/article/view/210065

Matuschek, C., Moll, F., Fangerau, H., Fischer, J.C., Zänker, K., van Griensven, M., Schneider, M., Kindgen-Milles, D., Knoefe, W.T., Lichtenberg, A., Tamaskovics, B., Djiepmo-Njanang, F.J., Budach, W., Corradini, S., Häussinger, D., Feldt, T., Jensen, B., Pelka, R., Orth, K., Peiper, M., Grebe, O., Maas, K., Bölke, E. & Haussmann, J. 2020. The history and Value of face masks. *European Journal of Medical Research,* 25:23. https://doi.org/10.1186/s40001-020-00423-4

Maxwell, J.A. 2012. *Qualitative research design: An interactive approach*. London: Sage.

Metha, V. 2020. The new proxemics: COVID-19, social distancing, and sociable space. *Journal of Urban Design*. https://doi.org/10.1080/13574809.2020.1785283

Makoe, M. & Shantu-Phetla, T.P. 2019. Using Mobile-Based Social Media to Facilitate Interaction and Build Communities through the Lens of Ubuntu in Distance Education. *Journal of Learning for Development*, 6(2):130-142.

Moyo, S. 2020. Nurses, doctors desert casualty section as woman indicates that she has Covid-19 & UK travel history. *MyZimbabwe News*, 22 April. https://www.myzimbabwe.co.zw/news/63440-nurses-doctors-desert-casualty-section-as-woman-indicates-that-she-has-covid-19-uk-travel-history.html [Accessed 12 August 2022].

Mulaudzi, Anokwuru, Du-Plessis & Lebese. 2022. Reflections on the Concomitants of the Restrictive Visitation Policy During the COVID-19 pandemic: An Ubuntu Perspective. *Frontiers in Sociology*, https://doi.org/10.3389/fsoc.2021.769199.

Muyambo, T. 2022. Social Distancing in the Context of COVID-19 in Zimbabwe perspectives from the Ndau religious indigenous systems: Resources from Ndau Inddigeous Religion. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa,* 37-51. New York: Routledge.

Ngomane, M. 2019. *Everyday Ubuntu: Living Better Together, the African Way*. London: Harper-Collins.

Nhongo, K. 2020. Could African indigenous knowledge hold answers to COVID-19? *Southern African research and Documentation Centre* [Web Page] https://www.sardc.net/en/southern-african-news-features/could-african-indigenous-knowledge-hold-answers-to-covid-19/ [Accessed 20 August 2022].

Nkengasong, J.N. & Mankoula, W. 2020. Looming threat of COVID-19 infection in Africa: act collectively, and fast. *Lancet,* Mar 14; 395(10227):841-842.

Noko, K. 2020. In Africa, social distancing is a privilege few can afford. [Opinion] *Aljazeera*. https://www.aljazeera.com/opinions/2020/3/22/in-africa-social-distancing-is-a-privilege-few-can-afford [Accessed 23 August 2022].

Nyabadza, F., Chirove, F., Chukwu, C.W. & Visaya, M.V. 2020. Modelling the Potential Impact of Social Distancing on the COVID-19 Epidemic in South Africa. *Hindawi: Computational and Mathematical Methods in Medicine,* Volume 2020. https://doi.org/10.1155/2020/5379278

Okyere-Manu, B. & Morgan, S.N. 2022. Exploring the Ethics Ubuntu in the Era of COVID-19. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa*, 25-36. New York: Routledge.

Peters, M.A. 2020. Love and social distancing in the time of COVID-19: The philosophy and literature of pandemics, Educational Philosophy and Theory. https://doi.org/10.1080/00131857.2020.1750091

Pinkowski, J. 2021. The history of the forgotten pandemic. *Yale Insights* [Webpage] https://insights.som.yale.edu/insights/the-history-of-the-forgotten-pandemic [Accessed 24 August 2022].

Ponde-Mutsvedu, L. & Chirongoma, S. 2022. Tele-evangelism, telehealth and cyberbullying in the wake of the outbreak of COVID-19 in Zmbabwe. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa*, 103-114. New York: Routledge.

Rahman, M.S. 2017. The Advantages and Disadvantages of Using Qualitative and Quantitative Approaches and Methods in Language "Testing and Assessment" Research: A Literature Review. *Journal of Education and Learning*, 6(1):102-112.

Ramose, M.B. 1999. *African Philosophy through Ubuntu*. Harare: Mond Books.

Samkange, S.J.W.T. and Samkange, S. 1980. *Hunhuism or Ubuntuism: A Zimbabwe Indigenous Political Philosophy*. Harare: Graham Publishing.

Taubenberger J.K. & Morens, D.M. 2006. 1918 Influenza: The Mother of All Pandemics. Emerging Infectious Diseases, January 12(1):15-22. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3291398/pdf/05-0979.pdf

UNICEF. 2020. Physical not social distancing. https://www.unicef.org/sudan/press-releases/physical-not-social-distancing [Accessed 24 August 2022].

Van Coller, H. & Akinloye, I.A. 2022. Religion, law and COVID-19 in South Africa. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the COVID-19 pandemic in Southern Africa*, 89-102. New York: Routledge.

Wabomba, C. and Mukesi, J. 2021. Vaccination in Africa: The Paradox of Human Rights and Human Experiments. In R. Makamani, A. Nhemachena & O. Mtapuri. *Global Capital's 21st Century Repositioning: Between COVID-19 and 4th Industrial revolution on Africa*, 45-76. Mankon: Langaa.

Yang, X. 2021. Does city lockdown prevent the spread of COVID-19? New evidence from the synthetic control method. *Global Health Research and Policy*, 6(20). https://doi.org/10.1186/s41256-021-00204-4

Molly Manyonganise

10 Mourning from a Distance: COVID-19 and the Disruption of African Funerary Rites in Zimbabwe

Abstract

Since the year 2019, the world has been grappling with the coronavirus. The virus which was first detected in the Chinese province of Wuhan in December 2019, landed on the African continent in February 2020. The fast spread of the virus threatened the socio-economic well-being of most countries of the world. To contain the spread of the virus, the World Health Organisation (WHO) put in place several measures. Some of these measures were masking up, sanitising, constant washing of hands as well as social distancing. While these measures were noble and seen as effective in containing the spread of the virus, some of them infringed on the African religio-cultural beliefs and practices mainly when it comes to the funerary rites. The purpose of this paper is to interrogate the measure of social distancing. This is done to establish the various ways in which this measure disrupted African ways of mourning and burying the dead. In doing this, the study explores whether it is possible, in the context of COVID-19, to come up with more acceptable ways of mourning that are indigenous to Africa while at the same time paying particular attention to international standards of dealing with the pandemic. Data for the paper were gathered through interviews with people who lost their loved ones in Zimbabwe as well as online media reports of the same. Secondary sources were utilised to support primary data.

Keywords: Africa, cultural beliefs, COVID-19, disruption, distance, funerary rites, WHO, Zimbabwe

Introduction

Grief and mourning continue to be central research topics in the anthropology of death (Robben, 2018:13). The study of death, grief and mourning has been done in various fields such as psychology (Robert, 2000; Klimczuk & Fabis, 2017; O'connor, 2019), medicine (Shear, 2012; Hagan, 2015; Schmidt et al., 2016), anthropology (Kiong & Schiller, 1993; Robben,

2018; Silverman et al., 2021), sociology (Riley, 1983; Walter, 2008; Puri, 2021), pastoral studies (Cox & Fundis, 1992; Cox et al., 2003; Baloyi, 2014; Bregman, 2019), and religious studies (Lloyd, 1996; Filippo, 2006; Setta & Shemie, 2015). Yet more recent publications have focused on this subject focusing specifically on the COVID-19 pandemic death experiences (Mortazavi et al., 2021; Trebski, 2021; Sibanda, Muyambo & Chitando, 2022). All these and many others are important in informing this study focusing on funerary rites in a COVID-19 context in Zimbabwe.

Since the year 2019, the world has been grappling with the coronavirus. The virus which was first detected in the Chinese province of Wuhan in December 2019, landed on the African continent in February 2020. The fast spread of the virus threatened the socio-economic well-being of most countries of the world. To contain the spread of the virus, the World Health Organisation (WHO) put in place several measures. Some of these measures were masking up, sanitising, constant washing of hands as well as social distancing. While these measures were noble and seen as effective in containing the spread of the virus, some of them infringed on the African religio-cultural beliefs and practices mainly when it comes to the funerary rites. The purpose of this paper is to interrogate the measure of social distancing. The study is cognisant of the fact that while the WHO has used the term 'social distancing' some scholars found this problematic. For example, Gudhlanga and Madongonda (2021:157) prefer the use of 'physical distancing' instead of 'social distancing'. For them, "in as much as people are physically distant through geographical location, the closeness of social relations is still emphasised although being exercised through technology rather than through actual physical closeness."[1] The study's focus on social distancing is done in order to establish the various ways in which this measure disrupted African ways of mourning and burying the dead. In doing this, the study explores whether it is possible, in the context of COVID-19, to come up with more acceptable ways of mourning that are indigenous to Africa while at the same time paying particular attention to international standards of dealing with the pandemic. Data for the paper were gathered through newspaper reports and informal discussions with people who lost their loved ones in and out of Zimbabwe. Secondary sources were utilised to support primary data. The chapter foregrounds Ubuntu as the theory informing the study. Ubuntu is premised on the maxim that 'I am because you are'. The Shona believe

[1] For me, this is a technical debate which is not part of this discussion.

that one's humanity resides within a community of persons. Thus '*munhu munhu nekuda kwavanhu*' (A person is a person because of other people). Chasi and Tagwirei (2020:23) argue that death and Ubuntu speak to each other implying that in order to deal with death the Ubuntu ethic is an enabling force. As such, the concept of Ubuntu remains relevant even when people are faced with difficulties in their lives, death included. When the Shona are faced with a seemingly insurmountable task or threat, they expect all hands on the deck. The Shona proverb "*Makudo ndemamwe, musi wenjodzi anorwirana*" (Baboons belong to the same class, on the day of danger they fight for each other) is echoed as well as the need for "*chirwirangwe*" (fighting together like leopards, sic). It is these concepts of togetherness which were challenged by the COVID-19 pandemic.

African Traditional Funerary Rites: Discoursing Tradition

Africans like other societies conceive death as something that one cannot get used to. It is a fearful phenomenon which Mbiti (1991:145) describes as inevitable and most disrupting in many societies. Ugwu and Ugweueye cited in Nwokoha (2020:70) opine that death stands between the world of human beings and the world of the spirits, between the visible and the invisible as a transition from one state of existence to another. This view is in line with Van Gennep who posits that death is one of the rites of passage. For Van Gennep (1960:2-3), the life of an individual in any society is a series of passages from one age to another and from one occupation to another. For example, one moves from birth, puberty, marriage, and then death. The Shona in particular categorise some deaths as bad and others as good, some are acceptable while others are not. For example, the death of a child or those who do not yet have children is bad while deaths of the old are good deaths because they would have lived full lives and can become ancestors after the performance of requisite rituals which for the Shona is the *Kurova guva ceremony* (domestication of the spirit). Unnatural deaths due to murder or suicide are viewed negatively among the Shona. Death by suicide is frowned at and the funerary rites are quite different from those of people who die due to sickness or other causes. Suicide leaves a different type of grief for the deceased's loved ones, including a terrible sense of guilt (Cumiskey & Hjorn, 2017: n.p). As such, there is a way in which the Shona in particular 'punish' the body of a person who commits suicide. For example, in some Shona ethnic groups,

their body is cast outside of their home as people mourn and upon burial it is whipped so that the spirit does not dare come back to haunt the living. Hence, while a good death presented the possibility of reincarnation and a welcome influence on the world of the living, a bad death brought only spectre of malevolent ancestral spirits (Lee & Vaughan, 2008:345). Hence, for the Shona, funerary rites are determined by the nature of death as well as age, gender, ethnicity, to mention but a few.

The Shona avoid speaking about death directly. Kaguda (2012:57) observes that the Shona have traditionally felt uncomfortable dealing with the subject of death using straightforward terms. In her analysis, they instead use euphemisms, metaphors and idiomatic expressions. For example, when referring to the death of an individual, the Shona may use terms like *watisiya* (s/he has left us); *waenda* (s/he has gone); *warara* (s/he has slept); *ashaya* (s/he is lost). Terms like *wafa* (s/he is dead) are avoided because they are frightening. Reference is also made to the way the deceased is buried with the use of terms like *tamuchengeta* (we have kept him/her); *tamuviga* (we have hidden him/her); *takamuradzika* (we laid him/her down). If the deceased has not been buried according to proper cultural traditions, the Shona refer to such a burial as *kurasa* (throwing away). The grave is perceived as the deceased's home (*imba yake*). A Zimbabwean singer, Simon Chimbetu used modern metaphors such as '*imba isina hwindo*' (a house without windows) in reference to the grave. Kaguda (2012:57) posits that "these indirect expressions play an important role in revealing the Shona people's understanding of death and how they cope with death and dying." Contemporary Zimbabwe has also witnessed the use of slang as people try to lighten the pain and burden of death. Terms such as '*atila*' (has died), and '*akika bhagidhi*' (has kicked the bucket)[2] have been used. Such terms have been condemned for disrespecting the dead. Shoko (2008:11) says the slang terms are considered too direct and impolite. Mawadza (2000:93) argues that slang is informal and less acceptable among the Shona because it is, generally, regarded as subversive and derogatory, therefore, inappropriate for use at a funeral. The use of appropriate language depending on context is crucial for the Shona. In funeral contexts, language performs an expressive function, to express the Shona people's emotions, feelings and thoughts in connection to death (Kaguda, 2012:58). In concurrence, Davis (2002:1) argues that "language is the very

[2] For more terms see Shoko, 2008 and Kaguda, 2012.

medium through which human beings obtain their sense of self-consciousness that it can serve so well the basis of reaction to the awareness of death." In his analysis, Davis views the use of language as an attempt by people to try and defy death.

The influence of Christianity on how the Shona now understand death is very apparent. While still holding on to the traditional notions of death, the Shona have infused these with the Christian understanding of death. Hence, to cope with death, they now usually refer to the dying of a relative as God's will. In most cases, people utter such statements as '*nguva yake yanga yakwana*' (his/her time was up), '*Mwari vaita kuda kwavo*' (God has done his will). Christian songs such as '*Akanzi mira ipapo nguva yakwana*' (He/she was told to stop there because the time was up, sic) allude to the Christian belief that no matter where one is, once their time to die comes, they cannot escape. Biblical texts such as Job 14:1 which says "Man that is born of a woman is of few days and full of trouble" (KJV) are often cited in order to console the bereaved. Christian rituals are combined with traditional ones in order to satisfy the requirements of both religions. At times this has brought to the fore the battle of supremacy of religions as conflict sometimes arises between conservative adherence of tradition and of Christianity.

The coming of colonialism brought changes to the social and political structure of African societies. The introduction of colonial cash economies led Africans to leave their ancestral lands in search of paid jobs in farms, mines and urban areas. Even then, according to African tradition, the dead could not be buried away from their ancestral lands. In Zimbabwe, during the colonial period, a cemetery for the blacks was put in a high-density suburb called Kambuzuma (now Warren Hills) in Harare. However, most people declined to be buried in this cemetery. A song to this effect was composed with the lyrics "*Ini Kambuzuma handidi, ndinonovigwa kumusha*" (Me, I don't like Kambuzuma, I will be buried at home). *Kumusha* for the Shona, when they are in the urban areas, refers to their rural origins, the area where their kith and kin reside and they occasionally visit, while Zimbabwe becomes *kumusha* when one is abroad. When one dies in foreign countries, their remains are transported to Zimbabwe, but the majority are further taken to their rural areas for burial. Though colonialism made most Africans to spend more time away from their rural homes, most of them maintained contact and also established their wives and children in them so that the homes could be taken care of. This was a sure way of ensuring that in the event of death, they had a place

of burial. Such beliefs continue to inform the worldview of African migrants in general and Zimbabwe in particular. Despite some having been in the diaspora for many years they continue to build homes in towns, cities and the rural areas around Zimbabwe. A quick look on Facebook reveals a number of groups (such as Let's build our rural homes) that have been formed to encourage people to build their rural homes so that their relatives will not be ashamed to bring their dead bodies home for burial. In the next section, it becomes crucial for the study to engage with the way post-colonial Zimbabwe has dealt with death and burial practices.

Migration, Death and Burial: Tradition at a Crossroads

According to Lee and Vaughan (2008:357) "in the post-colonial period, the growth of regional and international networks increased mobility (within Africa and globally) and the speed of telecommunications have contributed to a remapping of the ways in which people understand and exercise daily a sense of belonging. For example, in post-colonial Africa in general and Zimbabwe in particular, there has been a migration of Africans beyond their countries of birth due either to armed conflict or economic crisis which led citizens of a particular country to look for greener pastures. The effect of globalisation has seen some Africans seeking better opportunities in other African countries and beyond. In most cases, those that die beyond their country's borders are expected to be ferried back to be buried in their country of birth. The Shona of Zimbabwe still hold the belief that one has to lie beside his/her ancestors and for most men as well as unmarried, divorced, single women and children, this is where their umbilical cord was buried when they were born. Married women are to be buried in their husbands' homes except for the Budya of Mutoko whose women would traditionally be buried in their natal families. If this is not possible, still a decision has to be made by the families of the woman and that of her husband where her remains can be interred. To this end, Biwul (2014:18) avers that "those that die in some African countries other than the country of their ancestry, and even those who are domiciled outside the continent, when they die in the diaspora, their corpses are brought 'home' for proper burial in their ancestral lands." At the time of writing this paper, a prominent figure in Zimbabwean politics who was working in the United Kingdom, Alex Tawanda Magaisa, died on the 6th of June 2022. His body was flown to Zimbabwe on the 25th of June 2022. A quick look at Twitter comments showed his followers commenting,

"Musaigwa[3] is now home". This is testimony to the fact that the Shona's conceptualisation of home is not anywhere apart from one's ancestral lands where one's umbilical cord (*rukuvhute*) was buried. For the Shona, if one fails to be buried in the place where his/her ancestors are buried, it is a tragedy. For them, that person is in the forest (*musango*) where the remains have been cast away (*kuraswa*). This is the difference with those whose remains are buried at home because they are kept (*kuchengetwa*) or made to lie down/sleep (*kuradzikwa*). In cases where the body of the dead could not be brought home for whatever reason, the Shona had to perform a ritual in which soil from the place where the person was buried is brought to his/her ancestral home and then it is placed in a grave meant for that person together with a goat's head. This symbolic burial was perceived to be representative of the actual funeral, hence all applicable rituals were performed. The relatives of the dead would mourn in the same manner they would have done if the dead's body had been there. This was very important for the Shona because the spirit of their dead relative had to find rest among his/her people. For them, it was and continues to be dangerous for the spirit of the dead to stay among aliens (*vatorwa*). Kuper, Hughes and van Velson (2017) posit that the Shona, traditionally would refuse burial to strangers. The reason was that they feared that if the dead stranger's spirit turned rogue, they would not know how to tame it. In this case, the symbolic burial of their dead was seen as a transference of the spirit of the dead from the place where the body was interred to the place of symbolic burial. Hence, though the dead body remained buried in alien territory (*nyika yevatorwa*), the spirit was believed to lie at the place of symbolic burial.

The observance of burying the dead in their ancestral lands is necessitated by the desire to follow cultural practices. Biwul (2014:18) argues that Africans follow particular cultural traditional rituals when burying the dead. Writing on the culture and customs of Zimbabwe, Owomoyela (2002:121) observes that the Shona handle a person's death with solemnity and care because they want to ensure his/her spirit a safe passage and happy integration into the community of the ancestors. Among the Shona, the mourning process begins once one is declared dead. In precolonial Shona society, before announcing the death to the public, the body of the deceased was prepared and wrapped in preparation for the mourning process. Before wrapping the body, the Shona would fold the

[3] Musaigwa is derived from his totemic identity of the Dziva (Pool) clan.

body through a process known as *kupeta mufi*. This entails straightening the deceased's legs and arms as well as closing their eyes (Mwandayi, 2011:201). Shoko (2008) alludes to the fact that it is not acceptable to bury the deceased with their eyes open or any of their body parts folded. Hence, the rite of *kupeta mufi* is a compulsory one among the Shona. The hut in which the body was to lie in state was also emptied to create space for the mourners. Once everything was put in place, the closest relatives particularly women present would start mourning through wailing. Traditionally, there was a drum or horn that was used to announce death within a community. Once people heard this drumming and/or the sound of the horn, they would follow its direction to join others in mourning. For relatives that lived far away, messengers were sent to deliver the sad message of death. In contemporary Zimbabwe, the introduction of information technologies has helped in transmitting information in real-time. Hence, once one dies, information can be sent through cell phone calls as well as social media platforms like WhatsApp, Facebook, Instagram and Twitter, to mention just a few. While people can still die in their homes in contemporary Zimbabwe, most people now die in hospitals, hence, there have been some changes in the cultural forms of mourning. For example, the bodies of the deceased are now being kept in mortuaries and they are only released to the relatives a day before burial. Unlike in Western culture, mourning was/is a communal activity in most African societies. Jindra and Noret (2011:1) note that funerals in Africa draw neighbourhoods, and family members and friends who have migrated to other areas and countries are lured back. Cohen (2002) notes how family, friends and neighbours respond to a death in structured and patterned ways. It is conceived as disrespectful if one misses the funeral of a relative. In traditional Shona society, one could be suspected of witchcraft. Robben (2018:8) avers that "indifference to a death expresses a lack of moral and cultural unity, and an absence of social cohesion and solidarity." Hence, the ritual of *kubata maoko* (expressing one's sympathy through the mourning handshake) is expected of relatives and neighbours. Apart from the traditional handshakes, in contemporary Zimbabwe, people have also been using hugs[4] as expressions of sympathy and shared pain because of the loss. In

[4] The use hugs has been categorized as too elitist and a departure from traditional modes of showing sympathy. However, the practice has become acceptable even in Zimbabwe's rural areas where cultural practices are thought to be very strong.

Robben's opinion, weeping and embracing manifest the social attachment of the living and the dead as well as enhancing the social solidarity of the survivors, and mend the weakened social collectivity (2018:8).

Mourning through Ritual Performance: Enacting Tradition

The place of rituals during mourning has been analysed by a number of scholars. Baloyi (2014) conceives rituals as representations of cultural performances and rites of passage, which mark a people's life experiences. Cumiskey and Hjorth (2017: n.p) view rituals as sites of imagination for those engaged in their construction and performance. Focusing on death, Hall (2001) cited in Cumiskey and Hjorth (2017: n.p) argues that rituals can be used to promote meaning-making related to loss. They legitimise emotional expression related to grief and loss and allow for a sense of doing or acting upon the grief so as to produce an emotionally cathartic effect (Cumiskey & Hjorth, 2017: n.p).

As mentioned earlier, among the Shona, funerary rites start as soon as one is declared dead. Mungwini (2017:114) explains that among the Shona, "death is not considered as an end but simply a transition into another phase of being within the cycle of life that connects the yet-to- be born, the living and the dead." Hence, Mbiti (1991) calls them "the living dead." As such, cultural practices that ensure that this bond between the dead and the living is not broken are performed in the event of death. Hence, Robben (2018:7) opines that mourning is not a spontaneous emotion, but a collective obligation manifested in appeasement rituals. Scholarship focusing on death and dying in Africa has established the centrality of rituals throughout the mourning process which begins with one dying and can stretch to up to a year. Hertz cited in Robben (2018:3) argued that the death of a human being is not exclusively a biological reality or confined to the individual sorrow of the bereaved relatives, but that death evokes moral and social obligations expressed in culturally determined funeral practices. When writing about death among the Neur, Evans-Pritchard (1949:62) had mistakenly concluded that funerary rites were meant to cut the dead from the living. He interpreted the cutting of hair by the kin of the dead as symbolic of the cutting off of the dead from the living. In response, Lee and Vaughan (2008) contend that Africans do not cut themselves off from their dead, but live in relation to the world of the dead, which is the world of the ancestors. For them, "in Africa, the living

and the dead together constitute the social world." In sub-Saharan Africa, traditional funerary rituals are deeply rooted and positioned in African cultures (Park, 2020:75). Cohen (2002) observes that cultural guidelines determine the treatment and disposal of the body and prescribe a period of mourning for close relatives. Davies (2002:5) views funerals as symbolising society and death rites as an "inevitable consequence of human self-awareness and death as something that cannot be categorised as 'nature' or as 'animal' in opposition to 'culture' or 'human'. In other words, death rites are an expression of one's culture, which gives both the dead and living their identity. They are a medium through which the living come to terms with their physical mortality and the expectation of life after death. According to Davis (2002:16),

> funerary rites help and assist individuals over the period of their distress as well as expressing the social loss of a member of society. Through death ritual, the affected feel the support of others, many of whom are not directly affected by the death, until such time as they gain a sense of their own ability to cope. Communal support overcomes the sense of hopelessness of the individual who might otherwise have to stand alone.

Viewing funerary rites through the lens of embodiment, Van Wijk and Arendse (2013:46) argue that "African bereavement rituals render death a broadly dialectical process of shepherding the deceased's soul through a series of embodied rituals which steward the deceased's soul to an ancestral-spiritual realm." In his analysis, all the rituals performed are integral to attaining closure for the deceased and the bereaved. Owomoyela (2002:121) had earlier noted that the funerary rituals are important not only for the dying but also for the living. He argues that "for just as the post-mortality well-being of the dying person is at stake, so are the survivors' prospects of receiving favourable attention, rather than neglect or even possible angry visitations from the deceased ancestor." Evans-Pritchard cited in Lee and Vaughan (2008:341) noted that the elaborate rituals performed by Africans in relation to death show that death invoked fear and revulsion and posed a problem for the living.

COVID-19 and Social Distancing: Disrupting Culture

Ripoll (2020) makes a discursive analysis of how public health measures to mitigate the risk of infection during an epidemic infringe on the rights of religious communities to bid farewell to their loved ones in accordance

with their customs. He argues that there is evidence of competition between public health goals and religious rights as well as positionings of power between ethnic and religious majorities and minorities. In his analysis,

> Epidemic response as a secular project prioritises biomedical and epidemiological knowledge and treats it as if it were devoid of religion and culture. Culture and religion thus become residual, a world of meaning and practices outside the real world of disease to be either overcome, subverted, or harnessed (2020:7).

In terms of COVID-19, many of the public health interventions across the world related to death and burials have included banning funerals or related rituals limiting their size and imposing social distancing on them. Within the Zimbabwean context (this applies to other contexts as well), the World Health Organisation prescribed guidelines were embraced. Among these guidelines was the need to sanitise, mask up, regular washing of hands and social distancing. This chapter focuses on social distancing as having disrupted not only social relations, but the performance of funerary rites as well. While the practice was meant for people to leave a distance of between one to two metres with the next person to curb infection, it also meant that those who lived far away from their loved ones could not travel in the event of a funeral due to the enforcement of travel bans. This implied that close relatives were failing to attend funerals of their loved ones. This was resisted by some people who felt that there were certain funerals which one could not miss. Hence, within Zimbabwe, close relatives had to get an authorisation letter from the police after submitting the burial order of the deceased. However, it was not easy getting the police travel permit as some police officers wanted bribes (Gudhlanga & Madongonda, 2021:158).

At the onset of the pandemic in Zimbabwe, the government ordered that only one close relative witnesses the burial of a dead relative, particularly those who succumbed to the virus. Funeral night vigils were banned and dead bodies could not lie in state at home if COVID-19 was the cause of death. On 11 January 2021, Reuters reported that the Zimbabwe government had banned traditional funerals due the increased number of COVID-19 cases. In these new measures, families were banned from transporting their dead relatives between cities, implying that those that desired to bury their relatives in their rural homes could not do so. To make matters worse, the dead bodies were being transported from the morgue straight to the burial place. In cases where the cause of death was

not linked to COVID-19, night vigils were allowed, but the number of those who could attend was limited to thirty. Depending on how the government measures were understood, as the body lay in state, at times only one person was allowed to watch over the body throughout the night, at other times ten people were allowed with strict observance of social distancing. In some rural areas, village heads were innovative as they organised their villagers into groups of ten to give each other turns to attend funerals and express their condolences to the bereaved families. However, the cultural practice of loud wailing while hugging or handshaking was not permissible because of the social distancing rule. Traditionally, food is usually served at funerals in Zimbabwe. However, this was banned because of the pandemic.

The fact that those who died due to the virus were taken from the mortuary to the grave altered the funeral ritual practices of the Shona in a number of ways. The rituals of watching over the corpse while singing and testifying about the dead throughout the night had to be abandoned. The *sahwira* (friend) or *varoora* (daughters-in-law) who traditionally performed recognisable roles in preparing the body in terms bathing it, applying ointment, dressing it and finally placing the casket into the grave, had their roles vanquished by the pandemic. They too became spectators in the whole process which they once dominated. The ritual of body viewing where the final farewell with the dead is done was banned. What this meant was that the relatives could not ascertain whether the person being buried was truly their relative. Even the lowering of the body into the grave which is usually led by the *sahwira* with assistance of relatives and neighbours could not be done. Strangers in the name of medical experts became responsible for all these duties. The travel bans meant that even children of the deceased who were abroad could not travel to attend the funerals of their parents.

Arising from the above, some Zimbabweans devised ways of subverting these WHO and government protocols. Those in the rural areas whose relatives died at home usually had all rituals done because there was no certification of whether they had died from the virus. As a result, it would only become clear that the deceased was infected after those that got into contact with the dead body started showing signs of infection or die from the virus. Hence, attendance at funerals and performing culturally prescribed rituals were some of the many ways through which the virus spread. This was a bit different in cases where someone died at home in the urban areas because they had to be tested to ascertain the cause of

death. Being afraid that once it was ascertained that the deceased succumbed to COVID-19, they would be buried without the necessary rituals, some relatives resorted to bribing pathologists to lie on their reports so that the dead could be brought home for the funeral wake. In cases where burials were taking place in the rural areas, in some cases, where bodies were supposed to be buried upon arrival, they were kept and had some rituals done before they were buried. This shows conflict between cultural expectations and pandemic responses. Ripoll (2000:7) notes that,

> Conflict or tensions with religious communities often emerge when their public health needs are pitted against other needs. In the case of the care for the dead, conflict emerges as the symbolic, social, and emotional aspects of mortuary and funerary practices with which included caring for the dead, may be jeopardised by response guidelines on 'safe burials'.

In such cases, Ripoll argues that "the dead are viewed as bodies to be 'managed' and processed, to be 'disposed of' as quickly as possible" (2000:7). Ripoll views this as a secular view on death because it underlines that the end of individual lives on earth is the end of life itself. From this perspective, there is nothing important that happens to the person beyond death and instead of being viewed as a subject, the body is treated as an object. Hence, "one's body is 'disposed of' becomes a pragmatic decision based on logistics and infection prevention. However, such views are inconsistent with the views of many African societies, Zimbabwe included. The social distancing protocol in a COVID-19 context is not in tandem with the African religious worldview where death "is a crucial step in the journey of the afterlife" (Ripoll, 2000:11).

In order to understand the effects of the WHO regulation on social distancing, I sought views from people within and outside of Zimbabwe who failed to attend the funerals of their loved ones. I sought to understand (i) how restrictions imposed on travel affected them when their loved ones died and (ii) if they devised alternative ways of mourning. Those whose parents or siblings died while they were out of Zimbabwe found it hard to get closure. One woman whose mother died in Zimbabwe while she was in South Africa where she worked said she failed to attend the funeral because of the closure of the borders. She indicated that while the death of her mother was in itself painful, she was disappointed that she could not bid her farewell in the expected cultural way. She only managed to visit Zimbabwe nine months after her mother's death. It was only after she visited her mother's grave that she got some closure.

A man whose father died of COVID-19 while he was on duty in Iraq narrated how he cried all night because he could not travel to witness his burial. As a son, he was expected to lead the funeral proceedings together with his siblings. However, it was not possible. While his colleagues provided the much needed support during the time of his grieving, he said he felt the void of being absent from his father's funeral. For him, it was not possible to get closure for as long as he had not seen where his father's remains were interred. He, however, acknowledged that the video calls he had with his family members and friends assisted him to recover from the pain until the time he managed to go to Zimbabwe and visited his father's grave. As expected culturally, he addressed his father's spirit, asked for forgiveness for failing to be present at his funeral and he performed the ritual of throwing a stone (*kukanda chibwe*) on the grave.

In another case, a woman whose brother's daughter died in South Africa while she was in the United Kingdom narrated how they were all handicapped because of the restrictions. They are Zimbabweans in the diaspora. The deceased had to be buried in Zimbabwe under normal circumstances. However, they could not travel. Only those relatives in South Africa and their fellow church members could attend the funeral. They had to make the most difficult decision in their lives by agreeing to cremate their daughter until such a time as they would travel to Zimbabwe and have their daughter buried according to Shona customs. For this woman in the United Kingdom, it has not been easy to deal with the loss of her niece. She planned to go to Zimbabwe in August 2022, but even then she would not meet her brother who remains in South Africa. During the time of mourning, she found solace in putting the photographs of her niece on her WhatsApp status and writing about how she felt. She was also able to speak with her brother's family throughout the funeral process.

On 1 June 2021, Moyo and Mazvarirwofa of the Global Press reported the case of Isabelle Nyathi who missed her mother's funeral due to travel restrictions. She said "as the eldest child in the family, it was heart-breaking that I could not be present to bury my mother." Her pain emanates from the fact that she could not perform the necessary rituals expected of her by tradition. The reporters think that altering the funeral rituals due to the pandemic results in further diluting Zimbabwe's traditions that have been affected by western influences. Many other cases were reported in the media across Africa where relatives of the dead felt aggrieved by the

social distancing regulations. At times confrontations with health personnel occurred as relatives failed to come to terms with the way the bodies of their deceased relatives were being treated.

The above cases are just a few of the many cases of people who failed to attend the funerals of their loved ones due to the conventional response to the pandemic. Ripoll (2000:11) finds the conventional response to epidemics problematic in that as a secular project, it constructs itself as separate from all religion. As indicated by the cases of interviewees above, the banning of certain ways of preparing the body, or transporting it, or banning ceremonial gatherings, caused much grief and psychological distress when people have not been able to care for their loved ones beyond death (Ripoll, 2000:11). Writing on South Africa, the Transkei region, Bank (2020) notes that restricted access to viewing and interaction with the corpse had been a major source of anxiety. From this, he concludes that the government funeral regulations were colliding with local cultural sensibilities and historically established practices. Muyambo (2022) criticises the social distancing regulation as failing to speak to the African context. For him, it was a one size fits all yet this may not have been the best for contexts such as Africa. Due to the travel bans, those in the diaspora resorted to cremating the bodies of the deceased. Gordon Chavunduka interviewed by Shoko (2009:12) alludes to the fact that cremation is not a cultural practice among the Shona. He argued that since the dead are expected to come back to live with the living as ancestors, it would be difficult for them to do so in ash form. What this shows is that COVID-19 pushed Zimbabweans to adopt foreign cultures on death and mourning. For some of them, cremation was better because they would bring the remains of their loved ones home once it was safe to do so. This is evidence of the need for alternative ways of mourning and dealing with grief caused by the death of a loved one.

Bridging the Gap: In Search of Alternative Ways of Mourning

Death rituals in contemporary societies have greatly been influenced by processes of globalisation and can no longer be taken for granted because in case of pandemics, governments play crucial roles in controlling the disposal of dead bodies (Robben, 2018:9). The discussion above has shown how the interventions of governments through public health personnel disrupted the funerary rites in Africa in general and Zimbabwe in

particular, at times resulting in confrontations or subversion of the WHO regulations. Critical questions arise from such situations namely; (i) how can local expectations of dignified funerals and ritual practices be observed under WHO regulations? and (ii) In what way can COVID-19 prevention protocols be aligned with local cultural and religious practices? Bank (2020) recommends that the state and key stakeholders need to show greater sensitivity to local cultural beliefs in the way the regulations are enforced. Hence, in such situations, scholars have called for alternative ways of mourning during pandemics. In the same vein, Ngade (2021) avers that public health officials must find ways of balancing local knowledge, ancestral customs and global health protocols. For example, during the Ebola outbreak in Sierra Leone, Maxmenfor (2015) reports that there was a stand-off between public health officials and the relatives of a pregnant woman who had died due to the virus. Public health officials wanted to bury the woman with a child in her womb, while her relatives insisted that they had to remove the baby from the woman's stomach because not doing so was against their culture. A cultural anthropologist had to be consulted after which he engaged a traditional spiritualist in the community to negotiate with the family for alternative death rituals of reparation which excluded the touching of the woman's body. The family agreed and the rituals were performed with the WHO providing the necessary ritual materials required. The woman was finally buried with the baby in her womb. This case is proof that during a pandemic, it is possible to perform symbolic rituals that satisfy the cultural expectations of affected communities so that they also find closure while public health protocols are followed to reduce the rate of infection. There may not be need for cultural anthropologists all the time because cultures have internal mechanisms to deal with such scenarios.

Gudhlanga and Madongonda (2021:163) recommend prevention measures that do not cause fissures in African cultures. They suggest that consulting traditional leaders when coming up with prevention strategies is crucial. Within the Zimbabwean context, they noted the weakness of the top-down approach which the government was using to enforce these measures which led to resistance or people simply ignoring them. Furthermore, Gudhlanga and Madongonda are of the view that funeral wakes which are the core of Shona funerals can still go ahead. They argue:

> Funeral wakes and body viewing of COVID-19 corpses could still be done provided sealed caskets with a glass cover on the face section are used. The sealed caskets would make it possible to be in the same room with the dead

> body without getting any infection through inhalation of whatever gases that might be coming from the corpse. The glass showing the dead body of their loved one during the funeral service without putting themselves at risk (2021:163).

Maluleke (2020: n.p) acknowledges the importance of psychological, cultural and spiritual resources in responding to the pandemic.

The use of ICTs during the pandemic also became central as travel bans inhibited funeral attendance. However, the use of technological tools in trying to reconfigure the mourning process after a death precedes the COVID-19 pandemic. Lee and Vaughan (2008:342-343) observe that rapid urbanisation in Africa and international migration have given rise to the use of new technologies of death, seemingly far removed from the burial practices described by colonial anthropologists. For Lee and Vaughan (2008:359) "the forces of globalisation and technological change have helped fashion alternative cultural landscapes within which Africans could re-invent their relations to death and the dying process." In other words, technology is assisting in people finding ways of coping with death and mourning. During the COVID-19 pandemic in Zimbabwe, online live streaming of funeral proceedings allowed people to be part of the funeral from a distance. In other words, people made use of digital media to create new rites and ways of mourning during the pandemic. Cumiskey and Hjorth (2017) make a discursive analysis of the significance of digital and mobile media in funeral processes. They argue that digital media play a key role in representing, sharing and remembering loss. Christensen and Gotved (2015) allude to the fact that social media has become very influential in the mourning processes. They argue that physical death is now being mediated online and has entered the online sphere (2015:3). For Cumiskey and Hjorth (2017: n.p) mobile media "provide a continuum between older technologies and practices, while at the same time remediating rituals." Hence, it becomes increasingly rooted within place-making and memorial culture. In their analysis, mobile media provide people with ways to understand how death and the afterlife are negotiated, ritualised, and reimagined, especially everyday. Furthermore, the mobile phone is viewed as providing insight into how people process, represent and share practices and rituals around negotiating grief in an age of accelerated, networked and installed digital data (2017: n.p). Hence, the mobile phone can assist in creating a bridge between tradition and social change. For Cumiskey and Hjorth (2017: n.p) the mobile phone "can be part of the ritual as

an activity, it can be present between thought and activity, and it can mediate between the feelings and the acting (and enacting) of the cultural performance." In this case, online memorial strategies in relation to death play a significant social role. During the pandemic, they assisted those mourning from a distance to feel that they were still part and parcel of their social group. Thus, they did not feel that their social identity had been threatened though they failed to reassure their relatives that they still belong with them in the physical sense.

Conclusion

The intention of this chapter was to explain the various ways in which COVID-19 disrupted the death rituals among the Shona in Zimbabwe. It sought to critique the WHO protocol of social distancing in order to show that while it was a noble idea, it was not in tandem with cultural expectations pertaining to mourning. The study, therefore, highlighted the African conception of death as well as the rites that are performed in order to deal with the pain and loss of a loved one. The study argued that for the Shona in particular, death rituals reinforce both individual and collective identity. Up to the time of COVID-19, the death rituals depended on in-person contact. However, the study showed how travel restrictions as well as the fast-tracked burials of victims of the virus altered the traditionally held rituals for the dead. Even for those that were at funerals, the chapter showed that distance was created between mourners themselves as well as mourners and the dead body. In most cases, failure by the living to bath the body, perform body viewing, observe vigils as well as bury the dead themselves left many Zimbabweans without closure. Clinical psychologists have warned of post-COVID-19 trauma in those who lost loved ones and failed to bury them according to their customs. A critical analysis of the burial practices adopted during the pandemic may lead one to conclude that it will take time for people to return to the pre-COVID-19 burial practices. Prince Sibanda of the Zimbabwe National Traditional Healers Association (ZINATHA) interviewed by Moyo and Mazvarirwofa (2021) sees the impossibility of going back to whole cultural practices unless chiefs do something out of the ordinary to convince the younger generations. It is within this context that the study recommended the formulation of alternative symbolic rituals of death in order to support efforts by public health experts to contain the spread of viruses during pandemics. The use of digital media has been shown to have played a critical role in

ensuring that those mourning from a distance were somehow included in the funeral processes through pictures and live-streaming on online media platforms. Hence, while the pandemic disrupted traditional modes of mourning and rites of burying the dead, it provided people with new ways of dealing with grief and pain due to loss through death. It may be that going forward, ICTs are going to play a central role in the performance of funerary rites.

References

Bank, V.N.S.L. 2020. Funeral practices and cultural dignity in the time of COVID. At https://www.researchgate.net/

Biwul, J.K.T. 2014. The African Tradition of Burial? In the Ancestral Land and its Implications for the African Church Today. *TCNN Research Bulletin*, 61:16-30.

Bregman, L. 2019. Kubler-Ross and the Re-visioning of Death as Loss. Religious Appropriation and Responses. *Journal of Pastoral Care and Counselling*, 73(1):4-8.

Chasi, C. & Tagwirei, C. 2020. Death and Ubuntu in Oliver Mtukudzi's Music. *Muziki: Journal of Music Research in Africa*, 17(1):23-45.

Cox, G.R. et al. 2003. *Making Sense of Death: Spiritual, Pastoral and Personal Aspects of Death, Dying and Bereavement (Death, Value and Meaning)*. New Jersey: Baywood Publishing Company.

Cox, G.R. & Fundis, R.J. 1992. *Spiritual, Ethical, and Pastoral Aspects of Death and Bereavement*. London: Routledge.

Davis, D.J. 2002. *Death, Ritual and Belief: The Rhetoric of Funerary Rites*. London: Continuum.

Evans-Pritchard, E.E. 1949. Burial and Mortuary Rites of the Nuer. *African Affairs*, 48(190):56-63.

Filippo, D.S. 2006. Philosophical, Psychological and Spiritual Perspectives on Death and Dying. Faculty Publications. 31. https://digitalcommons.nl.edu/faculty_publications/31

Gudhlanga, E.S. and Madongonda, A.M. 2021. Shona Culture and a New World Order: Fissures, Strategies and Mitigation in COVID-19 Era. In R. Makamani, A. Nhemachena & O. Mtapuri (eds). *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 151-169. Cameroon: Langaa.

Hagan, J.C. 2015. Getting Comfortable with Death: Medicine at Death's Door. *Missouri Medicine*, 112(3):148-150.

Kaguda, D., 2012. Death and dying: An analysis of the language used in copying with death in the Shona society. *Journal of Studies in Humanities and Social Science*, 1(2):57-68.

Klimczuk, A. & Fabis, A. 2017. Theories of Death and Dying. In B. Turner et al. (eds). *The Wiley-Blackwell Encyclopedia of Social Theory*, 1-7. London: Wiley-Blackwell.

Jindra, M. & Noret, J. 2011. Funerals in Africa. An Introduction. In M. Jindra & J. Noret (eds). *Funerals in Africa*, 1-15. New York: Oxford University Press.

Kiong, T.C. & Schiller, A.L. 1993. The Anthropology of Death: A Preliminary Overview. *Southeast Asian Journal of Social Science*, 21(2):1-9.

Kuper, H., Hughes, A.J.B. & Van Velson, J. 2017 (New Edition). *The Shona and Ndebele of Southern Rhodesia*. Abingdon: Routledge.

Lee, R. & Vaughan, M. 2008. Death and Dying in the History of Africa since 1800. *Journal of African History*, 49:341-359.

Maluleke, T. 2020. The social and cultural implications of COVID-19. News 24. At https://www.news24.com/news24/ [Accessed 27 June 2022].

Mawadza, A. 2000. Harare Shona Slang: A Linguistic Study. *Zambezia*, 27(1):93-101.

Maxmenfor, A. 2015. How the fight against Ebola tested a culture's traditions. *National Geographic*, 30 January 2015.

Mbiti, J.S. 1991. African Religions and Philosophy (Second Edition). London: Heinemann.

Mortazavi, S.S. et al. 2021. Mourning During Corona: A Phenomenological Study of Grief Experience Among Close Relatives During COVID-19 Pandemics. *Omega-Journal of Death and Dying*, 0(0):1-22.

Moyo, F. & Mazvarirwofa, K. 2021. Pandemic could forever alter funeral rituals. *Global Press*, 1 June 2021.

Mungwini, P. 2017. *Indigenous Shona philosophy: reconstructive insights*. Grahamstown: AHP Publications.

Mwandayi, C. 2011. *Death and After-life Rituals in the Eyes of the Shona: Dialogue with Shona Customs in the Quest for Authentic Inculturation*. Bamberg: University of Bamberg Press.

Ngade, I. 2021. What a 'safe and dignified' burial means during a pandemic.

Nwokoha, P.A. 2020. Rites and Rituals for the Dead: Bases for Good Moral Behaviour in Ezzaland, Nigeria. *International Journal of Religion and Human Relations*, 12(1):67-85.

O'Connor, M.-F. 2019. Grief: A Brief History of Research on How Body, Mind and Brain Adapt. *Psychosom Med.*, 81(8):731-738.

Owomoyela, O. 2002. *Culture and Customs of Zimbabwe*. London: Greenwood Press.

Puri, J. 2021. The forgotten lives of Sociology of Death: Remembering Du Bois, Martineau and Wells. *The American Sociologist*, 52(3):638-655.

Riley, J.W. Jr. 1983. Dying and the Meanings of Death: Sociological Inquiries. *Annual Review of Sociology*, 9:191-216.

Ripoll, S. 2020. *Death and Funerary Practices in the Context of Epidemics: Upholding the Rights of religious Minorities*. Brighton: Institute of Development Studies.

Robben, A.C.G.M. 2018. Death and Anthropology: An Introduction. In A.C.G.M. Robben (ed). *Death, Mourning and Burial: A Cross-cultural Reader*. New Jersey: Blackwell Publishing.

Robben, A.C.G.M. 2018. *A Companion to the Anthropology of Death*. New Jersey: Blackwell.

Robert, K. 2000. *The Psychology of Death*. New York: Springer.

Schmidt, J.M. et al. 2016. Perspectives on death and dying: A study of resident comfort with End-of-life care. *BMC Medical Education*, 16:297. DOI 10.1186/s2909-016-0819-6

Setta, S.M. & Shemie, S.D. 2015. An explanation and analysis of how world religions formulate their ethical decisions on withdrawing treatment and determining death. *Philosophy, Ethics and Humanities in Medicine*, 10(6):1-22.

Shear, M.K. 2012. Grief and mourning gone awry: Pathway and course of complicated grief. *Dialogue in Clinical Neuroscience*, 14(2):119-128.

Sibanda, F., Muyambo, T. & Chitando, E. 2022. Introduction: Religion and Public Health in the Shadow of COVID-19 Pandemic in Southern Africa. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 Pandemic in Southern Africa*, 1-24. London: Routledge.

Silverman, G. et al. 2021. Culture and Grief: Ethnographic perspectives on ritual, relationships and remembering. *Death Studies*, 45(1):1-18.

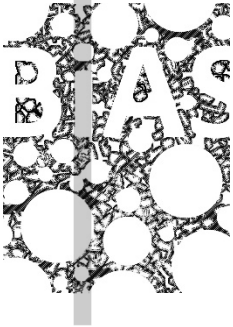
Shoko, T. 2008. From Ashes to Ashes, Dust to Dust: Cremation and the Shona Concept of Death and Burial in Zimbabwe. *Studia Historiae Ecclesiasticae*, 34(1):1-22.

Trebski, K. 2021. Grief and Mourning During the COVID-19 Pandemic: A Psychological and Pastoral Perspective. *Rocznik Teologii Katolickiej*, tom XX. Doi:10.15290/rtk2021.20.10

Van Wijk, C. & Hans-Arendse, C. 2013. Missing in Action: The Significance of Bodies in African Bereavement Rituals. *PINS*, 44:42-63.

Wang, P.T.P. & Tomer, A. 2011. Beyond Terror and Denial: The Positive Psychology of Death Acceptance. *Death Studies*, 35(2):99-106.

Walter, T. 2008. The Sociology of Death. *Sociology Compass*, 2(1):317-336.



Lovemore Togarasei

11 The Impact of COVID-19 on Christian handling of death, burial and the process of grieving: case study from Zimbabwe[1]

Abstract

Every society has its own death related rituals. The advent of Christianity among the people of Zimbabwe saw certain changes in the way death-related rituals were practiced traditionally. The advent of COVID-19 beginning March 2020 saw the introduction of measures that seriously affected the practice of death-related rituals. This paper will investigate the impact of COVID-19 on Christians' handling of death, burial rituals and the whole process of grieving among the Shona people of Zimbabwe. This paper investigates the impact of COVID-19 on Christians' handling of death, burial rituals and the whole process of grieving among the Karanga people of southern Zimbabwe. The paper is based on an ethnographic study of one family that I studied closely from the time of the death of their beloved one up to about a year later during which time most of the death-related rituals would ordinarily have been undertaken. This data is complemented by findings from literature and other observations and informal discussions I had with various people during the time of study. Christians generally want to be informed by the Bible in their practice of their religion. The paper investigates how the Karanga Christians interpreted certain biblical texts in their own cultural context as they either violated or observed the COVID-19 protocols.

Keywords: COVID-19, death, rituals, grieving, Shona, Zimbabwe

[1] While I am responsible for any shortcomings in this paper, I would like to acknowledge the input of my colleagues in the Department of Religious Studies and Philosophy at the Zimbabwe Open University and participants at the VAD 2022 conference held in Freiburg, Germany to whom the draft paper was first presented. Thank you for your comments that strengthened the paper.

Introduction

The advent of COVID-19 beginning in March 2020 saw the introduction of measures that seriously affected different facets of life. Guided by the World Health Organisation (WHO), different governments introduced measures to stop the tide of the pandemic. The need for social (physical) distancing, the need to stay at home, prohibition of huge gatherings, the use of masks to cover the nose and mouth were some of the measures introduced. These measures affected the day to day lives of people in many different ways. Muyambo (2021) accuses governments of failing to contextualise these measures as they took them as 'one size fits all'. Whilst studies are already coming up on the efficacy of the measures introduced by WHO (Muyambo 2021) and many other aspects of the Corona Virus (Sibanda, Muyambo and Chitando 2021; Makamani, Nhemachena and Mtapuri 2021), more academic work needs to be done. One such area that requires academic attention is that of death and death related rituals. Death, though a natural certainty, is never accepted or even understood among many, if not all, societies worldwide. Indeed, it is because it robs people of the beauty of life making all the toiling and labouring we undertake in life seem meaningless. For these reasons, death is feared and many beliefs are associated with its causes and meaning. Chitando (1999:10) describes the enigma of death thus, "Human beings everywhere are subject to the sting of death. This fact has troubled poets, confounded mystics and disturbed scientists." Resultantly, several rituals are also associated with it to lighten the pain it causes, to try and give it meaning, to honour the dead, to 'tame' it, among many other reasons for conducting death related rituals. Indeed, every society has its own death related rituals (Gordon 2015). Focusing on the Karanga people of Nyajena in southern Zimbabwe, Chitakure (2021) identifies three groups of death related rituals: pre-burial, burial and post-burial rituals. The advent of Christianity among the people of Zimbabwe saw certain changes in the way death-related rituals were practiced traditionally. Indeed, in his study, Chitakure (2021) rightly observed that in Zimbabwe there are now two types of death-related rituals: traditional and Christian. However, whether traditional or Christian, death-related rituals are meant to help the bereaved with healing and different ways of handling grief (Mortazavi et al., 2021). The question at the centre of this paper is: To what extent and in what ways were death-related rituals affected by the COVID-19 measures introduced from 2020? Proceeding from the assumption that the COVID-19 mitigation measures had tremendous effects on people's practice of

death-related rituals, this chapter investigates the impact of COVID-19 on Christians' handling of death, burial rituals and the whole process of grieving among the Shona people of southern Zimbabwe. The paper is guided by Van Gennep's (1966) theoretical view that death as one of a number of life cycle crises commands ritual observance as well as Smith's (1987) theory of ritual. Considering the number of Christian death-related rituals practiced by the Shona, how did the advent of the COVID-19 pandemic with its accompanying restrictions affect Shona Christians?

Methodology

The chapter is based on an ethnographic study of one family that I studied closely from the time of the death of their beloved one in early 2021 up to about a year later during which time most of the death-related rituals would ordinarily have been undertaken. My research journey with the family started in February 2021 when I attended the funeral of their son as a close acquaintance of the family[2]. I visited the family three times during the time of study. It was largely a participant observation study with very few questions paused to the subjects of study. This is because research on death and funerals need to be conducted delicately considering the trauma experienced by the bereaved. Through participant observation, I therefore avoided continuously reminding them about their traumatic experience. The few questions I asked to establish their feelings were done on the basis of my relationship with them. It was only after a year of participant observation and informal interviews that I asked them if I could use their experience to write an academic paper. They consented on condition that I was not going to mention their names and the family name. I have also tried to present the findings in such a way that it is impossible for readers to be able to identify the family. This data is complemented by findings from literature and other observations and informal discussions I had with various people during the time of study. Christians generally want to be informed by the Bible in their practice of their religion. The paper, therefore, investigates how the Christians interpreted certain biblical texts as they either violated or came to terms with the dictates of COVID-19 protocols.

[2] By family here, I am referring especially to the father and mother of the deceased.

To achieve the objectives of the chapter as stated above, the chapter is divided into four sections. In the first section, I give an outline of Christian death-related rituals as they have been practised before the outbreak of the COVID-19 pandemic. In the second section, I present the findings of the study based on the ethnographic study. The third section then gives a general discussion of the impact of COVID-19 on death-related rituals highlighting biblical readings and theologies that arose as people dealt with COVID-19 in relation to death rituals. The last section closes the study.

Christian death-related rituals in the Church of Christ Zimbabwe

Christianity is practiced differently among the Shona people of Zimbabwe depending on one's denomination. This is also true of the practice of death-related rituals. When it comes to death rituals, the situation becomes even more complicated as their practice is not only dependent on Christian denomination but also on the culture of the people as it remains influential despite one's Christian identity. The death-related rituals that I focus on in this chapter are, therefore, as practiced within the Church of Christ in Zimbabwe to which the family studied belonged. I also chose this church because, not only do I belong to it[3], but at one time served as the pastor of the Harare congregation and, therefore, related with the death rituals very closely. I am, therefore, familiar with the death-related rituals making it easier for me to investigate how these practices were affected by the COVID-19 pandemic.

While studies on death-related rituals among the Shona of Zimbabwe abound, they are generally limited to traditional practices like *kurova guva* (home bringing ceremony of the spirit of the recently dead) (Banana 1991, Cox 1995, Vambe 2009, Saidi 2017). Studies on Christian death-related rituals are limited with most of the publications on this subject focusing mainly on tombstone unveiling (Gundani 1999; Zwana 2000; Togarasei and Chitando 2003) and debates on cremation (Chitando 1999; Shoko 2008).

[3] Fully aware of the inherent problems of subjectivity associated with the 'insider' research approach, I try as much as possible to be objective. I also make use of the views of other scholars to balance my personal views.

At the point of death

Death rituals can be traced from the time that relatives feel the illness of their relative is likely to lead to fatality. This is the case with terminal diseases and also the severity of the illness. From the time they realise that there are little chances of survival for their patient, relatives call upon the prayers of the pastor or other Christian leaders. The biblical text, "Is anyone among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord" (James 5:14), though referring to any kind of illness, is often remembered and implemented when the patient becomes critical. My own studies in Botswana (Togarasei, Mmolai and Kealotswe 2016), which are likely to present the same results in Zimbabwe, show that when Christians have mild illnesses, they seek the services of bio-medical practitioners while they seek spiritual and traditional healing and advice when the illness becomes complicated. Whilst the hope is the healing of the patient, the search for prayers at this point is also meant to spiritually and psychologically prepare for the departure of the loved one. In the event of the death of the patient, many other rituals follow. It is very difficult from this point to isolate those rituals that are Christian from those that are traditional and cultural. This is because, as Chitando (1999:15) correctly observed, "…it is upon the death of a member that one witnesses how indispensable and enduring is traditional culture. Close relatives oversee burial rites, with church officials usually playing a supportive, though subsidiary role." Even on occasions where the relatives are also Christians and give Christians the full rights to bury their member, it is still difficult to separate the two. This, in my opinion, underlines the undeniable influence of culture over one's practice of any religion. Be that as it may, I will attempt to limit my discussion to what is generally agreed to be Christian death rituals.

At death

Upon the declaration of the death of the patient, relatives play a key role engaging in some of the rituals that are limited to the family. These include the closing of the eyes of the dead and the preparation of the body to assume the right posture, the washing and the dressing of the body. I have observed that even in the case of those who die in hospital and are taken to the mortuary where some of these rituals are done by the undertakers, a relative has to be there or in some extreme cases, the rituals have

to be redone when the body reaches home. The Church of Christ does not teach against these practices and so relatives are free to perform the rituals.

Masofa panze: pre-burial prayer meetings

As soon as news of death is announced, it is tradition that people gather at the home of the deceased, a system that has been described by the Shona as *masofa panze*, as couches have to be taken out to create room for more people in the seating room. The practice of *masofa panze* is prevalent in urban areas while in rural areas the gathering is in the kitchen.[4] This is where the body of the deceased has to lie in state for at least one night. However, even before the body arrives, fellow Christians, relatives and friends meet here daily until the dead is buried. In cases where the body was at the funeral parlour, a prayer service is conducted there before the body is taken to lie in state. It is believed that there must always be mourners with the bereaved family until burial. In view of escalating costs of catering for the mourners, in some cases, this process is now open only to close relatives and friends, while the rest of the mourners come during prayer times that are conducted daily for a specified time[5] until the day of burial. Fellow Christians play a key role during this period. Not only do they visit the family for prayers, they also conduct the 'prayers' that involve singing and preaching. Common Bible texts read during the prayers are 1 Thessalonians 4:1-13, 1 Corinthians 15, Revelation 14, all of which are meant to assure the bereaved family that the dead is not gone forever but is 'asleep' waiting for the day of resurrection. In fact, according to the Church of Christ pastor's manual, *The Church of Christ Book of Service*, all the church's death-related rituals are done in fulfilment of Romans' (12:15) command that Christians should 'mourn with those who mourn'. Christians are not only involved in worship but help with all other funeral logistics including making financial contributions through a system called *chema* in the vernacular.

4 This is often a rondavel, which is used as a combined kitchen, dining room and lounge.

5 The time varies depending on family logistics. In Zimbabwe today, where a number of families have family members in diaspora, they have to give them enough time to travel. Nevertheless, this period rarely goes beyond a week.

Burial

Following the prayer rituals which we can describe as the pre-burial ritual, comes the burial ritual[6]. This ritual begins where the body lay in state before the day of burial. The *Church of Christ Book of Service* gives the following outline of the ritual:

Appendix B: Funeral programme

1. Before leaving home/funeral parlour, pastor or his representative to pray for God to lead the whole process.
2. At the grave site, pray thanking God for the guidance. Give sermon on God's plan concerning human life from birth to death, the meaning of death and such other fitting topics.
3. After the sermon, pray before the coffin is lowered down and then ask those responsible to lower it down.
4. Some families want to participate in burial by throwing some soil into the grave, this can be allowed before the grave is completely covered.
5. After the covering of the grave, make a prayer thanking God for the guidance.
6. Ask the Master of Ceremonies to dissolve the gathering.
7. Christians should continue helping after burial in activities like feeding the mourners and such other tasks.

As outlined above, the ritual may start at home or at the funeral parlour. It is important to note that in some instances, the funeral process proceeds from home to the church and then to the burial site. There are many other rituals not mentioned in the above programme that vary from family to family. As long as they do not contradict the church's theology, the church leadership does not interfere. One example is the carrying of the casket to the grave. In some cases, especially where the graveyard is close to the homestead as is the case in many rural areas, the journey to the final resting place has many stations. Friends and family are responsible for carrying the casket from one station to the other. The process can be dramatic as the *sahwira* (close friend) and the *varoora* (daughers-in-law) perform various hilarious acts that are meant to, in the words of the legendary Zimbabwean musician, Oliver Mutukudzi, "*kurerusa ndima*" (to lighten the moment). Another ritual not mentioned in the book of service,

[6] Although I speak of it in singular terms, there are actually many rituals involved.

but that is practiced at all funerals, is the giving of eulogies. Various relatives of the deceased are given time to say something as they bid farewell to the deceased. It is another light moment as speakers reminisce the late highlighting moments in their life: their achievements, memorable events, their last words, wishes, and so on. Often, the deceased is addressed as if s/he is alive underlining the fact that s/he is still with the living.

Post burial

The church teaches the importance of journeying with the bereaved family during their time of grief. The church leadership and the whole congregation are urged to visit and encourage the family. Besides this, two other rituals are very important for the bereaved family. These are *nyaradzo* (memorial service) and tombstone unveiling. The Church of Christ endeavours to support all its teachings and practices with biblical texts. Therefore, concerning *nyaradzo* the book of service highlights, "This is a service that we do not have a teaching of in the Bible" (*Church of Christ Book of Service*, 2006:5). The church, however, observes this practice. The timing of *nyaradzo* varies from one family to the other. When the practice began among Christians, it was held a year after the burial of the deceased and therefore coincided with the practice of *kurova guva*. For this reason, some Christians are still not comfortable with *nyaradzo* as a Christian ritual. In fact, the *Church of Christ Book of Service* (2006:5) cautions the pastor, "The pastor must make sure that traditional rites of *kurova guva* are not disguised as memorial service. When that happens, the church must not be part of this process."

In the Church of Christ, *nyaradzo* is conducted over a period of two to three days. People gather either on Friday or Saturday evening and conduct prayer services until after the Sunday service. The gathering is characterised by singing, teaching and preaching centred around the theme of death and resurrection. The whole idea, "…is to encourage the family of the deceased to keep the faith reminding them that the deceased has completed his journey, is awaiting the resurrection and the task is now upon them to also successfully run the Christian race" (Church of Christ Book of Service, 2006:5). *Nyaradzo* has become such a key post-burial ritual, not only in the Church of Christ, but also in other Christian churches that those who would not have conducted it, feel that the mourning process is still incomplete.

Beginning in the early 1990s, a new death related Christian ritual was added in the form of tombstone unveiling. Togarasei and Chitando (2005) give an elaborate discussion of this ritual. In short, this is a ritual in which the deceased family unveils to the invited, the tombstone they would have erected for their late relative. Some Christian families combine it with *nyaradzo* but due to the cost of the tombstone, others hold it a long period after burial giving themselves enough time to put together resources for the tombstone. The tombstone unveiling ritual is conducted almost in the same way that *nyaradzo* is conducted serve for the fact that the participants will view the tombstone and prayers are made at the grave site to thank God and to ask God to allow the spirit of the deceased to continue resting in peace.

Although some families will occasionally[7] continue to visit the graveyard to put flowers on the grave of their relative and clean the area, *nyaradzo* and/or tombstone unveiling officially mark the end of the mourning period. It can, therefore, be concluded that the mourning period for a typical family is one year. It is also after one year that the widow or widower in the case of the deceased having been married, are free to begin other love relationships. With this in mind, let us now look at how the family studied for the purposes of this project handled the death related rituals in the context of COVID-19.

Study findings: how a family dealt with death and related rituals during the COVID-19 pandemic

My research journey with the family started in February 2021 when I attended the funeral of their son as a close acquaintance of the family. As I state below, the deceased was a married young man and sadly, the wife and two young children were not there at the time of death. The son fell ill two days before he died while on extended holiday caused by COVID-19 lockdown. He had visited his parents from one of the neighbouring countries where he was a migrant worker. He just woke up one morning with a terrible headache and they rushed him to the nearest clinic that referred him to the provincial hospital. This was at the height of the second wave

7 Some families will do this annually on the death anniversary of their beloved.

of the Corona Virus in Zimbabwe[8]. On arrival at the hospital, he was isolated even before he was tested for the virus.[9] That was the last time the family had contact with him. The next they would hear from the hospital, two days later, it was to inform them of his death. They received the body from the hospital tightly wrapped and with the instruction that they were not supposed to open it. Two family members were given instructions on how the funeral process was to proceed and that only a few people were to have contact with the casket. The family was to organise their own transport from the provincial hospital to their village, some 80 km distance. The instruction from the hospital was that the body was supposed to be buried on arrival. There was no disclosure on the cause of death as the few doctors at the hospital were said to be busy.[10] With a lot of unanswered questions on the cause of death, some family members insisted on autopsy. Attempts to have autopsy were, however, unsuccessful as personnel responsible for this were said to be unavailable. Eventually, the family agreed to take the body for burial with their many unanswered questions. To this point, ordinarily several rituals would have taken place. First, the local pastor would have been called to pray for the young man while he was in hospital. Unfortunately, when the pastor tried to visit together with some family members, a day after the young man was admitted in hospital, they were denied access as they were told that the young man was in the Intensive Care Unit (ICU) and COVID-19 protocols did not allow visitors. Second, prayers would have been conducted at the hospital parlour on collection of the body. Again, COVID-19 protocols did not allow such rituals.

---

8 About a week earlier, the government had banned traditional funerals and the movement of bodies across towns and villages for burial. Police Spokesperson, Paul Nyathi, had advised the public, "Police will only clear body movements for burial straight from a funeral parlour/hospital mortuary to the burial site" (Mutsaka 2021).

9 At the height of COVID-19, all patients entering hospitals were suspected to have the virus. While protocol dictated that they be tested, it did not happen in all cases due to various reasons such as understaffing.

10 Due to the prevailing economic challenges in Zimbabwe, public health is failing to deliver quality health care. Health procedures are often not followed due to understaffing and the frustrations of the few health workers due to being overworked and poorly remunerated. Sophia Chirongoma captures the situation perfectly when she says (as cited by Ponde Mutsvedu and Chirongoma (2021:107), "…strained health care facilities are often staffed by very few medical professionals who were already sighing under the heavy yoke of long working hours, coupled with very poor remuneration, long before the outbreak of the COVID-19 epidemic."

On arrival home, though the grave had been dug according to the instruction from the hospital officials, the family elders denied that the body be buried on the same day. Although the reason advanced was that it was already too late (around 8pm), others also felt that they needed to observe the culture to allow the body to lie in state at the family home before burial. There were, of course, serious arguments with each decision to be made as family members were not in agreement. Those who interpreted the tight wrapping of the body and the whole process the late was handled from admission to release of the body, to mean that he had died of COVID-19, wanted to follow the burial protocols the hospital authorities had instructed. Others who supported immediate burial also used the cultural argument saying the grave had been dug and it was uncultural not to bury on the day the grave was dug. Eventually, the argument to have the body lie in state for the night was upheld and to handle the dug grave issue, it was agreed that some people were to spend the night there taking guard of it.

Although, gathering was prohibited, on hearing news of the death, relatives and neighbours from nearby gathered and several who exceed the government limit, attended the funeral. I observed that social distancing, masking and other COVID-19 protocols were not observed. However, relatives from distant places and from the diaspora, including some brothers and sisters of the deceased could not attend the funeral due to the imposed travel restrictions. Quite painful was the absence of the wife and children whom the late had left outside the country where the couple was residing.

As mentioned above, despite restrictions on gathering, several people gathered over night and the following morning for the burial. Although the family pastor was absent during the night, preaching and singing proceeded. Self-appointed teachers preached and taught the Word of God. The pastor would arrive the following morning. He attempted to speed up the burial process by avoiding certain rituals such as body viewing and elaborate pre-burial sermons and eulogies. However, this created problems as some family members resisted this. It was almost dramatic at the grave site when the deceased's senior uncle declared that his nephew would not be buried before body viewing. All arguments on the need to observe the instructions of the hospital authorities came to nothing as he and other relatives insisted on body viewing or they would walk away before the burial process was over. Eventually, the casket had to be opened by those who were putting on some protective clothing and a few people viewed the body before it was buried. Contrary to COVID-19 protocols,

food was also served after the burial. I noticed that there were extra hygienic practices[11] compared to usual practice but still the protocols were not observed.

Of course, being at the height of the second wave of COVID-19, the mourners engaged in debates on the reality of the pandemic. I listened to the debates by the fireplace where the mourners were gathered the night before burial. With the majority of the mourners being Christians who fellowshipped with the family, the Bible prominently featured in the discussions. The sceptics argued that since God is in control, they were not to be afraid of the pandemic as one dies according to God's plan. They made reference to texts like Ecclesiastes 3:2, "there is a time to be born and a time to die…" and Job 14:15, "…thou hast appointed his bounds that he cannot pass." These were interpreted to mean that whether there is COVID-19 or not, when the bounds set by God come, one dies. Those who took COVID-19 seriously also found support from biblical texts that mention days when people will experience pandemics, "…and there will be famines, pestilences and earthquakes…" (Matthew 24:6-8).[12]

Since church gatherings were not allowed in Zimbabwe for the greater part of 2021, the church did not organise *nyaradzo* for the family, let alone the fact that almost everyone left soon after the burial. Discussing their experiences with me, the family also noted that after burial, few church members visited to console them. The same also applied to their relatives most of whom could not visit due to travel restrictions. The wife of the late only managed to come to pay her condolences a month later. This means the parents of the deceased had to mourn their son without the usual support of relatives and friends.

The sudden nature of the death, especially after the young man had just visited home from the diaspora where he was employed, meant that some family members would suspect witchcraft.[13] The lack of declaration

[11] For example, everyone had to wash their hands with soap and running water and each person was given their own plate of food contrary to the practice of a having a number of people sharing food from the same plate.

[12] There were various readings of the Bible that emerged during COVID-19. Fortune Sibanda, Tenson Muyambo and Ezra Chitando (2021) note the use of the Bible for security and individual/communal salvation (Numbers 31:49), for encouraging prayer and fasting (Ezra 8:21-23) and also to explain the death of political leaders as divine judgment (Proverbs 11:10). Sonene Nyawo (2021) on the other, noted the reading of the Bible that concluded that COVID-19 was God's punishment of errant humanity.

[13] Witchcraft beliefs are quite common in Zimbabwe. The successful in life are often thought of as targets of witchcraft by, especially, jealousy relatives.

of the cause of death and the failure to have autopsy conducted divided the family between those who suspected witchcraft and others who suspected COVID-19. While relatives departed after burial, the family remained with these questions with no one to direct them to. The grieving was, therefore, not only caused by loss of their son, husband and father, but also unanswered questions and lack of the usual social support due to COVID-19 restrictions.

Discussion: the impact of COVID-19 on Christian handling of death, burial and the process of grieving

Our case study clearly demonstrates the effects of COVID-19 on death-related rituals. The family could not undertake the traditional death rituals from the time death threated to post burial. Psychology has long established the emotional value of death related rituals in the process of grieving (De Oliveira Cardoso et al. 2020). As theoretically argued by Van Gennep (1966), death as one of a number of life cycle crises, commands ritual observance. Grieving is an important process that should follow loss if one is to heal and attain closure. Psycho-social support is necessary in helping the grieving process. As stated above, all societies have rituals that accompany the grieving process and for healing to be successful, the rituals should be followed. Although derived from ordinary human actions (Smith 1987), "rituals are symbolic actions, repetitive, standardized, and highly valued behaviors that help individuals to channel emotions, and share beliefs and transmit values" (Mikles 2022). The family could not visit their son when he was at the point of death. They could not get the support of the pastor, who ordinarily would have accompanied them to visit and pray over the patient. This process could have prepared the bereaved family to accept the eventuality. There was also no time for 'prayers', a ritual that allows family and friends to accompany, comfort and console the bereaved in preparation for burial. As outlined above, from the time of the announcement of death, ordinarily Christians would have started gathering at the home of the diseased to offer them psychological and social support. The funeral was rushed and gave little opportunity for this ritual even against the COVID-19 protocols. Although the family observed the ritual of having the body lie in state before burial, it was in violation of COVID-19 protocols and caused dissensions among family members who ordinarily should stand together during this time.

Due to COVID-19, the normal body viewing ritual was not conducted. It was only conducted in an unusual manner due to the protest of the uncle. Again, instead of the ritual serving as the last 'goodbye', it caused disagreements among family members almost making burial profane. Among the Shona, burial is a sacred ritual to be done when the family is in perfect harmony. The belief is that each and every individual should be given a peaceful and decent send off, thus the Shona saying, "*wafa wanaka*", which implies that the dead should not even be held accountable for whatever wrong they may have done in life. Ordinarily then, burial is also a time to celebrate the life of the deceased. As described above, the *sahwira*, would have entertained the mourners, reminiscing the life of the deceased with *varoora* also doing their part to lighten the moment. The church would have led in singing the favourite songs of the deceased, reading his favourite scriptures and pastors and teachers reassuring the deceased relatives and friends that the dead has transitioned into another life. Friends and relatives would have given their eulogies and reminded people of the late's naughty moments, memorable days and other stories of his life. This could not be done at this funeral held under COVID-19 protocols. The pastor, in obedience to the government gazetted guidelines on conducting funerals, rushed the whole process. The pastor was even absent from the prayers conducted the night before the burial as he was aware that it was illegal to do so. Thus, instead of the celebration of the life of the deceased, there were disagreements among family members even among fellow Christians. As we have seen above, while some family members wanted to observe the COVID-19 protocols, others wanted to respect the death rituals and while some Christians quoted biblical texts to support the observation of COVID-19 protocols, others cited those texts that trivialised COVID-19 declaring that it is God who gives and takes away life not observing COVID-19 protocols.

The worst effect of COVID-19 for the family studied was the church's failure to provide post- burial support, especially failing to conduct the *nyaradzo* ritual. The sudden nature of the loss and the fact that this was a young man in the prime time of his life, left the family with many questions that needed spiritual, psychological and social support. With some family members citing witchcraft as the cause of death, one can only imagine the trauma felt by the immediate family. The Church of Christ does not encourage witchcraft beliefs. Although this is true for the official teaching of the church, it is not so in practice. As Banana (1991:27) correctly observes about the people of Zimbabwe, "The pain of parting with

their loved ones in the physical form leads them to speculate upon the causes of the fatal break of their physical ties in their family." Ordinarily then, the pastors and church leadership provide post burial counselling which helps the bereaved to accept their loss and not locate the causes in the sphere of witchcraft. Such support was not there for the family studied.

While in more developed societies some death related rituals got to be conducted virtually (Mikles 2022), this could not be done in the case of this family given that they stay in the rural areas where there is no internet. It is, however, my opinion that even if there was internet, it is still a long way before ordinary Zimbabweans accept the veracity and efficacy of online rituals. Besides, African life is communal and thus the disturbances caused by COVID-19 affected all communal activities including death related rituals with devastating consequences. This communal life guided by the philosophy of *Ubuntu/Unhu*, explains the reason why, even in view of death dealing COVID-19, people gathered at the funeral. Attempt to practice this communality through modern media technologies, as argued by Lucia Ponde-Mutsvedu and Sophia Chirongoma (2021), is inconsistent with the spirit of *Ubuntu*.[14]

We have so far focused on elaborate rituals but among the Shona people, there are many other short rituals (I would like to call them ritualites), that are associated with funerals that Christian love actually dictates but are against COVID-19 protocols. These include handshakes, hugs, individualised conversations with the bereaved as one offers his/her words of condolences. It is the tradition among the Shona that when one arrives at a funeral, s/he goes around shaking hands with all in attendance. It is a tradition called *kubata mavoko* (literally handshaking but a sign of paying condolences). Equally, hugging the bereaved is a common practice of comforting the bereaved. In the process, one shares words of encouragement and comfort. In the case of funerals during COVID-19, all these ritualites were discouraged. Problems arose when some observed the protocols while others did not. I noticed at the funeral that those from urban areas and the more socially informed would try to observe COVID-19 protocols while those from the rural areas and less socially informed would not. Denying one's handshake, one's hug or reminding someone to keep the social distance, is considered a sign of pride and social aloofness. It is strongly disparaged especially at a funeral. COVID-19 funerals therefore

[14] Lucia Ponde-Mutsvedu and Sophia Chirongoma (2021) reached this conclusion analysing the use of tele-evangelism, tele-health services and other non-direct physical space sharing as necessitated by online platforms during COVID-19.

created conditions of uneasiness that divided instead of uniting families. This resulted in the bereaved emotionally bruised and taking long for them to heal and experience closure.

Concluding remarks

While the COVID-19 protocols introduced by governments to stem the tide of the pandemic were well meant, they had other negative social consequences. This article has focused on COVID-19 restrictions' impact on Christian death related rituals. Using the case study of a family that lost a son during the height of the second wave of COVID-19 in Zimbabwe, the article has demonstrated that the restrictions altered the way death rituals are conducted among the Shona in general and in the Church of Christ in Zimbabwe in particular. The dictates to bury the dead directly from the hospital, to limit the number of mourners, to limit the length of the burial programme resulting in rushing of the process, all went contrary to Shona funeral rites as practised in the Church of Christ. Travel restrictions, restrictions on gatherings and the need to maintain social distance in general meant that deceased families did not receive the usual social support needed following the loss of a loved one. This resulted in bereaved families experiencing emotional pain with no one to share it with. It is not surprising that a year after their loss, the family studied for the purposes of this article was still grieving.

We recommend, therefore, that while governments come up with scientific measures to address pandemics, there is need to also think of the social and psychological impact of these measures. As noted by Muyambo (2021) a one size fits all approach is not recommended. Attention needs to be given to developing mechanisms to address the negative social impact that may result from scientific measures. We also recommend that churches, traditional leaders, civic societies and other organisations that provide psycho-social support be involved in the formulation of mitigatory measures. The development of information and communication technologies (ICTs) that allow virtual social support is commendable (Ponde Mutsvedu and Chirongoma 2021). However, a lot needs to be done to make sure all in Africa have access to ICTs. In developed countries such as the United States of America, Mikles (2021) notes that religious groups such as Jews quickly adopted ICTs for contacting funeral rituals and these were providing the needed support. It is probably the way Africa needs to go as it is almost certain that once in a while, humanity experiences health

and other natural pandemics that alter the way we ordinarily do things. Religious and traditional leaders should also be encouraged to adopt ICTs in their rituals but this can only be possible following massive civic education so that their people accept the 'new normal' of contacting rituals.

Gudhlanga and Madongonda (2021) also suggest practical ways that would allow people to conduct death related rituals safely. They suggest, for example, not limiting the number of those attending funerals but insisting on physical distancing, the consistent use of masks even at prayer meetings, the use of sealed glass caskets that allow body viewing and other measures. While some of the suggestions they make have their own challenges, such as making sure that hundreds of mourners maintain physical distance, their recommendations underline the fact that current COVID-19 protocols prohibit the conduct of funeral rituals leaving the bereaved grieving and without closure as they do not allow people to render the usual psycho-social support.

References

Banana, C. 1991. *Come and Share: An Introduction to Christian Theology*. Gweru: Mambo Press.

Chitakure, J. 2021. *Death Rituals Among the Karanga of Zimbabwe: Praxis, Significance and Changes*. Eugene: Resource Publications.

Chitando, Ezra. 1999. Deathly Concern: African Christians and cremation in Zimbabwe. *Missionalia,* 27(1):10-19.

Church of Christ. 2006. *Church of Christ Book of Service*. Harare.

Cox, J.L. 1995. Ancestors, the sacred and God: Reflections on the meaning of the sacred in Zimbabwean death rituals. *Religion*, 25(4):339-355, DOI: 10.1016/S0048-721X(05)80019-3.

De Oliviera Cardoso, E.A. et al. 2020. The effects of suppressing funeral rituals during the COVID-19 pandemic on bereaved families. *Rev Lat Am Enfermagem* 28, Doi.org/10.1590%2F1518-8345.4519.3361.

Gordon, M. 2015. Rituals in Death and Dying: Modern medical technologies enter the fray. *Rambam Maimanodes Medical Journal,* 6:1, doi: 10.5041/RMMJ.10182.

Gudhlanga, E.S. & Madongonda, A.M. 2021. Shona Culture and a New World Order: Fissures, Strategies and Mitigation in COVID 19 Era. In R. Makamani, A. Nhemachena & O. Mtapuri (eds). *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 151-170. Mankon: Langaa.

Gundani, P.H. 1999. The Roman Catholic Church and the *kurova guva* ritual in Zimbabwe. In J.L. Cox (ed). *Rites of Passage in Contemporary Africa*, 198-223. Cardiff: Cardiff Academic Press.

Mikles, N. 2022. The pandemic changed death rituals and left families without a sense of closure. *The Conversation*, 26 January. At https://theconversation.com/the-pandemic-changed-death-rituals-and-left-grieving-families-without-a-sense-of-closure-175302 [Accessed 21 February 2022].

Mutsaka, F. 2021. Zimbabwe bans traditional funerals to battle COVID-19 spike. AP News, 11 January 2021.

Muyambo, T. 2021. Social distancing in the context of COVID-19 in Zimbabwe: Perspectives from the Ndau religious indigenous knowledge systems. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and COVID-19 Pandemic in Southern Africa*, 37-51. London and New York: Routledge.

Nyawo, S. 2021. Christian religious understandings and responses to COVID-19 in Eswatini. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and COVID-19 Pandemic in Southern Africa*, 141-154. London and New York: Routledge.

Ponde-Mutsvedu, L. & Chirongoma, S. 2021. Tele-evangelism, tele-health and cyberbullying in the wake of the outbreak of COVID-19 in Zimbabwe. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and COVID-19 Pandemic in Southern Africa*, 103-114. London and New York: Routledge.

Saidi, U. 2017. *agonya neiko mfanha uyu?* Of death and funerals – a semiotic exploration of the Shona funeral ritual in Zimbabwe, *African Identities*, 15(4):353-366, DOI: 10.1080/14725843.2017.1319758.

Shoko, T. 2008. From Ashes to Ashes, Dust to Dust: Cremation and the Shona Concept of Death and Burial in Zimbabwe. *Studia Historiae Ecclesiasticae*, 34(1):1-22.

Sibanda, F., Muyambo, T. & Chitando, E. 2021. Introduction, in *Religion and COVID-19 Pandemic in Southern Africa*. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and COVID-19 Pandemic in Southern Africa*, 1-24. London and New York: Routledge.

Smith, J.Z. 1987. *To Take Place: Toward Theory in Ritual*, University of Chicago Press.

Togarasei, L. & Chitando, E. 2005. Tombstone Unveiling Among Shona Christians: Phenomenological and Biblical reflections. *Missionalia*, 33(1):166-178.

Togarasei, L., Mmolai, S. & Kealotswe, O. 2016. 'Quinine,' '*ditaola'* and the 'Bible': investigating Batswana health seeking practices. *Journal for the Study of Religion*, 29(2):97-117.

Vambe, M.T. 2009. The function of songs in the Shona ritual-myth of *Kurova Guva*, *Muziki*, 6(1):112-119, DOI: 10.1080/18125980903037393.

Van Gennep, A. 1966. *The Rites of Passage*. Chicago: The University Press of Chicago.

Zwana, S. 2000. *Beyond the tombstone: Significance and Theological Implications of Tombstone Unveiling*. Harare: Methodist Literature Department.

Enna Sukutai Gudhlanga & Angeline Mavis Madongonda

12 Who is fooling who? Masking up and its implications on Zimbabwean society

Abstract

The world has witnessed the high infection and fatality rates of the corona virus which has resulted in the World Health Organisation declaring it a pandemic on 11 March 2020. As of 13 March 2022, there were over 455 million confirmed cases and over 6 million deaths that had been reported globally (WHO, 2022). In order to curb the spread of this pandemic and its spiral effects, countries have come up with mitigatory measures; among them is the wearing of face masks. This paper has been prompted by the failure to comply by the majority of Zimbabweans to the wearing of face masks, thus making it a criminal offence not to wear one. Thus, most Zimbabweans tend to wear face masks as a ritual – for fear of prosecution by the police or when the masks allow them to access certain benefits but not as a COVID-19 mitigation strategy. The chapter also further interrogates why even among those who police the wearing of face masks seem to be at liberty to remove their masks as and when they choose. In the midst of a pandemic, the question, which remains, is -who is fooling who? The chapter thus endevours to investigate why Zimbabweans in general appear to have rejected the wearing of face masks. The research is largely qualitative in nature and a sample of purposively selected people from Harare's CBD area were interviewed. Furthermore, the observations of Zimbabweans as they go about their daily business and their understanding of face masks were used. It is hoped that the people's perceptions about the face mask are brought to the fore and put under the spotlight for the benefit of the general populace. The chapter also accounts for the socio-economic and religious reasons behind non-compliance of wearing masks, hoping that this mitigation strategy is taken seriously. The study is informed by *Ubuntu/Unhu* philosophy, which calls for people of African cultural descent to protect and act in harmony with their communities as well as avoid hypocritical tendencies that are self-harming or which harm others.

Keywords: COVID-19, mitigation, face mask, *Ubuntu*, pandemic, infectious, fatality rate, Zimbabwe, Harare, curb

Introduction

The novel corona virus disease or COVID-19 which was first discovered in Wuhan in China in December 2019 has ravaged the world causing numerous deaths with no cure in sight. China reported this mysterious pneumonia to the World Health Organisation (WHO) on 31 December 2019 (Mukherjee & Dias, 2020). In order to curb the spread of this pandemic and its spiral effects, countries came up with mitigatory measures; among them was the wearing of face masks. This paper was prompted by the failure to comply by the majority of Zimbabweans to the wearing of face masks, hence, instigating government to make it a criminal offence not to wear one. Most Zimbabweans tended to wear face masks as a ritual; for fear of prosecution by the police or when the masks allowed them to access certain benefits but not as a COVID-19 mitigation strategy. The chapter also further interrogates why even among those who police the wearing of face masks seemed to be at liberty to remove their masks as and when they chose. In the midst of a pandemic, the question which remains is -who is fooling who? The chapter, therefore, endeavours to investigate why Zimbabweans in general appeared to have rejected the wearing of face masks. The research is largely qualitative in nature and a sample of purposively selected people from Harare's CBD area were interviewed. It is hoped that the people's perceptions about the face mask are brought to the fore and put under the spotlight for the benefit of the general populace. The chapter also accounts for the socio-economic and religious reasons behind non-compliance of wearing masks, hoping that this mitigation strategy is taken seriously. The study is informed by *Ubuntu/Unhu* philosophy which calls for people of African cultural descent to protect and act in harmony with their communities as well as avoid hypocritical tendencies that are self-harming or which harm others.

Background to masking up and mitigation against the spread of COVID-19

In March 2020, Zimbabwe recorded its first COVID-19 case which was from a foreign traveller who had visited the resort town of Victoria Falls (Cassim, 2020: n.p). In the same month the country recorded its first COVID-19 death of a son of a prominent businessman who had just travelled to New York for medical check-up (Chipunza & Marunya, 2020: n.p).

After realising that the virus had reached the country's shores, the Government of Zimbabwe then recommended the use of face masks among other measures, to prevent the spread of the virus. In Zimbabwe, the initial use of face masks in April 2020 as a mitigatory strategy was not mandatory. Masks were supposed to be worn by health personnel taking care of a person with suspected COVID-19 infection and by those who were coughing or sneezing (Ministry of Health and Child Care – MoHCC, 2020). This measure was in line with the WHO's recommendation that the wearing of face masks was only for healthcare workers and those health care workers who would be caring for COVID-19 patients (Aloi-Zarrouk, El Youssfi, Badu, Fagbamigbe, Matoke-Muhia, Ngugi, Dukhi & Mwaura, 2020).

The wearing of face masks as a mitigatory measure to curb the transmission of COVID-19 is controversial. The WHO does not encourage mandatory wearing of face masks. It encourages the use of face masks for curbing the spread of COVID-19 for infected individuals and health professionals caring for COVID-19 patients (Bukuluki & Kisaakye, 2021). While the European Centre for Disease Control and Prevention (2020) argues that for effective prevention of transmission there was need for mandatory wearing of face masks across the world (Bukuluki & Kisaakye, 2021), some scholars however, argue that the WHO does not call for mandatory wearing of face masks because the world does not have enough resources to produce masks to cater for the critical frontline medical health personnel (Aloui-Zarrouk, et al. 2020). Incidentally, the WHO after conducting a workshop in 2020, concluded that even though there was no evidence that face masking reduces COVID-19 transmission, it recommended that in a severe influenza outbreak use of face masks in public should be considered (Cheng, Lam & Laung, 2020).

Upon realising that there were also some community transmissions of people who did not have compromised immune systems and had never travelled out of the country, the Government of Zimbabwe shifted its stance on mask wearing (Murewanhema, 2021). On 4 May 2020 through a statutory instrument, the government of Zimbabwe made the wearing of face masks mandatory in all public spaces (MoHCC, 2020). This was believed to limit the transmission of the coronavirus and anyone who violated this measure would be prosecuted (Crisis24, 2020). In order to implement this measure, the Government of Zimbabwe deployed security personnel across the country to ensure that the public complied with lock-

down measures, the wearing of face masks included. It is not only Zimbabwe which made the wearing of face masks mandatory but quite a number of low-income countries which found this as a very good mitigatory measure. This has been necessitated by the fact that these countries do not have the financial resources to treat their people in the event of a COVID-19 attack. Some of the countries that called for mandatory wearing of face masks in public places include Nigeria, Morocco, Tunisia, Ghana and Kenya among others (Aloi-Zarrok et al. 2020).

It has to be noted however, that for effective prevention of the spread of COVID-19, face masks have to be properly worn. They are supposed to be worn covering both the mouth and nose (MoHCC, 2020; Matuschek, Moll, Fangerau, Fischer, van Griensvein, Scheider, Kindgen-Milles, Knoeffel, Lichtenberg, Tamascoviks, Djiepmo-Njanang, Budach, Corradine, Haussinger, Feldt, Jensen, Pelker, Orth, … Hausmann, 2020). If a mask gets damp from breathing it should be changed right away and any disposable mask should not be re-used. It is only the cloth masks that can be re-used after they are properly washed (MoHCC, 2020). Furthermore, when one is wearing a face mask, they are not supposed to touch the mask while using it. In addition, when disposing a mask, it should be put in a closed container to avoid transmission of pathogens to other people (MoHCC, 2020; Matschek et al.). Despite the controversy surrounding the effectiveness of the use of face masks it is believed that if properly used and adhered to, these would greatly reduce transmission of the virus (Lubenga, Mendoza, Nkeremahame, Niyongabo, Gonza, Nakahwa & Musoke, 2022). Aloui-Zarrouk et al. (2020: n.p) have also observed the importance of face masks when they state that, "Particularly in low- and middle-income countries, protecting by wearing of face masks is viewed as an affordable yet proactive preventative measure to avoid slow down viral spread based on experience from affected countries." Thus, Zimbabwe being a low-income country also found it prudent to just heed the call on the role of face masks in curbing the spread of the COVID-19 pandemic. Despite hearing these claims on the positive effects of proper use of face masks, the general Zimbabwean populace still seems to be reluctant to properly wear face masks and seems to do so only to avoid prosecution and not for protecting themselves. The present study, therefore, endeavours to investigate the perceptions of the use of face masks by the Zimbabwean society and why they have not wholly accepted its use as a reliable COVID-19 mitigation strategy.

Statement of the Problem

The mitigatory strategies imposed by the Government of Zimbabwe in a bid to curb the spread of COVID-19 include vaccination, physical distancing, hand washing and hand sanitising as well as the wearing of face masks in public spaces. Even though the general Zimbabwean populace has been made aware that these mitigatory strategies prevent the spiral effects of COVID-19, Zimbabweans seem to have not wholly accepted the wearing of face masks as a preventative measure against COVID-19. Thus, most Zimbabweans tend to wear face masks as a ritual for fear of prosecution by the police or when the masks allow them to access certain benefits but not as a COVID-19 mitigation strategy. The chapter also further interrogates why even among those who police the wearing of face masks seem to be at liberty to remove their masks as and when they choose. In the midst of a pandemic, the question which remains is -who is fooling who? The chapter thus endeavours to investigate why Zimbabweans in general appear to have rejected the wearing of face masks despite its benefits. It further highlights some strategies that can help make people accept the wearing of face masks as a COVID-19 mitigatory measure.

Theoretical Framework

This study is informed by the *Ubuntu* theoretical framework which is premised on "humanity through recognising the humanity of others" (Samkange & Samkange, 1980) and creating a communal atmosphere that emphasises "kinship among and between the indigenous people of Africa" (Ramose, 1991:271). Among the ethnic groups of Zimbabwe being human means having "*hUnhu/Ubuntu* and culture which implies being properly socialised into the cultural dictates of one's ethnic group" (Furusa, 2006:20). Gelfand (1973:104) avers that *hunhu* refers to "an appreciation of values that are more than the material or useful" to personhood. Okyere-Manu and Morgan (2022:22) also aver that *Ubuntu* "embodies the very identity of the African people and informs what they do, how they live, and their relationship with each other and others." It is imperative to ground the study in Afro-centred theoretical underpinnings that emanate from African culture and history because they demonstrate how mitigatory strategies to tackle the COVID-19 pandemic should not disregard *Ubuntu/Unhu* which undergirds African people's lives in general. Furthermore, *Ubuntu* is pertinent to this study which hopes to proffer a way for-

ward in which the wearing of face masks as a COVID-19 mitigatory strategy can be accepted among Zimbabweans. The African philosophy of *Ubuntu* which "connotes humanness, a pervasive spirit of caring, and community harmony and hospitality, respect and responsiveness, that individuals and groups display for one another" is very relevant to this study (Mangaliso, 2001). Even though the theoretical framework of *Ubuntu* has its own weaknesses exhibited by xenophobic tendencies among Africans (Manyonganise, forthcoming) the theory can still be found useful by encouraging the wearing of face masks as protection of the individual and humanity at large. Also, if the concept of fairness is embedded in *Ubuntu* through proverbs such as *gudo guru peta muswe kuti vaduku vakutye* (an elderly or a person of high position should behave with dignity for him to earn respect from the younger ones/ subordinates) is embraced it would go a long way in promoting masking up and prevention of the spread of COVID-19. It is our contention that if *Ubuntu* is fully embraced, the African community can prevent the spread of the COVID-19 pandemic.

Methodology

The study adopted a qualitative methodology design which made it possible to investigate why Zimbabweans seem to have rejected the wearing of face masks as a COVID-19 mitigatory strategy. Purposive sampling method was used in identifying the research informants who would clarify on how Zimbabweans perceive the wearing of face masks in curbing the spread of COVID-19. This type of sampling method enabled the researchers to select participants that were regarded as data rich sources (Cresswell, 2014). The researchers did not worry about sample size because this was determined by data saturation. Data was collected through in-depth open-ended interviews with identified informants in Harare's CBD and market places. The researchers chose Harare because it is a high risky area for COVID-19 cases and also had the highest COVID-19 cases (MoHCC, 2020). Furthermore, Harare also embodies urban dynamics such as an international airport, slums, traffic congestion, densely populated areas, trade centres and very busy vegetable markets which are fertile grounds for ease of transmission of the virus unlike in other urban centres of Zimbabwe. Ethical considerations were taken note of and interviewees were assured of anonymity, informed consent and freedom to pull out of the study whenever they felt like. Despite assurances of anonymity and privacy, one of the informants later confessed that they were not quite sure what the researchers wanted to do with the information and

did not want to be found on the wrong side of the law by discussing how the government strategies to curb the spread of the virus were not being taken seriously by the general populace. The chapter devised a coding system which represents the gender of the interviewee, for example F1 refers to the first female interviewee while M1 refers to the first male interviewee. The succeeding section indicates how Zimbabweans portray the use of face masking in preventing the spread of COVID-19.

Risky Behaviour: Mask Culture Projecting Personal Narratives

We observed that Zimbabweans engage in risky behaviour when using face masks. Most of the interviewees in Harare's Central Business District and Harare Markets stated that they did not believe that COVID-19 existed. They argued that it was a disease created by powerful nations as a way of controlling the weaker ones. One of the interviewees had this to say:

> Why do I bother myself wearing a face mask to protect myself from a disease that does not exist? If it really existed, why is it that on the onset of the Ukraine and Russian war, news on the devastating effects of COVID-19 subsided? If it was a real epidemic as the powerful nations would like us to believe, could they engage in a useless war when people are faced with a devastating pandemic such as COVID-19. Why do you allow people to make fools out of you?" (M1, 2022).

This demonstrates that some Zimbabweans do not even believe that COVID-19 exists and, therefore, did not see the need to wear a face mask as a mitigatory strategy against the epidemic. The interviewee argued that the world would not engage in a useless war as the Russian-Ukrainian conflict if there was a real threat that posed danger to people's lives. Such understanding would make it very difficult for Zimbabweans to consistently and properly wear face masks. He further stated that Zimbabweans were wearing masks for fear of prosecution and heavy fines since they perceive that the pandemic does not exist. This explains why people still wanted to go ahead with body viewing of their deceased relatives as well as being found in overcrowded areas because they doubted the existence of COVID-19. Instead, they believed that COVID-19 was a Western ploy created to serve other purposes.

Some of the interviewees also concurred with the above that COVID-19 was non-existent, instead the government of Zimbabwe wanted to be seen to be trendy by following what developed countries were doing. They even argued that the Government institutes lockdown, vaccinations and the wearing of face masks to be seen to be in good standing with the super powers that gave Zimbabwe some COVID-19 funds. Furthermore, they argued that COVID-19 was big business to politicians and their associates who would get tenders to supply COVID-19 material as well as receiving COVID-19 donor funds from abroad. In an interview with a vegetable vendor at Mbare market, she stated that:

> COVID-19 is a great opportunity to make money for those who are able to get tenders to supply COVID-19 material. As you can see this vegetable market is overcrowded and we come here everyday to sell our vegetables. We are overcrowded here and sometimes the police come to chase us from here. We run away and come back once they go away. We have to survive and not worry about wearing face masks instead of fending for our families. If COVID really existed we would have all died but we still come here every day and do our business as usual and we only pull up the face mask that will be dangling around our necks once we see a law enforcement agent (F1, 2022).

The interviewee also raised a very important aspect of COVID-19 being very big business, as an opportunity to make money. This is demonstrated in the case of a former health minister in Zimbabwe who was "charged with criminal abuse of office over the alleged awarding of a USD60 million contract for COVID-19 supplies" (Chingono, 2020) which was awarded corruptly. The lack of *ubuntu* where those in authority take advantage of the pandemic would make the ordinary people doubt the existence of COVID-19 and fail to take the wearing of face masks seriously.

Among some of interviewees who believed that COVID-19 existed, they still, however, did not believe that it would attack people of black descent. This group of people believed that the virus would only attack people who have suppressed immune systems as well as those who are exposed to international travel. One interviewee stated that she was jeered by colleagues at the market when she was found wearing a face mask. Some vegetable vendors said to her "Here at Mbare Musika there is no COVID. Why are you bothering yourself wearing *chi*-COVID (informal term for face mask)? This disease is for cold countries and also attacks those with suppressed immune systems" (F2, 2022). This demonstrates that some Zimbabweans believe that COVID-19 is foreign and will not

affect those who remain in the country and are not exposed to foreign travel or have contact with people from other countries. To such people the disease is foreign and should thus remain as such. Sipeyiye (2022) has also observed the mocking of people wearing face masks in Chipinge. Thus, the mocking of people who try to take heed and wear face masks is prevalent in Zimbabwe. After being mocked, such people normally remove their face masks because they also do not properly understand how face masking works in preventing an unknown disease. The jeering of those with face masks according to Sipeyiye (2002:48) "negatively impacts the uptake of preventative measures…since those jeered are subjected to humiliating experiences." If Zimbabweans could respect one another in the spirit of *ubuntu* this would greatly increase the uptake of masking up.

Chi-COVID that has been made reference to by interviewee F2 is a Shona name given to a face mask. Face masks in Zimbabwe are now synonymous with COVID-19. "*Chi-*" is a secondary prefix found in class 7 of the Shona language and is used in either praising or derogating the noun which will be affixed to it. In this instance, the prefix "*chi-*" is used in derogatory terms for Zimbabweans look down upon the COVID-19 pandemic and even the mitigatory strategies being used. They have not really accepted the use of face masks as a mitigatory strategy and hence they use a derogatory term which carries overtones of criticism, sarcasm and caricature to denounce the face mask. That way most people do not feel comfortable to wear a face mask but would shun it. If the mitigatory measures are taken in the spirit of ubuntu where people respect measures put in place by those in authority this would go a long way in curbing the spread of the virus.

Masking up as a fashion statement

Some interviewees viewed masking up was a fashion statement and they tried to put on masks that match with whatever they are wearing. If there is nothing that matches with their clothes then they would either not wear the mask or recycle a mask that matches whatever they are wearing. One interviewee stated that she preferred a black surgical disposable mask because it goes with so many clothes. Another elderly lady stated that she would want a mask that matches her women's guild church uniform and if she does not have the one which matches her uniform, she would rather not wear one because it goes against her uniform (F3, 2022). Most primary school children observed were wearing floral masks and this brightened

their day and make them happy. Thus, the reason they were wearing face masks are not for the prevention of the spread of COVID-19 but just a fashion statement. Schools in Zimbabwe have also produced masks with school logos and even employers have also produced some with their company's logos. One interviewee stated that he had one cloth mask with a company logo and when coming to work he would wear that one as a way of marketing his company in the crowded ZUPCO buses. Asking him whether he was wearing that cloth mask for preventing the spread of COVID-19, he stated that he personally did not believe it existed and that is why he was recycling his cloth mask which helped him to be fashionable just like other passengers on public transport who were putting on masks with company logos (M2, 2022). He also did not bother washing the cloth mask during the week and only did that over the weekends. Accordingly, people in general failed to be guided by the *ubuntu* philosophy which would make them want to protect the next person. They tend to be selfish and wear masks for their own selfish reasons.

Rebellion against the authorities/ Non-compliance as a political statement

The findings also revealed that some people did not wear face masks as a political statement against those in authority. Since mandatory wearing of face masks was a government directive, those who belong to the opposition party felt that if they complied, they would be agreeing with the government. For them, failure to wear a face mask was making a statement against those in authority. One opposition party member had this to say in an interview:

> These lockdowns as well as physical distancing and wearing of face masks are the ruling party, ZANU (PF)'s (Zimbabwe African National Union Patriotic Front) ploy to prevent the opposition party from campaigning for the by-elections to be held in March. Just like the face masks do you think it prevents transmission of the virus if it is really there? No. But these are part of stringent measures put by the ruling party to clip the wings of our party. Two female parliamentarians from our party were jailed for breaking lockdown measures, but look at what they do themselves? They continue to meet their supporters hold rallies, and address their supporters without wearing face masks. So why do they expect us to follow lockdown measures when they themselves who have put the measures are busy breaking them everyday?" (M3, 2022).

This amply demonstrates that some people are failing to wear face masks because they believe that it is a way which the government is using to control its people and prevent opposition party members from freely doing their business. This is not typical to Zimbabwe alone, even in some other countries. In the United States of America there were some "anti-mask rallies that were joined by people espousing conspiracy theories, such as the unfounded belief that the threat of COVID-19 has been exaggerated by the government in order to control the populace" (Taylor & Asmundson, 2021: n.p). Hence, some opposition party members believe that the wearing of face masks has been imposed upon the populace against their will and they tend to defy the government and those in authority. They tend to defy those in authority since there is no fairness in implementation of COVID-19 restrictions. Those who put down legislation are busy flouting the COVID-19 restrictions such that the opposition party members feel that the laws are only made to clip the wings of their party. It would be prudent if those in authority are also seen respecting the COVID-19 restrictions so that those in the opposition party could see the importance of the measures. Respecting of COVID-19 restrictions by those in authority would resonate very well with the Shona proverb which states that "*Gudo guru peta muswe kuti vaduku vakutye*" (an elderly or a person of high position should behave with dignity for him to earn respect from the younger ones/subordinates). Failure to lead by example is rebellious to *Ubuntu* philosophy which encourages those in authority to lead by example and earn respect from the people they lead since *Ubuntu* does not encourage blind loyalty.

Health factors and masking up

Some of our findings indicated that some of the people do not wear face masks because of some health challenges. Those with asthma stated that masks make it very difficult for them to breathe and that is why they do not properly wear face masks. One interviewee stated that she was asthmatic and always leaves her mask dangling around her neck and once she sees law enforcement agents, she tries to pull up her mask to cover her mouth but rarely does it cover her nose (F4, 2022). Another interviewee stated that she wears spectacles and masking up normally results in her eye glasses clouding up especially in the mornings. She would rather wear her mask covering only the mouth (F5, 2022). The researchers have also observed people who wear corrective lenses in the public transport improperly wear their mask covering only the mouth due to the challenges

brought about by the wearing of face masks when one wears spectacles. Other interviewees stated that they do not wear face masks because they are allergic to them, once they wear them, they develop some rash around their faces, they have very sensitive skin (M4, 2022). Another interviewee said she did not like the painful cuts behind the ears she sometimes gets when wearing a mask, a size too small to cover her head, hence, she resorts to removing it (F6, 2022). Thus, one-size-fits all approaches in trying to mitigate the COVID-19 pandemic do not always work. This leaves out quite a number of people exposed to the virus since they cannot mask up due to health reasons.

Religious beliefs and masking up

Religious beliefs also affected masking up in Zimbabwe. Some people are not masking up due to their religious beliefs. Those who belong to African Independent Churches (AICs) believe that the coronavirus was prayed for by their religious leaders and they were given holy water to ward off the devastating effects of the pandemic. One interviewee had this to say; "When I went to the prophetess to be prayed for wearing my face mask, I was told that we do not have COVID-19 here. Please remove your mask if you want me to pray for you. We had beginning of the year prayer sessions in which we prayed for the eradication of pandemics" (F7, 2022). The interviewee said that she had to comply and had to remove her face mask because she wanted the religious leader to pray for her. Similarly, Sibanda, Muyambo & Chitando (2022:10) have noted that the "Johanne Marange African Apostolic Church (JMAAC) flouted lockdown rules by holding their annual pascal meeting for 21 days in July 2021 without wearing face masks." Furthermore, other religious groupings like those in African Traditional Religion(s) also attributed sickness to evil spirits. In an interview, an elderly lady had this to say, "One can only get COVID-19 or any other sickness if the ancestors are angry with that person and have forsaken their descendants. If the ancestors are happy one is protected, no disease or ill thing can befall a person" (F8, 2022). This demonstrates that various religious persuasions also influenced people in the wearing of face masks. Those from AICs and ATR(s) believed that they were protected by the supernatural being. However, the conventional churches encourage face masking. However, within those churches there are still people who do not believe in the wearing of face masks to prevent the transmission of COVID-19. One interviewee from the United Methodist Church had this to say "I go and worship at the main circuit which is 5km

away because in that circuit, there is no nurse who enforces the wearing of face masks" (M5, 2022). This amply demonstrates that most people do not believe in COVID-19 and the wearing of face masks to prevent its transmission. If only they could take heed of those in authority as well as being considerate of others as enshrined in *Ubuntu* this could go a long way in curbing the spread of the virus.

Socio-economic factors and the non-compliance of face masks

Some of the findings also indicated that Zimbabweans are affected by socio-economic factors which result in them sharing and recycling masks. One interviewee stated that she and her family can use the same mask as long as they go out in public at different times. She stated that they have a place in their kitchen where they keep the face mask in use, if a child is sent to the shops, she can use the mask and when she gets back the mother can use it to go to church and when she returns, the father can also use the same mask without washing it and goes to meet his friends at a beer garden. The interviewee stated that she did this in her household for both cloth masks and disposable masks (F9, 2022). Another interviewee who works in government whom one would think is educated and would have a better understanding of COVID-19 also stated that she recycled disposable masks. She said:

> I normally prefer wearing black masks which do not get dirty so easily. I detest the light blue or white surgical masks because I only wear them once and cannot re-use them. Instead, I prefer buying a box of black surgical masks. When I come back from work, I hang it on my dressing table for use the following day. I use one black disposable mask for the whole week and will only throw it in a bin after using it for at least five days. Also, if the mask gets damp, I remove it and dry it using a tissue and then put it back. These masks are an unnecessary expense for a disease which we are not even sure exists. So, I must pretend as if I am complying with the government's directive (F9, 2022).

This clearly demonstrates the risky behaviour being practiced by Zimbabweans in the use of face masks. As people go about their business properly wearing a face mask by covering both the mouth and nose, they are using recycled masks, damp masks as well as touching their masks during use. Others are also washing surgical masks which should be disposed after a single use. The researchers have observed people moving around with masks dangling below their chin in public transport or even in shopping malls. These would quickly pull them up over their mouth

and nose at the sight of law enforcement agents. This was reiterated by one Harare resident who stated that, "It seems most people are wearing the masks for the wrong reason. They are doing it more out of fear of arrest than their own safety" (News24, 2020: n.p). Zimbabweans wear masks to evade heavy fines by the police and not their own safety (Makombe, 2021). Fearing the law enforcement agents defeats the whole purpose of wearing a face mask as a COVID-19 prevention strategy. Furthermore, in the event that they are caught by law enforcement agents without wearing a face mask, interviewees stated that they always pay a bribe to the police and get away with murder (M6, 2022). The fact that the police officers were accepting bribes and allowing those who flouted COVID-19 measures to go scot-free was also reiterated by the General Commissioner of police when he appeared before the Health and Child Care Parliamentary Portfolio Committee in June 2020 (Mutanda, 2022). Non-compliance to face masking is also prevalent in Uganda and they also had to use law enforcement agents to promote compliance (Lubenga, et al. 2022). Paradoxically, the law enforcement agents who are supposed to police people also violate the COVID-19 protocols by not wearing face masks and practicing social distancing (Maulani, Nyadera & Wandeka, 2021). If there are no security personnel in sight, or if they are bribed, then one can easily expose themselves and infect others. The people lack the spirit of oneness of fearing for another and hoping to protect one another from the COVID-19 pandemic. Furthermore, *Ubuntu* encourages those in authority to lead by example.

Even though people are aware of how these disposable masks should be used, they do not follow the procedure because the masks are very expensive for them. This cost is considered a luxury for people who live below 1 USD per person per day. It is not only in Zimbabwe where face masks are expensive but in Nigeria and Ghana where the prices of face masks trebled with the onset of COVID-19 because foreign tourists hoarded them for use back home (Junior & Dei, 2020). Hence, socio-economic factors have also resulted in non-compliance in the use of face masks for COVID-19 prevention in Zimbabwe and some other African countries. In the spirit of *Ubuntu* those who could afford to buy face masks could also assist those who could not. The following section demonstrates some of the measures that can be used to enlighten people on the use of face masks as a mitigatory strategy against COVID-19.

Mitigatory strategies that can be used to promote masking-up in the face of COVID-19 in Zimbabwe

The findings have clearly demonstrated that the general populace in Zimbabwe has not wholly accepted mandatory face masking promulgated by the Government of Zimbabwe as a mitigatory strategy in preventing the spread of COVID-19. There is need for a number of strategies that can be used to increase the uptake and adherence of face masking in preventing the spread of COVID-19 in Zimbabwe in particular and other countries in general.

The first possible strategy would be to rope in traditional leaders such as chiefs to be part of the intervention strategy. Even though chiefs are being empowered to raise awareness on COVID-19 protocols at gatherings they, however, have limited powers and cannot enforce masking-up as security forces do. Instead, community and traditional leaders should be empowered to enforce COVID-19 protocols. Hashmi, Iqbal, Haque and Saleem (2020:19) have also noted the importance of empowering community leaders in warding off epidemics and argue that it is important to always take traditional leaders on board. These are respected by their communities and if involved in raising awareness they are going to be in a better position to be listened to by the community as compared to top-down approaches that come from very high offices. The successful use of traditional leaders in combating epidemics has also been observed by Miller and Rubin (2011) in the context of HIV and AIDS. Sibanda et al. (2022) have also noted the importance of involving traditional leaders and medical health personnel to educate communities on deadly pandemics such as COVID-19.

There is also need to adopt a Training-of-Trainers model in training community leaders who live with people in the community about the importance of correct use of and adherence to face masks curbing the spread of COVID-19. The community should be made aware that that face masks are not worn for fear of prosecution but for one's own safety. The correct use and disposal should be highlighted otherwise people will continue to fool themselves by merely adorning these masks for the wrong reasons, fearing prosecution. The Training-of-Trainer model ensures sustainability because of its potential for up-skilling the workforce rapidly and economically (Momina & Pinder, 2018; Gudhlanga & Madongonda, 2021). The community members who would have been trained would in-turn

train other members on the correct use and adherence to face masks as well as understanding the COVID-19 pandemic.

Furthermore, there is also need to sensitise service providers on the benefits of using a face mask to curb the spread of COVID-19 (Mugambe, Ssekamalte, Kisaka, Wafula, Isunju, Naligia, Optain, Makanga, Mukiibi, Buregyeye, Kasasa, Kansiime, Balen, Kapoor & McGriff, 2021). There is need for sensitisation programmes in general in schools, churches and communities at large to improve people's "perceptions towards COVID-19 and face masks, and consequently increase correct face mask usage in the community" (Mwesige, Nalugya, Bulefu, Tigaiza, Nagawa, Balinda & Walekwa, 2021: n.p). Adequate public health education on correct use of masks removes the potential problems that might be encountered if one uses a mask without adequate knowledge (Lang, Cheng, Lam and Migliori, 2020). Once these initiatives on public health awareness are done, as well as the promotion of *Ubuntu* and the need to protect the another, this would go a long way in promoting the uptake and adherence of face masking to curb the spread of COVID-19 in Zimbabwe.

The other mitigatory strategy would be the use of indigenous languages to broadcast messages of pandemics. Most of the public health messages on COVID-19 and its devastating effects as well as the mitigatory measures are being broadcast in English. This leaves out a large sector of the population that speaks indigenous languages. People generally do not take seriously the messages broadcast in a foreign language (Gudhlanga, 2005; Gudhlanga & Makaudze, 2007). In very few instances where translation into indigenous languages is done, we find that the translated text will be an abridged version which leaves out vital information. For the general public to take the public health messages on COVID-19 and the use of face masks seriously, it would be good for such messages to be broadcast in indigenous languages that are spoken by a greater part of the population. Over and above broadcasting public health messages, there is need to hold workshops in communities teaching about COVID-19 and its mitigatory strategies. Sibanda et al. (2022:16) have also noted "the importance of the use of an accessible language and media and the need to use both traditional and western epistemics concomitantly in the face of pandemics as deadly as COVID-19."

In cases where religion flouts government regulations in its messaging about pandemics it is important to try and understand why the government is putting on those restrictions. There is need for roping in religious leaders so that they can comprehend the issues at play. In cases

where the government flouts its own rules it should be guided by *Ubuntu* where one should lead by example. Once those in authority spearhead the implementation of the preventative measures, they would set a very good example to the general populace.

Since some sectors of the population cited financial constraints there is also need to distribute free masks for all. These could be placed in public spaces for easy access as what happens with condoms in Zimbabwe that are placed in public toilets. Uganda gives at least a face mask to children aged six and above as a way of making them easily accessible to the general populace (Mwesige et al. 2021). Apart from distributing free masks, affordable ones could be produced as well. Ghana made an effort to mass produce affordable face masks for use by the general public (Junior et al. 2020). This could also be adopted in Zimbabwe to increase the uptake of face masking among those who cited financial constraints in acquiring some. It is hoped that if the given recommendations are taken on board, they would go a long way in promoting the uptake and adherence of face masking as a COVID-19 preventative measure in Zimbabwe.

Conclusion

The Chapter has discussed how face masking is being used as a mitigatory strategy to curb the transmission of COVID-19. It has brought to the fore various factors that have made it impossible for Zimbabweans to wholly accept face masking as a preventative measure against COVID-19. It has also highlighted the fact that Zimbabweans generally do not wear face masks to protect themselves against COVID-19 but for fear of prosecution by law enforcement agents. Thus, the chapter has brought to the fore how even those who seem to be wearing face masks in public are fooling those in authority for they are not following the proper way of wearing face masks. Even those in authority also seem to violate the face mask directive thereby only fooling themselves as they are the ones at risk. The chapter has also highlighted the various strategies that can be used to educate the general populace on the deadly effects of the pandemic and the correct use of face masks as a mitigatory measure that can be used together with other biomedical measures to prevent the spread of COVID-19. It has also demonstrated that in order for the war against COVID-19 to be contained there is need to engage even traditional community leaders, as well as broadcasting COVID-19 messages in indigenous languages so that people can understand the invisible enemy that they are fighting with and stop

taking it as a foreign pandemic. If *Ubuntu/Unhu* is used in the fight against COVID-19 it would go a long way in sensitising the general populace about COVID-19 and making them responsible citizens who can watch out for each other and make it their duty to protect each other against the deadly effects of the COVID-19 pandemic. The chapter has finally concluded that the wearing of a face mask is not a luxury of health personnel but a more affordable strategy that can be used by low-income countries in mitigating the transmission of COVID-19.

References

Primary sources

F1, Interview, Mbare Market, Harare, 1 March 2022.
F2, Interview, Harare Central Business District (CBD), 1 March 2022.
F3, Interview, Charge Office Rank, Harare, 16 March 2022.
F4, Interview, Harare CBD, 20 March 2022.
F5, Interview, Harare CBD, 21 March 2022.
F6, Interview, Harare CBD, 25 March 2022.
F7, Interview, Harare CBD, 17 March 2022.
F8, Interview, Harare CBD, 22 March 2022.
F9, Interview, Harare CBD, 17 March 2022.
M1, Interview, Mbare Market, Harare, 28 January 2022.
M2, Interview, Charge Office Rank, Harare, 19 March 2022.
M3, Interview, Harare CBD, 27 February 2022.
M4, Interview, Harare CBD, 27 March 2022.
M5, Interview, Harare CBD, 25 March 2022.

Secondary Sources

Aloui-Zarrouk, Z., El Youssfi, L., Badu, K., Fagbamigbbe, Matoke-Muhia, D., Ngugi, C., Dukhi, N. & Mwaura, G. 2020. The Wearing of Face Masks in African Countries Under the COVID-19 Crisis – Luxury or Necessity? *AAS Open Research*, 3(36). https://openresearchafrica.s3.eu-west-1.amazonaws.com/manuscripts/14175/8cff254d-6a3c-4a70-8f22-903bec4d686d_13079_-_zohra_aloui.pdf?doi=10.12688/aasopenres.13079.1&numberOfBrowsableCollections=4&numberOfBrowsableInstitutionalCollection s=0&numberOfBrowsableGateways=6.

Bukuluki, P.M. & Kisaakye, P. 2021. The Decision to Wear a Face Mask as a Protective Measure Against COVID-19: Survey Results from Greater Kampala Metropolitan Area, Uganda. *Frontiers I Public Health*, 9:675-734. doi.10.3389/FPUBH.2021.675734.

Cassim, J. 2020. Zimbabwe Reports First COVID-19 Case. https://www.aa.com.tr/en/africa/zimbabwe-reports-first-covid-19-case/1773705#:~:text=Zimbabwe%20announced%20Friday%20the%20country's,said%20Health%20Minister%20Obadiah%20Moyo [Accessed 18 September 2022].

Chingono, N. 2020. Zimbabwe Health Minister Facing Coronavirus Corruption Charge Sacked. *The Guardian,* 9 July. https://www.theguardian.com/global-development/2020/ju/09/zimababwe-health-minister-facing-coronavirus-corrption-charge-sacked [Accessed 18 September 2022].

Chipunza, P. & Marunya, K. 2020. Zim Records First Coronavirus Death. *The Herald,* 24 March. https://www.herald.co.zw/zim-records-first-coronavirus-death/ [Accessed 19 September 2022].

Cheng, K.K., Lam, T.H. & Leung, H.L. 2020. Wearing Face Masks in the Community During the COVID-19 Pandemic: Altruism and Solidarity. https://doi.org/10.1016/50140-6736(20)30918-1.

Creswell, J.W. 2014. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, (4th ed.). Thousand Oakes: SAGE Publications.

Crisis24, 2020. Zimbabwe: Face Masks Mandatory in Public Spaces, 6 May 2020. https://crisis24.garda.com/alerts/2020/05/zimbabwe-face-masks-mandatory-in-public-spaces-may-4-update-7 [Accessed 19 September 2022].

European Centre for Disease Prevention and Control. 2020. COVID-19 Situation Update Worldwide as of 2 September 2020. http://www.ecdc.europa.eu/en/geographicaldistribution-2019-cov [Accessed 20 September 2022].

Furusa, M. 2006. The Muse of History and Politics of Gender Representation in Zimbabwean Women's Literature. In Z. Mguni, M. Furusa & R. Magosvongwe (eds.). *African womanhood in Zimbabwean literature: new critical perspectives on women's Literature in African languages,* 1-23. Harare: College Press Publishers (Pvt) Ltd.

Gelfand, M. 1973. The Genuine Shona: Survival Values of an African Culture. Gwelo: Mambo Press.

Gudhlanga, E.S. 2005. Promoting the use and teaching of African Languages in Zimbabwe. *The Zimbabwe Journal of Educational Research*, 17(1):54-68.

Gudhlanga, E.S. & Madongonda, A.M. 2021. Shona Culture and a New World Order: Fissures, Strategies and Mitigation in COVID 19 Era. In R. Makamani, A. Nhemachena & O. Mtapuri (eds.). *Global Capital's 21st Century Repositioning: Between COVID-19 and 4th Industrial revolution on Africa*, 151-170. Mankon: Langaa.

Gudhlanga, E.S. & Makaudze, G. 2007. Writing and Publishing in Indigenous Languages is a Mere Waste of Time: A Critical Appraisal of the Challenges being Faced by Writers and Publishers of Shona Literature in Zimbabwe. *Occasional Paper* No. 26. University of Cape Town: Project for the Study of Alternative Education in South Africa (PRAESA).

Hashmi, F.K., Iqbal, Q., Haque, N. & Saleem, H. 2020. Religious Cliché and Stigma: A Brief Response to Overlooked Barriers in COVID. *Journal of Religion and Health*. Doi:org/10/10/1007/510943-020-01063-y.

Junior, E.K.D. & Dei, O.A. 2020. Adherence to Social Distancing and Wearing of Face Masks Within the Public Health Transportation During the COVID-19 Pandemic. *Transportation Research Interdisciplinary Perspectives*. https://doi.org.10.1016/j.trip.2020.100191.

Leung, C.C., Cheng, K.K., Lam, T.H. & Migliori, G.B. 2020. Mask Wearing to Complement Social Distancing and Save Lives During COVID-19. *International Journal of Tuberculosis Lung Disease*, 24(6):556-558.

Lubenga, G.B., Mendoza, H., Nkeremahame, J., Niyongabo, F., Gonza, J., Nakachwa, B. & Musoke, D. 2022. Community Mask Wearing as a COVID-19 Preventative Measure, its Barriers, and Motivators among Rural Households of Uganda: A Mixed Methods Approach. *PLOS Glob Public Health*, 2(7). https:///doi.org/10.1371/journal.pgph.0000485.

Makombe, E.K. 2021. "Between a Rock and a Hard Place": The Coronavirus, Livelihoods and Socio-economic Upheaval in Harare's High Density Areas of Zimbabwe. *Journal of Developing Societies*, 37(3):275-301.

Mangaliso, M.P. 2001. Building competitive advantage from *ubuntu*: Management lessons from South Africa. *Academy of Management Perspectives*, 15(3). https://doi.org/10.5465/ame.2001.5229453.

Manyonganise, M. (forthcoming). Caught in-between two worlds: *Ubuntu* identity and the African diaspora. *Zimbabwe International Journal of Culture and Heritage Studies*, 1(1):15-30.

Matuschek, C., Moll, F., Fangerau, H., Fischer, J.C., van Griensvein, M., Scheider, M., Kindgen-Milles, D., Knoeffel, W.T., Lichtenberg, A., Tamascoviks, B., Djiepmo-Njanang, F.J., Budach, W., Corradine, S., Haussinger, D., Feldt, T., Jensen, B., Pelker, R., Orth, K., ... Hausmann, J. 2020. Face Masks: Benefits and Risks During the COVID-19 Crisis. *European Journal of Medical Research*, 25(32). https://doi.org//10.1186/54000-020-00430-5.

Maulani, N., Nyadera, I.N. & Wandeka, B. 2020. The Generals and the War Against COVID-19: The Case of Zimbabwe. https://www.jogh.org/documents/issue202002/jogh-10-020388.pdf.

Miller, A.N. & Rubin, D.L. 2011. *Health Communication and Faith Communities*. Sudbury: Hampton Press.

Ministry of Health and Child Care 2020. Advisory on use of masks. htpps://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=249:advisory-on-use-of-masks-&catid=103&itemid=743.

Momina, M. & Pinter, S. 2018. A Conceptual Framework for Training of Trainers (TOT) Interventions in Global Health. *Globalisation and Health*, 14(1):1-16.

Mugambe, R.K., Ssekamatte, T., Kisaka, S., Wafula, S.T., Isunju, J.B., Nalugiya, A., Oputan, P., Makanga, D.K., Mukiibi, M., Buregyeye, E., Kasasa, S., Kansiime, W.K., Balen, J., Kapoor, R. & McGriff, J.M. 2021. Extent of Compliance with COVID-19 Prevention and Control Guidelines Among Supermarkets in Kampala City and Mukono Municipality, Uganda. *PLOS ONE*, 16(10). https//doi.org/10.137/journal.pene.0258840.

Mukherje, N. & Dias, A. 2020. Knowledge, Attitude and Perceived Effectiveness About Social distancing during COVID-19. *International Journal of Advanced Education and Research*, 5(3):69-76.

Murewanhema, G. 2021. COVID-19 Control Pitfalls and Challenges and Drivers of SARS-COV-2 Transmission in Zimbabwe. *Pan African Medical Journal*, 38(28). https://www.panafrican-med-journal.com//context/article/38/28/full.

Mutanda, D. 2022. Challenges and Opportunities for Zimbabwe's Responses to COVID-19. *Cogent Social Sciences*, 8(1):2084890. https/www.doi.10.1080/23311886.2022.2084890.

Muyambo, T. 2022. Social Distancing in the Context of COVID-19 in Zimbabwe: Perspectives from Ndau Indigenous Knowledge Systems. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 pandemic in southern Africa*, 37-51. New York: Routledge.

Mwesige, D., Nalugya, A., Bulafu, D., Tigaiza, A., Nagawa, B.T., Belinda, E. & Walekwa, A.W. 2021. Face Mask Use and Associated Factors Among Students in Rural Eastern Uganda Amidst COVID-19 Pandemic. *MedR*, xix. https://.doi.org/10.1101/2021.06.27.21.259/31.

News24 (2020). Zimbabwe Street Vendors Sell Cloth Masks to Make Ends Meet. https://www.news24.com/news24/Africa/Zimbabwe/zimbabwe-street-vendors-sell-cloth-masks-to-make-ends-meet-20200508.

Okyere-Manu, B. & Morgan, S.N. 2022. Exploring the Ethics of *ubuntu* in the era of COVID-19. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 pandemic in southern Africa*, 25-36. New York: Routledge.

Ramose, M.B. 2002. *Philosophy from Africa: A Text with Reading*. Oxford: Oxford University Press.

Ross, J. 2020. Coronavirus Outbreak Revives Dangers of Race Myths and Pseudoscience: Most Fictional Claims About Black Immunity to the Coronavirus are Connected to the Long History of Contradictory but Uniformly Racist Ideas. www.nbcnews.com.

Samkange, S. & Samkange, T.M. 1980. *HUnhuism or Ubuntuism: A Zimbabwe Indigenous Political Philosophy*. Salisbury: Graham Publishing.

Sibanda, F., Muyambo, T. & Chitando, E. (2022). Introduction: Religion and Public health in the Shadow of COVID-19 Pandemic in Southern Africa. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 pandemic in southern Africa*, 1-24. New York: Routledge.

Sipeyiye, M. 2022. Coping with Coronavirus (COVID-19): Resources from Ndau Indigenous Religion. In F. Sibanda, T. Muyambo & E. Chitando (eds). *Religion and the COVID-19 pandemic in southern Africa*, 52-71. New York: Routledge.

Taylor, S. & Asmundson, G.J. 2021. Negative Attitudes About Facemasks During the COVID-19 Pandemic: The Dual Importance of Perceived Ineffectiveness and Psychological Reactance. *PLOS ONE*, 6(2):e0246317. https://doi.org/10.1371/joournal.pone.pone246317.

Gift Masengwe

13 The Effects of COVID-19 and the Suffering of Pastors: Implications for the Provision of Pastoral Care and Counseling

Abstract

This chapter discusses pastoral care and counseling (PCC) in the context of the Coronavirus disease 2019 (COVID-19). The pandemic posed challenges towards religious practitioners in their care context. PCC provided solace towards dying or bereaved congregants. The rationale is that religion promised eternity, a concept that forces religious ministers to lose their lives without being able to avoid their dying members in both pandemic and non-pandemic contexts. PCC provides a holistic approach towards human comfort and hope for Christian sufferers and their families. In the academia, PCC contains key concepts of spiritual and psychosocial care that unites existential suffering and physical illness. This is provided for by trained religious practitioners in the service of the church and their needy members. Pastors tapped into the arena of the sacred on one hand; and psychosocially titillated the human psyche to heal human suffering. The theory and practice PCC appropriately reflects upon and implements religious resources towards care for persons facing in extreme physical, psychological, and social distress. The chapter used mobile instant messaging interviews (MIMIs) in this qualitative study. PCC is a holistic form of human care that positively affects families, health workers and patients during a health crisis like COVID-19. Religious resources provide vigilance for one to cope with highly contagious and fatal pandemics like COVID-19, and that can make a difference in the lives of sufferers.

Keywords: COVID-19; Pastoral care; Pastoral Counseling; suffering

Introduction

At the beginning of the year 2020, various presidents of African nations declared the Corona Virus disease 2019 (COVID-19) a national disaster.

COVID-19 like its precursor, Severe Acute Respiratory Syndrome – Corona Virus 1 (SARS-COV1) presented new complications that affected nations and religions alike. Christians who provided spiritual and psychosocial care through the church's pastoral care and counselling (PCC) programmes found social distancing to be a challenging requirement when providing PCC services. COVID-19 challenged how Christian pastors provided PCC services to sufferers. However, spiritual care became the third and important dimension of medical healthcare after physiological and psychological care. Spiritual care has become a key component in that it kept a holistic approach on human hope during health crises. Spiritual care assisted sufferers to find meaning in their relationships with their own bodies, other people, society, the environment and the spiritual dimensions of their lives. Religious remedies, using a wide range of spiritual resources, given by pious pastors changed circumstances for sufferers. Loving God for most COVID-19 sufferers in Zimbabwe became one of the greatest romantic practices that those who sought God went on a spiritual adventure to find their ultimate as a whole life achievement in their life history. Many pastors who became essential services providers had to attend many and bury people including other pastors who died in their call of duty. Pastors became chief mourners, burying colleagues, congregants and relatives alike. Due to the complications brought by COVID-19 and related illnesses religious practitioners were forced to attend to the dying and dead with COVID-19 related complications at greater risk to their own lives (Khosa-Nkatini 2022).

PCC affirmed the humaneness of sufferers in the era of the pandemic as pastors steadfastly delivered what is required in their professions on care-giving as they devised new ways of performing their pastoral duties in keeping with a conclave of health measures in the form of social distancing, de-socializing, masking, hand-washing and sanitizing. COVID-19 had socio-demographic and psychological characteristics as well as religious and spiritual factors to deal with the context of a seemingly untamable bug. COVID-19 brought higher levels of anxiety and depression among sufferers, which led to lower levels of psychological wellbeing. These elements led to higher levels of suffering as evidenced by qualitative MIMIs to understand the suffering of church members due to COVID-19. However, there were '[p]otential benefits of both integrating assessments of suffering into screening procedures and addressing experiences of suffering in mental health service settings' (Cowden, et al. 2021a:1).

It, therefore, became necessary for pastors to acknowledge their own pain and the need for them to change how they do their ministries. This chapter challenges pastors to look deeply into their caring and counseling during the COVID-19 pandemic with a view to take care of the caregivers in their process of caring for others. This chapter understands self-care during the COVID-19 pandemic as a change of ministry without necessarily committing suicide in their professional practices.

Theorising Suffering during the COVID-19 era

This chapter is written from the perspective of a spiritual and psychosocial care situation using the 'praxis theory of suffering' by an English-born qualitative health researcher, Dr. Janice Margaret Morse (born 1945). This is a caring intervention that measures a person's emotional response towards illness or untimely death of loved ones (Morse 2001, 2005:257, 2011; Foss & Nåden 2009). On the other hand, Finish-Swedish nurse Katie Erikson (1943-2019) developed the 'theory of caritative caring' in the nursing theory of suffering. She provided the fundamental elements of ontology when caring for sufferers (Eriksson 1997, 2007; Lindström 2013; Näsman 2020). On anthropology and science in the nursing care context, Morse (2001, 2011) focused on empirical results of suffering while Erikson (1997, 2007) focused on the ontology of suffering. They both provided useful information on the phenomenology of suffering for distressed COVID-19 sufferers to religious practitioners working in the science and art of spiritual and psychosocial care.

Researchers on suffering developed their theories by synthesizing theories from other qualitative studies making theories of suffering interventionist because of their emphasis on clinical care sciences. COVID-19 imposed scientific awareness upon the religious practitioner that spiritual and psychosocial care became transformed, with changing consequences on pastor and congregant relations. PCC focuses on helpful interactions and integrations for classified sufferers. The biggest challenge is the agony and anxiety of the caregiver who cannot operate as a disembodied professional due to the contagion of disease and suffering. To understand this challenge, Morse developed a model of physical care that had categories of ethos, care and suffering to support 'compathetic care-giving' (Morse 2011).

Eriksson on the other hand sought to synthesise similar concepts of caring sciences in the development of caritative caring. Pastors, thus, can

suppress emotions but they also need to release them as in praxis theory of suffering. 'Suffering is an emotional experience; emotion is reflected in, and evidenced in, the suffering person's behaviors' (Morse 2011:574). A sufferer usually exits the mode of suffering by reformulating their identity and dignity on life. This affects how pastors discharge their duties beyond their own experiences of suffering if they are not allowed to recover their normal selves and to learn from their suffering their God-given vocations.

Research Methodology

The study used mobile instant message interviews (MIMIs) from WhatsApp discussions to discuss issues of suffering during the COVID-19 era. The study engaged a total of ten (10) Church of Christ in Zimbabwe members, specifically four (4) pastors (RP1-4) and six (6) congregants who were engaged in a focus group (CFG1) in this study. MIMIs collected in situ data (Kaufmann, Peil & BorkHuer 2021). Questions were posed to pastors and congregants alike through WhatsApp groups. MIMIs produced data on the implications of suffering for Church of Christ pastors, of whom several pastors succumbed to the disease leaving their families struggling to make ends meet. Pastors were engaged through personal and key informant interviews while congregants were interviewed through the focus group discussions. All participants were asked to verbally consent to the study to meet the required validity and reliability concerns in trying to meet minimum ethical standards that included informed consent, confidentiality and anonymity to participants. These results may not be representative of how pastors in other denominations and religious institutions experienced during the era of the pandemic, but makes tentative suggestions that can apply to many religious entities of a similar nature such as the training and retraining of pastors and their churches on the exigencies of pandemics as well as how to protect practitioners. Data obtained was interpreted thematically.

Background to the Study

The outbreak of the Corona-Virus 2 in 2019 codenamed COVID-19 in Wuhan, China, is one of the novel Corona-Viruses that include Severe Acute Respiratory Syndrome Corona-Virus 1 (SARS-COV1), and the Middle East Respiratory Syndrome – Corona-Virus (MERS-COV). Diseases of the

respiratory nature have included various influenzas such as H1N1 and H5N1, which are subtypes of the Influenza A virus (Masengwe, forthcoming). 'The World Health Organization [WHO] also mentioned that there were cluster cases of pneumonia with unclear etiology originating from Wuhan City, Hubei Province, China' (Ngesthi, et al. 2021:789). The WHO later declared it a pandemic. COVID-19, like the different variants of other viral infections before it, caused great socioeconomic turmoil (Masengwe & Makuvaza 2021), due to political manipulation necessitated by the response to the pandemic (Masengwe, forthcoming). 'At the global level, response [to COVID-19] has taken place in the form of fiats for lockdowns, social distancing, and a new conclave of public health measures such as hand washing and sanitizing, wearing masks, and avoiding large gatherings' (Ma, Rogers & Zhou 2020:5). The recommended WHO's adaptive measures of limited physical contact that imposed travelling constraints, limited physical meetings, gatherings and events had socioeconomic consequences for most nations, especially developing countries like Zimbabwe (Masengwe & Makuvaza 2021).

When members contracted the virus, whether with chronic conditions or not, pastors were expected not to fear death but to walk the patient through the death process. The COVID-19 pandemic, however, claimed lives of both patients and pastors, disrupting the processes of PCC among other factors. The instability of the public health sector in the midst of the disease affected many patients and practitioners leading towards social isolation (Counted, et al. 2021; Daly & Robinson 2021; Twenge & Joiner 2020; VanderWeele, et al. 2021; Xiong, et al. 2020). In developing nations, besides complications caused by COVID-19 infection, there were too many stressors such as economic challenges, poor health facilities, chronic diseases and political instability that exacerbated the subjective experiences of pain and suffering. This chapter accepts the need for PCC towards sufferers of COVID-19, especially towards chronic patients, but mindful of the risks towards caregivers.

Further, the effects of COVID-19 on the global health emergency left developing nations unable to quickly and adequately respond towards disease containment and eradication due to ailing economies. Systemic global health inequalities in the face of rising global pandemics and lack of basic facilities left nations unable to invest, incentivise and support technological research and development due to lack of political will

(Masengwe, forthcoming). COVID-19 shocked economies, affected markets and depleted job opportunities. It led many institutions into indebtedness.

COVID-19 dealt away with past certainties on how to deal with health using insurances, which brought the need for religion to take centre stage through PCC during the era of the pandemic (Leduc & Liu 2020). Religious services to COVID-19 patients and the bereaved families in the midst of WHO measures raised another challenge to both the religious practitioner and the patient. This chapter seeks to investigate the suffering caused by COVID-19 upon both patients and religious practitioners in the provision of PCC to the patient and the families. This has implications for religious theory and practice in the context of pandemics. While some scholars like Damaris Parsitau (2020) thinks that religion also floundered in the face of COVID-19, it can still be argued that the pandemic gave religion a chance to assert itself in science and medicine with regards to the economics of pandemics (Ma, Rogers & Zhou 2020). Religion was affected, but remained vigilant with answers on the uncertainties of COVID-19 upon human survival and redundancy (Leduc and Liu 2020). Religious practitioners, as was with tradition, were forced to provide the care they usually provided in normal circumstances mindful that the disease was spreading among those "being susceptible, actively infected, and no longer contagious" (Ma, Rogers & Zhou 2020:2).

Due to its effect on economies, COVID-19 came at a time talks about a new recession were on the news. Many have accused governments of using COVID-19 to avert the recession by cutting back on economic activity through lockdowns and curfews. Unfortunately, decreased economic activity meant that religious practitioners could not acquire the latest equipments required to carry out PCC business as usual. Thus, ministers of religion became vulnerable as well as patients who, often than not would not be attended to as expected. The results from this study indicate that governments are called to capacitate and incentivise welfare projects, especially religious ones, which are with the people in the midst of their suffering. The following results indicate what pastors experienced during the pandemic era.

The Conception of Suffering in the Advent of Pandemics

The meaning, nature and implications of suffering during the era of COVID-19, as found in this study, indicated that it is a stage of existential

vainness caused by the sickness or death of a loved one. Study participants stated that the sickness of their relatives or their own led them to experience 'existential void', or a 'relational experience of meaninglessness' (RP2, RP4). Suffering is, therefore, a difficult concept to understand, especially for scholars of religion, but religious practitioners (RP) who have for long dealt with issues of happiness and suffering in the context of human wellbeing and flourishing is understood differently (CFG1). Religious practitioners may include scholars such as theologians, philosophers and psychologists who for long discovered the intricacies of suffering in connection to human existence. Literature indicates that existential suffering can only be stopped by death (Khosa-Nkatini 2022). Existential suffering is what 'every person trying to find meaning in illness and death' (RP1, RP3) undergoes through experiences of 'emptiness in my relationship with others' (CFG1). Suffering is a key emotion of value inferred to as one of the physical and emotional outcomes of COVID-19 (VanderWeele, et al., 2020). It is associated with pain, anxiety, depression and mental disorder in both clinical and pastoral practice.

This study has been supported by literature on suffering, which emerged to show that 'emotional and psychological stress' is one of the undesired experiences one undergoes when one loses 'personal and social goods' (RP1-RP4; CFG1). This is because suffering interferes with 'self-assertion', meaningful relations and achievement of personal goals as it threatens one's sense of self (Tate & Pearlman 2019; VanderWeele 2019; Fitzpatrick, et al. 2016; Cassell 2004). The intensity and duration of suffering (i.e. physical sickness and pain) posed by the COVID-19 pandemic maybe incomparable to the emotional and psychological turmoil endured (VanderWeele 2019). Participants reacted differently to the concept of suffering with religious practitioners stating that: 'I was dreaded by the pain of the disease' (RP2), 'My thoughts of the pain drained all energy out of me' (RP3), "I did not like COVID-19 because of the state of our hospitals' (RP1), or 'I did not like the sudden loss of my friends and relatives' (RP4). Congregants in the focus group discussion also concurred on fear of the 'incurability of the disease' and 'dreaded thoughts of incurability', or the 'locked down poor populations' or 'sudden death to people well-known to me' (CFG1). With these responses, one can state that suffering refers to the 'physical symptoms' (i.e. incurable illnesses), 'psychological crisis' (mental challenges), 'systemic problems' (i.e. poverty) and 'social losses' (for example, romantic break-down) (Cowden, et al. 2021b). Suffering

thus permeates all aspects of human life with some perceived loss of control (Cassell 2004). Participants viewed COVID-19 as something that had brought this kind of suffering, because 'the infected were distressed from fear of imminent death' (RP3, 3), while 'the affected were uncertain of the consequences of the illnesses of their relatives' (RP1, 4), and 'everyone had lost control of human wellbeing' (CFG1). All people alike were afraid, uncertain, distressed and hopeless because no one had medical or technological answers to the problem (VanderWeele 2019). Religion and spirituality however was the only institution with age-old answers to the problem of human suffering (Masvotore 2020).

Participants further indicated that suffering was conceptually and empirically different from anxiety and depression. 'Suffering is not only psychological and emotional but existential' (RP1, 3, 4), as it involved 'loss of human livelihood' (RP2). CFG1 indicated that suffering included 'psychological distress, mental sickness and physical pain due to the disease and lockdown measures' that followed it. In other words, suffering involved loss of: *health, livelihood* and *freedom* (Cassell 1999). In this way, suffering is distinctly subjective to human experience, and is highly personal (Cowden, et al. 2021b; VanderWeele 2019). Participants indicated that their sense of the self was diminished by COVID-19 leading to 'the degraded wellbeing of people' (RP1-4), and hence experienced 'lower levels of emotional and psychological health' (CFG1). This distress has been experienced by patients receiving end-of-life care from terminal illnesses like AIDS or cancer following the diagnosis of having been infected with COVID-19 (Cowden, et al. 2021a, b). This has also affected physical health as loss of hope due to negative psychological functioning affected the patient's ability to ingest food and water.

In all, all participants indicated that they received peace as soon as they surrendered, affirmed and accepted their own fate (RP1-4; CFG1). Literature supports this as one of the only available options in life, saying: "God is our ultimate goal, our ultimate meaning" (Masvotore 2020). Confused and disorientated people only received meaning by surrendering their beings to God. Meaning here is a a point of sacrifice, thoughtfulness and sensitivity towards ourselves, others and God. It calls for personal responsibility and commitment towards the grace of God. Pain and suffering however leads one towards deeper learning experiences and therefore acquiring deeper life values, personal imagination and compassion to the suffering of others (Masvotore 2020). The uniqueness of experiencing suf-

fering means suffering should not be regarded as a problem to be eradicated but a mystery to be actively accepted and affirmed by the sufferer to attain the needed holiness.

Psychological Distress from the COVID-19 pandemic

Participants further indicated that COVID-19 caused psychological distresses due to the hardships and losses people consistently suffered. Participants stated that: 'We have lost employment, our cherished religious rituals and social gatherings' (RP1-4; CFG1). Losses included physical mobility, psychological freedom, economic independence and social integration (Counted, et al. 2020; Meagher & Cheadle 2020; VanderWeele, et al. 2021; Wakam, et al. 2020). These losses threatened career development and gainful employment, spiritual resources provided by religious services and the value of connections in one's life. Participants stated that 'inconsistent public health messaging pronounced by the Minister of Information rather than the Minister of Health and Childcare, showed that we had lost control of ourselves' (RP1-4). In fact, participants stated that 'COVID-19 was intolerable as we had no hope in any foreseeable near future' CFG1). This total loss of hope was also experienced in other countries were nations had no typical coping strategies to deal with the health crisis (Rettie & Daniels 2021). Psychological suffering experiences have been measured among cancer terminal patients (Wilson, et al. 2007) in relations to mental health (Lehmann, et al. 2011; Abraham, et al. 2006; Al-Shahri, et al. 2012; Samelius, et al. 2010). COVID-19 however also dealt with physical and psychological health, suffering related to anxiety and depression (VanderWeele 2019).

This chapter addresses broader knowledge gaps on emotional and psychological suffering as patients sought for answers from difficult (esoteric) questions. Participants stated that 'COVID-19 is the will of God for fallen humanity' (CFG1), or questions like: 'How does God feel when people die in thousands?' (RP3, 4), or 'This is truly a punishment for our wrongdoing' (RP1, 2). This reiterates questions asked by scholars concerning suffering such as 'Where is God during the pandemic?' (Louw 2020:27). The cause of psychological suffering to both pastors and congregants were the increasing levels of sufferers in the midst of fears and anxieties of an incurable disease. In all, pastors in Zimbabwe thus understood the brevity and depth of this suffering with dire consequences on their own lives and families.

Spiritual Care for Members and their Limitation during COVID-19 Era

From the study results, it can be suggested that pastoral care, from Latin *curae*, and English cure, is the 'tending to the needs of the vulnerable' [pastoral], or, 'the attentive concern for the other' [care] (McClure 2012:269). The care for church members took priority during the era of the pandemic with huge adaptations on PCC services that gave primacy to safe responses towards calls for care and counseling. Care-giving in this case materially depends upon the care-receiver for effective-mutual healing and wellbeing (Klaasen 2018:6). The care-receiver informs the caregiver on sense-making and the meaning of things during the complex situation, while the caregiver accepts material proceeds from the care-receiver for devoted and effective spiritual services to the needy. Pastors began to 'back off, unless supported by full gear to attend funerals' (RP1-4), as they responded to the pandemic's effect towards their own finitude. They could state that 'we too, in a small way, can be healers of others' (Campbell 1986:41-42), if their members responded positively to the felt needs of the shepherds. Rather, many congregants 'do not produce milk to feed the shepherd' (CFG1), which 'wears away enthusiasm and excitement for serving others' (RP1-4). Such traumatic experiences have been recorded in literature as having caused suicides among pastors (Gugushe 2014). Though this contrasts the biblical image of 'a Good Shepherd who lays down his life for the sheep' (Khosa-Nkatini 2022:4), it needs to be understood that burned out pastors can lose their devotion due to illness and lack of sleep (Salari, et al. 2020). This speaks to the PCC services and the limitations thereof as COVID-19 affected allof the earth's inhabitants (Louw 2020).

PCC has for years been used in the care-giving context to routinely conduct funerals where pastors acted as front-runners, or even undertakers, in the lines of duty (Roman, et al. 2020:1). COVID-19 foiled the processes leaving members who used to rely upon religious and spiritual services of the underserved (Koenig 2009; Koronkiewicz 2009; Samuel-Hodge, et al. 2000). Dire consequences have been recorded wherein 7 of the estimated 300 pastors in the Church of Christ in Zimbabwe succumbed to the pandemic. Failure of science and medicine brought about this anxiety and uncertainty as pastors faced imminence of death in the context of COVID-19. This chapter challenges religious congregations to

devise a new culture of warm human interactions other than physical associations that care for practitioners and congregants during pandemics because 'PCC is informed by culture at every point' (Lartey 2015:61). Interactions are culturally informed processes that can be used for PCC.

Pastoral Protection and Care during COVID-19 Era

The care and protection of pastors during COVID-19 took two levels: care by members and self care. Participants noted that 'Our pastors are at the centre of our healing, but also need to be cared for' (CFG1). PCC is an important spiritual practice that also appeals to the Shona culture, and 'we cannot shortchange our members on such a service' (RP1). However, the pandemic demanded change of ministry-practice in association with prescribed WHO regulations. Pastors stated that 'We need congregants who understand the times so we can continue to provide pastoral services to Christian families' (RP2, 3, 4), because 'pastoral presence is essential in the broader context of loss of health and life' (RP1; De Backer 2021). During this time, PCC was required by those in need of essential services, or who lost livelihoods due to lockdowns and curfews, so they may not commit suicide (Khosa-Nkatini 2022). Suicidal behavior, due to emotional distress and anguish, is recorded as one of the leading causes of death and injury worldwide (Alexander 2008; Nock, et al. 2008). Distressed and anguished persons cannot fully live normal lifestyles without use of alcohol and drugs. Congregants and pastors who cannot use such substitutes could not escape suicidal tendencies. At the behest of COVID-19, most pastors experienced functional difficulties due to fear of infection. Advanced religious congregations provided physical, emotional, and psychological protection as PCC was extended to their families. Pastors lost loved ones, especially faithful congregants, making them wounded healers (Nouwen 2010 (1972/1979); Greenfield 2001). This called for congregations to extend a hand of care and protection as they carried out this difficult task of caring for people suffering from COVID-19. Most countries have called pastors to join their vital staff in providing essential services to the nations.

For pastors to receive care and protection from their members, they should be the first to acknowledge their own vulnerability (i.e. pain, fear and anxiety), before their members can provide them with their needs. Most of uncared for pastors live troubled lives (Duncan 2020; Usher, et al. 2020), yet 'we are essential for serving the least members of society'

(RP1-4; Ferrell, et al. 2020; Parkinson 2000). 'If COVID-19 kills us, our critics question our calling' (RP1-4). For this reason, congregations have devised new approaches to PCC that cannot replace 'our need for material support so we can freely, holistically and effectively give care to our members' full arc of life' (RP1-4; Vaccarino & Gerritsen 2013). Studies are replete with the enormity of work done by pastors during critical moments to their members (Roman, Mthembu & Hoosen 2020), but little on the services that must be rendered to the pastors. This leaves pastors serving their congregants with unmet needs such as burnout, stress and anxiety. This calls for pastors to take the first step in caring for themselves.

Self-care is a term used for pastors, but remains an ox moron because a burned-out pastor may not know that they are burned out, stressed or anxious. It is like asking a brain surgeon to remove a brain tumour in his own head. They may just experience 'a decline in energy, motivation and commitment' (Barnard & Curry 2011:49). This is not a sign of weakness for 'it is so easy for those who are care-givers of others to neglect their own welfare' (Horsfall 2010:52). Self-care demands that pastors distance themselves from the hurts in the people whose wounds they are mending. Pastors, who are traumatised by wounds of members, become themselves wounded that they collaterally infect other congregants (Greenfield 2001). This affects their spirituality, which is 'the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred' (Ferrell, et al. 2009:18). In fact, the most devout and committed pastors can be equipped to serve others better if their own existential and professional needs are met first (Oswald 1991; Horrex, n.d.:6). PCC, thus, becomes a prayer offered to God through the pastor for the healing of listening believers (Kelcourse 2002). Givers of this ministry thus need it for themselves first before they can give it to others (Khosa-Nkatini 2022). During the COVID-19 crisis, most pastors questioned the presence of God as they anxiously grieved for lack of balance in their own lives, yet they presided over funerals to provide essential services to their members (Khosa-Nkatini 2022).

Relevance of Pastoral Praxis in the Context of COVID-19

PCC is in the field of Practical Theology, which is a product of praxis; hence an academic study of the subject cannot be freed from its alma mater (Steyn & Masango 2011). Practical Theology thus cannot be separated from the theological convictions and phenomenon of the Christian family (Steyn &Masango 2011). Scholars and practitioners thus should influence practice in the daily living of care-receivers in their specific social settings (Miller 2015). Thus, "the subject matter of Practical Theology is identified as General Christian (or human) praxis due to the theological need to create a space for caring for different people in the church" (Maddox 2015:160). The practice of care takes place in the context of the Christian family in whose bosom are caregivers and care-receivers (Khosa-Nkatini 2022). Pastors receive the least of this care within that context; prompting this study to explore the need to equip pastors for self-care towards increased workloads in the midst of an incurable pandemic. The practice and theory of PCC bridges the gap between the caregiver and the care-receiver in their interaction within the congregation of the faithful (Ikenye 2016). Conceptually, COVID-19 challenges pastors and their congregations to adapt to new, safe and effective methods of serving, and be served by, congregants.

Church of Christ in Zimbabwe Virtual Services during Lockdowns

Virtual Services in the Church of Christ in Zimbabwe

A study on virtual services in one of the Church of Christ in Zimbabwe congregations shows that PCC is possible in many ways. The Inner City Church of Christ did not only provide counseling services, but also provided virtual services to their members in the comfort of their homes. Use of mass media technology on religious platforms to give members access to church services, funeral processions and live-streamed counseling programmes became central during the defined moment. The pastor no longer served as a minister but spiritual service provider to congregants who became clients and consumers. Technology however, cannot define or be defined by religion on what it offers in the spiritual moment. Rather technology liberated both the worshipper and the preacher by providing

greater possibilities in the worship moment. One has to guard against enslaving or being enslaved by technology rather than be used as an extension of human effort. Enslaved pastors cannot use rigid recordings because they see their own relevance in live streaming technologies. Users also must see technology as a solution to their problems. The value of technology therefore is in its functional definition to humanity, that is, usefulness to the human society only.

Most COCZ congregations broadcasted their services on Facebook and WhatsApp platforms to keep members informed of what was going on, in the church, at a funeral, home or hospital. They firstly depended on rigid recording, until later some adopted live streaming technology, and in fact many congregations remained unable to acquire live streaming technology and streaming data. Urban congregations like Inner City Church of Christ in Harare acquired a radio programme that has not fully functioned apart from recorded digital messages using Skype, Zoom and Microsoft Teams. Social media platforms, however, have remained central in the communication of the gospel (Khosa-Nkatini 2022). Some pastors in congregations that failed to embrace technology during lockdowns have succumbed to the virus. Of the seven pastors lost in the COCZ included a prominent business-pastor, an entrepreneur, and a passionate preacher. Pastors who adopted audiovisual strategies recorded their messages on video or audio and forwarded them to their church groups. This, however, did not give congregants the benefits provided for in live streaming.

Pastors eventually innovated in various ways to keep their congregants informed, especially on human vulnerability to the virus (Haußmann & Fritz 2020). At ColenBrander Avenue Church of Christ in Bulawayo, virtual meetings included forwarded audio and visual messages as well as live streamed Facebook messages for those who could afford to buy internet data. Live streamed services benefited members who could respond on the platform with prayer requests for the sick, to visit the bereaved and other needs. PCC could be done on the platform during the service. Interaction would further lead the pastor to urge members to send mobile money onto the line or into the church account to allow the pastor to serve those in need. Those pastors who could not emotionally and technologically connect with their congregants due to limitations became exhausted, anxious and afraid of their own relevance and welfare. One participant stated that 'I felt this emptiness and void in my life because I was disconnected to others' (RP3). Virtual services allowed distanced members to reconnect to each other.

'Calling one Another to Life' at Inner City Church of Christ

PCC is one of the most difficult pastoral services to be carried out virtually because it involves physical, emotional, intellectual and sensory receptors. While people can suggest many ways of providing PCC virtually, this study captures an innovation that was carried out by one of the young-senior pastors in the Church of Christ in Zimbabwe.

At Inner City Church of Christ during lockdowns, Pastor Smallmatter Zulu (senior church pastor) introduced the programme 'Calling One Another to Life'. The congregation had about 150 to 180 members. He created different platforms of accountability and communication for purposes of 'calling one another to life'. The pastor would call each of his elders and ministry leaders on a daily basis through WhatsApp call to find out how they were doing and if they had encountered any incidences that warranted attention during the day. He had to call and counsel eight senior church leaders on a daily basis. He also would call two committee members from each of the church wings: the youths, women, men and singles. In turn, each of the eight church leaders called would also call eight members of their cell group who represented households to find out how they had spend the day or if they needed help so that they could be assisted in whatever way possible. Each of the committee members for the church wings would also call at least eight people in their group to do the same. Masvotore (2020) says such an act "demonstrates the ministry of healing, compassion, and reverence". People who felt unaccepted in the church became healed as they felt wanted after their leaders called upon them for accountability. Leaders enabled followers to become concerned people as they became integrated into becoming whole by the gospel. This innovation and orthopraxis permeated into the whole congregation that even after the era of COVID-19, the congregational striving for human freedom has developed an approach that matures persons according to the design of God.

This was the strategy that allowed the pastor to worry about a few leaders under his care, while each of the leaders shared the pastor's burden to the rest of the congregation. The senior pastor indicated that he designed the strategy as a self-care approach to allow him to attend to the core of his calling: study of the word, prayer and fasting. Church leaders freed him from the daily care of the congregants. The pastor thus created a self-care programme that effectively reduced his workload, but at the same time allowed him to reflect upon his work as church leaders extended his

work through the 'Calling One Another to Life' Programme. Reports given to the senior pastor by elders and deacons encouraged this strategy; which has further cared for the welfare and needs of the pastor.

The second approach that was used in the same congregation was a public mass service. Mass services were contacted three times a week. There was a main service that was live streamed during a Sunday service only with the pastor's family in attendance. This encouraged families to cope with challenges of the moment. As families attended public mass services virtually, the pastor would attend to prayer requests, usually passed on to individuals through recorded messages or voice calls. Questions during services were attended to, with options to get hold of the pastor outside the service. A similar prayer service provided scriptural readings for each of the presenting problems during the week, including questions asked during and after the Sunday service. Lists of prayer requests from the pastor hinted on those who would have succumbed to COVID-19 needing prayers. Wednesday prayer meetings focused on praying for people and their needs, and this was live-streamed to congregants who would have fasted the whole day until after the 6 p.m. prayer sessions.

The third approach was a live-streamed discussion with experts in various fields affecting human life during the lockdowns such as medical doctors, researchers, scientists, politicians or economists, to help congregants cope with their situation. Discussions were also posted on WhatsApp platforms as audiovisual or typed questions and answers. This usually took about 45 minutes to one hour. These lively discussions were carried out after 8 p.m. as services would be live-streamed if the pastor had data for such purposes.

All these innovations in the practice of faith reached everyone including non-COCZ believers as it cared for the human person and not only a church member (Ganzevoort & Roeland 2014). For the regular Sunday services and Wednesday prayer meetings, congregants were encouraged to have a closer walk with Jesus, and hence, improved Christian life practices (Ganzevoort & Roeland 2014; Stadelman 1998). The Church of Christ in Zimbabwe, and in fact the Inner City approach, has motivated two young people to take up ministerial training because they were counseled and helped at the death of an uncle and a grandmother. Inner City focused on caring for, and putting others first, as part of loving God in doing, living and practicing one's faith (Ackermann & Bons-Storm 1998). This led the young people to restore the devastated lives of family members, and made home in the complexity of human relations (Swinton &

Mowat 2016). They practiced rather than merely verbalised their faith during the health crisis (Anderson, Jané-Llopis & Cooper 2001).

Implications for Theory and Practice

This chapter discussed the effects of COVID-19 to pastors involved in PCC in relationship to the broad concept of their suffering during the professional discharge of their duties during a public health crisis (Khosa-Nkatini 2022). Pastors who are unhealthy and unbalanced provide poor services. Despite this suffering, their administrators, elders, deacons and members regard them as incompetent yet their unmet needs are not dealt with. This calls for scholars to study suffering in the context of pandemics to translate theories into practices through empirical studies. Emphasis on practice forces church leaders to be sensitive towards subjective experiences of pastors during health crisis moments like COVID-19 because it eventually affects congregants, hence the need to further explore the etiology of anxiety, distress and burnout with regards to the pandemic. Analysis of PCC practices should go beyond surface perceptions of suffering by developing a more personalized approach to treatment. Therapies for distress during a public health crisis need to deal with subjective experiences of suffering as well as developing meaning-based focus that takes them away from their pain. Suffering and pain require patience and courage as philosophical and theological resources to promote personal growth are acquired (VanderWeele 2019). This has implications beyond clinical studies that must include socioeconomic and political inequalities, as well as material lack and poor health systems (Govender, et al. 2020). Exploring suffering in this context contributes to the refinement of context-informed treatment and intervention programmes that support COVID-19 sufferers inclusive of caregivers and care-receivers.

Conclusion

This chapter discussed PCC in the context of COVID-19 and its causal links for suffering among devout congregants and devoted pastors. The suffering of pastors in the COCZ in their call for duty was discussed as providing solace to their congregants. COVID-19 disrupted all public life settings that changed the way the life-giving warmth of PCC was done for eternity bound communities. The chapter emphasised the holistic nature of PCC to the care and comfort of members. Concern over the care of

pastors was raised as impeding with the quality of service provision to congregants. PCC is a product produced by the church but fails to serve the practitioner who is believed to tap into the arena of the sacred in healing the human psyche. The multitudinous levels of pain and suffering brought by COVID-19 increased the crisis in Zimbabwe, and herein make PCC relevant by actualizing the need to support the caregiver in their role of care-giving during the pandemic. The study encouraged an exploration of the theory and practice of PCC for the broader range of congregants as health conditions in Zimbabwe remained deplorable. The outbreak of COVID-19 could not stop PCC as churches adapted to new changes and strictly adhered to government regulations in keeping with members' dependence upon God. Interestingly, PCC is difficult to be practiced using remote contact, especially for bereaved families. While services have for the first time been held electronically, some pastors did not have relevant media technology to reach their congregants. In the Church of Christ in Zimbabwe, services have for long been streamed for both public and private viewing on Facebook, Whatsapp and compact discs. An attempt to use radio, television, Zoom and YouTube following the Inner City attempts have been affected by congregants' poor mobile networks and data costs. The pandemic, however, has forced these innovations in PCC due to workload burdens, health challenges and uncertainty associated with COVID-19. This has made the church vigilant in the face of the pandemic.

References

Abraham, A., Kutner, J.S., Beaty, B. 2006. Suffering at the End of Life in the Setting of Low Physical Symptom Distress. *Journal of Palliative Medicine,* 9(3):658-665.

Ackermann, D. & Bons-Storm, R. 1998.*Liberating Faith Practices: Feminist Practical Theologies in Context*. Leuven: Peeters.

Alexander, B.K. 2008. *The globalisation of Addiction: A Study in Poverty of the Spirit*. Oxford: Oxford University Press.

Al-Shahri, M.Z., Eldali, A.M., Al-Zahrani, O. 2012. Prevalence and Severity of Suffering among Patients with Advanced Cancer. *Supportive Care in Cancer,* 20(12):3137-3140.

Anderson, P., Jané-Llopis, E. & Cooper, C. 2011. The Imperative of Well-Being. *Stress and Health,* 27(5):353-355.

Barnard, L.K. & Curry, J.F. 2011. The Relationship of Clergy Burnout to Self-Compassion and Other Personality Dimensions. *Pastoral Psychology,* 61:149-163.

Campbell, A.V. 1986. Rediscovering Pastoral Care. London: Darton, Longman and Todd Ltd.

Cassell, E.J. 2004. *The Nature of Suffering and the Goals of Medicine,* 2nd ed. Oxford: University Press.

Counted, V., Neff, M.A., Captari, L.E., Cowden, R.G., 2021. Transcending Place Attachment Disruptions during a Public Health Crisis: Spiritual Struggles, Resilience, and Transformation. *Journal of Psychology and Christianity,* 39(4):276-286.

Counted, V., Pargament, K.I., Bachera, A.O., Joynt, S., Cowden, R.G. 2020. *Hope and Well-Being in Vulnerable Contexts during the COVID-19 Pandemic: Does Religious Coping Matter? The Journal of Positive Psychology* (Advance online publication).

Cowden, R.G., Davis, E.B., Counted, V., Chen, Y., Rueger, S.Y., VanderWeele, T.J., Lemke, A.W., Glowiak, K.J., Worthington (Jr.), E.L. 2021a. Suffering, Mental Health, and Psychological Well-being during the COVID-19 Pandemic: A Longitudinal Study of U.S. Adults with Chronic Health Conditions. *Wellbeing, Space and Society* 2 (100048):1-9.

Cowden, R.G., Counted, V., Ramkissoon, H. 2021b. Place Attachment and Suffering during a Pandemic. In V. Counted, R.G. Cowden & H. Ramkissoon (eds). *Place and Post-Pandemic Flourishing: Disruption, Adjustment, and Healthy Behaviors,* 45-54. Cham: Palgrave Macmillan.

Daly, M. & Robinson, E. 2021. Psychological Distress and Adaptation to the COVID-19 Crisis in the United States. *Journal of Psychiatric Research,* 136:603-609.

De Backer, L.M. 2021. COVID-19 Lockdown in South Africa: Addiction, Christian Spirituality and Mental Health. *Verbum et Ecclesia,* 42(1)a2135. Doi: https://doi.org/10.4102/ve.v42i1.2135.

Duncan, E. 2020. NSW Domestic Violence Support Groups Warn Corona-Virus Isolation is Prompting Surge in Demand for Services. *ABC News Australia*. At https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children [Accessed 15 June 2022].

Eriksson, K. 1997. Understanding the world of the patient, the suffering human being: The new clinical paradigm from nursing to caring. *Advanced Practice Nursing Quarterly,* 3(1):8-13.

Eriksson, K. 2007. The theory of caritative caring: a vision. *Nursing Science Quarterly,* 20(3):201-202.

Ferrell, B.R., Handzo, G., Picchi, T., Puchalski, C., & William, E.R. 2020. The Urgency of Spiritual Care: COVID-19 and the Critical Need for Whole-Person Palliation. *Journal of Pain and Symptom Management,* 60(3):e7-e11.

Fitzpatrick, S., Kerridge, I., Jordens, C., Zoloth, L., Tollefsen, C., Tsomo, K., Jensen, M., Sachedina, A., Sarma, D. 2016. Religious perspectives on Human Suffering: Implications for Medicine and Bioethics. *Journal of Religion & Health,* 55(1):159-173.

Foss, B. and Nåden, D. 2009. Janice Morse' Theory of Suffering – A Discussion in a Caring Science Perspective. *VårdiNorden,* 29(1):14-18.

Ganzevoort, R.R. & Roeland, J. 2014. Lived Religion: Praxis of Practical Theology. *International Journal of Practical Theology,* 18(1):91-101.

Govender, K., Cowden, R.G., Nyamaruze, P., Armstrong, R.M., Hatane, L. 2020. Beyond the Disease: Contextualized Implications of the COVID-19 Pandemic for Children and Young People Living in Eastern and Southern Africa. *Frontiers in Public Health,* 8:504.

Greenfield, G. 2001. *The Wounded Minister: Healing from and Preventing Personal Attack*. Grand Rapids/MI: Baker Books.

Gugushe, J.J. 2014. *Traumatic Suicide Attempt due to Lack of Remuneration to Clergy by the Church: A Pastoral Care Perspective*. Unpublished Master's Thesis, University of Pretoria.

Haußmann, A. & Fritz, B. 2020. Was stärkt Seelsorge in Krisenzeiten? *Pastoraltheologie,* 10(110):397-415.

Horrex, P. (n.d). *Care of the Pastor's Soul*. Research project submitted in partial fulfillment of the Spiritual Directors' Training Programme, Spiritual Growth Ministries, Manukau.

Horsfall, T. 2010. Working from a Place of Rest: Jesus and the Key to Sustaining Ministry. Abingdon: Bible Reading Fellowship.

Ikenye, N.J.B. 2016. HIV/AIDS, Trauma and Post-Traumatic Disorder in the Contexts of Ethnicity and Culture. *Kenya Journal of Guidance, Counseling and Psychology,* 5(1):51-59.

Kaufmann, K., Peil, C. & Bork-Huffer, T. 2021. Producing in Situ Data from a Distance with Mobile Instant Messaging Interviews (MIMIs): Examples from the COVID-19. *International Journal of Qualitative Methods,* 20:1-14.

Kelcourse, F. 2002. Pastoral Counselling in the Life of the Church. *Encounter,* 63(1/2):137.

Khosa-Nkatini, H.P. 2022. Clergies and Self-Care during the COVID-19 Pandemic: A Challenge to Pastoral Care. *Verbum et Ecclesia,* 43(1)a2338: https://doi.org/10.4102/ve.v43i12338.

Klaasen, J.S. 2018. Pastoral Care in Communities under Transition: Interplay between Care and Culture. *Indie Skriflig,* 52(1)a2332: https://doi.org/10.4102/ids.v52i12332.

Koenig, H.G. 2009. Research on Religion, Spirituality, and Mental Health: A Review. *Canadian Journal of Psychiatry,* 54(5):283-292.

Koronkiewicz, L.J. 2009. *Does Spirituality Affect the Level of Caregiver Burden in Alzheimer Caregivers?* Doctoral Dissertation, ProQuest, UMI Number: 3359669.

Lartey, E.Y. 2003. *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*. London: Jessica Kingsley.

Lehmann, V., Oerlemans, S., van de Poll-Franse, L.V., Vingerhoets, A.J., Mols, F. 2011. Suffering in Long-Term Cancer Survivors: An Evaluation of the PRISM-R2 in a Population-Based Cohort. *Quality of Life Research,* 20(10):1645-1654.

Lindström, U.Å., Nyström, L.L., Zetterlund, J.E. & Eriksson, K. 2013. Theory of caritative caring. *Nursing Theorists and Their Work, MR Alliegood, Ed*:171-201.

Louw, D.J. 2020. The Aesthetics of COVID-19 within the Pandemic of the Corona Crisis, from Loss and Grief to Silence and Simplicity: A Philosophical and Pastoral Approach. *Acta Theologica,* 40(2):125-149.

Ma, C., Rogers, J. & Zhou, S. 2020. Global Economic and Financial Effects of 21st Century Pandemics and Epidemics. *African Review of Economics and Finance,* 12(1):1-35

Maddox, R.L. 1991. Practical Theology a Discipline in Search of a Definition. *Perspectives in Religious Studies,* 18(2):159-169.

Masengwe, G. & Makuvaza, C. 2021. COVID-19, Global Economy, Development and the Future of Africa. In F. Machingura, B. Chazovachii & M. Mawere (eds.). *COVID-19 and the Dialectics of Global Pandemics in Africa: Challenges, Opportunities & the Future of the Global Economy in the Face of COVID-19*, 300-322. Mankon: Langaa.

Masengwe, G. (forthcoming). Legitimating Power Construction by COVID-19 Lockdowns and Curfews in Zimbabwe. In H.T. Asiru, O.D. Ochieng, (eds). *(De)Constructing Corona: The Language of Conspiracy, Power and Indifference in COVID-19 Health Discourses*. Lincom Europa, Germany.

Masvotore, P. 2020. The Healing Practitioner has Retreated Back to the Trenches: Healing and Spirituality during COVID-19. In R. Makamani, A. Nhemachena, & O. Mtapuri (eds). *Global Capital`s 21st Century Repositioning: Between COVID-19 and the Fourth Industrial Revolution on Africa*, 221-244. Mankon: Langaa.

McClure, B. 2012. Pastoral Care. In B.J. Miller-McLemore (ed). *The Wiley-Blackwell Companion Practical Theology*, 269–278. West Sussex: Wiley-Blackwell.

Meagher, B.R. & Cheadle, A.D. 2020. Distant from Others, but Close to Home: The Relationship between Home Attachment and Mental Health during COVID-19. *Journal of Environmental Psychology,* 72:101516.

Miller, K.D. 2015. Organizational research as practical theology. *Organizational Research Methods,* 18(2):276-299.

Morse, J.M. 2001. Toward a praxis theory of suffering. *Advances in Nursing Science,* 24(1):47-59.

Morse, J.M. 2005. Towards a praxis theory of suffering 16. *ANS Adv. Nurs. Sci*, 26(1):47-59.

Morse, J.M. 2011. The praxis theory of suffering. In J.B. Butts & K.L. Rich (eds). *Philosophies and Theories in Advanced Nursing Practice*, 569-602. Sudbury: Jones & Bartlett.

Näsman, Y. 2020. The theory of caritative caring: Katie Eriksson's theory of caritative caring presented from a human science point of view. *Nursing Philosophy,* 21(4):e12321. Doi.10.1111/nup.12321.Epub2020 Sep24.PMID.32974999.

Ngesthi, Y.S.E., Suparti, H., Daliman, M. and Purwoko, P.S. 2021. The Role of the Pastor in Stewardship of the Church during the COVID-19 Pandemic. *Technium Soc. Sci. J., 23*:781-793.

Nock, M.K., Borges, G., Bromet, E.J., Cha, C.B., Kessler, R.C. & Lee, S. 2008. Suicide and suicidal behavior. *Epidemiologic Reviews,* 30(1):133-154.

Nouwen, H.J.M. 2010 (1972/1979). *The Wounded Healer: Ministry in Contemporary*. New York: Doubleday.

Oswald, R.M. 1991. Clergy Self-Care: Finding a Balance for Effective Ministry. Washington/DC: Alban Institute.

Rettie, H., Daniels, J. 2021. Coping and tolerance of uncertainty: Predictors and mediators of mental health during the COVID-19 pandemic. *American Psychologist,* 76(3):427-437.

Roman, N.V., Mthembu, T.G. & Hoosen, M. 2020. Spiritual Care: A Deeper Immunity – A Response to COVID-19 Pandemic. *African Journal of Primary Health Care and Family Medicine,* 12(1):e1e3. doi:10.4102/phcfm.v12i1.2456.PMID:32634003;PMCID:PMC7343955.

Salari, N., Hosseinian-Far, A., Jalali, R., Vaisi-Raygani, A., Rasoulpoor, S., Mohammadi, M., et al. 2020. Prevalence of Stress, Anxiety, Depression among the General Population during the COVID-19 Pandemic: A Systematic Review and Meta-Analysis. *Global Health,* 16(1):57. Doi:10.1186/s12992-020-00589-w.

Samelius, L., Wijma, B., Wingren, G., Wijma, K. 2010. Lifetime History of Abuse, Suffering and Psychological Health. *Nordic Journal of Psychiatry,* 64(4):227-232.

Samuel-Hodge, C.D., Headen, S.W., Skelly, A.H., Ingram, A.F., Keyserling, T.C., Jackson, E.J., et al. 2000. Influences on day-to-day Self-Management of Type 2 Diabetes among African-American Women: Spirituality, the Multi-Care-Giver Role, and other Social Context Factors. *Diabetes Care,* 23(7):928-934.

Stadelmann, H. 1998. The Need for Ecclesiological Prolegomena in the Pursuit of Practical Theology. *Trinity Journal,* 19(NS):219-233.

Steyn, T.H. & Masango, M.J. 2011. The Theology and Praxis of Practical Theology in the Context of the Faculty of Theology. *HTS Teologiese Studies/Theological Studies,* 67(2):1-7.

Swinton, J. & Mowat, H. 2016. *Practical Theology and Qualitative Research*. London: SCM Press.

Tate, T., Pearlman, R. 2019. What we Mean when we Talk about Suffering – and why Eric Cassell should not have the Last Word. *Perspectives in Biology and Medicine,* 62(1):95-110.

Twenge, J.M., Joiner, T.E. 2020. Mental Distress among U.S. Adults during the COVID-19 Pandemic. *Journal of Clinical Psychology,* 76(12):2170-2182.

Usher, K., Bhullar, N., Durkin, J., Gyamfi, N. & Jackson, D. 2020. Family Violence and COVID-19: Increased Vulnerability and Reduced Options for Support. *International Journal of Mental Health Nursing,* 29(4):549-552.

Vaccarino, F. & Gerritsen, T. 2013. Exploring Clergy Self-Care: A New Zealand study. *The International Journal of Religion and Spirituality in Society,* 3(2):69-80.

VanderWeele, T.J. 2019. Suffering and response: Directions in empirical research. *Social Science & Medicine,* 224:58-66.

VanderWeele, T.J., Fulks, J., Plake, J.F., Lee, M.T. 2021. National Well-Being Measures before and during the COVID-19 Pandemic in Online Samples. *Journal of General Internal Medicine,* 36(1):248-250.

Wakam, G.K., Montgomery, J.R., Biesterveld, B.E., Brown, C.S. 2020. Not Dying Alone – Modern Compassionate Care in the COVID-19 Pandemic. *New England Journal of Medicine,* 382(24):e88. DOI: 10.5056/NEJMp2007781.

Wilson, K.G., Chochinov, H.M., McPherson, C.J., LeMay, K., Allard, P., Chary, S., Gagnon, P.R., Macmillan, K., De Luca, M., O'Shea, F., Kuhl, D., Fainsinger, R.L. 2007. Suffering with Advanced Cancer. *Journal of Clinical Oncology,* 25(13):1691-1697.

Xiong, J., Lipsitz, O., Nasri, F., Lui, L., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., McIntyre, R.S. 2020. Impact of COVID-19 Pandemic on Mental Health in the General Population: A Systematic Review. *Journal of Affective Disorders,* 277:55-64.

Bernard Pindukai Humbe

14 COVID-19 and the Virtual Church: (Re)imagining Spirituality in a Pandemic Context and Beyond

Abstract

The emergence of Covid-19 paralyzed the global religious systems and disoriented the norm especially in the operations of the church activities. In the African continent the far-reaching effects of coronavirus on the church was felt when governments ordered a full shutdown of all but essential services. This meant that churches were not on the "essential list, thus, a virtual engagement became an exception. With the notion of COVID-19 and the virtual church on the fore, this chapter focuses on the Zimbabwean situation, drawing examples from African Initiated Churches (AICs). Qualitatively, the study uses a phenomenological approach, interviews, observations and documentary analysis to gather information which shows that AICs in Zimbabwe are a spiritual and physical entity. The chapter argues that the new norm of a virtual church bred both benefits and challenges for indigenous adherents' spirituality. Partially, communication patterns, prayers and prophecies for believers have become easier to an extent of having a broader and often global reach. However, believers struggle to work out how best to worship and to feel connected to their faith in the absence of physical presence. This led some AICs to escape the government lockdown COVID-19 rules and regulations by resorting to forests as hide out places of worship. This is because most adherents are much more concerned about not being able to attend church, with all the trusted emotional and material support that it entails, than about COVID-19 itself. As the chapter (re)imagines spirituality in a pandemic context and beyond, it concludes noting that conservatism in AICs' religiosity requires re-adjustment from the norm and embrace a spirituality that is endorsed by virtualization of the church.

Keywords: African Initiated Churches**,** COVID-19, pandemic, spirituality, virtual church, Zimbabwe

Introduction

Christianity is the leading religious tradition followed by the indigenous people in Zimbabwe. In its current trends, Zimbabwean Christianity has witnessed the dominance of African Independent Churches/African Indigenous Churches/African Initiated Churches (AICs), whereby about 37% of Christians in Zimbabwe belong to the Apostolic Churches (Chingono 2021). For clarification purposes, the nomenclature Apostolic Church serves to represent AICs. An appealing characterisation of these churches is given by Appiah-Kubi (1977:117) when he says that

> these are churches founded by Africans for Africans in our special African situations. They have all African membership as well as all African leadership.

Movements of these churches which this study calls sects or church groups include Zionist, Apostolic and Ethiopian Churches as well as Pentecostal-Charismatic Churches. This specification is a manifestation of heterogeneity in their ideological make up. Of late, differences in spirituality among AICs have been noted in their response to mandatory vaccination and virtual worship as per COVID-19 rules and regulations in Zimbabwe. They used to be popularly known as white garment churches, but there are now assorted colours for their garments which include: blue, red, yellow, purple, green, pink and grey. Furthermore, in some instances, the garments are decorated with a lot of symbols like the sun, moon, stars and crosses. This is due to the AICs' continuous intensification and expansion. However, one thing in common about their spirituality is that they usually regard themselves as Spirit-type churches (Muguranyanga 2011) or *chechi dzeMweya,* and consequently base their religious beliefs and practices primarily on *Mweya* (Spirit) or *Izwi raMwari* (Voice of God). They receive advice and or guidance from the Holy Spirit or Voice of God through the mediation of prophets or church leaders who happen to be faith leaders. Their days of worship range from Thursday to Sunday. Their worship places, whether it is under a tree, on a mountain, or on open air surrounded by flags of various colours, capture what it means to express indigenous African Christian faith, and to be communally physically connected to one another and ultimately to God. With the emergence of COVID-19, the worship patterns became altered. This was after the obscurity of the pandemic led the Zimbabwean government to order a total shutdown of all but essential services. The lockdown was also extended to

churches, implying that churches were not on the 'essential list" (Openshaw, et al. 2021). At face value, the pandemic had wrecked the AICs which had been in existence for about a century in Zimbabwe. The advent of coronavirus simply called for a radical change in AICs' mode of operation to withstand their relevance in a new normal social life. This new normal had abandoned physical gatherings in preference of a "church without walls" something which had been deemed inconceivable in AICs before the emergency of the pandemic. In theory, the pandemic had brought the virtual church to the indigenous adherents' doorstep and virtual worship seemed to be prodded even beyond COVID-19 times. Online ministry was meant to reach thousands via social media, notably WhatsApp, Facebook and YouTube (Patterson 2021). It became a new era for a new missiological mandate of going into the entire world without limits to geographical boundaries. Participants would take part in the cyber practice of religion, complete with other identities, rituals and practices (Patterson 2021).

In a bid to explore the spirituality of AICs in a pandemic context and beyond, knowledge and information was coaxed using interviews, observations and documentary analysis. The following questions were central during the fieldwork: Is it feasible to have a virtual church when members always interact through their social network systems? Do the churches have the resources to embrace online worship? Does the concept 'virtual church' make sense when the place of worship they use is designated by the Holy Spirit? Is ritualistic worship and healing possible online? The study found out that AICs cling tenaciously to their conservative way of worship; being reluctant in giving up physical gatherings in favour of virtual Christianity. For them, the social communication platforms did not promote communication with the Holy Spirit. The new mode of worship was a threat to AICs' traditional power structures. Key to AICs' complacency in embracing the virtual church were the following commonly held myths: the internet and cyber gadgets were filthily filled with sin, too secular, source of Satanism, only for young people and distract people away from the church. Yet some AICs readily embraced virtual worship and healing to avoid the spread of the deadly pandemic.

Conceptual Framework

The conceptual analysis of this study is based on the notion of 'networked religion'. The concept networked religion is well theorized in this study

using the term virtual. According to Vocabulary.com Dictionary (n.d) it is an adjective which describes something that exists in essence but not in actuality. The perception 'networked religion' provides a framework for discussing how religion is practiced virtually through various digital media, in order to consider the broader shift in how people conceive of and practice religion in digital culture enforced by COVID-19. It fits in well in this study to unpack some of the dominant patterns and assumptions shaping popular belief and practices related to AICs spirituality. These traits of networked religion have important theological and practical implication of the spiritual life of the adherents (Campbell, n.d). The concept also provides a framework for discussing significant alterations in everyday religious practice to understand implications these alterations have for AICs groups. The framework provided by 'networked religion' suggests that AICs' relationships, identities, and understanding of their religious rituals are being transformed as they engage with newer technologies such as the internet, cyber gadgets and social media platforms.

'Networked religion' in this study is closely related to 'networked community'. It has a sense of membership, integration, and fulfilment of needs together with a feeling of shared emotional connections (IGI GLOBAL, n.d). The question is: are AICs operated as online or offline communities? This question is raised on the pretext that in matters of spirituality in a COVID-19 setting, the primary function of a networked community is to spiritually achieve the defined goals using interactive technology-supported internet backbone (IGI GLOBAL, n.d). For networked religion to thrive, it needs a set up created by a networked community suggesting that the communities function as loose social networks with varying levels of religious affiliation and commitment. The rationale behind (re)imagining AICs spirituality in a COVID-19 context and beyond in networked religion and networked community is grounded on the following bases: First, AICs in Zimbabwe acknowledged the existence of the coronavirus. Second, some AICs adhered to COVID-19 rules and lockdown measures. Third, education and commerce in AICs localities were done online during lockdown times. Fourth, in the same religious landscape, some mainline churches and Pentecostal churches in Zimbabwe had already embraced virtual worship even before the emergence of COVID-19. Fifth, a close relationship between AICs and the ruling ZANU PF government had a bearing on AICs' response to government COVID-19 rules and initiatives.

Technological compliance in AICs: A Virtual church is possible

A survey carried out by the study showed that some of the AICs are technology compliant. During lockdown periods, the Zion Christian Church (ZCC) led by Bishop Nehemia Mutendi was one typical virtual church in the family of AICs. Mutendi was on record saying that cancellation of traditional church gatherings in favour of virtual services was in compliance with lockdown rules and regulations to harness the spread of the global pandemic virus. However, he always assured his followers that Jesus Christ was present in their homes as he delivers his sermons. For example, during major Christian festivals, the faith leader reached out to his congregants in different parts of the world virtually. On the 9th of April 2020 at 1500hrs CAT, the church live streamed its service dubbed Masvohwani Big Thursday. The service had 8417 views. Study Participant A, a beneficiary of this online worship responded saying "I had no option except following the bishop's sermon online because I had missed church service". She further pledged to help other congregants join the ZCC online worship platforms for spiritual edification (Interview with Study Participant A, July 2022). Sticking to their liturgical year calendar, the ZCC church has managed to broadcast its message and songs to congregants online using Facebook, YouTube and WhatsApp. The 10 July, 18 October and 21 December videos containing Bishop Mutendi's messages to his followers are found on various media platforms for public consumption.

Looking at the ZCC operations, there is evidence that the indigenous church has sophisticated technology. This is because for a proper implementation of an online church service, there is dependence of high technology on information or communication systems, those systems that create, capture, move, organize, and retrieve information (Sims, n.d). The virtual ZCC is powered by the pervasiveness of high technology as the defining characteristic of the contemporary society which has been hard hit by COVID-19. Study Participant B succinctly affirmed that "This is what is expected of a modern church organisation. Bishop Mutendi is transforming the indigenous church to suit global standards" (Interview with Study Participant B, August 2022). This shows a shift in the spirituality of the ZCC whereby technology in information systems have been integrated into their worship patterns and outreach drives.

The above optimistically shows the possibility of having a virtual church even beyond the COVID-19 era. Contrary to the widely held belief that AICs members are illiterate, the study observed that technical expertise was found to be existing in AICs. A visit to their workplaces and residences showed that some have knowledge and proficiency in operations of cyber gadgets. This was notably found to be the case with people who are in the civil service and in parastatal institutions. Their knowledge was found to be handy in advocating for a renovation of AICs into virtual churches. In other words, technology can be discussed in terms of tangible things as well as intangible belief systems, attitudes and ways of thinking (Sims, n.d).

In an interview with Study Participant C, he explained that when the ZCC resorted to virtual worship, the reason was to ensure safety of the congregants, convenience for the followers to receive the word of God in the comfort of their homes and efficiency in reaching out to many people in the world (Interview with Study Participant C, June 2022).

However, commenting on ZCC virtual worship patterns, Study Participant D felt that, the new normal had affected the spirituality of this church by fashioning a worship experience of isolation both on the part of the leader and his followers. He stressed that in all this, what is missing is reverence and participation (Interview with Study Participant D, June 2022).

If this continues after COVID-19, there is no doubt that technology has eventually reshaped ZCC spirituality to fit into the dictates of the pandemic rules and regulations. This is because the goals of technology in COVID-19 situation are safety and convenience. In Study Participant E's words, considering the size of our church, about 20000 people gather for Easter festivals at Mbungo shrine, so congregating for worship was highly risky. Since I was in South Africa, it became more convenient, comfortable, safe to attend an online church on Facebook" (Interview with Study Participant E, July 2022).

However, there are a lot of ZCC congregants in rural communities who claimed not to have benefited from the innovation. An elderly Participant F stressed that she missed out the sermons because of lack of modern communication gadgets and data bundles (Interview with Study Participant F, August 2022).

This was also found to be the case with the majority of AICs groups, mainly which are under resourced. They worship under trees and the

bulky of their followers are from lower class of the society. Thus, virtual worship in Zimbabwe seems to be for the elite.

Mobile phones: networked AICs spirituality in action

The preceding paragraphs depicted sophisticated technology being used by the ZCC to power its virtual church activities. This is not the case with other AIC sects in Zimbabwe which lack the necessary resources to embrace online ministries. They do not have building structures, but what is available is unsophisticated technology like ordinary mobile phones. This casts doubt on the possibility of imagining virtual AICs in Zimbabwe beyond a COVID-19 context. However, the prospects of virtual operations are open. The starting point in the establishment of a virtual church is to recognise what is readily available in their technological information systems. The majority of AICs adherents possess mobile phones, whether rich or poor, literate or illiterate.

During the research, it was noted that the use of mobile phone gadgets was multivalent. Study Participant G explained that he uses his cell phone to communicate a wide range of issues including his religious life. "As a faith leader, followers raise questions about their spiritual lives when they have challenges at their homes or work places" (Interview with Study Participant G, July 2022).

The following excerpt from an interview conducted with Study Participant H aptly sums the views of the study participants in this category: "Mobile phones are used for making appointments when one intends to meet the prophet for healing. In some cases, communication about the day to day running of the church is done online through WhatsApp messages, WhatsApp voice notes and voice calls. WhatsApp helps us to link with a lot of our church followers who are in the diaspora, for example, our children are working in South Africa, UK, Botswana and Namibia. Funds to sustain our church especially during festival holidays like Easter reach to us via platforms like Western Union, Mukuru and Ecocash whereby we use mobile phones to access the monies" (Interview with Study Participant H, July 2022).

Most participants confirmed that the majority of AICs adherents have unknowingly operated in virtual environments. Prophets could detect a problem in the life of a church member and use gadgets like mobile phones to address the problems. They use mobile phones to record manifesting evil spirits. Study Participant J explained the efficacy of mobile

phones saying "These days if a prophet receives a vision of a congregant's troubled life, he/she alerts the person using mobile phones". He continued saying "One day my prophet simply called me saying she had seen me intending to undertake a journey to South Africa, her advice was for me to cancel off the trip to avoid a fatal accident that would befall me" (Interview with Study Participant I, August 2022).

In Masvingo, a prophet instructs his people to use their mobile phones if they want to be helped spiritually. Those who seek for his help are instructed to take hold of their mobile phones and lift them high enough in front of their faces, they dip a finger in water and put a drop on the top surface of the gadgets. As the drop rolls on the screen of the phone, the owners will be saying out their problem areas which need divine intervention. As soon as they finish their petitions, the faith healer wherever he will be, in spirit knows that they are done and starts praying for them. Study Participant J confirmed that this is how her marriage problem was successfully solved and now she is in a marital bliss with her husband. She said they made their petitions alone at her matrimonial home in Masvingo, while the prophet who helped her was in Mutare that time (Interview with Study Participant J, August 2022). Given this scenario, one can safely argue that there is generally an acceptance of the use of technology in AICs in matters to do with prophecy.

Prophets and faith healers work with messages, audios, pictures and videos to deal with problems presented to them by those who seek for spiritual intervention. In Victoria Falls, there is an AIC prophet who has confirmed that he is helping people online, especially using social media platforms like Whatsapp and Facebook. On 1 March 2021 Ncube, a Nehanda Radio journalist reported that a prophet called Musawenkosi Vundla who lives in Sizinda village, Victoria Falls has taken his healing business to social media where he uses Facebook and WhatsApp platforms to attend to those seeking "divine intervention." During lockdowns when physical gatherings were prohibited, Vundla said social media kept him busy. He explained how he did his prophetic healing activities saying the following:

> "One can send his or her name and surname or picture on WhatsApp and I use the information to establish their problems. I then explain my findings to the client and if he or she is happy that's when I prescribe a solution. I use Facebook to do live prophecy and link up with clients but then revert to WhatsApp platform for consultation for purposes of privacy" (Ncube, 2021, para. 7).

Defiant spiritualism against Satanism: No to ICT gadgets

Contrary to the above, within the AICs groups there are some which are pessimistic regarding the place of a virtual church in their spirituality. Study Participant K strongly believed in convergent worship practice (Interview with Study Participant K, August 2022). Bearing in mind that AICs were started by Africans for African specific problems (Appiah-Kubi 1977:117), there is no doubt that AICs thrive in an African communal set up. The indigenous people of Zimbabwe have a strong network system based on *ukama* (relationality), religious affiliation, and neighbourliness (Humbe 2021). Participant K emphasised his belief in the following words "We are black people, the true essence of a church is realized when people gather to worship. Worshiping online is not characteristic of African religiosity for our spirituality is communal-oriented" (Interview with Study Participant K, August 2022). Maybe, this is premised on the fact that in some cases, the African Christians follow what the Holy Spirit says. In their spirituality, it is the Holy Spirit which prescribes time for worship, the places for worship, regalia and colour for worship. It was observed during the study that as they gather at their worship places there is a greater involvement of signs and symbols in worship through water, holy stuff, clay pot artefacts, cloth banners, crosses, plants, and clerical vestments. It explains why at the height of COVID-19 from 3-17 July 2021, about 20000 Johane Marange Apostles gathered at Mafararikwa village in Bocha for Passover festival. Ironically, the government through its law enforcement agents did not disband the physical gathering (Nyangani 2021). In this case, the government was conflicted because it has been using these Apostolic churches as a source of votes during election times. This was a sign that it is not easy to realize a virtual church from these apostolic sects since violators of the COVID-19 rules should have been reprimanded.

Spirituality of some of the AICs discourages their followers from accessing the internet as recommended by some of the Johane Masowe and Johane Marange sects. In the same light, Study Participant L opined that "our church does not allow us to use internet, smart phones and television sets, social media platforms like Whatsapp and Facebook" (Interview with Study Participant L, August 2022). This is buttressed by Matare (2022) who avers that African Apostolic Church (AAC) goes as far as forbidding its followers to watch television and use social media in order to keep their sanctity. Study Participant M shared the following perspective: "we are

forbidden from using internet, social media platforms and televisions channels because they are a source of Satanism". She added that "barring the church from accessing internet and social media has helped immensely in shaping the behaviour of our children" (Interview with Study Participant M, August 2022). What the participant said implies that technology, internet and social media platform have become chief culprits of moral decadence in the name of modernisation. This modernisation has resulted in indigenous Africans dumping their culture for western life. In this process, indigenous Africans have embraced technology without censorship, they adopted everything including all the bad, hence, the prevalence of moral decay in the modern African society. Children at tender ages are exposed to extreme violent gaming, vile language and all the toxic things. Adults are also not spared, some technologies have come with addictive components that derail personal growth (Matare 2022). For example, about 70 percent of men between the ages of 18 and 34 who visit a pornography web site at least once a month, includes believers and church-goers (Sims, para. 15). Given this scenario, AICs which are pessimistic about feasibility of a virtual church, question the sincerity of using the secular world technologies to edify the spirituality of their members. However, Study Participant N criticized the negative attitude towards the use of ICT gadgets arguing that, that is a defeatist approach (Interview with Study Participant N, July 2022). From these sentiments, it can be said that avoiding technology produces a crop of backward adherents who are always out of touch with reality in the global world. Their conformist approach to the church authorities has barred the members to review or challenge any existing church doctrines since the leaders claim to be leading the church under the guidance of the Holy Spirit.

African indigenous church separatist reality

As the Internet has increasingly become part of many people's everyday lives, the use of virtual worship promotes adherents and non-adherents' connections. The church becomes home to everyone. This becomes a problem especially since the AICs' spirituality emphasises church strictness ideology. Strictness refers to the existence of particular expectations, and enforcement of such expectations, for churches' members or active congregants (Flynn 2010:4). They view themselves as having a separate spirituality from that of the western churches which happen to be pioneers in virtual worship. Study Participant M regarded his church as

strictly reserved for the saved ones and not for heathens (Interview with Study Participant L, August 2022). However, Study Participant N objected arguing that these church groups have a tendency of being very secretive in some of their ritualistic practices (Interview with Study Participant N, August 2022). Thus, virtual worship will provide a platform for outsiders whether westerners or not to become acquainted with what they do. This is well supported by Musoni (2021) when he says that Johane Masowe formed this black African movement to withdraw from all of the white man's initiatives to resocialise and appropriate the traditional African way of reaching out to God. The sect has a radical message of withdrawal from all European influences, the destruction of all religious books, including the Bible, and the shunning of all inventions by whites (Musoni 2021).

Meeting virtually is virtually not meeting: Physical healing in AICs

Earlier on, the chapter showed that AICs faith healers use cell phones in their healing operation making it possible for these churches to operate virtually. However, during fieldwork, it was also noted that it is the same healing discourse that has proved to be difficult for AICs to operate virtually. During the study, it was observed that at times the patients go to their sacred worship places (*sowe, kirawa*) where they make confessions and later receive healing. AICs leaders agreed that operating virtually as churches proves to be difficult because people flock to these churches to get spiritual assistance. Mostly, this needs physical presence of both the faith healer and the person to be healed. There are also clay pot artefacts and plants like reeds planted at the sacred worship centres. Besides, in some cases, AICs regularly go on pilgrimage to sacred forests and mountains which they believe have mystic powers to deal with their spiritual problems. Thus, according to Musoni (2021) the Johane Masowe Chishanu congregating under sacred traditional African trees or near traditional African sacred shrines, such as pools, hills and mountains is a conscious decision. For example, Johane Masowe Chishanu yeNyenyedzi church in Zimbabwe's sacred places are the Chivavarira Hill and the Ngarikure Pool (Musoni 2021). So, use of technology at these sacred worship places is an 'insignia of colonialism' (Musoni 2021).

Closely related to Modiko's (2011) template, there are several steps to the procedure of healing. The first step is to access the worship place through a ritualized entrance (*gedhe*). In some instances, there is a holy

rite of spiritual vetting at the entrance manned by prophets. Secondly, there is some preparation that takes place before a patient is healed. At times there must be a lot of singing, clapping of hands and dancing until the prophet goes into a trance where he will communicate spiritually. Thirdly, confession of any wrong doing is an essential and primary part of the healing service in AICs where it is regarded as self-cleansing to ensure successful healing Modiko (2011). This activity is also known as *kupupura/kupfuudza* and it all means confession. Fourthly, the prophet or faith healer traces the cause of the suffering. Fifthly, is treatment which sometimes also incorporates exorcism. The exorcism usually happens when a member is baptized (*kujorodhwa*). Mostly, the divine treatment part is done through laying on of hands, blessing various mundane objects, such as strip of cloths, strings, papers, needles, walking sticks and water to confer healing and protection (Modiko 2011:89). It is done in order to provide protection against magic, spirits, witchcraft or demonic attacks. Of late, the most common mode of healing in some AICs is *kudira magate* (pouring anointed water from clay pots). According to Study Participant H, it ensures *zambuko/kundiso* that is spiritual victory (Interview with Study Participant H, August 2022). This is because AICs emphasise so much on purification which is brought by anointed water.

Possibility of a virtual church in Zimbabwe? A Discussion of the Findings

Disregarding physical presence has become a necessity in the operations of AICs in a COVID-19 context. In a way, there is virtualisation of prophetic healing activities. Due to the fact that the faith leaders and the followers believe in its efficacy, there has been reliance on this type of prophecy without any vehemence of face-to-face interaction. That strong spiritual network system has managed to connect the faith leaders and their congregants or patients conveniently. Vundla succinctly said that "I started attending to clients online even before the outbreak of Covid-19 as I considered the distance that people have to travel for consultation. On social media, I attend to an average of 70 people per day" (Ncube 2021, para.3).

Due to the intensification of COVID-19, Vundla's clientele base has expanded to countries like Botswana, Germany, South Africa, Swaziland and Zambia. To this end, one is persuaded to maintain that technology is now the defining element of the modern society. It has produced a culture

of self-orientation that is designed to procure a comfortable and individualistic lifestyle of what prophet Vundla is doing. Thus, science and technology are the standards against which all claims are evaluated (Sims, n.d, para.15). The internet, mobile phones, television, videos, radio, etc., all have made it possible to interact with the world without actually confronting the world face-to-face. As what emerged from the findings, diasporans have helped the local AICs with financial resources for the sustenance of the churches. So, it is possible to talk about e-giving when the AICs have turned virtual.

AICs have largely thrived because of their enculturation ideology. According to Modiko (2011) enculturation involves the insertion of the tradition of Christian faith into a non-Christian culture and a subsequent ongoing dialogue between that faith and the culture into which it is inserted. If the African church succeeded in merging Christian tradition with African cultural tradition what is expected of the African church in times of pandemics is to incorporate information technology and go by virtual worship. As such, virtual worship should be part of the church's enculturation and assimilation practice.

However, on the other hand, there is a pessimistic slant which rejects technology and brings about a sense of hopeless despair toward a virtual church. The discoveries in research painted a gloomy picture of the possibilities of an online church. In some AICs, there is no motivation to embrace technology since the church groups are not very active in virtual campaigns of proselytization. Investment in virtual church is done as a marketing strategy for the church's material and financial needs. The lack of zeal in this endeavour is a testimony that AICs are not missionary churches which rely heavily on communication strategies. It is only the 'netizens' who benefit from online church endeavours.

When virtual worship was popularised as the alternative to physical gathering during the COVID-19 era, more AICs groups migrated into inaccessible places than ever before, prompting this study to call the current generation of AICs "the age of migration". They misconstrued the ban in physical gatherings as a direct way of advocating for a destruction of the church, an attribute given to Satan. The increasing pressure to worship online was not appreciated for the same gadgets which they viewed as promoting Satanism and sin would be used for the purposes of worshipping God. There are some AICs which perceived a symbiotic relationship between technology and Satanism. They understand the internet as a product of satanic innovation aimed at reaching the world community in

its propagation strategies. This mind-set has stifled the developments in use of virtual worship in AICs. Thus, they saw it fitting to withdraw to the forests than compromising their spirituality. In the city of Masvingo, AAC followers embarked on the endless religious marches to the forest for spiritual fulfilment. In that regard, members of this sect had repugnance for government unilateral regulation to stall spiritual edification. Instead of concentrating on uploading videos onto Facebook and scheduled posts, their focus was on circumventing COVID-19 rules and escapist solutions. Their rejection of a virtual church has nothing to do with lack of resources, but it is theologically oriented.

It should be also pointed out that some of the AICs sects could not conceive of a church which can survive separate from their worship places where they have personal connection for engagement. The authority vested in the church leaders might be compromised. This persuades some commentators to think that the way these church groups are run resembles cults. Founders detest use of internet in their churches because the internet provides individuals unique opportunities to influence others in ways that challenge religious leaders and authority structures. When the churches congregate to worship in the periphery of the society, in the bushes under trees, they are accused of carrying out abusive practices especially those associated with women. They want to keep the face of their churches hidden.

Like what has already been seen for ZCC virtual worship, the church evaluates itself by the same standards as those used by the culture of technology. Since technology provides immediate information and feedback, the church has begun to operate on a poll basis. Because the contemporary technical driven culture requires efficiency, convenience, and entertainment, then the Church must provide that. So the Church has tried to meet the standards of technology in order to remain relevant to the contemporary society. The Church, because of desperateness to succeed by the standards of technology, has become more and more acculturated (Sims, n.d, para.20). From the findings it seems that in the AICs, virtual worshipping is a real challenge. The sects showed that they will remain conservative even if pandemics continue ravaging their communities.

Conclusion

The use of technology in AICs for worshipping purposes has proved to be possible. In future, the possibility could be realized when faith leaders acknowledge that a ban of physical gatherings does not mean a ban of Christianity. In the context of a networked religion frame, Churches are allowed to worship virtually to avoid the spreading of contagious diseases. This should be the same with AICs groups which have the capacity to have a virtual church. Bearing in mind the chaos that prevailed during lockdown periods, these AICs sects should consider having new ways of keeping the church afloat to save it from sinking. This should be a holistic approach of merging physical gatherings and virtual worship.

References

Appiah-Kubi, K. 1977. African Theology En-Route: *Papers from the Pan African Conference of Third World Theologians*, December 17-23. Accra: https://books.google.com.ng/books/about/African_Theology_en_Route.html.

Campbell, H.A. *What Religious Practice Online Can Teach Us about How Religion is Perceived in Digital Culture*. https://www.digitalliteracytoolkit.org › 2019/03 [Accessed 18 September 2022].

Chingono, N. 2021. We are protected by prayers': the sects hampering southern Africa's vaccine rollout.

Flynn, R.A. 2010. Are strict churches really stronger? A study of strictness, congregational activity, and growth in American Protestant churches.

https://nehandaradio.com//2021/03/01/prophet-uses-social-media-to-diagnose/ [Accessed 22 September 2022].

https://www.theguardian.com/global-development/2021/nov/01/the-sects-hampering-southern-africa-covid-vaccine-rollout [Accessed 16 September 2022].

Humbe, B.P. 2020. *The Meaning of Traditional Religion for modern society: Zimbabwe as a case study*. Submitted in fulfilment of the requirements in respect of the Doctoral Degree in Religion in the Department of Religion Studies in the Faculty of Theology at the University of The Free State, South Africa.

IGI BLOBAL. https://www.igi-global.com/dictionary/networked-community/20207 [Accessed 17 September 2022].

Maguranyanga, B. 2011. *Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe*. Collaborating Center for Operational Research Evaluation, Unicef, Mconsultin group.

Matare, S. 2022. The Good the Bad, We Took It All. https://www.linkedin.com/pulse/good-bad-we-took-all-sallomy-matare?trk=public_profile_article_view [Accessed 24 August 2022].

Modiko, B.V. 2011. *The Concept of Healing Power in the African Initiated Churches (AICs) with Special Reference to the Vaal Triangle*. Submitted in Partial Fulfillment of the requirements for the degree Masters Artium in Biblical Studies (Theology). At the Vaal Triangle campus of the North West University Vanderbijlpark.

Musoni, P. 2021. African spirituality in the Johane Masowe Chishanu religious movement in Zimbabwe: A Christian church-sect dichotomy. *HTS Teologiese Studies/Theological Studies,* 77(4), a6317. https://doi.org/10.4102/hts.v77i4.6317.

Ncube, L. 2021. *Prophet uses social media to diagnose*.

Nyangani, K. 2021. *Zimbabwe: Police 'Shield' Marange Sect,* https://allafrica.com/stories/202107190655.html [Accessed 29 September 2022]

Openshaw, K., Vokes, R. and Rocha, C. 2021. *What worshipping online during the COVID-19 pandemic has meant to African Australians*. https://www.sapiens.org//culture/worshipping-online-covid-19 [Accessed 10 August 2022].

Patterson, J. 2021. *Virtual worship is here for good*. https://www.umnews.org/en/news/virtual-worship-is-here-for-good [Accessed 20 August 2022].

Sims D.B. *The Effect of Technology on Christianity: Blessing or Curse*? https://www.dbu.edu/friday-symposium/schedule/archive/_documents/the-effect-of-technology-on-christianity.pdf [Accessed 25 September 2022].

Vocabulary.com Dictionary, https://www.vocabulary.com › dictionary › virtual [Accessed 16 September 2022].

Tenson Muyambo & Jane Tendere

15 Beyond the COVID-19 Pandemic: Is Rethinking the Interface of Religion and Science Possible in the Zimbabwean Context?

Abstract

The advent COVID-19 has not only changed the religious arena but has reawakened the age-old debate between religion and science. Previously science has regarded religion as non-verifiable and confessional whereas religion viewed science as atheistic and incompatible to religious beliefs and practices. Interestingly, COVID-19 has made humanity re-imagine and re-think the compatibility between religion and science. This chapter seeks to demonstrate that the age-old debate between religion and science in the context of COVID-19 has been reignited. Data were collected using observations of what people did and still do in dealing with the pandemic and other related literature. The study revealed that when faced with a crisis, people straddle on the two: religion and science without any misgivings. The religion-science debate seems to be too scholarly for the ordinary Zimbabweans. They utilise whatever is within reach as long as it is for life sustenance and human flourishing. Religion and science were found to be the flip sides of the same coin. Therefore, basing on the findings and using cultural evolution theory and belief studies, this chapter argues that in Zimbabwe COVID-19 has made it evidently possible to re-imagine and re-think the interface between religion and science from now and beyond. We, therefore, argue that science and religion will continue to interface beyond the COVID-19 pandemic and humanity should continue to utilise them as need arises and circumstances evolve for human flourishing.

Keywords: COVID-19, pandemic, religion, science, social capital, Zimbabwe

Introduction

The advent of the coronavirus in late 2019 "created exceptional circumstances that altered nearly all facets of society (Manyonganise 2022; Kofman & Garfin 2020). One of the exceptional circumstances is that people found themselves confronted by a pandemic that they had no idea of. Given the novelty of the pandemic, people in Zimbabwe were left with no option but to rely on two safety valves available to them. They had religion and science at their disposal. Religion and science were patronised as people sought a window out of the pandemic. This patronising was not without its challenges as the old age debate between religion and science did not only resurface, but posed questions about the future. That the pandemic knew and still knows no boundaries "...no religion, or ethnicity or nationality or skin pigmentation" (Ukah 2020:448) as it comes in different mutations, it becomes very difficult to predict the future. People are not quite sure whether the gains achieved so far in mitigating the COVID-19 pandemic in Zimbabwe have got something to do with the adoption of religion, or science or both. Although this chapter does not intend to rekindle the debate, it is important to highlight some of the few salient features of the debate as this sets the tone of the chapter. The section below is an attempt to put the discussion at hand in context.

Religion and Science Debate: A Brief Review

It is important that before we give a brief review of the religion-science debate, we need to clearly state what we mean by religion and science in this context. We take religion and science in this chapter from a very broad perspective. The use of the term 'religion' follows an old-age debate on its elusiveness, culture specificity, flexibility, non-normative and non-universality (Smith 1964; Cox 1996; Chitando 1997). Sibanda et.al (2022:2) insinuate that the term religion is "fluid and at times associated with misleading connotations because it is binding and confessional". Because of this, Smith (1964) suggests that we should jettison the term religion and replace it with two concepts, viz 'personal faith' and 'cumulative traditions'. Arguing from the same perspective, Smart (1969) is of the view that we must not expend efforts and energy in defining religion but rather look at its dimensions from which he comes up with six or seven. Sharma (2011:44) cites Smart (1969) where Smart prefers the term 'worldview' over 'religion'. His argument is that the term 'worldview' is inclusive and

beneficial. For him "the separation of religion and the secular is unnecessary because essentially what we deal with is the religious and the symbolic aspect of human life-rituals, ultimate beliefs, myths and so on" (Sibanda, et al. 2022:2). For this reason, this chapter adopts the term 'worldview' as the term gives a new and more relevant view of religion. Religion is, therefore, a collection of a people's beliefs, values, norms and practices. The beliefs, values, norms and practices need not to be approved by anyone save the very people who partake of them. Religion is not static but dynamic as people reshape and redefine that which they believe in, value and practice as a people. Understood from this wider perspective religion encompasses that which provides people with assurance and resilience in the midst of anxiety, confusion and hopelessness as evidenced by the context of the COVID-19 pandemic. Religion is that which cushions people in crisis by providing answers to hard questions about existentiality. It is a rallying point for the people as it offers solace in the midst of hopelessness, desperation and helplessness. Wibisono et al. (2021) are instructive when they argue that religion can be interpreted as knowledge and belief that is sacred, which functionally becomes or is used to guide human actions as social beings to fulfil biological, social and integrative needs. It is from this understanding that this chapter makes it clear from the outset that religion, inasmuch as it is about faith, it is equally a science *sui generis*. This argument was well explained in Muyambo, Sande and Tendere (2022) '*Wash and Pray: The nexus of African Christianity and Science in the context of COVID-19 in Zimbabwe*', and therefore, we need not to belabour it again here save demonstrating how religion and science were and still are being used in mitigating COVID-19.

The next issue that we feel strongly need unpacking is the conceptualisation of science. By science do we mean hard sciences or what? Do we mean biology, chemistry and physics? The answer to these questions is 'No' and 'Yes'. No in the sense that by science we mean that which people utilise and it improves the human condition. Phillips's (2020) understanding of science informs this chapter. He conceptualises science as largely medical science or western biomedicine. It is that which promotes human flourishing by diminishing those factors that threaten health and well-being. Science is that which promotes wellness in a given community. This understanding has resulted in people talking of social sciences. These are sciences that ensure society is in harmony within itself. Yes, in the sense that the hard sciences not only verify facts, opinions and views but 'validate' (for lack of a better word) faith. Science actualises faith. Taking a cue

from Adeleke's foreword to the book, *New and Emerging perspectives on Science, Religion and Society*, edited by Adebayo et al. (2020), science is an intellectual discipline that is concerned with the natural world. He further argues that it is anchored on the rational approach to knowledge.

The debate on whether science is compatible with religion has been an issue of concern among the intellectual community from the 19th century (Adeleke 2020). According to Paul (2020) the science-religion debate has been a fascinating one for centuries with inconclusive results. The overreliance on the rationality of science questioned the authenticity of religion. As a result, the relationship between science and religion was seen as one of conflict and not interdependence. Adeleke (2020) further states that the debate exists at both the epistemological and utilitarian levels, raising questions as to whether religious beliefs are compatible with science and the extent to which these religious beliefs hinder or promote science. Such questions arose because most discussions on the relationship between science and religion focused on Western science and the Christian religion.

However, with the widening of the knowledge base, a growing number of people have begun to support both religion and science, arguing that the relationship between the two does not necessarily have to be that of conflict. The debate is now given a wider focus by "extending it to other frontiers of knowledge beyond the natural sciences as well as other religions that dot the landscape of different regions of the world including Islam and the various indigenous Eastern and African religions" (Adeleke 2020:iii). Today, as the dialogue grows, disciplinary boundaries are being broken down and a wider understanding of the nature of the relationship between science and religion is being created. This means that religion needs science and science needs religion, more so in times of crises like the COVID-19 pandemic. Having contextualised our use of the terms religion and science, the next question could be why religion and science/health? Religious institutions or communities were identified as spaces where misinformation about the COVID-19 infection proliferated which further cultivated mistrust towards science and health care directives among religious adherents of these communities (Lee, et al. 2021). This creates antagonism between religion and science, an antagonism that the COVID-19 pandemic has come not only to dispel but set the record straight that indeed, religion and science are the flip sides of the same coin. Without one, there is no coin. According to Einstein (1995) science without religion is lame and religion without science is blind.

COVID-19: The Context

When COVID-19 was reported in China's province of Wuhan in December 2019, people thought it was one of those diseases that would come and go without much ado. Due to its severity in the areas it had already affected and its fast spontaneous spread, the WHO had to declare it a global pandemic. In Zimbabwe, the pandemic was declared a health hazard on 30 March 2020 (Muyambo 2022). The government of Zimbabwe speedily instituted a raft of measures as a way to fight the pandemic. These included national lockdown, staying at home, face masking, social distancing, among others. In spite of these measures, the pandemic continued to affect and infect people. Due to the prolonged economic downturn that Zimbabwe has been witnessing, some measures were violated. People could not stay indoors when there was no food on the table. Zimbabwe's economy is largely informal where people eke a living through buying and selling. People had to clandestinely find their way into public places for purposes of eking a living. They had to face the full wrath of the police and soldiers who were mandated to ensure that COVID-19 containment measures were adhered to. While the police and soldiers were implementing presidential orders, people's rights were trampled upon. People were denied access to a variety of needs that include health, food, right and freedom of movement and many other rights. Another problem created out of the strictness of the police and the soldiers was the proliferation of corruption as people had to bribe their way to access some of their needs. The introduction of vaccines also saw false vaccinations where some Christians bribed health workers, paid them to get vaccination cards when regulations became coercive. This is problematic as it does not only jeopardise benefits that accrue from the deployment of science and religion in the fight against COVID-19 but denies science and religion their agencies in mitigating COVID-19.

In the midst of hopelessness, helplessness, desperation and shock induced by COVID-19, a ray of hope was witnessed on the faces of the people when talks of a vaccine for the pandemic were ensuing. It was at this juncture that this chapter intends to discuss how religion and science found their ways into the lives of the people. In other words, it was at this point that the collaboration (or lack) of religion and science was put into question. Here we repeat the same fundamental questions that Lumbreras and Oviedo (2020) posed. These are: To what extent has the pandemic

experience contributed to our better distinguishing, distributing and assigning the territories and functions of science and religion? Has science lost its authority due to the limitations exposed during the pandemic and its management? Has religious faith gained more appreciation in this uncertain context? These questions lead us to further ask: Has the experience modified our perception of how religion and science interface in the context of COVID-19 in Zimbabwe? What is the future of religion and science beyond the COVID-19 pandemic?

Theoretical framing

Given the nature of the issues in this chapter, we borrow two frameworks of Lumbreras and Oviedo (2020) from their six theoretical toolbox that can be deployed in the study of the shifts related to the pandemic. The two frameworks are the cultural evolution theory and the beliefs studies. These theories assist in framing our understanding of the roles of religion and science as "sources of meaning and resources for coping with threat and loss" (Lumbreras & Oviedo, 2020:6).

Cultural evolution theory

According to Lumbreras and Oviedo (2020), cultural evolution theory is that which embraces several research programmes. It is a theory that borrows from biological evolution by Charles Darwin where the catchword is 'evolve', that is, moving gradually from one form to another, a movement that discards the less desirable and adopts the desirable. From Darwinism, that is a process where human beings transitioned from rudimentary to finer forms due to a number of factors, chief among them being environmental and climatic changes. Boyd & Richerson (2005); Mesoudi et al. (2006) and Laland (2017) are of the view that cultural evolution is where there is a demonstration of specific patterns in cultural change, drift, and adaptation to shifting contexts and conditions. What this means is that as conditions and contexts change, it cannot be business as usual. The advent of COVID-19 has not only ushered in new perspectives and practices but is a gamechanger in a people's socio-economic, cultural and religious milieus. For example, cultural beliefs and practices in funeral rites have been adapted to suit the COVID-19 context. Body viewing, bathing and attending funerals have undergone metamorphosis. Although these funeral rites changes are hard to accept, they have become the 'new normal'.

Culture in this sense is not static. The COVID-19 pandemic has made people reconfigure that which they were used to do. This reconfiguration means culture has to keep on evolving, thereby calling for the need "to adapt to changing times and stressful circumstances" (Lumbreras & Oviedo 2020:7). Cultural evolution theory, therefore, offers us, in this chapter, clues on how we can understand the changing times and what we need to do in the context of COVID-19 such as redefining and reconfiguring what we were used to doing if the war against COVID-19 is to be won. This redefining and reconfiguring means changing perceptions on the role of science and religion.

The Belief studies

The belief studies programme is aimed at better understanding how beliefs are formed, nourished, stabilized, and eventually decline and may even get lost or be replaced by other beliefs (Lumbreras & Oviedo 2020). The programme provides interesting tools to improve analysis of how beliefs about science and religion are formed and interact. It explores the extent to which science and religious beliefs are deeply influenced by contextual features, and are not mere cognitive issues that reflect mental structures and patterned ways to deal with reality (Lumbreras & Oviedo 2020). This chapter provides solid evidence to test how cognitive schemas interact with cultural models, and how both are played out in a broad field of big changes and historical shocks (Lumbreras & Oviedo 2020). The above also points to the idea that people's beliefs are not projected in a vacuum but in a context. The COVID-19 pandemic has brought changing beliefs about the role of science and religion in crises. We, therefore, adopt these two frameworks in this chapter to assess if we can rethink the interface between science and religion in Zimbabwe in the context of COVID-19 and beyond.

Methods of data collection

This chapter undertakes research on how communities utilised both religion and science in the context of COVID-19. The research used the qualitative method of the observation of what people were and are still doing to fight the COVID-19 pandemic as well as reading available literature on the interface of religion and science on earlier pandemics. We used both overt and covert observations. We were not oblivious of the challenges of

this method in research ethics but we had to use it in order to capture people in their natural settings amidst the pandemic. Making our intentions clear in some places would mean we were not going to get what people were really doing. Once people learn that they are being observed there is a tendency to pretend, thereby jeopardising the outcome of the research. Where it was possible researchers would casually throw in discussion items for people to casually talk. Here we had to use our memories very well for we could not be seen to be taking notes. We would immediately record what we were still remembering as soon as we left the place where these discussions were taking place. This had the limitation that we had to solely rely on what we remembered but had the advantage that people would freely share what they were doing in fighting against the COVID-19 pandemic. Literature on how people dealt with earlier epidemics and pandemics such as measles, the Spanish Influenza of 1918/19, Ebola, HIV and AIDS was also utilised in this study. The idea was to assess the extent to which religion and science were deployed in the fight against such epidemics and pandemics.

Religion and Science: Lessons from previous pandemics

Globally, the interface between religion and science is not a recent one as witnessed in the context of COVID-19. It has been there from the past. Epidemics and pandemics that come to mind are the 1819 cholera outbreak, the Spanish Influenza (1918-19), the Ebola virus and the HIV and AIDS pandemic. In all these epidemics and pandemics different communities employed different measures to mitigate them. The measures ranged and still range from appealing to religion as well as science. For example, some pastors laid hands on Ebola victims in Africa to cure them of spiritual attacks (Falade 2020; Muyambo, et al. 2022). From a religious perspective the argument is that Ebola is caused by evil spirits. While religion views evil spirits as the causative agent of Ebola, science has its own scientific explanations of the Ebola virus. For instance, according to science, Ebola is caused by certain type of virus from chimpanzees in East Africa. Such different explanations do not only confirm that "everything has a cause' (Wibisono, et al. 2021), but that people deploy both religion and science in trying to understand why natural disasters and some of these pandemics occur. What is evident here is that religion and science

are both avenues that communities utilise whenever the need arises. They are never in conflict. We cite, at length here Wilkinson (n.d.):

> Lots of people believe that science and Christian faith are in conflict. But I think one of the real problems of the conflict model is it claims that science and theology say exactly the same things about the world. And therefore, if they say different things, one has to be right, and one has to be wrong...I think that's far too simplistic.

The excerpt above points to the incompatibility of religion and science in the provision of explanations and answers to existential questions and the occurrence of natural disasters such as epidemics and pandemics. When people allow pastors to lay hands on them when suffering from Ebola as referred above, it is a clear indication that for most of recorded history, fearful humans have turned to a version of theodicy in their search for an explanation for disaster in the actions of some powerful, supernational force, whether divine, malevolent, or ancestral (Phillips 2020). They are quite aware of the agency of science but still believe there is need to consult the supernatural force. It is out of such beliefs that we often see Christians vacillating between religion and science whenever dealing with existential challenges that confront them. They consult pastors during the day and *sangomas*, medicine men and women during the night. Already we see a people who straddle both systems for health and wellbeing for one cannot really tell the history of medicine without the history of religion and vice versa.

The foregoing explains why people, over 200 years ago, resorted to both religion and science when the 1819 cholera outbreak hit humanity. When the cholera spread across the world, it demanded an explanation. It is not surprising that the Hindus of that time in India believed that it had been caused by the local deities who had been offended or displeased by people (Phillips 2020). When western biomedicine was introduced by the British, there was scepticism as Hindus believed that the introduction of biomedicine was a further provocation of the local deities. The same response was evident among Buddhists who equally believed that cholera was sent either by angry local demi-gods as punishment. The same also happened to Christians in the initial stages of the HIV and AIDS pandemic. HIV and AIDS was associated with a lot of stigma and discrimination in the church (Chitando 2007), the reason being that those who were affected by it were getting their due punishment for their sins. These scenarios explain that religion is the first port of call when a pandemic of the COVID-19 magnitude strikes. People seek explanations from religion but

will, with time, embrace biomedical measures. This is the very case with the COVID-19 pandemic in Zimbabwe. It was apprehension at first as people sought explanations but with time, science was adopted, though, in some cases through coercion as shall be demonstrated later on.

Bringing Religion and Science together in the context of COVID-19

Through the observation method, we established that religious leaders combined faith and science in the fight against the COVID-19 pandemic in Zimbabwe. Muyambo, Sande and Tendere (2022) are instructive when they indicate that from their study, most pastors straddle religion and science in the 'wash and pray' theology that churches adopted in the context of COVID-19. Other observations not necessarily related to the COVID-19 pandemic *per se* are that Christians exercised to keep healthy. For example, researchers' observations are that the founder and Archbishop of Zimbabwe Assembly of God Africa (ZAOGA), Ezekiel Handinawangu Guti, observes these health exercises and we gathered that he observes dietary restrictions. These scientific undertakings and his keeping of faith are believed to be the secrets behind his good health despite his advanced age. The deployment of science and religion in people's lives happens consciously or unconsciously. What we observed is that people just utilise what is possible as long as it promotes human flourishing.

There is an argument that the advent of COVID-19 brought about an acid test of religious denominations' faith. For instance, COVID-19 requires that all places of public gathering, including those used for worship be closed so as to minimise the social contact which medical science argued was a major mode of infection (Phillips 2020). Ukah (2020) praises African Pentecostalism for having listened to the prophetic voice when they took religion online through televised sermons well before the advent of COVID-19. When gathering restrictions were imposed, African Pentecostalism was not adversely affected like those denominations that had not practised religion online because it used online platforms for its activities. Although Ukah bemoans the failure by African Pentecostalism to effectively take its vantage position in dealing with COVID-19, African Pentecostalism was a step ahead insofar as the deployment of science in their religious activities were concerned. Even if this places science on an upper spectrum, observations have been that communities continue to straddle both spaces depending on what they perceive to be convenient

for them in particular contexts. We observed that although the government of Zimbabwe decreed no church gatherings during the peak period of the pandemic, certain church organisations violated the decree depending on their beliefs. Most of the white garment Apostolic movements believed that they were protected by prayers. The belief emanates from the understanding that both science and religion are God's weapons in performing his work. One member of Vadzidzi Apostolic Church was saying "We believe in God, and science is entirely subject to God's will" (Chingono 2021). Muyambo, et al. (2022) confirm this through the maxim 'Wash and Pray' meaning that after embracing science for mitigating COVID-19, prayers solidify and concretise science efforts. This is consistent with Phillips (2020) who argues that WHO director recently called on faith and science to 'work hand in hand'. The two do not contradict, they work together. Congruent to this argument is Wilkinson (n.d.) who poses a very fundamental question that call for deep reflection: What if science and religion were not opposites at all? Instead, what if they needed each other? Wilkinson (n.d.) argues that science is a gift from God but that too often Christian leaders lack the confidence and tools to engage with scientific questions. We observed that most Christian movements in Zimbabwe embraced both science and religion by putting into practice WHO COVID-19 containment measures and praying at the same time. Admittedly, not all denominations behaved the same in the deployment of science and religion in the context of COVID-19, but statistically the larger percentage complied with the use of science. For this reason, we argue that science and religion are the flip sides of the same coin.

From an Islamic perspective, Dube (2022) is instructive when it comes to Muslims' partaking of science and religion as measures to fight against the COVID-19 pandemic. Dube (2022) argues that the Muslim communities in Zimbabwe cancelled *umrah*, a minor pilgrimage to Mecca. *Hajj* was equally cancelled in 2020. On the Muslim calendar, Ramadan is a special occasion but due to COVID-19 lockdown, the Muslims cancelled the outdoor celebration of it despite it being the Muslim "annual season of worship, comradeship and relationship" (Shaban 2020:1). They opted to celebrate Ramadan in their individual households. The same can be said again regarding vaccination. Dube (forthcoming) admits that Muslims were and still continue to accept COVID-19 vaccines. This compliance with science measures as a possible outlet from the pandemic points to the idea that "…what is changing is not the way science and theology are produced or researched, but how public beliefs about these activities and

their meaning are affected by this severe crisis" (Lumbreras & Oviedo 2020). What is important here is to assess how much science is reliable in its capacity to fix human problems and to what extent religion still plays a role in such difficult circumstances, threats, uncertainty caused by the pandemic.

We observed that although science and religion could have been viewed as antagonists in previous encounters, COVID-19 has either elicited new perceptions or corrected previous views on how much science can be relied upon, and how effective it is (Lumbreras & Oviedo 2020). People's beliefs are subjected to different evolutionary pressures, new adaptations, drifts and struggles, and the COVID-19 pandemic offers a unique case-study to test such influences and how beliefs evolve to adapt to the new conditions. Through the lenses of the cultural evolutionary theory and the belief studies, the antagonistic relationship between science and religion is slowly changing into one of interfacing as people's cultures and beliefs evolve to suit the ever-changing circumstances like the one being posed by the COVID-19 pandemic.

The deployment of science and religion in African Traditional Religion(s)' approach to COVID-19 has been ambivalent. While some communities embraced science as one of those measures that can be adopted in the fight against COVID-19, others were and still continue to be sceptical. This ambivalence is attributable to several factors, chief among them being mistrust in western epistemologies and lack of adequate knowledge about the pandemic (Sipeyiye 2022) and the 'wait and see' attitude that people generally adopt when confronted by a crisis. This kind of response reminds us of the people's response to the HIV and AIDS pandemic that hit Zimbabwe in the early 1980s. It was denial at first and, therefore, it is not surprising that with the advent of COVID-19, the same denial attitude characterised people's first response. Observations are that some people in rural areas thought COVID-19 was a town pandemic while those in urban areas thought it was for the affluent who frequent outside countries. For those in the rural areas, it was business as usual since they thought they were 'safe' or rather 'immune' to the pandemic. We also observed that COVID-19 containment measures were very difficult to implement within rural communities as well as those in the urban areas who are in informal employment. The government had to deploy soldiers and the police in growth points, townships, towns and cities enforcing adherence to the COVID-19 measures. Those found on the wrong side of the law were punished. They were either sjambokked or made to roll on the

muddy ground. In other cases, arrests were instituted and the culprits had to pay fines for violating the COVID-19 measures.

Being religions based on relationships (Taringa 2014; Mbiti 1969), African Traditional Religion(s) were adversely affected by the ban on contact with one another through social distancing. It is important that what we observed with African Traditional Religion(s)' practitioners is that while some of them loathed the social distancing measure against COVID-19, others were amenable. For instance, the Ndau communities of south-eastern Zimbabwe have not found measures of social distancing and quarantining much of a problem due to lessons and experiences gained with other epidemics such as leprosy, chicken pox, measles, scabies just to mention a few (Muyambo 2022).

We also observed that people do not necessarily engage themselves into the science-religion debate in their deployment of the two in fighting COVID-19. They use what is convenient for them at any given time. For example, we have observed people steaming, taking *zumbani*, getting vaccinated and at the same time praying. Christians and Muslims, alike did not cease praying even though they were adhering to COVID-19 prevention measures as directed by government and WHO. In addition to praying and embracing science, they too resorted to traditional means such as *zumbani* and steaming. Equally, practitioners of African Traditional Religions resorted to science and religion in their fight against COVID-19 as they deployed both. Sipeyiye (2022) argues that traditional healers were consulted as a way of trying to understand the COVID-19 pandemic and that prayers to ancestors were made so that a cure could be discovered. As people were doing this, they never bothered whether this is religion or science, but were just looking for anything that could assist in the fight against the pandemic. Such a mixed approach means that people consciously or unconsciously straddle between the two.

Voluntarism or Coercion?

There have been arguments from general conversations that people's acceptance of COVID-19 protocols in Zimbabwe has been as a result of coercion, where the government used a heavy-handed approach to the adherence of COVID-19 protocols including vaccination. Muyambo, et al. (2022) indicate that the pastor interviewees revealed that their adherence to COVID-19 protocols as enunciated by WHO and the Zimbabwe gov-

ernment was voluntary. However, what we observed was that the adherence was coerced in the sense that certain privileges were withdrawn for people who were not vaccinated. For instance, they were denied to move in public transport, enter supermarkets, getting to work places, especially government employees and attending church services. Such a withdrawal of benefits and services, forced people to get vaccinated in order for them to have access to these services. At the time of writing this chapter, there were reports of Apostolic movements such as Johanne Marange African Apostolic Church which were initially against vaccination, be it of COVID-19 and measles, that have all of a sudden accepted their vaccination against COVID-19 and of their children against the resurgent measles epidemic that has hit Zimbabwe. Bishop Andyby Makururu who leads Johanne The Fifth of Africa International Church, an apostolic church based in Manicaland, has warmed up to COVID-19 vaccination. He said:

> I have already taken my two shots of the COVID-19 vaccines and I'm encouraging my followers to take the vaccines too. I'm happy that my followers are also accepting the COVID-19 vaccines. They are following my spiritual guidance (Mambondiyani 2021).

Similarly, a senior leader of the Johanne Marange African Apostolic church in Mashonaland West is also quoted as having said, "Our church doctrine says we don't go to hospital when are sick or get vaccinated, but with COVID-19, it is a new ball game altogether" (Nyathi 2021). The question that comes to mind here is: Are these religious leaders doing this voluntarily or there is coercion? Chances are high that they are doing this in order to conform to government's decree on vaccination to all. As religious leaders of Apostolic churches known to be anti-vaccines, they want to give an impression that they are pro-government especially with the frequent visits political leaders are making to these churches. One wonders why the Johanne Marange African Apostolic Church member openly says this when in public. Is it true that they are now vaccinating or they want to give a false impression in public? Although it is very difficult to ascertain whether the embracing of science into the fight against COVID-19 is voluntary or coercion by these religious groups, especially where evidence thereof is not produced, the culture evolutionary theory and belief studies may explain the occurrence. This could be that due to the elapsing of time, mindsets change or evolve abandoning long held beliefs that are no longer in tandem with prevailing circumstances. This is consistent

with what Ukah (2020:455) observes when he says that when church leaders such as Oyedepo, founder-owner of the Living Faith Church in Nigeria discovered that his flouting of the COVID-19 pandemic by holding church gatherings under the belief that "[s]hutting down churches would be like shutting down hospitals…", received unprecedented criticisms, he apologised and urged his church members to comply with all initiatives of the government to combat COVID-19. The same can be said of Emmanuel Makandiwa, founder of United Family International Church (UFIC) in Zimbabwe, who initially denied in public the acceptance of the vaccine but later changed and urged his followers to be vaccinated. One wonders why such a change of position by these men of God. Is there [political] pressure behind the scenes? Isn't this coercion rather than voluntarism? The point we are making here is that when we observe Christians in this case straddling both religion and science it could be that they have no option because they are coerced. Their deployment of the two in fighting against COVID-19 is not necessarily because of the close affinity and agency between the two, science and religion but circumstances beyond their control dictate their compliance.

Religion and Science beyond the COVID-19 Pandemic

This last section of the chapter focuses on whether it is possible or not to rethink the interface between religion and science beyond the COVID-19 pandemic in Zimbabwe. Judging by what has been going on, that religious communities in Zimbabwe straddle between religion and science as they search for answers to the pandemic, we argue that the deployment of science and religion in crises is likely to continue as circumstances dictate. The COVID-19 pandemic has made it possible for religious leaders not only to innovate as we observed them "continuing religious commitments and rituals through social networks, TV channels, or live streaming" (Capponi 2020; Frei-Landau 2020 cited in Lee, et al. 2021), but effectively implementing public health information. This clearly demonstrates the importance of collaborating with religious sectors when facing public health crises.

Lessons learnt from the past epidemics and pandemics such as cholera, Ebola, HIV and AIDS have indicated diverse influences of religion when it comes to public health crises. According to Lee, et al. (2021) religion has acted as an important platform for intersectoral collaboration

with science and government to combat COVID-19. Within this collaboration, religion provides meaning, determining the indeterminate, or managing unmanageable risks (Lehmann 1977). Experiences from the past health crises have indicated that where other social systems exhaust their resources due to excessive complexity and uncertainty, religion has come to the rescue (Lumbreras & Oviedo 2020). According to these scholars, when uncertainty and risk increase as was with COVID-19 during its peak, the role of religion becomes more necessary and more difficult to replace by secular means. They further argue that religious faith can act as a value system which coexists with other value systems that arise from different social sources.

Another function that religion plays in the stressful time, the COVID-19 context, just like during the times of cholera, Ebola and the HIV and AIDS, is religious coping. The need for religion was witnessed when people were up in arms with governments where the church was closed. Since religion could not be accessed due to lockdown, religious leaders of different religious movements had to quickly find a solution on how this essential service of coping could be offered. That is when we witnessed the swift transition from face-to-face worshipping to online religion, even for those religious groupings that were not all that technology savvy. We do not see such a role changing beyond the COVID-19 pandemic. Religion as one of the value systems that include science is not in competition but works together with others. We anticipate no change of the role of religion and science beyond COVID-19 because the two are the flip sides of the same coin. It is, therefore, not a farfetched argument that it is possible to rethink the interface between religion and science beyond COVID-19 in Zimbabwe. The two value systems will continue to provide safety valves in times of public health crises. They will continue to be reconfigured as circumstances dictate.

Conclusion

The intention of this chapter was to show that it is possible to rethink the interface between religion and science beyond the COVID-19 pandemic in Zimbabwe. The chapter has shown that religion and science have been complementing each other from the past, especially in the earlier public health crises such as cholera, Ebola and HIV and AIDS. We have established that religion and science are the flip sides of the same coin, and that if ever there are signs of combat antagonism, it is simply a matter of

how one views the two value systems. Religion made coping with stressful situations possible where the other value system seemed to have failed. We noted that although COVID-19 containment measures could have been complied with, we must be alive to the reality that the compliance could have been due to coercion not voluntarism as well as instances of false vaccinations where members bribed health officials for them to get vaccination cards without getting the jab. Nevertheless, the interface between science and religion is likely to continue as circumstances dictate and people straddle between the two without necessarily getting into the science-religion intellectual debate.

References

Adeleke, M.A. 2020. Foreword. In R.I. Adebayo, O.M. Agbolade, T.M. Salisu, A.A. Adebayo and C.F. Ojetunde (eds.). *New and Emerging perspectives on Science, Religion and Society*. Lagos: MOCPED & NARES, iii-iv.

Boyd, R. & Richerson, P.J. 2005. *The Origin and Evolution of Cultures*. Oxford: Oxford University Press.

Chingono, N. 2021. 'We are protected by prayers': The sects hampering Southern Africa's vaccine rollout. *The Guardian*, Monday I November.

Chitando, E. 1997. A curse of western heritage? Imagining religion in an African context. *Journal for the Study of Religion*, 10(2):75-98.

Chitando, E. 2007. *Living with Hope: An Invitation to Faith in the context of HIV and AIDS*. Geneva: World Council of Churches Publications.

Cox, J.L. 1996. *Expressing the Sacred: An Introduction to the Phenomenology of Religion*. Harare: University of Zimbabwe Publications.

Dube, E. 2022. The influence of health perceptions on Zimbabwe Muslim responses to COVID-19 restrictions over Ramadan, pilgrimages and funeral rights in 2020. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the Covid-19 pandemic in Southern Africa*, 202-212. London: Routledge.

Einstein, A. 1995. *Ideas and Opinions*. New York: Broadway Books.

Falade, B. 2020. 'COVID-19, religious institutions and the accommodation of science in Africa'. https://blogs.lse.ac.uk/africaatlse/2020/04/20/COVID-19-religious-institu tions-public-health-science-africa/ [Accessed 13 July 2021].

Kofman, Y.B. & Garlin, D.R. 2020. Home is not always a Haven: The Domestic Violence Crisis Amid the COVID-19 Pandemic. *Psychological Trauma: Theory, Practice and Policy*, 12(SI):S199-S201.

Laland, K. 2017. *Darwin`s Unfinished Symphony: How Culture Made the Human Mind*. Princeton/N.J.: Princeton University Press.

Lee, M.L.H., Xavier, M.S. & Lee, E.Y. 2021. 'A divine infection': A systematic review on the roles of religious communities during the early stage of COVID-19. *Journal of Religion and Health*, 866-919. https://doi.org/10.1007/s10943-021-01364-w [Accessed 8 August 2022].

Lehmann, N. 1977. *Funktion der Religion*. Frankfurt a.M.: Suhrkamp.

Lumbreras, S. & Oviedo, L. 2020. The pandemic and its influence on the relationship between science, religion and theology. *ESSAT News & Reviews*.

Mambondiyani, A. 2021. Apostolic Churches warm up to COVID-19 vaccines in Zimbabwe. file:///Users/tensonmuyambo/Desktop/Apostolic%20Churches%20warm%20up%20to%20COVID19%20vaccines%20in%20Zimbabwe%20%7C%20Gavi,%20the%20Vaccine%20Alliance.webarchive [Accessed 15 September 2022].

Manyonganise, M. 2022. 'When a pandemic wears the face of a woman': Intersections of religion and gender during the COVID-19 pandemic in Zimbabwe. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the covid-19 pandemic in Southern Africa*, 232-243. London: Routledge.

Mbiti, J.S. 1969. *African Religions and Philosophy*. Oxford: Heinemann.

Mesoudi, A., Whiten, A. & Laland, K.N. 2006. Towards a unified science of cultural evolution, *Behavioral and Brain Sciences*, 29:329-383.

Muyambo, T. 2022. Social distancing in the context of COVID-19 in Zimbabwe: Pespectives from Ndau religious indigenous knowledge systems. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the covid-19 pandemic in Southern Africa*, 37-51. London: Routledge.

Muyambo, T., Sande, N. & Tendere, J. 2022. 'Wash and Pray': The nexus between African Christianity and Science in the context of COVID-19 in Zimbabwe. *Journal of Religion in Africa*, 52(3-4):348-373.

Nyathi, K. 2021. Religious groups warm up to COVID-19 vaccines in Zimbabwe. file:///Users/tensonmuyambo/Desktop/Religious%20groups%20warm%20up%20to20COVID19%20vaccines%20in%20Zimbabwe%20%7C%20UNICEF%20Zimbabwe.webarchive [Accessed 15 September 2022].

Paul, A. 2020. Religion and Science: A brief introduction to the great debate. In R.I. Adebayo, O.M. Agbolade, T.M. Salisu, A.A. Adebayo and C.F. Ojetunde (eds.). *New and Emerging perspectives on Science. Religion and Society*, ix-xix. Lagos: MOCPED & NARES.

Phillips, H. 2020. Religion and science in three pandemics, 1817, 1918, and 2019. Published online. Cambridge University Press.

Shaban, A.R.A. 2020. 'Ramadan 2020: Muslim Stratein rows for the locked down fasting'. *Africa News*. https://www.africanews [Accessed 17 July 2022].

Sharma, A. 2011. *Problematising Religious Freedom*. London: Springer Dordrecht Heidelberg.

Sibanda, F., Muyambo, T. and Chitando, E. 2022. Introduction: Religion and public health in the shadow of COVID-19 pandemic in Southern Africa. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the covid-19 pandemic in Southern Africa*, 1-24. London: Routledge.

Sipeyiye, M. 2022. Coping with the coronavirus (COVID-19): Resources from Ndau indigenous religion. In F. Sibanda, T. Muyambo & E. Chitando (eds.). *Religion and the Covid-19 pandemic in Southern Africa*, 52-71. London: Routledge.

Smart, N. 1969. *The Religious Experience of Mankind*. Englewood Cliffs/NJ: Prentice-Hall.

Smith, W.C. 1964. *The Meaning and End of Religion*. London: SPCK.

Taringa, N.T. 2014. *Towards an African- Christian environmental ethic*. Bamberg: University of Bamberg Press.

Ukah, A. 2020. Prosperity, Prophecy and the COVID-19 pandemic: The healing economy of African Pentecostalism. *Pneuma* 42, 430-459. https://doi:10.1163/15700747-bja10010 [Accessed 21 September 2022].

Wibisono, M.Y., Truna, D.S. & Rahman, M.T. 2021. Turning religion from cause to reducer of pandemic during the COVID-19 pandemic. *HTS Teologiese,* 77(4), ab366. https://doi.org/10.4102/hts.v77:4.6366 [Accessed 14 July 2022].

Wilkinson, D. (n.d.). Science is a gift from God. Durham University.


11

Contributors' List

Vengesai Chimininge is currently a Senior Lecturer in the Department of Religious Studies and Philosophy at Zimbabwe Open University, Zimbabwe. He is a former Junior Research Fellow at Lancaster University, United Kingdom. His research interests include: Ritual Studies, African Christianity, Religious and Family Studies, Religion and Community Development. Email address: *vchimininge@gmail.com*.

Enna Sukutai Gudhlanga holds a Doctor of Literature and Philosophy in African Languages from the University of South Africa. She is an Associate Professor and Chairperson of the Department of Languages and Literature at Zimbabwe Open University. An avid researcher, Enna holds certificates in Gender Mainstreaming from OSSREA, CODESRIA and UNIDEP. Her study interests constitute gender, Africa and the development of its literatures, cultures, and world outlooks. Enna teaches African and Zimbabwean literature, gender and cultural studies, HIV and AIDS and Communication in Negotiation courses. She is concerned with the ultimate self-definition and complete mastery of the African people's own life. Her publications include: *African Literature, Mother Earth and Religion* (Delaware: Vernon Press, 2022), coedited with Musa W. Dube and Josephine Muganiwa, and (*Gender, politics and land use in Zimbabwe, 1980-2012* (Dakar: CODESRIA, 2015). She has presented papers on gender issues at many international conferences. Enna is also interested in socio-linguistic issues like democracy, language rights, planning and policy. She is also a Research fellow at the University of South Africa and is a member of the Circle of the Concerned African Women Theologians. She has also been appointed into the Zimbabwe National Language Advisory Committee for the period 1 May 2022- 30 April 2027. Email address: *gudhlangaes@gmail.com*; https://orcid.org/0000-0003-2485-728X.

Bernard Pindukai Humbe is a PhD holder in Religion Studies from the University of Free State, South Africa. He is a lecturer, Department of Philosophy and Religious Studies, Great Zimbabwe University. He is also Academic Associate/Research Fellow, Research Institute for Theology and Religion, College of Human Sciences, University of South Africa. His areas of research

interest include: Religion and Covid-19, African Traditional Medicine and Traditional Healing, African Indigenous Religious Knowledge Systems (AIRKS), Traditional Law and Social Development, Religion and Entrepreneurship, Religion and Social Transformation, and Religion and Power.

Angeline Mavis MADONGONDA is a senior lecturer in the Department of Languages and Literature with the Zimbabwe Open University. Currently she is the Programme Leader for the Bachelor of Arts in English and Communication Studies programme (BAECS) and a PhD candidate. She is an accomplished writer, researcher, and academic. Her research interests include subaltern voices, and geocriticism. Her publications include; 'Environmental Intrusions and Land Dispossession: A Post-colonial Eco-critical Reading of Selected Poems in Musaemura Zimunya's Jikinya, Kingfisher and other stories.' In ES Gudhlanga, J Muganiwa, MW Dube (eds.). *Mother Earth, Mother Africa, Creative Literature and the Global Environmental Crisis*. New York: Vernon Press (2022); "Knock Knock Knock" The paradox of the Music genre and Serious Discourse in HIV/AIDS Communication *African Journal of Rhetoric: Rhetoric and Language of Decolonisation in Africa* Vol II, pp151-171 (2019), *The Art of Survival: Depictions of Zimbabwe and the Zimbabwean in Crisis*. Cambridge: Cambridge Scholars Publishing, (2015). Email address: *angieruswa@gmail.com*; https://orcid.org/0000-0003-2417-8076.

Clemence MAKAMURE is a senior lecturer, Curriculum Designer and Chairperson of the Department of Religious Studies and Philosophy at the Zimbabwe Open University. He holds a PhD in Religion and Social Transformation from the University of KwaZulu Natal (South Africa). He has research interests in African Christianity, with special focus on African Independent Churches and their leadership system, Religion and Politics, Religion and Social Transformation, Religion and Development, Religion and Disability, Human Sexuality, Human Rights, Religion and Environment and Leadership and Ethics. Email address: *makamurec@zou.ac.zw*.

Molly MANYONGANISE holds a PhD in Biblical and Religious Studies from the University of Pretoria. She is a senior lecturer in the Department of Religious Studies and Philosophy at the Zimbabwe Open University. She is a research associate of the Department of Religion Studies, Faculty of Theology and Religion of the University of Pretoria. She is currently a Georg Forster Postdoctoral research fellow, Alexander von Humboldt Foundation, Germany. Her

research interests comprise religion and politics, gender and religion, religion and sexuality, African Indigenous Religion(s) as well as African Christianity. Email address: *mollymanyonganise@yahoo.com*; https://orcid.org/0000-0002-8092-3467.

Gift MASENGWE holds a PhD from the University of South Africa. He is currently a Research Fellow, Research Institute for Theology and Religion, University of South Africa, Pretoria, South Africa and a Research Fellow, Department of Education, University of the Free State, South Africa. He is a promising researcher in the field of religion in contemporary society. He has held adjunct teaching appointments at Zimbabwe Open University since 2012. His recent workand co-authored publications include: Constraints and Challenges of Multi-Faith Religious Education in Zimbabwe (2022); Registering land offer letters (2022), The timing and legitimacy in the announcement of presidential results in the 2018 general elections in Zimbabwe (2021); Critical Entitlement Theory on Post-Missionary Paternalism in the Church of Christ in Zimbabwe (2021); The Legacy of Sir Reginald Stephen Garfield Todd in Zimbabwean Public Life History (2021); Africanising the Four Self-Leadership Formula in the Church of Christ in Zimbabwe (2021) and Covid-19, Global Economy, Development and the Future of Africa (2021). Topics of current interest include the church and the 2023 general elections, religion and chieftainship and religion in education.

Email address: *masengweg@gmail.com*.

Peter MASVOTORE is a research fellow at the University of South Africa (UNISA). He is a lecturer in Theology at United Theological College (UTC). He is an Academic Dean and an accredited member of the Theological Society of South Africa (TSSA). Masvotore Peter is an external examiner of Theology at Kwazulu Natal University (UKZN). He obtained his Bachelor of Arts honors and Masters of Arts in Theology at the University of Zimbabwe. He did his PhD majoring in Systematic Theology at the University of Kwazulu Natal (UKNZ), Pietermaritzburg South Africa. He has published in peer reviewed international journals and books. His research interests and publications focus on current topical issues, liberation, gender justice, eco-theology, youth identity and migration, indigenous knowledge systems, poverty and Decoloniality. Email address: *masvotorep@gmail.com*; https://orcid.org/0000-0002-8398-1160

Tawanda MATUTU is a lecturer at the Zimbabwe Open University in the Faculty of Arts, Culture and Heritage Studies, Department of Religious Studies and Philosophy. He holds a Master of Arts in Philosophy from the University of Zimbabwe. He has research interests in Medical Ethics, Business Ethics and Social and Political Philosophy. Email address: *tawandamatutu@gmail.com*.

Tenson MUYAMBO is a PhD holder from University of KwaZulu Natal (UKZN). He is a Research fellow at the University of South Africa's (UNISA) Research Institute for Theology and Religion (RITR), College of Human Sciences. He is a lecturer at Great Zimbabwe University, School of Heritage and Education. He has researched and published extensively on indigenous knowledge systems, religion (Ndau indigenous religion), gender, education, pandemics. Some of his co-edited books are: *Religion and the COVID-19 Pandemic in Southern Africa* (2022), *Re-imagining Indigenous Knowledge and Practices in 21st Century Africa: Debunking Myths and Misconceptions* (2022). Email address: t*mabhuyamuyambo@gmail.com*.

Bednicho NYONI is a Lecturer, Researcher and Consultant. He did his PhD, with the University of Rostock, Germany. He is a part-time Lecturer at Catholic University of Zimbabwe; Zimbabwe Open University (ZOU) and Zimbabwe Ezekiel Guti University (ZEGU), in the Faculty of Humanities and Social Sciences and Department of Religious Studies and Theology, respectively. His research interests are in Religion and Development (RD), Political Theology, Religion in the public sphere, Religion, Gender and Sexuality. Email address: *abednyoni@gmail.com*.

Nomatter SANDE holds a PhD in Religion and Social Transformation from the University of KwaZulu-Natal, South Africa. He is a Practical Theologian and a research fellow at the Research Institute of Theology and Religion (RITR) in the College of Human Sciences at the University of South Africa. His research interests include disability studies, Pentecostal theology, religious violence, peace and gender. Email address: *pastornomsande@yahoo.com*; ORCID: https://orcid.org/0000-0002-4177-8391.

Jane TENDERE is a Mathematics lecturer at Great Zimbabwe University, School of Heritage and Education. Her research interests are in current issues in

education such as pandemics and Mathematics education and has published in this area. Email address: *jtendere@gzu.ac.zw*.

Lovemore TOGARASEI is a Professor and Programme Leader of Religious Studies and Theology at the Zimbabwe Open University where he teaches courses in Biblical Studies. His research interests lie in the area of the Bible and African Christianity, especially Pentecostal Christianity. He has published widely, addressing such issues as the gospel of prosperity, leadership, health, politics and popular culture. Among his latest publications is an edited volume, *Lobola in Contemporary Africa* (2021). E-mail: *ltogarasei@gmail.com*.

Lindah TSARA is a holder of PhD from the University of Kwazulu Natal (UKZN) in Systematic theology and Gender. She is a Lecturer in the Department of Religious Studies and Philosophy at Zimbabwe Open University (ZOU). She obtained her Bachelor of Arts Honours and Master of Arts in Religious studies at the University of Zimbabwe (UZ). Her research interest focuses on Theology and gender, girl child education, sexual and reproductive health and rights, Apostolic indigenous churches, gender, and culture. Email address: *lindah.tsara@yahoo.com*.

Silindiwe ZVINGOWANISEI is a lecturer at the University of Zimbabwe. She teaches in two departments; the Philosophy, Religion and Ethics Department & in the Peace, Security and Society Department. Her research and publications focus on Islam in Africa, Religion and Society, Peace and Gender Studies. Email address: *silindiwetz@gmail.com*.

BiAS at University of Bamberg Press

The book series **B**ible **i**n **A**frica **S**tudies (**BiAS**) was established in 2009 by Joachim Kügler, Lovemore Togarasei and Masiiwa Ragies Gunda.

All volumes of BiAS series are available online at:

- **http://www.uni-bamberg.de/ubp/verlagsprogramm/reihen/bible-in-africa-studies/**
  (information and overview of the series)
- **https://fis.uni-bamberg.de/cris/series/series00016/seriespublications.html**
  (download of the full texts)

We will always keep you updated if you follow us here:

- **http://uni-bamberg.academia.edu/BiasSeries**
  (information, additional texts, tables of matters, download links; pre-print versions)

Previously published volumes of the BiAS series

BiAS 1 **The Bible in Context**: Essay Collection / by Lovemore Togarasei, Bamberg: UBP, 2009

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-2131

BiAS 2 **Reign with Him for Thousand Years (Rev 20:6)**: A Socio-Hermeneutical Exposition of Biblical and Contemporary Millenarian Movements in Zimbabwe as Radical Responses to Deprivation / by David Bishau, Bamberg: UBP, 2010

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-2457

BiAS 3 **The Bible and Homosexuality in Zimbabwe:** A Socio-historical analysis of the political, cultural and Christian arguments in the homosexual public debate with special reference to the use of the Bible / by Masiiwa R. Gunda, Bamberg: UBP, 2010

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-2522

BiAS 4 **From Text to Practice:** The role of the Bible in daily living of African people today / ed. by Joachim Kügler & Masiiwa R. Gunda, 2nd ed., rev. & expanded, Bamberg: UBP, 2013

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-20465

BiAS 5 **Pauvreté ou paupérisation en Afrique:** une étude exegético-ethique de la pauvreté chez les Beti-Fang du Cameroun / par Jacques F. Owono, Bamberg: UBP, 2011

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-3259

BiAS 6 **Death and After-life Rituals in the eyes of the Shona:** Dialogue with Shona Customs with the Quest for Authentic Inculturation / by Canisius Mwandayi, Bamberg: UBP, 2011

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-3336

BiAS 7 **The Bible and Politics in Africa** / ed. by Masiiwa R. Gunda & Joachim Kügler, Bamberg: UBP, 2012

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-4726

BiAS 8 **The Messianic Feeding of the Masses:** An Analysis of John 6 in the Context of Messianic Leadership in Post-Colonial Zimbabwe / by Francis Machingura, Bamberg: UBP, 2012

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus-4032

BiAS 9 HIV/AIDS and the Bible in Tanzania: A Contextual Re-reading of 2 Samuel 13:1-14:33 / by Mussa S. Muneja, Bamberg: UBP, 2012

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-9957

BiAS 10 Aluta continua biblical hermeneutics for liberation: Interpreting biblical texts on slavery for liberation of Zimbabwean underclasses / by Obvious Vengeyi, Bamberg: UBP, 2013

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-37641

BiAS 11 The Book of Ruth from a Lomwe perspective: ḥesed and ikharari / by Justino M. Alfredo, Bamberg: UBP, 2013

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-50966

BiAS 12 Prophets, profits and the Bible in Zimbabwe: Festschrift for Aynos M. Moyo / ed. by Ezra Chitando, Masiiwa R. Gunda & Joachim Kügler, Bamberg: UBP, 2013

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-55996

BiAS 13 Towards an African-Christian Environmental Ethic / by Nisbert T. Taringa, Bamberg: UBP, 2014

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-64812

BiAS 14 Beyond Making Money: The Prophetic Songs of Paul Dzampah from Ghana; Edition, Introduction, and Annotations / by Joachim Kügler, Bamberg: UBP, 2014

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-101753

BiAS 15 ERA 1 | Multiplying in the Spirit: African Initiated Churches in Zimbabwe / ed. by Ezra Chitando, Masiiwa R. Gunda & Joachim Kügler, Bamberg: UBP, 2014

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-105096

BiAS 16 Analysing the Frames of a Bible: The Case of the Setswana Translations of the Book of Ruth / by Sidney K. Berman, Bamberg: UBP, 2014

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-250198

BiAS 17 The Bible and Children in Africa / Lovemore Togarasei & Joachim Kügler (eds.), Bamberg: UBP, 2014

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-252876

BiAS 18 On the Public Role of the Bible in Zimbabwe: Unpacking Banana's "re-writing" call for a socially and contextually relevant Biblical Studies / by Masiiwa R. Gunda, Bamberg: UBP, 2015

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-255608

BiAS 19 Offering the Gospel ADAPANON: An interpretation and application of 1 Corinthians 9:18 / by Johannes M. Wessels / Ed. & provided with a foreword by Joachim Kügler, Bamberg: UBP, 2015

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-264687

BiAS 20 The Bible and Violence in Africa: Papers presented at the BiAS meeting 2014 in Windhoek (Namibia), with some additional contributions / Johannes Hunter & Joachim Kügler (eds.), Bamberg: UBP, 2016

https://nbn-resolving.org/urn:nbn:de:bvb:473-opus4-461656

BiAS 21 At the Crossroads: A Call to Christians to Act in Faith for an Alternative Zimbabwe / by Masiiwa R. Gunda, Bamberg: UBP, 2018

https://doi.org/10.20378/irbo-53039

BiAS 22 The Bible and Gender Troubles in Africa: Papers presented at the BiAS meeting 2016 in Harare (Zimbabwe) with some additional contributions / Joachim Kügler, Rosinah Gabaitse, Johanna Stiebert (eds.), Bamberg: UBP, 2019

https://doi.org/10.20378/irbo-54678

BiAS 23 ERA 2 | Abundant Life and Basic Needs: African Religions as a Resource for Sustainable Development / by Bednicho Nyoni, Bamberg: UBP, 2019

https://doi.org/10.20378/irbo-54768

BiAS 24 ERA 3 | African Pentecostalism, the Bible, and Cultural Resilience: The Case of the ZAOGA / by Kudzai Biri, Bamberg: UBP, 2020

http://doi.org/10.20378/irb-47003

BiAS 25 ERA 4 | Religion and Development in Africa / Ezra Chitando, Masiiwa Ragies Gunda & Lovemore Togarasei (eds.) in cooperation with Joachim Kügler, Bamberg: UBP, 2020

https://doi.org/10.20378/irb-47759

BiAS 26 ERA 5 | Religion and Social Marginalisation in Zimbabwe / Lovemore Togarasei, David Bishau & Ezra Chitando (eds.), Bamberg: UBP, 2020

https://doi.org/10.20378/irb-47836

BiAS 27 Witwen und Bibel in Tansania: Eine leserinnenorientierte Lektüre von 1 Tim 5,3-16 / by Stefanie Beck, Bamberg: UBP, 2020

https://doi.org/10.20378/irb-48219

BiAS 28 ERA 6 | "The wounded Beast?": Single Women, Tradition, and the Bible in Zimbabwe / by Kudzi Biri: UBP, 2021

https://doi.org/10.20378/irb-48992

BiAS 29 Mother Earth, Mother Africa, and Biblical Studies: Interpretations in the Context of Climate Change / Sidney K. Berman, Paul L. Leshota, Ericka S. Dunbar, Musa W. Dube, Malebogo Kgalemang (eds.), Bamberg: UBP, 2021

https://doi.org/10.20378/irb-49839

BiAS 30 ERA 7 | That all may Live! Essays in Honour of Nyambura J. Njoroge/ Ezra Chitando, Esther Mombo & Masiiwa Ragies Gunda (eds.), Bamberg: UBP, 2021

https://doi.org/10.20378/irb-50019

BiAS 31 ERA 8 | COVID-19: African Women and the Will to Survive/ Helen A. Labeodan, Rosemary Amenga-Etego, Johanna Stiebert & Mark S. Aidoo (eds.), Bamberg: UBP, 2021

http://doi.org/10.20378/irb-51639

BiAS 32 Paul's Ethics of Reconciliation in Dialogue with Ndebele and Shona Ethnic Cohesion/ by Ishanesu S. Gusha, Bamberg: UBP, 2022

http://doi.org/10.20378/irb-54882

BiAS 33 ERA 9 | An Anglican "Quest for Belonging?"/ by Farai Mutamiri, Bamberg: UBP, 2022

http://doi.org/10.20378/irb-55722

BiAS 34 Luke's Gospel on Material Possessions and Christian Practise in Nigeria/ by Kingsley I. Uwaegbute, Bamberg: UBP, 2022

http://doi.org/10.20378/irb-55730

BiAS 35 ERA 10 | Daring Patriarchy? A Biblical Engagement with Gender Discourses on Political Participation in Post-colonial Zimbabwe / by Molly Manyonganise, Bamberg: UBP, 2023

http://doi.org/10.20378/irb-57154

University of Bamberg Press

BIAS 36 explores the intersection of religion and health in a COVID-19 context specifically focusing on Zimbabwe. With the menace of COVID-19 across cultures, this volume places its focus on this pandemic and how it has reshaped the discourse on the way, religion interfaces with health. The book further examines the ambivalence of religion in shaping attitudes towards health-seeking behaviour as well as influencing responses to pandemics. This book, therefore, makes a valuable contribution to the body of knowledge by offering an incisive analysis of how the pandemic has shaped the way religion has contributed both positively and negatively to the discourse on health in Zimbabwe. Such an analysis is crucial in informing policy on the future relationship between science and religion in public health both during this pandemic as well as in the post-pandemic era and the crises ahead.

Molly MANYONGANISE (ed.) / Vengesai CHIMININGE / Enna Sukutai GUDHLANGA / Bernard Pindukai HUMBE / Angeline Mavis MADONGONDA / Clemence MAKAMURE / Gift MASENGWE / Peter MASVOTORE / Tawanda MATUTU / Tenson MUYAMBO / Bednicho NYONI / Nomatter SANDE / Jane TENDERE / Lovemore TOGARASEI / Lindah TSARA / Silindiwe ZVINGOWANISEI

ISBN: 978-3-86309-911-4

www.uni-bamberg.de/ubp