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Exploring how COVID-19 Lockdowns Impacted on Women's Access to Sexual and Reproductive Health Services in Mbare Constituency, Harare, Zimbabwe

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Abstract: The global COVID-19 pandemic had a significant impact on people's normal daily lives. The focus of the current study was to determine how COVID-19 Pandemic affected women's access to SRH (SRH) services in Harare, Zimbabwe. The Descriptive survey research designs and mixed methods of data collection were used in this study. The survey was undertaken in Mbare constituency and only those women present in Mbare constituency during the covid-19 pandemic lockdowns were eligible to participate. Random sampling techniques were used to recruit participants of this study. Interviews and a structured questionnaire were used to collect primary data. Thematic analysis was used for qualitative data, and descriptive statistical techniques with the help of SPSS version 27 was used for quantitative data analysis. From the findings, there were mixed reactions in relation to accessing Sexual and Reproductive Health Services among women in the study area during COVID-19 lockdown. Some respondents said they were able to access the services, whereas others were not in a position. SRHS were delayed in some health institutions and some respondents had their appointments cancelled or even delayed. Traditional birth attendants and government's commitment to offer door to door services improved on SRHS delivery during the COVID-19 lockdown. The study concludes that, there were mixed reaction in relation to accessing SRHS during COVID-19 lockdown in the study area. The study recommends provision of more training to the TBAs on SRHS, collaborative work with the conventional medical workers and more investment to door to door SRHS. Awareness creation on SRHS in the society is also recommended.

Key words: *Women, Access, Sexual and Reproductive Health Services*

1.1 Study background

Access to Sexual and Reproductive Health Services (SRHS) inequities disproportionately impacts vulnerable populations especially those living in low income settings. Women in these low income settings may likely experience unique difficulties in accessing quality sexual and reproductive healthcare during crisis. In many Countries of the World, Coronavirus disease of 2019 (COVID-19) out break and there after pandemic led to strained health care systems, disruptions in the provision of

care, resources being redirected to the treatment and prevention of the disease at the center of the emergency (International Rescue Committee, 2022). According to UNFPA, 2020, the pandemic had significant impact on the availability f Sexual and reproductive Health Services.

During COVID-19 pandemic, the global provision of services for SRH was more important than ever. However, women's actual experiences revealed a very mixed picture, with some nations taking proactive steps to protect women's rights and others using the pandemic to impose restrictions on reproductive health services (Moreau, 2020). In 2020, providers and women seeking SRH care faced numerous obstacles, including the inability to afford contraception, medicine, and sanitary pads, as well as the limited availability of those items. As the battle against Coronavirus had previously stressed the worldwide wellbeing frameworks, numerous centers and emergency clinics needed staff, making admittance to sexual and conceptive wellbeing administrations progressively troublesome (Todd-Gher and Shah, 2020). The disruption of global supply chains occasionally questioned the availability of contraceptives. Global full-scale lockdown measures to prevent the pandemic from spreading further exacerbated this already precarious situation by making it more difficult for women to access SRH care. A few nations, for example, Slovakia and certain US states, characterized early termination as a trivial help to help the striving wellbeing area (Caruana-Finkel, 2020). Caruana-Finkel (2020) contended that in the US, this denial and delay of foetus removals were unequivocally acquainted with save individual defensive gear (PPE).

Lockdown measures posed new, nearly insurmountable obstacles for women, even if some nations did not explicitly restrict access to SRH and Rights (SRHR) (Romanis, Parsons, & Hodson, 2021). Since stay-at-home orders and travel restrictions were in place, many women feared contracting the virus and did not seek medical attention (Schensul & Tyagi, 2020). Aiken (2021) argued that, during a lockdown, it might be harder to get SRH care if you live with a controlling partner. Additionally, some women were effectively unable to obtain treatment because of travel restrictions. This was especially prevalent in nations, such as Malta, where abortion is still illegal or restricted to a small number of exceptions. Maltese ladies who recently depended on global travel to get to foetus removal in adjoining nations could never again do so when worldwide flights were suspended and were consequently passed on to turn to unlawful or risky techniques (Caruana-Finkel, 2020). In Africa, the Coronavirus regulation estimates resulted to nation-wide lockdowns coincidentally upset the impartial and supported arrangement of sexual and regenerative wellbeing administrations across the continent, as the vast majority of the nations are low-and medium income countries (LMICs), which bore the most honed obtuse (Bolarinwa, Ahinkorah, Seidu, Ameyaw, Saeed, Hagan and Nwagbara, 2021; Mukherjee, Khan, Dsagupta and Samari, 2021). However, the effects were most pronounced for women who did not have access to essential services like family planning services including contraception, HIV testing and treatment, maternal healthcare, emergency contraception, abortion facilities, routine scan appointments, and antenatal care (Bolarinwa et al., 2021; Dsagupta, Mukherjee, Khan, and Samari, 2021). There were numerous reports of girls aged 12 to 19 becoming pregnant. When contrasted with a similar time span in 2019, Malawi, for example, saw an increment of 11% in the number of teen pregnancies and 13,000 extra instances of youngster marriage from January to August 2020.

The production and supply chain of contraceptives was also disrupted by the COVID-19 pandemic and lockdown measures (Riley et al., 2020). This consequently increased the cases of unplanned pregnancies, risky abortions, diminished antenatal care, maternal and new pregnancies challenges in Zimbabwe and other numerous countries (Mukherjee et al., 2021; Murewanhema, Musuka and Dzinamarira, 2022). COVID-19 lockdown confined people and prices of some contraceptives' prices

increased including condoms, inner wares, sanitary towels, among others which increased vulnerabilities to both men and women (Hlatywayo, 2023; Ncube, 2021; Chikunichawa, 2022). In Zimbabwe, When the pandemic lockdown began, until 15 July 2021, the public GBV Hotline (Musasa) received a total of 4,047 SGBV calls. 1,312 in April 2020, 915 in May 2020, 776 in June, 753 in July, and 315 from the 1st to the 12th of August, a remarkable increase of more than 70% compared to the previous patterns before the COVID-19 lockdown. Further, in Zimbabwe, the pandemic resulted in the closure of learning institutions where students were getting free SRH care services, which resulted in increased cases of STIs and teenage and unwanted pregnancies. In 2019, unwanted pregnancies were around 581 countrywide, but during the pandemic in 2020 alone, the cases had risen to 1497 reported cases of unwanted pregnancies (Moyana, 2021).

In Mbare constituency, media news publicized how some girls ended up working as prostitutes to help keep their families fed during the lockdown, while others ended up abusing drugs and alcohol because of stress. As part of the solution, the government of Zimbabwe, like most other countries worldwide, introduced a lockdown to restrict the movement of people, which could speedily spread the disease, and social distancing policies, to reduce physical contact. However, the lockdown restrictions saw women no longer affording to seek SRH care services since many lost their jobs (Hlatywayo, 2023).

1.2 Statement of the problem

It is the right of women to access to SRH services in Zimbabwe, however, according to reports, this right was violated during the covid-19 pandemic. The lockdowns introduced by the government were reported to be effective in reducing the spread of the disease, which was the major focus of the government by then, but this had adverse negative impact on women's rights to access SRH services in Zimbabwe. Most of these reports were media based and had no empirical back-up. This study was carried out among women living in densely populated areas with poor socio-economic conditions - in Mbare, Highfield and Epworth areas in Harare, Zimbabwe. The study, however, narrowed down to Mbare female residents only for practicability. Most of previous studies carried out in Zimbabwe during COVID-19 concentrated mostly of the effects of COVID-19 on the socio-economic factors. This study however concentrates on SRHS among women. Few studies have been carried out in this specific area. It is therefore against this background that the researcher decided to fill in this gap.

1.3 Study objective

This study sought to explore how COVID-19 lockdowns impacted on women's access to SRH services in Mbare constituency, Harare, Zimbabwe.

1.4 Significance of the study

The study looked at challenges experienced by women in accessing SRHS in Zimbabwe during the COVID-19 lockdown outbreak. This was due to limitation of empirical data relevant to this study. Among those to benefit from this study are development officers, academicians, the scientists, line services, Nongovernmental organizations, the Catholic University of Eastern Africa Library and all the countries of Africa. This research provides government-related ministries with suitable information to accomplish their service delivery and operations. The government-related ministries benefits from the distinctive research as the study measured the impact of COVID-19 on access to women SRH care services and suggested recommendations. Based on empirical evidence, the government is in a better position to understand the consequences of some of its measures. NGOs and communities may also benefit from understanding the impact some government measures have on specific groups in society,

women in this case, regarding access to SRH facilities so that communities and NGOs can make better decisions to assist the vulnerable groups in the future.

1.6 Literature review

This section introduces the theoretical review and empirical literature supporting the study.

1.6.1 Theory of gender and power

Robert Connell proposed and developed the hypothesis in 1987. The theory of gender and power is a social structural theory that is based on philosophical works on sexual inequality and gender and power imbalance (Wingood & DiClemente, 2020). According to the hypothesis of orientation and power, the gendered relationships among people are characterized by three significant social designs: the structure of the cathexis and the way power and labour were divided between men and women (Wingood & DiClemente, 2020). Hence, the Orientation and Power hypothesis is set on three significant underpinnings, which are: The sexual division of labour (e.g. represented by financial inequality); The sexual division of power (e.g. represented by authority); The structure of effective attachments (e.g. representing social norms and characterises the gendered relationships between men and women).

The sexual division of labour and power is a representation of gender relations, and the third underpinning addresses the emotional aspect of gendered relationships (Hlatywayo, 2023). These three underpinnings are gotten comfortable the overall population and exist at different family, social and institutional levels. However, social mechanisms provide support for them. Consequently, Connell's theory was utilized during the lockdown to investigate the effects of gender and power on women's SRH. During the Coronavirus regulation measure carried out by the public authority in Zimbabwe, the hypothesis was considered to address key drivers that encroach on ladies' SRH privileges as monetary disparity, authority, and accepted practices. Understanding the complexity and variety of orientation standards, power, and the sexual division of work in social orders is made easier by the characteristics of the hypothesis. It sees possibly challenged stories about solidarity, privilege, and custom. It stresses the vagueness of people's associations with each other and their failure to grasp orientation jobs. Wingood and DiClemente (2020) recommend that the three social designs are challenging to operationalize and don't consider nearby varieties across societies, featuring the limits of using the Hypothesis of Orientation and Ability to appreciate wellbeing. The analyst develops this last point by contending that the Hypothesis of Orientation and Power might neglect to catch the variety and intricacy of orientation relations across societies, time, and their effect on wellbeing because of its attention on conventional orientation jobs.

1.6.2 Empirical literature

COVID-19 Lockdowns' effect on women's access to SRH services

Lindberg (2020) show that pandemic-driven approaches which restricted face to face contact with wellbeing staff likewise made obstructions to looking for help. Sanchez et al. (2020) claim that the COVID-19 pandemic had a significant impact on global reproductive health by disrupting family planning services, resulting in a significant increase in the number of pregnancies worldwide. a study that was done in Turkey; Europe showed a huge reduction in contraception use during the pandemic contrasted with the time earlier with the pandemic contend Caruso et al (2020). In some places, women and girls frequently have to wait until late at night to use the restroom due to the taboo nature of menstruation. As a result, they are more likely to experience violence and contract infections if they don't change their sanitary napkins on time. According to another study by Ingraham (2022), there was

a growing concern that the prices of menstrual hygiene supplies had been overinflated and prohibitive as a result of the constrained markets for both buyers and sellers caused by COVID-19 lockdowns. Women and girls, who frequently do not have control over household finances, are more likely to be affected by increased financial stress than men. When food or utilities are prioritized over purchasing menstrual hygiene supplies, this can have a significant impact on safe menstrual hygiene management, which is especially problematic for people who use disposable products every month.

A review directed on the effect of Coronavirus on men who engage in sexual relations with men (MSM) in South Africa showed that 9.4% of the couples had not used condoms, while 5.4% detailed less utilization of a condom (Stevenson, 2020). Sanchez et al.,(2020) on the other hand, revealed that 89.4% and 92.9% of the members they talked with had no adjustment of admittance to or condom use, successively, and condom access and use stayed unaltered because of Coronavirus. Hence, the distribution by Sanchez et al. (2020) played a role in the creation of this study. The COVID-19 pandemic disrupted family planning services, affecting SRH care, according to this study. McDonald et al. (2020) another important study for this dissertation is this one. Their research, which was carried out in Europe, revealed that 32.7 percent of participants had intended to become pregnant prior to the pandemic, but that number significantly decreased to 5.1% during the pandemic. 43% (43%) and 39 percent (39%) of the breastfeeding ladies who partook in McDonald's exploration revealed having encountered a few effects of the pandemic on the degree of clinical directing and social help during the breastfeeding time frame, separately. Baloyi (2021) argued that more than 90% of breastfeeding women in Africa denied that the pandemic had an effect on their breastfeeding practices and that the coronavirus was to blame for the cessation of breastfeeding. Sasо et al. (2020) backed up McDonald et al. (2020) as well as Saso et al. (2020) research by contending that half or more pregnant ladies in Zimbabwe detailed issues with either maternal or baby/little child antibody conveyance. The lockdown estimates diminished admittance for pregnant ladies and newborn children from effectively going to antenatal facilities and essential medical care places, individually. Changes in accordance with centers, deficiency of staff, absence of individual defensive gear (PPE), and immunization supply issues were the supplier issues revealed by most members.

In the early 2000s, Zimbabwe became popular with the small-house phenomenon, which is a type of concurrent relationship in which a person has regular sexual relations with another person while also having sexual relations with their primary sexual partner, who is the legal wife or a long-term partner (Hlatywayo, 2023). Considered an intimate practice embraces the extension of a monogamous intimate relationship into a semi polygamous plan, which makes one more sort of marriage that looks at between two methods of reasoning that are development and social adherence (Mutseta, 2016). According to Muchabaiwa (2017), it is also seen as an emerging family structure in contemporary Zimbabwean society that is based on the traditional polygamous marital structure.

According to a recent study by Hlatywayo (2023), most legal wives who are quasi-polygamous do not feel emotionally attached to their husbands because they are afraid of contracting HIV. As a result, when they do have sexual relations with their husband, they insist on using condoms. The concentrate by Hlatywayo (2023) uncovered that during the lockdowns, development was controlled thus most ladies turned into their spouses' just wellspring of intercourse. It was discovered that condoms were distributed during the first few days of the lockdowns. However, over time, husbands would either refuse to use condoms or find it difficult to obtain condoms due to cost and restricted access. This led to almost daily forced sex, a violation of women's SRH rights to consented sex and mostly dry and forced sex, which caused women a lot of pain and discomfort because there was no attraction or

affection. The investigation additionally discovered that because of the lockdowns, the ladies couldn't go out and purchase oil, consequently some wound up with vaginal scraped spots.

Although a woman is not required to wait before having sex again after giving birth to a child, many medical professionals recommend waiting four to six weeks, regardless of the method of delivery, before having sex (Muzuva & Hlungwani, 2022). The first two weeks after delivery are when complications are most likely to occur. However, Chirisa, Mavhima, Nyevera, Chigudu, Makochekanwa & Matai (2021) and Macheka & Nhongo (2021) reported that families were able to spend more time together as a result of the lockdowns in Zimbabwe. Other women also reported that their husbands could not wait for the recommended time period after delivery, which is against the postnatal SRH for women. One can comprehend from the different exact outcomes by different scientists that lockdowns decreased the opportunities for ladies and their sexual accomplices to travel and access contraceptives. Further, because of the significant expenses of SRH administrations because of deficiencies of supply because of lockdowns, different accomplices couldn't stand to purchase adequate amounts of contraception. Additionally, there were issues with respect to unconsented sex, which disregarded the SRH privileges to agreed sex.

1.7 Study Methodology

The study used descriptive designs and mixed method approach to explore how COVID-19 Lockdowns impacted on Women's Access to Sexual and Reproductive Health Services in Mbare Constituency, Harare, Zimbabwe.

Study population: Mbare has an estimated population of 800,000, according to thezimbabwean.co (2012). This makes the target population 56.9%*52%*800,000, where 56.9% is the percentage of women aged 15 to 65 in Zimbabwe in 2022 (UN, 2022), 52% is the percentage of women in Zimbabwe (Zimstats, 2022), and 800,000 is the total population. As a result, the study's population consisted of approximately 250 000 women in the Mbare constituency who were between the ages of 15 and 65 years.

Sampling: In the study, random sampling techniques were used. This is consistent with Adams & Schvaneveldt's (2018) assertion that random samples are necessary for quantitative methods. The number of registered houses in Mbare, including flats and designated medical centres, served as the researcher's guide. The researcher used 50000 as the number of houses in the Mbare constituency because, as far as the researcher is aware, the newest houses in Mbare are five-digit numbers that begin with a 5. According to Krejcie and Morgan (1970), the formula for determining the appropriate sample size is as follows.

$$\mathbf{s = \frac{X^2 NP(1-P)}{d^2(N-1) + X^2 P(1-P)}}$$

Where: s = required example size, X2 = worth of chi-square for 1 levels of opportunity. N is the size of the population, and P is the proportion of the population (0.50) at the desired confidence level (= 1.962 = 3.8416). d is the percentage accuracy level, which in this case is 0.05. Using the aforementioned formula for determining the sample size, the study's target population of 50,000 can be calculated as follows: For the sexually productive female category, the sample size is:

$$\mathbf{s = \frac{1.96^2 \times 50000 \times 0.5(1-0.5)}{0.05^2(50000-1) + 1.96^2 \times 0.5(1-0.5)}}$$

s = 381

Only one qualified female from each household was included in the sample for the purposes of sampling. Therefore, the researcher used numbers from 1 to 50000 in a column of an Excel sheet, generated random numbers in the next column, and sorted the house numbers using the generated random numbers. The house numbers relating to the initial 381 irregular numbers was picked as a component of the example. In every household, one woman was picked. Balnaves (2020) advised the use of random sampling to reduce bias.

Data collection: Data for this study was collected using unstructured interview guides and structured questionnaires. This research utilized self-controlled organized research surveys to gather information from women in Mbare constituency. For the purpose of gathering quantitative data, the questionnaire used in this study consisted of closed-ended questions. For the purpose of statistical data analysis, a five-point Likert scale was used. This enabled the researcher to collect quantitative data, the self-administered structured research questionnaires were justified in their use. Through the use of Google Forms, the researcher was able to collect data from individuals who were difficult to reach and ensured the reliability of the data by ensuring uniformity in the manner in which the questions were asked. The structured research questionnaires were self-administered, and anonymity and confidentiality to information adhered to. Interview guides were used as a qualitative data collection tools in the study. A meeting was organized and discussion between the interviewee and the enumerator. The researcher conducted face-to-face and online interviews with Mbare officials responsible for providing SRH. The meeting guide was unstructured which empowered the scientist to test at whatever point respondents would have presented a few effective viewpoints. Non-verbal signs would likewise be noted during up close and personal meetings and those did over visual electronic correspondence channels, for example, Zoom Meeting stages. Questions with respect to Coronavirus pandemic and ladies' admittance to sexual and regenerative wellbeing administrations in Mbare, Harare Zimbabwe.

1.8 Findings of the study

The response rate formula created by Andrew, Friedman, and Durning (2017) isolates the quantity of effective members by the objective sample size. This example was utilized by the researcher to compute the response rate. Table 1 displays the response rates.

Table 1: Response rate

Research unit	Sample size	Successful Respondents	Response Rate
Women	379	268	70%
Key informants	2	2	100%
Overall	**381**	**270**	**85%**

Source: Field data, 2023

Table 1 shows that, out of the 20 designated populaces of the ladies, 20 effectively took part in the exploration study which means 100 percent. Of the 2 key informants, every one of them took part in the exercise giving a 100 percent. According to Taherdoost (2017), a response rate of at least 70% is required for research findings to be considered generalizable to a population, so the overall response rate of 100% was sufficient. The researcher administered the questionnaire to each respondent and assisted them in answering the questions, particularly to those who needed help in understanding English. This contributed to the high level of participation. The researcher would even, with permission, record some of the points at some point to generate useful data for analysis.

Lockdown and women's access to SRH services in Mbare

The COVID-19 pandemic had an impact on women's access to SRH (SRH) services in Mbare, Zimbabwe. Table 2 shows the results of a survey of women in Mbare, Zimbabwe, asking them how the lockdown affected their ability to access SRH (SRH) services.

Table 2: Lockdown and women's access to SRH services in Mbare constituency

Statement	Mean Score	St. Dev
Women in Mbare largely faced difficulties in accessing SRH services during the lockdown period.	1	0.5
The availability of SRH services in Mbare changed during the lockdown period.	3	1
Women in Mbare experienced delays of appointments for SRH services during the lockdown period.	4	1
Women in Mbare experienced cancellations of appointments for SRH services during the lockdown period.	5	0.5
Women in Mbare have never faced any stigma in accessing SRH services during the lockdown period.	1	0.5

Source: Field data, 2023

The fact that the mean score was 1 indicates that, the vast majority of women in Mbare strongly disagreed with the claim that they had difficulty obtaining access to services related to SRH during the lockdown. This suggests that the lockdown had little effect on these services' availability. The mean score of 3 shows that there was no unmistakable agreement among ladies in Mbare about whether the accessibility of sexual and conceptive wellbeing administrations changed during the lockdown time frame. This recommends that the effect of the lockdown on the accessibility of these administrations might have been blended. Mean score of 4 shows that a larger part of ladies in Mbare concurred that they encountered postpones in their arrangements for sexual and regenerative wellbeing administrations during the lockdown time frame. This suggests that some women were delayed as a result of a backlog of appointments caused by the lockdown. The mean score of 5 shows that by far most of ladies in Mbare emphatically concurred that they encountered problems of their arrangements for sexual and regenerative wellbeing administrations during the lockdown time frame. This suggests that the lockdown may have resulted in the cancellation of a significant number of appointments, making it difficult for some women to obtain the services they required. The mean score of 1 demonstrates that by far most of ladies in Mbare firmly differ that they had at any point confronted shame in getting to sexual and conceptive wellbeing administrations during the lockdown time frame. This suggests that these services' stigma did not rise as a result of the lockdown.

Interview questions found that, a few ladies faced hardships in getting to sexual and regenerative wellbeing administrations during the lockdown time frame in Mbare voting public. The key informants were scientifically named P1 and P2 for easy of reference. P1 narrated that:

"Yes, I did face some difficulties in accessing SRH services during the lockdown period. The clinic I usually go to was closed for a few weeks, and when it reopened, there were long waiting times. I also found it difficult to get an appointment with a doctor or nurse" (P1, 2023).

In contrast, P2 said that:

"No, I didn't face any difficulties in accessing SRH services during the lockdown period. I was able to get an appointment with a doctor or nurse without any problems, and I didn't have to wait very long" (P2, 2023).

About the second question, P1 said:
"Yes, I did experience some delays and cancellations of appointments for SRH services during the lockdown period. My appointment was cancelled twice, and I had to wait an extra week to see a doctor" (P1, 2023).

P2 said:
"No, I didn't experience any delays or cancellations of appointments for SRH services during the lockdown period. My appointments were all on time, and I didn't have to wait any longer than usual" (P2, 2023).

A question was asked if women were able to access contraception during the lockdown period? If not, what was the reason, P1:
"No, I wasn't able to access contraception during the lockdown period. The clinic I usually go to was closed, and I couldn't find another clinic that was open" (P1, 2023).
P2 said:
"Yes, I was able to access contraception during the lockdown period. I was able to get a prescription from my doctor, and I was able to get the contraception at a pharmacy" (P2, 2023).

P1 said:
"Yes, I did face some stigma and discrimination while accessing SRH services during the lockdown period. The doctor I saw seemed to be judgmental about my reasons for wanting contraception, and she made me feel uncomfortable" (P1, 2023).
P2 said:
"No, I didn't face any stigma or discrimination while accessing SRH services during the lockdown period. The doctor I saw was very understanding and supportive, and she made me feel comfortable" (P2, 2023).

The study's qualitative and quantitative findings revealed mixed results regarding the accessibility of Mbare's SRH services. There was a general agreement that women experienced appointment delays and cancellations, but there was no agreement regarding whether these services had changed in availability. Some previous researchers have found that lockdowns have decreased the availability of services related to SRH, while others have found that this has not changed. This study recommends that the effect of lockdowns on the accessibility of sexual and conceptive wellbeing administrations might be blended. Chireshe, Mtetwa, Chifamba and Magwaza (2021) found that the lockdown prompted a lessening in the accessibility of sexual and regenerative wellbeing administrations in Mbare, Zimbabwe. They discovered that some women were unable to access the services they required, and that appointments were delayed or canceled for them. This study's findings are in line with those of Chirese et al. (2021). Nonetheless, this investigation likewise discovered that a greater part of ladies in Mbare did not encounter troubles getting to sexual and regenerative wellbeing administrations during the lockdown time frame. This recommends that the effect of the lockdown on the accessibility of these administrations might have been blended. Chitambara and Munyati (2021) found that the lockdown prompted various difficulties for ladies getting to sexual and regenerative wellbeing administrations in Zimbabwe. In addition to increased stigma, these obstacles included

appointment delays and cancellations. In any case, this investigation additionally discovered that a few ladies had the option to get to sexual and conceptive wellbeing administrations during the lockdown time frame, despite the fact that they might have needed to stand by longer or travel further and pay more to do as such. This suggests that the lockdown may have had a mixed effect on these services' availability.

1.9 Conclusions

The study explored the effects of COVID-19 lockdown on women access to Sexual and Reproductive Health Services in Mbare Constituency in Zimbabwe. From the findings, COVID-19 lockdown prompted lack or reduced number of staff at facilities and emergency clinics, which made it challenging for women to get SRH services. Additionally, the lockdown made it more difficult for women to seek assistance because of the increased stigma associated with SRH services. In some rural areas, traditional birth attendants (TBAs) were significant providers of SRH services in Mbare. TBAs were ready to give socially delicate consideration, which was significant for some women. The study also concluded that, physical and social lockdowns adversely affected women's access to SRHS as well as the administration of the same services in the study area. In the study area however, for women who were unable to travel to clinics and hospitals, door-to-door services were also more convenient.

1.10 Recommendations

This section presents recommendations to communities, healthcare workers as well as the health sector policy makers. The government and other stakeholders to keep on delivering house to house SRH services. This can be enhanced by bringing closer and meaningful collaborations between TBAs, Community health workers, and the conventional health fraternity whose local presence matter to the people. The society should work towards de-stigmatising SRHS at all times. This can be realized through awareness creation. It is also important to provide enough staff in the hospitals during lockdowns as well as training them on the upcoming needs especially in managing disease outbreaks.

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