Addressing Gender Disparities in Healthcare Delivery: Strategies and Innovations for a Post-COVID-19 Era

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Abstract

Gender inequalities in healthcare have persisted for decades, with women often facing access barriers, poor treatment outcomes and inadequate care. The COVID-19 pandemic further exacerbated pre-existing inequalities. This qualitative study sought to explore the nature and impact of gender inequalities and identify strategies for addressing them in the post-pandemic period. A comprehensive search of multiple databases and sources was conducted, including PubMed, Google Scholar, and WHO publications. Search terms such as "gender disparities," "health care disparities," "women's access," and "COVID-19" were used in various combinations. A comprehensive literature review of databases from 2015 revealed that inequalities persist between different health services. Data were analysed using a thematic approach to identify key themes and patterns. Women reported facing sociocultural barriers, financial constraints, and a lack of autonomy in healthcare decision-making. They also suffered disproportionately from negative effects on their physical, mental, and economic well-being as a result of job losses, and increased family responsibilities brought on by the pandemic. Proposed strategies included gender-sensitive training for healthcare providers, involving women's groups in planning, increasing financial protection, and using technology to deliver integrated services. Concerted efforts are required to mainstream gender equality with community participation in all health systems. If left unchecked, pre-existing inequalities could persist and undermine public health goals.

Keywords: Gender inequalities, healthcare disparities, women's health, COVID-19, access barriers, strategies

Introduction

The problem of gender inequalities in health systems is a global problem that primarily affects women. According to the World Health Organisation (WHO) (2021), women's access to health services, information, resources and decision-making power is limited due to discrimination and prejudice caused by deep-rooted social and cultural norms. Addressing the underlying causes of

these inequalities requires immediate attention as the COVID-19 pandemic has exposed and widened pre-existing gender disparities (Kauer et al., 20, 2021). The purpose of this qualitative study conducted in Zimbabwe, was to examine the causes and effects of gender disparities in healthcare and to find solutions in the post-pandemic period. Similar to many other African countries, Zimbabwe has persistent gender inequalities in its healthcare system. These inequalities were exacerbated by the COVID-19 pandemic. Improving health outcomes and achieving national health coverage depend heavily on eliminating these disparities.

Background

Globally, there has been extensive evidence of gender disparities in quality and access to healthcare for decades. Through international agreements, national constitutions and supporting laws, progress towards achieving gender equality and universal health coverage has been made in many countries worldwide (UN Women, 2020). However, patriarchal social structures and sexism continue to permeate cultural beliefs, laws and practices that threaten the health, human rights and empowerment of women everywhere (EIGE, 2020). Women face barriers joining healthcare workforce where they occupy only 25% of professional positions (WHO, 2021). According to UN Women (2021), women's care experiences and outcomes are often worse than those of men because health services often do not adequately address their unique biological and social needs throughout their lives. Although there has been some progress, current published literature indicates that significant disparities still exist at sociocultural, economic and political levels (Langer et al., 2015). Many healthcare systems are constrained by deeply rooted social and gender norms. For example, a comprehensive analysis by WHO (2019) concluded that over 70% of 104 nations studied allocated smaller budgets to address women's health issues. The analysis also concluded that millions of women and girls worldwide still lack adequate financial protection through insurance coverage and formal employment.

Furthermore, gender differences in access to and quality of healthcare have been widely documented worldwide for many years. Women often face barriers to accessing preventive, curative and rehabilitation services for various health conditions. According to EIGE (2020), women face economic discrimination, barriers to education and barriers to joining the healthcare workforce globally hence exacerbating the gender pay gap. This disproportionately affects girls and women from lower socioeconomic backgrounds. Moreover, the advent of lockdowns and

business closures during the COVID-19 pandemic resulted in millions of job losses, with women disproportionately affected as most are engaged in informal sectors such as domestic work, agriculture and small to micro-enterprises without paid leave or sick pay protection (International Labour Organisation (ILO), 2019).

In the African context, gender inequality has its historical roots in patriarchal social norms that restricted women's autonomy and rights, marginalised their roles, and promoted traditional gender stereotypes of masculinity and femininity. These norms also justified discrimination as indicated by the National Biodiversity Strategy and Action Plan (NBSAP) (2020). Since then, most African nations have enacted new legislation and progressive constitutions that establish fundamental rights such as gender equality (Zimbabwe Ministry of Health, 2019). The ILO (2019) reports that systemic barriers, such as inadequate financing, weak implementation structures, patriarchal attitudes within policymaking spheres, and cultural norms that conflict with equality frameworks are still embedded in communities, impede the full realisation of these goals. As highlighted by Morgan et al. (2016), in most southern African countries, women's autonomy to make decisions about their sexual and reproductive health needs is weakened by cultural practices and beliefs. Adding on to that, Sen and Ostlin (2018) also submit that these practices and beliefs perpetuate the idea that “community health issues” are more important than “women's health issues” hence perpetuating inequalities. Furthermore, WHO (2021) highlighted that low status and restrictive patriarchal systems in many rural communities in Africa mean that women have little control over their healthcare and less access to health services. For example, in certain regions of West Africa, despite legal prohibitions, harmful practices such as female genital mutilation still continue, putting girls and women at risk of serious acute and chronic health problems (United Nations Population Fund (UNFPA), 2021). The WHO (2021) also noted that most African women are disproportionately affected by reproductive health issues because of high rates of maternal death, limited access to family planning and contraception as a result of poverty and flaws in the health system, and a lack of comprehensive sex education that would assist them to make informed decisions. As a result, cases of HIV/AIDS continue to be severely feminised with young African women in sub-Saharan Africa being three times more likely to get infected with the virus than men because of sexual violence, lack of control over condom use, and other sociocultural factors (UNAIDS, 2020).

Consequently, these existing vulnerabilities in health systems that disproportionately affect women have been exacerbated by the COVID-19 outbreak. Research concluded that women have been disproportionately affected as evidenced by an increase in gender-based violence and reduced access to healthcare (WHO, 2018; UNFPA, 2021). This was also evidenced by the closing of most outpatient facilities and the sudden allocation of resources towards the pandemic, which also resulted in the disruptions to routine care service. Moreover, gender-disaggregated data from several countries also shows that, as a result of the pandemic, most women suffered job and income losses; and those greatly affected were women in the informal sector like domestic work, street vending, retail shops and tourism. This was worsened by lockdowns and social restrictions that significantly reduced the incomes of millions of people working in the informal sector, particularly in low-income areas (ILO, 2020). The restricted movement during lockdowns also resulted in limited access to sexual and reproductive health services hence negative impacts on prenatal, maternity and postnatal care (UN Women, 2020).

In Zimbabwe, the COVID-19 pandemic exposed the persistence of patriarchal norms that perpetuate gender disparities within the healthcare system. Reports by the Ministry of Health and Child Care in Zimbabwe (MOHCC) (2019) showed that patriarchal gender norms embedded in the country's laws, policies and communities have led to discrimination against women and health inequalities within the country. The NBSAP Zimbabwe (2020) also reported that a lack of public education, male dominance over resources and decision-making, negative attitudes and inadequate funding continue to create health implementation gaps despite progressive laws and policies on paper setting guidelines for gender equality and women's empowerment in Zimbabwe. This was exacerbated by harmful practices such as child marriages, which remain widespread and endangers girls' rights, health and education (Dziva et al., 2021). Furthermore, before COVID-19, access to services in Zimbabwe's health systems was already severely limited by a lack of both domestic and international funding, which made it difficult for the country to obtain enough qualified healthcare providers, equipment, and medications (Burke & Valdivia, 2021). Since 2000, the nation has also seen an intensifying economic crisis, with rising inflation rates significantly outpacing declining living standards, wages, and the calibre of public services (IMF, 2018). Because of this, more than 60% of the Zimbabwe population still depend on subsistence farming for food and income, making them more susceptible to changes in the weather and economic shocks as their level of poverty rises (FAO, 2021). Due to its disproportionate effects on women's

safety, access to care, and economic security, the advent of the COVID-19 pandemic made the already existing gender disparities in Zimbabwe's health system worse. Just like in many other African countries, millions of women in Zimbabwe lost their jobs and income due to lockdowns and movement restrictions that restricted their earning opportunities, leading to a rise in household poverty and financial instability (ZIMSTAT, 2021). Also, those who were working in the informal sector, for example, small scale enterprises, fruit and vegetable vending, domestic work, and the agriculture sector dominated by women, were greatly affected (ILO, 2020). To make matters even worse, the closing of schools during lockdowns resulted in a rise in stress levels as women and girls took on more caregiving duties, including cooking, cleaning, and childcare, regardless of their studies (Dziva et al., 2021).

Consequently, inequalities between genders in the healthcare system remained a problem in Zimbabwe. The full realisation of women's health and rights has been hampered by systemic gaps and socioeconomic barriers, despite legislative progress establishing principles of equality and non-discrimination. The COVID-19 pandemic exposed pre-existing disparities and had a disproportionately negative impact on women's well-being by exacerbating their vulnerabilities. Before the crisis, patriarchal norms and a lack of funding prevented Zimbabwe from implementing supportive policies effectively and women had limited access to healthcare. Many women gave birth without professional assistance, and rural communities faced significant distance barriers to services. Traditional practices undermined the empowerment of girls, while reproductive health programmes were concentrated in cities. Due to gender biases, the male-dominated system also neglected to satisfactorily consider the specific needs of women.

It is therefore still difficult to address the deeply ingrained gender disparities in healthcare and in society. Multi-sectoral strategies addressing root causes through policies, programmes, and systemic reforms led by meaningful participation of women and leadership are therefore required (WHO, 2020). Coordinated actions are now necessary to address the unequal health, social and economic impacts on women. Despite some progress made so far in many countries, as well as in Zimbabwe, the COVID-19 crisis has shown that patriarchal norms that perpetuate gender inequalities health sector remain resistant to change. Lessons must be learned from the difficulties encountered in responding to the COVID-19 pandemic to strengthen gender-responsive recovery and strengthen resilience to future health systems. Restoring healthier, more gender-sensitive

systems requires more evidence-based policies and strategies than ever before (Kauer et al., 2021). If pre-pandemic inequalities are not addressed, they will continue to be damaging long after the COVID-20 era, particularly for disadvantaged groups within our societies (EIGE, 2020). The social factors that contribute to disparities in health systems between men and women need to be addressed through targeted interventions. It is now essential to put a renewed emphasis on empowering marginalised groups to address systemic root causes to strengthen resilience against shocks in the future. Prioritising disadvantaged populations, and targeted remedies that consider intersectional identities and community-level factors are necessary to strengthen Zimbabwe's post-pandemic reconstruction.

Statement of the problem

Gender inequality in health systems is a global problem that primarily affects women. The World Health Organization (WHO) asserts that discrimination and prejudice caused by deeply rooted social and cultural norms limit women's access to health services, information, resources and decision-making power (WHO, 2021). The COVID-19 pandemic exposed and widened pre-existing gender gaps. Therefore, it is imperative that the underlying causes of these inequalities are addressed immediately (Kauer et al., 2021). Like many other African countries, Zimbabwe is experiencing negative impacts on women's physical, mental and financial well-being due to long-standing gender inequalities in the health system, and these were also exacerbated by the COVID-19 pandemic. Improving health outcomes and achieving national health coverage depend heavily on eliminating these disparities.

Research questions

i) What are the major gender disparities in healthcare service delivery and access before, during and after the COVID-19 pandemic in Zimbabwe?
ii) How have these disparities affected the physical, mental and financial well-being of women in Zimbabwe?
iii) What innovative and successful approaches can be used to address gender disparities in the post-COVID-19 health system in Zimbabwe?

Methodology

This study used a document analysis methodology that employed a qualitative research design. According to Creswell and Creswell (2018), a qualitative approach made sense given the goal of examining complex issues of gender inequality and identifying viable solutions through the analysis of written evidence. Relevant documents were found by using keyword combinations such as “gender disparity”, “health care Zimbabwe” and “women's access post-Covid-19” to search databases such as PubMed, Google Scholar, WHO Global Health Library and organisational repositories. Documents included in the collection of the pertinent data were those published between 2015 and 2022 that provided context for Zimbabwe and other African countries. Fifteen documents were retrieved that met the criteria and from these documents data was collected. Purposive sampling was used to select documents that contained detailed information on the study objectives from authoritative sources such as Ministry of Health reports, WHO country assessments, NGO briefs, and peer-reviewed articles (Peters et al., 2020). Recent publications with gender-disaggregated qualitative and quantitative data on the impact of COVID-19 and the opinions of key stakeholders were also prioritised. The sample size was determined by data saturation (Guest et al., 2006).

The research used thematic analysis following the guidelines of Nowell et al. (2017) to uncover critical concepts through a thorough examination of the documents. A list of initial codes was created and then divided into potential themes covering different aspects. These themes were refined, defined and supported with evidence to achieve the study objectives. To ensure the reliability of the analysis, a peer review process was implemented in which a peer researcher double coded a sample of the data to compare consistency. An agreement rate of over 90% was achieved, meeting the recommended standard for demonstrating credibility in qualitative research (Creswell & Miller, 2000). The analysis was conducted using publicly available secondary data sources to protect the anonymity of individuals and maintain confidentiality. The research results would be shared to achieve broader benefits without compromising the privacy of the organisations mentioned in the documents. However, the researcher acknowledges limitations such as differences in depth and scope of data in this study.

Presentation of findings

These findings are based on information from verified documents. Several factors have surfaced that address the nature of gender differences in health systems before and during the COVID-19 pandemic. Disparities were found in various health categories such as maternal health, sexual reproductive health, non-communicable diseases and mental health. Findings also revealed that there was an increase in disruptions to health systems during the pandemic, which also had a major impact on the lives of marginalised groups. The pandemic had a major impact on people's sexual reproductive health, livelihoods and education, among others. This was exacerbated by the lockdowns and movement restrictions due to the pandemic.

These findings also informed the possible strategies to address these gender disparities in our healthcare system. Information from the documents reviewed indicates that some of the proposed strategies include, among others, integrating gender into all COVID-19 policies and programmes, implementing gender audits in health systems, implementing awareness and engagement programmes, and developing financial mechanisms for disadvantaged groups and monitoring and evaluation of these activities, among others. These findings are presented thematically based on the objectives of this study.

(a) Gender disparities in healthcare delivery pre-COVID-19

Maternal health

Documents reviewed found that, although maternal mortality rates in Zimbabwe had declined since 2000, many women continued to have unequal access to quality antenatal, delivery and postnatal services (WHO, 2019). There was a severe shortage of female nurses, midwives and doctors, particularly in rural areas, leading to a higher likelihood of obstetric complications due to delays in care (MOHCC, 2017). Traditional beliefs also negatively impacted health-seeking for maternal needs, with some communities perpetuating practices such as wife inheritance that put widowed mothers at risk (Chadamoyo, 2018).

Sexual and reproductive health

Before the pandemic, reports showed that Zimbabwean women faced obstacles such as a lack of autonomy and financial hurdles that made it difficult for them to access family planning, screening and treatment for infections such as HIV/AIDS (Ministry of Health, Labour and Social Services,

2019). Gender differences in HIV prevalence resulted in women being at higher risk without adequate support services tailored to their vulnerability (UNAIDS, 2020). Adolescent girls had difficulty obtaining contraceptives and counselling due to conservative social norms that prevented open discussions about sexuality, especially for the yet to be married young women (UNFPA, 2018).

Non-communicable diseases

According to national health surveys, over the years women in Zimbabwe were more likely to be affected by non-communicable diseases such as heart disease, diabetes, high blood pressure (BP), asthma, depression and certain cancers (e.g., breast, lung and colon) (Kamvura et al., 2022). Unfortunately, risk assessment, early detection initiatives and treatment plans are not tailored to address gender differences in the development and progression of these diseases. Furthermore, health promotion efforts have predominantly focused on communicable diseases like influenza, malaria, TB, and HIV/AIDS, among others, and failed to educate the public about lifestyle factors that contribute to noncommunicable diseases, which are prevalent among middle-aged and older women (ZHDR, 2018).

Mental health

Most research studies done before the advent of COVID-19 revealed that mental disorders significantly contributed to poor health among women and girls in Zimbabwe. This was primarily attributed to factors such as gender-based violence, poverty, inadequate nutrition, and lack of sufficient support systems (MOHCC, 2015). Moreover, Maeresera (2022) also noted that primary care service providers offer insufficient psychosocial support and specialised psychiatric care, particularly in most rural communities. This was also worsened by traditional beliefs that contributed to the under-reporting and under-diagnosis of conditions such as depression and PTSD, resulting in treatment gaps for women and girls (Chibanda et al., 2016).

Out-of-pocket expenditures

In line with expenditure, the documents reviewed revealed that high costs of living continued to prevent many women from accessing necessary health care due to low income, lack of health insurance coverage and limited alternative financing mechanisms before the advent of COVID-19 (Zeng et al., 2018). This was worsened by how public institutions charged their consultation and treatment fees, which were being charged without taking into cognisant levels and sources of

income of people in their communities (HSGZ, 2018). As a result, many pregnancies were treated at home and chronic diseases remained uncontrolled because most women could not afford expensive diagnostics or medications from private healthcare providers (ZHDR, 2017).

(b) Impact of COVID-19 on healthcare delivery during the pandemic period

Documents reviewed revealed that studies on the gender impact of the pandemic in Zimbabwe have shown that women faced greater risks of infection and suffered more severe health, social, and economic consequences due to existing vulnerabilities that were exacerbated by lockdown and movement restriction measures. The pandemic had a major healthcare disruption that impacted people's sexual reproductive health, livelihoods and education, among others.

Healthcare disruptions

Findings from documents reviewed revealed that hospitalisation records from most health institutions indicated a significant decrease in outpatient visits during the peak of lockdown and movement restriction measures, with public health facility utilisation dropping by over 40% (MOHCC, 2020). This decline was mainly due to reduced access to non-COVID-related services, particularly affecting women. Maternal health services experienced notable disruptions as attendance for antenatal care decreased due to concerns about potential exposure to the COVID-19. Furthermore, limited access to transportation as restrictions intensified also prevented high-risk pregnant women in remote rural areas from visiting maternity hospitals and clinics, leading to a rise in unsupervised home-based deliveries, for example, the use of midwives (*mbuya utano*) where unsterilised gloves and razor blades were used. Moreover, findings also showed that treatment of chronic non-communicable diseases was also affected, with drug shortages, closures of chronic disease clinics and disruptions to health supply chains affecting continuity of care for conditions such as hypertension and diabetes, which predominantly affect women. This led to uncontrolled symptoms and poorer health outcomes. In addition, access to mental healthcare was further limited by social restrictions that separated patients from community-based counselling services, leading to a drastic increase in mental health disorders during the stressful period of the pandemic. Moreover, the telemedicine initiatives launched by the Ministry of Health faced some implementation challenges. Telemedicine implementation was hindered by limited internet penetration and technological literacy, especially among older women in rural areas (POTRAZ, 2019). This resulted in discouraging healthcare seeking for many non-emergency conditions.

Furthermore, with schools closed for more than six months, full responsibility for childcare fell to women and girls since they were always domiciled at home. The pressure of the unprecedented quadrupling of care work resulted in high levels of stress, fatigue and anxiety among women (MHRR, 2021). Hence, their livelihoods were greatly affected since most of their usual time dedicated to income generation activities was now diverted to domestic duties.

Livelihoods and poverty

Findings revealed that the informal sector, where over 70% of Zimbabwean women earn their living, was hit hardest by the lockdowns and movement restrictions. Sectors that were heavily affected were the hairdressing, fruits and vegetable vending, cross-border trading and even some parts of the agriculture industry (ZIMSTAT, 2020). Findings also exposed that millions of people fell into extreme poverty as soon as they lost their daily wages because there were no social security programmes. As the country enforced movement restrictions, remittances from family members in bordering countries also fell significantly (IOM, 2021). Due to the lack of alternative income opportunities and social support networks, most women especially single ones experienced higher rates of hunger and homelessness. As a result, over 50% of people living in cities were unable to pay for essentials such as food, rent and medical care, pushing poverty to its highest level during this period.

Gender-based violence

Documents reviewed revealed that a widespread escalation of intimate partner violence was witnessed as many victims were spending more time alongside perpetrators due to lockdown and movement restriction measures (ZWRCN, 2021). These restrictions removed the usual support networks and coping mechanisms hence the increase in GBV, especially intimate partner violence. Moreover, fear of social stigmatisation was noted as one of the major factors that discouraged women from reporting, as perpetrators threatened to expose lockdown violations. As a result, incidents of physical and sexual violence increased in both frequency and brutality. According to a report by the Ministry of Women's Affairs (2021), over 60% of GBV cases reported involved serious injuries and the use of weapons against helpless partners and children. This was also worsened by the failure of traditional and religious leaders who had difficulties in resolving disputes as stress increased in communities that lacked resources to cope. The lockdowns further limited access to justice as court hours were also shortened and this encouraged perpetrators who

took advantage of the absence of imminent legal retribution for their outrageous acts (ZHRC, 2021). With limited resources, combating COVID-19 took precedence over long-term gender-based violence prevention programmes, and the shadow pandemic of violence persisted.

Sexual and reproductive health

Reviewed documents also reported sexual and reproductive health concerns during the COVID-19 pandemic. Findings from these documents revealed that the provision of essential sexual and reproductive health services during the pandemic was hindered by the allocation of staff and resources to the COVID-19 response, resulting in the prioritisation of emergency procedures. This led to a decrease in access to routine family planning, prenatal care, and cancer screenings for women and girls. Furthermore, outreach programmes that used to deliver contraceptives to rural areas were discontinued, hence exacerbating the problem. It was also revealed that the closing of schools heavily impacted access to condoms and educational materials for adolescents, leading to a decrease in safe sex educational activities. Restriction of access to these services was also worsened by fear of contracting the virus at crowded facilities where these services were offered. Furthermore, limited transportation due to movement restrictions hindered HIV testing, infant feeding support programmes, and follow-ups for survivors of gender-based violence.

(c) Strategies and innovations for a post-COVID-19 era

The reviewed information suggested several innovative measures that can be taken to address various gender disparities that existed within the health systems which were also intensified by the advent of COVID-19. These strategies are explained below.

Integrating gender in COVID-19 policies and programmes

Most reviewed literature suggests that gender focal points be established within emergency response coordination structures to ensure that protocols ought to consider the different needs, barriers, and vulnerabilities faced by various groups (UN Women, 2021). Analysing fiscal relief packages and care guidelines through a gender lens could help address the disproportionate social and economic impacts faced by certain populations.

Gender audits of health systems

To address gaps in reproductive, primary care, mental health, and community health workforce programmes heavily used by women, reviewed documents highlighted assessments to track

resource allocations and access disparities (ChiZwHA, 2021). Budget support from external donors should therefore prioritise revitalising dysfunctional women-centred programmes and services (WOZA, 2021).

Awareness-raising and engagement

Mass media and social education interventions that challenge toxic masculinity and promote positive masculinity have been noted as important in changing restrictive social norms that fuel inequalities (ZWRCN, 2021). Advising women's groups on planning broadened grassroots perspectives on obstacles and possible solutions (MWAGCD, 2021).

Respectful maternity care

The focus of most studied literature was on the development of the capacity of health workers to provide non-judgmental and trauma-informed treatment specifically tailored to the needs of marginalised women (Hughes et al., 2022). To provide access to lifelong health support, community midwifery models should be improved to reach remote communities (CHITA, 2021).

Financing mechanisms

Some of the reviewed documents have proposed social insurance programmes and universal health insurance to protect women from crippling out-of-pocket medical costs and promote continuity of care (ILO, 2021). To promote economic empowerment and reduce vulnerability over time, some documents also proposed the introduction of conditional cash transfers, microcredit programmes and skills training measures (UNDP, 2021).

Multi-sectoral coordination

To address overarching challenges such as increasing gender-based violence, most of the reviewed documents suggested protection from threats and exacerbation of causes of poverty for non-health reasons, and a comprehensive strategy covering education, social welfare, finance and women's ministries. Literature also revealed that the involvement of religious and traditional leaders can contribute to the sustainability of community-led changes (HelpAge Zimbabwe, 2021).

Monitoring and evaluation

To ensure that programmes reduce gender inequalities, studied literature recommended the use of disaggregated qualitative and quantitative indicators to track impact and this can result in guiding iterative optimisations (WHO, 2020).

Discussions of findings

Based on the findings from the various reviewed documents pertinent to this study, it can be confirmed that gender disparities in health care and access were already widespread in Zimbabwe before the COVID-19 pandemic. Findings concluded that the underdiagnoses of non-communicable diseases affected women in various ways, for example, high out-of-pocket costs that discouraged health care use, barriers to sexual and reproductive care, unequal maternal health care, and inadequate attention to mental health issues. The national health surveys and reports from Zimbabwe examined for this study supported findings from previous studies in other African countries showing disparities in maternal health between rural and urban areas due to a lack of trained obstetricians and emergency obstetric care facilities, which disproportionately affected women (Kruk et al., 2018). Studies revealed that similar cultural beliefs limit women's health choices and undermine progress in other African countries such as Zimbabwe are consistent with findings about the continued influence of traditional norms and practices that undermine women's autonomy in sexual and reproductive decisions (Akachi & Kruk, 2017). Similarly, barriers in the unequal prioritisation of programmes for the life-course health needs of women compared to men across much of Africa have also been highlighted in the areas of cervical cancer screening, uptake of HIV/AIDS prevention services, universal access to modern medicine and identified contraceptive options (Simbayi et al., 2017). Due to conservative socio-cultural barriers, results concluded that single adolescent girls could not be reached through youth-friendly approaches with stigma-free counselling and care

Furthermore, the findings highlighted gender differences in disease expression and threats thereby neglecting addressing the increasing non-communicable disease burden. This is consistent with the neglection of epidemic of non-communicable diseases that disproportionately affected African women but were not adequately addressed by financing, community education and health policy (WHO, 2011). Moreover, findings also mentioned Zimbabwe as one of the countries where women are deprived of essential community mental health support services. This can be supported by

evidence of significant gaps in mental health treatment, where women's plight was excluded from mainstream care (Lund et al., 2011). Results also outlined various approaches to overcoming gender disparities exacerbated by the COVID-19 epidemic. It was noted that mainstreaming gender in all aspects of health planning, financing, service delivery and monitoring and evaluation by integrating expertise into relevant policymaking, budgeting processes and guidelines developed, is a strategy that has the potential to have a significant transformative impact (WHO, 2021). This approach is consistent with recommended practices in research that support the need for gender-responsive health systems that consider the needs, priorities and analysis of both genders to achieve equitable outcomes (Kuhlman et al., 2021).

It was also revealed in the results that comprehensive gender-sensitive reviews of resource flows and access patterns in the Zimbabwean health sector could support mainstreaming efforts by helping to identify specific vulnerabilities that would enable strategic sector investments that address underlying causes. Research confirms gender auditing techniques as crucial tools for tracking progress in addressing imbalances (EIGE, 2020). A proposed strategy, consistent with research highlighting the importance of gender-disaggregated indicators for impact tracking and iterative course corrections, is to strengthen regularly collected gender-disaggregated health data to support decision-making (UN Women, 2021). Other innovative tactics highlighted by findings as promising included capacity-building programmes for the trauma-informed and respectful maternity care that improve coverage and quality for marginalised women (Nikodem et al., 2021). Community midwifery models (use of *ana mbuya utano*) that increase grassroots reach have been particularly highlighted due to their focus on best practices in supporting women's access to comprehensive lifelong health care (WHO Regional Office for Africa, 2019).

Conclusion

This study provides insightful information about the nature and extent of gender disparities in health care delivery and access that already exist in Zimbabwe, as well as the unique impacts of the COVID-19 pandemic that are exacerbating inequities for women. Findings demonstrate the existence of structural barriers and socioeconomic factors that limit health outcomes for women in diverse service settings. Routine care has been disproportionately impacted by the epidemic and the impact on marginalised groups has not been adequately addressed. It also offers the opportunity to rebuild using gender-responsive, egalitarian strategies that increase community resilience.

Therefore, a consistent effort is required to implement coordinated initiatives and legislation that support the achievement of universal health coverage based on equality between men and women. Pre-existing gender inequalities have the potential to exacerbate the long-term health impacts of the COVID-19 pandemic on women and communities unless they are addressed through targeted, rights-based solutions. As Zimbabwe continues to recover from COVID-19, the recommendations highlighted below offer an opportunity to urgently reverse inequities and build stronger systems.

Recommendations

Based on the key findings and the proposed strategies, several recommendations have emerged:

i) Gender knowledge must be considered at all stages of planning, policymaking, and budgeting cycles, as well as service delivery policies, protocols, training and infrastructure development in Zimbabwe's health facilities.

ii) To ensure that equal health rights are maintained for men and women, explicit goals and metrics are needed to monitor the reduction of disparities.

iii) To identify priority areas for investment in closing gaps, a thorough gender review of resource distribution patterns and access disparities should be conducted regularly.

iv) It is imperative to include women's groups and civil society leaders to actively participate in campaigns to promote community participation in reform initiatives. Particularly in remote rural areas where access to primary care is limited, expanding the scope of community-based midwifery models and establishing mobile clinics may be helpful.

v) Policymakers must work with partners to coordinate cross-sector initiatives in areas such as domestic violence prevention, employment development, education and poverty reduction.

For future research studies, I suggest that these ought to examine effective implementation models for proposed tactics such as incorporating gender education into career readiness curricula or developing conditional financial assistance plans that have been shown to improve equal access. The unique needs of marginalised groups should be identified through qualitative research on the intersectional vulnerabilities and systemic constraints faced by subcategories such as adolescent

girls, minority groups, older women, and people with disabilities. Moreover, analysing excellent practices in different African contexts and comparing them could provide transferable knowledge across the continent.

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