SRHR in the context of COVID-19: The sad story of adolescent girls and young women in resource-constrained communities of Zimbabwe

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Abstract
Adolescent girls and young women (AGYW)'s access to sexual reproductive health services is a topical issue in Zimbabwe. The 15-24 age group is less protected from sexual and reproductive health risk factors which include among others: early and forced marriages, early pregnancies, school dropouts and sexual and gender-based violence. A qualitative study was done in three resource-constrained communities aiming at assessing AGYW's access to SRHR services during the COVID-19 era so as to inform policy. The objectives were to examine the availability of SRHR services to AGYW during the COVID-19 lockdowns, unearth the challenges experienced in trying to get access and recommend strategies that can be adopted in disseminating SRHR services to the target group in poor communities during disastrous situations. The study was conducted between May and June 2020 in Mutare, Chipinge and Masvingo rural areas where two wards were chosen per area. Four focus group discussions were conducted per area. Each focus group comprised of ten participants. Two groups per area comprised of 15-19-year-olds and the other two comprised of 20 -24-year-olds. A sample of 120 young women was drawn using purposive sampling. Thematic data analysis was utilised and six key themes emerged. These included that SRHR services were unavailable, the lockdowns restricted AGYW's movements in search of SRHR services; adolescents could not freely communicate their need for such services with adults; SGBV cases escalated, health institutions prioritised COVID-19 issues to the neglect of all other issues and the government did not priorities many organisations offering such services. Conclusively, movement restrictions posed by COVID-19 pandemic further exacerbates the challenges experienced by AGYW in accessing SRHR services as the government less prioritised these issues. The findings of this study recommended strategies that can be adopted by policymakers and other stakeholders in trying to value SRHR of AGYW even in pandemic situations.
Keywords: *SRHR; COVID-19; challenges; resource-constrained communities; lockdowns*

1. Introduction

In December 2019, there emerged the novel coronavirus disease (COVID-19) in Wuhan, China. This disease was declared a pandemic by World Health Organisation on 11 March 2020 leading to a serious rise of COVID-19 cases globally. In trying to curb the spread of the disease, many countries adopted stern measures which included among others, strict movement restrictions, lockdowns and other containment efforts. The pandemic and its consequences negatively affected the availability of and access to sexual and reproductive health rights (SRHR) services. Many organisations encountered the difficult decisions to reduce, reorganize, reroute or close SRH services as a way of protecting service providers and clients. Service providers and facilities were called upon to support many governments globally, in their response to the pandemic. The availability of SRHR services was affected by the reduction in health workers, scarcity of essential SRHR commodities and supplies, lack of protective gear and equipment and restricted mobility.

Research studies point out that, there are a lot of barriers concerning accessibility of SRH services by girls and women. These barriers according to Robertson et.al., (2020), can include cognitive accessibility where, especially girls, might not be aware of the existence of these services (lack of information), psychosocial accessibility of services in relation to the feeling of shy or discomfort owing to negative cultural connotations and attitudes

attached to premarital sex. Affordability is yet another barrier where in most cases if not all, SRHR services need to be paid for and women and girls from poverty-stricken communities cannot afford the service being aided to by geographical inaccessibility.

The pandemic exacerbated already existing inequalities for women and girls. Evidence from past epidemics like Ebola and Zika outbreaks reflects that such occurrences put women and girls at a greatest risk thereby affecting them negatively (Eghtessadi et al. 2020; PAI, 2020). The Ebola crisis reflected how a pandemic can have a sharp impact on maternal services for instance in Sierra Leone approximately 3,600 maternal deaths, neonatal deaths and stillbirth were link to the disruption of services and fear of searching for treatment during the outbreak (Santoshini, 2020; Guttmacher Institute, 2020). These statistics were almost equal to the fatalities caused by Ebola itself. Just like Ebola outbreak in Sierra Leon where SRH services became so scant and accessible, the story is the same with the emergency of COVID-19 in Africa (Velavan,.et.al 2020). Professionally, many women are frontline health workers which puts them at a higher risk of contracting the disease. In many contexts, women and girls are the main caretakers at the household level, taking care of children and the elderly family and now it includes taking care of family members infected with COVID-19 in domestic isolation. The pandemic ushered in a wave of closure of formal and informal work which led to a loss of income thereby compelling families to resort to negative coping strategies to source for income or reduce the cost of living. Such negative strategies may include sexual exploitation and abuse of young women and girls.

1.2 Aim of the study

The study aimed at assessing adolescent girls and young women's access to SRHR services during the COVID-19 era so as to inform policy on any identified gaps.

1.3 Objectives of the study

- To examine the availability of SRH services to adolescent girls and young women during the COVID-19 lockdowns.
- Unearth the challenges experienced by young girls and women in trying access SRHR services during COVID-19 lockdowns.

Recommend strategies that can be adopted in disseminating SRH services to the target group in poor communities during disastrous situations

2 Literature Review

Research has shown that, access and availability of sexual reproductive health services in the Sub Saharan was and is still very poor. The coming of COVID-19 has to a greater extent exacerbated poor access to SRHS leading to the disastrous consequences to many girls and women in Africa. Such plights were worsened by disruption of livelihoods activities, education and healthcare including community based SRHR services which were halted (Velavan,.et.al., 2020). This was evidenced by a general increase in child marriages, unwanted pregnancy and later high levels of school dropouts.

It has been noted by different scholars that, the underlying and key drivers of child marriage in countries like Zimbabwe, Zambia and South Africa can include but not limited to family poverty, idleness, high levels of drug and substance abuse, harmful religious and cultural practices together with movement restrictions that proved

to stifle efforts to visit health service centers. As a result of the crisis, many girls below the age of 18 were exposed to several forms of sexual exploitation, physical and emotional abuse owing to gender related inequalities and movement restrictions.

Preparation and awareness was another area of concern. Tomori (2020), postulates that preparedness is of value especially regarding the need to deal with the knock-on effects of a pandemic. Most countries worldwide were caught unaware with the virus and in Africa COVID-19 task force initiative seem to be questionable in terms of their capacity to provide the much needed SRH related commodities. This can be evidenced by high incidences of child marriages and unwanted pregnancies (UNAIDS, 2020). In many Africa countries, antenatal and postnatal care services are provided within the premises of health centers with very limited to no mobile SRH facilities. In this regard, it became very difficult if not impossible to access services like, emergency contraception, post-abortion care and even safe abortion due to the restrictive and containment measures of COVID-19 pandemic.

IPP (2020), notes that everyone is prone to sexual and gender-based violence (SGBV) but the weight weighs heavily on women and girls. Thus, in light of the COVID-19 movement restrictions, young women and girls became more isolated which increased their vulnerability to SGBV as they found themselves in forced confinement together with family members or partners who may be perpetrators of the violence. Iyengar, the executive director of Action Research and Training for Health in India was quoted by Santoshini (2020), when he said that due to COVID-19 lockdowns, women were now facing a double tragedy of lack of money due to job losses and failing to move in search of reproductive health services due to movement restrictions as well as living in a police state. Globally, countries that depended on community health workers for essential family planning services saw the services swiftly disappear. According to Santoshini, (2020), movement restrictions and suspension of community mobilisation in Zimbabwe affected the activities of one of the country's largest family planning providers, Marie Stopes, which saw a 70% reduction in the frequency of women that it could reach and support. Similarly, Reproductive Health Uganda which also used to reach almost 70% of its clients through community outreach programs had to suspend a lot of its work during the outbreak.

The pandemic led to the closure of many public places where young people could access SRHR services and comprehensive sexuality education which include schools, community centres and local health clinics. In some contexts, these places were turned into quarantine centres for the infected and some health centres started concentrating on COVID-19 issues to the neglect of all other health issues (Tapera, 2020). According to IPP (2020), these changes coupled by restrictive measures toward the containment of the pandemic negatively affected SRHR needs of nearly 90 percentage of the global student population. The services that were disturbed included SRHR and CSE information and counselling, contraception services, safe abortion services, maternal and newborn health services, services for gender-based violence (GBV), STIs/HIV, infertility and reproductive cancers (IPP, 2020). In addition, the International Planned Parenthood Federation (IPPF), reported that more than one in five member clinics globally were shut down, 5 000 mobile clinics across 64 countries closed mostly in South Asia and Africa due to the pandemic and related restrictive measures (Cara, 2020). The consequences of such disturbances in service provision could elevate cases of unintended pregnancies, unsafe abortions, possible complications of pregnancy and childbirth as well as maternal and newborn morbidity and mortality.

Santoshini (2020), quoted Dupte, the medical director of Family Planning Association in India who stated that, just like in other countries, in India when COVID-19 lockdowns were first introduced, family planning and abortion services were not regarded as essential services thus negatively impacting on women's sexual reproductive health. Carra (2020), also reiterated that implementation of lockdown as a way of curbing the pandemic put multitude of women in Africa, Asia and elsewhere at the mercy of failing to access birth control and other sexual and reproductive health services. In some cases, family planning was available but women dreaded going out and get beaten by security forces for not taking heed of movement restriction regulations. Thus, generally the pandemic made access to SRHR services uneven or non-existent.

The COVID-19 pandemic resulted in a decline in global supply chain of medical health products. IPP (2020), noted that this global supply chain crisis came as a result of an increased demand for essential medical and health equipment and supplies, personal protective clothing (PPE) and increased use of simultaneous lockdowns implemented around the world. This situation impacted production and distribution of medical health products. It has been documented that some powerful suppliers of pharmaceutical ingredients like China and India experienced export restrictions hence negatively affecting the critical supply chain of essential health products. Satoshini (2020), pointed out that main suppliers of condoms and IUDs in India and Malaysia testified to production and shipping restrictions. The IMAP statement documented by IPP (2020), also state that many countries experienced shortages of PPE and other sexual and reproductive health commodities and supplies. In relation to this, the UNFPA Technical Briefs (2020), noted that shortage of these supplies included modern contraceptives commodities and supplies which include menstrual health and hygiene which are crucial in adolescents and women's health, empowerment and exercise of sexual and reproductive health rights. The same brief also highlighted that, the closure of borders and constrains in manufacturers' delivery flows affected the import and in-country availability and distribution of sexual reproductive health products thus reversing the gains that have been acquired towards universal access to sexual and reproductive health. This has seen UNFPA (2020), updating that nearly 46 countries ran short of contraceptives in 2020. In addition, Santoshini, (2020), noted that the collapse of medical supply chains was catastrophic for women in developing countries and this was worsened by the lockdowns.

Health services delivery which included the distribution of SRHR products were also affected. According to UNFPA Technical Briefs (2020), as well as Chattu and Yaya, (2020), human and financial resources are often diverted during public health emergencies to respond to the outbreaks and this has seen sexual and reproductive health services being impacted by the pandemic. In addition, in low- and middle-income countries public health disruption related to COVID-19 were associated with a likelihood of a 10 percent decline in SRHR service access especially by girls and women (Oladele et.al., 2020; Riley et.al., 2020). On another note, Santoshini, (2020), stated that in March 2020 sexual and reproductive health supplies ran low due to the pandemic leaving women without any forms of birth control. In support of this, Seema Jalan, executive director of Universal Access Project as quoted by Santoshini (2020), reiterated that sexual and reproductive rights were globally in crisis even before

the pandemic hence the pandemic just exposed the injustices further. The Marie Stopes Zimbabwe country director, Shibru (2020), reiterated that everything from political will to resources have been diverted towards COVID-19 at the expense of women which means that in future most African governments are likely to encounter another disaster in the form of increased maternal mortality. Due to limited supplies women and girls have been robbed of receiving life-saving services that can give them an opportunity to make informed decisions about their sexual and reproductive health needs which include delaying, preventing and spacing pregnancies.

3. Materials and Methods

The study utilised a qualitative research approach which proved to be the most appropriate design for the issue of interest. Qualitative research is holistic in nature and its fundamental aim is to understand social life and the meanings that people attach to it. The approach is based on the belief that people create their own reality and researchers who subscribe to this approach attempt to view reality from the eyes of those who experience it as they generally believe that there are multiple realities (Babbie & Mouton, 2001). Phenomenology was the qualitative design that was utilised as the researchers wanted to get an in-depth understanding of the lived experiences of girls and young women in relation to accessibility to SRHR services and challenges they faced during the COVID-19 era. According to Cohen et.al., (2007), as cited in Sloan, Bowe and Brian (2014), phenomenology is a theoretical point of view that advocates for the study of individual experiences as human behaviour is determined by the phenomena of experience instead of objective, physically described reality that is external to the individual. This phenomenological approach gave the researchers of this study an opportunity to 'give voice' to the experiences that adolescent girls and young women went through in accessing SRHR services during the COVID-19 pandemic. Thus, basically the methodology was chosen because the aim was to get to the roots of the lived experiences of the targeted group.

3.1 Data Collection Procedure

Data was collected between May and June 2020 from three selected areas. The researchers managed to access the participants by gaining permission from the community gatekeepers. Permission was granted on the grounds that the researchers and the participants adhered to COVID-19 preventive measures which included wearing of face masks, sanitising and maintaining social distance. In collecting data using the phenomenological approach, the researchers of this study utilised focus group discussions. These discussions helped in exploring what the participants went through during the pandemic era. They also facilitated sharing of experiences amongst the participants themselves. Four focus group discussions were conducted per area making a total of twelve for the whole study. Each focus group comprised of ten participants. Two groups per area comprised of 15-19-year-olds and the other two comprised of 20 -24-year-olds. The researchers facilitated the discussions and they were audio recording the sessions with the consent of the participants. The discussions ran for one and half hours or an hour. In most cases the discussions were terminated when they reached data saturation. The researchers familiarised themselves with the data by thoroughly transcribing and reading the transcriptions. The audio recorded discussions were transcribed verbatim within a period of 48 hours of conducting them.

3.2 Population

The study's target population consisted of adolescent girls and young women aged between 15 and 24 who were permanent residents of the selected rural communities described as hard to reach or resource-constrained communities. These communities included very remote rural wards found in Mutare, Masvingo and Chipinge rural areas which are all found in Zimbabwe. This group was selected as it mainly constitutes the most active group of girls and women in relation to sexual reproductive health. Hence their lived experiences during COVID 19 era became very important as they could help in informing policy and national responses to disasters on girls and women' sexual reproductive health- related issues.

3.3 Sample and sampling strategy

The sample used was adequate enough to be a true representative of the targeted population. Three rural districts were purposively selected as researchers had to use their own discretion in picking out areas which fell in the category of areas which are resource-constrained. From those three rural districts, the researchers randomly selected two wards per area. A sample of 120 girls and young women was selected using purposive sampling. The sample was relatively small which suites qualitative research as it is more concerned with quality and depth than with quantity. Purposive sampling is used when selecting elements on the basis of the researcher's judgment about their level of usefulness and representativeness (Borbasi & Jackson, 2012). In addition to this, Parahoo, (2014) says that this type of sampling may involve making a judgment or relying on the judgment of others in the selection process. Therefore, this strategy was used to select participants who could meaningfully contribute to the exploration of girls and young women's experiences in their attempt to access sexual reproductive health services during the COVID-19 lockdowns.

4. Findings

Thematic data analysis was employed in analysing the results. According to Attride-Stirling (2001), thematic network analysis delves into the perception of an issue or the importance of an idea (Attride- Stirling, 2001) and aims to unearth the salient themes together with patterns in a specific linguistic domain. One of the advantages of thematic analysis is its theoretical independence that can either be inductive or theory driven (Braun & Clarke, 2006). Despite this flexibility nature of thematic analysis, the researchers followed systematic and rigorous guidelines to gain meaningful and useful results. Six key themes emerged from this study and have been expounded in the following sections.

4.1 Availability of SRHR services

Unavailability of SRHR related services during a pandemic was a cut across experience in all the three communities. This was related to the reported high incidences of gender-based violence (GBV). Violence against women and girls and harmful practices remain pervasive and order of the day as a result of the pandemic where access to services was highly compromised due to lockdown restrictions. Key impediments to access SRHR services proved to be entrenched cultural norms and gender inequalities among men and women. Social norms

determine sexuality behaviour of girls and women which was found to be determined by male figures (who happen to be breadwinners). Due to the aforementioned reasons, SRHR services became partially accessible or totally inaccessible with the majority of girls and women finding it difficult to access them. The following points were raised in the focus group discussions:

> *Some of us used to secretly get family planning methods from community health workers but due to movement restrictions these local service providers are not mobile too.*
>
> *We cannot access SRHR services for fear of being victimised by our partners who are always at home now hence there is no way we can search for the services in their presence as they do not approve of that.*
>
> *I heard the local clinic does not have the supply of contraception we used to get so I have been going for about two months without. I fear that I will have an unplanned pregnancy during this COVID-19 era when life is this difficult.*

4.2 COVID-19 lockdowns as restrictions on AGYW's search for SRHR services

Research findings revealed that, there were decreased access to sexual reproductive health rights coupled with increased violation of sexual reproductive health rights as a result of COVID-19 restrictions. SRHR services like contraceptives and ARV service delivery proved to be a tragedy for young women and HIV positive clients in different communities as a result of movement restrictions and closure of many Opportunistic Infections Centres (OICs). The participants also noted that they could not access sanitary wear as they could not access shops and other centres where they could get such services. Some HIV positive participants had this to say:

> *Our local OI clinic was closed during the lockdown and I could do nothing to get my refill due to travel restrictions.*
>
> *OI clinics that were open during the lockdown were highly congested to such an extent that the need to collect my refill was fruitless.*
>
> *Due to closure of the local OI clinic and unavailability of transport coupled by lack of exemption letters caused me to default for close to two months.*

Such findings were a clear evidence of the untold sufferings incurred by HIV positive people in different communities. Indeed, COVID-19 restrictions contributed to defaulting and compromised wellbeing of quality of health among HIV positive people. In addition to that reduced access to SRHR services led to the influx of psychological problems such as hopelessness, stress and depression among people living with HIV.

In relation to difficulty in accessing contraceptives and sanitary wear, the participants noted the following:

> *Lockdown due to COVID-19 caused a lot of stress and I experienced a mental health problem thinking about what my health was going to be due to limited or unavailability of ARVs at local service providers.*

In connection to information concerning SRHR service provision during COVID-19 lockdown, political will was another area of concern. Evidence has it that political will has the capacity to support SRHR service delivery to

ensure efficiency and solidification of such services during a pandemic. Majority of participants confirm that there was a great decrease concerning SRHR related access across different age groups due to a drastic shift of focus in the health fraternity where the main focus was on COVID-19 response in terms of treatment and prevention.

4.3 Communication Difficulties on SRHR issues between Adolescents and the Elderly

Adolescents were suffering silently during the lockdown period. SRHR related dialogue was and is a taboo to be initiated by parents to their children. Parents to child communication (PCC) was perceived a taboo by parents and guardians and having such a dialogue with an adolescent child was regarded as promoting early sexual debut by the child. On the other hand, children found it very embarrassing to have an SRHR dialogue with parents.

> *SRHR dialogue with my child is not possible but it has to be done by aunties and uncles*
>
> *I don't feel comfortable to have an SRHR dialogue with my parents, it's embarrassing*
>
> *I might want to have a dialogue with my children about SRHR but I don't know when or where to start and also, I don't have the information and skills to initiate such a dialogue*

4.4 Prioritisation of COVID-19 Issues over other Public Health Issues by Health Institutions

The findings of this research established that, COVID-19 disease has exacerbated limited access to sexual reproductive health services. This challenge was fueled by fear as many women and girls were afraid of contracting coronavirus hence were hesitant to seek care. This was also worsened by the fact that, all public health efforts with the aim of advising girls and women concerning when, where and how to seek sexual reproductive health services were either limited or unavailable. This was aided to by the fact that a lot of SRHR professionals and paraprofessionals were unable to operate effectively during pandemic owing to such factors like travel restrictions.

> *In our community antenatal care services or family planning in general were unavailable as a result of the pandemic, hospitals and clinics were committed to COVID-19 patients.*

Research findings have indicated that, Zimbabwe healthcare system rarely prioritised sexual (SRHR) during COVID-19 period. It was quite evident that, women and girls as well as people with disabilities found it hard to access SRHR services. In other words, the pandemic decimated the healthcare system that halted many local clinics and mobile SRHR service provision in many parts of the country. Due to the lapse in sexual and reproductive health there was a general increase in teenage pregnancies, maternal deaths, unintended pregnancies as well as sexually transmitted infections.

4.5 Non-prioritisation of Organisations Offering SRHR Services during the Pandemic

The findings highlighted that the government did not prioritise many organisations offering SRHR services hence they could not reach out to their clientele as they also experienced movement restrictions. It was noted that all

other public health issues were neglected in favour of COVID-19 related matters. The participants had the following to say:

> *Organisations that used to give us family planning services have are also on lockdown we cannot reach them. The government does not allow them to be mobile under this lockdown.*
>
> *We used to get information about our reproductive health from the local clinic and other organisations but the clinics are now COVID-19 isolation centers and other organisations are either closed or are also focusing on COVID-19. We do not know what is going to become of us under this pandemic.*

4.6 Hostile Environment at Local Health Centres for Adolescent Girls

The discussion done with adolescent girls brought out that health centers were not very accommodative in terms providing SRHR services to girls. The participants indicated that the situation has been like that even before the emergence of the pandemic hence the disaster just worsened it. It seemed as though the priority was given to sexual reproductive health needs of adults especially married ones. Adolescent participants said some of the following statements:

> *Nurses at our local clinic shun us when we go in search of condoms or family planning methods. They say it is a sign of indecency, such services are meant for married people.*
>
> *COVID-19 has worsened our situation. Sometimes when we ask for sexual reproductive health services at local centres we are told that the little that are available are reserved for adults especially those who are married.*

5. Discussion of findings

Findings from this study managed to confirm what came out in some previous studies. Some of the findings could be connected to the fate that was experienced by some women during the outbreak of other pandemics like the Ebola and Zika Virus. The findings also confirmed the fact that Zimbabwe, just like most other countries was also ill-prepared to address sexual and reproductive health needs of adolescent girls and young women during the initial occurrence of the COVID-19 pandemic. The country was also found prioritising COVID-19 issues to the neglect of other public health issues.

It was found that SRHR services for adolescent girls and young women were either limited, non-existent or difficult to access. Some AGYW could not access the services due to gender-based violence as well as restrictive cultural norms and gender inequalities among men and women. Such findings can be linked to Robertson et.al. (2020), who notes that some girls and young women may find it difficult to search for SRHR services during disastrous situations due to feelings of shyness or discomfort caused by negative cultural connotations and attitudes associated with premarital sex. Other studies found out that pandemics aggravate already existing inequalities for women and girls just like what was experienced during the outbreak of Ebola and Zika virus where maternal health services were disrupted leading to high rates of maternal mortality (Eghtessadi et al. 2020; PAI, 2020; Santoshini, 2020; Guttmacher Institute, 2020). Hence pandemics negatively affect sexual reproductive health needs of young girls and young women.

Movement restrictions as a preventive measure towards the spread of COVID-19 pandemic was lambasted as a major hindrance to adolescent girls and young women's search for and access to SRHR services. The study found out that many could not access services like contraceptives, sanitary wear and ARVs due to movement restrictions. Some could not go out in search of such services for fear of harassment from the state security officers while others were afraid of victimisation from spouses or other male figures in the household. Among those who could not access ARV services, there were others who were negatively affected psychologically as they became hopeless, stressed and depressed. According to IPP (2020), movement restrictions exposed girls and young women to heightened sexual and gender-based violence as they would spend most of their times confined together with perpetrators or potential perpetrators of such violence. Santoshini (2020), reiterated that movement restrictions exposed women to the double burden of being financially incapacitated as well as failing to access SRHR services. The restrictions also affected community initiatives that would bring the services to the community where girls and women reside. In support of this, Carra (2020), reiterated that the restrictions robbed women the opportunity to access birth control and other SRHR services especially in Africa and Asia. Therefore, movement restrictions during the COVID-19 pandemic left many girls and young women without access to services vital for their sexual and reproductive health.

The use of lockdowns was also regarded as a major disturbance to the supply of SRHR services. Participants from this study noted how they failed to get services like family planning commodities and ARVs as they were out of stock. Literature reflected that the shortages were not only caused by local constrains but it was actually a chain that affected almost all nations. IPP (2020), highlighted that there was a global supply chain crisis which manifested in the decline of supply of medical health products. The decline was caused by a high demand for PPE and health equipment required to deal with COVID-19, simultaneous global lockdown characterised by movement restrictions which negatively affected production and distribution of medical health products. Major Chinese and Indian suppliers of pharmaceutical material were reported to experience export restrictions which affected the global supply chain (IPP, 2020). In relation to this, Satoshini (2020), also noted that Indian and Malaysian suppliers of condoms and IUDs experienced production and shipping restrictions. The shortages of sexual and reproductive health commodities were also testified in IMAP statement in IPP (2020), and in UNFPA Technical Briefs (2020). This led Santoshini, (2020), to reiterate that the collapse of medical supply chains was a disaster especially for the sexual and reproductive health of women in developing countries. This study managed to confirm that indeed there was a global supply chain crisis which affected many countries and was felt at the grassroots in the form of shortages of sexual and reproductive health commodities.

The study also established that SRHR matters were undermined by the government. This was witnessed when the government focused more on COVID-19 than any other public health issues, closed or converted some health centers which used to offer SRHR services to COVID-19 quarantine or isolation centers and also stopped some SRHR community-based practices. These challenges were noted by participants as hindrances to the availability and accessibility of SRHR commodities during COVID-19 lockdowns. Literature has it that during health emergencies human and financial resources are diverted to attend to the outbreak at the neglect of other public health services which include sexual and reproductive health (UNFPA Technical Briefs 2020; Chattu & Yaya 2020;

Oladele et.al. 2020; Riley et.al. 2020; Santoshini 2020). In addition, Shibru (2020), emphasised that most countries diverted everything including political will and resources in responding to COVID-19 pandemic hence exposing women and girls to sexual and reproductive health risks.

6 Conclusions and Implications for Policy

COVID-19 movement restrictions exacerbated the challenges experienced by adolescents and young women in accessing SRHR services. The gendered impact of COVID-19, put at risk sexual and reproductive health of girls and young women mostly. Africa is characterised by pre-existing gender inequalities that have resulted in economic and social injustices as well as poor health outcomes which have been aggravated by disruptions caused by the pandemic. History has it that, epidemics like Ebola and Zika virus left long term adverse impact mainly on girls and women's sexual and reproductive health outcomes. Such outcomes are usually experienced when concerned governments reroute scarce resources to contain epidemics while neglecting other public health needs of the populations. In addition, this gendered impact of COVID-19 instigated an upsurge in domestic violence cases against girls and women specifically sexual and gender-based violence and unintended pregnancies. Lockdown restrictions caused women and girls to have limited access to social protection which put at risk their sexual and reproductive health rights. The outcome included an increase in new STI and HIV cases, unplanned and unwanted pregnancies, unsafe abortions as well as mental health problems amongst girls and young women.

COVID-19 caused closure of some important institutions like schools and community centers thereby robbing adolescent girls and young women's access to SRHR information. Interrupted access to education, skills development and learning spaces have intensified the gendered impact of COVID-19 causing devastating effects on adolescent girls and young women. In Zimbabwe, schools have been a source of comprehensive sexuality education which provided access to information and establishes agency of girls in relation to their sexual reproductive health and rights. Inaccessibility of such information means devastating effects on adolescent girls and young women for example girls' inability to practice body autonomy, get social protection and heightened exposure to sexual abuse. Such a scenario may lead into an increase in teenage pregnancies, unsafe abortions, increase in home deliveries conducted by unskilled attendants thereby plunging the country into higher maternal and infant mortalities and morbidity. Closure of learning institutions therefore have derailed the educational trajectory of adolescents and young women simultaneously impeding their access to comprehensive sexuality education and contraceptives coupled by increased exposure to sexual and gender-based violence, early and unplanned pregnancies, poor menstrual hygiene management and forced or early marriages. Such adverse effects on SRHR outcomes for adolescents and young women has heightened poor mental health conditions and psychosocial well-being such as anxiety, depression, frustration, and feelings of isolation which have been intensified by exposure to hunger and poverty.

Containment measures towards the pandemic led to compromised access to sexual reproductive health and rights of adolescent girls and young women. Curfew measures which were enforced caused reduced access to SRHR services to adolescent girls and young women especially in rural and remote areas of Zimbabwe. Mobile

community workers were also restricted in their activities due to curfew measures and lockdowns. Closure of some health facilities also contributed to reduced accessibility of SRHR services as well as sexual and gender-based violence services for instance it compromised timely access to post rape treatment. Disturbances in the supply chain of SRHR commodities affected many communities for example some girls and women could not access sanitary wear either due to scarcity or hiked prices and this affected their menstrual hygiene and dignity.

Government put less priority on women and girls' SRHR issues meaning their emergency response is gender insensitive. Sexual and reproductive services and medicines are vital and lifesaving. The pressures from COVID-19 response on strained health services in the country has disrupted essential care which include maternal health, cervical cancer screening, SGBV counselling and safe places, HIV care treatment, contraception, safe abortion care and post-abortion care. Such disruptions place sexual and reproductive health needs of adolescent girls and young women at stake.

6. Recommendations

Basing on the findings of this study the following recommendations have been proposed.

In responding to health emergencies, the government must adopt a gendered approach in delivering SRHR services. A gender lens is critical as part of intervention towards outbreak of pandemics. The response must be gender responsive simultaneously acknowledging the needs and rights of women and girls as well as other vulnerable groups of society like the elderly and people with disabilities.

There is need for prioritisation of mobile clinics during pandemic outbreaks. Governments must promote the services of mobile clinics during lockdowns so as to ensure that though there are movement restrictions adolescent girls and young women will still be in a position to access SRHR services within their communities.

Healthcare providers must promote introduction and implementation of telemedicine for SRHR services, use of online prescription, mHealth services and create partnership with other sectors like online commercial platforms or commercial service deliveries. Under this initiative, women and girls should be granted opportunities to renew their prescriptions or get new prescriptions through telemedicine, receive SRHR services through phone or online consultations. They can also get online mental health services. Telemedicine is crucial as it reduces physical visits by adolescent girls and young women to doctors in search of prescriptions or other sexual and reproductive health needs. It protects the health of both women and healthcare providers by evading unnecessary exposure to the virus.

Online education on SRHR must also be introduced in all communities. This can take the form of SMS on mobile phones. Stakeholders involved in SRHR services must be encouraged to embrace new technologies which are key to the provision of comprehensive sexuality education which has been disrupted by the closure of schools. They should strengthen the accessibility of virtual comprehensive sexuality education by simultaneously providing SRHR information and education directly on their website and through social media (Facebook, WhatsApp and Instagram), making use of SMSs and providing teachers with the CSE packages that can be used for virtual schooling.

Government to address socio-cultural factors when developing policies on SRHR. Such policies may be helpful in promoting intergenerational dialogues targeted at necessitating free discussion on SRHR issues among the young and the elderly. The policies must also address cultural issues to give girls and women the autonomy to express themselves in matters relating to SRHR. The government must also continue to guarantee non-discriminatory access to SRHR services, information and commodities for all during the crisis by acknowledging that they are life-saving and usually sensitive services. This should be done in line with WHO guidelines coupled by an adoption of a client-centered, human rights-based approach.

Author Contributions:
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