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Covid-19 pandemic and women's vulnerabilities in Zimbabwe

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ABSTRACT
While the Covid-19 pandemic affects the health and well-being of all, women and girls are disproportionately affected, especially in developing countries. Thus, the desk review sought to establish women's vulnerabilities in face of the Covid-19 pandemic in Zimbabwe. The intersectional thinking was used to analyse and conclude the study. It emerged from the analysis that while the measures instituted to combat Covid-19 including calls for social distancing, quarantining and lockdowns remain key, they have disproportionately affected women's socio-economic well-being exacerbating the long-standing gender inequalities. As shown by intersectional feminism, women and girls' social identities overlap, and compound with pre-existing inequalities that subjugate them in society including patriarchy, culture, religion, and poverty to limit women's community and personal security, access to employment and income, safety nets, and sexual and reproductive health. The study recommends gender mainstreaming in socio-economic response measures by state and non-state actors during, and after Covid-19 pandemic.

KEYWORDS
intersectionality, feminism, pandemic, vulnerability, women

1. Introduction

On December 31, 2019, Chinese officials reported cases of an unusual pneumonia in the city of Wuhan, Hubei province. One week later, the officials realised that the illness was caused by a novel coronavirus which would later be called SARS-COV-2, and the illness it causes, Covid-19. Over the following weeks, the virus spread throughout much of China, and then outside of that country with the first case reported in Thailand on 13 January 2020. On 30 January 2020, the World Health Organization (WHO) declared Covid-19 a global emergency, and on 11 March 2020, WHO designated the illness as a pandemic, and since then, almost all countries in the world have reported cases. To date, over 197 million cases of Covid-19 have been officially reported with over 4.2 million deaths (WHO, 2021).

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Zimbabwe's first case was confirmed on 21 March 2020 and on 23 March 2020, the first death related to the virus was recorded. As of 28 July 2021, the country has reported over 103,000 cases with 3,340 fatalities (WHO, 2021). Due to the high infection rate as well as the serious effects caused by the disease, social distancing, and lockdowns, have been a common method used by governments around the world to combat the pandemic. The use of lockdowns has been a policy in other modern health crises such as the 2014-2016 Ebola Virus Disease (EVD) epidemic which affected several countries in West Africa; but this is the first time that mass lockdowns have been placed in countries across all continents. Zimbabwe has been on lockdown since 30 March 2020 with strict restrictions between 30 March 2020 and 17 May 2020, and again between 2 January 2021 and 15 February 2021, and in July 2021 due to the surging cases. During the periods of strict lockdown, only businesses designated as essential were allowed to be open, and all other citizens confined to their homes except for trips to the grocery store, pharmacy and doctors' visits.

While lockdowns, and social distancing strategies have been effective in reducing the number of cases, the strategies have had significant impact on societies. Not only is the pandemic a health and economic event, it is also a societal crisis with women in particular suffering as policies enacted lack gender sensitivity. In a country with an already challenging economy, rising inflation, increasing food insecurity, and weak public health system, the lockdown, and social distancing measures, have exacerbated the social norms, and economic as well as social stress that make women vulnerable in Zimbabwe. Areas in which women are more affected relate to sexual and reproductive health, gender-based violence, increased economic stress, and lack of access to basic resources. All these issues make social distancing for women difficult, and place women in more vulnerable social conditions. Not only does Covid-19 and the methods to contain it present difficulties to women, but it also threatens to harm the progress made towards women's empowerment in the country.

Even with these indications, emerging empirical studies on Covid-19 in Zimbabwe remain vague, and run short of revealing the gendered effects of the pandemic. An attempt to cover the subject by organisations, and media reports, has benignly focused on acknowledging that women, and girls, are affected most by the pandemic without showing the extent, and the ways, in which they are impacted upon. This gap in empirical studies thus far, speaks to the need to reveal, and explain, the ways in which women and girls are disproportionately affected by the Covid-19 pandemic in Zimbabwe. A study of this nature adds to the calls by the United Nations (UN) for the urgent need to reach the disadvantaged groups, make their plight be heard during the pandemic, and to make governments #LeaveNoOneBehind in their Covid-19 response plans.

2. Methodology and theoretical approach

This study utilised a qualitative research approach rooted in descriptive design. Data for the study was collected through document review. The reviewed documents included government, media and non-stakeholder reports and communications regarding the Covid-19 pandemic. Based on review of extant literature, the study understood the past, and emerging vulnerabilities of women in pandemic situations. The study was rooted in intersectional thinking to understand the gendered nature of the pandemic in Zimbabwe. Intersectionality is primarily concerned with how the exercise of power affects individuals who face multiple social inequalities, and consequently, multiple intertwined and simultaneous experiences of privilege and marginalisation (Crenshaw, 1989). An intersectional approach helped researchers understand the complexity of identity beyond only gender and sex; the study recognises the ways that gender intersects with other historical social identities such as poverty, environment, rurality, religion, and class to affect the position of women during this pandemic (Davis, 2008). The study, therefore, recognises that there is diversity within the experience of being a Zimbabwean woman navigating the pandemic.

3. Results and discussion

This section presents and discusses findings that arose with regards to women and girls' vulnerabilities due to the Covid-19 pandemic in Zimbabwe. The results are presented and discussed in main themes which are: the economic impact, care roles and resources, limited access to pandemic information, sexual and reproductive rights, Gender Based Violence (GBV) and personal security challenges, and increased online sexual abuse.

Economic impact

Health crises caused by the Covid-19 pandemic's nature are often accompanied by economic crises, in which women bear the brunt. Globally, most countries fell into recession during the Covid-19 pandemic, with the global economy falling by 4.4 percent (Jones, Palumbo & Brown, 2021). Zimbabwe is not immune to the crisis. As a country that is dominated by an informal economy, the effects of a recession are felt deeply. Zimbabwe has been in the depths of an economic crisis for decades which has seen a massive spike in the women-dominated informal market as employment in the formal market has decreased. The Labour Force Survey of 2014, revealed that among those who are employed in Zimbabwe, 94% fall within the bracket of informal employment (Zimstats, 2014; UNICEF, 2014). Work in the female dominated informal market is insecure, lowly paid with little or no income security and social benefits (ILO, 2021). During the lockdown, informal markets were shut down, thereby affecting the majority of women who rely on it for their survival. The same scenario happened in West African nations during the EVD outbreak when many women who participated in informal trading were disproportionately affected by restrictions to combat the epidemic (UNDP, 2014).

When there is no income security in the informal sector, the time away from work is unpaid, which will exacerbate economic inequality between men and women during and after Covid-19. In addition, municipal councils across Zimbabwe took steps to remove the stalls in markets used by informal workers. In 2020, municipal councils in Harare, Chitugwiza, Mutare, and Gweru, among others, took advantage of the lockdown and removed vendor stalls within their city limits. In 2021, Harare, and other cities, continued the process of removing vendor stalls. This means that when informal markets are reopened, workers will need to find new places to sell their wares (ZCIEA, 2021).

The economic situation of informal traders is worsened by the difficulties in traveling during the lockdown. ZUPCO and commuter omnibuses are the only modes of public transport, and they are very few and do not travel with enough frequency to provide reliable transport (Muronzi, 2020). Moreover, police roadblocks throughout cities made it difficult for people to travel into city centres or travel to different residential suburbs. Thus, with the pandemic lockdowns, women became destitutes because of limited or no participation in the informal trading. More so, women make up the majority of cross-border traders, relying on sales in community markets. This has been heavily affected by the pandemic as borders remain closed to the public and informal traders (Mhetu, 2020).

The Covid-19 pandemic, and subsequent lockdowns, also resulted in many people losing their jobs. Anecdotal evidence shows that the Covid-19 pandemic primarily affects jobs performed by women in service sectors such as hospitality, food and beverage, and retail services. One of the industries affected most includes restaurants, which were shut down completely for a while before being allowed to open for take-away, and delivery services as such operating only with limited staff working for fewer hours per day. This has proved difficult for restaurants, and their suppliers, as many have not been able to cope under the restrictions as income from take-aways do not provide enough earnings to cover operational costs such as wages and licensing fees paid to the government (*The Herald*, 2021). In March 2021, the Restaurant Operators' Association of Zimbabwe (ROAZ) revealed that up to 100 restaurants had not been able to reopen since the introduction of the first lockdown. In addition, up to 2,000 people lost their jobs in the sector, of which the majority of them are women. Because the sector has not received any financial assistance, continued limitations of services

provided by the industry could lead as many as 50 percent of restaurants, employing about 5,000 people, closing permanently (Kuyedzwa, 2021).

Women are also more likely to be employed at lower levels of a company with less power as such they are more likely to lose their jobs if companies retrench employees (Chuku et al., 2020). In addition, certain jobs in the formal sector which include tourism, are at risk of taking longer to recover since this disaster took away people's disposable income. The problems of those retrenched is exacerbated by high inflation in Zimbabwe, with food inflation being recorded at 700 percent in December 2019 (Nevill, 2020). This eroded the purchasing power making food insecurity a real problem for many Zimbabweans, especially women. The lockdown exacerbates survival challenges as people continue to lose their sources of income, impeding their ability to buy food, and other essentials, leading to missed meals.

Pregnant and breastfeeding women are vulnerable to malnutrition and those with weakened immune systems are more likely to succumb to infections (Korkoyah & Wreh, 2015). Inability to buy food also affects people's ability to take their medication. In Zimbabwe, 15 percent of the adult's population is HIV positive and the anti-retroviral drugs taken to manage the illness must be taken with food to prevent side effects (Molelekwa, 2020). The government and non-governmental organisations are providing aid relief for vulnerable people but only a fraction of those identified as needing aid have received it. During the pandemic, the government of Zimbabwe made some measures to alleviate the economic burden on families, one of which was providing monitary transfers to the needy. By October 2020, 202,077 households had benefited from the cash transfers of ZWL$300 (approximately US$4). However, this amount is small given that a family of six needed ZWL$ 20,985 (approximately USD$260) per month at the time (Chipenda & Tom, 2020).

Research has shown that one group of women worst affected by this situation include those dependent on payment of maintenance by co-parents. As the majority of people employed in informal sector, and non-essential companies, lost their jobs in lockdowns, many separated men have claimed that they cannot honour the maintenance obligations. In South Africa, attorneys have begun representing clients who say the fathers of their children are failing to pay maintenance for their children, claiming that the pandemic is affecting their pay (Versluis, 2020). This then means separated women with the custody of children had to bear the brunt of looking after these children on their own.

Care roles and resources

In addition to social distancing measures, one recommendation for preventing the spread of Covid-19 is washing hands with clean water and soap. This is a challenge for many Zimbabweans, in rural and urban areas, as they do not have regular access to clean tap water (Dziva, 2020). Over the past few years, Zimbabwe has seen decreased access to clean water. In 1998, WHO reported that 84 percent of Zimbabweans could access safe drinking water. Between 2000 and 2017, access to clean safe water decreased from 72 percent to 36 percent (HRW, 2020). Zimbabwe's water crisis has lasted for years due to crumbling infrastructure and shortages of materials. This was exacerbated by a drought which began in 2018. In Harare, two of the city's four reservoirs are 'empty', and a main water treatment plant has been idle since 2019 when it ran out of chemicals to treat the water (Muronzi, 2020). In Harare and the surrounding areas, two million people do not have household access to safe drinking water or waste disposal services (HRW, 2020). In Bulawayo, the second largest city, three of the six supply dams were decommissioned, and the city is only able to provide water to residents twice per week (Tshili, 2020). These water shedding schedules mean that for people who receive water once or twice per week, they must supplement by using communal boreholes thereby limiting opportunities for social distancing.

As a result of the lack of water, women are the most affected as they are responsible for the welfare of the family. Women and children face the brunt of the water crisis as they are the ones who spend time in water queues at communal boreholes. In areas where people have to queue for water, it has increased tensions between married couples, who fight because one spouse accuses the other spouse of using water

queues as an excuse to sleep outside the home (Muronzi, 2020). Queuing for water also exposes women to violence outside the home. Increased number of trips and distance travelled to communal boreholes expose women to risks of gendered and sexual violence. The police have issued warnings to women, encouraging them to walk in groups (Zimbabwe Republic Police, 2016). Walking in groups contradicts the advice for social distancing.

The extension of work for women extends to other household duties that are performed traditionally by women and girls. With everyone home, the amount of work in the home is increased. Women and girls are the ones who fetch water from wells, and communal boreholes for domestic use, and firewood for cooking. These communal activities make it difficult for social distancing, thereby increasing women's risk to contracting Covid-19. In cholera-hit Yemen, women and girls were more vulnerable because their household duties of preparing food, fetching water, and cleaning bathroom exposed them to the bacteria that causes the disease (UNFPA, 2017).

Care responsibilities also include looking after children, and the sick. As schools have been closed for much of the pandemic, women have been the primary caregivers for children, limiting time for other pursuits. With every school closed for in person learning, some schools were able to provide education materials for students to learn from home. Private schools have been providing materials to allow their students to continue learning from home. Home-schooling requires access to computers and the internet. Women are already doing the majority of the care work and educating children is also falling predominantly on them. Because level of education, and access to information, varies among women, some have had an easier experience assuming the role of assisting their children with schoolwork. When schools reopened for in-person learning, they did so in stages, with those writing exams returning to school first, then secondly early childhood education learners. For middle- and upper-class women, this had a lesser impact on the care of their children as many of them employ live-in care for their children.

When schools reopened after the first lockdown, more vulnerable students were unable to return to the education system as some of the girls were either pregnant or married while for others it was lack of schools fees as their parents' income streams had been heavily affected by the pandemic lockdown. This will likely lower the long-term earning possibilities for them and their families, as well as reducing the overall human capital for the nation's economy (Guinea, 2014). Adolescent girls are particularly affected as the closure of schools increases their workload at homes, with older girls often assisting in the care of younger children. Many of those who were unable to return were girls. In Manicaland province, 415 girls in examination classes did not return to school, the majority of them due to having entered into an early marriage (Dzinamarira & Masuka, 2020).

The caregiving roles women do put them at risk for contracting Covid-19. The 2014 EVD epidemic in West Africa saw women accounting for more deaths in Liberia, Guinea, and Sierra Leone. This emanated from the fact that in homes, women took care of those who were sick from EVD disease or other illnesses. Women's care roles included feeding and washing patients and in burial rites that require handling bodies (Fawole et al., 2016). In hospitals and clinics, women were directly involved in the care of people who had been in contact with people infected with EVD. In Zimbabwe, women make up the majority of those in the nursing field and traditional birth attendance. They also tend, and look after the sick in homes including washing their clothing. It is this constant contact with people, often without protective gear, that places them at higher risk of contacting the illness.

Limited access to pandemic information

Lack of access to information also makes women more vulnerable to diseases. Throughout the world, women have lower levels of access to education, and information to access, read and act upon disaster warnings (UNDP, 2013). More women are illiterate, and when information is sent out in writing such as in print newspapers or text mobile messages, they are not able to read and understand as such miss out on warnings (Khan et al., 2017). In Zimbabwe, the highest proportion of people who have never been to school are rural women (Zimstat, 2016).

Announcements, and public addresses, and updates on the crisis by the President, the Ministries responsible for Health, and Information, as well as non-state actors have been in English. The national Covid-19 hotline is only available in three languages although the country recognises 16 official languages. For those who do understand English, poverty is a barrier to access information as impoverished people may not have access to the technology needed to access the updates on the pandemic.

Ownership of communication devices has been increasing in the country, but a large portion of the country still lacks access to these devices. In 2018, 73 percent of people lived in a home with a radio, 48 percent a television, 23 percent a computer, and 95 percent owned a cell phone or lived in a house with someone with access to one (Chingwete & Ndoma, 2020). A divide regarding ownership of communication devices has been recorded between men, urban residents; the youth and educated Zimbabweans; women, rural residents, and the elderly people who have less levels of education with the latter groups reporting lower levels of ownership (Chingwete & Ndoma, 2020). Econet Wireless, the nation's largest mobile service provider, reported in 2020 that only 52 percent of the population had smartphone and the number of people with active internet and data subscriptions declined as the year progressed (Econet, 2021). In addition to poor communication, distrust of the government was noted as a factor in people's reluctance to believe information (UNDP, 2014).

Another area with limited knowledge was vaccines. As Covid-19 vaccines became available, Zimbabweans faced a barrage of misinformation, and conspiracy theories which have been linked to vaccine hesitancy. Some religious groups were among the most affected with some popular faith leaders urging congregants to avoid vaccination. Like most countries with the majority Christian populations, women are more likely to be regular church members than their male counterparts, meaning that women were more likely to come under the influence of church leaders who doubted the efficacy of vaccines (Pew Research Centre, 2016). In May 2021, the Ministry of Health and Child Care, and UNICEF hosted a gathering with leaders from across the different religions to discuss the barriers which contribute to vaccination hesitancy wherein denominations stated their support of the vaccine strategy (UNCEF, 2021). Since this then, several religious leaders have supported vaccines, and have been urging their eligible congregants to get vaccinated.

Sexual and reproductive health

Previous crises have provided examples of the factors effecting sexual and reproductive health. For instance, during the EVD outbreak, resources for reproductive and sexual health were redirected to the emergency response, which resulted in increased maternal mortality (UNDP, 2014; Sochas et al., 2017). As a result, more people began to rely on traditional and home-made remedies for varied ailments (UNDP, 2014). With Covid-19, fear of the virus has led people to stay away from health facilities for professional care, including reproductive health care. Anticipated is higher infant and maternal mortality as well as more deaths from malaria, and other diseases (Zimfact, 2020).

In addition to fear and lockdown measures, the pandemic has lessened people's ability to seek medical attention in other ways. Due to the increased care work, it means women are unable to consult medical doctors as often as they need. Women also have less power than men, and as a result, their health needs, including sexual and reproductive health, may be unmet (UNFPA, 2020). Reduced use of health services can lead to the spread of HIV/AIDS and malaria. UNAIDS, dedicated to eradicating the disease by 2030, is already warnings nations not to be distracted from fighting AIDS as they focus on controlling Covid-19. In 2020, the agency projected that 500,000 more AIDS related deaths could take place in Africa between 2020-2021 if there was a six-month disruption in anti-retroviral therapy. In Zimbabwe, 1.2 million people are living with HIV and women are the majority of those affected, making up 60 percent of patients (UNAIDS, 2019). For people between 15 to 24 years, young women are twice as likely to be living with HIV than men in the same group (UNAIDS, 2021). Of the new infections, among them youths aged 15-19 in sub-Saharan Africa, six in seven new infections are among girls and women, and girls make up 63 percent of all new infections (UNAIDS, 2021). The majority of women and children living with HIV are

receiving treatment, 93 percent and 76 percent respectively, but the number could decrease during the pandemic (UNAIDS, 2019). This is partly a result of the pandemic lockdowns that disrupted health service delivery including HIV diagnosis, and the anti-retroviral drug supply chain (UN, 2020).

Some countries have already taken steps to maintain health services by allowing patients to collect bulk packets of treatments as well as self-testing kits. Population Services International (PSI) along with its partners, attempted to supply up to 80 percent of their clients with three to six months' worth of medications, including ARVs and PrEP (Taruberekera, 2020). While there has been a decrease in the number of infections in youths since 2010, the UN estimates that if services are disrupted for 6 months, new infections in children could rise by 78 percent (UN, 2020).

Gaps exist in providing comprehensive sexual education, limiting girls' knowledge on how to protect themselves from unintended pregnancies and sexually transmitted infections. Fear of contracting Covid-19, and the lockdown measures, made it harder for sexual and reproductive health workers to move around educating women and girls. More so, the referral pathways for sexual and reproductive health services were largely disrupted during lockdown. Prior to lockdowns, young people could access services such as family planning and free HIV testing and they could get information on safe sex from school, but lockdowns have forced new thinking on ways to reach and engage young people. One method championed by UNFPA has been online engagement, but with limited access to the internet, particularly in rural areas, this limits the number of people who can access the services (UNFPA, 2020). In January and February 2021, a government report indicated that nearly 5,000 teenage girls became pregnant with 1,800 entering into early marriages (Mavhunga, 2021). Many of the pregnancies were recorded in impoverished neighbourhoods. While pregnant girls and mothers are allowed to continue their education after the passing of the Education Amendment Act, stigma prevents many from attending lessons.

Gender-based violence and personal security

Gender-based violence (GBV) is a social problem during normal times as well as during crisis periods. Pre-existing social norms and gender inequalities, increase violence against women and girls. Increased stress due to the financial hardships caused by the restricted movements has further contributed to the rise in the GBV. Hotlines created by service providers are reporting steep rises in calls about domestic violence. Globally, less than 40 percent of women who experience violence seek help of any kind, and less than 10 percent seek help from the police (UNWomen, 2021). Musasa Project, a social services organisation, reported that in the first 11 days of the lockdown, 764 cases of domestic violence were reported, significantly higher than the 500-600 cases reported each month before the lockdown (Sachiti, 2020). Confinement at home under increased stress levels, uncertainty, and fear, can create a stressful environment that contributes to violence against women in the home. While men are also victims of domestic violence, the majority of victims in Zimbabwe are women while the perpetrators are men (Dziva 2018). In a study conducted by the Gender Links (2013) in Zimbabwe, one in every four women was found to be in an abusive sexual relationship, and at least one in every three women to have been repeatedly beaten or subjected to sexual abuse in her lifetime. For women who already live with abusive partners, they are now locked in homes with violent persons, separated from people and resources that can provide support. Thus, the victims have few opportunities to distance themselves from their abusers. As the crisis continues, the number of women who are victims of domestic violence is likely to grow, impacting on the wellbeing of women, their mental and physical health, as well as their ability to participate in the recovery of society and economy in the post Covid-19 world (Social Development Direct, 2020).

The increase in the domestic violence scourge is also linked to shifts in social safety nets and access to information. With lockdowns come limited access to phones and helplines, and disrupted public services like social services and police. Victims' inability to reach social services or family can fuel impunity for the perpetrators. As reported cases increase, it can overwhelm social systems, limiting their ability to adequately assist women in need (Care International, 2020; Social Development Direct, 2020).

Similarly, increasing food insecurity heighten tensions in the household, resulting in increased intimate partner violence and other types of domestic violence. Some men in the informal sector feel emasculated as they are unable to fulfil their breadwinner role and lash out violently toward their spouses (Murozvi & Khosa, 2020). Economic stain and increasing insecurity make it harder for women in abusive relationships to escape as the women may be unable to care for their children without income from the abusive partner.

The additional time needed to perform tasks outside the home has also been linked to the rise in violence. Under the lockdowns, grocery stores are open for fewer hours each day, and social distancing limits the number of people who can be inside the shop at one time. Due to these restrictions, people are often queuing outside for hours waiting to enter the store and then queuing again at the till, and for transport. The overcrowding on public transport puts women at greater risk to street harassment. Women who depend on the Zimbabwe United Passenger Company (ZUPCO) transport have reported that they have been subjected to various types of sexual harassment with little means available for addressing it. Some women are afraid of reporting because they do not want to be ridiculed for reporting something viewed as a small crime. In 2019, when ZUPCO was reintroduced and harassment was reported, a police spokesperson said police are doing their best but the congestion means that officers cannot monitor everyone (Phiri, 2019).

Girls are at risk of sexual exploitation when they are out of school. For many girls, school is a protective environment and being removed from that environment increases risk of violence. The distance that they walk to get water and firewood also puts them at risk of abuse. In Liberia, the most common type of GBV reported was child sexual assault, which was attributed to students being out of school during the EVD outbreak (Jackson-Garrett, 2016). In Sierra Leone, there was a noted rise in teenage pregnancies during the EVD epidemic. In some areas, teenage pregnancies increased by 65 percent during the EVD outbreaks (Jackson-Garrett, 2016). The pregnancies were attributed to the lower levels of return to school for girls once the epidemic was over. Pregnancies were also linked to child marriage as girls who were impregnated were sometimes sent to stay with their abusers (Plan International, 2014). This has also been the case in Zimbabwe. In January and February 2021, 5000 girls were impregnated in Zimbabwe (Mavhunga, 2021). The number of school-going girls who were impregnated is likely to increase due to the long period of time students are spending outside of school.

The plight of women was also worsened by the establishment of quarantine centres. Thousands of Zimbabweans returning from abroad are placed in quarantine centres across the country. By their nature, quarantine centres left women and girls vulnerable to coercion, exploitation and sexual violence. As noted by Jackson-Garrett (2016) during the EVD epidemic, women in quarantine centres were at greater risk of gendered attacks as they were in centres with strangers (Jackson-Garrett, 2016).

Rise in online violence

The pandemic, and subsequent lockdowns have seen increased reliance on virtual modes of communication due to the calls, such as #StayAtHomet, as one way to observe social distancing and combat Covid-19. While this remains key during crisis time of Covid-19's nature, the use of technology has also increased gendered violence. While the majority of Zimbabwean women and girls are not online with great frequency, a sizeable population use the internet daily or weekly to study and work. Some reported types of cyber-violence include receiving unwanted, offensive messages via email, text or WhatsApp, and offensive advances on social media sites. For underage children, this increases the risk of online grooming into exploitative situations (UNWomen, 2020). Another danger is video conferencing, whose use is becoming more frequent as people study and conducts work meetings. There have been rising reports of bullying and sexual harassment from people who dial into events through virtual chatrooms (UNWomen, 2020).

4. Conclusion

The study has shown the gendered nature of Covid-19 in Zimbabwe. While the global and national measures to combat Covid-19 including social distancing, quarantining and lockdowns remain key, they are reported to have exposed women and girls to vulnerabilities in the home, and public spaces. Intersecting with other vulnerabilities that subjugate women including poverty, patriarchy, religion, culture and location, the pandemic, and the subsequent measures to combat the pandemic, have compromised women's security, access to employment, social protection, sexual and reproductive health. Thus, the impacts of the Covid-19 crisis have exacerbated gender the pre-existing gender inequalities in Zimbabwean society.

The study vouches for gender-sensitive policy response that guide state and non-state actors to largely empower women, and above all mainstream gender needs in pandemic and epidemic response measures including social protection, sexual and reproductive knowledge and services. More so, there is need for empirical-gender disaggregated data generation on the impact of Covid-19 in Zimbabwe by government and non-state actors. State and non-state organisations engaged in pandemic response are also urged to largely mainstream women's needs and rights so as to continuously respond to women's inadequacies that further exacerbate their increased participation in unpaid labour, and vulnerability to GBV; restrictions in accessing social security, and other basic needs including sexual and reproductive services.

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