

Elderly women and COVID-19 vaccination in the indigenous religio-culture of the Ndaу of south-eastern Zimbabwe

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Coronavirus disease 2019 (COVID-19) is steadily becoming a tameable, mild communicable disease globally. In the Western countries and some countries in Asia, such as China, for example, this milestone is owed to a high response to vaccination programmes. The same cannot be said of Africa, where the uptake of vaccines has not been encouraging. In Zimbabwe, for example, the government had intended to vaccinate at least 10 million of its estimated 16 million population in order to reach herd immunity. The figures are still very small, indicating vaccine hesitancy. In this article, it is contended that vaccination campaigns must be adapted to local religious culture and engage critically with the elderly women in particular. Indigenous religio-cultural beliefs and practices can either mobilise or immobilise individuals and communities in implementing the COVID-19 containment measures, depending on how they are approached. To this end, any response to the pandemic should never be exclusively unidirectional. This article employs cultural hermeneutics as its lens of analysis. It does not only seek to promote life-giving values associated with elderly women in African religio-cultures but also to interrogate negative practices driven by religio-culture that put their lives at risk in the era of COVID-19. Elderly women are at worst vulnerable to the disease, and at best they are the hub of communities' health services. Packaging the vaccination campaigns in the religio-cultural and spiritual consciousness of a people has a potential to increase vaccine uptake in line with the spirit of Goal 3 of the United Nations Agenda 2030. This article is both theoretical and empirical. It uses the Ndaу of south-eastern Zimbabwe to ascertain the meaning that they create about the elderly women's interaction with the public health call for vaccination in the context of their religio-culture. The term 'religio-culture' has been used because throughout Africa, religion and culture are inseparably tied together. Data are generated through interviews with key informants.

Contributions: Elderly women are vulnerable to COVID-19. Despite their vulnerability, Ndaу elderly women find themselves compelled by their religio-culture to respond to the crisis in their communities. There is no literature that addresses the paradox and its attendant opportunities and challenges that characterise the circumstances of elderly women in the context of COVID-19 in the efforts to motivate vaccine uptake. The article shows that indigenous religio-cultural beliefs and practices can either mobilise or immobilise individuals and communities in taking the COVID-19 vaccines, depending on how they are approached.

Keywords: coronavirus; vaccination; vaccine hesitancy; elderly women; indigenous religio-cultural beliefs; cultural hermeneutics.

Introduction

Coronavirus disease 2019 (COVID-19) is steadily becoming a tameable, mild communicable disease globally. In the Western countries and some countries in Asia (China, for example), this milestone is owed to a high response to vaccination programmes. The same cannot be said of Africa, where the uptake of vaccines has not been encouraging. For example, Zimbabwe was one of the first countries to roll out a national COVID-19 vaccination programme in Africa (Murewanhema et al. 2021). The government had intended to vaccinate at least 10 million or 60% of its estimated 16 million populations in order to reach herd immunity by December 2021 (Murewanhema et al. 2022). The figures are still very small and were pegged at less than 5% of the population fully vaccinated by November 2021, indicating vaccine hesitancy. Murewanhema

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et al. (2021) opined that 'addressing vaccine hesitancy requires an understanding of its complexity, the key concerns people have and the context in which people make decisions about their health, healthcare and well-being'. This information is vital for informing public health interventions targeting the voluntarily unvaccinated. Religio-cultural beliefs and practices have not been emphasised in the public health interventions, yet these are among the drivers of vaccine hesitancy that are contextual and unique to specific populations. In this article, it is contended that vaccination campaigns must be adapted to local religio-culture and engage critically with the elderly in general and women in particular in order for the programme to be accepted and to increase vaccine acceptance.

The choice of elderly women in this discourse is not to be construed as an assumption that their male counterparts are irrelevant in mobilising for a wider COVID-19 vaccine coverage. Rather, it is motivated, firstly, by the observation that the politics of gender have once again emerged in responses to COVID-19. As Sibanda, Muyambo and Chitando (2022) observed, different settings in Africa mirrored pre-existing gender norms where, quite often, the faces of religion and politics responding to COVID-19 were mostly those of middle-aged to older men, with their women counterparts conspicuous by their absence. Secondly, as with any global crisis, women have been hardest hit by COVID-19 within the Zimbabwean context (Manyonganise 2022). Regardless, they have also shown a strong sense of commitment and resilience in their usual strong resolve in the face of crisis of the pandemic. Again, the elderly women are influential religio-cultural and spiritual leaders in most African societies in general and Ndaу communities in particular. Suffice to note that health matters among the Ndaу are a religio-cultural and spiritual issue that falls within the area of expertise of the senior and elderly women (Mapuranga 2010; Muyambo 2018). It is in light of this paradox of their circumstances where, regardless of their vulnerability to the pandemic, they find themselves compelled by their irresistible religio-cultural and spiritual standing to respond to the crisis in their communities that the article seeks to answer the following main question: how are the elderly women responding to the public health call for COVID-19 vaccination programme? The research questions are: what are the elderly women's views about COVID-19? What is the elderly women's conception of vaccination? What are the elderly women's initiatives within their health-world that can contribute towards increasing vaccine uptake in particular and COVID-19 containment efforts in general? Creating synergies between public health initiatives and elderly women's experiences with pandemics or epidemics from their contextual indigenous health-world could motivate vaccine uptake by locals. It is pertinent to note that indigenous religio-cultural beliefs and practices can either mobilise or immobilise individuals and communities in implementing the COVID-19 containment measures depending on how they are approached.

This article proceeds by discussing cultural hermeneutics. It defines the concepts 'elderly women', 'religion' and

'vaccination' to clarify the way they are used in the article. It also describes the geographical location of the researched community and offers the rationale for its selection. Then the methodology that is employed in the article is discussed, followed by the presentation of findings, discussion and finally, the conclusion.

Cultural hermeneutics

Cultural hermeneutics is a form of cultural analysis. It is therefore broad, as it can be applied to any culture. In this article, it is used as it is reflected from the perspective of two African women theologians, namely Odugoye (1995) and Kanyoro (2002). They developed it to provide an African feminist cultural response to patriarchy. It therefore aims to provide an accessible tool that can be used in the liberation journey of women from the oppression of patriarchy in Africa and beyond. Cultural hermeneutics operates within the larger framework of gender analysis that highlights patriarchal oppression and suffocation of women. The theory has largely been the thrust of the Circle of Concerned African Women Theologians (CIRCLE), founded by Odugoye. Cultural hermeneutics shuns romanticising culture. Rather, it is critical about culture, applauding the positives while deplored the negatives associated with it. As Kanyoro (2002:5) observed, the thrust of cultural hermeneutics is its emphasis on the necessity of coming to terms with identifying in our cultures the things that are beautiful, wholesome and life-affirming and to denounce those which deny life and wholeness. The analytic tool guides this article as it seeks not only to promote life-giving and life-enhancing values associated with elderly women in African cultures as they engage with the novel coronavirus but also to interrogate negative perceptions driven by culture that put their lives at risk in the era of COVID-19. Elderly women as a category are, at worst, vulnerable to the disease, and at best, they are the hub of communities' health services. It is this paradoxical situation of the elderly women in the context of COVID-19 and the gendered nature of the same that calls for delicate balance between accessing invaluable services from the group and at the same time being committed to ensuring that the group is safe through conscientisation. A careful packaging of the vaccination campaigns in the religio-cultural and spiritual consciousness of a people has a potential to increase vaccine uptake in line with the spirit of Goal 3 of the United Nations Sustainable Development Agenda 2030.

Elderly women

In the Western context, the term 'elderly' is ageist. Terms that are 'ageist' create a stereotype in which treatment is delivered differently on the basis of age. Like racism and sexism, ageism is conceived as prejudicial and therefore shapes perceptions that tend to diminish older adults (Avers & Brown 2011). 'Older adult' or 'older person' are alternative terms that are considered to be respectful. The United Nations Committee on Economic Social and Cultural Rights of Older Persons (1995) rejected the term 'elderly' in favour of the term 'older adults'. However, in this article, the term 'elderly'

is used contextually to refer to the aged among the Ndau. Terms and meanings attached to them differ from one cultural context to another. The variables of age, marital status and religious affiliation are mostly viewed from a Western point of view where they are often 'investigated as statistical variables without emphasising on their cultural significance in relation to the research problem' (Hlatywayo 2017:81). Among the Ndau, like many other African communities, ageing does not carry any negative stereotype. In fact, it is celebrated as a gift from the divine. Therefore, old age is sacred. For example, terms such as *musharukwa*, (an elderly man, in most cases the most senior male member of the family [Pfukwa 2001]) and *mbuya* (the eldest female member of the family) are statuses that denote ageing and are carried with pride and dignity by the bearers. So in this article, the elderly women refer to *anambuya* (old women in the Ndau community), who are approximately 65 years and above. *The US Medicare Strategy for Quality Assurance* volume 1 (1990) defines the 'elderly' as persons aged 65 years and older. The Ministry of Health and Childcare Zimbabwe defines the 'elderly' as persons who are 60 years and above (MoHCC 2020).

The elderly are considered a priority group in the Ministry of Health and Child Care Zimbabwe's COVID-19 vaccine deployment and roll-out plan. They were in the first phase stage 2, together with people with chronic illnesses, prison inmates and others in confined settlements (MoHCC 2020). As part of the campaigns to increase the uptake of the vaccine among the elderly, some newspapers carried stories about a remarkable response from the elderly population. For example, *The Herald* of 10 April 2021 carried the story: 'Think of others: Elderly people in Zimbabwe dispel scepticism on COVID-19 vaccine'. The setting was the capital, Harare, featuring the images of the elderly of the urban upmarket suburbs, some of them from the white community. The question that would ordinarily follow in the mind of the reader is: could it be the same story with the elderly in the rural communities and high-density suburbs in the urban areas?

Religion and vaccination

Admittedly, any attempt to define the phenomenon of religion has, since time immemorial, been elusive. This is so because the concept of religion is culture specific, flexible, non-normative and nonuniversal (Sibanda et al. 2022). The author concurs with Smart, quoted by Sharma (2011:49), who averred that 'often the vocabulary of a people simply reflects its own religious history and that is typically not good for describing other systems'. For instance, in this article, religioculture has been used to express the inseparability of religion and culture in most African societies (Odugboye 1995; Thomas 2015) and Ndau communities in particular. That being the case, the author adopts Smart's (1969) stance that seeks to shun any attempt at reaching a universally acceptable definition but rather conceives of religion as constitutive of seven dimensions. These are myths, rituals, doctrines, ethics, social, experiential and the political dimensions. These

dimensions are crucial in this article that addresses the interface of religio-cultural practices of elderly women and COVID-19 vaccination programmes. The dimensions characterise much of the religio-cultural practices of the said category as it responds to the pandemic.

Vaccination is a form of immunisation (Anderson et al. 2015). Vaccines help humans to control many types of infectious diseases by eliminating them, particularly among children. Immunisation is a World Health Organization (WHO) recommended preventive measure in both children and adults that is usually achieved through the inoculation of an individual with weakened or killed microorganisms such as bacteria or viruses (Anderson et al. 2015). The weakened 'pathogen stimulates the immune system into producing specific mediators that enable the host to generate an acquired immunity against the particular pathogen' (Elkalmi et al. 2021:1463). The effectiveness of a vaccination programme on a population centres on the number of people who received it (Elkalmi et al. 2021). Vaccination, in the light of the given discussion, is a biomedical approach that is promoted by public health.

The interface of religion and public health has not always been wholesome, not only in Africa but also in the Western countries, although the situation is much more serious in the former. The relationship is characterised by suspicion and mistrust, deriving from Africa's experiences of her colonial past. The biomedicines that are developed in the Western countries serve to exacerbate the mistrust, as they are often located in the discourse of the cruelty of colonisation and therefore conceived as intended to perpetuate the colonial agenda. However, this is not to suggest that there is no mutual cooperation through and through. With a robust mobilisation and conscientisation process, religio-culture can be a convenient resource that can deliver the much-needed outcomes, because religio-cultures shape the worldview of a people and dictate their health-seeking behaviours, whether positively or negatively. More importantly, religio-cultural leaders are 'very well placed to influence their constituents in matters relating to health' (Sibanda et al. 2022:9). They also have a big impact on the community's trust or lack thereof, comfort or anxiety associated with immunisation practices originating from the Western countries (Leach & Fairhead 2008 cited by Anderson et al. 2015:2). African communities in general and Ndau communities in particular view their elderly women and men as fountains and reservoirs of local knowledge and leadership. Above all, immunisation is not a new concept among the Ndau. More importantly, they have their own indigenous forms.

The immunisation processes reflect the religious, cultural and spiritual consciousness of the communities and fall within the area of expertise of elderly women. Chavunduka (1978, 1994) opined that traditional female health practitioners in Zimbabwe are in the majority as compared with their male counterparts. Thus, women are 'knowledge managers in health matters' (Judi 2006:3). In this regard, public health immunisation programmes must be conducted in a manner

that is consistent with cultural mores, traditions and constraints, lest they be resisted on the basis of religious, cultural and reproductive health-related fear, resulting in lower coverage rates than expected.

The Ndaу people

The present-day Ndaу people are found in the Chimanimani and Chipinge districts in the Manicaland province of Zimbabwe. They sprawl into the central and western parts of Mozambique (Dube 2017). Chipinge has seven Ndaу chiefdoms (Garahwa, Gwenzi, Mpungu, Mahenye, Mapungwana, Musikavanhu and Mutema) while Chimanimani has five chiefdoms (Chikukwa, Ndima, Mutambwa, Muusha and Ngorima) (Sithole 2018). The first six Chipinge and first five Chimanimani chiefdoms given here straddle the international border. Beach (1980:34 cited by Konyana 2018:52) said that the Ndaу are linked together by bonds of intermarriages between families of different totems, the distinct Ndaу dialect and the cultural beliefs and practices which they have always shared. Patricio (2011) and MacGonagle (2007) had also shown that for centuries the Ndaу have remained undisturbed by the border. They have maintained close links and are united in all spheres of social, economic and political lives, to the extent that they are identified as one large community that extends from one country to the other across the international boundary.

However, the Ndaу, like any other African ethnic groups, have experienced new dynamics in their Ndaуness owing to several socio-economic and political factors such as religion, intermarriages and migration. For example, firstly, the initial inception of Christianity among the Ndaу in Chimanimani and Chipinge created a dual society that embodied both the Christian and indigenous ways of life (Taringana & Nyambara 2018). Secondly, in the current Zimbabwean context where 'believers move from one religion/strand of religion to another in search of tangible benefits and spiritual succour', (Chitando 2018:16) it would be naïve and essentialist to talk of a pristine and static Ndaу community. Although many Ndaуs have converted to Christianity, most of them have not relinquished their connection with Ndaу religio-culture, to the extent that in moments of crises of life that do not find a satisfying solution from Christianity, COVID-19 being one of them, they resort to 'the foundation of their forefathers' (Mbiti 1969:258).

Methodology

This article is a combined theoretical and empirical qualitative phenomenological study based on the inductive research theory that treats reality or knowledge as subjective, attainable through interaction with the life-worlds of the researched community (Creswell 2003). The article employed a theological ethnography design because the author's quest was to access the meaning that the Ndaу of south-eastern Zimbabwe create about the elderly women's interaction with the public health call for vaccination in the context of their

religio-culture. Vigen and Scharen (2011) defined (theological) ethnography as:

[A] process of attentive study of, and learning from, people: their words, practices, traditions, experiences, memories, insight, in particular times and places in order to understand how they make meaning (cultural, religious, ethical) and what they can teach us about reality, truth, beauty, moral responsibility, relationships, the divine, etc. The aim is to understand what God, human relationships, and the world look like from their perspective-to take them seriously as a source of wisdom and to de-centre our own assumptions and evaluations. (p. 16)

The perspectives of respondents were accessed through physical in-depth interviews of purposively sampled elderly women, elderly men and senior women on the basis of the author's knowledge of the population that would produce the best information to address the purpose of the research. A tentative 35 participants, 20 elderly women, 5 elderly men and 10 senior women were sampled. While the focus of the research is primarily on elderly women, it was considered imperative to get the views of the elderly men about their female counterparts and those of the senior women, a category of women who work with the former. It was felt that these other two groups have important information about the elderly women's discharge of responsibilities. The sample comprised people who were known, by virtue of their age and status in the Ndaу society, to be involved in specific experiences related to community's indigenous health delivery system. The sample was later adjusted to 25 (15, 4 and 6, respectively) on the principle of saturation, the point when new data no longer brought additional insights to the research question. Merriam and Tisdell (2016) posited that qualitative researchers need to give a tentative number of respondents at the beginning and do research until they reach the saturation point.

Firstly, the author purposively sampled the religio-culture of the Ndaу people of south-eastern Zimbabwe because African religio-cultures are not monolithic. They are characterised by diversity, so any researcher needs to be specific when dealing with them to avoid the challenge of generalisation. Secondly, the Ndaу of chiefdoms Musikavanhu and Gwenzi were sampled on the basis of the author's geographical and cultural location. The author himself is Ndaу and is familiar with two sampled chiefdoms. Mack et al. (2005) asserted that researchers in qualitative research who possess a solid base of cultural awareness stand a better chance of gaining the consent of the researched communities than those without. The author was also aware of the potential of biases in the data of researchers working within their cultural setting. To guard against this risk, the author faithfully embraced the phenomenology of religion's methodological principle of *epoché* that prioritises the need to suspend preconceived ideas about the phenomena researched (Chitando 2010). All important ethical norms in qualitative research, including informed consent, confidentiality, privacy and anonymity were observed (Merriam & Tisdell 2016). The author also explained to the participants the reason they were chosen in the sample and why they were being requested to answer the

research questions and the voluntary nature of their participation. Research respondents were coded to ensure confidentiality. Alphanumeric codes instead of real names were used so that the respondents remained anonymous. For example, EW1 was used for elderly woman 1, EM1 for elderly man 1 and SW1 for senior woman 1, in that order. The elderly women and men were in the age group of 65 and above, while the senior women were in the 45 to 65 age group. The available literature on the Ndaū religio-culture and health was also consulted.

Findings

Awareness of the meaning of vaccination

The majority of the respondents were aware of the general meaning of vaccination as one of the forms of immunisation against epidemics. They have had prior experience with vaccines, including smallpox, BCG (bacillus Calmette-Guerin, a vaccine against tuberculosis), measles and chicken pox vaccines. They also had their indigenous ways of preventing the said epidemics. However, there were mixed feelings among the elderly women and senior women among the Ndaū regarding the public health's COVID-19 vaccination programme. The responses could be categorised basically in two groups. There were those who were very sceptical about the whole COVID-19 vaccination programme to the extent that they were not willing to participate, either through getting vaccinated themselves or mobilising community members to get the vaccine. There were also those who encouraged the young to get vaccinated, but they themselves were unwilling to get the jab. In short, vaccine hesitancy characterised all the responses across the categories given here. Nevertheless, the elderly women had trust in their own indigenous religio-cultural herbal therapies that operated as alternatives for the containment of the COVID-19 pandemic.

EW1 showed some depth in understanding of the purpose of a vaccine. She explained:

'The immunisation practices are not a new thing. They were there since time immemorial. They included *mutondoro* vaccine [*indigenised name for smallpox vaccine*], *rufuba* vaccine [*indigenised name for BCG*], *biripiri* vaccine [*measles vaccine*] and *manyembana* vaccine [*chicken pox vaccine*]. However, there was also the wide use of various preventive indigenous herbal therapies prepared by local experts with vast knowledge in healing, especially the elderly and senior women. These herbal therapies differ from one community to another and are not effective on their own. They owe their effectiveness to the spirit elders and alien spirits of the intended patients. The modern immunisation approach of vaccination where you are called to receive a jab – you do not know its source and its ingredients – is not easily acceptable in the Ndaū health-world.'

The views of the respondent show that vaccine hesitancy has always been experienced with vaccines that do not originate within the religio-cultural context of the receiving population. Thus, the views call for the vaccination programme to show sensitivity to the religio-cultural and spiritual worldview of the local communities to improve vaccine coverage in the

population. Despite the wealth of knowledge of the use and purpose of vaccines, she had no regret for her negative response to public health's call for vaccination. The author probed her further on whether they have employed these indigenous herbal preventive therapies in the wake of COVID-19 and the role of their male counterparts in response to the pandemic. She responded that:

'We never experienced serious cases of COVID-19 in our community. At any rate, it is very rare for adults and the elderly who partook of *shupa* [*ritualised herbal porridge*] in their infancy to be infected with diseases in general. *Shupa* is preventive; it cures and heals and guarantees strength of body. The processing of indigenous preventive herbal therapies requires depth of knowledge, special expertise and skill of experienced elderly women that men do not possess. Can a man grind at the grinding stone? Can he winnow, sieve and prepare porridge to the required viscosity? Above all, the herbal preventive therapies are characterised by a litany of taboos and prohibitions that suit well the elderly women. But this does not mean that men do not have a role to play in the whole process. They can be sent to fetch the herbs as well as cutting them to the required sizes.' (EW1)

The views of the respondent imply that the issue of gender among the Ndaū is fluid. Women and men complement each other for the good of the society. In fact, the herbal therapies are couched in deep religio-cultural beliefs that make them sacred and therefore inevitable religious duties that elderly women feel compelled to undertake for the good of the social group.

EW2 echoes the same views but went further to express the general resilience of the elderly women and some men in the face of the dreaded pandemic. She said:

'The type of food that we ate as we grew up built our strong immunity. Coupled with indigenous herbs and strategies, we are assured of higher chances of surviving the disease. The disease may infect us, but it will pass just like other respiratory diseases, such as general flu and colds. We do not panic because we have a strong immunity. We are concerned though about the situation of the young. That is why we are providing them with, and encouraging them to take, indigenous precautionary measures to protect them against the disease. Some of these precautionary measures include fibres of *muyembe* [*Annona senegalensis*] and charcoal that are very effective against infectious and communicable diseases that include tuberculosis, whooping cough and measles.'

Views about the COVID-19 vaccine

EM4 had this to say about the COVID-19 vaccination programme:

'[I question] why the vaccine is made mandatory for everyone yet there were lives that were lost needlessly countrywide because the deceased could not afford medical expenses for their various life threatening ailments. Why this sudden fuss about having everyone vaccinated, whether they like it or not, for a disease that we do not really understand? We would rather continue on the tried and tested indigenous remedies for respiratory diseases that include steaming, taking *mushani* concoction as a tea, *chibayamphondoro* foam, honey, ginger, garlic and lemon.'

The inconsistencies of the public health on whether the elderly should take the COVID-19 vaccine further justify our doubts about the whole vaccination programme.'

The views of the respondent show that, firstly, the whole vaccination programme was not adequately taken to the people, and secondly, the little that was done did not convey the message in the manner that reflects the people's indigenous health world.

EW8 said:

'I do not support the vaccines, especially for the young. We are told that those who take the vaccine would not live beyond five years. This means that the immortality of the lineage is under siege since the young are the ones who perpetuate the future of the same. We have hidden our young adult returnees from South Africa before when they were required to go into quarantine. We were afraid that they might be vaccinated while they were in quarantine camps and risk their future.'

There were those who encouraged the young to get vaccinated but they themselves were unwilling to get the jab citing old age. In short, vaccine hesitancy characterised all the responses across the categories given here.

EW7 expressed herself as follows:

'[First], I have confidence with the effectiveness of traditional preventive herbal medicines on the elderly and not the young of today who are exposed to junk food stuff. So the young may benefit from the vaccine. Second, the announcement by the government that its unvaccinated workers would lose their jobs means five of my children would lose their jobs, leading to their children dropping out of school. So taking the vaccine might safeguard their jobs. Third, in case the vaccine is effective, our children would survive the pandemic. The vaccine is not important for us, the elderly, who are in the twilight of their life.'

The respondent's second view for supporting the vaccine was for socio-economic reasons. She was in a dilemma with regard to the best way forward, especially after the government of Zimbabwe announced that unvaccinated government workers would risk losing their jobs. She could not imagine a situation where five of her children who are in the civil service would be laid off for failing to get vaccinated. This would imply that her grandchildren would drop out of school, as their parents would have become jobless and thrown into poverty. Thirdly, she employed the theory of the balance of probability that, in case the vaccine is genuine and effective, her children would survive the pandemic. As an octogenarian, the remaining part of her life was much shorter than the one covered, so much so that with or without the vaccine, death was beckoning anyway. The views of the respondent showed some sense of desperation. The encouragement for the young to take the vaccine was driven more by the fear of the possibility of losing employment rather than trust in the efficacy of the vaccine.

EW6 had a different view; she explained that the young are a very mobile population, owing to the nature of their jobs and the state of the national economy that compels them to reach far and wide in search of greener pastures. As a result, their chances of contracting the coronavirus were higher than those of the rural elderly, who spend most of their time in the countryside away from the urban centres that are the hotspots of the disease. However, she would not force anyone to get vaccinated; rather, she would leave it to the individual's discretion. She did not want to carry the blame in the event that one dies of vaccine-related complications, because this would attract the wrath of the spirit of the deceased upon her. She raised scepticism about getting vaccinated, citing old age that she felt might compromise the capacity of her immune system to cope with the vaccine. She would rather use indigenous preventive remedies that do not have side effects.

The author also gathered from SW5 that there were some people, including the elderly women, who were vaccinated but would not want their vaccination status to be known. This was said to be largely because of stigma associated with it. It is a commonly shared view in the researched community that those who received the vaccine would not last for the next five years. The stigma and fear derive from the conspiracy theories about the vaccine and generally the mistrust that people have for their government.

Discussion

There are three important broad themes emerging from the data that provide some answers to the research question that this article sought to answer. These broad themes are the resilience of the elderly women in the face of COVID-19 and their resistance to the vaccine despite their vulnerability, religio-cultural therapy as sacred duty to their community and the fluid nature of gender within the Ndau community.

Resilience of the elderly women in the face of COVID-19

Creative branding of COVID-19

Public health findings show that elderly people are vulnerable to COVID-19. They are among other vulnerable groups that include people with underlying health conditions, who are prioritised as an at-risk group that should ordinarily receive prompt access to COVID-19 vaccines (Murewanhema et al. 2021). Despite their vulnerability to COVID-19, the field data show that Ndau elderly women showed resilience through their creative branding of COVID-19 to reflect familiar communicable diseases. This avoidance of accepting COVID-19 as a new disease with a unique identity is a deliberate effort undergirded by the philosophy of refusing to name an anti-life force or trait. Naming has an effect of conferring recognition and respect on something. Magaisa (2019) observed that 'we can choose, very deliberately to not give a name to something because we disapprove of it or its conduct'. Admittedly, the whole thing may be considered counterproductive from the public health approach, but it

makes meaning from the respondents' religio-cultural experiences with diseases. So employing the prism of already known diseases to understand COVID-19 has the effect of watering down the anxiety that often accompanies the description of the disease as a 'pandemic' that the majority of Zimbabweans often use. A 'pandemic' assumes the presence of an epidemic experienced in several parts of the world at a given time. The sudden occurrence of pandemics often traumatises societies worldwide, and the first port of call for answers is associated with religion (Isiko 2020:78 cited by Humbe 2022:75). The description of 'pandemic', as Humbe (2022:74) rightly observes, has a 'paralysing rather than an energising effect on the people'. Therefore, elderly women's act of mobilising for the uptake of indigenous food and preventive herbal therapies boosts confidence, as it challenges and deflates the narrative of the disease as incurable. It sends the message that the disease is manageable and therefore deactivates the panic mode that is often engaged by the thought of the absence of a cure in any discourse on pandemics. The effort gives a tenacious hope to the community as it embraces a tried and tested religio-cultural response.

Vulnerability of the elderly women

The elderly women are vulnerable to the COVID-19 disease on two levels. Their age makes them vulnerable. They are also under pressure from 'irresistible' compulsive religio-cultural beliefs and practices that expect them to be at the thick of things because, by virtue of their experience, they represent the first line of care. Employing a cultural hermeneutical perspective, the cultural beliefs and practices that inform the participation of the elderly in risky healthcare issues need to be reviewed. Writing from a North American indigenous community context, Whitt (2022) posited that the '...Native communities understood that if we don't take steps to protect elders and perpetuate our knowledge systems, then we're going to experience even greater losses from this pandemic'. There is need for sustained effort, amid envisaged resistance, to tap the same wisdom to conscientise and protect the elderly among the Ndau in particular and African communities in general. The public health vaccination campaigns and any other initiative should therefore consider undertaking robust conscientisation and education programmes that target the elderly women.

Elderly women and religio-cultural therapy

Reframing the COVID-19 vaccination campaigns

The elderly women who prepare, administer and manage the indigenous religio-cultural herbal preventive therapy are placed in a very influential position in the society. Through their link with Mother Nature, they have a strong connection with their natural environment, which acquaints them with a mastery of indigenous herbal therapies. As a result, they preside over most of the religious rituals in the Ndau health-world. The elderly women's belief that the indigenous health

therapies owe their effectiveness to spirit elders explains their worry and fears about a COVID-19 vaccine originating from an unknown context that does not reflect their religio-cultural realities. So the campaigns must focus on reframing the COVID-19 vaccination in the religio-cultural beliefs that shape the community's health-world. This would have a net effect of motivating the integration of the COVID-19 vaccine and available indigenous religio-cultural beliefs and initiatives in the communities to boost its coverage on a population. In this regard, the COVID-19 vaccination should 'not just be a shot in the arm' (Anderson et al. 2015). A narrow focus on vaccines that negates other religio-cultural, social, political and economic dimensions of the pandemic can be an obstacle to vaccine acceptance. The methodology of public health research needs 'a religio-cultural epidemiological approach' where health determinant patterns are viewed from a scientific and religio-cultural context (Humbe 2022:75). This line of thinking finds support in the African Religious Health Assets Programme that identified, among other intangible religious assets, the 'religion's ability to motivate and mobilise communities in shared causes and engender compassion, purpose and hope' (Barmania & Reiss 2021:19).

Elderly women's concern for life

The elderly women's concern for the immortality of the lineage through the young constitutes a potential site for synergies with the public health drive to save life. The elderly women are propelled by strong emotional feelings of motherhood to take a leading role in employing indigenous responses to ensure that the life that they brought into the world is not only prolonged but also sustained (Muyambo 2018). It makes sense when understood from the conception of immortality in African worldview, where the aspects of motherhood, of creation of life and nurturing it, afford recess into the understanding of humans' relationship with ancestral spirits and God. God bestows a divine duty on the women to nourish, protect and guide children into the future (Hebblethwaite 1984 cited by Hansson 1996:51). This respect for life is further demonstrated by the elderly women's zeal and energies to participate in their trusted indigenous lived approaches to health. The implication here is that the elderly women have such a great respect for life that they are sceptical of implementing health remedies that do not speak to their lived realities. Public health approaches ought to build on the shared common goal through erasing the scepticism in a manner that encourages resonance with the lived realities of the Ndau. However, the ethic of care associated with women, beautiful as it may appear, falls prey to the essentialist critique that women's nature is to nurture. This has a tendency of essentialising the caretaking and nurturing traits that are assigned by patriarchy.

Fluid gender dynamics

Women and men as coworkers in human life

The elderly women portrayed a wholesome picture about the issue of gender dynamics in their response to pandemics that include COVID-19. Respondents indicated that men do not feature prominently in the fetching, preparation,

administration and management of indigenous disease preventive remedies, but they can be sometimes called upon to assist, especially in fetching the herbs. The interpretation given is that men lack the expertise in the area of primary healthcare, as this has been culturally understood as the women's domain. These views are construed as implying that the issue of gender among the Ndau is not rigid. Rather, it is fluid, and men and women are ready to complement each other for the good of the social group. Thus, women may call upon men to carry out a certain task where possible under the instructions of the elderly women. The conclusion that is drawn from this working partnership is that African women are not enemies of African men; rather, they are coworkers in human life (Muyambo 2018). This is succinctly expressed by Oduyoye's (1989) two-winged theology that emphasises partnership between men and women. The belief can be the starting point for public health vaccination campaigns targeting the elderly women with a view to getting their confidence that is important in influencing vaccine acceptance in communities. If their religio-cultural powers to give instructions even to men are exercised in the context of COVID-19 vaccination programme, they can become a crucial asset in efforts to shift the mindset of communities about the vaccine. Be that as it may, there is need to be wary about overburdening the elderly women. Elderly women's dominance in the area can be a result of men's avoidance of the labour-intensive tasks associated with indigenous primary healthcare; thus, they may assign it to women. Women in general have long been the slaves of culture. They are often subjected to oppressive practices that are justified as 'cultural' practices valued by the community and the women themselves (Woods 2014). Values of equality and dignity of humanity espoused in the human rights that would condemn the practices are jettisoned and rejected as alien to the cultural context. Culture is a powerful concept in society where there is often a successful use of 'cultural' defences in cases of patriarchal system's oppression of women (Woods 2014). Women would burden themselves with energy-draining and sometimes risky duties such as caring for the sick in the name of culture, while their male counterparts show little involvement, if any. Some research findings, for example, Vassallo et al. (2021) stress that sociocultural gender constructs disproportionately influence susceptibility to infection by the coronavirus that causes COVID-19 because of differing exposures to the disease, where frontline healthcare workers are predominantly women.

Gendered space of religio-cultural therapies

Elderly women are also particular about taboos and prohibitions that should characterise the preparation, administration and management of indigenous preventive herbal therapies. Such taboos favour postmenopausal women, disqualifying men from participating in the processes. The belief can be appropriated in a way that encourages the support of the elderly women in promoting vaccine acceptance. However, the belief and the attendant practices can be explained as a duty ascribed to them by patriarchy to advance its interests. There is a lurking

patriarchal interest of accepting this category of women because they have become 'men' and therefore cannot threaten men's monopoly of power (Sipeyiye 2020). Nonetheless, the involvement of elderly women in the awareness campaigns has a potential to build the confidence of this crucial age group, thereby capitalising on their influence in the communities to increase vaccine uptake. One organisation, Friendship Bench, reported success in its response to mental health challenges related to COVID-19 in Zimbabwe. It credited the success to the involvement of grandmothers in its programmes, because they are an asset in their communities on issues of health (NewZimbabwe 2021).

Conclusion

From the foregoing discussion, it emerged that the COVID-19 vaccination campaign programmes have not been reframed to reflect the religio-cultural realities of the Ndau to motivate vaccine uptake. Public health efforts must engage seriously with community opinion leaders, especially the elderly women who have been ignored in previous initiatives, with a view to finding some strategies of reframing the vaccination campaign communications in order to get the support of the community. They should therefore seek to understand religio-culture as 'a meaning-making framework' (Park 2005) of a society meant to respond to its existential needs and challenges. This realisation would enable them to package the vaccination campaigns in the religio-cultural and spiritual consciousness of the Ndau with a view to increasing vaccine uptake in line with the spirit of Goal 3 of the United Nations Sustainable Development Agenda 2030. This is important because indigenous religio-cultural beliefs and practices can either mobilise or immobilise individuals and communities in implementing the COVID-19 containment measures, depending on how they are approached. Conscientising of and collaborating with the elderly women, a key category among the Ndau, would go a long way in shifting negative perceptions about the COVID-19 vaccines that fuel vaccine hesitancy.

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