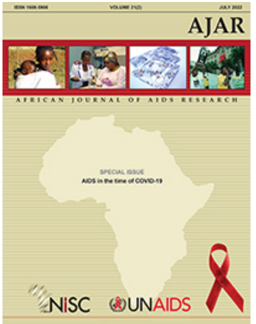

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Research Article

Utilisation of HIV services by female sex workers in Zimbabwe during the COVID-19 pandemic: a descriptive phenomenological study

Idah Moyo[1,2]*, Livhuwani Tshivhase[3] & Azwihangwisi Helen Mavhandu-Mudzusi[4]

[1]*Department of HIV Services, Populations Solutions for Health, Harare, Zimbabwe*
[2]*Department of Health Studies, University of South Africa, Pretoria, South Africa*
[3]*Department of Nursing Sciences, Sefako Makgatho Health Sciences University, Pretoria, South Africa*
[4]*Office of Graduate Studies and Research, University of South Africa, Pretoria*
**Correspondence: idahbandamoyo@gmail.com*

This study focuses on female sex workers as a key population group that suffers a degree of vulnerability according to the World Health Organisation (WHO). Key populations refer to people at heightened risk of contracting the human immunodeficiency virus (HIV) due to specific behaviours and social and legal environments which increase their vulnerability to the virus. Key populations are disproportionately affected by HIV, yet they have less access to HIV services compared to the general population. The coronavirus (COVID-19) lockdown and its restrictive measures have further widened the inequalities and gaps in accessing HIV services for this group. A descriptive phenomenological study was undertaken to explore female sex workers' experiences of utilisation of HIV services during COVID-19. The study setting was the Bulawayo Metropolitan Province, Zimbabwe. Data were collected through in-depth individual interviews with 10 female sex workers. Purposive sampling coupled with snowballing was utilised for recruiting participants. Data were analysed guided by the seven-step Colaizzi technique. Rigour was ensured through adhering to Lincoln and Guba's trustworthiness criteria. The study found that the COVID-19 pandemic adversely affected the livelihoods of sex workers and their utilisation of HIV services. There was limited access to HIV services due to an initial lack of travel authorisation letters and financial challenges experienced by study participants. In addition, the quality of care in health care facilities was further compromised by poor screening processes and reduced provider-client interactions. Maintaining access to HIV services for female sex workers during pandemics is critical for the country to attain HIV epidemic control.

Keywords: COVID-19, descriptive phenomenology, female sex workers, HIV services, livelihood, utilisation

This article is part of a special issue on *AIDS in the time of COVID-19*

Introduction

This article reports on the experiences of female sex workers as they utilised HIV services during the COVID-19 pandemic in Bulawayo Metropolitan Province, Zimbabwe. Female sex workers are categorised as a key population in the fight against HIV and AIDS. The World Health Organization (WHO, 2016) defines key populations as populations at higher risk of HIV irrespective of the epidemic type or local context. These populations also face social and legal challenges. They include sex workers, men who have sex with men, transgender people, people who inject drugs and people in prison and other closed settings (where inmates do not interact with outsiders on a regular basis). According to the WHO (2016), sex workers include female, male and transgender adults (18 years old and above) who receive money or goods in exchange for sexual services that are consensual between adults. In Zimbabwe, like other countries, sex work and related acts, including solicitation, procuring and keeping a brothel, are illegal but pervasive. The dire economic situation in the country has led many women to engage in sex work. In addition, criminalisation of sex work exacerbates the female sex workers' vulnerability to HIV outcomes (Footer et al., 2016; Busza et al., 2017).

Statistics indicate that in 2020, of all the new adult HIV infections globally, 62% were among key populations and their sexual partners as reported by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2020a). The results showed that nearly 4 000 new HIV infections occur annually among female sex workers, with a prevalence of around 57.1% compared to 12.9% among adults in Zimbabwe (Zimbabwe Ministry of Health and Child Care, & the National AIDS Council, 2018). A study in Zimbabwe demonstrated that police intimidation, harassment and arrests increase sex workers' vulnerability to HIV (Busza et al., 2017). The local laws and police harassment, stigma, discrimination and

service availability are key determinants for sex workers to access HIV care services (Footer et al., 2016; Busza et al., 2017). In times of crisis such as COVID-19, such vulnerable groups suffer disproportionately (Weiner, 2020).

While the COVID-19 pandemic started as a localised outbreak in China at the end of December 2019, the virus soon spread all over the world (WHO, 2020). The outbreak was declared an international public health emergency by the World Health Organization on 30 January 2020 and a pandemic on 11 March 2020. Recommendations by the WHO resulted in nationwide lockdowns and home-confinement strategies in many countries to prevent further disease transmission (Rubin & Wessely, 2020; Lai et al., 2020). This has taken an economic and psychosocial toll on the population (WHO, 2020). In line with the WHO guidelines, nations resorted to measures that included imposing various restrictions such as those on movement and closure of businesses (bars and restaurants), quarantines and isolation of COVID-19 positive patients (WHO, 2020).

Zimbabwe was not spared this pandemic and implemented COVID-19 restrictions and measures. These included the closing of businesses and entertainment centres. The closure of brothels and night clubs resulted in sex workers lacking clients and having no source of income. In addition, the introduction of curfews and related regulations meant that street-based soliciting could not take place either. Evidence from Zimbabwe suggests that during the COVID-19 lockdown, female sex workers were affected as they were forced to confine themselves to their homes and hence lost income (Mavhandu-Mudzusi & Moyo, 2022; Nyabeze et al., 2022). According to a non-profit human development organisation based in the US, FHI 360 (2020), during the lockdown, some governments put in place social safety nets and public food distribution systems for residents in the general population. However, none of these measures were tailored for key populations, making access to food and other essential services difficult for these groups. The discrimination and marginalisation experienced by key populations placed them at greater risk of psychosocial challenges during the COVID-19 national lockdowns and associated restrictions of movement (UNICEF, 2020). The closure of areas where sex workers operate their businesses and a lack of targeted support led some of the sex workers to resort to street-based sex work, which made them prone to violence, low or no pay and condomless sex (Global Network of Sex Work Projects [NSWP], 2020; UNAIDS, 2020b). Machingura et al. (2021) found evidence that in Zimbabwe during the COVID-19 lockdown, female sex workers were forced to engage in condomless sex out of desperation. This is consistent with findings by Nyabeze et al. (2022) and Matiashe (2020) on the prevalence of condomless sex by female sex workers during the COVID-19 pandemic in Zimbabwe. The situation of limited condom usage by sex workers affects the attainment of UNAIDS' fast-track 95:95:95 targets and other critical priorities in achieving HIV epidemic control. Crucial in this regard is the threat to gains made in HIV programmes for continuity of treatment and viral suppression among people living with HIV (FHI 360, 2020).

Before the emergence of COVID-19, a number of studies highlighted the challenges faced by sex workers in accessing health care services in sub-Saharan Africa (Cowan et al., 2017; Wanyeze et al., 2017; Nnko et al., 2019; Moyo & Macherera, 2021) . This study will add to the growing body of knowledge on how these challenges were further compounded by the COVID-19 pandemic. Outside sub-Saharan Africa, SWAN and ICRSE (2020), Ferguson et al. (2017) and Benoit et al. (2020) are some of the studies focusing on challenges faced by sex workers before and during COVID-19. With reference to the sub-Saharan African context, some empirical evidence has been generated focusing on sex workers and their access to health services during COVID-19 (Gichuna et al., 2020; Kimani et al., 2020). The present study will add empirical evidence to other studies on female sex workers and their access to HIV services in Zimbabwe (Mtetwa et al., 2013; Cowan et al., 2017, Moyo & Macherera, 2021).

Anecdotal evidence suggests that while the COVID-19 restrictive measures, economic meltdown and financial losses have affected many, it has disproportionately affected female sex workers (United Nations Development Programme, 2020). Due to prevailing stigma and discrimination, key population groups are more vulnerable to harassment by law enforcement agents trying to enforce COVID-19 restrictions (Gichuna et al., 2020; NSWP, 2020). We explored the experiences of female sex workers with regard to the utilisation of HIV services during the COVID-19 pandemic in Zimbabwe. In this study, HIV services refers to the provision of pre-exposure prophylaxis (PrEP), CD4 scores, viral load and antiretroviral therapy (ART) (UNAIDS, 2016).

Methods

Design

A descriptive phenomenological design was used to explore and describe the experiences of female sex workers accessing HIV services during the COVID-19 pandemic in Bulawayo Metropolitan Province, Zimbabwe. This design owes its origins to Alfred Schutz and Edmund Husserl who contended that a phenomenon should be viewed as it is lived and experienced (Wertz, 2011). We intentionally chose Husserlian theory because of its assumptions related to reality, which is underpinned by the fact that a human's lived experience shapes an individual's understanding of their life world. The theory's principles of natural attitude, intentionality and phenomenological reduction are also relevant because the study participants were sex workers and those elements are very relevant to determine how they understand their world. The Husserlian phenomenology is premised on the philosophical belief that the lived human experience, which is at the very core of this article, facilitates understanding of the phenomenon under study (Christensen et al., 2017). Husserl held that the experience as recognised by human consciousness has importance and should be the subject of scientific study (Lopez & Willis, 2004). It assumes that a human's lived experience shapes their understanding of their lived world and their attitudes and responses to a specific phenomenon. In addition, each participant's experience is considered unique and a complete description of the phenomenon (Moustakas, 1994). We opted for

this design because of its potential to bring out the lived experiences of female sex workers during the COVID-19 pandemic. We found this design more appealing because of its ontological and epistemological assumptions.

Inherent in this research paradigm is the need for the researcher to be free from any preconceptions, suppositions, attitudes and beliefs so as to focus on the participants' experience of the phenomenon and identify the essence of the phenomenon (Lopez & Willis, 2004). According to Wertz (2011), the researcher must remain neutral and unbiased with respect to the phenomenon under study — a process referred to as bracketing. We found bracketing difficult because it is not possible to eliminate biases and prejudices completely as indicated by Rau (2020). We were conscious of our biases and used open-ended questions to avoid channelling participants responses. There were no pre-set probes, but probing was based on an individual's narration of their experiences.

Critical to descriptive phenomenology is the concept of the validation of the study findings by participants (Grbich, 2012). In the context of this study, validation of data was done through the process of member checking to ensure that the identified essence reflected each participant's experiences.

Settings and participants

In Zimbabwe, sex work is illegal, and in health care settings, this group experiences unfriendly and discriminatory treatment (Moyo & Macherera, 2021). The illegal nature of the job in Zimbabwe and the high rates of unemployment disproportionately affecting women have made sex workers more vulnerable. Zimbabwe is characterised by a fragile economy and political instability. In the given context, women then move to urban settings for employment and ultimately resort to sex work as an alternative means of survival. The context of COVID-19 saw sex workers losing their income during the COVID-19 lockdown.

The study setting was the Bulawayo Metropolitan Province, Zimbabwe. It has two central hospitals, 17 city health facilities and two private facilities that provide HIV services to key populations. The study population was female sex workers in Bulawayo. However, only female sex workers who met the following criteria were included in the study: self-identifying as sex workers; willing to participate; owning a cell phone; being a female aged 18 years or older; and receiving ART or PrEP from any of the health care facilities in Bulawayo. Purposive sampling coupled with snowballing were used to identify study participants. Because sex workers are considered a hard-to-reach population (Bungay et al., 2016), we accessed the first two participants as referrals from the staff working at an organisation that provides services to key populations. Through snowballing, participants led us to other sex workers until data saturation was reached. A sample size of ten participants was determined following data saturation.

Data collection[1]

The participants identified through snowballing were given the cell number of one of the researchers and then voluntarily sent a WhatsApp message showing their willingness to participate in the study. The approach of referral to other vulnerable and hard-to-reach populations using snowballing technique is considered ethical (Morgan, 2008, Polit & Beck, 2018). The researcher then phoned the potential study participants. After establishing a willingness to participate in the study, an appointment was made. Data were collected by the first author (IM) of this article, through face-to-face interviews from 15 December 2020 to 14 March 2021. To mitigate the risk of contracting COVID-19 during the data collection process, the World Health Organization guidelines were followed: disinfection of chairs and tables with a sanitiser that contained 70% alcohol, use of hand sanitiser, use of face masks, maintaining social distancing of at least two metres during the process of data collection and sterile wipes to sanitise equipment such as the audio recorder and pens (WHO, 2020).

To ensure privacy, the participants were interviewed in a private room at the centre. An interview guide with a central question was used to guide the interviews and probe the sex workers' experiences. The participants were interviewed in the local language (isiNdebele). Prior to embarking on the main study, the interview guide was piloted on two participants. These participants provided relevant responses to the questions without difficulty and also sought minimal clarification on the research questions asked. The questions were rephrased to enhance clarity and the interview guide was adjusted accordingly. The in-depth interviews were conducted one-on-one and audio recorded. The researcher (IM) started with a central question: "*What have been your experiences in utilising HIV services during the COVID-19 lockdown?*" This was followed by open-ended probing questions to explore further and obtain detailed descriptions of the participants' experiences. The follow-up probes were based on the participants' responses. This is in keeping with Polit and Beck (2018), who posit that open-ended probes enable the researcher to delve deeper into personal and sensitive issues. Each interview lasted between 45 and 60 minutes. Field notes were taken to enhance data collection and to provide a rich context for analysis (Creswell & Creswell, 2017).

Data saturation was reached at participant number eight. However, two additional participants were interviewed, but no new information emerged. Data collection stopped when all questions were thoroughly explored in detail and no new concepts or themes emerged in subsequent interviews (Marshall et al., 2013). The sample size of 10 is justifiable in a descriptive phenomenological study as supported by Polit and Beck (2018), who reported a sample of 10 or more as adequate. This is corroborated by DeJonckheere and Vaughn (2019), who posit that a sample of six to twenty is suitable for a phenomenological study.

The researcher who collected data was conscious of the possibility of bias, but made a deliberate effort to remain professional and non-judgmental. The researcher kept a reflective diary where she recorded her thoughts, feelings and perceptions throughout the research process. A reflective diary is considered an important tool in developing bracketing skills (Wall et al., 2004). This allowed the researcher to re-examine her position on a continuous basis on issues that may affect the research process, such as emotions. It also enabled the researcher to keep track of the research process as a whole.

Data analysis

Colaizzi's method of data analysis was applied (DeJonckheere & Vaughn, 2019). The first author, as she is fluent in both isiNdebele and English, transcribed and translated the isiNdebele version into English. This approach follows the seven data analysis steps outlined below. Table 1 shows a summary of the cluster of themes and themes developed from significant statements and formulated meanings. In this study on lived experiences of female sex workers accessing HIV services during COVID-19, the researcher gained holistic insights into the participants' experiences through conducting physical interviews. In addition, the researchers listened to the audio recordings three to four times in an attempt to comprehend the thought processes and the feelings of the participants. This is consistent with Colaizzi (1978), who indicated the researcher should listen to the audio recording many times to clearly understand the content. This process was followed by transcribing the recorded interviews verbatim (Colaizzi, 1978).

During the second step, the researchers examined documents for rich data and extracted significant statements and phrases pertaining to the experiences of female sex workers in accessing HIV services during the COVID-19 lockdown. The researcher read the transcript several times and analysed each transcript and identified significant statements from each of the participant's transcripts (Colaizzi, 1978).

This was followed by step three, where two researchers independently formulated meanings from the significant participant statements about their experiences of accessing HIV services during the COVID-19 pandemic. The formulated meanings and the significant statements were discussed by the two researchers as recommended by Colaizzi (1978; DeJonckheere & Vaughn, 2019). Though not fully implemented, the researchers used bracketing (putting one's own ideas about the phenomenon aside) to avoid misinterpretation of the participants' views. Because of her work in HIV programming and with sex workers, the researcher who collected data brought some foreknowledge and experience of sex workers which needed to be put aside. The researchers therefore kept a reflective diary noting possible biases and made a conscious effort to keep them at bay. The researchers' interpretations were compared with the original meanings for consistency of

Table 1: Development of clusters of themes and emergent themes from significant statements and formulated meanings

Significant statements	Formulated meanings	Cluster themes	Emergent themes
It was difficult to go to the clinic to collect my medicines since the police required an authorisation letter to travel, so I defaulted taking treatment for two weeks. I had to carry my empty tins of medicines to be allowed to pass through the police roadblock.	Authorisation letters were required for participants to move around or pass through police roadblocks to access either PrEP or ART from health care facilities	Lack of authorisation letters	Limited access to HIV care
I had no travel authorisation letter and was removed from the ZUPCO bus because I did not have it. I failed to access my PrEP resupplies.	Without authorisation letters participants were denied permission to pass through the police roadblocks		
It was difficult to get money from sex work. My PrEP supplies got finished and at the time I had no transport fare to get to the clinic.	Participants had challenges getting money from sex work, as a result they had no transport fares to the clinic	Financial challenges	
With the lockdown, the source of income disappeared. I was no longer doing sex work as usual. I had no money for food, rentals and transport fares to the clinic.	Reduced income levels and in turn no money for food, rentals and transport fares resulting in defaulting treatment		
Cervical screening that was due could not be done since there were fewer service providers during the lockdown and my medicine for the prevention of tuberculosis [isoniazid] *could not be supplied.*	Screening at the facilities was not done effectively and clients left the facilities without getting all the medicines that were due	Poor screening services	Compromised quality of care
My viral load results should have been out just before the lockdown. When I went to the facility for medicines pick-up, I did not ask about them and the service provider seemed pressured. I have not heard anything about my viral load.	Screening not properly done, the providers said to be under pressure, client left the facility without getting their viral load results		
The providers seemed to be in a hurry and not keen to listen as in the past. As a result, there was minimal interaction with the nurses. I could not even ask questions concerning my treatment. The usual counselling was not there anymore.	Health care providers perceived to be in a hurry, minimal provider-client interaction	Reduced patient and service provider interaction	
Previously, there was ample time with the nurses, to discuss challenges associated with taking treatment and counselling was always provided. With the lockdown, the situation was different; we spent very little time at the clinic.	Reduction in time spent by client at the facility and counselling not provided		

descriptions. Minimal differences were found between the researchers. The derived meanings were given to an independent coder to check the process and the consistency of the meanings. Through this process, it was established that the meanings were consistent.

The researchers continued to step four and then arranged formulated meanings from significant statements into clusters of themes (Colaizzi, 1978). The clusters of themes were then condensed into emergent themes displayed in Table 3 which shows how the themes were formulated. The clusters of themes were checked for accuracy by a researcher (AHM) experienced in qualitative research.

In step five, all emergent themes were refined into an exhaustive description of the phenomena under study. This was achieved by combining all the theme clusters, emergent themes and interpretations into a description to create an overall structure. The expertise of the experienced researcher was sought. She reviewed the findings for richness and completeness to provide sufficient description and to confirm that the exhaustive description reflected the experiences of female sex workers during the COVID-19 pandemic (Colaizzi,1978; Beck, 2019).

This led to step six, where the fundamental structure of the phenomenon was constructed after an exhaustive description. This process involved reviewing the description to identify key elements that were then transposed into a definition of the participants' descriptions of their experiences during the COVID-19 pandemic.

During the final step, which is step seven, the exhaustive description was validated with each of the participants by using a "member checking" technique as described by Shosha (2012). This was achieved by providing the participants with a summary of the research findings and discussing the results with them on a telephone call. The participants confirmed that the findings reflected their feelings and experiences through follow-up telephone interviews.

Ethical considerations

Approval for the research was obtained from the Medical Research Council of Zimbabwe (Ethics Clearance Number MRCZ/A/2659). Authority to gain access to the study participants was obtained from the director of the centre that offers services for key populations. Before each interview was conducted, an informed consent form was signed by participants following receipt of background information related to the study. Participants also consented to audio recordings of the interviews. As part of the consent process, participants were informed that participation was voluntary and that consent could be withdrawn at any time without prejudice. Anonymity and confidentiality were observed through the use of pseudonyms. Only the researchers reviewed and transcribed the data. To minimise costs for participants, each participant was given 5 US dollars for transport costs to and from the centre where the interviews were conducted.

Measures of ensuring trustworthiness

Measures were taken to ensure trustworthiness and rigour (Maher et al., 2018). According to Beck (2019), to ensure trustworthiness, the research should satisfy four criteria, namely credibility, transferability, dependability and confirmability. Credibility refers to the accuracy of the findings (Shosha, 2012). To enhance credibility, all interviews were audio recorded and transcribed verbatim. Member checking, peer evaluation and a co-coder were used to enhance credibility. The third researcher, who was not involved in data collection and acted as an independent co-coder, reviewed and challenged the analysis to ensure rigour and credibility (Lincoln & Guba, 1985). Transferability relates to the ability of the findings to be transferred to other contexts. A "thick description" of the research context was provided to allow the reader to assess whether or not it is transferable to their situations. The researcher thoroughly described the research context, participants and data collection method.

To enhance dependability, the research process is described in detail to enable another researcher to replicate the study (Beck, 2019). All records were kept locked away and a step-by-step description of methods was done to ensure an audit trail. Confirmability was enhanced by the use of bracketing to minimise researcher bias. To enhance authenticity, verbatim extracts from the interviews were utilised and member checking was done. A week after the interviews, the researchers re-engaged the participants through phone calls and went over the individual transcripts with each participant. The transcribed verbatim transcripts were summarised and discussed with each participant in a simplified and understandable way as per insights from Carlson (2010) and Harvey (2015). This facilitated checking for accuracy of information contained in the transcript and the participants confirmed that their perspectives were adequately captured and represented.

Findings

Biographic information

The sample consisted of 10 female sex workers of between 31 to 45 years old. These participants were either collecting PrEP or ART from Bulawayo health care facilities in Zimbabwe. Of these, four participants were on PrEP, while six were on ART. Table 2 displays the participants' biographic data. Data analysis resulted in two emergent themes with related cluster of themes, as presented in Table 3. Two emergent themes, namely (i) limited access to HIV services and (ii) compromised quality of care, with related cluster of themes, emerged during data analysis.

Limited access to HIV services

This emergent theme relates to the challenges encountered by study participants in accessing HIV services due to COVID-19 restrictions. It has the following cluster of themes: lack of authorisation letters and financial challenges.

Lack of authorisation letters

Participants in this study had restricted access to ART and PrEP due to COVID-19 lockdown regulations as they were expected to have authorisation letters when they travelled to the treatment centres. Without authorisation letters, they were denied free movement and the excerpts below confirm this.

> *With the emergence of COVID-19, it was difficult to go to the clinic to collect my medicines since the*

Table 2: Biographic data of participants

Pseudonym	Age range (years)	Level of education	Number of children	Employment status other than sex work	Service	Duration of accessing services	Treatment access site
Sue	36–40	O Level	1	Domestic worker	PrEP	2 years	Private
Moe	31–35	Form 2	4	Not employed	PrEP	3 years	Private
Rue	31–35	O Level	2	Hairdresser	ART	2 years	Public
Liz	41–45	Grade 7	3	Not employed	ART	4 years	Public
Sie	31–35	O Level	3	Shopkeeper	ART	8 years	Private
Roo	41–45	Form 2	4	Not employed	ART	4 years	Private
Tee	36–40	O Level	2	Hairdresser	ART	3 years	Public
Noe	31–35	O Level	2	Not employed	PrEP	2 years	Private
Sae	41–45	Grade 7	3	Not employed	ART	3 years	Private
Lera	36–40	Tertiary	2	Not employed	PrEP	2 years	Private

Table 3: Cluster of themes and emergent themes on sex-workers' experiences

Emergent themes	Cluster of themes
Limited access to HIV care	Lack of authorisation letters
	Financial challenges
Compromised quality of care	Poor screening services
	Reduced patient and service provider interaction

police required an authorisation letter to travel, so I defaulted taking treatment for two weeks…[paused interaction and took a deep breath]. *I had to carry my empty tins of medicines to be allowed to pass through the police roadblock* (Liz).

I ran out of PrEP for five weeks because I had no travel authorisation letter. I was removed from the ZUPCO bus because I did not have it. I failed to access my PrEP resupplies (Lera).

This was further enforced at police roadblocks where travel authorisation letters were required. In the absence of this document, participants had to produce their medical records as proof of going for a medical check-up. The clients felt this was an interference with their privacy and confidentiality.

I was only able to pass through a police roadblock after showing ART medicines or records to police as a passport to be allowed to go to the clinic. This used to frustrate me so much because it was an involuntary disclosure of my HIV status, but I had no choice. In one instance, I had to call the nurse at the clinic, who had to call back and speak to the police to allow me to proceed to the clinic to access my medication (Roo).

Participants related how the situation at the police roadblocks resulted in forced disclosure as they had to produce their medical records.

I had to display my medical records at the police roadblock. I felt that was interference with my privacy. The thought of having to go through the roadblock made me skip my ARVs on some days (Tee).

At the roadblock, I was forced to show the police my PrEP medical records. They were reading, checking and asking me about the kind of medication I was taking. This forced me to disclose that I am taking PrEP. I felt frustrated, angry and it would take me time to gather strength to go through the same process again [raised tone of voice and facial expression changed] (Sue).

Apart from experiencing challenges related to authorisation letters, participants also faced difficulties in accessing HIV services due to financial problems.

Financial challenges

The study found that during the COVID-19 lockdown, there was a loss of income because participants could not access their clients. The loss of income had a bearing on participants getting transport fares and food. The inadequate food supplies resulted in clients not adhering to or discontinuing the intake of medicines.

It was difficult to get money from sex work and at times I would charge less than usual. My PrEP supplies got finished and at the time I had no transport fare to get to the clinic. I discontinued taking PrEP, yet I knew I was at risk of getting HIV infection (Moe).

With the lockdown, the source of income disappeared. I was no longer doing sex work as usual. My income levels dwindled, I had no money for food and rentals. Transport fares to the health facility were also a challenge. I defaulted treatment. I only got assistance when the nurse from the clinic phoned me (Roo).

Lack of food supplies also had a bearing on participants' treatment adherence.

Because I did not have adequate food supplies, hunger remained a challenge and I would skip taking my tablets [ARVs] *on some days...The food pack that I received from the organisation that assisted us with food aid had to be shared with the rest of the family and was not enough. It was not easy to take my medication without having eaten* (Rue).

Compromised quality of care

This theme highlights the downside of attempts to reduce the number of clients served at health care facilities per given time to adhere to COVID-19 regulations. Two clusters of themes emerged: poor screening services and reduced patient and service provider interaction.

Poor screening services

Participants voiced that they were never screened for other conditions such as cervical cancer and viral load monitoring as they used to when coming to access ARV medicines.

> *Cervical screening that was due could not be done since there were fewer service providers during the lockdown and my medicine for the prevention of tuberculosis* [isoniazid] *could not be supplied* (Liz).

> *My viral load results should have been out just before the lockdown. When I went to the facility for medicines pick up, I did not ask about them and the service provider seemed pressured. I have not had anything about my viral load. In the past, providers were concerned about how viral load results look and the emphasis that these signify my body's response to ARVs* (Tee).

Prior to entry into the health care facilities, screening activities were done as part of prevention strategies to reduce COVID-19. This screening exercise resulted in unintended effects.

> *The system had changed. There was this extensive screening outside before entry into the clinic. After standing for a long time, I felt frustrated, and I left without collecting my ARVs* (Sie).

It emerged that the screening activities also resulted in unintended HIV disclosures at health care facilities. The participants felt that COVID-19 screening activities at the health care facilities exposed them and threatened their privacy and confidentiality.

> *At the facility where I get my ARVs, during the lockdown, we had to wait outside for COVID-19 screening purposes. The concern was that if I am seen standing outside the facility, it would cause a lot of suspicion from my clients or they would know that I am accessing ARVs and this would jeopardise my work as a sex worker* (Sae).

> *Clinic staff would unintentionally announce and disclose client's HIV status by calling and screening clients to check whether they have come for ART or PrEP. We had to stand outside the facility for COVID-19 screening. I did not like the new system. Because of this new system I left without collecting my ARVs* (Tee).

Reduced patient and service provider interaction

Communication between the service providers and patients is important in the provision of patient-centred care. Participants noted that there was reduced interaction with service providers.

> *The providers seemed to be in a hurry and not keen to listen as in the past. As a result, there was minimal interaction with the nurses. I could not even ask questions concerning my treatment. The usual counselling was not there anymore* (Sae).

> *We had ample time with the nurses. It was easy to highlight challenges associated with taking treatment and counselling was always provided. During COVID-19 lockdown, the situation was different, we spent very little time at the clinic* (Noe).

> *I had concerns about feeling nauseous after taking my medication, but I had no opportunity to explain my situation because the nurse did not have time to listen to me* (Moe).

Discussion

From our findings, the COVID-19 pandemic has adversely affected the livelihoods of sex workers as well as their access to HIV services with a potential for dire outcomes. This discussion will focus on two key findings and their implications, namely the limited access due to COVID-19 restrictive measures and the compromised quality of care. During data collection process, the researcher observed non-verbal cues from study participants showing that they experienced challenges and frustrations at police roadblocks emanating from issues such as unintended HIV disclosures.

The lockdown restrictions resulted in treatment interruptions and hence the need for service delivery adjustments. Even though some participants were getting their medication from either the public or private health care facilities, their experiences of accessing HIV care services were not different. As part of the COVID-19 restrictive measures, authorisation letters were required from everyone for movement from one place to the other. The study findings reveal that sex workers with no authorisation letters had difficulties passing through police roadblocks and were, like everyone else without the letters, often turned away. Out of desperation, they resorted to carrying empty ARV bottles or medical records as proof that they needed to travel to the health care facility. This resulted in the unintended disclosure of HIV status and to treatment interruption as sex workers stopped taking ARV medicines for some time. Participants also attributed non-adherence to HIV medicine to lack of food brought about by dwindling resources as a result of the COVID-19 lockdown.

A study conducted in Kenya by Gichuna et al. (2020) found that measures by the government to contain the spread of COVID-19 made it difficult for sex workers (as in this study) to access health care services. Evidence from southern and eastern Africa (Baleta, 2015) established that sex workers are often victims of controversy and stigma, resulting in limited access to health care services — a situation worsened by COVID-19. According to the United Nations Population Fund (UNFPA, 2020), COVID-19 has exacerbated prevalent vulnerabilities and inequalities for sex workers in eastern and southern Africa. Other COVID-19-related studies in Africa (UNFPA, 2020; El-Sadr & Justman, 2020) found that the COVID-19-induced disruption to health care services may lead to poor health outcomes for the sex worker community. Since studies elsewhere (UNICEF, 2020; Nam et al., 2021) have demonstrated that vulnerable

populations such as sex workers are prone to emotional challenges during pandemics, the idea of providing and strengthening counselling services for sex workers can enhance the quality of their lives. Given the stresses to which female sex workers are subjected, the provision of psychosocial support for this vulnerable group becomes critical.

The study found that COVID-19 restrictions have had a serious financial implication on sex workers as they either lost income or earned less since they charged less for their services. This resulted in them not having transport fares to get to the health care facility, resulting in treatment interruption. In addition, due to loss of income, participant were unable to buy basic food supplies. Participants in this study indicated that they had challenges taking their medication while they were hungry. While some participants in this study accessed food aid through a non-governmental organisation, the food was not enough since it was shared among family members. This is consistent with study findings in Uganda and Kenya where sex workers lost income and experienced challenges of sourcing money for rental, food and funding for their families in general (FHI 360, 2020; Kawala et al., 2020). Loss of income meant that sex workers had challenges in getting the transport fare to health facilities to access HIV services. Studies have found that one of the causes of non-adherence to antiretroviral therapy was, as in this study, food insecurity (Bukenya et al., 2019; Macharia et al. 2020).

Prior to entry into the health care facility, there was screening for COVID-19 infection and to establish the purpose of the visit. However, this exercise was done in an open space in the presence of other clients. This study found that efforts to conduct COVID-19 screening in health care facilities resulted in threats to privacy and confidentiality in the form of unintended HIV disclosures. In some instances, some participants left the facility without collecting their medication, as in the case of Sae — a situation that may result in treatment interruption. Defaulting or stopping of antiretroviral therapy may result in the deterioration of quality of life, a further compromise to one's immune system and the possible development of opportunistic infections (Hughes & Sharrock, 2016). Other authors (Kheswa, 2017; Sun et al., 2020) call for the need for sensitivity to maintain privacy and confidentiality and guard against unwanted HIV disclosure during service provision in the context of the COVID-19 pandemic.

This study found that in health care facilities, there was poor screening and service provision. Participants indicated that when they visited the health care facilities, they noted that service providers seemed pressured and did not focus on checking or giving the clients their viral load test results. This poses a concern with regard to viral load monitoring and patient health outcomes. Related to this, a study conducted in Zimbabwe (Centers for Disease Control and Prevention, 2021) found implementation gaps in viral load testing and utilisation of test results and, as a result, treatment was not fully optimised. Another study (Apollo et al., 2021) demonstrated that the COVID-19 pandemic had affected HIV care outcomes and viral load suppression rates. In addition to overlooking the issue of viral load monitoring, participants noted that service providers seemed to be in a hurry and there was reduced verbal interaction between service providers and clients.

This study also established that the usual counselling was no longer available. This is contrary to evidence elsewhere (Spinelli et al., 2020) that has demonstrated the critical role health communication plays in influencing positive behaviours in the HIV care continuum. The authors further highlight that counselling is an effective strategy in HIV care and contributes to positive health outcomes. This must be seen in the context of the already existing negative and discriminatory attitudes of health care workers towards sex workers as demonstrated by studies in South Africa (Duby et al., 2018; Nnko et al., 2019), in Uganda (Wanyeze et al., 2017) and in Zimbabwe (Moyo & Macherera, 2021). There is a need for in-service training of health care workers that allows them to offer sensitive, non-discriminatory and inclusive services that eliminate stigma against female sex workers. There is sufficient evidence of the effectiveness of this approach as demonstrated in studies in Bangladesh (Geibel et al., 2017) and in South Africa (Duby et al., 2018).

Participants in this study indicated that they failed to access services that they were due for, such as cervical cancer screening, because there were fewer providers at the facilities. This resulted in missed opportunities. Similarly, a study conducted in Zimbabwe (Murewanhema, 2021) established that due to the COVID-19 pandemic, there was a reduction in cervical cancer screening services. In addition, another study by Murewanhema and Makurumidze (2020) also found that there were disruptions of essential services in areas of sexual and reproductive health (inclusive of cervical cancer screening) services in the majority of health care settings as a result of the COVID-19 pandemic. To deal with this challenge, other scholars (Castanon et al., 2021) advocate for optimising access to cervical cancer screening through the utilisation of such strategies as tele-health (for counselling and providing information on where to access the services) and making appointments to avoid overcrowding in health care facilities.

Conclusion and recommendations

Since sex work is criminalised in Zimbabwe and access to HIV services has always been a challenge even before the onset of COVID-19, it is critical that the government and Ministry of Health develop innovative, well-thought-out strategies that increase access to HIV services for sex workers. This is a critical pathway in contributing to HIV epidemic control (UNAIDS, 2020a). In addition, the HIV prevalence among sex workers is disproportionately high compared to the general population (Zimbabwe Ministry of Health and Child Care, & the National AIDS Council, 2018; UNAIDS, 2020b).

The study has demonstrated that due to COVID-19 measures, sex workers experienced psychosocial and economic challenges that significantly affected their access to HIV care services. Loss of income, food shortages and lack of transport fares cannot be tackled in isolation. There is a need for a robust strategy that addresses both HIV service access and issues of livelihood. Policing lockdown measures and provisioning of health services need to be innovative and sensitive to the fact that this group carries

a high HIV burden in terms of new adult HIV infections and prevalence (UNAIDS, 2020a).

In the current context where the government prioritises curtailing the spread of COVID-19, sex workers will continue to experience financial hardships, impacting on their access to HIV services (Benoit et al., 2017). This calls for a paradigm shift by both government and society, which have criminalised sex work (Graham et al., 2018). Sex workers need financial assistance to survive under these difficult conditions and treatment interruptions must be prevented. If the country is to maintain the gains made in rolling back the HIV pandemic, service providers need to continue to be innovative in HIV prevention treatment and care strategies.

Limitations

Due to the COVID-19 restrictions and limited movement, recruiting participants for the study was not that easy because the hot spots (bars, night clubs) were closed during the data collection period. However, the researchers were able to get an adequate sample for the study.

The study used purposive and snowballing sampling, which could have introduced an element of bias. However, the selection bias was minimised by involving staff working at the study setting to recruit the first two study participants. The study was also limited to the experiences of female sex workers and not the other groups of key populations and it was conducted in one province of the country. Hence the results cannot be generalised.

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Note

1. To maintain anonymity and confidentiality of participants, the datasets (audio and transcripts) are not publicly available, but can be accessed from the corresponding author on special request.

ORCID iDs

Idah Moyo – https://orcid.org/0000-0002-6122-8151
Livhuwani Tshivhase – https://orcid.org/0000-0002-7544-9393
Azwihangwisi H Mavhandu-Mudzusi – https://orcid.org/0000-0002-6916-8472

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