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CHALLENGES FACED BY WOMEN IN AREAS OF UNREST AT THE INITIAL STAGE OF COVID-19 OUTBREAK. FOCUS ON THE NORTHWEST REGION OF CAMEROON

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ABSTRACT

The aim of this study is to show the challenges faced by women living in areas of conflict during the initial stage of the covid-19 outbreak. The North West Region of Cameroon, specifically Bamenda, which is the region's main town, was chosen for this study because of the high intensity of social unrest which has contributed to the displacement of many women into this city. Due to the increased vulnerability in the suburbs and the different sorts of abuses experienced as a result of the unrest, many women were prompted to move from these suburbs to the central city for refuge. Living in such precarious conditions, many displaced women found it so challenging to put into practice the measures prescribed by the government to fight against Covid-19 as a result of the continuing conflict in the region. Furthermore, attitudes and practices toward the prevention of the spread of the coronavirus in this area were not easy to manage especially amongst women who were already exposed to hardship. With an already fragile healthcare system due to the prevailing fierce conflict that started in 2016, the outbreak of the COVID-19 pandemic just increased the burden of an already paralysed region. Faced with limited access to healthcare services and many controversies on the origin of the virus many people turn to alternative or complementary medicine for prevention and treatment. Alternative health care practices were carried out individually as well as collectively to prevent the spread of the pandemic in this area. Women in the North West Region, who are already living in a risky situation because of the social unrest, turn to indigenous methods to manage the outbreak and spread of COVID-19 in this area. Relying on indigenous knowledge about disease aetiology enabled them to provide diverse solutions to curb the spread of the pandemic in an environment already aggrieved by social unrest.

KEYWORDS: ***COVID-19, Health, Social Unrest, Pandemic, Women.***

1. INTRODUCTION

Every society has a way of demonstrating its plight, whether individually or collective. This usually stems either from frustration, disappointment, and disagreement, anger resulting from unmet needs, desire and relegation, which usually lead to conflict (Mayer B, 2000). However, conflict can be explained from three dimensions. Firstly conflict can be seen as perception that is, the conviction that one's own needs, wants, interests and values are discordant with that of another person and secondly it can be expressed as a feeling through anger, fear, sadness, worries and hopelessness while the third dimension suggest that conflict is expressed through actions which are usually carried out differently by the concerned (Mayer B, 2000). Be it in a developed or developing society, conflict through action usually leads to destruction and social unrest which appears to be correlated across both space and time, with regional waves of unrest such as the Arab uprisings or recent protests in Latin America appearing to be a relatively common phenomenon (Barrett et al 2000).

No matter the origin of the unrest as mentioned above, those who suffer disproportionately are usually women and children whereby the devastating implications of war have left many of them socially handicapped and psychologically disabled (Maina G, 2012). However it is critical to understand what the challenges are, and how they knit into other challenges that confront women in post-conflict societies, especially those challenges that are directly linked to their health (Maina G,2012). Also, women and girls have unique health needs but they are less likely to have access to quality health services, essential medicines and vaccines which end up posing serious threat to their health during a widespread health crisis (United Nations 2020).

It is absolutely vital that when we talk of a crisis, we understand how it affects communities and more so the ones already with increased vulnerabilities or marginalised characteristics (Sana M, et al 2020). During the second half of 2019, when the coronavirus broke out in China, Wuhan province, major protests and other forms of conflict were going on in locations as diverse as Bolivia, Chile, France, Hong Kong, India, Iraq, and Lebanon (Sana M,et al 2020). More than 37 countries experienced massive anti-government movements in the last few months of 2019 alone (ibid). Furthermore, over the course of 2019, anti-government protests occurred in 114 countries with 31 percent more than just a decade ago and in all of these, women are at the center of multiple discrimination especially refugees and internally displaced (Samuel et al 2020).

In Europe, one of the key concerns for women and women's health has been the questioning of essential services

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and what it constitutes in each administration, these raised several questions of equity within health and prioritisation of resources (Claire W 2020).

Unrests have not been limited only to particular countries or continent but the frequencies have been higher in some and less in others. For example, sub-Saharan Africa saw the largest increase in anti-government protests in the world, with annual protests increasing by 23.8 percent each year more than twice the global average of 11.5 percent (laurel W, 2020). In the midst of these uprising, the World Health Organisation (WHO) declared the first coronavirus case in Africa on February 2020 in Egypt and by 30th April, there were already 37393 confirmed cases in the whole of Africa and 1598 deaths. Though WHO declared it a global pandemic, it did not stop protesters from protesting (ONUFEMMES 2020).This seriously influenced the spread of Covid-19 and increased the burden of precarious communities in Africa especially women who were at the forefront of the battle against the pandemic and made up almost 70% of the health care workforce but under-represented in leadership and decision making processes in the health care sector (OECD, 2020). During crisis, women are more prone to risks due to gendered nature of the health workforce, which involves more women fighting the disease at the forefront and are also subjected to limiting work and economic opportunities (OECD, 2020). Protesters targeted health facilities even at the peak of the coronavirus pandemic, hence putting women more at risk, like the case in Libya, where a hospital treating COVID-19 patients was bombed in early April, and in May 2021 a maternity hospital in Afghanistan was attacked (United Union Women, 2021). Ongoing threats and experiences of violence such as these increased the burden of COVID-19 as individuals avoided accessing health facilities and seeking the medical care they desperately needed especially pregnant women and nursing mother (UN WOMEN, 2021).

In Cameroon, protest and social unrests have been frequent, though they were very recurrent in the 90s as a result of differences in political opinions (Delancy, M D et al), The most recent phase of discontent began in October 2016, when thousands of teachers and lawyers in the Anglophone regions took to the streets to protest what they termed a systematic marginalisation by the Cameroon government of jurist, who were only conversant with French civil laws and not the common law that applied to the Anglophone regions (Billy A, et al 2016). Also, teachers recruited by the government and deployed to the Anglophone regions were faulted for not being able to speak in English, since then, all efforts to bring the situation under control have been challenging to the government and some organization in charge with peace keeping and human rights, thereby leading to the creation of arm groups in this section of the country (Billy A, 2016).

Since after that period, there have been continuous fighting, indiscriminate torture, murder, arson of villages, and rape of women and young girls in this part of the country (ibid 2016). Three years into the conflict, the unpleasant face of the coronavirus pandemic took the stage. The first case of the coronavirus was confirmed in Cameroon on March 2020 and the number kept soaring. With this, Cameroon recorded the highest number of deaths from the pandemic in August 2020 than any African country with about 400 confirm cases of death from the virus, Cameroon remains the 10th most affected African country with the highest number of COVID-19 Cases in 2020 (International Crisis Group, 2020). Though many people did not believe in its existence, media sources like the Cameroon Radio and Television kept reporting high case fatality in major cities like Yaoundé, Douala and Baffousam which later spread to other regions including North West region with its prevalence in urban settings like Bamenda, which is one of the hotspots of the ongoing crisis in the Anglophone regions. (Nkansah, S N, 2019) This region recorded 1959 cases of coronavirus in March 2021 with an increase case fatality rate from 4.1% to 5.8% from these figures, one could say that Chronic vulnerability and structural suffering as a result of the ongoing crisis in this area imposed many challenges on the management of the coronavirus pandemic especially on women who were experiencing heightened level of insecurity at all levels (OCHA, 2020). These women had been grieved by economic hardship, distorted social structure and mistrust of information from the authorities and those around them even before the outbreak of the virus. However, the combined effect of the COVID-19 outbreak and the conflict had led to serious economic hardship on women who were struggling to catch-up from the effects of the conflict. This headed to other challenges like increased poverty, gender violence and food insecurity.

2. METHODOLOGY

A qualitative approach was used to conduct this study and the design was descriptive. It was carried out in Bamenda which is the capital city of the North West region.

2.1. Sampling procedure and sample size

To get the sample for this study, a sampling procedure was used. We tried to get respondent who have been displaced by the ongoing crisis from other parts of the Northwest region and were residing in Bamenda town. This was gotten through purposeful sampling, where participants were obtained through snowball sampling technique. Respondents such as nurses and doctors were also chosen through this method. With the help of purposive sampling, 15 males and 25 females' displaced persons were selected as respondents for the study. Five health workers were also chosen from the different health structures hosting COVID-19 patients.

2.2. Data collection procedure

For the purpose of this research, both primary and secondary data were collected. Secondary data were gotten from journals and books while primary data were gotten from respondent with the help of some data collection tools such as interview guide, observation guide, pens, paper, and recorder. The data was

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collected in 2020 when the corona virus was gaining ground in this region.

2.3. Method of data collection

In carrying out this research, different methods were used to get information from our respondents. Such as interviews and observations

2.3.1. Interview

Due to the pandemic and the ongoing crisis, a one on one interview method was used to collect data from respondents. This method was used to get information on people's perception of Covid-19 outbreak, how they managed the outbreak within the ongoing crisis and the challenges they faced.

2.3.2. Observation

This method was used to get information on the different practices carried out by these women. Where they searched for therapy and how they apply it. It was also used to get information on the types of activities they carry out to sustain their lives

3. RESULTS

3.1. Perceptions of covid-19

Beliefs and perceptions of ill-health are influenced by the socio-cultural context and indigenous healers, who form an alternative health service in many societies (Kahissay et al, 2017). Public health is an area that is particularly susceptible to disruption as a result of social unrest, and continuous unrest predisposes people to an inherent elevated risk of poor health outcome (Robert, 2018). However, the etiologies of health problems are perceived differently in all societies. Though origins of illnesses and diseases may be traced in social or spiritual realms according to anthropological perspectives, all cultures have disease theory systems which include ascription and concepts that explain causality (Ndenecho, 2011). However, some diseases are particularly embedded in the society in which they are found, they directly derive meanings which shape how society respond to those afflicted and influence the experience of that illness (Edjenguèlè, 2009). From the above statements one can say that strife and social unrests ease the spread and transmission of diseases especially among displaced women who have little or no access to information related to their health.

Examples can be drawn from the second cholera epidemic in the United States of America, where contagiousness was associated to recent immigrants and to African-Americans while in India, the British believed that it stemmed from the barbaric superstitions and traditions from Hindu pilgrim (Robert et al, 2020). This is the case with the current coronavirus pandemic. The causes of the COVID-19 pandemic have been socially constructed even though some research findings came up with claims that it was zoonotic jumps from animals (intermediate host) to humans. One can still consider that illnesses and diseases are socially constructed at the experiential level based on how persons and groups try to understand and live it. Scientific explanations still play a vital role in understanding their causes. Attempting to make sense of the causes of the coronavirus outbreak and trying to contain it within this period of social unrest in Bamenda many people perceived the cause of the outbreak differently. Sampling the opinions of the various respondents, we realized that these people have a wide variety of opinion related to the causes of the coronavirus pandemic outbreak.

We understood from our interviews that many people associated the COVID-19 to several layers of causality which exist and varies from supernatural, natural and social. Since Europe and America recorded the highest numbers of death cases during the first wave, some people thought the pandemic was a form of punishment in those parts of the world. During our discussion with some women in this area it was assumed that with advanced technology in the Western world and their inability to master and provide immediate treatment for COVID-19 indicated that the virus had a supernatural origin. Another factor that kept coming up during our focus group discussion with some women was the fact that many people had violated the law of nature turning away from God's original plan for man.

Men are getting married to men while women are getting married to women and abortion is being legalised in many countries which is considered a bad practice. Some people were of the opinion that the disease was fabricated in the laboratory by the Chines to gain control over the world's economy and became the next world power. While others believe they were indications that the world was coming to an end. This brought us to the different perspectives societies have about the causes of diseases. Though blame game for the causes of the pandemic was on China because it started there, many people still thougth that the pandemic was a weapon produced in the laboratory to weaken strong economic powers in the world. Still from the interviews, others believed that COVID-19 was a conspiracy by the Western World to reduce the population of the world and the vaccine they are producing is to cause sterility in women and young girls. This is the same with the fifth Cholera epidemic outbreak in Naples which the people thought it was a conspiracy theory by the government to reduce the population of the poor (Robert et al 2020).

3.2. The Influence of covid-19 on women's lifestyle

During the process of data collection, we observed that many women had been removed from their original environment to a new one as a result of the ongoing unrest. In this case, they found it hard to manage the outbreak of the coronavirus in their new location. They explained that the frustration they were experiencing by trying to adapt in a different environment as a result of the social unrest in this area and the COVID-19 outbreak had further changed their lifestyles. Women who were carrying out small business to sustain their families could no

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longer do it because of the pandemic. Some displaced women were at the battle front of taking care of their sick husbands in the hospital and providing care for the kids in the house. They said at one point they became sick and did not know whether they were attacked by coronavirus or malaria. Due to their pivot role in the family as caregivers most of these women did not have time to visit the hospital for checkup. Perceptions about the etiology of the pandemic were embedded within different realities experienced by women.

The drastic change of lifestyle as a result of the social unrest impacted negatively on women in such a way that they even perceive the COVID-19 to be less harmful as compared to the suffering they were experiencing due to the unrest. These women lived in areas with limited economic opportunities, poor accommodations and limited health facilities. In order for them to survive in this new environment, they need to come up with some coping strategies. During our stay on the field, we noticed that the most frequent coping strategy used by some women was transactional sex, even those with small businesses also used this coping strategy to enable them earn financial security.

This coping method however increased the risk of other disease transmission, unwanted pregnancies and unsafe abortion among adult women and young girls. The outbreak of the coronavirus and its controlled measures which included confinement, social and physical distancing as a means to limit its spread had a negative effect on these women. Those involved in transactional sex as a means to survive found it difficult to do so because of limited cash flow from their clients due to the health threat caused by coronavirus. Others, who indulged in small businesses just to make ends meet, saw the businesses crumbling because of limited goods flow as a result of closed borders. Women however stood high chances of contracting COVID-19 because of the gender role ascribed by the society to them as caregivers. In most cases they needed to fend for themselves and their families and, the situation was even very critical in female headed households.

3.3. Women's exposure and transmission of covid-19

Infectious disease prevalence can vary significantly between societies because of differences in culture, social structure, ecological setting, and historical context (Munyikwa, 2015). However, infectious diseases cannot be understood through biology alone but rather must be considered within the context of the cultural and social worlds they inhabit, nonetheless disease transmissions exist in an interactive model where the physical environment, human host, disease agents and sociocultural practices are taken into consideration (Munyikwa, 2015). During moments of unrest, women are more exposed to diseases outbreak because of limited resources. Apart from that, the frequency of women in the hospital is usually high, this is because they have more health needs which require regular checkups; if not for their children it will be for themselves and other members of the community. For example, pregnant women are supposed to attend anti-natal clinic every month and as the pregnancy comes to term, their visits are more regular.

With the advent of the coronavirus pandemic, most pregnant women disrupted their anti-natal follow up and some of them decided to deliver their children at a traditional birth attendants or at home where they thought the risk of contracting the virus will be low and the cost of delivery will also be small. At the initial stage of the outbreak, of COVID-19, there was little data on adverse pregnancy outcomes in pregnant women with COVID-19 but data from previous coronaviruses (SARS-CoV and MERS-CoV) suggests that pregnant women may be at higher risk of severe illness, morbidity, or mortality compared with the general population (Zarchi, 2020). As COVID-19 virus was still spreading, more infections in pregnant women were likely to be seen and COVID-19 infection in pregnant patients were said to have increased the risk of maternal mortality (Zarchi, 2020). We also realized that the fact that some informants did not believe in the existence of the virus, facilitated its spread. Such people were not serious in respecting the barrier measures put in place by the government (wearing of mask, washing of hands and keeping physical distancing) on the other side, since friendship and solidarity ties keep bringing people together either for fellowship, marriages, births or dead of love ones and continuous even during moments of strife, such people may be more vulnerable to COVID-19 than the rest as stated.

'I believe my mother contracted COVID-19 during my sister's traditional marriage. During the marriage, barrier measures were not followed; we just ignored the existence of COVID-19 and focused on the ceremony. Some few days after my mother fell sick but did not go to the hospital, when we saw the way she was coughing and complaining, that is when we realised it was COVID-19. We did not take her to the hospital immediately; we tried to redress the situation at home. When the situation was not improving, we decided to take her to the hospital. At the hospital, we were informed that her system had been destroyed by COVID-19. After some few days, she gave up the ghost.'(UMDIV, Age 37, Bamenda, May, 2021, 2pm).

In such encounters, most people probably forget about the silent killer (COVID-19) and went about shaking hands, embracing and speaking without wearing face mask. During moments of unrest in this area, there is usually high movement of people especially when there are sporadic gun shots. Women carried their children and moved from one part of the town to the other irrespective of their health situation, just to seek refuge. Most women run without putting on face mask while others shouted as they ran, thereby exposing themselves to the coronavirus through airborne transmission.

Airborne transmission is however different from droplet transmission as it refers to the presence of microbes within droplet nuclei. These nuclei are said to be particles that have the tendency to remain in the air for long periods of time, and be transmitted to others over distances greater than 1 meter. In this case, many people ran a high risk of contracting this virus during

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moments of unrest, especially when they were trying to escape from their perpetrators. The fact that they were yelling, screaming, chanting and exerting themselves, provided opportunities for the virus to spread (Apoorva, 2021). Those who were asymptomatic stood a high chance in the transmission of COVID-19. Since they did not manifest any signs or symptoms of the disease, they went about their activities without any measures.

3.4. The influence of conflict on health services within the context of covid-19

Conflicts usually keep populations in awful poverty, internally displaced or seeking asylum, they however have poor access to essential services and consequentially vulnerable to infectious diseases (Iheanyi, 2009). The ongoing social unrest in the Northwest region of Cameroon has helped to breakdown the already weak social services in most part of the area. It has also pushed service providers to abandon their duty posts and move to other towns for safety.

These sudden movements have drastically affected service provision both at the private and public levels. Even though other services have been affected as a result of the crisis, healthcare services have been the most affected segment, most especially the public health sector which is considered to be one of the driving force of Cameroon's health care system, whose core objectives are based on disease prevention as well as providing and improving health services to its population (Boniol et al, 2019). Some workers who left their duty post as a result of the unrest and could not live in other towns because of limited financial resources, had to seek employment in some private and public structures in Bamenda. We realised from our interviews that most of the jobs available were typically those of cleaning, guarding, baby-sitting and nursing, which were usually done by women and they earned very little salaries from these jobs.

At the level of healthcare, it was noticed that female staffs were at the center of in and outpatient services in hospitals, health centers and clinics. The majority of frontline healthcare professionals globally are women whose access to healthcare had been worsen by the pandemic (Boniol et al 2019). Even with little pay packages, female staffs put in much effort to provide health services to pregnant women and lactating mothers so as to help reduce their susceptibility to other diseases and sustain the already weak health system caused by the ongoing crisis. One of the ways that the state helped to mitigate the spread of COVID-19 within the ongoing crisis in this region was to provide three quarantine centers through the ministry of public health. The first one was situated at the general hospital, the second at the Bingo Baptist hospital Nkwen and the third at the District hospital in Nkwen, to enable stress-free access to health services for COVID-19 patients. Poverty, conflict, social norms and gender discrimination made women and girls more vulnerable to contracting COVID-19 and less likely to access critical services including general healthcare (Zarchi, 2020). From our analyses, we noticed that many women had less access to healthcare information because they were less empowered and did not trust the sources of information even when it was coming from the authorities. This is because of the discrimination and marginalisation they faced as a result of the on-going crisis. The coronavirus pandemic caused some health structures to lay off some of their worker while others imposed stay at home measures to some nurses who made up the majority of staffs in the health sector. These workers went without salaries for the period of time they stayed at home. On the other hand, medical personnels found it extremely hard to travel with test kits and vaccination for Coronavirus to other divisions as a result of the social unrest. They were afraid to travel to these areas because of the intermittent kidnaps and fire exchange between the military and the separatist fighters.

In areas where people had access to health care services, there were limited material resources like beds, oxygen, test kits and medication. Some patients even refused going to the hospital with the fear that they will be declared COVID-19 positive when they were not suffering from it. In March 2020, the World Health Organisation issued interim guidance for maintaining essential services during the outbreak, which was comprised of advice to priority services related to reproductive health and efforts to avert maternal and child morbidity and mortality (Medecien Sans Frontier, 2020). A research carried out in Likoni, Kenya, health centers where women normally deliver, were shut down and health workers reassigned to the COVID-19 crisis (Medecien Sans Frontier, 2020). This was the same with the prenatal/maternal integrated health center situated at Nkwen, which was destined for mother and child care but was later transformed into a quarantine center for COVID-19 patients.

3.5. Stigma and fear linked to the covid-19 pandemic

We noticed that, the unknown aspects about illness, creates fear, myths, and rumors that can help amplify social stigma. The outbreak of coronavirus disease in 2019 (COVID-19) created social stigma and discriminatory behavior towards individuals who were perceived to had any contact with the disease (Prama et al 2020). Generally, those tested positive for COVID-19 were quarantined or isolated for 14 days. Even when the illness ended up in dead, their families had no right over their corpses. This caused a serious disruption in cultural practices carried out during funerals. Rites of separation like the one done by majority of women who lose their husbands (widowhood rite) were also halted. It was observed that people became angry when the deaths of their relatives were attributed to COVID-19. This was because it was not going to follow the normal burial rites.

Those who died from the virus were buried by the council workers. One of the elites in this area specified that giving last respect to deceased family members was very important. According to the social and cultural practices of the people, family members and friends travel from different towns and countries to offer their last respect to the deceased and lend

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their support to the bereaved family. Women who are usually at the center of organisation during such moments to makes sure that there is enough to eat and drink were also very afraid not to contract the virus. Prayers and ritual practices are very essential during funerals. Some families usually take their corpses to church for prayers, believing that the deceased soul will gain eternity while others performed some ritual practices to send away the spirit of death from their families and to enable the soul rest in peace.

At the peak of the coronavirus outbreak, the corpses of those who died as a result of coronavirus were not given proper burial rites both traditionally and religiously. People were restricted from taking part in this burial ceremony to avoid contamination. This new burial style provoked tension and fear amongst people in this town. Some women believe the spirit of their deceased relatives especially their husbands might hunt them and cause more deaths in the family because they were not buried properly. Some said they were afraid to die during that period because their corpses will be buried by the city council workers and no one will be able to trace their graves, we noticed from our interview that most people did not take their illnesses to the hospital; they said the doctors related every illness to the coronavirus and were afraid theirs could be linked to the virus. It was noticed that some people were not even afraid of the virus but complained of the isolation or quarantine if they were declared positive. They believed that any person who was isolated will surely die since corpses of those who died as a result of the virus were confiscated and buried without the consent of the family. Some family members refused to accept that the council should bury their relatives claiming they did not die of COVID-19.

'***My uncle went for checkup at the St Mary hospital at Ntarikon. The nurses did some tests and asked him to stay in the hospital because he had coronavirus. After two days he died and the hospital staff refused to give us the corpse, they said it will be handed to the council for burial. When we insisted, they sent us out and locked their gate. We went to the quarter and explained to our neighbours. In less than 30 minutes there was a crowd at the hospital gate reclaiming the corpse of my uncle. The angry mob forced themselves in the hospital and got the matron well beaten and they released the corpse of my uncle'. (Izak, Male, 10/6/2020, 10 am,Bamenda).***

Some people assumed that the drama surrounding the coronavirus was too much especially in an area where people were already undergoing structural suffering as a result of social unrest. The COVID-19 pandemic also induced fear in frontline workers whose majority are women. Coming in contact with infected persons, pre-exposed many of them to the disease. This caused serious disruption in those families whose members work in hospital hosting COVID-19 patients. Survivors of COVID-19 found it difficult to integrate in the society especially women who lacked social protection and financial sustenance. Talking to some of them, we realized that they were really careful not to be contaminated the second time. Those who had not yet had the experience tried to keep away from them, thus limiting their freedom to interact in the society. One can say that COVID-19 outbreak has stimulated fear and segregation in an area already experiencing serious social, economic and psychological breakdown.

3.5. The challenges faced as a result of barrier measures

One can say that people carry out practices to prevent misfortune, disease outbreaks, illnesses and sufferings so as to stay safe. In some societies, biomedical healthcare services are equipped so as to manage any disease emergency. In Cameroon there are health measures put in place to give preventive treatment, which is usually done through vaccination campaigns. This does not stop families from preventing themselves and their children from the unknown by using complimentary treatment. From our interviews we understood that many people considered the coronavirus to be the unknown and those affected were the unfortunate ones.

We observed that the continuous lock down imposed by the separatist fighters before the coronavirus outbreak helped the inhabitants of this town to become accustomed with the issue of quarantine. While the government was thinking on how the lockdown will cripple the economy of the country and looking for ways to manage the issue, those in the affected regions (North West) were already familiar with the lockdown. Though the imposed lockdown had been detrimental to the psychological wellbeing of the inhabitants in this region especially women who have been internally displaced, it helped them to maintain social and physical distancing amongst them during the outbreak. Apart from this, another way of preventing the spread of the coronavirus had been through the wearing of face mask. Though the wearing of face mask had been understood as one of the most effective ways of preventing people from contracting the virus, accepting this new mode of life had been very difficult.

' I am tired of wearing the face mask. It is very uncomfortable to stay with it the whole day. It is something new to us and very difficult to adopt it as a lifestyle'.
(Tritia, Female, 15/6/2021, 5pm, Bamenda)

From observation on the field, it was perceived that many people were not putting on the face mask as required. Some people put it at the chest level and others put it under their chin or at the level of their mouths while others did not put it at all. Some women made me to understand that putting on the facial mask was not good for them because their husbands will not admire them any longer others said their facial make up will not last under the mask so they were not confortable wearing it. Some pregnant women complained that they were finding it difficult to breath with the mask thereby making them remove it frequently. Others said speaking under the face mask was so challenging because the conversation was not flowing, they had to speak loudly or shout.

Still, it was noticed that the separatist fighters refused to put on the face mask because the measures were coming from

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the government. This is because they are against any reforms made by the government in this region. According to information gotten from those in charge of maintaining law and order in the town, all those who were seen without face mask at their disposal were considered terrorists and were brought under the law. Those who were found with the mask under their nose were also penalised, culprits where imposed a fine of 6000fcfa and were given a receipt upon payment. This action put the separatist fighters and the law enforcement officers in constant disarray. People travelling from other towns into this town were expected to put on facial mask. If at the main check point travelers were found without it, they also paid a fine of 2000fcfa. Women with low income did not see the need of buying facial mask all the time, instead they choose to stitch several of them and kept changing each day. Those who could not stitch another one kept wearing the same mask all the time irrespective of its hygienic condition.

'***I was embarrassed when the law enforcement officers asked me to pay a sum of 2000fcfa, when I tried to find out what my crime was, they told me I was not putting on my face mask. I had the mask on my face but it did not cover my nose. They treated me like someone who did not have the mask at all'*** *(PAT KAFO, Female, 8/7/ 2020; 2pm)*

This respondent was surely coming from a town where the wearing of face mask was not as strict as in Bamenda. Feeling embarrassed showed that she was not taking the coronavirus threat serious.

3.6. Sorting therapy for covid-19

Healing practices usually go with the awareness and practices put forth by individuals and groups toward a disease. Also, therapy may be sorted individually or collectively depending on the availability of resources and the cultural beliefs and practices associated to the disease outbreak. Episodic and exceptional in nature, epidemics are a real-time crisis that compels immediate response (Kelly et al 2019). However, societies come up with different methods and ways of responding to them. Without any concrete treatment for the coronavirus at hand, many women here have sorted therapy within different healthcare systems. We noticed that most women focused on the use of alternative or complimentary medicine rather than biomedical prescriptions for the prevention and treatment of COVID-19.

3.7. Healing practices carried out to fight covid-19

Women who were already facing serious discrimination as a result of the breakdown of health systems caused by the current social unrest, had to look for alternative ways of providing health care for themselves and their families in this period of COVID-19 uncertainty. It was observed that in the absence of a concrete treatment, women in this area struggled to provide therapy for COVID-19 from indigenous knowledge.

Depending on the symptoms experienced by different people in this area, many healing practices were carried out to restore the health of those suffering from the pandemic. Healing practices for COVID-19 ranged from spiritual, dietary and herbal practices. During my interview with some Bamenda city dwellers, many women provided self-care for themselves and their families. They did this by taking items such as limes, ginger, onions, salt, hot water and other herbs or plants such as Artemisia, fever grass and Aleo vera plant. According to some respondent these items are usually used to treat malaria, cough and other respiratory tract infections. Since coronavirus is a respiratory tract infection they indulged in consuming these products indiscriminately without watching for the side effect. Also the fact that most patients notice some signs and symptoms of malaria, it cause them to use Artemisia plant to combat it. Women have been at the frontline in providing these products because of their high demand in the market. Many of the respondent said they got these preventive remedies from media sources and others were told by their relatives and friends.

Others decided to consume a combination of these items in hot water because they thought hot water will make the virus less active in the body. Some people decided to carry out vaporisation therapy where they inhale the vapour from hot water as often as possible to keep their body hot. Some of our respondent said, they heard from other people that the coronavirus manifested like malaria fever so they decided to carry out another form of prevention and healing known as vapour healing, where leaves from different fruit trees such as mango, pear, orange, pawpaw and guavas were harvested and boiled together and the patient was covered with a blanket, while under the blanket the pot containing the boiled leaves is open for the patient to inhale the vapour. They believe that the vapour from these leaves help to break down the malaria parasite in the body, which comes out through sweat. This method has been widely used in this area to provide healing to the coronavirus pandemic. Respondent exposed that this method of healing was usually done individually or collectively. The entire family carries out this practice once or twice a week since it was easy to get the materials needed for it.

Those who could not access the hospital especially in far off areas used this method as often as possible. This is very common in those areas where people have limited access to health care services as a result of the ongoing social unrest. Those who presumed these methods were not sufficient, decided to indulge in prayers and fasting. Faithfulls who thought the virus was sent by God, use prayers and fasting as a way of remedying the situation. Spiritual leaders kept encouraging their followers to pray without ceasing. Talking with some medical staff, it was noticed that hydroxychloroquinine drug, zinc and vitamin C were prescribed for those who tested positive and they were isolated to reduce the spread. Those with underlying health problems like diabetes, high blood pressure and cardiovascular diseases were requested to be more careful since they were more susceptible to the virus than people without such health problem.

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4. CONCLUSION

This article goes forth to show the challenges faced by women in areas of unrest at the initial stage of the covid-19 outbreak. The Northwest region of Cameroon was chosen because of the ongoing crisis plaguing the town. Though the conflict already had a direct impact on the well-being of these women, the presences of the covid-19 pandemic went a long way to worsen the risks. The presence of the pandemic helped to reinforce the concern of the separatist leaders who think every activity should be halted. The continuous look down and the outbreak of the pandemic actually limited women's access to sustainable livelihood activities. On the other hand the coronavirus outbreak was also used strategically by the government to reinforce it authority in this region and get hold of it by imposing strict measures to everybody with the separatist inclusive. Also, the frequent lockdowns enabled most women to turn to alternative or complimentary healing practices. This is because the resources were easy to access than those in the hospital. Turning to complimentary medicine enabled most families to better manage the pandemic.

This article also portrayed that even though women were living in precarious situation as a result of the unrest, and have been trying to pick up sustainable livelihood activities, the presences of the coronavirus seriously affected their efforts. Although the government struggled to provide suitable responses to the situation of Covid-19 and social unrest no responses were gear specifically to women who were more vulnerable at every stratum.

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