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COVID-19 vaccines, sexual reproductive health and rights: Negotiating sensitive terrain in Zimbabwe

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The COVID-19 period caused a lot of suffering globally, as millions lost their lives while others went through the pain of being infected. The introduction of vaccines to minimise chances of infection and death was a welcome development. However, it was also fraught with its own challenges in the area of sexual health and rights of both women and men. Scholarship on gender and religion noted the way women failed to access contraception in a period in which sexual activity had increased as most couples were together for long periods of time. The introduction of vaccines was accompanied by a lot of misinformation. Lack of clarity on the effect of the vaccines on pregnant and lactating mothers caused a lot of anxiety. This was exacerbated by the information that was being circulated on social media platforms that the vaccines would interfere with individuals' reproductive capacity. Yet African religio-cultural beliefs and practices place so much importance on both women and men's ability to have children. In fact, one's respectability in African indigenous societies is greatly linked to their ability to have children. This article seeks to examine the fears of some Zimbabweans to accept COVID-19 vaccines, establishing how these fears were tied to issues of sexual reproductive health and rights. The article focuses on showing how the terrain of sexual health and rights is a sensitive one which called for caution in a COVID-19 context in Zimbabwe. Data for the article were gathered through informal interviews and social media platforms.

Contribution: The article makes a significant contribution to the way COVID-19 interfaced with issues to do with SRHR in Zimbabwe.

Keywords: COVID-19; men; rights; sexual reproductive health; women; Zimbabwe.

Introduction

In Africa in general and Zimbabwe in particular, the discourse on reproduction is closely tied to religio-cultural beliefs and practices. Within the home, men are defined by how prolific they are in bed while women go to great lengths to ensure they satisfy their husbands sexually. Above all, precolonial African societies regarded sexual activities as significant in producing progeny. In fact, human fertility was and continues to be central in most if not all contemporary African societies. Notions of respectability are closely linked to one's ability to have children. Hence, human infertility is frowned upon and is a source of shame. Adongo, Phillips and Binka (1998:24) observe the significance of African spiritual traditions in structuring high fertility. They argue that such traditions have a great influence on reproductive choices and beliefs. In their analysis, therefore, religion reflects high fertility norms and determines fertility attitudes and practices. Caldwell and Caldwell (1995) aver that African Traditional Religion(s) were centred on fertility and that prestige was closely related to fertility. From an indigenous African perspective, sexual activities were permitted within the confines of marriage. Mbiti (1969:130) alludes to the fact that marriage is embedded within the economic, social and religious aspects of African life and that these aspects often overlap to the extent that they cannot be separated from one another. Mbiti (1969) argues:

> For African peoples, marriage is the focus of existence. It is the point where all the members of a given community meet: the departed, the living and those yet to be born. All the dimensions of time meet here, and the whole drama of history is repeated, renewed and revitalised. Marriage is a drama in which everyone becomes an actor or actress and not just a spectator. Therefore, marriage is a duty, a requirement from the corporate society, and a rhythm of life in which everyone must participate. Otherwise, he who does not participate in it is a curse to the community, he is not only abnormal but 'under-human'. Failure to get married under normal circumstances means that the person concerned has rejected society and society rejects him in return. (p. 130)

For marriage to be complete, Mbiti observes that it should produce children. In this case, Magesa (1997) is of the view that conception does not only rest on a man and woman having sexual intercourse, but a result of a blessing from God and the ancestors. The pressure to reproduce still

persists in most African societies despite the introduction of Western family planning methods. The desire to keep one's lineage growing makes human fertility in Africa significant. Caldwell and Caldwell (1987) notice that the African religious system operates directly to sustain and reward high fertility. In their analysis, 'so great is the pressure toward fertility that African societies are permeated by a male fear of impotence and a female fear of acquiring an impotent husband' (Caldwell & Caldwell 1987:409). Hence, despite most African women embracing contraception, its introduction for men has been very problematic in Africa. The fear of impotence has led men in most if not all African societies to reject vasectomy. Such a practice touches at the core of African masculinity, which rests primarily on virility. Murewanhema et al. (2022) notice that because of the patriarchal nature of Zimbabwean society, family planning is usually relegated to women.

Scholarship on gender has noted the gendered nature of human infertility in sub-Saharan Africa. In most cases, infertility is blamed on women even before scientific evidence has been produced. In traditional African societies, efforts were made to hide the infertility of men, yet that of women was publicly announced. Among the Shona, they practised what is known as '*kupindira*', a practice whereby a man's brother or nephew would secretly have intercourse with his wife in order to produce children for him. Such a practice was not possible for barren women. In most cases, such women were shunned by society. Writing on the Akan of Ghana, De-Whyte (2014) observes that a barren woman was pitied because of her experience of barrenness as well as one who is regarded to be a threat to the continuity of the family and larger community. What this implies is that while childbirth was celebrated, the barrenness of a woman was shameful. Hence, polygamy or divorce were and continue to be justifiable in cases where a woman is barren. Scholars have also observed how a woman's barrenness can lead to gender-based violence (Baloyi 2017). The Shona proverb '*Chembere ndeyembwa, yemurume ndibaba vevana*' [Old age belongs to women, a man continues to father children, sic] sought to emphasise the fact that while women cannot have children in old age, such a 'weakness' does not apply to men. In this case, for both women and men, attention has to be paid to one's reproductive health in order to ensure that before one's death, they leave behind children who are expected to carry on with their legacy, so that they are not forgotten. Hence, in the coronavirus disease 2019 (COVID-19) context, the introduction of vaccines to reduce the rate of infection and the severity of the disease resulted in conspiracy theories relating to the effects of the vaccines on human reproduction. This, to a large extent, led to suspicion and utter rejection in some circumstances. A brief overview of COVID-19 in Zimbabwe is necessary before zeroing in on this discussion.

COVID-19 in Zimbabwe: An overview

The impact of COVID-19 has been studied from multidisciplinary perspectives, namely religion (Sibanda, Muyambo & Chitando 2022; Ukah 2020; Wildman et al. 2020), public health (Gisachew et al. 2021; Mbako et al. 2022; Vito 2022), psychology (Haas 2021; Jetten et al. 2020; Pillay & Barnes 2020), sociology (Leininger et al. 2021; Ozili 2020; Weber 2020), politics (Hartwig & Hoffmann 2021; Mutekwe & Vanyoro 2021), and gender (Ahinkorah et al. 2021; Mackett 2021; Manyonganise 2022). The intention of all these works has been to show the impact of the pandemic from different vantage points. Zimbabwean scholars have contributed to the COVID-19 discourse showing how the pandemic landed within the country as well as its impact. Edited books by Makamani, Nhemachena and Mtapuri (2021), Mawere, Chazovachii and Machingura (2021), Sibanda, Muyambo and Chitando (2022) as well as Manyonganise (2023) contain chapters written by Zimbabweans who focus on how the pandemic was experienced in Zimbabwe. It is envisaged that more academic works will be published in the future as reflections in a post-pandemic era. As of 06 January 2023, the World Health Organization reported that statistically, Zimbabwe had recorded 259 947 infections and 5635 deaths as a result of COVID-19. The low death rate has been explained in various ways. Manyonganise (2023) has dealt with this issue and will not be repeated in this article.

What has generally been agreed by most Zimbabwean authors is how religious beliefs and practices have been instrumental both in mitigating as well as exacerbating the transmission of the virus. This analysis is crucial as it informs us of the crucial role that religion plays in the fight against pandemics. In a COVID-19 context, Zimbabwe witnessed religious leaders either encouraging or discouraging their followers from adhering to government as well as public health pronouncements of mitigating the spread of the virus. Galang (2021) argues that:

> [*A*]lthough religious leaders are morally obliged to lead their followers toward the good through information dissemination and promotion, they are also equally obliged to abide by the findings of science. (p. 1)

For Galang (2021), such a call is imperative given that several religions across the globe were ignoring scientific responses and were spreading misinformation about the COVID-19 vaccine. Hence, nuancing the COVID-19 context in Zimbabwe remains incomplete if attention is not paid to the influence of religion. Within the area of sexual reproductive health and rights (SRHR) during the pandemic, religion played a critical role in informing Zimbabweans on how to navigate public health demands that were meant to contain the spread of the virus. Hence, Galang (2021:1) is correct in observing that a scientific–religious issue arises when it comes to promoting the COVID-19 vaccine. In this case, first understanding the impact of the pandemic on SRHR becomes imperative.

Sexual reproductive health and rights in the COVID-19 context

The impact of the COVID-19 pandemic in the area of SRHR has been a challenge globally. Dupuis, Ali-Gami and Wisofschi (2021) highlight the way the pandemic constrained

an already underfunded area in Canada. Lindberg, Bell and Kantor (2020) focus on the effects of the pandemic on adolescents and young adults in North America. They argue that 'the pandemic has imposed economic and logistical barriers to obtaining contraceptives and other sexual reproductive health (SRH) services for all ages' (Kantor & Kantor 2020:76). The International Planned Parenthood Federation (2020) noticed the many ways in which COVID-19 was endangering the sexual and reproductive health and safety of women and girls as well as vulnerable people across Europe. Writing more generally, Hall (2020:1175) argue that globally, responses to the pandemic converged with pervasive existing sexual and reproductive health and justice inequities to discriminately impact the health, well-being and economic stability of women, girls and vulnerable populations. Mukherjee et al. (2021) found that COVID-19-related disruptions in essential sexual reproductive health (SRH) care (would) result in declines in short and long term reversible contraceptive use and increases in unintended pregnancies and unsafe abortions. Zimbabwe falls within the category of countries affected in some of the ways listed here. For example, in a survey carried out by the International Planned Parenthood Federation (2020), Zimbabwe is recorded as one of the countries that had greatly been affected in the area of SRHR. Murewanhema et al. (2022) argue that existing gaps in access to family planning services specifically in the marginalised communities in Zimbabwe could lead to their disproportionate suffering because of the COVID-19 containment measures that resulted in transport challenges and closure of health facilities. Some scholars have noticed the genderedness of this effect. In the initial phase of lockdowns, Manyonganise (2022) observes the increase in forced sexual encounters among married couples in Zimbabwe. She highlights how women in Zimbabwe complained about their failure to also put their uteruses on lockdown even as the nation was locked down. Then the consequences were unwanted and unplanned pregnancies as well as sexually transmitted infections as women failed to access contraceptives as rigid lockdown regulations were enforced. Manyonganise (2022) also avers that as schools closed, young girls were exposed to sexual abuse and child marriages, which implied that these girls would drop out of school thereby exacerbating the already existing inequalities. Among men, the virus itself was shown to have an effect on their SRH. According to Lo et al. (2021), research showed that some men who tested positive for COVID-19 had decreased level of testosterone, although it was not clear whether this was a result of the virus. In addition, Lo et al. (2021:140) found that proposals had been put forward on how the effects of COVID-19 on the cardiovascular system and the central nervous system lead to decreased blood supply to the genitalia, which can lead to erectile dysfunction.

COVID-19 vaccines and sexual reproductive health and rights: Negotiating sensitive terrain in Zimbabwe

The introduction of COVID-19 vaccines was met with varied responses in Zimbabwe. While some responses can be located within the political discourses of the Global North and the Global South, it was noticeable that other responses had to do with concerns about individual's sexual reproductive health. In order to ascertain the responses that were influenced by people's sexual reproductive health concerns, I sought the views of 10 research participants who were conveniently sampled because of time. Six of these were women while three were men. For ethical purposes, the research participants were coded as C1 to C10. The participants were interviewed in a focus group (FDG). Questions posed sought to find out the following: (1) the information that was shared on social media regarding the presumed effects of the COVID-19 vaccine on men and women, (2) the reasons that could have caused the misinformation of the sexual reproductive effects of the vaccine, (3) whether public health officials were able to correct the 'misinformation'. The gathered data were interpreted using Ubuntu theory, which foregrounds communal living and relatedness to the extent that individual decisions should be made for the greater good of the community. From the discussions, a number of themes emerged and these are presented next.

The vaccine viewed as causing infertility in men and women

In a research carried out by Lo et al. (2021), findings indicated that there had been concerns among the public about the impact of vaccines on sperm count and infertility, mostly driven by vocal conspiracy theorists. The same concerns are notable within the Zimbabwean context. The three men in the FDG agreed that social media as well as public discussions with workmates, family and friends carried messages relating to the effect that the vaccine would cause infertility in men while the women reiterated the same point as relating to women as well. C1 indicated that in his discussions with his uncle, he was adamant that the vaccine was not good for men at all. The uncle said:

> '*Ichi chinhu chinoderedza fertility zvekutadza kubarisa mukadzi. Chinouraya simba remurume repabonde. Chinoita kuti musana wababa uote pabonde*.' [This thing (in reference to the vaccine) decreases fertility to the extent of failing to make a woman conceive. It kills a man's virility during sex. It weakens men's sexual prowess].

In relation to the aforesaid, women also indicated that they had heard that women's desire for sex would be weakened if they were vaccinated. C5 explained that her friend had shunned the vaccine because she wanted to have a baby yet she indicated that:

> '*ndakaudzwa kuti vaccine iri rinoita kuti munhu asabereke*' [I was told that the vaccine causes infertility in women].

This was supported by C4 who said she had had discussions with women of child-bearing age who were shunning the vaccine because they argued that they still wanted to give birth. C3 also brought a new dimension in which his wife had been told that the vaccine causes cervical cancer in women. She indicated that it was a struggle to convince her to get vaccinated, which she later did. Wesselink et al. (2022:1383)

indicate that concerns about possible side effects of the vaccine have been a top reported reason for remaining unvaccinated and that among reproductive-age adults, there is particular concern about the potential effects of vaccination on fertility. For Lo et al. (2021:142), the fear that the vaccine causes infertility stemmed from a lack of understanding about the newly developed mRNA-based vaccines and a possibility of one's deoxyribonucleic acid (DNA) being altered. Such claims were also put forward by church leaders in Zimbabwe such as Emmanuel Makandiwa, founder of the United Family International Church (UFIC). Other women were concerned with allegations that the vaccine would affect their menstrual cycle. Some women in the FDG reported that after vaccination, their cycles changed, while others bled for longer periods of time. The CovidVaccineWA.org (2021) explained that a portion of COVID-19 vaccinated women had reported changes in their menstrual cycles after getting vaccinated such as long-lasting periods, shorter intervals between periods or heavier bleeding than usual. Wesselink et al. (2022:1384) notice that 'anecdotal reports of menstrual cycle irregularities after vaccination have also contributed to concerns about the vaccine's potential effect on fertility'. As such reports came out, other women were deterred from getting the vaccine.

Erectile dysfunction as a result of the vaccine

In most African societies, men's virility defines their masculinity. Hence, the fear of not only becoming impotent but also the failure to sexually satisfy a woman in bed is a cause for concern for most men in Africa in general and Zimbabwe in particular. C3 indicated that messages circulating on social media claimed that the vaccine would cause erectile dysfunction in men. He jokingly said:

> '*nyaya iyoyo yekuti nhengo yangu yaisazomira yakandityisa kwazvo*' [the narrative that my organ would fail to erect instilled fear in me].

Hence, he chose to avoid the vaccine. In his analysis, it was better to die of COVID-19 than to live and fail to sexually perform as a man. In his own words, '*kusiri kufa ndekupi*?' [It was death either way]. In other words, for C3, he would culturally be regarded as dead if he were to fail to perform sexually. In this case, his fear of erectile dysfunction superseded the fear of infection from the virus. For him, erectile dysfunction would mean that society would view him as someone '*akafa achifamba*' [someone who is dead but still walking or alive].

On the other hand, women in the FDG explained how social media was awash with messages indicating that the vaccine would lower the women's sexual *libido*. As a result of their experience of contraceptives such as *depo provera*, they were afraid that they would fail to satisfy their husbands in bed because of a lack of interest in sex. This would cause problems in their marriages as men would turn to extra-marital affairs in search of sexual satisfaction. C7 argued:

> that '*patsika dzedu, murume akashaiswa bonde, anonotsvaga vamwe vakadzi, saka zvaive nani kusabaiwa pane kuisa wanano panjodzi*' [culturally, if a man is denied sex, he looks for other women, so it was better to avoid vaccination than to endanger one's marriage].

What C7 said is a cultural norm, where men's extra-marital affairs are blamed on women failing to satisfy their husbands sexually, yet the same demand is not placed on men. From the responses of men in the FDG, none of them feared that if they fail to satisfy their wives, they would think of engaging in sexual activities outside of their marriages. It needs to be noticed that some women got infected because, despite the physical distancing rule, their husbands demanded sex even though they were infected and were supposed to isolate. For fear of being judged according to societal norms, they ended up succumbing to the demands and they got infected in the process. I had a discussion with one woman who works in a hospital. Although she had not tested positive for COVID-19, she reckoned that she needed to isolate because she was in the frontline as the nation fought the pandemic. She only managed to sleep in her own room for two nights. However, on the third day, the husband joined her in the room she was isolated. She said she could not refuse him because he felt that 3 days without sex was too much. For him, it was better to risk infection than to suffer the pain of sex deprivation.

Fear of dying young before having enjoyed sex

Many studies carried out on the pandemic have a causal link between COVID-19 and death anxiety (see Chalhoub et al. 2022; Mani et al. 2022; Pradhan, Chetri & Maheshwari 2020). The role played by misinformation in increasing this anxiety is notable. In Zimbabwe, some of the misinformation that was being peddled by opinion leaders in communities was that after vaccination, the vaccinated would live for less than 5 years. For example, Emmanuel Makandiwa who is the founder of the United Family International Church told his followers that the vaccine was going to cause a serious pandemic, which would wipe out African people from the African continent. This was also supported by Chris Oyakhilome, founder of Christ Embassy, and has some followers in Zimbabwe. These church leaders explained the vaccine in terms of the struggle for control between the Global North and the Global South. For Emmanuel Makandiwa, the Global North had invented the vaccine as a way of wiping out Africans so that they could recolonise it. As a result of such scary explanations from opinion leaders, young couples and the not-yet married refused to be vaccinated for fear of dying young before they had fully enjoyed sex in their lives. C2 said that while he is not afraid of vaccines per se, he was afraid of the fact that it was being peddled that after vaccination, he was not going to live for long. For him, he has not yet fully enjoyed sex. He also indicated that for his friends who are not yet married, it was scary that after vaccination, they would die before they got married. Culturally, they would be buried together with a rat [*kuvigwa negonzo*] because they do not have children to accord them societal respect at death. This was made worse by the fact that some social media messages alleged that if the

vaccinated would have children, such children would suffer from multiple disabilities. In Zimbabwean society, particularly among the Shona, disability is seen as a curse, and the acceptability of people with disability is still very low. In this case, they chose to ignore the call by government to get vaccinated. Hence, Mani et al. (2022) aver that it was crucial for public health institutions to improve health literacy on COVID-19 and mitigate fear and consequently death anxiety in societies.

A lack of clear communication from public health officials

From the FDG, the other theme that came out was the lack of clear communication from public health officials pertaining to the effects of the vaccine. While they indicated that the vaccines were safe, they did little to allay the fears of the public and to counter the misinformation that was being spread through social media platforms. Guljaš et al. (2021:n.p.) argue that the lack of knowledge and mistrust towards vaccines represent[ed] a challenge in achieving the vaccination coverage required for population immunity. In Zimbabwe, the greatest challenge was that public health officials had indicated that pregnant women and lactating mothers were not supposed to be vaccinated at the onset of the vaccine. For C10, the lack of clear reasons why these groups were not to be vaccinated raised a lot of questions than answers. She argued that:

> '... *zvakakonzera kuti vanhu vave nemibvunzo kuti sei vachinzi vasatore vaccine. Vanhu vakasara vaine mibvunzo kuti hazvina here zvarinokonzera zviri kuita kuti vakazvita- kura nevanoyamwisa vasabaiwa.*' [It caused people to have questions as to why these were told not to get vaccinated. People were left with questions relating to whether the vaccine did not have side effects which caused the pregnant women and lactating mothers not to be vaccinated].

The question of clear communication is crucial. Guljaš et al. (2021:n.p.) observe the utilisation of social media platforms during the pandemic, but are quick to point out the uncensored information that was being spread. They argue that while social media:

> [C]ould be very useful as a way of quickly spreading correct information by medical authorities, this also challenges medical and public health authorities, giving patients a wealth of misinformation and anecdotal evidence, and encourages them to participate more actively in medical decision-making, which can have potentially dangerous consequences for the public. (Guljaš et al. 2021:n.p.)

For them, honest reporting of epidemiological and scientific facts should suppress the impact of such information on the formation of public opinion. However, in Zimbabwe, public health officials failed to give clear reasons why the pregnant and the lactating mothers were not eligible for vaccination. Yet, their condition fits in the realm of SRH, hence, those who still looked forward to conceiving and giving birth were left wondering if it was safe for them to get the vaccine and then conceive later. It was important for the reasons to be clearly explained in order to allay the fears of the public. This was exacerbated by some incidences where some of the people who got the vaccine died. Explanations of the causes of death tended to absolve the vaccine itself, yet some of the people who appeared to be healthy before vaccination, got sick and died after vaccination.

As the government sought to enforce vaccination by placing restrictions of movement on the unvaccinated public, some chose to acquire the vaccination cards clandestinely. As a result, it defeated the whole purpose of the vaccine itself. The public health messaging failed to convince the public. As a result, some Zimbabweans, both men and women are masquerading as having been vaccinated yet they are a danger not only to themselves but to society at large as the threat of the virus still looms large. Studies performed showed that COVID-19 vaccination does not affect male or female fertility or fertility treatment outcomes. In any way, the COVID-19 virus was said to have more long-term implications compared to the vaccine itself. Such findings needed to have been communicated to the Zimbabwean public so that they could weigh the benefits of getting the vaccine. For Guljaš et al. (2021:n.p.), it was important for public health officials to have listened to the concerns or rumours that were being peddled on social media as a way of fine-tuning the vaccination communication and motivation strategies. In concurrence, Murewanhema et al. (2021:n.p.) aver that 'addressing vaccine hesitancy requires an understanding of its complexity, the key concerns people have and the context in which people make decisions about their health, healthcare and well-being' while Sipeyiye (2022:n.p.) alleges that religio-cultural beliefs and practices have not been emphasised in the public health interventions, yet they are among the drivers of vaccine hesitancy.

The aforesaid themes that emerged from the study are revealing of the fact that SRH is a sensitive terrain in Zimbabwe particularly in connection with the COVID-19 vaccine. They are also indicative of the fact that decisions that have to do with individual SRH are embedded within socio-religious as well as cultural beliefs, norms and values. Guljaš et al. (2021:n.p.) list social and cultural factors, among others, as influencing health behaviour and decisions. In their analysis, the decision to vaccinate is a dynamic process, which is subject to the influences of personal beliefs, experiences and social circumstances in which public media have a crucial role. The fear to fail to have children or to perform sexually played a key role in vaccine hesitancy in Zimbabwe. This was because society shuns people who fail to have children, and African men's egos generally are affected if they are impotent or weak to satisfy their wives sexually. The pervasiveness of cultural beliefs in influencing health-seeking behaviour needed to have been part of public health messaging during the pandemic. However, in his study of the Ndau of South-Eastern Zimbabwe, Sipeyiye (2022:n.p.) observes that vaccination campaign programmes had not been reframed to reflect the Ndau's religio-cultural realities in order to motivate vaccine uptake.

By failing to allay the fears of the concerned public, public health officials failed to understand the extent to which religion and culture are critical components of health. In addition, failure to take note of the fact that socio-cultural factors inform sexual activity within the home led to women's exposure to sexual gender-based violence (SGBV) within the home because of blanket lockdown measures. While lockdowns were critical in reducing viral transmission, as alluded to earlier, their enforcement reduced women's access to contraceptives. Manyonganise (2022:238) critiques the demand for passes by the Zimbabwean government for women who required to travel to access contraception for its blindness to the gendered effects of the pandemic. She highlights the fact that those who were eligible for these passes were deemed to belong to the critical service sector. In such cases, women who were in need of contraceptives did not make the grade of those who were authorised to receive the passes. As a result, homes became unsafe spaces for women's SRHR during the pandemic as religio-cultural dictates forced them to adhere to some 'dangerous' norms and values relating to sexual encounters. It is, therefore, imperative that future responses to pandemics factor in religio-cultural factors pertaining to SRHR for quick vaccine uptake.

Conclusion

The intention of this article was to establish the embeddedness of religio-cultural beliefs within the SRHR discourse in a COVID-19 context in Zimbabwe. Such beliefs were shown to be critical in public health responses to pandemics. In Zimbabwe, religio-cultural norms greatly influenced vaccine uptake. This was exacerbated by the misinformation on the effects of the vaccine on human SRH that was spread through social media platforms. The article also highlighted that the incomplete messaging from public health institutions in Zimbabwe worsened people's fears. A critical analysis of the FDG responses leads us to arrive at the following conclusions. Firstly, both men and women feared that the vaccine would make them infertile, which would lead to cultural backlash. Secondly, the initial removal of pregnant and lactating mothers from those eligible to receive the vaccines without a clear explanation led to pessimism from women of child-bearing age. Thirdly, reports of changes in women's menstrual cycles after vaccination were a cause for concern for most women, some of whom then chose to shun the vaccine. Fourthly, having listened to responses from the FDG and considering research findings coming out, the study concludes that any pandemic response needs to factor in socio-cultural norms and values as they inform the receptivity of measures put in place by public health institutions to contain the spread of viruses. While useful information was provided by participants in the FDG, the sample is relatively small. This, therefore, implies that more research is required in this area so that the SRHR fears of the Zimbabwean public in relation to the COVID-19 vaccine can be documented and policymakers can be equipped in the event of other pandemics emerging in the future.

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M.M. declared that they are the sole author of this research article.

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Data availability

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Disclaimer

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