Julias Nyerere School of Social Sciences

COVID-19 PANDEMIC AND RURAL WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICE IN CHIRUMHANZU RURAL DISTRICT.

By

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Submitted to Nehanda Centre for Gender & Cultural Studies

Great Zimbabwe University

In partial fulfilment for the requirements of the Master of Science Degree in Gender and Policy Studies

Masvingo, Zimbabwe
2023

DECLARATION FORM

I, BRIAN S. MAFUSO (M223321), hereby declare that this dissertation is the result of my own work, investigation, and research, with the exception of the references and acknowledgements that are included in the body of the dissertation. I also declare that this dissertation has not been submitted in whole or in part for any other degree or to any other university.

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COVID-19 PANDEMIC AND RURAL WOMEN'S ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICE IN CHIRUMHANZU RURAL DISTRICT

Submitted by: **BRIAN S. MAFUSO** in partial fulfilment of the requirements of the Master of Sciences in Gender and Policy Studies

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Date : **31 October 2023**

DEDICATION

I would like to dedicate this work to all the strong rural women and girls who constitute the majority of women in Zimbabwe, it is my hope that everyone within marginalised communities gets to have an equal chance to reach their full potential through receiving essential Sexual and reproductive health services that gives them a chance in life.

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I want to start off by praising and honouring my mighty father God, Yahweh, who created everything that is and also creating me. His grace is sufficient every day. Secondly, I want to also express my gratitude to my sweet wife Mrs. Claire Mafuso for her support and affection during this difficult time as well as her ability to endure the pressure from my studies. My utmost gratitude to my parents, Mr. Albert Mafuso and Mrs. Precious Mafuso, who supported me through the difficult times and raised me to be a person that dreams big. You are both my role models and my universe. Last but not least, I would want to express my sincere gratitude to Dr. Dziva, who served as my supervisor and gave me helpful technical advice throughout the dissertation development process. He was very accommodating and sympathetic to the needs of the study, which contributed to its success. I would also like to thank Great Zimbabwe University for allowing me to pursue Gender Studies which is was so insightful and fulfilling.

LIST OF ABBREVIATIONS

AU	African Union
BDPA	Beijing Declaration and Programme for Action
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
ICPD	United Nations International Conference on Population and Development
MoHCC	Ministry of Health and Child Care
WHO	World Health Organisation
SDG	Sustainable Development Goals
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific, Cultural Organization
WCoZ	Women Coalition of Zimbabwe
ZDHS	Zimbabwe Demographic Health Survey
ZHRC	Zimbabwe Human Rights Commission

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Abstract

Women and girls in rural areas have often struggled to access essential health services especially sexual and reproductive health services due to their remote location, social and economic status. These conditions are aggravated by disease outbreaks and pandemics which disrupt the delivery of SRHR with rural areas being among the worst affected. A research to investigate the impact the impact of the recent COVID-19 pandemic on rural women's acess to SRHR was conducted in the most remote and resource strained parts of Chirumhanzu rural district. The research was mainly qualitative and used convenience and purposeful sampling to select 20 respondents that participated in the study. The research also utilized various research tools including focus group discussions, informant interviews and observation to establish essential information of the impact of COVID-19. Data gathered from the research highlighted that though the COVID-19 prompted massive recruitment of much needed health personnel and also ensured increased procurement of condoms and distribution of condoms in rural areas. A large majority of participants highlighted that the COVID-19 pandemic affected the delivery of SRHR affecting availability, accessibility and affordability of essential SRHR commodities. Women struggled to acess contraceptives, antenatal care, HIV testing and counselling and, STI testing and treatment. These conditions increased the risk of women getting unwanted pregnancies, gender based violence and child marriages.

This information calls for renewed commitment to redouble efforts towards accelerating provision of SRHR services in rural areas even in the face of pandemics and health disasters through increase budget allocation by government towards SRHR. Integration of gender sensitive policies in the planning of pandemic responses.

CHAPTER ONE: BACKGROUND INFORMATION

1.1 Introduction

In many parts of the African Continent, nations have struggled with poor economic performance, political instability and insecurity, something that has aggravated the impact of disease outbreaks and pandemics. The unfolding of the novel COVID-19 pandemic in Africa reinforced the unfortunate living reality of vulnerable health systems that are gender blind and disproportionately affect women and girls when pandemics hit. Women in rural areas who usually bear the brunt of socio-economic hardships during disease outbreaks due to structural inequalities and marginalisation that are deeply rooted in patriarchy and gender inequality. The arrival of the COVID-19 pandemic in Zimbabwe triggered a raft of policy measures, statutory instruments and presidential decrees that aimed to curb the spread of the pandemic, some of which limited the movement of people. However, the measures significantly affected the economic and social lives of vulnerable groups of people. The context of the issue that will affect the study will be explained, along with the problem statement, the research objectives and questions, the justification and importance of the research, the study's parameters, and a summary of the findings.

1.2 Background of the Study

Since gaining its independence in 1980, Zimbabwe has made significant strides toward achieving gender equality and empowerment in line with its international obligations. The state is a signatory to a number of conventions that advance the rights and welfare of women including the right to access health services. These included the 1979 United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), Maputo Protocol on women rights and the SADC Gender Protocol. With regards to CEDAW, Zimbabwe has pledged to fulfil most of the obligations required within these conventions including article 14 of CEDAW which recognizes the significance of rural women. The article further emphasises the urgent need for states to treat rural women equally with their urban counterparts through ensuring equal rights, access to education, health care and other array of civil and political rights.

Policy wise, Zimbabwe committed to implement measures for the realisation of Sustainable Development Goals (SDGs) particularly SDG 3 on good health and wellbeing, and SDG 5 on gender equality and women empowerment. At the centre of implementation of these SDGs is a clarion call to "leave no place and no one behind" in the access of services especially SRHR commodities for marginalized groups including rural women and girls. The government of Zimbabwe has made efforts to ensure that "no one is left behind", it has mainstreamed key components of SDG 3 and 5 within its policy frameworks and development strategies including the National Health Strategy (2015-2020), National Health Strategy (2020-2025) and the National Development Strategy 1 (2021-2025) among many other documents. These documents have guided rollout of various programs including the re-launch of the Campaign to end maternal mortality (CARMMA 2020), cervical cancer awareness programs (2018-2020) and also family planning programs.

At a local level, Zimbabwe's 2013 constitution provides for the right to access health care services including reproductive health services for every citizen of Zimbabwe. Specifically, Section 76 (1), '"Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services" (Constitution of Zimbabwe 2013). The freedom to make decisions concerning reproduction encompasses a variety of issues which include, among others, decisions on whether to use birth control, the type of contraception to use, the number and spacing of children. Zimbabwe according to her national laws is obligated to accord these sexual and reproductive rights to all women without segregation.

Nevertheless despite these significant strides, Zimbabwe's ability to accord and deliver the rights to access health services especially SRHR services has over the years been challenged by emergence of disease outbreaks and pandemics. The nation has grappled with multiple disease outbreaks and pandemics ranging from escalating cholera outbreaks to severe pandemics including HIV and AIDS. These crises have threatened to rollback hard earned gains towards equality of women and their rights in accessing basic services especially health commodities. According to UNAIDS (2004), the outset of the HIV and AIDS pandemic in Zimbabwe during the late 1980's disproportionately affected women and children as they suffered from increased poverty and high mortality. The ability for millions of women to access essential SRHR services for prevention of HIV was drastically challenged.

According to the Zimbabwe Herald (2020), Zimbabwe confirmed its latest pandemic on the 20th of March 2020 through the Ministry of Health which communicated that a novel COVID-19 virus was spreading across the country. The Zimbabwean government swiftly moved to respond to the COVID-19 pandemic through implementation of a number of unprecedented measures that limited movement of people to curb the spread of the virus through border closures, curfews and forced closure or scale down of private and public entities.

Women's Coalition of Zimbabwe (2020), highlighted that the impact of the pandemic and measures put in place would be catastrophic to the health and wellbeing of women in Zimbabwe, especially access of SRHR services for vulnerable groups of women in rural areas. *A Gender Assessment of COVID-19 and the Countrywide Lockdown Process,* carried out by UN Women Zimbabwe (2020), revealed that the closure of various businesses and disruption of the agricultural value chain caused hardships to a large proportion of women including those in rural areas. The assessment further revealed that the financial isolation of women caused by COVID-19 had a spiral effect in issues of access to critical sexual reproductive health especially for rural women who needed money to buy health commodities and transport to access health care facilities. .

According to UNFPA (2020), the restriction of movement, curfews and lockdowns also disrupted access to lifesaving health services and compounded the ability for survivors to report cases of Gender Based Violence. These restrictions also meant that in rural areas couples were spending more time together and this increased the need for contraceptive products. However, according to Murewanhema and Makurumidze (2020), during the peak of COVID-19 pandemic there were several reports of shortages of hormonal contraceptives and condoms in health facilities including rural areas. These lockdowns also heightened the risk of unwanted and teenage pregnancies in rural areas due to disruption of routine community outreach programs for family planning services in rural areas. UN Women (2020) estimates that in March at the beginning of the lockdown there was a 60 % increase in reported cases of Gender Based Violence with national hotlines for GBV like Musasa receiving 4 616 GBV related calls per day.

Another significant challenge to the hurried emergency measures was just like in many disease outbreaks and pandemics before, the present government of Zimbabwe had done little to reform delivery of health services especially in rural areas. According to the Community Working Group

on Health (CWGH) Post National budget Analysis (2020), the Ministry of Health and Child Care was allocated ZWL 6.6 billion constituting 10% of the total budget, which was far below the 15% threshold set by the Abuja Declaration of African countries to improve their health sectors. According to Chigarande (2020), the first lockdown imposed by the government to curb COVID-19 saw an increase of urban to rural migration by many Zimbabweans.

According to Women Coalition Zimbabwe (2020), in an effort to curb COVID-19 infections the government imposed a mandatory obligation for all women to take a mandatory Polymerase chain reaction test (PCR) for COVID-19. According to the Herald Zimbabwe (2020), most health institutions in Zimbabwe charged around 65-120 USD for PCR test for COVID-19. According to a Human Rights Watch briefing (2020), placing high financial requirements for COVID-19 tests on vulnerable women created significant barriers for vulnerable groups especially women in rural areas to access essential services including antenatal care , contraceptives and other services for survivors of GBV. According to the latest data by the Ministry of Health in Zimbabwe (2020), the nation already has an unacceptably high number of maternal mortality which is 363 per 100,000 live births.

According to Women Coalition of Zimbabwe (2021), women and girls in rural areas who were raped and subjected to physical violence had structural challenges in accessing health services due COVID-19 test requirements. In a press statement on in 2020, UNICEF stated that pregnant mothers and babies born during the COVID 19 pandemic were threatened by strained health systems.

Based on the above summary of the challenges in accessing health services for rural women, this research will explore in detail the impact of COVID-19 in women's ability to access services and some of the peculiar challenges rural women face. The research will further suggest recommendations on what can be done to strengthen such initiatives in Zimbabwe or improve on weak areas.

1.3 Problem statement

The United Nations Population Fund (UNFPA 2020) published a policy brief on the impact of COVID-19 on Gender Equality across the Globe. In its findings the research revealed that in many nations, the rights of women and adolescent girls during disease outbreaks and pandemics were overlooked as priority as often efforts were directed at addressing existing crises. It further warned of a looming crisis of rising partner violence, maternal death, unintended pregnancies, sexual violence and child marriage which would disproportionately affect women and girls mostly in developing nations due to disruption in health service delivery and limited access to SRHR services. This information prompted an interest to investigate the impact of COVID-19 on rural women's access to health services using a case study of Chirumhanzu Rural District. In Zimbabwe despite experiences from past pandemics and disease outbreaks demonstrating the adverse effects on women's ability to access health services, the nation has done little to transform its health programming to ensure a gender responsive approach to disease outbreaks and pandemics. The majority of women in rural areas continue to face barriers in accessing health services due factors such as availability, accessibility, and affordability of health services. It is important to ascertain the contribution of the disease outbreaks and pandemics in worsening and exacerbating the factors mentioned above through carrying out a comprehensive research to analyse all aspects.

1.4 Justification of the Study

The study aims at bringing in new information on reducing health inequality gaps for women in rural areas through discussing the several factors behind poor or limited access of health services during the COVID-19 pandemic. By doing so the research will thus highlight the importance of prioritising access to health services for women in rural areas during disease outbreaks and pandemics as a mechanism to attain Gender Equality for all. Through the study various stakeholders are persuaded not to be spectators when disease outbreaks and pandemics hit but rather to redouble their efforts in delivering gender responsive services to vulnerable people especially women in rural areas.

The study findings are likely to broaden the policy makers theoretical and conceptual understanding of the nexus between disease outbreaks, pandemics and access to health care services for marginalised groups especially women in rural areas. It will assist other researchers that might want to investigate a topic related to the researched field. The study will also likely be significant to the government in informing relevant authorities about the direct implications that the response plans and decisions have in social and economic areas of women in rural areas. This thesis can be relevant in empowering governments to recognize some of the weaknesses and challenges that its policies and response plans to disease outbreaks and pandemics have had on its aspirations towards Gender Equality and Women empowerment by 2030

This study is likely to establish factual evidence on the impact of COVID-19 on rural women's access to health services in rural areas using the case of Chirumhanzu District which will provide critical information for policy makers, government, non-governmental organisation and others in coming up with inclusive plans to build back better as the world works to recover from the devastating consequences of COVID-19 pandemic.

1.5 Research Objectives

- To investigate the impact of COVID-19 and response measures on women's access to SRHR care services in rural Zimbabwe.
- To unpack the coping mechanisms for rural women and girls in accessing SRHR services in the context of COVID-19 pandemic.
- To recommend gender responsive social protection systems that can be able to protect women and advance Gender Equality in the context of present and future disease outbreaks and pandemics.

1.6 Limitations at the end

Rahi (2017), argued that limitations are those aspects of a study that influenced the discovery of the research's findings. The upcoming 2023 presidential and parliamentary harmonised election made it difficult for some respondents to participate in the study as they feared the research was identifying political opponents and hence some feared victimisation. In some cases local rural

district councils and other authorities took time to acknowledge and grant permission for the research to be conducted and on several occasions the researcher had to wait and also do follow up interviews with authorities including police officers to discuss if the research was politically motivated or apolitical. Another limitation was in regards to access to data, Secondary data from key informants, the Ministry of Foreign Affairs and International Trade, and the Ministry of Home Affairs was only to be used in the immediate vicinity of their workplace

1.7 Delimitations

This component, according to Hoffman (2003), relates to decisions taken by the researcher that should be made public before starting a study. In this study, the research investigates the Impact of COVID-19 on rural women's access to health services: a case of Chirumhanzu Rural District . The study researcher chose Chirumhanzu Rural District because it has 6 health centres under its jurisdiction and of these 4 are registered with two not yet registered. The reason for focusing on this area rather than other rural district is because the council has well documented records of its health response mechanisms and the other reason why the researcher chose not to focus on a nationwide study of other rural districts was because, investigating other areas would require the researcher to assess the other 10 provinces of Zimbabwe and over 70 districts which would be impossible given the time and resources available.

The study will focus specifically on the impact of adopted policies of curbing COVID-19 and their effect on rural women's social and economic status. The researcher chose to specifically leave out the political aspects in the research due to anticipated challenges that could occur in gathering data given that the research was being done in an election year, the researcher wanted the research to be apolitical in order to ensure maximum participation of all relevant stakeholders. The study used a qualitative research design in which participant observation and interview guidelines were used to collect data.

1.8 Definition of terms.

Disease Outbreak- refers to a sudden rise in the number of cases of a disease. An outbreak may occur in a community or geographical area, or may affect several countries.

Epidemic - describes an epidemic as an unexpected increase in the number of disease cases in a specific geographical area.

Pandemic- refers to an epidemic of an infectious disease that has spread across a large region, for instance multiple continents or worldwide, affecting a substantial number of individuals.

Sexual Gender Based Violence- refers to violence committed against a person because of his or her sex or gender. It is forcing another person to do something against his or her will through violence, coercion, threats, deception, cultural expectations, or economic means.

1.9 Chapter Summary

This section outlined all of the important aspects of the study. This chapter outlined some of the contributing gaps in access to health services for women during pandemics that led to investigation of the impact of COVID-19 on access to health services for rural women. The research objectives and research questions, which serve as the study's pillars, focused at highlighting government's response to COVID-19, socio and economic impact that the virus had on women and recommendations for future responses to disease outbreaks and pandemics that are Gender responsive. The thesis' structure was established, laying the groundwork for the subsequent chapters. Chapter two follows, which will cover the reviewed literature that was in line with the study.

CHAPTER TWO: LITREATURE REVIEW

2.1 Introduction

This study's main objective was to evaluate how COVID-19 affected rural women's access to healthcare in the Chirumhanzu Rural District. The literature review will comprise an evaluation and analysis of the information that was pertinent to the study, as well as a review of the current body of knowledge on the subject under consideration. The purpose of this section is to examine the work of various scholars in relation to the study, as well as what has been done in the past in order to solve the problem at hand. According to Rahi (2017), a literature review is a process of looking into the current literature in order for the researcher to identify gaps in the effectively existing body of knowledge. The reviewed literature under this section was in line with the research objectives outlined in Chapter One.

2.2 Theoretical Framework

A theory is a broad viewpoint through which we view and interpret the world. It covers our perspective on the social environment, the language and syntax we use to discuss it, the structure of our conceptual framework, the categories into which we classify objects, and the logical relationships between concepts. A theory also explains how and why certain connections result in certain outcomes. As a result, these relationship explanations are essential for developing sound theories. This section of the thesis reviews health theories in order to give the reader a thorough overview of the subject and also an opportunity for analysis on how these theories relate to Gender dynamics of access to healthcare services and how rural women are affected. The study was impacted by the three theories which include the Health Utilization model.

2.2.1 Health utilization Model

The goal of the Andersen healthcare utilization model is to illustrate the factors that influence the use of health services. This framework's goal is to identify factors that either make utilization easier or more difficult. The objective is to create a behavioural model that measures access to healthcare or other services. The framework underwent four phases after its initial development in the 1960s.

The following framework, created in the 1990s, stands for the fourth phase. Three factors are thought to influence how someone uses and has access to health services:

According to the model, usage of health services are determined by three dynamics:

1. **Predisposing Factors**: The sociocultural traits of people that they have before getting sick. Social structure, education, occupation, ethnicity, social networks, interpersonal relationships, and culture are a few of these. In addition, they emphasize people's attitudes, values, and understanding of the healthcare system as well as demographic factors like age and gender. Finally, they highlight people's health beliefs, which also include these.

2. **Enabling Factors:** The practical aspects of getting medical attention. Personal/Family: The ability to travel, income, health insurance, a regular source of care, and the quantity and caliber of social connections. Community: The accessibility of medical staff and resources, as well as wait times. Added elements: psychological traits and genetic factors

3. **Need Factors**: The most immediate cause of health service use, from functional and health problems that generate the need for health care services. "Perceived need will better help to understand care-seeking and adherence to a medical regimen, while evaluated need will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider." Perceived: "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help."

Anderson's health utilization model is a diagnostic tool within this study as it provides a guide to understanding enabling factors that influenced uptake of Sexual and reproductive health services in the context of disease outbreaks and pandemics. The researcher argues that it is important to understand key issues of geographic accessibility, travel time, waiting time, age, income, service costs, infrastructure, staffing and education. In the context of rural women, they face predisposing factors including the key challenges attached to their gender as women and other social factors including education, ethnicity and location. These factors present unique challenges in accessing SRHR services and increase vulnerabilities for women and girls in rural areas. Within this study

the researcher also argues that these factors may be used to evaluate the extent to which COVID-19 worsened affected utilization of health services specifically access to SRHR services for women and girls in rural areas.

2.3 LITREATURE REVIEW

2.3.1 Defining Sexual Reproductive Health and Rights

At the backdrop of various international instruments on Sexual reproductive health and rights, the international community met in Cairo, Egypt in 1994 for the historic International Conference on Population and development (ICPD). The ICPD conference was significant at setting a benchmark for the definition of SRH. According to the ICPD conference reproductive health is defined as follows,

"Reproductive health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

While the conference also defined Sexual reproductive rights as,

"Right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."

It is from this background that the right to access sexual reproductive health and rights should be accorded to everyone by governments through ensuring access to safe, effective, affordable and acceptable sexual reproductive health services.

2.3.2 International commitment on Sexual and Reproductive Health and Rights

Sexual and reproductive health rights are an integral part of human beings, they are essential in carving a development trajectory for any society. One of the foundations of this strong belief is the 1979 Convention on the Elimination of all forms of Discrimination against Women (CEDAW) which was adopted by the United Nations General Assembly on 18 December, through Resolution 34/80.301. CEDAW within article 16 guarantees women equal rights in deciding various aspects

of SRHR rights including the right to “ freely and responsibly on the number of children and to have access to information, education and means to enable them to exercise these rights” . While the 1995 Beijing Platform for Action which is recognized as one of the most important platforms that followed up after the 1979 CEDAW. The Beijing Platform for Action states that “the human rights of women include their right to have control over and decide freely and responsibly on matters of their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

On a continental level, African member states enacted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol which came into effect in 2005. Within Article 14 African member states including Zimbabwe are obligated to ensure the health of women, including sexual and reproductive health is respected and promoted. These rights include the right to control their fertility, the right to decide whether to have children, the number of children and the spacing of children and the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS. African states are obligated to ensure that all citizens are accorded these rights.

2.3.4 Right to Sexual and reproductive health under siege in Emergency settings

According to the Centre for Reproductive Rights (2015), Health outbreaks and diseases have been among the biggest threats to enjoyment of sexual reproductive health rights especially for vulnerable groups of people including women. During these outbreaks, crisis are created that affect availability of health services, the costs of health commodities, transportation and basic commodities goes up usually more than double the normal prices. These crisis have created significant barriers to accessing health services due to disruption of enabling factors of accessing health services.

According to UNHCR (2017), in many countries facing humanitarian crises have increased disruption in social protection systems due to anarchy and lawlessness caused by the crises. The most affected by the poor enforcement of social protection systems are the vulnerable groups of people especially women and girls who face escalated violations of their rights. Some of the common violation include increased cases of child marriage, rape, abductions, sexual assault and female genital mutilation among others which dissapropotinately affect women and girls. Chief

among these challenges is the significant barriers in accessing health services, women despite being survivors of various human rights violation face barriers in accessing health services.

According to a Global Human Rights Report (2019), there have been documented reports of denial of access to reproductive health services and, discrimination and poor services. These factors have been directly linked to increase unsafe abortions, increased harmful practices especially child marriage and female genital mutilation. CARE 2020, further states that without access to proper care, health crises can increase the risks of sexually transmitted infections, unwanted pregnancy, and pregnancy-related complications that can lead to illness and death for mother and child.

According to World Health organisation (2020), conflicts compounded by disease outbreaks and pandemics including Ebola, HIV and COVID-19 have created humanitarian crisis that have caused increased displacement and a breakdown in social order. It is from this background that these situation make it very difficult and in some cases impossible for people to access health services.

Among the most affected within the challenges of accessing health are vulnerable groups including women and girls who face worsened gender inequality in accessing health services due to their social standing.

2.3.5 An Already Strained Health Delivery System within Rural areas

According to Zimbabwe Health Journals (1990), before gaining its independence in the 1980's, Zimbabwe's healthcare delivery system was biased towards the urban areas were the minority of ruling white population from the Rhodesian front resided. The healthcare system was very weak within rural systems were the majority of black people stayed. Although upon gaining independence, Robert Mugabe worked towards redressing inequality through provision of primary healthcare in rural areas and also building of clinics and hospitals to deliver primary health care to the majority of people. These gains were short lived and eroded by the series of economic turmoil in 2002, 2008 and recently the worst economic crises witnessed in 2019 worsened by COVID-19 pandemic.

These challenges according to the Centre for Reproductive health (2020) have worsened an already deteriorating health care systems that has years of inadequate infrastructure, loss of skilled health personnel and a decline in the quality of health services available for the population. Among the worst affected areas is the rural areas of Zimbabwe which although efforts had been made

previously to address key infrastructure, staffing and quality of health delivery still suffers from marginalization and segregation due to economic challenges compounding rural development. A demographic health survey (2015), highlighted that the majority of people in rural areas still faced a significant barriers in accessing health including issues of distance due to inadequate hospitals, limited availability and integration of services and poor quality services. The emergence of COVID-19 was among the worst nightmares for such a fragile health systems that is structurally unequal towards provision for rural areas.

2.3.6 Gap in Literature

With the onset of COVID-19 pandemics across the international development community there were various questions about the anticipated impact of the pandemic towards various aspects of Gender Equality especially women's access to sexual reproductive health services. These questions have led various researches and seminal studies that have investigated the effects of COVID-19 on women's rights and access to health on a global, continental and national level. Women Deliver (2020) global report, "The impact of COVID-19 on Sexual and Reproductive health and rights: youth-led perspectives and solutions" reinforced that reproductive health was side-lined and seen as non-essential in many contexts in order to prioritise the pandemic response. The report further emphasised the effects of COVID-19 on under-resourced health systems and the negative ripple effect this had on delivery of SRHR services especially for women and girls. However within the Women Deliver's report there are some gaps in literature, the report places women as a homogenous group and fails to also take into account the heterogeneous nature of women and unique challenges women in rural areas faced in accessing SRHR health services.

On a national level, Chigevenga et al (2020) focused her research on the impact of COVID-19 on women in High-density Suburbs of Zimbabwe. In her study she highlighted the challenges that various policy measures including lockdowns and curfews had in worsening inequality for the most vulnerable. It further highlighted as a result of lockdowns and financial constraints cases of Gender Based Violence against women sharply increased and most women faced constraints in accessing legal and healthcare services in cases of sexual violence including rape, domestic violence and also antenatal care. However, Chigevenga's research only focused on women in

urban areas and did not focus on the effects of laws enacted to curb COVID-19 in rural areas and the effects they had for rural women in accessing SRHR services.

A recent study by the African Union in 2020 on COVID-19 and Gender Based Violence evaluated the impact of COVID-19 on access to health services for victims of sexual gender-based violence in African Union member states including rural areas. The research, though well-articulated, was fragmented and lacked comprehensive information on the national response mechanisms in Zimbabwe and also the effects of the COVID-19 measures for women in rural areas.

Mortazavi and Ghardashi (2021) research, “The lived experiences of pregnant women during COVID-19 pandemic: a descriptive phenomenological study” highlighted that in most epidemics, pregnant women were among the most vulnerable groups of people. In its findings the research revealed that pregnant women had faced challenges in accessing sexual reproductive health services due to COVID-19 disruptions which caused cancellation of pregnancy related appointments, closing down of some specialist’s private offices and increased crowds of visitors at doctors’ appointments when they were available. The research however has a significant gaps in literature, it only highlights pregnant women and fails to account for live experience of all women in rural areas including adolescent girls, elderly women and women that are no longer at child bearing stage.

A recent study by UNFPA and UN Women on Gender Based Violence and COVID-19 evaluated the nexus between lockdowns and increased violence against women. However the research lacks information on the country specific statistics on cases of gender based violence and also fails to highlight some of the internal policies and measures that community leaders including in rural areas adopted to address the scourge of sexual gender based violence against women during lockdowns. There is a need to unpack substantive information on the Zimbabwean situation and delve deep information on the reporting cycle and health service delivery systems in rural areas.

Ferguson’s thesis analysed the policies of the Zimbabwe National Family Planning Council, the practices of local level health workers and their impact on the reproductive self-determination of women living in Mabika village. Ferguson’s study did not, however, focus on how he did not focus on the impact executive statutory instruments and presidential decrees on access to health for rural women during pandemics. There is a need to assess what other countries have done to address the

needs of marginalised rural women in accessing health services and what part gender responsive policies play in increasing uptake of sexual and reproductive health services for rural women.

2.4 Chapter Summary

This section of the study unpacked a wide range of literature with empirical evidence from various sources and texts relevant to the study. The theoretical frameworks including the Marxism theory and Third World Countries Political Economy Approach, highlighted the rationale behind focus on rural women and access to sexual reproductive health. They further emphasised that rural women are different from other women in urban areas as they face dynamic challenges due marginalisation, poverty and location. The literature that was outlined under this chapter were in line with the research objectives sketched in Chapter One. This chapter paved the way for the next chapter which will give an overview of the research methodologies used in conducting the study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Rahi (2017), asserts to research methodology as a variety of methods that can be used in a study, and these methods describe how to collect data and calculate results for a particular study. This study was qualitative in design. Within this research, primary and secondary data were utilized, these were crucial in obtaining a broader perspective on the subject of study. The research data collection methods, design, sampling techniques, data analyses, research tools used, and ethical considerations that were central to the study are all discussed in this chapter. The thrust of this study was to analyse the COVID-19 pandemic and rural women's access to sexual and reproductive health service in Chirumhanzu Rural District.

3.2 Research Methodology

According to Fouche (2002), the term research methodologies refers to numerous activities as well as measuring instruments to be deployed within a study. This study used a lot of qualitative research techniques. In the context of the impact of COVID-19 pandemic on acess to SRHR, qualitative technique best captures the perspectives and experiences of rural women and also provides a contextualised description of human behaviour within pandemics. Creswell (2009) highlighted that qualitative research is effective at examining and comprehending the significance that individuals or groups assign to social or human problems. Additionally, he said that it functions best when applied to key issues of society including challenges facing marginalized groups who often have no voice to express themselves. In-depth verbal descriptions, situations, contexts, and systems are provided by qualitative research after interaction, interviewing, and observation of social phenomena.

3.3 Research Design

A research design, according to Ragin in Uwe (2004) is a strategy for gathering and examining data that will allow the investigator to respond to any questions posed within the research. The researcher used the phenomenology research design as the main tool of acquiring knowledge. According to Ghosh (1992), the major goals of phenomenological research are to develop in-depth

descriptions of a phenomenon and to look for reality in people's experiences and narratives. It is from this background that the researcher utilised descriptive design to acquire information on challenges and lived experiences of rural women in accessing SRHR in the context of the COVID-19 pandemic. Phenomenology was applicable as it provided in depth and descriptive information that was important in analysing issues of attitudes, behaviours and other complex gender relations issues.

3.4 Population and sample

Polit and Hungler (2017) asserts that population is defined as the total number of elements, with components relevant to the study, which also satisfy the central requirements of the study. For this study, the researcher selected Chirumhanzu Rural District because the researcher is close to this area making it easily accessible. Within this research the targeted population was a total of 25 respondents which comprised ordinary rural women, men and village health workers. The researcher also selected civil servants working for the Zimbabwe Ministry of Health and Child Care and Ministry of Women Affairs who were key informants for the research. Males and females were covered by the research. Respondents selected started from 18 years to 55 years old. This was done on the basis of legal age of consent to participation in the study and that this age group had a better understanding of the subject matter.

3.4.1 Sample size

Punch (1998, p193), argued that it was literally impossible for a research to study everywhere and doing everything. Saunders (2014), noted that targeted population should be realistic in any research. Within this study the 20 people were selected to participate and this research. According to Clarke and Braun (2013), qualitative studies require a minimum sample size of at least 12 in order to achieve data saturation.

3.5 Sampling Methods

According to Bhojanna (2009), sampling is the process of selecting participants for the conduct of a study. Since a sample refers to a smaller, more precise subset of the population, sampling is the

systematic selection of cases for inclusion in the study. While Mishra, 2021, asserts that sampling refers to a large population is sampled in order to provide a current number of observations for statistical analysis. Various sampling methods were used including purposive sampling, the essence purposive sampling was to locate a population of interest, in this research rural women and men with first-hand experience in key issues faced in accessing SRHR in the context of COVID-19 were purposively selected. The researcher used convenience sampling in selecting individuals close to the proximity of road networks in Chirumhanzu District and in some instances individuals close to health centres. This decision made it easy to gather data within rural areas and also helped with saving time. The identified groups were picked from various households close to the road and also health centres without wasting much costs.

The Ministries of Women Affairs and Health and Child Care participated in key informant interviews. These provided information on significant barriers to SRHR access in the context of COVID-19 in rural areas.

3.6 Data collection methods

According to Knatterud et al (2015) data gathering is the method of gathering data and assembling it in the quest of satisfying research objectives. Within this study, questionnaires and interviews as data gathering instruments. The Chirumhanzu Rural District was the choice of the researcher for this study. The researcher first obtained written permission from University authorities before proceeding to data collection in the field. The data collection process began after submitting supporting documents from the University to Chirumhanzu local authorities including council, police and others. The researcher conducted interviews with respondents and administered questionnaires.

3.6.1 Focus Group Discussions

One group comprised of between 10-14 participants that participated in the focus group discussions. This group was purposely chosen and divided in relation to sex which comprised women and girls. The Ministry of Women Affairs and women's village networks were used to find the participants. The researcher was a facilitator and chose to take a stance of speaking less and letting women and girls talk, but the main role of the researcher was just to guide the discussion

using key components of the research objectives. The researcher also captured data through writing and also recording the session which he had obtained consent from all participants.

3.6.2 Interviews

Key informants from the Ministries of Women's Affairs and Health and Child Care were interviewed. The researcher also interviewed rural women and men within Chirumhanzu district ward 8 and 9.Due to busy schedules of people in rural areas with various duties like farming and other house chores, interviews were conducted in a short period ranging from 6-10 minutes. The researcher in some instances would ask further questions to respondents for clarification.

3.7 Validity and Reliability

According to Lawrence (2007), validity refers to the quality of information acquired within an investigation as well as the relevance to the study. While, De Vaus (2006), asserts that the term "reliability" refers to the ability of results to produce the same results when repeated. Validity and reliability can help in indicating if the targets and also strategic objectives of the research have been addressed. To ensure reliability, the researcher ensured the confidentiality and anonymity of respondents. To ensure reliability, the researcher made uniform well-structured questionnaires and conducted them in a standard and proper manner in line with all ethical guidelines. In order to ensure validity the researcher guaranteed confidentiality and anonymity to all respondents. The research's validity was also improved by utilisation of primary sources of data.

3.8 Ethical considerations

According to Denzin and Lincoln (2003), ethics is a code of behaviour controlling how a research process is carried out. The researcher followed a wide range of ethical guidelines while conducting this study. Some of the ethical principles followed included informed consent, confidentiality, protection from harm and right to withdraw.

3.8.1 Informed consent

According to (Shaw et al, 2011), for consent to be valid, the onus is on the researcher to show that they provided the requisite information and adequate understanding of the research to respondents. To ensure informed consent the researcher would begin by informing respondents his name and would highlight the research and its objectives. He further explained the apolitical nature of the study and the University that the research is being conducted under. The researcher also disclosed

to respondents that information obtained from them would be used for scholarly purposes and the information was confidential.

3.8.2 Confidentiality

The researcher ensured that the highest level of confidentiality was kept through omitting the gathering of personal information within research tools. The researcher further assured respondents that the data gathered would only be used for educational purposes and that their answers were their confidential secrets.

3.8.3 Protection from harm

To ensure protection from harm and in some instances retaliation due to the study. The researcher used pseudo names in cases that data was imparted to outsiders. The researcher further explained all the truth regarding the study including the pros and cons.

3.8.4 Right to withdrawal

The researcher informed all respondents at the start and end of interviews and administration of questionnaires that they had the privilege to withdraw their examinations and viewpoints that they contributed.

3.4 Chapter Summary

An overview of the research methodology and design used to look into the research topic on COVID-19 pandemic and rural women's access to SRHR was presented in this chapter. The sampling methods and data collection instruments were provided. The Chapter also outlined the reasons why the researcher chose certain approaches instead of others and how the study was conducted. The methods employed also aimed at providing trustworthiness of the study. The next chapter will provide results obtained from the study and interpret findings.

CHAPTER 4: RESULTS AND DISCUSSIONS

4.1 Introduction

The research findings, data analysis, and critical evaluations of the findings are the main topics of this chapter. This chapter's information presentation is based on the questionnaires, focus group discussions and interviews that were used to gather data in Chapter 3. The study's goal was focusing on COVID-19 pandemic and rural women's access to sexual and reproductive health services in Chirumhanzu rural District. In light of the research goals presented in the first Chapter, this section highlights the study findings. The chapter secured, the response rate, the demography of respondents, the presentation of gathered data, and finally the chapter rundown.

4.2 Response Rate

The research achieved a response rate of 100%. All 20 participants invited to participate including 5 key informants from the Ministry of Health and Ministry of Women Affairs fully participated in the scheduled interviews.

Targeted participants	Actual participants	Response rate
20	20	**100%**

Table 4.2.1: results based on study (2023)

Focus group discussions were grouped according to sex that is male and female. The first group of females had a target of 10 respondents which were gathered from the Ministry of women Affairs. The second group had a target of 4 men which were gathered from various Village Heads in Chirumhanzu. All the 14 respondents participated in the discussions and there was a response rate of 100% from both groups.

4.2.3 Interview Response Rate

Population	Sample	Responses	Non-responsive	Responsive Rate %
Ministry of Health Work ers (nurses, doctors)	3	3	0	100%
Ministry of Women Affairs (programs officer)	3	3	0	100%
TOTAL	**6**	**6**	**0**	**100%**

Table 4.2.3.1: Result based on study (2023)

A good response was received from the villagers' health workers, government employees at the Ministry of Health and as well as women living in rural Chirumhanzu, with a response rate of 100% overall. As a result of their active participation and sharing important details with the researcher about the coordination structures and sexual reproductive initiatives in the context of the COVID-19 pandemic, the Ministry of Women Affairs' response rate was 100%.

4.3 Sample distribution with regards to Age.

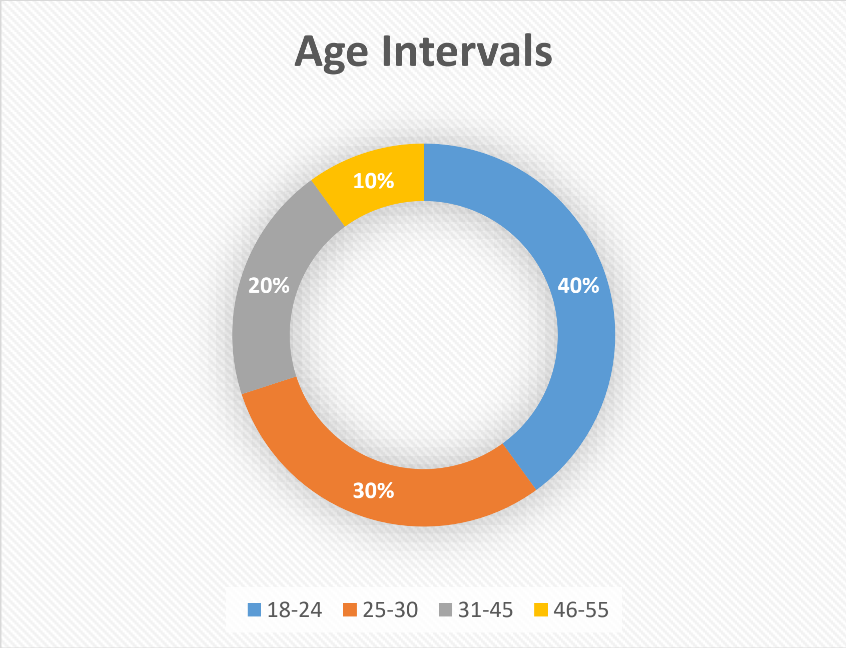

Fig 4.3.1: Age intervals

The age range of 18-24 years had most respondents of 8 (40%). This group is among the highest number of residents in Chirumhanzu District and comprises adolescents and young people who were either unemployed or earning a living doing part time farm work. The second-highest number of respondents (6, or 30%) were within the age range of 25 to 30 years, indicating that this age group makes up the majority of those who routinely seek out medical care in the Chirumhanzu district. This age also comprised health professionals who were on nurse aid training. The age respondents of 31-45, had 4 respondents (20%) while the age of 45-55 had 2 (10%) who were all civil servants and health professionals working in hospitals and also in key Ministry of Health and Ministry of women affairs.

4.3.2 Sample distribution with regards to Marital Status.

Marital Status

	Frequency	Percentage
Valid		
Single	5	25
Married	12	60
Divorced	3	15
Total	20	100

Table 4.3.3: results based on study

With regards to marital status, most respondents were married 12 (60%) and the major reason was based on village level norms were women of the view that it is necessary to find a husband as a means of survival in the village, as they would provide financial support for the family through agriculture. While men got married in order to reproduce and also have women that could help in their farm work. The percentage of single 5 (25%) and divorced 3 (15%) was low as some youth hesitated getting into marriages. Young boys feared getting into marriage due to limited financial resources while girls felt they wanted to pursuer tertiary education before getting married. In regards to divorce, the researcher noted that although divorce was low most of the divorces were due to escalating tensions and disputes within polygamous marriages.

4.4 Characteristics of research sample

Under this part the composition of the characteristics of respondents will be presented, which were based on the responses given in the questionnaires. In line with the laws of Zimbabwe the researcher noted two gender orientations which are male and female.

4.5 Sample distribution in terms of Sex.

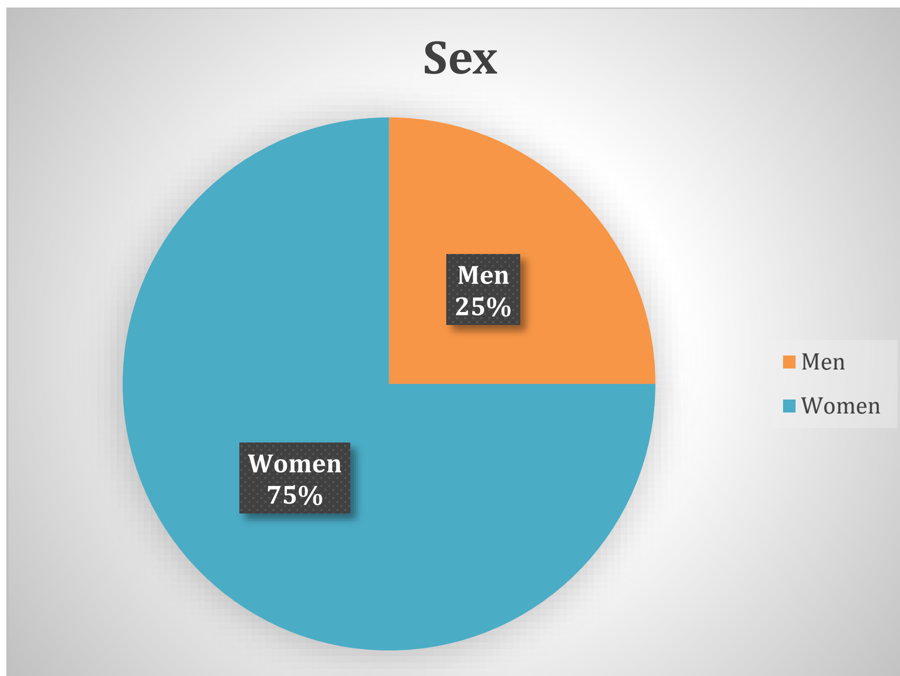

Fig 4.5.1 sex distribution

In terms of sex, females aged 15 (71%) and males aged 5 (25%) made up the majority of responses. The findings showed that, in comparison to their male counterparts, women were more open and forthcoming in their participation and sharing of information. One of the reasons for the high number of females could have been attributed to the high medical seeking behaviour of women as compared to men and also that women and girls may have related more to key issues brought out in the study. The researcher utilized convenience and purposive sampling techniques, as a way to balance the gender perspectives and provide insights and information from both men and women, however despite this effort it was observed that a low number of men were willing to participate.

4.6 Sample distribution with regards to Education.

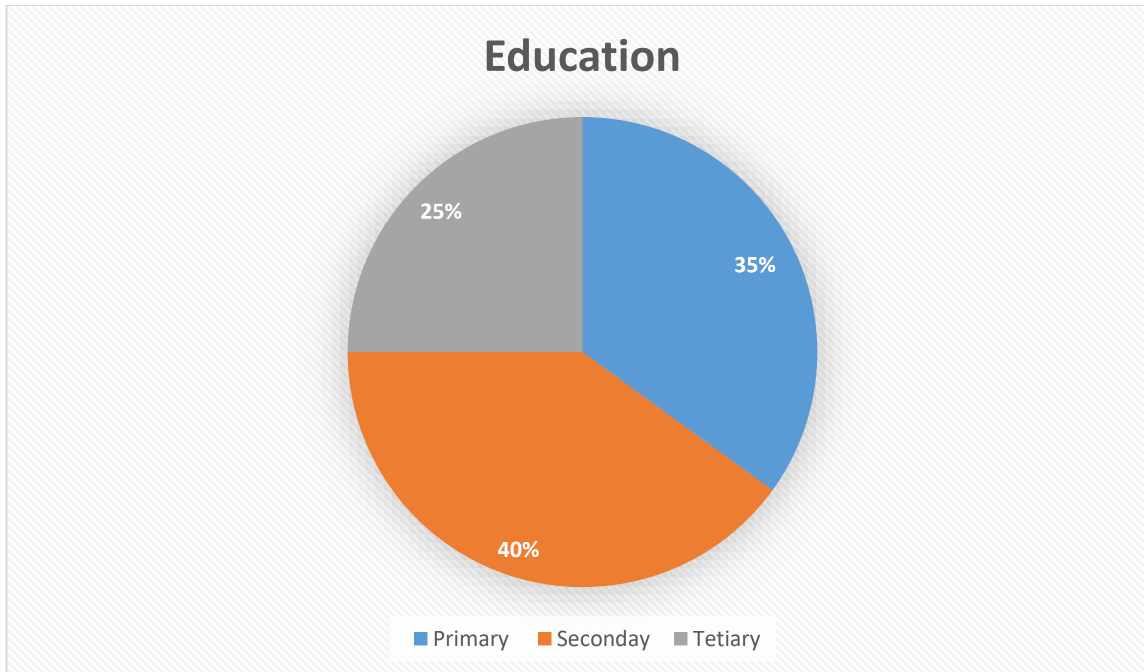

Fig 4.6.1 Education intervals

With regards to education, most respondents in the Chirumhanzu had attained secondary education which was represented by 8 (40%) respondents. The respondents who had attained primary education were 7 (35%), one of the reason stated for not pursuing higher education was family responsibilities and marriage. There was a low number of respondents who had tertiary education that is having obtained at least a degree 5 (25%).The results outlined that the most women and men who had higher tertiary education were health personnel and technical staff. The researcher noted that most youths especially girls and women had basic secondary education but had no formal jobs but rather worked as contract workers in farms.

4.7 Findings

Subsequent sections are presentations of the study's results.

4.7.1 Impact of COVID-19 and response measures on women's access to SRHR care services in Chirumhanzu rural district

4.7.2 Availability of SRHR services In Rural Health Facilities

The study noted the presence of two main hospitals in ward 7 and 8 of Chirumhanzu which are Mvuma General Hospital operated by the government and Driefontein Mission hospital. These hospitals have over the years served thousands of rural people with provision of sexual and

reproductive health care services with the highest number of clients being women and girls due to their high SRHR needs. A positive development highlighted by participants was that despite COVID-19 many hospitals continued providing SRHR services. Participants also indicated the availability of one contraceptive which was mainly condoms.

Condoms were readily available during COVID-19 due to adequate procurement of the contraceptive at hospitals patients could access these at any time- responded d

However despite this positive development many participants highlighted that COVID-19 negatively affected delivery of SRHR services especially in rural areas. Some participant's especially health care personnel, highlighted restrictions in movement put in place by government disrupted the global supply chain of essential SRHR commodities with rural areas being among the worst affected. Participants in Chirumhanzu backed this view as they highlighted that routine services that were offered in the main hospitals including HIV and STI testing , antenatal care and other contraceptives including implants, contraceptive pills, vaginal rings and other were limited and in most cases not available. The disruptions by COVID-19 also affected routine procurement and service of essential health machines including one for routine antenatal care which are essential in routine check-ups for women's abdomen, growth of babies and pregnant women's blood pressure.

Ever since this lockdown was announced it has become more difficult for us as women to access hormonal contraceptives which are easy to use for us. We have a high risk of getting unplanned pregnancies because the hospitals only offer condoms which we all know are difficult to use when married – respondent x

By the end of the first week of the lockdown, here at our hospital we started receiving no contraceptives and had limited HIV testing kits which was hard for us as nurses to do our job. We had to give women the only commodities which were mostly condoms due to lack of many commodities- respondent y

We depend on a lot of things from our Harare Headquarters, due to many technicians being busy with COVID-19 medical equipment. Our 2 Ultra machines used for antenatal care were never fixed and the procurement department never bought anything. We had to refer many pregnant women requiring scans to Gweru Hospitals – respondent c

4.7.3 Availability of health personnel

The study revealed that due to COVID-19 there was a significant increase in the number of health personnel. Key informants revealed that the Zimbabwean government as part of its measures to curb the spread of the COVID-19 pandemic had conducted a massive recruitment for health personnel to support the Ministry of health.

In Chirumhanzu we had adequate number of nurses addressing various issues of COVID-19 including testing, contact tracing and conducting counselling- responded q

However, despite the increased availability of health personnel, the study noted that there was inadequate number of health personnel providing SRHR services as most of the health personnel were working on addressing COVID-19. Participants revealed that most rural health facilities in the area under study had one trained nurse providing services to a significant number of patients. Most patients expressed that because the nurse would be doing a workload for 4 people, the services were very slow and in some cases they did not receive SRHR services at all. Participants expressed concern over lack of prioritisation by government to have adequate health staff addressing SRHR needs. Many also highlighted that government was favouring addressing COVID-19 and leaving behind provision of SRHR to rural women which required additional health staff to be hired but none were hired during the pandemic.

I love my job as a nurse and providing SRHR services especially to rural women is so fulfilling in my career. However during COVID-19 it was so difficult to do my job we were understaffed despite our requests for other staff government ignored our calls which affected delivery of services- responded d

Nurses providing services like inserting implants were very difficult to find in the hospital everyone was in the tent working on COVID-19- responded j

4.7.4 Access to SRHR Services

Participants in this study revealed that they had limited access hospitals and clinics due to vigorous COVID-19 mandatory measures. Many pregnant women wanting to give birth revealed that many clinics required a mandatory PCR test for admission into the maternal ward which was difficult for most women and resulted in a high number of women preferring to have unsafe home deliveries. Due to temporary closure of a number of local hospitals women and girls revealed it was difficult to access health facilities in other cities due to high cost of bus fares which were increased by operators due to low business. In other cases women and girls were forced to walk long distances to access the nearest health facility however this reduced the number of people seeking health services to decrease at the cost of their own health.

I gave birth to my child at home assisted by my Aunt. It was scary for me but I had no choice because the requirements to get admitted into hospital including mandatory PCR tests were difficult, due to financial challenges my husband and I could not afford- responded m

I was scared of walking to Mvuma hospital from Musena, many girls were getting raped and murdered in the road. Because I could not access contraceptives, I tried using the withdrawal method but unfortunately I got an unwanted pregnancy – responded a

4.7.5 Affordability of SRHR Services

The study revealed that due to COVID-19 related economic shocks, the government as a way to cushion women had made other essential SRHR services free and maintained that position even when the COVID-19 pandemic hit.

As pregnant women, we come for medical check-ups at Mvuma hospital and the services are free-responded h

However due to COVID-19 most commodities in hospitals were not available and many women and girls in rural areas were forced to buy commodities in the private sector. Participants also revealed that COVID-19 increased inflation thereby affecting prices of other commodities including pregnancy test kits and HIV kits for those women and girls who wanted to access them privately due to their unavailability in hospitals. Participants also revealed that the mandatory COVID-19 test which cost an average of USD 50-60 which were required by hospitals for admission drastically affected access to services as it was hard for many women and girls who face financial constrains due to lockdowns.

I always buy sanitary pads at the growth point for ZWL800 but ever since COVID-19 started they started charging ZWL 2500 which is very expensive for me, I am no longer working short time jobs. I had to find cheap ways to manage – responded f

To tell the truth, I don't know why they wanted us to pay COVID-19 tests for admission into hospital. It is because of this requirement that we chose to stay home because they can't help you at hospital if you don't have this test. - Responded t

4.7.6 Prioritisation of COVID-19 Issues over Sexual and Reproductive health services

Results of this study showed that many health institutions prioritised COVID-19 related issues as compared to other health issues especially sexual and reproductive health issues. Participants highlighted many health staff were redeployed to handle COVID-19 tests and quarantine procedures. While this happened many hospitals in Chirumhanzu limited and in some cases stopped routine services like contraceptive insertion procedures.

Since COVID-19 started as nurses we were instructed that our priority was addressing COVID-19 issues of SRHR services were scaled down due to structural challenges in the hospital- Respondent S

4.8 Coping mechanisms for rural women and girls for accessibility to SRHR in the context of COVID-19 pandemic.

The second objective was to investigate the various copying mechanisms of rural women and girls in accessing SRHR services in the face of COVID-19 pandemic. Key informants and also women were asked to share their insights.

4.8.1 Use of unsafe and Unconventional Methods

The study revealed that due limited or lack of sexual reproductive health in most of the hospitals and clinics in Chirumhanzu women and girls employed various unconventional methods to cope with their SRHR needs. Participants revealed that due to unavailability and in some cases high price of sanitary pads, most women and girls used pieces of clothes and in some cases cow dung in place of sanitary pads.

During COVID-19 things were hard, we did not receive any free sanitary wear from donors. I had to use anything that I could find including cow dung, clothes and newspapers to stop blood from leaking-responded z

Due to the high cost of the mandatory COVID-19 test required for admission, the study revealed that a considerable number of women and girls resorted to home delivery through either close relatives in the form of Aunties or through traditional midwives. This is a situation that put thousands of women at risk of avoidable maternal deaths and a number of people reported knowing of women and girls who lost their lives giving birth.

I gave birth to my child at home assisted by my Aunt. It was scary for me but I had no choice because the requirements to get admitted into hospital including mandatory PCR tests were difficult, due to financial challenges my husband and I could not afford- responded r

4.8.2 Regular travel to Urban Areas to Access SRHR services

Participants revealed that in most cases they had to travel long distances to urban areas to access SRHR services especially antenatal care services. In most cases the study revealed that due to restrictions women and girls went through a challenging circumstances including having to pay high transport costs and having to bribe police officers manning roadblocks who required an

exemption letter and permit for them to allow essential people to travel. However most women in rural areas are unemployed and depend on subsistence farming and were classified as non-essential making it difficult for them to travel to urban areas to access health services that were unavailable in Chirumhanzu.

It was so difficult travelling to urban areas due to travel restrictions. But we had no choice we had to bribe police and other officials in order to freely travel to get antenatal services – responded I

4.8.3 Gender responsive social protection systems that can be able to protect women and advance Gender Equality in the context of present and future disease outbreaks and pandemics

The third and last objective looked at the gender responsive social and protection systems that can be implemented to advance Gender Equality in the context of disease outbreaks and pandemics. The following were suggested.

4.8.4 Financial Support

Participants emphasised the importance of providing financial support to women and girls in the context of health emergencies to ensure they are cushioned from economic shocks that affect their access to SRHR services. They also highlighted that the financial support can also be used to maintain delivery of SRHR service including provision of contraceptives, STI, HIV testing kits and antenatal care.

Financial support for provision of SRHR services is a lifeline it decides whether I am going to live or die while giving births and also protects from unwanted pregnancies which can cause hardships in life – responded o

4.8.5 Capacity Building and advocacy for SRHR in the context of Health Emergencies

Participants especially in the health sector emphasised the need to train government officials and policy makers on the need to maintain and prioritise delivery of a minimum SRHR package for women in rural areas in the context of disease outbreaks and pandemics.

There is urgent need to ensure capacity building and training of health workers to ensure continued delivery of SRHR services in the context of disease outbreaks and pandemics. If policy maker, government and others don't take it seriously we risk going backward in the movement for equality of women- responded x

4.8.9 Integration of Women in Emergency Response Teams

Participants within the focus group discussion emphasised the need to integrate women in key decision making platforms within the disaster response mechanism of Chirumhanzu rural district. They also emphasized how having women in technical committees tackling pandemics and disease outbreaks like COVID-19 helps to ensure that women's needs are promoted.

We as women now also need to be included in emergency response teams, we can't always let men decide for us. They do not have regular SRHR needs as we do- responded p

4.9 Discussions

The following section discusses the results presented in preceding sections. The discussion proffers possible reasons and implication of findings along the research objectives.

4.9.1 Impact of COVID-19 and response measures on women's access to SRHR care services in rural Zimbabwe.

Findings from this study confirmed that COVID-19 pandemic had both a positive and a negative impact on rural women's access to SRHR care in Chirumhanzu rural district. On a positive note the outset of the pandemic increased the availability of provision of condoms to rural areas which were already procured by government before the outset of COVID-19. The pandemic also saw government increasing the number of health personnel in rural hospitals and financial funds towards addressing health issues especially for women and girls. However the number of health personnel added was specifically to address COVID-19 and there were inadequate health personnel to provide SRHR services.

COVID-19 restrictions put in place to curb the pandemic including limited movements, mandatory COVID-19 tests and curfews affected availability of SRHR commodities like contraceptives, HIV and STI test kits, and antenatal care services especially in Chirumhanzu Rural District. The impact of the restriction affected global supply chain for SRHR commodities, however in Zimbabwe among the worst affected was rural areas as many urban areas limited supply of commodities to rural areas due to restricted movement. The study revealed that due to these interlinked challenges there was limited availability of SRHR services and women struggled

to access services due to long distances and rural to urban travel that they had to embark on sometimes due to lack of availability of services.

This structural disruption in access to health services especially for women and girls in Chirumhanzu is best cements the notion of the Health Utilization model outlined in Chapter 2. The model highlights that uptake and utilization of services is determined by enabling factors such as distance, availability of services and commodities. The COVID-19 pandemic disrupted logistical aspect of attaining these enabling factors through restrictions of movement, limited and lack of availability for access to SRHR services causing low uptake and access of services by rural women.

A key issue among the findings was the high cost accessing services and commodities. Although government made significant efforts to ensure that services are affordable through providing free health services and SRHR health commodities due to restrictions many services were unavailable. Government also placed conflicting policies as it placed mandatory measures to access SRHR services which required high financial costs and became a barrier. As an example all pregnant women and girls requiring admission for delivery were mandated to pay for a COVID-19 test which many could not afford. The high cost of sanitary pads, HIV and pregnancy testing kits within growth point shops and pharmacy hindered access to SRHR services and led to many women to have limited access. The government's failure to address this structural injustice amounted to a violation of rural women's rights and a failure to uphold Zimbabwe's obligations under CEDAW's Article 12, the African Women's Protocol's Article 14, and the CRC's Article, all of which call for Zimbabwe, as a State party to the treaties, to take steps to guarantee that its citizens have access to reproductive health services when they need them. These findings were also in line with the Health Utilization model which highlighted that enabling factors costs related to services and health insurance affect uptake of services. The model also argues that predisposing factors such as class and gender affect utilization of services, in this study women due to their gender are undermined by patriarchal systems and this affects their ability to be economically independent. Women also due to their class and location are given short term jobs which are low paying in farms which explains why when COVID-19 pandemic hit many could not afford COVID-19 tests and other commodities.

The findings also revealed that often during the COVID-19 pandemic the needs of women and girls were not prioritised as the high precedence was given to addressing the COVID-19 crises. 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; Women Deliver (2020) global report. A key issue for lack of prioritisation can be lack of gender responsive policies and plans within the disaster response mechanism of Zimbabwe. The lack of a gender responsive mechanisms has been long demonstrated in the past HIV pandemic when many policies to address the pandemic were gender blind.

4.9. 2 Coping mechanisms for rural women and girls in accessing SRHR services in the context of COVID-19 pandemic.

The study revealed that many women and girls after failing to access health services due to various issues of high costs, long distances and availability women and girls in Chirumhanzu resorted to unconventional practices such as unsafe home deliveries. This is in line with Mortazavi and Ghardashi (2021) research, who highlighted that during COVID-19 pandemic pregnant women were among the most vulnerable groups of people. From a theoretical perspective using the Health Utilization model some women could have chosen to traditional home deliveries due to their perceived need which states that, "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help." Some women resorted to these methods because of their general perception of their challenges that they felt it could be solved through home deliveries which was very unsafe and life threatening.

4.9.3 Gender responsive social protection systems that can be able to protect women and advance Gender Equality in the context of present and future disease outbreaks and pandemics

Within the findings many stakeholders expressed concern about the exclusion of women within decision making platforms on health emergencies. It is from this assessment that there should inclusion of rural women in planning meetings in order to ensure inclusion and representation that

helps plan gender responsive plans towards disease outbreaks and pandemics. The findings also highlight the Third World Approach that highlights that women are grouped according to class and this is source of inequality, due to low education levels women are often left in technical meetings and planned for. The findings highlighted the need to provide capacity building to relevant authorities to ensure strengthened political will towards gender responsive mechanisms. It is from this background that one can note the strong influence that political players having in guiding the trajectory of response mechanisms and provision of SRHR services in health emergencies. It is from this background that stakeholders should always include them.

4.10 Chapter Summary

In summary, this chapter unpacked the presentation of the findings of the study's results and discussion. The chapter provided a detailed response rate of the study and presented demographic data and other biographical data of respondents. The chapter also went further to discuss the findings and the theoretical frameworks that can best explain various outcomes and perceptions within the study.

CHAPTER 5
SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND AREAS OF FURTHER RESEARCH

5.1 Introduction

This chapter is of the research will summarize, analyse and capture key methods used for investigation of the research topic, draw conclusions and recommendations. The key discussions on the following are listed below.

5.2 Summary

The research sought to investigate COVID-19 pandemic and rural women's access to sexual and reproductive health services in Chirumhanzu rural district. A qualitative approach was adopted and used through use of structured interviews, focus group discussions and use of questionnaires to gather data. The study was promoted and necessitated by wide spread reports that indicated COVID-19 was going to affect access to SRHR services for women and would increase vulnerabilities. The research utilized various theories to including the health utilisation model to highlight peculiar challenges rural women due to their location and gender face in accessing health services. The research findings highlighted that COVID-19 pandemic increased women and girls vulnerability in accessing SRHR services and created various barriers that resulted in women and girls having low to no access of essential SRHR services.

5.3 Conclusions

The research highlighted that COVID-19 pandemic created a crisis that affected rural women's access to sexual and reproductive health services in Chirumhanzu rural district. The study also revealed that provision to SRHR services in Chirumhanzu was overlooked as priority was given to the curbing spread of COVID-19.

The first objective of the study was to investigate the impact of COVID-19 and response measures on women's access to SRHR care services in rural Zimbabwe. This research was successful in

Achieving its intended research goal. The first goal involved analysing access and availability of services in hospitals and clinics. According to the data gathered, there was limited and in some cases no availability of health services and commodities like contraceptives. Most hospitals also lacked availability of staff, all these factors made it difficult for women and girls to access SRHR services. Looking at it from a Third World Approach, it could be that many areas in Zimbabwe including in Zimbabwe still overlook women in rural areas and their need for provision of SRHR services and other health services during Health emergencies. One of the possible key reasons for such outcomes has been largely due to a fragile government health system that lacks prioritisation for SRHR services for women in rural areas. Most of the clinics operating including governments are depended on donor funds for SRHR commodities and when the pandemic affected funding mechanisms and donors many programs stopped or were disturbed but government failed to fill in this gap.

The second objective of the study, was to unpack the coping mechanisms for rural women and girls in accessing SRHR services in the context of COVID-19 pandemic. The study highlighted that women adopted unconventional methods of meeting their SRHR needs which included using cow dung for menstruation, unsafe home deliveries and traveling to urban areas to access services using their resources. These results revealed that indeed measures put in place to curb COVID-19 were hurried and gender blind as they affected access to SRHR services for many women and girls. A possible reason for adoption of some unconventional methods like unsafe home delivery and use of cow dung for menstrual cycles could point out to the lack of economic empowerment that is deeply rooted in patriarchy. It also shows women in rural areas suffer from economic disfranchisement which can be linked to lack of access to SRHR services. The COVID-19 pandemic worsened economic situation which affected everyone including the already challenged women and girls. This observation is again supported by the third world theory which highlights that rural women are seen as second class citizens and suffer from economic marginalisation.

The third and final objective was to recommend gender responsive social protection systems that can be able to protect women and advance Gender Equality in the context of present and future disease outbreaks and pandemics. The study was able to highlight key recommendation that there is need to capacity build policy workers and politicians who are influential in agenda setting of policies. The study also revealed that there was need to include women and girls in planning processes for disaster to ensure a gender responsive approach. These results show that there if there

is wide stakeholder engagement and inclusive planning there can be gender responsive mechanisms that protect and cushion women from barriers of accessing SRHR when disasters and health emergencies strike and gender equality can be achieved. This is also linked to the Third world approach which highlighted the significance of class in addressing inequality.

5.4 Recommendations

I. Government

Based on these study findings it is important for government as the signatory of various international, regional and national instruments that guarantee the right to sexual and reproductive health to take various measures to ensure that these women's right to SRHR is realised. Below are some of the recommended actions,

a) **Strengthening gender responsive policies to Health Emergencies-** The government must adopt and strengthen a gender-responsive approach when providing SRHR services in response to health emergencies. In order to effectively intervene in pandemic outbreaks, a gender lens is essential. The solution must be gender-responsive while simultaneously recognizing the rights and needs of women and girls, as well as other societally vulnerable groups like the elderly and the disabled.

b) **Increase financial resource allocation towards Health**- Within the context of disease outbreaks and pandemics, government should prioritise the scale up of domestic funding for delivery SRHR commodities and services especially in marginalized communities and rural areas. Increased domestic funding in line with the Abuja declaration can ensure strengthened resilience when health emergencies hit and also ensures that even if NGOs and other players are not able to deliver services government can provide SRHR services to rural women and girls. Government also needs to ensure that there is high retention of nurses and doctors within hospitals and needs to ensure that they receive competitive salaries including hardship allowances which can make health professionals stay and deliver during health emergencies and pandemics.

c) **Establishment of Clinics and Hospitals in Rural Areas-** There is urgent need to increase establishment of clinics and hospitals that are at least in a 5km radius within rural communities to ensure that in future crisis restricted movement and barriers caused by health emergencies does not affect access to SRHR services. These local clinics need to also have sufficient health personnel and availability of essential services including antenatal care, HIV testing and STI treatment just to mention a few.

d) **Strengthening Social Protection Systems during Health Emergencies-** Government must come up and scale up its social protection initiatives to include provision of economic grants and vouchers during health emergencies to ensure women and girls in rural areas have financial resources to access SRHR services. The financial resources can be used to cater for things such as transport costs and procurement of SRHR commodities. Government also needs to further ensure that it subsidises the price of SRHR products including sanitary pads especially during disease outbreaks and pandemics as many stakeholders tend to increase prices due to economic shocks caused by the crisis.

e) **Use of Innovative ways to deliver SRHR in Health Emergencies-** There is need to scale up innovative measures in delivering SRHR services in the context of disease outbreaks and pandemics. The key issue of restricted movement and challenges of accessing services can be addressed through use of modern technology such as air drones which can deliver SRHR commodities to remote areas. Government needs to ensure strengthened public and private partnership which can help in delivering such technology to rural areas.

II. Non-governmental Organisations

Non-governmental organisations should support government by ensuring that their national and district disaster response teams support local governments in the integration process of women and girls in planning processes to facilitate discussions on how to best address the crisis. Deep rooted cultural issues including issues of patriarchy can also be addressed by these platforms to ensure women and girls access SRHR services during disease outbreaks and pandemics.

a) **Technical Guidance -** There is urgent need to regularly formulate and create knowledge material for government departments that can provide technical guidance to field health workers and other community members working on delivering SRHR services in the context of disease outbreaks and pandemics. NGOs can also provide a critical role through recruitment and seconding health workers within health facilities to ensure that issues of SRHR are not overlooked.

b) **Research** – There is need for further research on the impact pandemics have on vulnerable groups in rural areas especially women and girls. NGOs can provide financial support to the Ministry of health and capacitate them to do a joint research on these issues. Having such vital information can help in informing policy and program decisions.

5.5 Chapter summary

The final chapter of this thesis, outline significant highlights of the study and also provided Recommendations on various ways to scale up uptake of SRHR services for women in rural areas in the context of disease outbreaks and pandemics. Chapter 5 also outlined the extent to which the objectives of the study were met. The research findings led to conclusions that were concentrated on the objectives of the study that were described in the first chapter. This research was divided into chapters that established the framework for the investigation, beginning with Chapter 1. In Chapter 2, the method literature review was successfully secured. In Chapter 3, the methods for data collecting, strategy, and research design were described. In chapter 4 displayed results and discussion of findings.

Annex 1: Focused group discussion with rural women and men guiding questions.

1. Can you please tell me about yourself in a self-introductory statement please sate the following ;

    a) How old are you?
    b) Village of origin?
    c) Marital status?
    d) Level of education?

2. What do you understand about sexual and reproductive health rights?

3. What other factors affect your access to reproductive health services here in Chirumhanzu rural District?
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4. What are your experiences in accessing reproductive health services during the COVID-19 error in relation to ;

    a) Availability?
    b) Affordability?
    c) Accessibility?

5. What are some of the copying mechanism that you did to address the challenges that you faced in access, affordability and availability of SRHR products?

6. What are some of the gender responsive measures that you think need to be deployed to advance Gender Equality in the context of present and future disease outbreaks and pandemics in Chirumhanzu rural district?

Annex 2: Interview guide for Key Informants at the Ministry of Health and Child Care and Ministry of Women Affairs.

Background Information

1. Please can you state the ministry or department that you work for
    a) What is your position?
    b) How long have you worked there for?
    c) What is your age?
    d) Education level?

Programmatic Questions

2. Please state some of the programs that you are coordinating or implementing on sexual and reproductive health rights in Chirumhanzu?

3. How did the onset of COVID-19 affect delivery of these programs from a strategic point of view?

4. Do you believe that your Ministry did enough to ensure adequate provision of Sexual and Reproductive health commodities to vulnerable groups during COVID-19 especially rural women and girls?

5. What do you believe needs to change within the Ministry to ensure improved and gender sensitive response to disease outbreaks and pandemics?

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