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Women Mental Health Illness and COVID-19 in Zimbabwe: A Gendered Perspective

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Abstract

It is not contested that women are pillars of African society and contribute significantly to the economy, leadership and stability of families. Such work sometimes makes them vulnerable. The emergence of COVID-19 not only resulted in the death of so many people but also exposed more challenges affecting women, adding to their vulnerability. During the pandemic, women were disproportionately affected more than their male counterparts. Besides celebrating women's resilience and their selfless sacrifices in caring for the sick, there is a need to address issues of women's mental health during and after COVID-19. In Zimbabwe, there are not many public and academic discourses about mental health illness. People who suffer from mental health illness are frowned upon, defamed, and even neglected. Besides the challenges of adequate demography of mental health patients and how mental health illness is gendered, affecting women more than men. This article explores responses to mental health illness and COVID-19 in Zimbabwe. The social recognition theory is used to understand women's behaviour leading to mental health illness after COVID-19. This paper uses social recognition theories to understand women's behaviour during and after COVID-19 that triggers mental health issues. Qualitatively, the paper uses desktop research to gather data. Besides finding out that there was an increase in mental health illness during COVID-19, mental health issues are complex and affected by cultural, religious and medical perspectives. Accordingly, this paper concludes that mental health issues are not yet prioritised in Zimbabwe. This paper recommends that double sustainable interventions and efforts be given to women to help them deal with mental health challenges, particularly during and after pandemics.

Keywords: COVID-19, mental health illness, gendered perspective, women, Zimbabwe.

Introduction

Mental health illness is a real challenge worldwide and among the topmost challenges in Africa (Sankoh, Sevailie & Weston, 2018). Most of the causes of mental health problems in Africa are linked to ill health and social challenges (Ministry of Health and Child Care, 2016). Mental health issues are uncommon in African public discussions (Bird et al., 2011). Zimbabwe comprises at least 1,3 million people suffering from diverse mental health illnesses (World Health Organization, 2018). The failure to adequately address mental health issues includes inadequate funds, understaffing and a lack of understanding about mental health (Runyowa, 2022). Most explanations about the sources and triggers of mental health illness are influenced by different factors, making the study of mental health interdisciplinary. Most scholars use a blanket summary of the sources and triggers of mental health illness. For instance, Arango et al. (2018) suggest that many factors that contribute to mental health illness comprise biological, psychological, and environmental factors. These facets may give the impression of conjoining or seldom as a distinct aspect. Mental health illness has diverse kinds and affects individuals differently. The sorts of severe ones are depression, anxiety,

schizophrenia, bipolar mood disorder, personality disorder and eating problems (Dogra, N., & Leighton, S. (2009). The problem is the existence of diverse intervention voices promising to cure mental health. Countless untold pain, ill health and stigmatisation are among the challenges faced within African society when they attempt to access mental health cures. Besides the failures and complexity of getting treatment, people have a poor understanding of mental health (Monteiro, 2015). In Zimbabwe, "the COVID-19 pandemic has brought a lot of challenges and disruptions to our lives. The livelihood of people has been affected, and the pandemic has taken a toll on people's mental and psychological health" (Egwu, 2021:1). According to the World Health Organisation Report (2018), a significant finding revealed that Zimbabwean health staff faced mental health issues and sensed the desire to be dealt with resulting from the economic meltdown faced by the country as well as COVID-19 challenges. Using desktop research, this article does not delve much into the nature of mental health but explores responses to mental health illness and COVID-19 in Zimbabwe.

Theoretical Framework

The study uses social recognition theories to understand and interpret women's mental health illness and COVID-19 in Zimbabwe. Social recognition theories are prominent within health contexts, mainly predicting behaviour (McEachan et al., 2011). Studies have successfully used social recognition theories to identify relevant processes that account for unique variance in behaviour during COVID-19 (Tong et al., 2021; Norman, Wilding and Conner, 2020). Social recognition theories assume individuals decide whether to engage in a target behaviour (Fishbein and Ajzen, 2010). Individuals' belief-based judgment informs their behaviour and actions (Bandura, 1986). The social recognition theories are helpful to this study because COVID-19 required behaviour change to manage the pandemic effectively (Michie et al., 2020). COVID-19 preventive measures included social distancing, wearing facial masks, avoiding large group gatherings, hand sanitisation, self-isolation and uptake of vaccines, rapid antigen testing and booster shots (Bar-On et al., 2021; Crozier et al., 2021). In this study, social recognition theories help to understand whether women perceive the risk of mental health challenges during and after COVID-19. According to Vandrevala et al. (2022), social recognition theories have been shown to have unique effects on intentions and behaviour.

Covid-19 and Women's Mental Health in Zimbabwe: A Gendered Phenomenon

Gender is a critical factor in both trying to understand and deal with mental issues in Zimbabwe. This article argues that problems concerning mental health affect males and females differently. Although both males and females are affected by mental health, women are affected more. Pattern et al. (2006) in Albert (2015) assert that the numbers showing gender differences in mental health are alarming. There is a general observation that some types of mental health are prominent in women or men. Accordingly, mental health-related symptoms such as depression and anxiety are prominent in women. Zimbabwean women tend to suffer from depression and anxiety (Chibanda et al., 2011). World Health Organisation (2005) argues that most women in Africa suffer from mental health due to forced marriages, forced abortions, in-law challenges and involuntary care tasks, which worsens mental health illness.

Stravropoulou and Samuels (2015) contend that while men are usually affected by substance abuse, the entire experience of mental health problems is suffered by women. Most issues are gendered, and women tend to be affected and suffer the most. Scholarship shows that poverty has been feminised (Ringson, 2019), and this study suggests the feminisation of the COVID-19 pandemic. In Zimbabwe, gender plays a critical role on how issues of health are handled. According to Gajendragad (2015), gender is stated to be discriminatory; for instance, there is a hegemonic tendency for men to rule over women in every area of life, such as economic and social matters. The social values and hierarchy militate against women, causing depression and anxiety (Nolen-Hoeksema, 2001). Thus, male dominance causes most

women in Africa to suffer depression and anxiety. Since depression and anxiety are triggers for mental health problems it follows therefore that women are living in a society that subjects them to mental health illness.

Further, in Zimbabwe, several women have low educational training, poor lifestyle, and no financial independence. Given the fact that Zimbabwe is predominately patriarchal, many females are subjected to abuse, leading to a more extraordinary occurrence of mental disorders. According to Abas and Broadland (1997), a male-controlled system in Zimbabwe has been linked to a greater rate of mental health illness in women since they cannot get official employment and stay in unhealthy circumstances. Furthermore, the country's economic meltdown is increasing mental health issues among individuals. According to the World Health Organisation (2002), women are lowly paid, leading to subjugation, which causes depression. In addition, women go through tedious life experiences, which include but are not limited to abuse, rape and caring for persons with contractible diseases. During the COVID-19 pandemic, women were exposed to challenging situations. According to Mutamiri (2021:4):

> The COVID-19 aftermath led to an increase on the importance of mental health and mental wellbeing. Mental health has become as important as physical health, thereby increasing the need for treatment, diagnosis, and intensive psychological care. Such rise in mental health issues can be attributed to such problems as economic depression, the rising cost of living, loss of income, unemployment, and the uncertain, slow recovery of economic systems from the post-COVID-19 pandemic.

Women often find themselves in risky living conditions and dangerous places of work, putting them in a life-threatening situation than men. The suffering of women has been seen in terms of doing double work within a day, such as household chores, looking after the children, farming, and any other activities that will bring food to the table. This reveals that women put more time into working than men, seeing that they are involved in different financial and domestic obligations, which could cause overtiredness or burnout, constant worry at the end of the day and depression because of working too hard.

Anatomy plays a significant contribution to the reasons why mental health illness is increasingly more prevalent in women than men in Zimbabwe. Hormonal imbalances are a trigger to depression and anxiety. According to Albert (2015), women experience hormonal imbalance, especially when menstruating, during pregnancy and menopause, which cannot be ignored as a potential trigger for mental health challenges. The interface of psychosocial issues with hormone concerns appear to end up in a more significant challenge for mental health. A comparison between girls and boys also shows that depression is more likely to be experienced by girls than boys. Hence, girls face depression, especially when they turn 13 years and older (Albert, 2015). A possible explanation is that this status quo is caused by an inferiority complex, moody, and feeling that their body is not good enough.

Mental Health Challenges in Zimbabwe after COVID-19

It is essential to explore responses to mental health illness and COVID-19 in Zimbabwe using the grey literature. According to Cassim (2020), medical practitioners feel that “the COVID-19 pandemic is a mental health time bomb that will soon explode with catastrophic results in Zimbabwe”. One reason cited is that Zimbabweans were afraid to contract the COVID-19 virus. Adding to the burden was the stigma around the disease. According to Mukwekwezeke, “we must realise that there is a psychological impact on patients if the duration between tests and results is so long” (Cassim, 2020). The health sector in Zimbabwe has an agenda to deal with mental health illness. The Zimbabwe mental health policy (2014-2018) has been revamped to prioritise mental health illness.

However, the Zimbabwean health system has been declining, and COVID-19 has worsened the situation. The decline of the healthcare system has pushed mental health to become a matter of secondary importance (Cassim, 2020). The other downside of medical intervention is the need for more health specialists. In Zimbabwe, mental health facilities are inadequate and poor in providing adequate patient management (Liang et al., 2016; Patel & Kleinman, 2003). According to Mangezi (2020:134), "Zimbabwe now has 17 registered psychiatrists with 13 practising in-country for a population of 15 million people. There are 0·1 doctors and 1·3 nurses per 1000 general population". Skilled mental health professionals are migrating to greener pastures with attractive working conditions (Refworld, 2009; Bonde, 2014). Mangezi and Chibanda (2010) assert that mental health nurses are offered training at Ingutsheni Hospital in Bulawayo; however, not many enrol for this course, as shown by the figure that merely 12 student nurses per year apply.

At large, there is excellent alarm of mentally ill patients in the community. There have been experiences of threats by people with mental challenges, and as such, this chases the mental health staff from the facilities. According to Krupa et al. (2009), the effect of rejection of mental health staff poses challenges as many people are neglected in and outside the facilities due to shortages of staff. Society has lacked backing from the government, and as such, after discharge, the patient is no longer their problem. However, taking psychiatry as a career proved difficult due to the lack of critical developmental programmes. According to Laing et al. (2016), mental health lay workers perceive that taking psychiatry as a career was fruitless since there were problems with growing and improving mental health. In addition, the motivational factor that could increase staff was being awarded hefty packages or the desire to assist due to one's family encountering mental sickness at home. Mental health is solely a top source of problems in Zimbabwe; however, several complications block many from getting help from mental health facilities. As such, many of the complications are the lack of health staff in mental facilities. To alleviate mental health staff, it is essential to have a society who are mentally well. Yet, it is crucial to understand that anyone can suffer from mental health.

An imperative way to ascertain the reasons health staff did not want to dedicate themselves to psychiatry was due to stigmatisation linked to the job. Additionally, the terror of mentally sick people, customary and ethnic viewpoints on what instigated the sickness and insignificant mental health programmes during learning also play a role. The matters of significance that surfaced were the necessity to remove shame from mental health specialists, informing the community on the reasons for mental sickness, revisiting the programmes on mental health educational facilities and intensifying safety for works.

Besides the stigma found in communities about mental health, hospitals in Zimbabwe are known to stigmatise patients with mental health by isolating them away from normal patients (Kalra, 2012). Such a statement by Kalra (2012) suggests an unfair practice conducted by health professionals and society towards mentally ill patients. So, mental health challenges need to be looked into to bridge the gap arising from stigma and bias. According to Chingono et al. (2022:1), healthcare workers experienced "anxiety and psychological distress during the COVID-19 pandemic," there is not much evidence to show interventions to increase the resilience and the mental health of healthcare workers. Further, Chingono et al. (2023:13) mentioned that other factors like "financial insecurity, unmet physical health needs and inability to provide quality care within minimal resources impede the mental well-being of healthcare workers". Other psychological pressures during COVID-19 were caused by the feeling of uncertainty, loss of hope, and depression (Pavari, 2022).

The empirical study by Kurevakwesu (2021: 712) concluded that "COVID-19 is affecting mental health services delivery and mental healthcare workers should find ways to continue offering quality services. This is against the reality that mental health services are affected at a time when they are needed the most". Zimbabwe launched a mental health investment case hosted by the Ministry of Health and Child Care in partnership with the World Health

Organisation and United Nations country teams (WHO, 2021). During the launch, the Vice President of Zimbabwe Constantine Chiwenga highlighted that "providing mental health services is essential to upholding human rights and scaling up cost-effective action is a priority for Zimbabwe"; the launch of this investment case will help to find out how to prioritise mental health illness. Other benefits of the launch include reducing social inequalities, protecting human rights, and improving the efficiency of mental health services in Zimbabwe. Scholars like Matsungo and Chopera (2020:210) recommend that "it remains the responsibility of the governments to create a supportive policy environment to enhance the physical and mental health of individuals in the context of COVID-19 pandemic, without also neglecting the potential risk of 'lockdown associated obesity' during lockdowns".

Strategies Used to Mitigate COVID-19 Challenges

The 'Friendship Bench' used a community-based approach to provide solutions to people struggling with mental health during COVID-19 (Egwu, 2021). The 'Friendship Bench' in Zimbabwe aims to lessen the impact of mental health symptoms. According to Chibanda et al. (2018), the friendship bench was designed as an approach for individuals showing signs of unsuccessful therapy, suicidal thoughts, or mental illness to be reassigned to mental health specialists. The friendship bench was created to afford either successful or unsuccessful treatment. The ushering in of Zimbabwean (friendship bench) is witnessed by non-professional trained health staff in giving counsel invention as a noteworthy improvement. Echoing the same notions, Bell and D'Zurilla (2009) state that friendship bench resolves critical issues combined with more successful problem-solving therapy interventions and support groups.

Talking therapy has been used as a method to deal with mental health issues during COVID-19. The 'Friendship Bench' invention was created in Zimbabwe, and its goal was to lessen therapy gaps for common mental disorders by delegating some work whilst utilising lay health workers Chibanda et al (2016). These trained non-professional workers would afford short sessions and one-on-one problem-solving therapy for people with common mental disorders, together with peer guidance. The friendship bench workers comprise trained older adults who use problem-solving therapy books and Shona symptom question papers to ascertain common mental disorders in the country's set-up involving diverse ethnic perceptions. The individuals undergo four stages in the sessions, and an extra group of supporting methods is called Kubatana Tose circles. The initial stage concentrates on accepting one's drawbacks, solving drawbacks, and comprehending. Group meetings are where individuals account for their experiences and simultaneously listen to others. According to Chibanda et al. (2017), the traditional problem-solving therapy models have been modified to Zimbabwean cultural aspects, for instance, the usage of native vocabulary and through a focus on significant challenges (HIV) associated concerns and stigmatisation. The reconstruction has eased the execution of the problem-solving therapy afforded by unqualified lay health workers. In this manner, friendship is affordable to low-income people, is an all-encompassing motivation, and appears bearable to most people in Zimbabwe. During COVID-19, the Friendship Bench went Online. It introduced an opportunity to access trained specialists called the "open liners" to provide free counselling for patients suffering from mental health illness via WhatsApp (Egwu, 2021). Further, the WhatsApp services are open from Monday to Friday, 8 am to 5 pm, and every patient has a session lasting between 30 minutes and one hour. More than 600 mental health patients received counselling.

The indigenous culture intertwined with the African Traditional religion has a long history of providing intervention for mental health in Zimbabwe. According to Pitorak et al. (2012), publicly or privately, Zimbabweans prefer going to traditional healers. In most cases, they would go to other interventions like medical later or simultaneously. Regardless of the popularity of medical intervention, most Zimbabweans live in rural areas where there are no medical institutions which specialise in mental health. Traditional healers are available and, in

some instances, cheaper for consultation. According to Lund (2018), traditional healers charge reasonably and are reachable. Besides accessibility and affordability, traditional healers may give explanations about mental health conditions in a way that resonates with the culture of Zimbabweans. Unlike the Western medical approach to mental health, traditional healers explain issues of mental health using Indigenous artefacts, ancestral spirits, vengeance spirits, bad luck and ornaments (Ventevoge et al., 2013).

In any society where the challenge of mental illness is experienced, particularly in the Shona context, for example, a person may be viewed as being witched due to jealousy. The family members engage in traditional assistance. Findings by Okpalauwaekwe et al. (2017) assert that customary and ethnic perception concerning mental sickness is a crucial experience that needs a decision on where the person would be taken for help. Many people trusted mystical origins and therapy regarding mental sickness and, as such, failed to acknowledge professional help for mental illness. Accordingly, Okpalauwaekwe et al. (2017) relate that mystical mental sickness was caused by evil forces that imparted misfortunes and witches. At the same time, the traditional belief that helping and working with mentally ill people could affect the person, resulting in the illness transferring to the mental health personnel, chases many pursuers from being mental health staff. However, this view tends to be supported by the idea that mental health staff experience behavioural transformation due to being in the presence of people with a mental health condition. It is worth noting that the research shows that people express the desire for a paranormal aspect to deal with mental illness.

According to Pavari (2022:240), during COVID-19, "the banning of gatherings of faith-based organisations deprived citizens of social and psychological supports at a time they were needed the most". Church had challenges in ministering to believers and those with mental health illnesses (Pavari, 2022). The pastoral letter from the Zimbabwe Catholics Bishops Conference urged the church to prioritise mental health training to help and offer counselling and psycho-social support to the effects of the COVID-19 pandemic (Nyangani, 2022). Further, the pastoral letter recommends that "traditional means of corporate worship and fellowship may have been affected, but there should be people equipped in every parish, small Christian communities and guilds to offer a listening and objective ear to the suffering" (Nyangani, 2022:1).

The contributions of the Christian religion to solutions to mental health issues cannot be underestimated. Although missionaries brought Christianity to Zimbabwe, it needs to be corrected to bundle them under one jacket. Missionary churches, whose mother churches and leadership are linked to the West, predominately believe that mental health can be treated using medical institutions. African Initiated churches that broke away from the mainline churches do not believe in medical solutions. Most of the African Initiated churches do not use medical institutions. A concerted effort is to encourage African Initiated churches to use medical facilities. African Pentecostals do not delve much into psychiatric interpretations such as schizophrenia, drug use, or psychological trauma. Predominantly, African Initiated churches believe that spiritual methods can treat mental health. Mental health is caused by angry spirits seeking vengeance (Makamure, 2017). Prophets and leaders in African Initiated churches prescribe prayer and fasting to chase away evil spirits, which cause mental health. Other artefacts commonly used include holy waters, oils, salt, small pebbles and eggs.

Like the African Initiated, Pentecostal churches believe that evil spirits cause mental health. New religious Pentecostals distinct from classic Pentecostals in Zimbabwe use a "coalition of religious artefacts between Neo-Pentecostalism and African Traditional Religion forming a new hybrid of African Pentecostalism in Zimbabwe" (Sande, 2017, 57). The causes of all health problems are evil spirits. This resonates with Biri and Manyonganise (2021,1), who argue that "while Pentecostals claim, "a complete break from the past", there have emerged new dimensions that show that the belief in witches and witchcraft is deeply entrenched among Pentecostals. It also brings the underlying aspects of the creativity and innovation informed

by African spiritual or metaphysical realities". Exorcisms and baptisms of the Holy Spirit are methods commonly used to deal with mental health. The link between mental health issues and demonic influences is difficult to interpret. African Pentecostals connect "beliefs and the importance of theodicy and help-seeking behaviour. Religion and help-seeking are connected by symptom recognition and cultural beliefs on the aetiology of illness and misfortune. For example, many people perceive their problems to be spiritual rather than mental; others look to religion as a means of understanding suffering and also a strongly beneficial way of coping with it" (Leavey, Loewenthal & King, 2017).

Conclusion

The emergence of COVID-19 has not only magnified the idea that the information about mental health issues is still lagging in many discourses in Zimbabwe but also that there is a stigma to persons with mental health illnesses. Mental health is gendered, and women tend to experience mental health challenges more than men, even during COVID-19. Several triggers for mental health affect women because of diverse conditions. Besides women's experiencing hormonal imbalance, especially when menstruating, pregnancy and menopause, which cannot be ignored as potential triggers for mental health challenges, there are other contributing factors. The health sector and churches have intervened to alleviate issues of mental health illness during COVID-19, but their efforts were not adequate. More needs to be done to protect the rights of people with mental health.

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