ACCESS TO SEXUAL REPRODUCTIVE HEALTH SERVICES BY WOMEN IN THE INFORMAL SECTOR IN ZIMBABWE: REFLECTIONS BASED ON THE EXPERIENCES OF THE COVID-19 PANDEMIC ERA

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Abstract

In 2019, the COVID-19 pandemic ravished the world. COVID-19 is linked to the same family of viruses as severe acute respiratory syndrome. Its symptoms included fever, cough, shortness of breath and, in severe cases, pneumonia and breathing difficulties. Like other pandemics, the spread of COVID-19 was rapid and quick. Many efforts, including lockdowns, were made to curb the spread of the virus. Normal essential service delivery came to a halt. However, the effects of the pandemic in African nations were expected to be more severe and draining than any in other continent because of their weak health systems. Africa is characterised largely by a weak health system and high prevalence of malnutrition, HIV&AIDS and malaria (WEFORUM, 2020). The COVID-19 pandemic resulted in the escalation of child marriages, teenage and unwanted pregnancies, high rates of sexual and gender-based violence (GBV), failure to access contraception, ARV treatment, sexually transmitted infections, unsafe abortions, and maternal and neonatal deaths. This study focuses on the effects of COVID-19 on the access to reproductive health services for women in the informal sector of Chipadze high density suburb of

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Bindura, Zimbabwe. The research adopts a mixed approach which encompasses both qualitative and quantitative techniques. The research adopts exploratory designs in answering the research questions. The sampling methods are also highlighted. Questionnaires and interviews were the research instruments. Ethics that guided the research are also highlighted.

Keywords: *health care, gender, disease, social effects*

INTRODUCTION

The novel coronavirus was detected in Wuhan, China in the year 2019 (WHO, 2020). There were no previous cases of human infection of this type of virus at the time. It was discovered that it was very severe and spread very quickly in human beings. In the year 2020, COVID-19 was declared a global pandemic. Africa was the last continent to be hit by the pandemic. However, the effects of the pandemic in African nations were very severe and more draining than any other continent because of the weak health systems. Africa is characterised largely by a weak health system and high prevalence of malnutrition, HIV&AIDS and malaria (WEFORUM, 2020). Due to the rapid spread of COVID-19, it was necessary for lockdowns to be put in place to contain its spread. This meant that everything had to come to a halt and people had to isolate themselves from each other for a period of time to minimise infections. In march 2020, Zimbabwe announced a total lockdown and everything came to a standstill, except for some essential services. The COVID-19 pandemic rapidly altered the programming landscape for sexual and reproductive health delivery. It strained the healthcare system even in the most developed countries of Europe. Girls and women had constantly faced significant barriers in accessing sexual and reproductive health information and services even before the pandemic (Plan International, 2020). The pandemic worsened their situation as these rights moved out of their reach during the lockdown. Frontline service delivery capacity was threatened since March 2020. A

growing number of reports from frontline service delivery organisations indicated that the supply and provision of contraception, abortion, post-abortion care and wider sexual health services had been heavily affected by COVID-19 (IPPF, 2020). The pandemic itself affected multiple service delivery channels.

In Zimbabwe and other countries, clinics were forced to close due to lack of medical personnel under strict lockdowns, hospitals were working under strict measures attending only to issues of emergencies and most were operating on reduced hours. Public hospitals were also in a crisis of having shortages of personal protective equipment (PPE) which was necessary as the virus could be spread easily . Women and girls were put in very compromising situations as some required monthly contraceptives, monthly check-ups pertaining to reproductive health. Some were also in compromised circumstances as some were in the lockdown with their abusers and were victims of sexual and gender-based violence (GBV). Unlike men, women constantly require medical check-ups, post exposure care, reproductive health education, contraceptives, abortions services and maternity health. The lockdown limited access to these services. Reproductive health issues, rights of women and issues of child marriages, teenage pregnancies, female genital mutilation and unplanned pregnancies began to increase.

In Zimbabwe the COVID-19 pandemic evolved against the backdrop of a difficult macroeconomic environment and climatic shocks. More crucially, the pandemic affected socio-economic and gender groups differently with women, children, poor households, persons with disabilities and people living with HIV and AIDS most adversely affected. Without urgent collective responses to address the social and economic impacts of the COVID-19 pandemic, suffering escalated, endangering lives and livelihoods (United Nations Zimbabwe, 2020). The Guttmacher Institute of Zimbabwe (2014) analyses that many obstacles prevent young Zimbabweans from acting on their desire to

postpone parenthood and stay HIV-free. As a result, protecting adolescents from unintended pregnancy and HIV infection by providing them with essential sexual and reproductive health information and services would be critical if Zimbabwe was to fulfil its long-term economic development goals. Supporting adolescents' needs would also bring the country closer to achieving two reproductive health-related Millennium Development Goals.

LITERATURE REVIEW

THEORETICAL FRAMEWORK

This study is guided by the Structuration Theory and the Health Belief Model (HBM), as a way of addressing the research questions. The Structuration Theory is a social theory that acknowledges the establishment of a social framework that is fixated on both its operators and structure. This theory was propounded by Giddens (1984), who notes the link between elements in the social system. For this study, this theory reverberates and highlights the perpetuation of the vulnerability of women and their sexual reproductive health. It is a concern and reality that the COVID-19 pandemic changed and shaped the daily living of people across the globe both in the formal or informal sector.

The HBM was developed during the 1950s in the US Public Health Service, as a model to understand why people fail to adopt disease prevention methods or screening tests for early disease detection. According to Champion and Skinner (2008), this model highlights the behaviour of an individual's socio-demographic characteristics, attitudes and knowledge. The HBM suggests that individuals will take action to prevent illness if they believe they are susceptible, if the consequences of the illness are severe and if the benefits of action outweigh the costs (*ibid.*). According to Koyama *et al*. (2009), young people and women are the most vulnerable groups with regards to

results such as unintended pregnancies and sexually transmitted infections as result of their propensity to engage in risky sexual behaviours. The HBM highlights that one of the predictors of sexual behaviour is an individual's perceived susceptibility to negative consequences such as unintended pregnancies or sexually transmitted infections

AN OVERVIEW OF SEXUAL AND REPRODUCTIVE HEALTH

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. Sexual reproductive health is at the core of health service provision for women. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so (UNFPA, 2021). Generally, women require more medical services and care than men because of their reproductive nature. As the COVID-19 pandemic affected all nations of the world, their consequences were also felt amongst women as they constantly require one or more sexual reproductive health services mentioned above. Communities often have groups where women discuss and empower themselves with issues of sexual and reproductive health information. These are often facilitated by health workers and nurses in respective communities. Women need to be informed and empowered to protect themselves from sexually transmitted infections and to have knowledge on issues regarding their reproductive health and when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby. Every individual has the right to make their own choices about their sexual and reproductive health (*ibid.*). The COVID-19 pandemic also worsened the situation, especially for low-income women as they have challenges economically and socially. Before the COVID-19 pandemic, around 810 women died every day from preventable causes related to pregnancy and childbirth (Who Fact Sheet, 2019). A huge percentage of these

deaths occurred in low middle-income countries. When routine health care is disrupted and access to food is decreased, the increase in child and maternal deaths also escalates.

GLOBAL OVERVIEW ON SEXUAL REPRODUCTIVE HEALTH

The 1994 United Nations International Conference on Population and Development (ICPD) led to the broadening of sexual reproductive health issues from traditional fertility control programmes, which emphasised demographic goals, to a more affirmed sexual and reproductive health, reproductive rights, and gender equality as cornerstones of sustainable development (UN, 1994; Henry, 2019). A global overview of sexual reproductive health outlines major challenges for action. Sexual reproductive health is a human right which is essential to human development and the achievement of Sustainable Development Goals (SDGs). The United Nations 2030 Agenda for Sustainable Development includes universal access to sexual and reproductive health as a target (UN, 2015); therefore, this has been a constant subject which requires attention globally. About 529 000 women die from complications of pregnancy and childbirth and three million children die in the first week of life every year. Thirty-eight million people are currently living with HIV and 340 million people contract sexually transmitted infections each year (DFID, 2004). An estimated 210 million women worldwide become pregnant each year and of these, eight million experience life-threatening complications related to pregnancy and many more develop long-term physical and psychological ill health and disabilities. About 80 million women globally face an unwanted or unplanned pregnancy each year (ICDP, 2004), almost three million deaths each year of babies in the first week of life and 2.7 million stillbirths are related to poor health of the mother and to inadequate care during pregnancy, childbirth and the period immediately after birth. Maternal mortality risk is highest in developing countries,

especially those in Africa and lowest in developed countries (Fathala, 1991).

However, failure to access sexual and reproductive services accounts for at least 20% of the burden of global ill health for women of reproductive age (15-44 years). Sexual and reproductive health reveals the largest gaps between low-income and developed countries and the starkest inequities between rich and poor people. Socio-economic conditions that determine reproductive health are poverty, literacy, and women's status. Availability, utilisation, and efficiency of health care services and level of medical knowledge also determine women's reproductive health (*ibid.*). Globally, the most significant risk factor for poverty is female gender and a significant number of poor women have limited to no access to sexual reproductive health information (Rogers, 2006).

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE AFRICAN REGION

There has been significant progress over the past years by the Sothern African Development Community (SADC) Member States to improve sexual and reproductive health. These improvements have been noticed through reductions in maternal and child mortality, increases in the numbers of people living with HIV initiated onto treatment, fewer deaths from AIDS-related illness and life expectancy at birth steadily increasing across the region (UNAIDS, 2020). The SADC Sexual and Reproductive Health and Rights (SRHR) Strategy 2019-2030 was formed because of the progress made by Member States in achieving the Millennium Development Goals (MDG), while addressing gaps and critical challenges that continue to shape poor sexual and reproductive health outcomes and act as a brake on sustainable human development in the region. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) recognises women's economic,

social and cultural rights noting the denial of these rights often leave women vulnerable to further abuse (African Union, 2003). The Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) calls on states to take appropriate measures to ensure women's social and economic empowerment and to address the intersecting disadvantages and discriminatory practices and policies that inhibit women's access to social and economic rights.

Africa accounts for about 10% of the world's population and 20% of global births. However, nearly half of the mothers who die during pregnancy and childbirth are from this region (Kestela, 2020). Many African countries have put in place reproductive health policies that seek to address issues relating to sexual reproductive health and rights. However, HIV&AIDS prevalence has remained very high in this region. The use of contraceptives among single women (15-24 years) rose from 23% to 33% in a period of less than five years. Issues of women's health have been a major cause of concern in African countries since the MDGs to the SDGs(Remez, Woog and Maloy, 2014). Countries like Zimbabwe, South Africa and Botswana, have also been working to end issues of gender discrimination. The SADC SRHR Strategy (2019-2030) calls upon Member States to provide accessible and affordable SRHR information and services to all individuals who need them regardless of their age, marital status, socioeconomic status, race or ethnicity, sexual orientation or gender identity.

SRH IN ZIMBABWE

Zimbabwe has identified health as a human right and prioritised the improvement and extension of health services as a necessary and primary condition of development (Centre for Reproductive Rights, 2003). Reproductive health is one of the most important factors that the country is focusing on as women form the majority of the population. Zimbabwe faces severe economic challenges and this has led the

country to see foreign donor-led systemic and crisis management interventions to address HIV and AIDS, and SRH) challenges. The vision of the Ministry of Health and Child Care is to have a Zimbabwe where pregnancy and childbirth do not pose a threat to mothers and new-borns, where children are healthy and free of the preventable common childhood illnesses (Ministry of Health and Child Care, 2021). However, women continue to face challenges every day, especially those of low income.

Various strategies have been put in place in the country to address sexual reproductive health issues and rights. Zimbabwe has recently made a commitment toward the global strategy for women, children and adolescent's health. It is also one of the signatories to the 2011 United Nations General Assembly Political Declaration on HIV and AIDs that set a global target of placing 15 million people on antiretroviral therapy (ART). To improve SRH outcomes, Zimbabwe implemented the ICPD action plan through various policies including the National Reproductive Health Policy, the Zimbabwe National HIV and AIDS Strategic Plan, the National Health Strategy and the Educational Policy. The right of access to basic health care, including SRH and chronic conditions, is enshrined in the 2013 Constitution of Zimbabwe. Therefore, everyone has a right to access health services regardless of their race or social background.

In a bid to address issues of SRH, the country has tried to put in place various policies that help women and girls. The National Adolescent Sexual and Reproductive Health Strategy of 2010-2015 and the National Policy on HIV&AIDS have been some of the policies put in place to address reproductive health issues. Young girls between the ages of 15-30 make up the majority of the population who are sexually active. A number of these women would like to delay child birth one way or another. This is an endeavour to address all the inequalities

which make some women not to have access to these services because of lack of income.

COVID-19 AND SEXUAL REPRODUCTIVE HEALTH

The emergence of coronavirus disease 2019 (COVID-19) in Africa has presented the most severe public health challenge, placing about 1.2 billion people at risk (El-Sadr and Justman, 2020). The COVID-19 pandemic deeply affected the environment in which women, children and young people grow and develop. Existing gender and other inequalities were exacerbated with girls and young women facing increased threats of GBV, discrimination, little or no access to reproductive health systems and abuse as protective structures were disrupted and economic stresses increased. Nearly 2,700 young people across Ghana, Indonesia, Kenya, Nepal, Uganda and Zimbabwe felt more vulnerable to harassment, sexual, physical, emotional or financial abuse than before COVID-19 (UNFPA, 2021) and about one third of young people were not able to access family planning services they needed.

Lockdown measures imposed as a response to the COVID-19 pandemic put adolescent girls and women at heightened risk of violence in the home and cut them off from essential protection services and social networks. There was an upsurge in violence against women and girls in Africa since the pandemic started, specifically sexual gender-based violence (SGBV) and unintended pregnancies (Ajayi, 2020; UN Women, 2020). Women and girls under stringent lockdown rules had limited access to social protection, threatening their SRH rights (United Nations Human Rights Office of the High Commissioner, 2020). Although movement restrictions were applied with exceptions for medical staff and hospitals remained open, primary health facilities in urban and rural areas were largely closed or the staff was not be available. This limited women's access to their regular health services and the treatment of sexually transmitted

infections (STIs), availability of contraceptives, and provision for clinical management of rape (CMR) was reduced. Globally, quarantines or home lockdowns inevitably increased the risks of GBV against women and adolescent girls, particularly with regards to domestic and family violence (Guterres, 2020). School closures also led to less access to information about sexual and reproductive health. The closure of schools and economic insecurity also exposed many women and girls to sexual activity and sexual violence.

IMPACT OF COVID-19 ON SEXUAL REPRODUCTIVE HEALTH FOR WOMEN IN THE INFORMAL SECTOR

Since the pandemic began, women were the most disadvantaged group. COVID-19 brought about issues of sexual and GBV in the homes of many. COVID-19 is not discriminatory but its impact is. Some women failed to access basic health care services concerning sexual and reproductive health. Although sexual reproductive health services were regarded as essential services during the lockdown, many women failed to have access to these services because of the tight restrictions on movement. The lockdown led to intensification of GBV, high rates of child marriage, school dropouts and teenage pregnancy in many countries. Pandemics can make it difficult for women and girls to receive treatment and health services. The gendered impact of COVID-19 was illustrated by the upsurge in violence against women and girls, especially in African countries, SGBV and unintended pregnancies (Ajayi, 2020; UN Women, 2020). Women and girls under stringent lockdown rules had limited access to social protection, threatening their SRH rights (United Nations Human Rights Office of the High Commissioner, 2020; UN Women *et al*., 2020). Many women had complications from pregnancy to childbirth whilst some had unplanned pregnancies and others had to give birth at home. Also, a larger number of women were unable to use modern contraceptives because of lockdowns, leading to a high rate of unplanned and unwanted pregnancies. Emerging evidence on the

impact of COVID-19 suggests that women's economic and productive lives were affected differently from men (UN Policy Brief, 2020). Most women in the informal sector had less access to social protections and medical aids, they depend mostly on government and council medical centres. The informal workforce bore the highest vulnerability, due to poor working, health and safety conditions, and lack of safety nets. Resources had to be diverted in some way and this resulted in exacerbated maternal mortality and morbidity, increased rates of adolescent pregnancies, HIV and sexually transmitted diseases.

GAPS IN LITERATURE

The study essentially highlights the nexus between the COVID-19 and SRH of women. This study was stimulated by the impact caused by COVID-19 on the SRH of women in the informal sector. In this regard, the study unpacks the importance of the SRH of women even during pandemics which acts as a research pillar for future research. It also adds knowledge to the growing concerns of COVID-19 as a long-term pandemic is. In this regard, the study seeks to add voice to the plight of the SRH of women in the informal sector with regards to the effects of COVID-19.

Also, this study seeks to provide factual proof and securing the patterns of the SRH of women in the informal sector prior to and post COVID-19 and highlighting how best these can women be helped. This study additionally seeks to analyse the challenges faced by women in the informal sector with regards to COVID-19 and capturing those aspects which were in line with the SRH. By doing so, this study seeks to give recommendations to be adopted in helping the plight of women in the face of COVID-19 with regards to their SRH. Reproductive health is a human right. Sexual and reproductive health is a significant public health issue, including in emergencies. Clearly, disastrous consequences for women and their families in developing countries such as Zimbabwe are possible if core SHR services are

reduced or deemed non-essential during pandemics. Additionally, women's, especially adolescent girls', reproductive rights were likely to remain unmet as the government prioritised expenditures, including health sector expenditures, towards the fight against the pandemic. Academia and research institutions play an important role in the analysis of the impact of the pandemic and the various response measures on the Zimbabwean economy, especially the poor, women and the marginalised in the area of SRH. It is against this background that this research saw the need for a research study into the effects of COVID19 on the reproductive health of women and girls in this particular community.

METHODOLOGY

QUANTITATIVE RESEARCH

The deduced quantitative data was gathered through questionnaires. The use of SPSS was important in outlining the relationship between various factors. Also, the research used simple counting and tallying.

QUALITATIVE RESEARCH

Qualitative data was analysed through the use of thematic and content analysis. In analyzing auxiliary data, thematic analysis was embraced in capturing the essential themes of the study. Thematic analysis entailed orchestrating various words into small themes and also highlighting recurring themes of the study.

EXPLORATORY EXPRESSIVE DESIGN

In this regard, this approach was deemed to be appropriate in examining the effects of the COVID-19 pandemic on SRH of women in the informal sector in high density areas. Descriptive research provided a clear picture of the exact characteristics in real life situations.

TARGET POPULATION

The targeted population of the study was 60 women in the informal sector in the Chipadze high density are of Bindura, Zimbabwe. The age range of the targeted women was 18-55 years, as it was believed that they would provide valuable information to the study.

SAMPLING

Under this study, purposive and convenience sampling techniques were used.

SAMPLE SIZE

Sample size is given so as to enable the calculations in gathering data. The data gathered under this study was established under a pre-designed plan. This research used cost-base strategy, which denotes gathering of sampling components that were convenient to gather.

SAMPLE SIZE DETERMINATION

For this study, the formula propounded by Krejcie and Morgan, is utilised.

$$S = \frac{x^2 NP(1-P)}{d^2(N-1) + x^2 \mathrm{P}(1-P)}$$

where: S = required sample

x^2 = the table value of chi-square for 1 degree of freedom at the desired confidence level (3.841)

N = the population size

P = the population proportion (assumed to be .50 since this would provide the maximum sample size)

d = the degree of accuracy expressed as a proportion (.05).

$S = 60\ women\ in\ the\ informal\ sector$

METHODS OF DATA PRESENTATION AND ANALYSIS

According to Bryman (2012), methods of data presentation are ways to display the gathered data and the analysis of that data. this study also consulted primary and secondary sources. Thematic analysis was embraced in presenting qualitative data. Quantitative data was captured through the questionnaires that presented biographic data. For quantitative analysis, the SPSS package was used in presenting data through visuals such as pie charts, bar graphs and tables.

DATA PRESENTATION, ANALYSES AND DISCUSSION

RESPONDENTS BACKGROUND AND THEIR RESPONSE

The groups that were important to the research were identified. Sexual and reproductive health affects everyone regardless of sex, age, religion or race. However, this research focuses on women in the informal sector. Respondents were the women in the informal sector. The study chose high density areas in Chipadze, comprising areas such as Musvosvi, Ma1 and Chiyedza. Key informants the Chipadze Clinic and the Ministry of Women's Affairs Bindura District. The target population was 60 respondents, 30 for quantitative and 30 for qualitative, and 55 responded. For this study 50 respondents were studied and the age range was from 18-55years. The ages 18-30 were really viable in the study and their response was high. The age range of 40 years and above was difficult to access due to various reasons.

BIOGRAPHICAL DATA

Table 1: Beneath presents bio data of respondents presenting their age, religion, marital status, and educational level and type of business.

Characteristics	Details	Number	Respondents %
Age	18-24	21	42
	25-30	15	30
	31-45	10	20
	45-55	4	8

Total		**50**	**100**
Status	Single	17	34
	Married	22	44
	Widowed	6	12
	Divorced	5	10
Total		**50**	**100**
Qualification	Primary	10	20
	Secondary	29	58
	Tertiary	11	22
Total		**50**	**100**
Type of Business	Vegetable vendor	15	30
	Selling second-hand clothes	15	30
	Selling food in nearby mines	13	26
	Prostitution	7	14
Total		**50**	**100**
Religion	Christianity	25	50
	Traditionalist	13	26
	Islam	7	14
	Others	5	10
Total		**50**	**100**

Information presented in Table 1, presents bio information for this study. The targeted population was 60 respondents and 55 responded but the research used 50 respondents for this study. Most of the respondents (36, 72%) were in the age range 18-30 years. The age range of 18-24 years had most respondents (21, 42%). The age range of 45-55 was for (8%). The majority of respondents that were married were 22 (44%) and the single respondents accounted for 17 (34%) .

The most elevated number of respondents (25, 50%) were Christians, 13 (26%) were of the Traditional religion and seven (14%) were Muslims. Most respondents (29, 58%) had accomplished secondary education, 11 (22%) attained tertiary education and 10 (20%) completed primary school. All respondents were in the informal sector. Most respondents, 15 (30%), indicated that they survived on selling vegetables, 15 (30%) sold second-hand clothes, 13 (26%) sold food in

mining areas like Garati, Ran Mine and Kitsiyatota. Also, 7 (14%) indicated that they were into prostitution as a way of survival during the COVID-19 era.

Respondents' knowledge they had on COVID-19 and the sexual reproductive health .

Respondents were asked questions to discover the knowledge they had on COVID-19 and sexual reproductive health.

Table 2: respondents' knowledge on COVID-19 SHR

Question Asked	**Correct Answer**		**Incorrect Answer**	
	(Number)	%	**(Number)**	%
What do you understand by the term COVID-19?	44	88	6	12
What do you understand by the term sexual reproductive health?	22	44	28	56
Any education given to you about sexual reproductive health?	20	40	30	60
Any form of assistance given to you by the government during the COVID-19 period?	10	20	40	80
Did you ever attend any COVID-19 or SRH workshop or an awareness campaign?	12	24	38	76

The Table 2 highlights information respondents had on COVID-19 and SRH. Most respondents (44, 88%) had knowledge on what was COVID-19. However, six (12%) did not give satisfactory answers. Most respondents (28, 56%) did not understand the meaning of SRH. The women who understood SRH numbered 22 (44%). The respondents

who had received education on SRH totalled 20 (40%) and 30 (60%) did not. The research noted that women in the informal sector lacked awareness and knowledge on SRH. This is be illustrated by the statement below from one respondent;

> "Since I started staying in Chipadze, I have never received any form of education on SRH. This is my first time hearing this phrase, otherwise we grew up just knowing that they are STIs and contraceptives out there but I didn't know more about my sexual reproductive health" (Musvosvi resident).

For the UNFPA (2021), SRH implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. This is also supported by Plan International (2021) who note that women constantly require information pertaining to access to modern contraception, emergency contraception, menstruation, HIV and STI testing and treatment, gynaecology, pregnancy testing and services, safe abortion, counselling, GBV and harmful practices, counselling and referral, among others. Most respondents (80%) indicated that they did not receive any social safety nets during the COVID-19 period, only 10 (20%) indicated that they did. One respondent stated:

> "Since the start of COVID-19, we were told to register with our branch chairperson so that we could receive the social safety nets. We were told to open NetOne sim cards but we never received anything up today. We work in the informal sector and at first were not allowed to work and I wonder how our government thinks we are surviving?" (Ma1 resident).

Most respondents (38, 76%) said that they never attended any COVID-19 or SRH workshop.

> "The problem is that your leaders will lie that the programme is for SRH for women, when the programme is political. We attended most programmes that will turn political, especially linked to the ruling party. That is why we don't attend programmes" (Chiyedza resident).

The discoveries shows that the government under the Ministry of Health and Women Affairs had a duty to play in raising awareness in women in the informal sector.

Negative impact posed by COVID-19 on sexual reproductive health of women in informal sector in high density suburbs.

Respondents were posed a question to find out the negative impact of COVID-19 on SRH of women in the informal sector in high density suburbs. The graph below delineates responses provided by respondents.

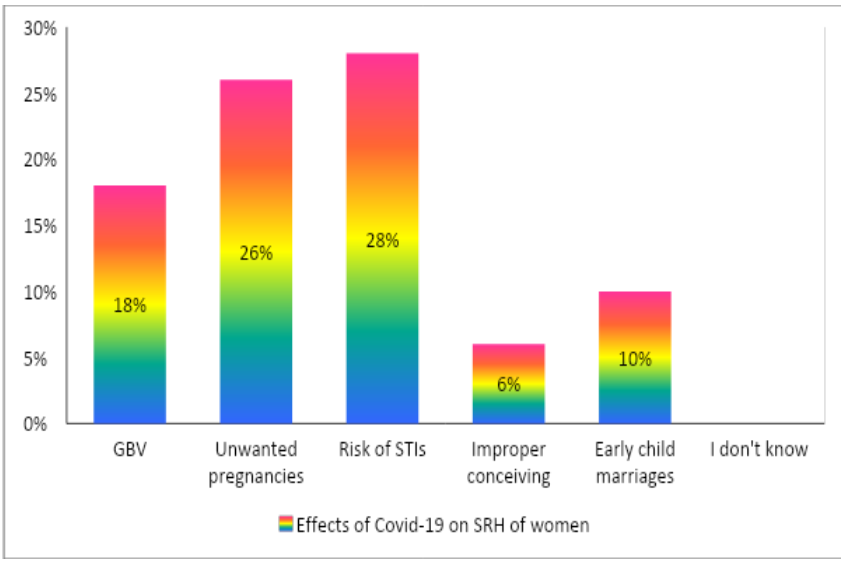

Figure 1: Negative impacts posed by COVID-19.

Most respondents (14, 28%) indicated that the risks of STIs was the major impact posed by COVID-19 with regards to the women in the informal sector in Chipadze high density suburb. According to Koyama *et al*. (2009), young people and women are vulnerable groups with regards to unintended pregnancies and sexually transmitted

infections as result of their propensity to engage in risky sexual behaviours. The HBM highlighted that one of the predictors of sexual behaviour is an individual's perceived susceptibility to negative consequences such as unintended pregnancies or sexually transmitted infections. The research notes that most women in the informal sector were engaging in multiple sexual activities, especially in nearby mines like Garati and Ran Mine, as one Musvosvi residents narrated:

> "After the imposed lookdowns, life became so difficult that we could engage in various sexual activities to sustain our lives. Exposure to STIs is our greatest concern but we have no option. Miners at Garati are readily available and ready to pay good money, so we are tempted"

Another impact of COVID-19 was unwanted pregnancies which was selected by 13 of the respondents (26%) respondents. This is supported by the UNFPA (2021) who state that nearly 2 700 young people across Ghana, Indonesia, Kenya, Nepal, Uganda and Zimbabwe felt more vulnerable to harassment, sexual, physical, emotional or financial abuse than before COVID-19 and about one third of young people were not able to access family planning services they needed. The present research noted that the respondents did not get their contraceptives since the beginning of lockdowns. One respondent said:

> "Due to the induced lockdowns, I failed to get my monthly contraception. I have been using a monthly induced contraceptive in which I failed to access after the lockdowns. My main clinic is Chipadze clinic which was turned into a quarantine centre for COVID-19 patients" (Chiyedza resident)

Another impact of COVID-19 which GBV selected by nine (18%) respondents. The respondents noted they were facing various forms of GBV during the COVID-19 era. This discovery was supported by UN Women (2020), who note that there was an upsurge in violence against women and girls in Africa since the pandemic started, specifically sexual gender-based violence and unintended pregnancies. Women and girls under stringent lockdown rules had limited access to social protection, threatening their SRH rights (United Nations Human Rights Office of the High Commissioner, 2020). Various forms of GBV

like rape, sexual abuse and domestic violence were mentioned by respondents:

> "Since the beginning of the lockdowns, we have been experiencing countless fights with my husband. It is not about infidelity or something, but it was because I told him to look for another form of employment like panning and that provoked him and he assaulted me. I have not known peace in my house in a very long time" (Chiyedza resident)

Challenges faced by women in the informal sector in Chipadze high density suburbs during the COVID-19 pandemic.

Respondents were posed a question on the challenges faced by women in the informal sector in Chipadze high density suburbs during the COVID-19 era.

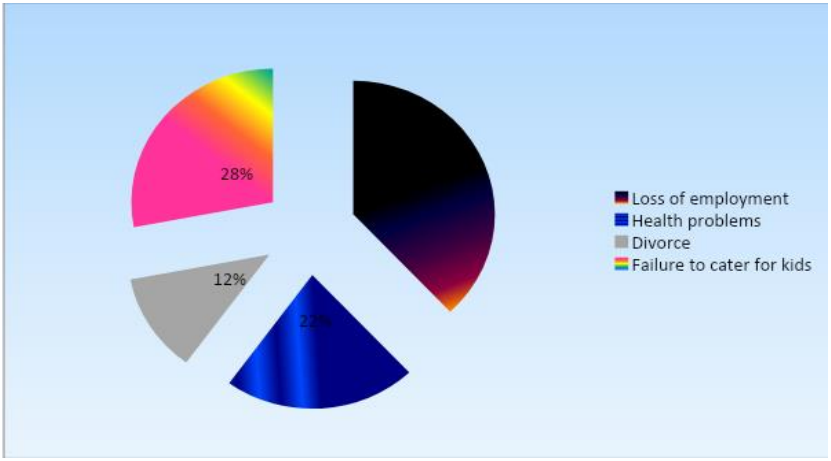

Figure 2: Challenges by women in the informal are caused by COVID-19.

Sixteen respondents (38%) pointed out that the loss of employment was their greatest challenge posed by COVID-19. The respondents noted that during the first induced lockdowns, they were not allowed

to trade in the informal sector which was difficult for them to make ends meet, as illustrated thus:

> "We lost our employment due to COVID-19 and it's been hard for us to make ends meet. I survive by selling second-hand clothes which the government deemed illegal, but we still do it. If it wasn't for the COVID-19, my business would have grown. And the government had promised to give us social safety nets but they failed to do so" (Ma1 resident).

Another challenge highlighted by 11 (22%) respondents were health problems. Most women in the informal sectors failed to get medication for BP, diabetes and cancer, among others Ma1 inhabitant) confirms:

> "I am a BP patient, and since the induced lockdowns it was difficult for me to access my medication. My worst fear was that I was pregnant that time and I was fearing for my life and the kid. However, I am a member of the Johane Marange and I was helped, so there is no longer need for me to go to clinics."

Other respondents (14, 28%) noted that they failed to cater for the kids due to induced lockdowns. Most kids dropped -out of school and girls were the most vulnerable groups and this can be supported by one of the respondents:

> "After my husband passed on, I was the breadwinner and had to cater for two kids, one boy and a girl. I could only manage to provide for one child and sacrificed that my girl child should drop out of school because she would be married one day. She dropped out of school when she was in form two and she eloped to this other miner. At least it lessened the burden of paying double school fees" (Musvosvi inhabitant).

Another challenge faced by and revealed by six (12%) respondents, was divorce. According to Hove (2011), poverty increased GBV in Zimbabwe. This implies that COVID-19 worsened poverty among societies because the government had failed to provide social safety nets for vulnerable groups.

Ways to assist and promote the sexual reproductive health of women in high density suburbs during COVID-19 pandemic

Respondents were posed a question on how best the SRH of women in high density areas could be promoted during the COVID-19 era.

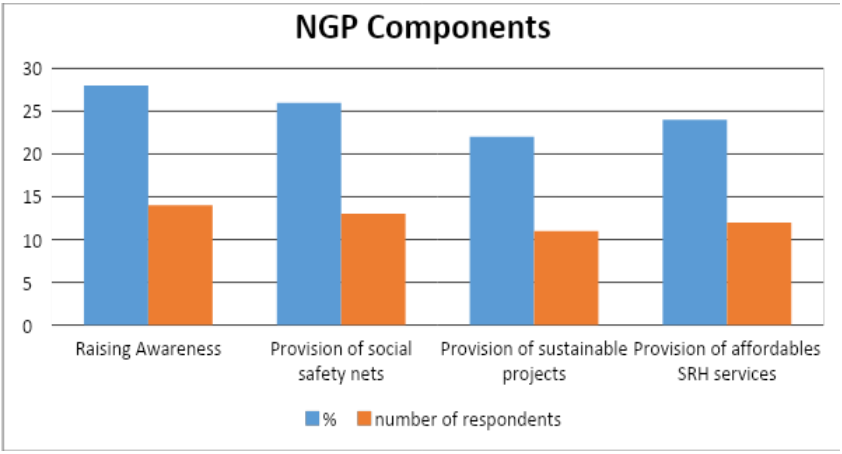

Figure3: How women SRH can be promoted during COVID-9.

Figure 3 presents the answers given by respondents in the ways they think can promote their SRH during COVID-19 era. A number of respondents (14, 28%), indicated that the government should raise awareness in both women and men about the importance of SRH because it affects both sexes. The Centre for Reproductive Rights (2003) states that Zimbabwe has identified health as a human right and prioritised the improvement and extension of health services as a necessary and primary condition of development. The vision of the Ministry of Health and Child Care is to have a Zimbabwe where pregnancy and childbirth do not pose a threat to mothers and new-borns, where children are healthy and free of preventable common childhood illnesses (Ministry of Health and Child Care, 2021). In this regard, awareness is really important as noted below:

> "Before you came here, my sister, we didn't know what SRH was or its importance. I think the government and its ministries like Women's Affairs and Health should raise awareness to both women and men with regards to SRH. Even TV programmes can do"(Chiyedza resident).

To improve SRH outcomes, Zimbabwe implemented the ICPD action plan through various policies, including the National Reproductive Health Policy, the Zimbabwe National HIV and AIDS Strategic Plan, the National Health Strategy and the Educational Policy. The right of access to basic health care, including SRH and chronic conditions, is enshrined in the 2013 Constitution of Zimbabwe. The National Adolescent Sexual and Reproductive Health Strategy 2010-2015 and the National Policy on HIV&AIDS are some of the policies put in place to address reproductive health issues. Other respondents noted that the government should use newspaper, television programmes and radio programmes in raising awareness with regards to SRH. Twelve respondents (24%) felt that the government should provide affordable SRH for women.

Also, the 11(22%) respondents urged the government should also provide sustainable projects for women in the informal sector for them to be economically self-sufficient. The respondents pointed to issues such as expensive SRH, GBV, prostitution as being caused by economic constraints. In this regard, the women were advocating for sustainable projects.

FACTORS HINDERING WOMEN IN SEEKING SRH

Respondents were asked to respond on challenges hindering women in seeking SRH

Table 4: Challenges hindering women seeking SRH

Challenge Posed	**Statistics**
	Number / %
Lack of awareness	12/24
Economic hardships	8 /16
Cultural and traditional customs	10 / 20
Expensive SRH services	20/40

Twenty of the respondents (40%) indicated that most women were not seeking SRH because the service was expensive

This is supported by the United Nations in Zimbabwe (2020) which noted that without urgent collective responses to address the social and economic impacts of the COVID-19 pandemic, suffering would escalate, endangering lives and livelihoods for years to come. The Guttmacher Institute of Zimbabwe (2014) analysed that many obstacles prevent young Zimbabweans from acting on their desire to postpone parenthood and stay HIV-free.

SUMMARY, CONCLUSIONS AND IMPLICATIONS

RESEARCH CONCLUSIONS

The above research proffered for the following research conclusions: Objective One: to analyse the negative impact posed by COVID-19 on SRH of women in the informal sector in high density suburbs. This research managed to figure out that the induced lockdowns left many women in the informal sector in high density suburbs vulnerable as they lost their form of employment which meant that they had to look for other means of survival and, in this case, sexual activities which exposed them to STIs. The research also concludes that women in the informal sector failed to acquire their monthly contraceptives which led to unwanted babies and abortions. Objective Two was to explore challenges faced by women in the informal sector in Chipadze high density areas during the COVID-19 pandemic. The findings of the study indicate that women in the informal sector in the Chipadze high lost their employment, since the informal sector was once closed which made women look for other means of survival. The study notes that it was imperative for the government to prioritise SRH for women in the informal sector and also assist them with sustainable projects so that they could afford SRH services. Objective Three was to establish ways to assist and promote the sexual reproductive health of women in high

density suburbs during COVID-19 pandemic. The research discovered that it is important to raise awareness for both women and men. The research also concludes that lack of knowledge with regards to SRH was common among women in the informal sector in high density areas, necessitating the need for awareness. The study highlights that there was a need to empower women in the informal sector with initiatives like sustainable projects.

RECOMMENDATIONS FOR RESEARCHERS AND POLICY MAKERS

RESEARCHERS

The first recommendation that can be noted is that COVID-19 is still a national pandemic and its effects are still felt across the globe and affecting SRH, not only women in the informal sector, but everyone, which means continuous research is needed. Further research will provide comprehensive information with regards to COVID-19 and its effects on SRH which will be useful in coming up with better solutions to minimise the problem. Additionally, SRH should be an area of further study, because many women in the informal sector are lacking the knowledge thereby making them vulnerable.

POLICY MAKERS

The discoveries indicated that policy makers should develop an integrated approach towards SRH in light of COVID-19. They should compile data on how best they can help women in the informal sector with regards to SRH where COVID-19 is concerned. Policy makers should prioritise SRH, and awareness should be raised on various platforms. Government should come up with sustainable projects for women in the informal sectors so that they can afford to seek SRH services.

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