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COVID-19, gender and health: Recentring women in African indigenous health discourses in Zimbabwe for environmental conservation

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In precolonial Africa, women were the major authorities in herbal remedies within their own homes and at the community level, where they focused on disease prevention and cure. Such roles were pushed to the periphery of Africa's health discourse by the introduction of Western modes of healing. Furthermore, missionaries branded African indigenous medicine (AIM) as evil and categorised it within the sphere of witchcraft. However, the emergence of new diseases which conventional medicine has found difficult to cure seems to have caused Africans to rethink their position on AIM. For example, there appears to have been a resurgence of interest in utilising AIMs during the coronavirus disease 2019 (COVID-19) pandemic. Greater utilisation, while positive, may lead to herbs and plants becoming extinct if the harvesting is done haphazardly. Therefore, the intention of this article is to examine the intersections of gender and health in the COVID-19 context. The article seeks to establish the role that was and continues to be played by women in the utilisation of AIM within the context of COVID-19. The focus of the paper is on finding out the ways in which women are safeguarding plants and trees whose leaves, roots and barks are envisioned as effective in preventing infection as well as curing the disease. Data were gathered through informal interviews. Theoretically, the article makes use of gender and Afrocentricity as theories informing the study.

Contribution: The article highlights the need for placing women at the centre of both health and environmental discourses for sustainable development. It argues for the recentring of women in Earth discourses. Hence, its contribution is in retrieving women's voices in health and Earth discourses in Zimbabwe for sustainable development to be achieved.

Keywords: African indigenous medicine; COVID-19; environment; gender; healing; health; herbs; pandemic; plants; women; Zimbabwe.

Introduction

Scholarship on gender and the environment has noted the close connection between women's oppression in society as well as the careless exploitation of the environment. Renowned ecofeminist Warren (1990:125) argues that there are important connections – historical, experiential, symbolic, theoretical – between the domination of women and the domination of nature. From Warren's (1990) perspective, such an understanding is crucial to both feminism and environmental ethics. From her analysis:

> [*T*]he promise and power of ecological feminism is that it provides a distinctive framework both for reconceiving feminism and for developing an environmental ethic which takes seriously connections between the domination of women and the domination of nature. (p. 125)

In most cases, the environment is viewed through the prism of 'woman'. Hence, Hosseinnezhad (2017) posits that the environment is gendered in the way terms like 'mother nature', 'mother earth' and 'virgin land' are utilised. When describing the way the environment is overexploited, terms such as 'raping the land' are used. These are the same terms that are used when discussing sexual violence against women. Harris (2017) argues that:

> [*W*]hile conceptualizing the planet as 'mother', (feminization of the planet) can serve as a connecting point to the lives of women, there is also an eerie of familiarity to the structural nature of violence that the earth has faced (ecoviolence) and the structural forms of violence that black women have historically faced. (p. 7)

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Therefore, the United Nations (UN) Environment (2019:2) argues that understanding the gender–environment nexus is not only key to understanding social and environmental inequities and barriers to sustainable development but to unlocking options for transformative action as well. Hence, Ruether (1975) argues that:

> Women must see that there can be no liberation for them and no solution to the ecological crisis within a society whose fundamental model of relationships continues to be one of domination. They must unite the demands of the women's movement with those of the ecological movement to envision a radical reshaping of the basic socio-economic relations and the underlying values of this society. (p. 204)

Commenting on Ruether's analysis, Glazebrook (2002:14) explains that Ruether is calling for a unification of feminist and ecological interests in the vision of a society transformed from values of possession, conquest and accumulation to reciprocity, harmony and mutual interdependence. In the same vein, ecowomanist Harris (2017) argues for the deployment of ecowomanism in understanding issues to do with gender and the environment. For her, ecowomanism emphasises interdisciplinary, interreligious and intergenerational dialogue as approaches to environmental ethics. For her, ecowomanism validates the importance of the perspectives and contributions of women of African descent. It further acknowledges the connection between oppression and violence against black women to the oppression and domination of the environment (Karon 2020). The usefulness of ecowomanism lies in that it has its roots in African cosmologies and experiences by making black women's earth stories the starting point (Harris 2017:5).

In Africa, there is a unique way that women are connected to nature. Their experiences with menstruation equipped them with unique knowledge on how to explain the hidden meanings of the moon and cloud movement. Women use the phases of the moon to track their menstruation periods (Holbrook 2020:1). For Holbrook, the physical properties of the moon are often perceived as being connected also to women's fertility and pregnancy, which leads many African cultures to consider the moon to be female (2020:2). The position of the moon in each given month was/is and is perceived as communicating a message on how people must relate with Earth. Among the Shona, when a woman starts menstruating, it is described as *kuenda kumwedzi* [going to the moon]; if she fails to menstruate for a particular month, it is said that *adarika mwedzi* [she has skipped the moon]; on becoming pregnant, it is said that *atsika mwedzi* [she has stepped on the moon]. Commenting on the Pedi of South Africa, Holbrook (2020:3) observes that the moon and its phases have layers of meaning, some connected to women and others to life more generally. This ability to decipher the hidden meanings being conveyed by the moon, and at times the sun, explains why women were and are good weather and season forecasters. In a study carried out in Gutsa Village in Domboshava communal lands, Zimbabwe, Gutsa (2019) indicates that mostly elderly women and other community members use their stock of local knowledge to understand the weather and climate change. In his analysis, Gutsa concluded that the knowledge of the elderly women related to long-term weather and local climate is grounded in the historical and contemporary understanding of their environment. From the precolonial period to the present, rural women are able to interpret the meanings of bird sounds, the presence of certain birds and insects in a particular season, the direction of the wind and the smell from the forest, among other things. They could and still can predict whether there is going to be abundant rain or drought in a particular season through the analysis of certain indications from the environment. Furthermore, the sociocultural construction of women as primary caregivers and nurturers of children, the elderly and the sick causes whole communities to rely on them for, among other things, the provision of medicines from the wild. However, the discourse on women and the environment has focused so much on rural women in different contexts to an extent that urban women are left largely invisible. This study seeks to include urban women and show how urban women in Harare have been managing the environment even as they harvested medicinal herbs in the coronavirus 2019 (COVID-19) context. In this study, I contend that COVID-19 reawakened the desire and awareness for the need to preserve the ecosystem in case of such times as the one the world has found itself in because of the pandemic. Dankelman and Jansen (2010) contend that it is not enough to look at the position of women and the environment in isolation. In this case, the resurgence in the interest in African indigenous medicine (AIM) calls us to revisit discourses on not only gender and the environment but gender and health as well. The study attempts to locate women in the gender, health and environment nexus in a COVID-19 context as a way of establishing their contribution to sustainable development. Contributors to the volume *Mother Earth, mother Africa and African traditional religion* (2020) show the interconnectedness of gender, religion and the environment. It is hoped that this study deepens the understanding of this link by adding dimensions of health and sustainable development. For data, the study relied on informal interviews as well as online reports. The study focuses on women without implying that men were not traditional healers. For a long time, women's contribution to the development of their communities has been treated as invisible and their voices completely silenced. I envisage that this study contributes to making the role of women in their communities visible as well as retrieving women's voices. Theoretically, the study utilises gender as a category of analysis and acknowledges the influence of ecowomanism to the study's conceptualisation of the role of religion and gender to both health and the environment.

African indigenous medicine in precolonial Africa: Locating the role of women

Religion in precolonial Africa permeated all facets of life, including healing and health (Mbiti 1967). This can also be said of postcolonial Africa. Shoko (2016:1) posits that religion

and healing are intricately intertwined. Healing in African indigenous cultures was and continues to be a corporate matter involving the totality of the person, family and community (Olademo 2012:53). In precolonial Africa, women played critical roles in the health of their families as well as communities. Noel (2012:2) correctly notes 'the history of health and healing in Africa is one of social ties and family economics, emphasising the importance of kinship and community cooperation'. Indigenous health practitioners were put into two categories, the first of which was those who derived the trade from supernatural forces such as ancestors or from alien spirits such as *njuzu* [mermaid]. These among the Shona were termed *n'anga*. Cheater (1986) explains how women in precolonial Zimbabwe played:

> [*P*]ivotal roles as spirit-mediums and how they often used their possession by male spirits to escape their standardized female identity, or to make demands on their husbands for material goods and special treatment that are not part of their normal expectations. (p. 68)

The other category was those who just learn to be healers from observation and training. Most women belong to this category, and they derived herbal knowledge from their mothers and grandmothers. Most women were trained to harvest and use herbal medicine from an early age. They would observe and memorise the names and usage of the herbs from their mothers and grandmothers (Olademo 2012:59), as well as other female members of the community. In concurrence, Hosken (2015) highlights that:

> Traditionally, from an early age, girls learn from their mothers and grandmothers. They become ecologically literate, learning through practice in the gardens, fields and forests. (p. 23)

In this case, the significance of older women particularly in transferring medicinal knowledge in Shona society cannot be over-emphasised. Writing on South Africa, Mji (2019:78) notes that the traditional older women as healers seem never to have left the Mother Earth as the centre of their healing experience and practices. Therefore, they were and continue to be reservoirs of traditional healing methods that are compatible with environmental sustainability. According to Manyonganise and Museka (2020:68), in precolonial Africa, women played a key role in indigenous systems of environmental protection because for them, the environment guaranteed the existence of future generations.

As health providers, women were central in taking care of other women's maternal health, playing crucial roles in midwifery. Among the Shona, women with such skills were known as *nyamukuta.* In cases where the pregnancy was not wanted, they provided medication for abortion. There were also women who were experts in areas of ensuring that couples were faithful to each other. Such women would prescribe medicines that caused the man's manhood to disappear or fail to become erect if he wanted to cheat on his wife. This medicine is known as *runyoka* [central locking system] among the Shona. At times, *runyoka* would cause the cheating couple to fail to separate from each other after the sexual encounter. Love charms [*mupfuhwira*] were also given by women healers to women who wanted to safeguard their marriages. It is important to note that although male healers were also involved in the trade of *mupfuhwira*, the majority were women. A study carried out by Goebel (2002) identified more women than men who were involved in providing *mupfuhwira* to other women. The usage of *mupfuhwira* was mainly common in polygamous unions where wives would compete for the attention of the husband as well as in those marriages in which the husband was violent. Hence, *mupfuhwira* was used as a taming tool. Goebel (2002:462) argues that "the examination of the micro-relations of gender as expressed through the phenomenon of husband-taming herbs reveals that while marriage is the most important economic strategy available to women, it comes burdened with struggle and precariousness." She, however, views the use of *mupfuhwira* as an expression of women's agency. Chitando (2010) argues that in the present-day Zimbabwean society, *mupfuhwira* can act as a metaphor for transformative masculinities; hence, he encourages men to be what women intended to see in a man who had had *mupfuhwira* administered to him. While *mupfuhwira* was aimed at domesticating men, women endeavoured to sexually satisfy their husbands. Therefore, they shared knowledge on herbs that were useful in this regard. Certain herbs and barks were used for vaginal drying purposes in order to improve the sexual encounter. The woman's vagina was made tighter. A study carried out by Kadivirire (2014) shows that the practice is still rampant in contemporary Zimbabwe, and women engaged in the business of these medicines testified that most women do not hesitate to buy them. Such medicines are known as *mishonga yekupfeka* [medicines for insertion].

Provision of healthcare to children was also crucial in precolonial African societies. This was a responsibility that women had to carry primarily because socially they were, and continue to be, expected to care for and nurture children. Hence, from birth, a child was introduced to both preventive and curative herbal medicines. It was the duty of every mother to administer traditional medicine to their young children through premastication [*kutsengera*]. Zhao et al. (2018:1) posit that premastication or prechewing of foods or medicines before feeding to a child has been a common practice in human society. Various herbal medicines were harvested from the forest for this purpose among the Shona. Herbal medicines like *Karuparuramhanje, kahazvieri, karunyokadombo* and *mushwirikiti* were utilised to cure stomach problems in infants. Another herbal medicine called *karambadonhwe* dealt with hard cough in children, called *chipande*. In its preparation, *Karambadonhwe* was mixed with cooking oil for it to be effective. Some medicines were turned into amulets which were tied on the child's waist, wrist and ankles in order to ward off evil spells from enemies. Pelto, Zhang and Habicht (2010) report that abundant antimicrobials have been reported in maternal saliva, which might be helpful to protect infants from infectious diseases. In concurrence, Aaltonen and Tenevuo cited in Zhao et al. (2018) argue that through premastication, mothers transfer

oral microflora to infants, which might provide potential benefits.

Apart from curing and preventing disease among children, premastication was seen as useful for the social regulation of children's behaviour. Hence, a child who exhibited wayward behaviour was seen as not having received this treatment or enough of it from his or her mother. Hence, they were usually told '*Amai vako havana kukutsengera*' [Your mother did not premasticate for you] or '*Amai vako Havana kukutsengera zvakakwana*' [Your mother did not premasticate enough for you]. A study carried out by Pelto et al. (2010) established that premastication was a crucial behavioural adaptation process. It is evident that the role of the mother was central in the whole process of harvesting and administering the medicines to infants, the major reason being that children were always under the care of women who were their mothers, grandmothers and sisters. Furthermore, every child was expected to suffer from diseases like *gwirikwiti* [measles]. Hence, women made sure that areas in which medicines for such diseases grew were well kept. A child suffering from measles was bathed in water mixed with an herb called *ruredzo* [*Dicerocaryum zanguebarium*]. The herb was important as it aided the diseases to come out of the child's body, leading to a process of moulting [*kuvhunura*]. For disease prevention, certain herbs were burnt and crushed into powder. Excisions were then done on children's feet, back, palms and buttocks, and the powder was rubbed on these places. It was believed that the blood would then transport the medicine to different parts of the child's body. In contemporary society, such practices can be equated with the various vaccines that children receive from the point of birth. *Nhova* [fontanelle] was a feared illness that attacked infants. A sunken fontanelle required the services of an expert, who in most cases was a female traditional health practitioner. They would treat the child by rubbing a black powdered herbal paste on the fontanelle. The major cause of this disease was believed to be the work of witches. Hence, it was always advised that women with infants should seek the services of these experts before evil befell them.

Generally, Shona women were responsible for taking care of sacred places within their communities. They were and continue to be firewood and fruit gatherers in forests within their communities. Such activities ensured that women developed a close relationship with the flora and fauna in these places. Such relationships were of interdependence. The constant interaction between women and their natural environment led them to develop and enforce certain taboos which were meant for its protection. As they gathered firewood and fruits in the forests, women created spaces for negotiating their femininity as well as how to either subvert or reconfigure their relations with patriarchy. The forests were crucial in providing such 'free' spaces for women's interaction, sharing pain and joy as well as ideas. It was in such spaces that knowledge about herbal medicine for different purposes was shared. Writing on India, Gururani (2002) argues that:

> [*T*]he forest becomes a special place, saturated with meanings and memories, full of women's stories, in and through which gendered identities and gendered relations of work, company, competition and conjugal responsibilities were continually articulated and reconstituted. (p. 230)

Through their interaction in and with the forest, women shaped narratives of what it meant to be a good mother, responsible wife as well as acceptable member of society. Hence, Gururani (2002:230) avers that 'forests are arenas in and through which culturally specific notions of proper behavior, "good mothers" and "dutiful wives" and other such gendered attributes are constituted'. However, from Gururani's perspective, colonial processes and practices of power and knowledge have dismantled the fusion of nature and society, which has resulted in the continued shaping of new forms of nature, subjects, representations and identities. The next section therefore examines how the colonial period disrupted Shona women's relations with nature in as far as AIM is concerned.

African indigenous medicine in the colonial period in Zimbabwe: Decentring women

Colonialism moved Africans from their ancestral lands through the creation of reserves. The implication is that Africans were removed from areas whose sacred grooves they were acquainted with. The reserves were completely new areas for most Africans. For most women, colonialism detached them from an environment with which they were connected. Resettlement to new areas was not carried out in ways that would maintain one's kinship circle. In most cases, different ethnicities with different or conflicting cultural backgrounds were brought together. It therefore meant that it would take time for the displaced black people to become acquainted with the new environments and to connect to natural habitats. They needed to learn anew the names of herbs that grew in the new areas and their properties, as well as how to utilise them. The introduction of Christianity reinforced this detachment, as it was accompanied by the introduction of biomedicine. Noel (2012:6) elaborates on how missionaries used biomedicine to aid spiritual conversion. He further argues that biomedicine was used to promote the empire. Hence, the other reason for its introduction, apart from catering for Europeans in Africa, was to prove its superiority over African medicine as well as African modes of healing. In the process, they disregarded the African perspectives on kinship, as they viewed these as pagan. The Christian notions of the family were valorised over and above traditional ideologies of kinship (Vaughan cited in Noel 2012:2).

In order to entrench the use of Western medicine, missionaries had to demonise African indigenous health practitioners. Within the Zimbabwean context, Cavender (1988) notes that

the indigenous health practitioners were misnamed as 'witchdoctors' or 'witch-hunters'. Missionaries described them as agents of the devil. Accompanied by the introduction of legislation that outlawed their practice, the *Witchcraft Suppression Act (1899)*, the missionaries and the colonial government in Zimbabwe were able to control the field of health by ensuring that traditional practices of healing were thrown away. Noel (2012) argues that when colonialists labelled these popular healers as 'witchdoctors', they delegitimised a vital centripetal force in communities. This eroded the critical role of women, who were the majority of spiritual leaders as well as health practitioners. From Noel's analysis, the terminology was not only offensive, but it ignored the social roles that the indigenous healers occupied, both as physical healers as well as harmonisers who worked towards maintaining positive relationships (2012:6). Unfortunately, some African scholars continue to perpetuate the misnaming of certain African cultural practices. Machoko (2014:28), for example, describes *mupfuhwira* and *runyoka* as witchcraft practices. He avoids explaining the sociocultural function of these practices by adopting colonial descriptions. Such attitudes are indicative of the long way that Zimbabwe still has to travel until AIM is mainstreamed into the formal health systems.

I have indicated above how women were custodians of herbal knowledge for treating children as well as some elderly people. In order to counter these, mission hospitals introduced compulsory immunisation programmes against diseases such as polio and measles. The women who used to provide medicines for the prevention and cure of these diseases were the same ones who were being called upon to bring their children for immunisation. Furthermore, African women were the major recipients of the Christian message. What this means is that they were made to throw away the indigenous ways of healing by adopting the Western ones. Practices such as premastication were labelled as unhealthy and unclean. Their religiosocial as well as health significance were not considered. Pelto et al. (2010:6) note that the abandonment of premastication is reinforced by modern biomedical concepts of hygiene, which have labelled the practice 'unhygienic' and 'dangerous'. In addition, traditional amulets were substituted with buttons. Feierman (2000:317) argues that the central question that was asked about the African healing practices was how comparable they were to science. Scholarship on African history and religion has highlighted, however, that despite these spirited efforts, Africans continued to utilise their indigenous modes of healing, albeit in secret.

Furthermore, Christianity decentred women from utilising AIM for their own healing. The establishment of mission hospitals encouraged African Christians who converted to Christianity to seek healing in these hospitals. When African-initiated churches (AICs) were formed, one of the contention points was the monopolisation of healing by the colonial government through mission hospitals. Women who felt marginalised in mainline churches assumed their roles as healers and prophets in the newly formed churches. Their objects of healing shifted from AIM to new ones such as water, stones, prayer, cloths, milk, etc. These churches claimed that they had made a total break from the past; hence, they continued to demonise African traditional health practitioners and AIM.

African indigenous medicine in postcolonial Zimbabwe: Searching for the forgotten women

In postcolonial Zimbabwe, the government sought to formally recognise traditional medicine as well as traditional health practitioners. The formation of the Zimbabwe National Traditional Healers Association (ZINATHA) in 1980 (Cavender 1988; Chavunduka 1986; Patel 1995) and the enactment of the *Traditional Practitioners Council Act (TPCA)* in 1981 (Cavender 1988) should be understood in this context. The new government sought to deal with colonial legacies of discrimination and stigmatisation of indigenous modes of healing. This move was seen as a starting point for the integration of traditional medicine into the formal health system of the country. This had been the call by the World Health Organization (WHO) since the Alma Ata Declaration of 1978. The declaration intended to make healthcare available to the poor, thereby strengthening the idea of considering all alternatives such as traditional medicine to ensure that healthcare is accessed by all (Mutola, Pemunta & Ngo 2021). In this case, the TPCA made it a requirement that all traditional health practitioners be registered in order for their activities to be regulated. Most of these traditional health practitioners were also registered with ZINATHA.

The adoption of the Economic Structural Adjustment Programme led the government to cut its subsidies in a number of areas, including health, resulting in the cost of living going up. The cost of seeking healthcare forced many in the rural areas as well as the poor residing in towns to revert to traditional medicine. While the use of traditional medicine in Zimbabwe has been associated with rural areas, the cost of healthcare has seen an upsurge in its usage in urban areas as well. Shoko (2018) observes that Zimbabwe has been flooded with herbal medicine from China, India and Tanzania. The use of TianChi products became very popular, with marketing agents travelling throughout the country selling the herbal products. Women constitute the majority in this trade because of the fact that most of them are not formally employed because of historical gender imbalances within Zimbabwe's education system. Shoko (2018) notes the establishment of herbal gardens during this period, particularly in urban areas. Zimbabwe's rural areas have gone through considerable transformation. Firstly, overpopulation has led to wanton exploitation of land and natural resources. Areas once reserved for nonhuman species have been cleared for human habitation. Secondly, the resettlement programmes embarked upon by the government were not only chaotic but gendered as well. Manyonganise and Museka (2020) have shown how women were side-lined

in the process of the Fast Track Land Reform Programme (FTLRP). In their analysis, the silencing of women has resulted in the degradation of the environment. The desacralisation of the taboos, particularly in resettlement areas, has worsened the situation (Manyonganise & Museka 2020:73). Hence, women have remained largely invisible as they have been pushed to the margins on issues pertaining to land and the environment. They, however, noted that the government had, through the Ministry of Primary and Secondary Education, started a programme where it is putting in place 'culture' huts in primary schools. These huts are manned by retired female teachers. Manyonganise and Museka (2020) applauded this development as one that is giving women a voice as well as creating spaces for critical engagement between women as culture teachers and the younger generation. Such spaces were shown to be critical for inculcating positive environmental attitudes in young people. If young people treasure their natural environment, the implication is that the much-needed traditional medicines are readily available when pandemics erupt.

The COVID-19 pandemic occurred within a context where some people in Zimbabwe were already using foreign herbal treatments for various conditions. However, since these required money, it meant that those who could not afford were not catered for, hence, the resurgence in interest in local herbs. In the next section, I look at the role that women in Zimbabwe played in the distribution and administration of local herbal treatment both for the prevention and treatment of COVID-19.

Zimbabwe in a COVID-19 context: (Re)membering women as healers

The emergence and transmission of COVID-19 has been covered by many scholars (Manyonganise 2022; Murphy 2020; Rashid & Yadar 2020; eds. Sibanda, Muyambo & Chitando 2022). Its impact on Africa in general as well as Zimbabwe in particular continues to be researched and studied (Elbany & Elhenawy 2021; Lone & Ahmad 2020; Mashige et al. 2021). Some of the published works focus on gender and the pandemic. The major focus has been on how the pandemic has affected women in unique ways when compared with their male counterparts. For example, African women have continued to be constructed as carers and nurturers of households and communities, making them more vulnerable to infection. Manyonganise (2022) has highlighted the challenges of that social construction in a COVID-19 context. One of the challenges she highlights is that of physical distancing while at the same trying to fulfil the cultural duty of caring for the sick. Other scholars have focused on the increase of gender-based violence (GBV) during the pandemic to an extent that violence against women has been termed a 'shadow' and 'twin' pandemic during COVID-19 (see Blofield 2021; Dlamini 2021; Manyonganise 2022; Mittal & Singh 2020). In all this, women have been presented as victims, and yet, in Africa in general and Zimbabwe in particular, there are various ways in which women have expressed their agency in response to the pandemic. This study therefore challenges notions of women's perennial victimhood by acknowledging their agency in a pandemic situation such as COVID-19.

From the time that COVID-19 was confirmed to have landed on Zimbabwean soil, women reclaimed their close links with the natural environment. In order to understand women's agency in a COVID-19 context, I interviewed 10 women in a focus group discussion (FDG) with ages ranging from 35 to 70 years. The focus group comprised six urban women and four women who spend most of their time in their rural areas but visit Harare occasionally. For ethical reasons, these women were given codes ranging from W1 to W10. Questions were asked that were intended to establish the role women have been playing in response to COVID-19; how COVID-19 reconnected them with the environment; and how women can be capacitated to champion the conservation of the environment for sustainable development.

All the women in the FDG highlighted the fact that the burden to care for the sick lies with them. Although they also fear becoming infected, they felt that the government's rule that they should observe social distance is difficult to enforce. They felt that it is difficult to 'ignore' a family member who has been infected with the virus. While isolating the sick is possible, these women felt that they would have to show their love for an affected family member. It is even more challenging if the infected is one's husband. W3[1] narrated how after her husband got infected with the coronavirus, she felt that it was her duty to care for him. While it was expected from the WHO protocols that the husband be isolated, she only made sure that the children would not come into contact with her husband. However, she continued to sleep in the same room as her husband. As her husband was recovering, she became seriously sick with COVID-19. In her opinion, she only recovered because she could afford to have her personal doctor treat her from home and she also had oxygen cylinders. On being asked what they thought was wrong with the social distancing rule, all of them were agreed that although it is a noble requirement intended to minimise contact with the infected in a bid to save lives, for them, it is difficult to enforce in a context such as Zimbabwe. They argued that culture is the greatest impediment because it requires that the sick be taken care of. Isolating them is tantamount to neglecting them in their time of need. It would be difficult to deal with the consequences in the event that the sick loved one dies. The relatives would live with a guilty conscience all their lives. In a study carried out by Muyambo (2022:45) among the Ndau of Eastern Zimbabwe, the same sentiments were echoed. Muyambo's study was focused on finding out if social distancing does not violate the *ubuntu* ethics of care. In response, one of the traditional leaders interviewed, TL3, indicated that social distancing puts them in a serious dilemma because it is inhuman to abandon a sick loved one. Culturally, caring for the sick requires that they be close to the patient. Furthermore, Manyonganise (2022:238)

1.W3 is a 50-year-old woman who lives in Harare.

avers that in a context such as Zimbabwe, where women are expected to carry the burden of care, social distancing becomes a luxury. She asks pertinent questions that show social distancing as difficult to enforce, particularly for women.

In light of the above, I sought to find out how they navigated the terrain of social distancing. The women revealed that they felt nudged to ensure the safety of their families. When it was announced that modern science had failed to find a cure, for them it only became obvious that they had to look within. The women indicated that they resorted to traditional herbs for both prevention and cure. W4[2] indicated that she was infected with the virus during the pandemic's first wave in Zimbabwe. She visited the clinic and she tested positive for the virus. She was then told to go to the district hospital but failed to be admitted for various reasons. She was told to go back home. She says:

> *'Ipapo ndipo pandakaona rufu mumaziso angu. Ndaitadza kufema. Ndaisagona kufamba kwenhambo pfupi. Saka ndakatongoona kuti mishonga yechivanhu ndiyo yaigona kundibatsira. Saka mhuri yangu yakanditsvagira mishonga iyi sekunzwa kwavaiita paWhatsApp. Vaindipa zumbani, mufandichimuka, mashizha emutsvanzva, muguava, mugumtree nemimwewo. Uye ndainatira. Saka kubva ipapo, ndinokoshesa mishonga iyi.'* [Right there I saw death in my eyes. I had difficulty breathing. I could not walk even for a short distance. So I perceived that only traditional medicine could help me. So my family looked for these medicines following messages that were circulating on WhatsApp. They would give me zumbani, mufandichimuka, mutsvanzva, guava, eucalyptus leaves and many more. I also steamed. Since then, I hold these herbs in high esteem. (authors own translation)]

Most of the women agreed with W4. W9[3] added that some of her relatives also used *bute* [snuff] for the prevention of infection. Although they had not tested positive for the virus, they had used all the herbs mentioned by W4 for prevention. They had also administered these herbs to family members for the purpose of 'boosting' their immune system. In this regard, I sought to find out who was harvesting the herbs for these purposes. W6[4] indicated that both men and women were harvesting the herbs from the forest. She was, however, quick to indicate that more women looked for herbs for their families than men. This appeared to be true for women in Harare as well. Because Harare as an urban area has fewer wild forests and bushes, women scrambled for the few uninhabited spaces available in search of the herbs. The scramble meant that the urban people would harvest more than was necessary, thereby wantonly exploiting the available resources. W1[5] indicated that she depended on her mother in rural Murehwa to send the herbs to her through Kombi and bus drivers. W5[6] indicated that after the lifting of the first lockdown, her husband would bring various herbs from his workplace. On asking where he would have gotten them, she indicated that he would buy them from his female workmates. As time progressed, W8[7] and W2[8] indicated that supermarkets in Harare like OK and OK Mart, as well as other vegetable stores, were also selling the herbs. Some big companies realised the high demand for these herbs, and they quickly embarked on growing some of the herbs before processing them into tea leaves. Hence, more people were able to access the herbs. W7[9] said that apart from providing the herbs for her family, she started harvesting the herbs for sale in Rusape (an urban town in the east of Zimbabwe).

Critical issues come out of the responses of these women. For example, they highlight how the harvesting of the herbs became a gendered exercise. It was mostly women who went into the forests and bushes in both rural and urban centres to find the necessary herbs. Men in urban areas chose the path of buying from women at their workplaces. Even where men in the rural areas would bring the herbs home, they surrendered them to their wives or mothers to prepare before usage. This brings women to the centre of both harvesting and treatment processes. The other fact coming out has to do with the commercialisation of the herbs. The pandemic provided economic avenues for women. Those already formally employed grabbed the opportunity of earning extra income. However, some of the responses pertaining to the wanton exploitation of herbal plants, particularly in urban areas, raise serious concern. I therefore inquired from the women how they were dealing with this problem. They indicated that it was very difficult for them to enforce any regulations because they do not own the places where the herbal plants grow. However, they have been proactive in starting their own herbal gardens where they are planting indigenous herbs. For them, the domestication of indigenous herbs would ensure a constant supply as well as retention of the indigenous knowledge on health and healing. Once everyone can grow these herbs, it would also imply that interest in exploiting the herbal plants in the wild is lowered. It was also interesting to note that even those who live in rural areas have started the domestication of the herbal plants in their rural gardens. When asked about their reasons, they indicated that the rural forests are growing smaller as more people come to settle in their communities. Some people continue to use the bush system for relieving themselves, hence the need to ensure that they are harvesting the herbs from clean places. However, they indicated that unlike their urban counterparts, they can report perpetrators who cause unwarranted damage of the environment to the village heads, who can take the cases to the chief for further prosecution if offenders do not show remorse. This authority structure has gone a long way in ensuring the protection of the environment from uncontrolled exploitation.

Overall, I sought to find out if the women believe they have any role to play in conserving the environment in their

2.W4 is a 55-year-old woman from Gutu, in the south-east of Zimbabwe.

3.W9 is a 48-year-old woman who lives in Wedza, in the south-east of Zimbabwe.

4.W6 is a 70-year-old woman from Mhondoro Ngezi, in the south-west of Zimbabwe.

5.W1 is a 35-year-old woman who lives in Harare.

6.W5 is a 43-year-old woman who lives in Harare.

7.W8 is a 60-year-old woman who lives in Harare.

8.W2 is a 47-year-old woman who lives in Harare.

9.W7 is a 38-year-old woman who lives Nyanga, North East of Zimbabwe.

communities. All the women affirmed their significance in this regard. W6 said:

> *'Vakadzi takakosha zvikuru pabasa rekuchengetedza nharaunda. Isu hatiparadzi nekuti tinoziva kuti tichada zvinhu izvi mangwana zvakare. Sekuchengetedza kwatinoita mhuri dzedu, ndizvo zvimwezvo zvatinoita kunharaunda. Mukaona panguva ino yeCOVID, vakadzi vaitsvaga mishonga iyi nenzira kwadzo. Vaitanha mashizha vosiya hunde kuti miti yacho idenhere zvakare. Asi paidarika nevarume waigona kuona vatodzura nemiti yacho nekuti havana mutsa.'* [We women are very important in the duty of taking care of the environment. We don't destroy because we know we will need the same resources tomorrow. The same way we take care of our families is the same way we take care of the environment. If you look at the time of COVID, women used good ways of harvesting herbs. We would take the leaves and leave the stems intact so that more leaves can grow. Where men passed through, you could see that they had uprooted the plant because they lack patience. [author's own translation])

Most of the women agreed with W6 that there is a difference in the way women and men relate to the environment. W9 further said that even in cases where she wanted to take the roots of a plant, she did not uproot the plant completely, but would dig one side of it and take just a part of the roots in order for the plant to continue being alive. She, however, said that in most cases, she has seen men uprooting whole plants, arguing that more would grow. W5 said that ever since she started domesticating the herbs in her garden, her husband rarely checks on the plants. She tends to them alone. All this made the women argue that women are crucial in environmental conservation for sustainable development. From their analysis, COVID-19 has brought women to the centre of health and healing even in informal spaces. The resurgent use of AIM has fallen on the shoulders of women as well. For them, the COVID-19 context has called nations, particularly in Africa, to embrace inclusive health models where AIM is not treated as the alternative but as part of the centre. In doing this, countries like Zimbabwe can build on the work that women have already started so that depleted natural habitats can be restored. Tapping into women's knowledge of harvesting and domesticating wild plants can go a long way in reviving interest in the conservation of the environment for sustainable development.

Conclusion

The intention of this article was to show that COVID-19 did not only bring women to the centre of discourses on health and healing but also of discourses on the environment and sustainable development. In developing this argument, the article made a historical analysis of the role women played in the utilisation of AIM in precolonial Africa in general and Zimbabwe in particular. It argued that the cultural construction of women as carers and nurturers of households placed them at the centre of community and household health discourses. Such a role was disrupted by colonialism, which introduced not only new forms of health but a new religion as well. The demonisation of indigenous forms of health and healing was highlighted as contributing to the invisibilisation of African women, both in the utilisation of AIM as well as in formal health discourses. A postcolonial analysis showed that women continued to be invisible, mainly because the legal frameworks put in place to recognise AIM have largely remained on paper with little or no implementation. However, the article argued that COVID-19 has challenged patriarchal notions of health and healing as women deployed their agency in search of a solution to protect their families from infection. The resurgent demand for AIM in the face of no cure for COVID-19 saw women taking centre stage in both the harvesting and administration of treatment of patients and family members. Their skills in harvesting herbal medicine were shown to be crucial for environmental conservation, which can result in the realisation of sustainable development. The study envisages that bringing women to the centre of health and healing discourses in Zimbabwe in the COVID-19 context is sure to result in creating positive attitudes towards the health of the environment. Future research may require focus on how both urban and rural communities can create large projects for the domestication of the herbal medicines while at the same time ensuring that those in the wild are not wantonly exploited. The commercialisation of the herbal products has already shown that if done well, AIM can contribute to the African economies.

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