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Women, Biblical Texts and COVID-19 in Zimbabwe: Navigating the Mental Health Terrain

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Abstract

From its onset in Zimbabwe, COVID-19 disrupted the mental health of many Zimbabweans. Its quick transmission and viciousness caused fear and panic as people tried to ensure their safety from infection. When lockdown was first declared as the death toll slowly climbed up, it became clear that a number of people would suffer from mental health problems mainly because of isolation, failure to take care of the sick loved ones as well as stigmatization of those who got infected and recovered. In most cases, name calling resulted from ignorance of how to treat those who had recovered from the disease. While recovery was celebrated, the recovered patients were labelled as '*vaya vakamborwara neCOVID*' (those ones who once suffered from COVID) or '*pamba peveCOVID-19*' (the home of the COVID-19 sufferers, *sic*). As infection cases soared and hope seemed to be lost, many people turned to religion. The genderedness of the pandemic became clear as women suffered the most, both as carergivers for the sick as well as from Gender-based Violence (GBV). In such cases, the deployment of biblical texts took centre-stage in most Zimbabwean societies and beyond as women tried to make meaning of their situation. The purpose of this article, therefore, is to investigate how biblical texts were deployed by women for the sake of taking care of their mental health in a threatening environment. The intention is to establish the many ways that religion becomes a useful resource in pandemic contexts particularly for the mental wellbeing of women in Zimbabwe. This is largely a qualitative paper which utilizes in-depth interviews of women in Harare's Central Business District (CBD). The African Womanist Approach informs the study.

Keywords: COVID-19, gender-based violence, mental health, sacred texts, women, Zimbabwe;

Introduction

From its onset in Zimbabwe, COVID-19 disrupted the mental health of many Zimbabweans and mental health provision services (Kurevakwesu, 2021). Its quick transmission and viciousness caused fear as people tried to ensure their safety from infection (Pavari, 2020; Tom & Chipenda, 2020; Chitungo, et al, 2021). When lockdown was first declared as the death toll slowly increased, it became clear that a number of people would suffer from mental health problems because of isolation, failure to take care of the sick and stigmatization of those who got infected and recovered from the disease. In most cases, name calling resulted from ignorance on how to treat those who had recovered from the disease. While recovery was celebrated, the recovered patients were labelled as '*vaya vakamborwara neCOVID*' (those who once suffered from COVID) or '*pamba peveCOVID-19*' (the home of the COVID-19 sufferers, *sic*). As infection cases soared and hope seemed to be lost, many people turned to religion (Bentzen, 2021; Mugari & Obioha, 2021). The genderedness of the pandemic became clear as women suffered both as caregivers for the sick and from Gender-based Violence

(GBV) (Manyonganise, 2022). As such, the deployment of sacred texts in Harare and beyond took centre-stage as women tried to make meaning of their situation. The study investigates the deployment of biblical texts by women as a strategy of taking care of their mental health. It endeavours to establish the many ways that religion becomes a useful resource in pandemic contexts particularly for the mental wellbeing of women in Zimbabwe. The key question to be answered in this study is: What are the gendered effects of the pandemic on mental health? The study is qualitative and it utilized in-depth interviews of Christian women in Harare's Central Business District (CBD). The African Womanist approach informs the study. This approach is useful in that it prioritises women's experiences and validates their voices (Manyonganise, 2023). The theory is important in understanding the experiences of Zimbabwean women during the pandemic and how the Bible became a key resource in their coping strategies. Heath (2006:160) avers that the use of the [African] womanist theory is critical in mental health research because it embodies the art of participatory witnessing and an ethic of caring which is based on the realization of the interconnectedness of a group's well-being. Hence, its relevance to this study is that it assists us to examine how women were able to affirm themselves through the recognition of how their faith was crucial in helping them to navigate a very difficult and scary pandemic. Thus, it is important to take an overview of the intersections of religion and mental health.

Religion and Mental Health: An Overview

Studies on mental health have shown the crucial role of religion (see Plante & Sharma, 2001; Koenig, 2009; Levin, 2010; Marashian & Esmaili, 2012; Dein, 2013; Jakovljevic, 2017; Patwa-Wojciechowska, Grzegorzewska and Wojciechowska, 2021). While earlier studies on religion and mental health had concluded that religious beliefs and practices led to hysteria, neurosis and psychotic delusions, recent studies have shown that religion may serve as a psychological and social resource for coping with stress (Koenig, 2009:283). The separation between religion and mental health that occurred in the 19th century was a result of scholars like Sigmund Freud who viewed religion as causing neurosis and hysteria, thus, a dangerous threat to individual psyches and to society (Levin, 2010:n.p). Therefore, from Freud's perspective, religion and science are moral enemies and any attempt at bridging the gap between them is bound to be futile (Levin, 2010:n.p).

However, negative attitudes towards religion in the field of psychiatry have significantly shifted in contemporary societies as people begin to recognize its positive effect in mental health. In threatening situations, Marashian and Esmaili (2012:1831) argue that behaviours such as trust in God, prayer, pilgrimage among others can lead to positive attitudes of hope and encouragement. In the same vein, Koenig (2009:283) posits that religion is a "powerful coping behaviour that enables people to make sense of suffering, provides control over the overwhelming forces of nature…and promotes social rules that facilitate communal living, cooperation and mutual support." In his analysis, religion provides spaces that can be deemed safe by those seeking good mental health. Levin (2010:n.p) opines that there is considerable evidence that one's religious life has something significant to say about one's mental health.

Levin's view (2010:n.p) implies that religion acts positively in the mental health of believers. In concurrence, Dein (2013:2) argues that religion can lead to positive coping through benevolent religious appraisals and religious forgiveness which are reflections of a good relationship with God and can result in improved mental health. Furthermore, Patwa-Wojciechowska, et al (2021) also attest to a close relationship between religion and mental health, though they note religion's negative impact on the same. They provide five positives that religion brings to the mental health discourse namely that religion can be an expressive outlet for present psychological problems and mental disorders, allow escape or soothe given life problems that underlie the disorders, inhibit symptoms and foster socialization, provide an opportunity to constructively cope with stress and problems, and contribute to the worsening of symptoms and development of disorders. In short, Patwa-Wojciechowska et al (2021) are arguing that religion plays a significant role in shaping an individual's active and adaptive ability to cope

with mental problems. For example, communities of faith provide structured support systems that help religious adherents deal with stressful situations. In Christianity, for example, church pastors are trained to offer pastoral care and counselling and journeying with the sick and bereaved. In their study of adolescent mental health, Estrada, et al, (2019:80) note the effectiveness of religious education in the mental health of adolescents. They argue that "religious education can be instrumental in improving adolescent mental health by developing religious morality, reinforcing religious coping, developing respect for religious diversity, and promoting connectedness."

Despite the positives, Dein (2013:1) points out that religion can also play a negative role in individual lives through inducing guilt and dependency. Hence, Jakovljevic (2017) interrogates the relation that exists between psychiatry and religion to establish whether the two concepts are opponents or collaborators. In his analysis, religion and psychiatry have had complicated, sometimes competitive and antagonistic relations over their long histories (Jakovljevic, 2017:S82). Patwa-Wojciechowska, et al (2021:n.p) note that the "negative religion-health relationship is especially visible with regard to schizophrenia due to similarities between religious experiences and psychotic episodes." In their analysis, religious involvement can become a risk factor in schizophrenia. In adolescents, religious moral beliefs' objections to suicide have been blamed for influencing suicide rates and attitudes towards suicide (Estrada, 2019:n.p). In such cases, religious beliefs would result in depression, obsession and anxiety.

Sacred texts that promote radicalism and fundamentalism can be detrimental to mental health. The same is true for religious discrimination where targeted populations feel excluded in what matters to them. For example, certain religions exclude women, youth, LGBTQI people and those that do not belong to their religions. Such practices can be fertile ground for negative mental health outcomes. Hence, Verhagen (2019:39) views the negative aspects of religion that undermine rather than boost mental health. In his analysis, religion has the ability to impede spiritual growth, induce fear and emotionally empty preoccupation with religious precepts thereby becoming a source of worry and a burden. In light of this, it becomes crucial to be aware of the ambivalence of religion in mental health even as the study seeks to establish how women utilized sacred texts for good mental health in a COVID-19 context in Zimbabwe.

Women and Mental Health in a COVID-19 Context

From December 2020 to mid-2022, the world grappled with the COVID-19 pandemic. Scholars have written about its advent and effects both globally and within their specific contexts which will not be repeated herein. This section discusses the impact of the pandemic on Zimbabwean women's mental health. At the onset of the pandemic, the impact of lockdowns on mental health was not adequately understood (Gloster et al, 2020). Semo and Frissa (2020) correctly note that the impact of COVID-19 in sub-Saharan Africa had not received enough attention at the time they wrote their article. However, as the pandemic continued, scholars began to focus on the pandemic's impact on mental health both globally and specifically focusing on Africa. As noted by Markiewicz-Gospudarek, et al (2022), the pandemic [put] at risk the health and life of people around the world due to the possibility of death and to the experience of an individual sense of danger. They further argue that COVID-19 can be associated with the onset of symptoms such as insomnia, depressive disorders, concentration disturbances, anxiety and memory loss. Al Dhaheri et al, (2021) aver that the magnitude of the pandemic had repercussions on human health and well-being which were coupled with psychological distress and related symptoms such as stress, panic and anxiety. At the onset of the pandemic, the World Health Organisation (WHO) had predicted that in the first year of the pandemic, Africa could witness about 44 million people infected and around 190000 deaths depending on intervention measures employed to curtail the spread of the virus (Semo & Frissa, 2020:16). Semo and Frissa (2020:716) argue that if the estimates of the WHO were correct, their prediction then was that the impact on mental health would be immense for sub-Saharan Africa due to the dilapidated health care systems. In their analysis, COVID-19 would result in health

problems among those with no prior mental health problems which could persist even after the pandemic was over.

Scholarship on gender and religion has shown the gendered effects of the pandemic. There is a way that COVID-19 affected women more than men. Smith (2019) cited in Eltayeb and Badri (2022) argues that the public health efforts and response have not addressed the gendered impacts of the pandemic. Manyonganise (2022) makes a disaggregation of the unique way that the pandemic affected women vis-a-vis men. Hence, it is clear that women's mental health when compared to that of men was greatly affected within the Zimbabwean context. The United Nations Population Fund (2020) noted that women bore a large brunt of the stress in the home and other impacts in general during the pandemic. For example, Manyonganise (2022) avers that in most African cultures, women are the face of care in homes and communities. In fact, women are the front line staff in terms of caring for the sick both in homes and in public health institutions. Hence, in a COVID-19 context, they were exposed to infection as a result of societal cultural expectations and the demands of their job if they were employed as doctors and nurses. Those employed as nurses suffered greatly from panic attacks, fear and anxiety if they were employed in government hospitals where personal protective equipment (PPE) was hard to come by. Such equipment was virtually absent in homes where care was necessary. Hence, women as primary care givers became exposed to infection. For Opanasenko, Lugova, Mon and Ivanko (2021:S20) "being a woman was one of the most common risk factors associated with increased risk of depression and anxiety, exposure to COVID-19 patients and fear of being infected." The fear of not only getting infected, but also losing loved ones impacted their mental health greatly.

The closure of businesses as a way of containing the spread of coronavirus had a great impact on women's sustenance of their livelihoods. Opanasenko et al (2021) and Manyonganise (2022) note the effect of the pandemic on women's economic activities. From the point of view of Opanasenko et al (2021),, women were greatly affected due to their socio-economic and humanitarian circumstances in various ways, namely, facing adverse consequences for their education, safety, health, income, nutrition and food security. Manyonganise (2022) highlighted that in Zimbabwe, women failed to feed their families. This negatively affects women's mental health as they worry over the lack of food in their households. In most African societies, Zimbabwe included, it is a woman's duty to make sure that families are fed enough food. Writing on Sudan, Eltayeb and Badri (2022) note that socially prescribed roles govern women's direct responsibility of sanitation, homeschooling, caring for the elderly, and the sewing of facial masks. For them, these demands in addition to economic hardships were associated with increased stress and adverse mental health.

The disruption of economic activities meant that women who relied more on informal trading had to rely on their husbands for sustenance. Opanasenko, et al (2021) aver that economic insecurity resulted in worsened dependence of women on their spouses or intimate partners. Within the Zimbabwean context, Manyonganise (2022) notes how some of the husbands who also rely on informal businesses found their masculinity challenged as they failed to provide for their families. Yet, society constructs them as sole providers within the home. Hence, she concluded that part of the reasons for increased violence cases against women had to do with challenged African masculinities. For Opanasenko et al (2021), sudden unemployment on the husband's side may render him unstable and temperamental which leads him to take his anger out on his spouse. Hence, apart from the direct impact of COVID-19 , women suffered from what has been termed a' shadow pandemic' (UN Women, n.d; Roy et al, 2021; Aborisade, 2022) which is gender-based violence (GBV). Keynejad (2023) opines that reasons for such violence include stress arising from economic impacts of COVID-19 restrictions, increased contact between partners living in close proximity, exacerbation of inequality between partners as a result of unemployment or responsibility for child care and homeschooling.

The fact that one of the critical responses to the virus was lockdowns and bans on travel, most women found themselves cornered at times with violent partners. Opanasenko, et al (2021)

note that intimate partner violence (IPV) offenders weaponized the anxiety and fear caused by COVID-19, thereby indirectly using it against their partners. In a lockdown context, Manyonganise (2022) notes that in Zimbabwe, women experienced psychological, physical, emotional, sexual and verbal violence specifically from men within their households. Due to lockdowns, women were forced to endure abuse within the confines of their home (Opanasenko et al, 2021; Manyonganise, 2022). The United Nations Population Fund (2020) notes that gender-based violence increased as a result of COVID-19 lockdown thereby making it challenging for women to have safe shelter and support. It is, therefore, not far from the truth to say that the pandemic disrupted social protective networks and impeded victims of domestic violence from seeking help and accessing protective community support (Opanasenko, Lugova, Mon and Ivanko, 2021; Keynejad, 2023). Manyonganise (2022) opines that lockdowns restricted intimate partner and domestic violence victims from seeking shelter in other people's homes. The enforcement of COVID-19 family bubbles meant that victims had to remain stuck with perpetrators of violence. Hence, women could not access social support from families, friends, social organisations and workmates. Barili, Gembi and Rosso (2021) note that lifestyle disruption is a strong predictor of deterioration in mental health. Thibaut & Van Wijngaarden-Cremers (2020, n.p) opine that in countries where lockdown was mandatory, it was later discovered that the home was not always safe space for women. In their analysis, "a lack of domestic and emotional support can have consequences on women's mental health" (2020:n.p). Opanasenko, Lugova, Mon and Ivanko (2021) argue that the stay at home order had the potential of exacerbating mental health conditions.

Furthermore, girls were at risk of being married off early as schools closed and families' livelihoods were threatened. Sexual violence increased against girls as schools were closed and they found themselves spending more time with men in their households and communities. Some of the girls would offer themselves to men so that they could get food or money to buy pads for their monthly periods. As noted by Opanasenko, et al (2021), writing on Bangladesh, the frequency of domestic violence was higher in regions which were struggling with the economic repercussions of COVID-19 pandemic. Hence, in their analysis, economic problems were a major contributing factor to the sharp rise in domestic violence cases of which sexual violence was a part. In such cases, the disaggregation of the impact of the pandemic on women's and man's mental health is imperative as it enables us to examine how they deployed religion to navigate this terrain. Commenting on Egypt and Morocco, Clavijo, Spinard, Henkens and Isamiddinova (2022) argue that certain household and employment-related factors, such as food insecurity and labour market participation, are associated with the difference in the self-reported mental well-being between women and men during the pandemic. The next section examines the deployment of sacred texts by some women in Zimbabwe as a way of safeguarding good mental health during the pandemic. The significance of such an analysis is to show that in crisis situations, religion becomes a powerful resource with which to navigate the negative mental health impacts.

Women, Biblical Texts and COVID-19 in Harare, Zimbabwe: In Search of Safety

In order to understand the deployment of sacred texts for good mental health in a COVID-19 context in Zimbabwe, I sought the views of ten women purposively sampled in Harare. The composition of the women included those that were infected and affected by the virus as well as those that suffered gender-based violence (GBV) within the confines of their homes. For ethical purposes, the women were coded WC1 to WC10 with WC standing for Women and COVID-19. In the interview questions, I sought to find out the ways in which the women's mental health was affected; if they were affected, whether they turned to religion; and if Christians, if they had specific biblical texts which they held onto for good mental health as well as how these texts were useful for this purpose. The following questions were posed to interviewees: i. What were the effects of COVID-19 on your mental health? ii. Did you turn to religion to overcome these effects? iii. If you are Christian, which biblical texts did you use? iv. In what way were these texts useful for your mental health? A number of themes emerged as data were analysed as shown below.

COVID-19 caused fear and anxiety which affected women's mental heath

Scholarship on COVID-19 notes how the pandemic resulted in people fearing for their lives. For example, Coelho, Suttiwan, Arato and Zsido (2020, p.3) as well as Ornell, Schuch, Sordi and Kessler (2020) note the many ways that COVID-19 caused fear, anxiety and an increase in stress levels. In this study, all the interviewed women were agreed that they were fearful and anxious of getting infected themselves and their loved ones. WC1 indicated that COVID-19 affected her mental health because she always had anxiety and fear for her family. She also constantly worried for her husband who had been sick before the onset of the pandemic in Zimbabwe. Her views were corroborated by WC2 who said

> COVID-19 affected my mental health in many ways. To begin with, when the whole 'drama' began, my daughter was away at college in Chinhoyi. It boggled my mind as to how she would be able to get home as lockdown had been put in place. When she finally told me that she was coming home, anxiety nearly got the better of me as I wondered how safe she was. She had to travel in public transport. What if she travelled with someone who had COVID-19? I kept calling her to remind her to sanitise her hands at intervals. When she got into Harare, she could not proceed to my work place so she went to stay with my friend for a whole three months. You can imagine what would go around in my mind. Everyday, with the COVID-19 cases rising, it was a living nightmare.

What WC2 brings to the fore is the fact that while COVID-19 pandemic was the source of fear and anxiety, the imposed lockdowns exacerbated the fear specifically in cases where family members were scattered around the country. Those that failed to travel in time to beat the lockdowns were left in the middle of nowhere while the virus was taking its toll on the population. The issue of distance was also echoed by WC6 whose daughter got infected by the virus while alone in South Africa. At the time that she was worrying about her daughter, her two sisters also got infected with the virus. She indicated that these incidences affected her greatly since she could not go to be with her sisters who were in Zimbabwe nor with her daughter in South Africa. She said she felt useless since she "could not be with them and could not help them especially my daughter who was in a foreign land."

COVID-19 caused feelings of insecurity and uncertainty

It also emerged from the interviews that the pandemic brought with it feelings of insecurity and uncertainty. WC4 indicated that because of the fear of infection, she did not go out of her home when the initial lockdown was announced. WC3 said

> I lived in fear of the unknown for at least three weeks after the announcement of the first lockdown. I was worried about the security of my children in the event that I fell ill or died being a divorcee. I was also unsure of my financial security – thinking every thing would eventually come to a standstill leaving me and my children in poverty.

What comes out clearly from the above interview is that fear of infection, death as well as loss of livelihood had its toll on women's mental health. The concerns of WC3 brings to the fore that the degree of the effect of COVID-19 on women's mental health could have been informed by their social status. For example, WC3 is a single mother taking care of her children. In such a case, she might have been affected in different ways from those with husbands as she feared that if she got infected and die from the virus, her children would be vulnerable financially. Since she is the breadwinner in this family, she feared the economic impact of the pandemic on her livelihood. As indicated by Salah, DeAngelis and al'Absi (2023:21470), there is a correlation between uncertainty and negative mental health outcomes during the COVID-19 pandemic. Chirumbolo, Callea and Urbini (2021) also show how COVID-19 exposed both formally and informally employed workers to job and income losses.

COVID-19 as torture

A number of women interviewed testified to the pain they felt when they lost their loved ones to COVID-19. WC2 constantly repeated the word 'torture' when narrating how she lost a number of relatives to COVID-19 within a week. She explained

> I lost relatives and friends. In particular, in a space of one week when the Delta variant hit. I lost my aunt and a week later, her husband died. My aunt had just been promoted in the education sector and I had jokingly told her *kuti zvangu zvanaka, ndave kuzokwirawo* ladder (My luck has come, I am now going to climb the ladder). Little did I know that she was going to succumb to the ravages of the pandemic. In that week, another blow dealt our family when my cousin also died. He had contributed immensely in my life and I was very fond of him. His death left our family devastated. In that same week, I again lost a close friend –such torture. With COVID-19, I failed to attend burials of these loved ones. We were not given opportunities to pay our last respects to them. They were given pauper burials. It's torture.

WC2 felt that COVID-19 had caused her torture by taking a number of her loved ones within the space of one week. She also unravels the nepotism in Zimbabwe's employment sector where one's upward mobility is determined by whom they know in positions of power. The promotion of her aunt had brought some hope for her, but the pandemic robbed her of this opportunity. What pains her more is the fact that she failed to attend any of her relatives and friend's burial as is expected culturally. Her failure to do so coupled with the way COVID-19 victims' bodies were treated at burial, leads her to conclude that they were buried as paupers. Manyonganise (2022, 2023) highlights the lack of closure for women in Zimbabwe as they failed to perform the burial rituals for their dead loved ones during the time of COVID-19. Experiences elsewhere have shown how the pandemic altered the death rites causing much pain to those seeking closure for the loss of their loved ones.

Stigmatisation as a result of COVID-19 infection

Some of the women suffered from the pain of being labelled and discriminated against as a result of having been infected and healed from the virus. WC7, WC8, WC9 and WC10 are survivors of COVID-19. While they narrate the pain they went through after getting infected, they also said that they suffered more when society, relatives and friends started to stigmatise them for having survived the infection. They all noted how they began to have labels stuck on them like '*vaya vakamborwara neCOVID*' (those that suffered from COVID) and '*pamba peveCOVID*' (the home that belongs to those of COVID). As a result, most people refrained from associating with them and their families. While physical distancing was meant to reduce the transmission of the virus, COVID-19 stigmatisation meant that the survivors were socially isolated which also affected their mental health.

WC10 explained that she began to have questions as to why she had gone through such an experience. Instead of receiving sympathy from those around her, she faced rejection and isolation. As a result, the four women indicated that they chose to stay within their own homes. WC8 indicated that she came to a point where she thought death was better than the treatment she got from her surrounding community, relatives and workmates. Even though she survived, they thought she needed to carry the tag of 'once infected' person. Her identity became closely linked to the COVID-19 pandemic. Hence, it was not easy for her to wriggle out of such perceptions or to face the public with courage. Such occurrences of stigmatization have been recorded in scholarship. Bagcchi (2020:782) explains how a COVID-19 survivor in Harare, Zimbabwe, was shocked when the road in front of his house was named as 'Corona Road' and some people opted to avoid the road fearing the possibilities of infection. Commenting on India, Bhanot, Singh, Verma and Sharad (2021, p.3) note that the infected were treated as "untouchables, receiving the humiliating taunts, and fingers pointed against them and their family."

COVID-19 and GBV

WC7 indicated that while hiding from COVID-19 infection at her home, she began to experience intimate partner violence (IPV). She was not surprised by this because her husband had always been violent even before the onset of the pandemic. However, most of the times, she had avoided direct confrontation with her husband by ensuring that before he came from

work, she would have gone to bed. COVID-19 induced lockdowns caused her to spend long hours of the day with her husband which made him irritable. Thus, she was physically, emotionally, psychologically and verbally abused. Her mental state became very unstable as she feared for her life every day. She could not defend herself in such a situation. Before COVID-19 regulations, she used to find refuge from the abuse of her husband in neighbour's homes and her parents' home. However, her neighbours could not open their homes in fear of infection. The lockdown made it impossible for her to travel to her parents' home since they live in a different location. Since she was not fitting within the government's definition of frontline staff, she would have been fined or imprisoned if she was seen by the police. As has been discussed above, during the COVID-19 pandemic, GBV has been described as a pandemic within a pandemic. This proves what scholars have already mentioned about the intersections of the pandemic and GBV (see Manyonganise, 2022; Opanasenko, et al, 2021).

The Bible as a resource to cope

All the women interviewed confirmed that they are Christians. Nine of them indicated that they turned to the Bible in order to cope with the effects of COVID-19 and for good mental health. It is interesting to note that the women relied on different biblical texts yet they all claim to have found safety and comfort. WC1 said she depended on Psalm 118:17 which says "I shall not die but live to declare the works of the Lord" (ESV) and John 14:13 which says "Whatever you ask in my name, I will do, that the Father may be glorified in the son." She explained that these Bible verses gave her courage and faith that COVID-19 was not going to destroy her family at all. WC2, WC7, WC8 and WC10 said they relied on Psalm 91 which stresses the need for believers to hide in God with the promise of perpetual protection as well as the granting of long life. Through this text, the women said they got the assurance that God would protect them from such deadly pandemics like COVID-19. WC7 used the text to find assurance that she would be protected from both COVID-19 and GBV.

WC3 depended on Jeremiah 2:11, Psalm 82:6, Matthew 6:26 and 17:20-21. For WC3, these biblical texts acted as a reminder that God is the "scope and not the events of this world." As such, her fear of death was taken away as she held on to these texts. In the same vein, WC6 counted on Psalm 50:15 and Jeremiah 3:33. She explained that the Psalm text gave her strength as she looked up to God's help while the Jeremiah text made her to understand that if she calls on God, he answers. In such a case, when she felt tired, she remembered that God neither sleeps nor slumbers. She, therefore, had the faith that God was going to watch over her loved ones and others as well. In her opinion, the Bible proved to be not only helpful, but also a companion. She explained that the Bible journeyed with her throughout the COVID-19 pandemic as she relied on it for strength and a pillar to lean on. Hence, the observation by Dessio et al (2004) that religious practices such as reading the Bible is one among other activities that are mostly used to cope with adverse health conditions is validated by these responses.

Total reliance on God through prayer

Nine women indicated that they used the Bible in conjunction with prayer. Prayer acted as a tool to communicate with the supernatural as they sought supernatural intervention against COVID-19. WC1 said when her mental health was bad, she did not seek professional help, but resorted to praying fervently with the support of intercessors who provided her with strength and more faith. WC4 belongs to a Christian tradition that does not read the Bible. While she did not name her church, she indicated that she resorted to prayer and prophecy only. Hence, when lockdown restrictions were relaxed, they would meet at their place of prayer (*Sowe*) to pray and wait for God to speak through the 'prophets'. After receiving the message, they would then use social media platforms to inform others of the specific instructions given concerning the pandemic. In her opinion, her faith took her through the pandemic. Scholarship on religion and health have highlighted the increase in religiosity during COVD-19 pandemic (see Kocak, 2021; Szalachowski & Tuszynska-Bogucka, 2021; Chataira, 2022).

Kocak (2021) notes that in Turkey, religious commitment increased satisfaction with life by reducing depression. Szalachowski and Tuszynska-Bogucka (2021) argue that prayer is a psycho resource. In their analysis, referring to the sacred sphere in situations of uncertainty or threat is quite evident mechanism and it is meant to deal with difficult circumstances that are beyond human capacity. In other words, prayer acts as a mollifying agent where worries, fears and anxieties are left in the care of invisible supernatural being, but with the hope and faith that this being will intervene on behalf of humanity. For those who believe in God acting in history, Szalachowski and Tuszynska-Bogucka (2021) argue that what matters is their strong faith in the prospect of God's aid in illness and its threat, and the transcendental activity of God in response to this faith. Hence, Stando, Piechnik-Czyz, Adamski and Fechner (2022) note that most findings on researches done so far confirm a significant positive influence of religion on strategies for coping with the anxiety and depression triggered by the COVID-19 pandemic.

Conclusion

The article examined the utilization of sacred texts during COVID-19 pandemic by women in Zimbabwe as a way of safeguarding their mental health. Hence, the study first engaged with the intersections of religion and mental health. In doing this, the study highlighted the ambivalence of religion in mental health discourses. It, therefore, becomes imperative that its deployment in mental health spheres be done with caution and aimed at making use of its positive aspects. The study also focused on the general impact of COVID-19 on mental health before zeroing in on the gendered nature of COVID-19 and mental health. A critical analysis of the responses given by interviewed women, leads us to draw a number of conclusions. First, COVID-19 caused fear and anxiety in women which ultimately affected their mental health. Second, lockdowns were a major source of this fear and anxiety as women could not visit their sick loved ones neither could they travel to other countries due to the closure of boarders. Third, most women who could not attend the funerals of their deceased loved ones still fail to find closure and felt as though COVID-19 was torturing them. Such pain can be present in their lives for a very long time. Fourth, COVID-19 lockdowns endangered the lives of women living with abusive husbands. Fifth, being infected with COVID-19 became a source of stigmatization, discrimination and isolation. Sixth, during the pandemic, most women turned to religion and in cases where they were Christians, the Bible came in handy in providing the much needed comfort, safety and reassurance.

Prayer also accompanied the deployment of biblical texts as women sought to strengthen their belief in the intervention of the supernatural against the pandemic. In such cases, religion positively influenced good mental health for the interviewed women. While the responses of the interviewed women are informative of the way sacred texts were deployed for good mental health during the pandemic, a larger sample can be more useful in also understanding how some women may have found the promises in sacred texts hollow specifically as their relatives succumbed to the disease in their droves. In addition, future research needs to also focus on other religions apart from Christianity in order to understand the utilization of sacred texts for good mental health in times of pandemics.

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