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COVID-19 Lockdown containment measures and women's sexual and reproductive health in Zimbabwe

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The devastating COVID-19 pandemic and its accompanying containment measures brought exceptional challenges to the health delivery system, and in particular, women's sexual and reproductive healthcare (hereafter referred to as SRH). The re-routing of health resources and funding to mitigate the effects of the pandemic obstructed the provision of essential SRH services for women and girls. Coupled with the incessant socio-cultural and patriarchal norms and gender inequalities, the COVID-19 pandemic aggravated the pre-existing SRH disproportions already affecting women. By adopting a qualitative approach and drawing on the experiences of women from three high density suburbs in Harare. Firstly, the study sought to explore the implications of the COVID-19 pandemic on SRH for women and girls. Secondly, the research sought to determine key drivers that affect women's SRH in the context of COVID-19. Participant responses indicated that the COVID-19 lockdown containment measures which confined spouses to the home setting for prolonged periods of time, which is in contrast to the norm, exposed women to SRH related challenges. Participants cited that (i) bruised male ego due to lack of employment as a result of downscaling of companies resulting from COVID-19 containment measures resulted in men asserting their masculinities through heightened sexual intercourse, (ii) restraint of movement resulted in limited time for men to visit their small houses and side-chicks or side dish (euphemisms for illicit sexual relations) therefore resulting in frequent and unprotected sex with their spouses, giving rise to unplanned pregnancies and increased exposure to STIs due to limited access to SRH services and, (iii) increased intimate partner violence (IPV) and sexual abuse. Therefore, the research sought to explore the response of religious leaders and faith-based actors to providing psycho-social support and safe spaces as ways of addressing intersectional injustices giving rise to SRH challenges for women and girls.

Contribution: The intersecting crises of the COVID-19 pandemic have extensively hindered progress towards the promotion of women's SRH. Relating to sustainable development goal 3 (SDG3), the article acknowledges the trust and respect of religious leaders within communities as change agents who can encourage shifts in behaviour, beliefs and practices in ways that promote holistic SRH for women.

Keywords: coronavirus disease 2019 (COVID-19); masculinities; religious leaders; sexual and reproductive health (SRH); intimate partner violence (IPV); small house; socio-cultural practices.

Introduction

The outbreak of the COVID-19 pandemic beginning in China, December 2019, presented severe disruptions in the provision of healthcare services across the globe. On 11 March 2020, the World Health Organization declared COVID-19 a global pandemic and on 18 March 2020, the government of Zimbabwe declared the disease a national disaster. The COVID-19 pandemic had a direct effect on the global economy (Pak, Adegboye, Adekunle et al. 2020). This exacerbated cross-sectional and prevailing structural inequalities in various sectors of the economy. This is explained by Chirisa et al. (2021) who pointed out that for the past two decades and prior to the outbreak of the pandemic, Zimbabwe had been battling with a suppressed economy giving rise to a 'societal and business haemorrhage induced by the COVID-19' (2021:1). The pandemic further restrained resources and institutional capacity resulting in a disproportionate impact directly affecting women and girls. Within the

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Zimbabwean context, it has been duly observed that women were the most affected by the effects of the COVID-19 pandemic (Dziva, Zhou & Zvobgo 2022; Manyonganise 2022; Muzuva & Hlungwani 2022). However, this is reported to be a common phenomenon whereby historically, women have been disproportionately affected by any presenting crisis or pandemic (Macheka & Nhongo 2021; Manyonganise 2022). Coupled with the structural and institutional barriers refraining women from visiting healthcare centres, the fear of COVID-19 infection inhibited women from seeking sexual and reproductive healthcare (SRH) services and routine care.

The COVID-19 containment measures and their effects on sexual and reproductive health

The COVID-19 containment measures enforced through the country-national lockdown inadvertently disrupted the equitable and sustained provision of sexual and reproductive health services across the globe, with low- and middle-income countries (LMICs) bearing the sharpest blunt (Bolarinwa et al. 2021; Mukherjee et al. 2021). However, the effects were most pronounced for women who failed to get access to essential services inclusive of the provision of family planning services (including access to contraceptives), negative consequences of changing contraceptives in the absence of proper medical assessment, treatment of sexually transmitted infections (STIs), human immunodeficiency virus (HIV) testing and treatment, maternal healthcare, emergency contraception, abortion facilities, routine scan appointments and antenatal care, deterioration and transmission of diseases (Bolarinwa et al. 2021; Macheka & Nhongo 2021; Manyonganise 2022; Murewanhema, Musuka & Dzinamarira 2022; Murewanhema et al. 2022). Since the outbreak of the COVID-19 pandemic, the prioritised healthcare services by governments, healthcare departments and frontline workers excluded SRH services. However, such an exclusion of SRH services is not an entirely new phenomenon. It has been observed that during emergency calamities such as pandemics, SRH needs are often side lined (02 July 2020, msf.org). In addition, SRH services such as contraception (which includes family planning pills and condoms), and safe abortion care are regarded as non-essential; hence, they are deprioritised during a crisis (Mukherjee et al. 2021). Resultantly, during the COVID-19 pandemic, SRH services, especially those aligned to women's needs, were treated as non-essential services. As such, resources otherwise previously allocated to cater for women's SRH needs were diverted to support COVID-19 activities (GiHA 2020; Hara & Chindimba 2020). The COVID-19 pandemic and the lockdown measures also disrupted the manufacture and supply chain of contraceptives (Riley et al. 2020) and this resulted in secondary consequences of the pandemic in terms of unplanned pregnancies, unsafe abortions, decreased antenatal care, maternal and new-born deaths and other related SRH challenges (Mukherjee et al. 2021).

Theoretical framing

In a bid to understand the gendered implications of the COVID-19 lockdown spiral effects to women's SRH, the study adopted the theory of Gender and Power, which was developed by Robert Connell (1987). The Gender and Power theory is posited on three major underpinnings, which are:

- The sexual division of labour (e.g. represented by financial inequality).
- The sexual division of power (e.g. represented by authority).
- The structure of effective attachments (e.g. representing social norms and characterises the gendered relationships between men and women) (Connell 1987).

The sexual division of labour and the sexual division of power represent gender relations while the third underpinning addresses the emotional element within gendered relationships. These three underpinnings are entrenched in the society and exist at different family, societal and institutional levels. They are, however, maintained by social mechanisms. As such, Connell's theory will be used to explore the effects of gender and power in women's SRH during the lockdown period. Therefore, the study seeks to determine whether financial inequality, authority and social norms are part of the key drivers that infringe upon women's SRH rights.

Research methodology

The study employed a qualitative research design to guide the process of data collection and analysis. Qualitative research is informed by the interpretivist paradigm, which allows for an in-depth exploration of the experiences, attitudes, feelings and perceptions of a research phenomenon. It also brings to the fore voices that are often silenced (Frisby, Maguire & Reid 2009). Qualitative data collection in the form of personal in-depth interviews and focus group discussions (FGDs) were adopted for the study, and these were conducted virtually. The duration of the in-depth interviews (IDIs) was 30–50 min while the FGDs were conducted for 90 min. For both IDIs and FGDs, a sample of 20 research participants was purposively selected, comprising 15 married women and 5 ministers of religion from 3 high-density suburbs of Kuwadzana, Kuwadzana Extension and Warren Park in Harare, Zimbabwe. All the participants were interviewed with their consent. Pseudo identification was used to protect the privacy and maintain anonymity of the research participants.

Discussion of findings

The results of the study revealed the spill-over or secondary effects of the COVID-19-induced lockdown on women's SRH. Research findings on the key factors affecting women's SRH during the lockdown period included:

- Heightened sexual intercourse because of restrained movement resulting in limited time for men to visit their small house and side chicks.

- Heightened sexual intercourse as a means of asserting male dominance.
- Increased intimate partner violence (IPV) and sexual abuse.
- Socio-cultural, gender inequalities and patriarchal norms inhibiting women from taking control of their SRH.

Heightened sexual intercourse because of restrained movement resulting in limited time for men to visit their small house and side chick or dish

Within the context of Zimbabwe, the small-house phenomenon became popular during the early 2000s, and it refers to a form of a concurrent relationship whereby a person partakes in regular sexual relations with another person while contemporaneously having sexual relations with their primary sexual partner who is the legal wife or a long-term partner. It is considered a marital practice that sanctions the extension of a monogamous marital union into a quasi-polygamous structure, which creates a new form of marriage that juxtaposes between two ideologies that are modernity and cultural adherence (Mutseta 2016). It is also viewed as an emergent family structure in the Zimbabwean contemporary society, and it takes after the traditional polygynous marital structure (Muchabaiwa 2017).

The side chick or dish literally draws from its name from the nature of the relationship – it is a side relationship that may be undertaken by a man with a wife and a small house and the man will occasionally enjoy a side dish outside the other long-term relationships. The side dish is more of a casual short-term sexual relationship, usually undertaken by persons in existing long-term relationships.

As the small-house phenomenon is taken to have replaced casual sexual encounters, the sense of a long-term secret relationship provides a phony safety net for extra-marital sexual relations that are undertaken without any form of protection. Narratives from research participants indicated that most men have a small house with children born out of the union. The participants also posited that while the men who have small houses believe that because they cater for the economic needs of their small houses, there is a pretentious assumption that these partners are faithful, while in actual fact, they may be a small house for one person and a side chick for another man. Such a situation creates a cycle of unprotected sexual relations, which in turn expose the legal wife or primary partner to the risk of HIV infection as well as STIs.

While there are varying conceptualisations to the small-house phenomenon, this quasi-polygamous structure has been identified as a key driver of HIV (ZIMSTAT & ICF International 2012). This emanates from both the public and private discourse's conceptualisation of the small house as a survival transactional sex relationship that has been identified as one of Zimbabwe's key driver of the HIV epidemic (Christiansen-Bull 2013). Drawing from participant narratives, it is believed that the small-house women maximise on what are deemed as the shortcomings of the woman in the big house who is the legal partner, that is nothing is taboo for them when it comes to the act of intimacy and men appraise them for their sexual prowess. Hence, the COVID-19 pandemic-induced lockdown that restrained movement restricted to those men with small houses and side chicks to meet their regular sexual escapades. This in turn led to heightened sexual intercourse with the big house or legal wife. This shift in sexual frequency exposes the big house to SRH-related challenges. Some of the cited challenges by the research participants include vaginal discomfort, uterine pain, spot bleeding and exposure to STI and HIV infection and thus was reiterated by one research participant:

> Since I discovered that my husband had both a small-house and a side-chick, (discovered through messages of complaint sent to my husband by the small-house on his cell phone), I had since stopped having regular intercourse with my husband. The very few times we met, I insisted on condomising. So during the lockdown, movement was restrained and I became my husband's only source of intercourse. For the first few days, we used condoms but he ended up refusing to use them. This resulted in forced intercourse on almost a daily basis. Sex with someone you have emotionally written off due to his extra-marital relations is just not on – you do not get turned on, hence, it was mostly dry and forced sex which led to a lot of pain and discomfort for me. The restraint of movement also disabled me from going out to buy lubrication. I ended up with vaginal abrasions. (RP16, Female, 38 years)

The small house is a masked polygynous relationship, which is long term; therefore, no protection is used in most instances. While this arrangement is supposedly kept secret, more time is spent with the small house, a situation that was disrupted by the lockdown containment measures, hence, exposing the big house to SRH-related challenges. Participant narratives reflected how the sexual division of power and prevailing social norms that privilege the male species denied women their voice and agency with regard to sexual relations with their spouses.

Heightened sexual intercourse as a means of asserting male dominance

Ninety per cent of the research participants confessed to recurrent and heightened sexual intercourse during the lockdown period. According to participant narratives, a large number of males lost their formal employment, especially those working for entrepreneurs or private corporations. In addition, those involved in self-income-generating activities with no alternate sources of income were also affected. This unprecedented scenario meant that the position of these men as breadwinners and family providers was highly compromised, and this resulted in bruised male ego. Hence, in order to maintain and assert their position of dominance, which, according to the research participants, is manifested in the ability to economically provide for the welfare of the family, the men asserted their position of power through heightened sexual intercourse.

One of the research participants, RP1, remarked:

> I could clearly tell the way and frequency we were having sex was a way of asserting power over me – at first I complained but then my husband responded angrily. He accused me of

> undermining him because of our financial instability – he angrily shouted that when we have money, I do not withhold sex from him. I just understood that it was a way of asserting his power and authority and for the sake of peace in the home – I just had to endure it despite the discomfort it caused me. (RP1, Female, 33 years)

Similar to the sentiments expressed by RP1, RP4 also bemoaned that the frequency of sexual intercourse during the lockdown period felt as if she was being punished for the COVID-19 induced financial and economic challenges:

> By the end of the first week of the lockdown, I was experiencing severe uterine pain and I started spot bleeding – my husband was not bothered by this and he actually insisted we continue having sex but we use condoms because of the spot bleeding. The frequency with which we had intercourse was like a punishment being inflicted on me – the act was devoid of any feelings or love – but just proving to me that he is the man and he calls the shots. Ironically, this began during the first lockdown period – I suspect it was the frustration of being financially challenged and since he had no other ways of diffusing his frustrations – sex became the escape route. (RP4, female, 28 years)

These participants' narratives were consistent with findings from a study carried out by Manyonganise (2022), where the women bemoaned the failure to 'put their uteruses on lockdown during the lockdown period' (p. 234). Manyonganise (2022) observed that the COVID-19 pandemic has defied African masculinities whereby men were faced with the failure to enact their role as family providers. As a result, it is reported that men resort to the use of violence as a way of masking the vulnerability associated with the failure to fulfil their socially constructed roles (Manyonganise 2022). These sociocultural beliefs and practises exert unnecessary pressure on men resulting in hegemonic masculinities. As such, there's a need to deconstruct the socially prescribed roles, especially in the 21st century where both men and women have equal employment opportunities.

Increased intimate partner violence and sexual abuse

Narratives from the FGDs reported a number of IPV cases where both verbal and physical abuses were experienced by some women during the lockdown period. One of the participants (RP5) from a FGD shared the following:

> For me it was plain marital rape – since he started his small-house shenanigans we had stopped having sex and I was ok with it because it safeguarded my health. During lockdown, I was literally forced into having sex consecutively – any complaint of discomfort resulted in both physical and verbal abuse. (RP5, female, age 41)

Another research participant, RP9, similarly expressed her sentiments:

> Our culture does not provide a safety net against abuse within the marital set-up. It is taboo to complain that the husband's sexual appetite is insatiable because it is believed that the primary purpose of marriage is intercourse followed by procreation. (RP9, female, 44 years)

Women experiencing IPV had no access to support networks during the lockdown period because of restricted movement, and most support organisations were also on lockdown. As such, victims of IPV were locked down with their abusers for a prolonged period. Other identified key drivers of IPV during the lockdown period included marital irritants, a lack of personal space and anxiety from the enforced quarantine. Uzobo and Ayinmoro (2021) identify various factors associated with why women chose to stay in abusive relationships. These included the fear of uncertainty (failure to remarry), financial instability, preservation of self-identity (linked to African socio-cultural expectations that attach a woman's dignity to marriage), maternal bond with children, preserving the family dignity, avoiding the stigma and shame associated with broken relationships and adherence to religious precepts that forbid divorce or separation. Uzobo and Ayinmoro (2021) have further observed that IPV is linked with health-related challenges for women such as STIs and gynaecological dysfunction.

In response to why there were increased incidences of IPV during the lockdown period, one of the religious ministers, RM2, who was part of the research sample, cited that most husbands often complain that they do not get enough sexual intimacy at home; hence they resort to the small house. As a result of the restraint of movement during the lockdown period, the husbands were unable to visit their alternate sources of sexual intercourse. Therefore, they had to contend with women who were unwilling to have regular intercourse. The minister cited that this led to IPV as the husbands wanted to assert their sexual rights within the marital unions.

Socio-cultural, gender inequalities and patriarchal norms inhibiting women from taking control of their sexual and reproductive healthcare rights

Within the context of Zimbabwe and elsewhere in other African countries, women are predisposed to socio-cultural practices and other presenting dynamics that infringe on their SRH. Women in intimate relationships, especially within the setup of the marital union, do not have sexual autonomy. Cultural practices, especially the concept of *lobola* (bride price) and the accompanying socio-cultural ideologies that subjugate married women, corrodes their capacity to practise their SRH rights. Narratives from research participants indicated that women lack control over their own sexuality as well as reproductive rights.

Feminine timidity and masculine authority were cited as cultural expectations that restrict women from making informed SRH choices and decisions for the good of their own and their family's healthcare (Musandirire 2016). Drawing from the Shona culture and similar to other ethnic

groups in the African context, it was observed that cultural dictates do not allow women to have control of their sexuality or reproductive rights (Musandirire 2016). Research participants cited that they secretly took ownership of their SRH needs, especially with regard to family planning and routine check-ups for STIs and HIV screening. However, the lockdown period placed women under scrutiny. One of the research participants, RP14, shared that she was on controls (contraceptive pills) without the knowledge of her husband. During the lockdown, it was difficult to adhere to her normal schedule of taking the controls, which resulted in her falling pregnant.

Probed on how the persisting socio-cultural practices, gender inequalities and destructive patriarchal norms that infringe upon women's SRH can be deconstructed, some of the research participants cautioned that direct confrontation breeds animosity. It is seen as a direct challenge to prevailing cultural norms that have, since time immemorial, served as guiding ethical principles. Direct confrontation is also interpreted as an act of defiance to the culturally constructed African marriage precepts that position men in authority, lording over all aspects of women's lives. Hence, some of the women participants indicated that there are some aspects of SRH where they can assert their control. For example, with contraceptive pills, some of the women mentioned that they have long-term family planning methods, that is, the injection while others shared that they take contraceptive pills during their working hours and they keep them at their workplace. The participants who are full-time housewives also shared that they used to take contraceptive pills (commonly referred to as controls) when their husbands left for work and they kept them hidden away. Clearly, the COVID-19 lockdown disrupted the secret routine uptake of birth control by taking contraceptive pill, and this resulted in unplanned pregnancies for some of the women.

Religious responses to the impact of COVID-19-induced sexual and reproductive healthcare challenges

Religious leaders are usually positioned among the first responders to a crisis because they are deeply rooted within the communities they serve. Religious leaders, by virtue of their social standing within local communities, yield authority and trust, hence, positioning and enabling them to respond even to spill-over effects induced by the COVID-19 pandemic. However, religion can serve as a double-edged sword that can either hinder or promote positive SRH responses. Namasivayam et al (2017) posit that the re-emergence of religious influence within the public and political domain intensifies patriarchal attitudes, which certify male dominance and control over women. Namasivayam (2017:11) further argues that 'women's bodies, their sexuality, reproductive systems and rights, and familial and societal roles are used as a prop in religio-political feud'. Furthermore, women are regarded as custodians of culture and tradition and their bodies are regarded as belonging to the society and the family:

> [*H*]ence a women's assertion of her basic rights is condemned as a crass display of selfish individualism which is deemed to be an abandonment and betrayal of her family, community, and, quite often, religion (Namasivayam 2017:11).

Despite the ambivalent role of religion in responding to healthcare needs, religious leaders who were part of the case study indicated that they continued to offer virtual support to their congregants during the lockdown period, and at times they had to be physically present despite the high exposure to the COVID-19 infection. However, some of the research participants felt that some of the responses by the ministers of religion, especially to SRH issues were biased in favour of the male counterparts.

While the COVID-19-induced lockdown period presented a number of SRH challenges for women, one of the research participants who is a minister of religion, RM3, remarked that some positives also came out as a result of the prolonged period where married couples spent more time together in the confines of their marital homes. RM3 was quick to point out that a number of marriages were fragile because of the small-house and side-chick phenomenon, which has become a norm in contemporary Zimbabwe. He posited that the COVID-19-induced period was also part of God's plan to mend those broken marriages and their associated challenges. He narrated that:

> I told the men in my church that they should make love to their wives and do all the styles they do with their small-house and side-chicks. I advised them that this is the time to explore each other and then decide if it's worth having a side-chick. I equally told the women that now was the time to claim their marriages back and desist from being novices in the bedroom. God could not find a better time to rebuild marriages hence the lockdown. (RM3, Male, 54 years)

Similarly, another religious leader, RH4 reported that the lockdown period was God sent as it resulted in a number of childless couples becoming first-time parents. He stressed on the importance of SRH and that it should be part of the church's programme and teachings:

> There is need to teach couples to understand the female cycle, i.e. how to detect the ovulation period and women must understand their physiology. I had a number of couples who had no children and they assumed that the women were barren. During the lockdown, mainly due to the fact that the couples spent more time together, five of them conceived and have since given birth! Now I know that it was just mistimed or miscalculated fertile periods – you see, most of these modern couples do not spend enough time together – either due to work commitments or the husband having a small-house. (RH4, Male, 47 years)

In this regard, the busy lifestyles and times spent apart by these couples hindered their chances of conception, and hence the lockdown period enabled them to copulate during the women's fertile period. Apart from these positives, a number of challenges were presented. Another minister of

religion, RM1, shared the counselling dilemma on the issue of abortion:

> One of my female congregants contacted me and shared that she had run out of her control medication (family planning pills) and the husband did not want to stop having intercourse. So she ended up falling pregnant and currently she is suffering from high blood pressure and cannot afford to keep the pregnancy based on her medical condition as well as the family's financial standing. In this regard, she wanted to abort but secretly without her husband knowing and she wanted my counsel. (RM1, Male, 61 years)

The given narrative reflects the relationship between religion, sexuality and reproductive health. Most major religions are guided by set doctrines that prescribe how adherents respond to particular health matters, inclusive of SRH. However, Bijlmakers, de Haas & Peters (2018) posit that some religious doctrines and traditional cultural ideals connected to gender and sexuality impinge on sexual rights, thereby obfuscating efforts to improve SRH. Most religious traditions are against the idea of abortion. For example, both Christianity and Judaism uphold the perspective that once conception takes place, the embryo should be perceived as a human being and hence, abortion is forbidden (Schenker 2000). It is further believed that marriage is instituted for procreation and the use of contraceptives negates the creation of new life (Schenker 2000). As such, RM1's response was against abortion as it was contrary to Christian beliefs.

Besides the psychosocial support religious leaders had to offer during the COVID-19 lockdown, there is a need for faith organisations and actors to adopt new intervention strategies that can mitigate the undesirable effects of a pandemic, especially the gendered effects on vulnerable populations. Whereas, a number of religious institutions have adopted tele-evangelism and the use of ICT through Facebook, Twitter, WhatsApp platforms, etc., there is a need to also adopt tele-health as a supplement to the customary health service delivery. Tele-health transcends the boundaries of geography and shortages of health personnel, especially within the context of a pandemic where health resources are restrained (Ponde-Mutsvedu & Chirongoma 2022). In the context of COVID-19 where self-isolation, social and physical distancing and quarantine are standing mitigating measures against infection, tele-health has been identified as a suitable healthcare delivery system (Ponde-Mutsvedu & Chirongoma 2022).

In addition, for religious actors to be able to promote positive SRH health outcomes, there is a need to deconstruct theologies that subjugate women's lived experiences. Manyonganise (2022) argues that the tenacious lobbying for ending gender-based violence should be embraced as a 'lived reality and not just a confessional one'. Furthermore, there is a need to read and interpret biblical texts in ways that are life-giving for women as a strategy for redressing gender inequalities (Manyonganise 2022), which subsequently impinge on women's SRH.

Conclusion

The COVID-19-induced lockdown measures brought unprecedented challenges to women's SRH. This chapter highlighted that the restraint of movement necessitated by the lockdown exposed women to IPV, heightened sexual intercourse with otherwise absent spouses leading to the risk of HIV and STI infections, unplanned pregnancies and other SRH-related health challenges. The chapter also highlighted the intersectional relationship between religion and SRH, paying attention to the role of religious leaders in responding to women's health challenges induced by the COVID-19 lockdown measures.

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Competing interests

The author has declared that no competing interests exists.

Author's contributions

A.M.H. is the sole author of this research article.

Ethical considerations

The research included human participants. Ethical clearance (004/22) to conduct research was granted by the Midlands State University, Faculty of Arts and Humanities Ethical Committee. Pseudonyms were used to maintain confidentiality of research participants. Data collected are kept at the department of Religious Studies and Ethics of the Midlands State University.

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Data availability

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