CRIMINALIZATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION: IS IT THE SOLUTION TO THE PROTECTION OF WOMEN AGAINST VIOLENCE IN ZIMBABWE?

By

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Abstract

This research seeks to interrogate whether section 79 of Zimbabwe's Criminal Law Codification and Reform Act which criminalises wilful transmission of HIV protects women against infections and violence. The research's main focus was on the attitudes towards sexuality by various women as well as the problems of prosecuting such cases. I used methodologies which include the women's law and human rights approaches as well as the analysis tools of actors and structures and sex and gender. Each methodology assisted me to explore the real challenges in using the law to prevent new infections of HIV as well as protecting women against such. The women's law approach was useful in finding out what the women really wanted in cases where they had been infected by the virus and how they thought this law could help them. Using the actors and structures analysis tool helped me to interrogate deeply into what key informants (including law enforcement, legal and health experts) thought about the law and how they deal with the problems they encountered with such cases. One example concerns prosecutors who bring the cases before the court. They face various challenges in trying to prove beyond a reasonable doubt that an accused person actually infected a complainant with the virus and if he did, whether he did so deliberately. I also interrogated the law surrounding the doctor/patient relationship and how the laws should be reformed so that prosecutors know what to do when doctors who have personal knowledge of an accused person's HIV status are required to testify. The current problem is that the doctor/client privilege is interpreted so as to prevent them from testifying against their patients. I also discussed the conflict between a complainant's right to know their partner's HIV status against an accused person's right to privacy (i.e., not to disclose or have his HIV status disclosed by a third party), and sought to strike a balance between the two competing rights.

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Declaration

I, Huni Hilda Varaidzo, certify that this dissertation is my original work; it is an honest and true effort of my personal research. I certify that the work has not been presented anywhere else before for any other thesis.

Signed……

Date……

This dissertation was submitted for examination with my approval as the University Supervisor

Signed…….

Date…….

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Dedication

Jayden Tinovimba, my son, Kudakwashe Juanita Mellisa, my daughter. I was not there for you when you needed me the most. But thank you my children for your patience throughout the time I was studying. You stood the test of time and yearned for motherly love at a time when I could not give you all the attention you needed.

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Executive summary

Everyone is potentially susceptible to HIV, but women are particularly vulnerable, as gender relations configure with sexual behaviour and economic security. This study was carried out in Harare (Zimbabwe's capital) and it seeks to interrogate the law on the deliberate transmission of HIV (section 79 of the Criminal Law Codification and Reform Act), concentrating on women as victims. Many women are being infected by their sexual partners who are fully aware of their positive status but choose not to disclose it and because of attitudes towards sexuality, the women find it difficult to negotiate for safe sex, and therefore become easily infected. A change of attitudes towards sexuality would mean that there will be a need to engage with the mutuality of interests among sexual partners in seeking forms of protection which ensure the survival of themselves, their children and their communities (Baylies, 2000).

Wilful transmission of HIV is prevalent in Zimbabwe, with women being at the deepest end of vulnerability. 'All else being equal, the probability of male to female transmission is estimated to be two to four times that of female to male transmission' (UNAIDS, 1997). Women's vulnerability to HIV infections derives from their low status in society and their low status and powerlessness in connection with HIV. When the law was enacted, it sought to protect those who are negative from being infected deliberately by those who know their HIV positive status and choose not to disclose it.

This research was conducted using different methodological approaches. These methodological approaches are the women's law, grounded theory, actors and structures as well as the human rights approaches. The women's law approach embraces women's experiences which are the starting point in the unearthing of women's lived realities. The grounded theory approach comes in as an innovative approach, where I had to keep an open mind always alert to new or emerging issues that came out of my research. I then used the human rights approach which places individuals as holders of basic rights at the core process of development, emphasizing the relevance of the whole array of human rights in development processes. I also used the actors and structures approach, which entails an examination of bodies as well as the attitudes of the personnel in charge of those bodies, thereby ascertaining how that affects the field of research.

The findings of this research revealed that attitudes towards sexuality make it difficult for women to talk about sex and HIV. Relations of intimacy are formed by the same cultural prescriptions and notions of personhood that operate within the larger society, therefore, attitudes, culture and religion influence the gender divisions as well as the gendered structure ideologies. Also, issues of deliberate transmission are not easy to prosecute in that magistrates find it difficult to convict alleged culprits since the state often fails to prove beyond a reasonable doubt that an accused infected the complainant with the virus. Many people do not want to get tested and for them to claim that a certain person infected them and at what point they did so is very difficult to prove. I also found out in this research that private relations involve a prescription of relative passivity of females, giving all sexual decision-making and initiative to men, along with a tolerance of men's greater sexual mobility both prior to and after marriage. 'Women often have too little power within their relationships to insist on condom use, and they have too little power outside of these relationships to abandon partnerships that puts them at risk' (Heise and Elias, 1995). I also discovered that men are especially endangered by ideologies of masculinity and there is a need for them to be intellectually and emotionally released from the cultural entrapments that require the female to be submissive. I also found out during the research that socialisation in sexual matters, including the language used, and the way sex is approached, understood and valued more often than not lead to women's considerable disadvantage, as negotiation is not even at issue, as a result of which they are easily infected by their sexual partners and often subject to violence. Another finding was that there is also a tendency for husbands who have lost their wives to remarry quickly, in the process sometimes infecting their new partners without first disclosing their status to them.

The war of wilful transmission of HIV is far from being won because of the shortcomings of the law, especially on the issue of doctor/patient privilege. However, commitment from the government through educational campaigns and addressing gender relations, thereby increasing levels of knowledge and awareness, improving women's negotiation skills as well as enhancing their assertiveness and heightening their self-esteem can be effective measures in improving their protection in intimate relationships. Such recommendations are suggested since the research proves that simply criminalising the exposure, transmission and infection of HIV on its own does not protect women in any way, in fact it exposes them to more infection and violence.

In other words, the root of the problem needs to be addressed, that is, the way gendered power relations work, especially those in intimate relationships as they currently restrict the ability of women to protect themselves against being infected.

CHAPTER ONE

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

Emmaculate, my mother's best friend, was a teacher in the rural areas of Wedza, Zimbabwe. She was married to Muza, who was a pastor who belonged to a church called, Let There Be Light, as well as a herbalist. I grew up knowing this couple as they would always visit us and we would visit them. In 2007, Emmaculate went to Namibia, because of the economic hardships in Zimbabwe and left her children with her husband, who then decided to go looking for gold in order to take care of the family during his wife's absence. This was their story:

Emmaculate was a holder of a diploma in education and her husband did not have any qualifications so they always had some problems because he felt she was not being submissive. She decided to go to Namibia to look for a job during the period when things were very tight in Zimbabwe and she left her husband with the children. She was away for almost a year, sending money home for the upkeep of the children.

When she came back in December 2008, she saw a card from the New Start Centre, proof that her husband had gone for HIV testing. She was surprised and asked him why he had decided to go and get tested and he said he simply wanted to know his status. She asked his results and he told her he was HIV negative. They stayed together as husband and wife, having unprotected sex for about four years after that incident.

Emmaculate commenced her duties as a teacher and one day Muza fell sick. Since he was a herbalist, he always took his herbs and his wife never really knew what they were treating as he always said they were good in keeping one healthy. His health then kept on deteriorating and he decided to go to the hospital. When he came back he told her that the nurses had asked him to bring his wife, and the following day they went together.

When they arrived, the nurses encouraged them to get tested for HIV and they tested positive. She was so devastated and she asked her husband what had happened as she knew she had only slept with him and no one else. That is when he confessed that he had slept with a

certain woman during his gold panning days and all along he knew he was HIV positive but kept it from her for the fear that she would dump him since she was the bread winner. He was actually taking herbs to suppress the virus for the past four years. He however said there was no guarantee that she had not had sexual intercourse with someone else when she had gone to Namibia.

She came to me looking for legal advice and we decided to make a police report. He was however acquitted of the charges because she did not have any proof to show that she was HIV negative before she had sexual intercourse with her husband when she came back from Namibia and in court he denied outright that he had once confessed to her that he knew his HIV positive status and chose not to disclose it. He argued that he only knew of his status when he went to get tested at the clinic and the following day he took her to get tested as well.

It was heartbreaking to listen as the magistrate read out his judgement. I knew he had his facts right; his hands were tied because the words had been uttered in their bedroom and no one was there to testify to that. I wondered how this law would protect women against infections and decided to write this dissertation in honour of all those women whose husbands choose not to disclose their HIV positive status to their partners, thereby exposing them to the virus or even transmitting it to them.

Zimbabwe is one of the sub-Saharan countries whose people have not managed to escape the severe impact of HIV/AIDS, the majority of which are women who contract the disease from partners who know their HIV positive status but choose not to disclose it. This dissertation looks at those women who are victims of the deliberate transmission of HIV. It seeks to interrogate whether section 79 of the Criminal Law Codification and Reform Act, Chapter 9:23 protects women against infections and violence. It provides that:

> ‘any person who, or realising that there is a real risk or possibility that he or she is infected with HIV; intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realises involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person, and shall be liable to imprisonment for a period not exceeding twenty years.’

This catastrophe of non-disclosure threatens to devastate women and seriously hinder the development of the country. Adopting several methodologies which are guided by the women's law approach, I chose to do my research at the Harare Magistrates Courts, interviewing regional magistrates and prosecutors who deal with cases of deliberate transmission of HIV as well as those women who were once victims of such. I collected and analysed data for interviews with several key informants, including doctors, nurses and men who were once accused of such, presenting the research within a comprehensive theoretical policy and legal context from these informants.

The 'criminalisation of HIV' refers to the enactment of criminal statutes that penalise the exposure of/or the transmission to another of HIV (Burris and Weait, 2011). Many countries across the globe, Zimbabwe being one of them, are now criminalising HIV non-disclosure, exposure and transmission. The rationales and justifications for this are different, including incapacitating of offenders and protecting the community from the risk of transmission. Many might see it as a powerful and effective way of articulating social disapproval for conduct. As a feminist and a student in the Master in Women's Law programme, I therefore sought to interrogate if there is any compelling evidence that it protects women against infections and violence. Weait (2011) notes that there is an increasing amount of evidence that it does harm women, especially those who are particularly vulnerable.

1.2 Background of study

As a public prosecutor, experience has taught me that if a case ever reaches court the prosecution of deliberate transmission hardly ever results in a conviction. When vetting cases, I discovered that there was hardly any evidence linking the accused to the commission of this offence and I sought to interrogate why this was so, and how the law could be used to protect women against infections, re-infections and violence. Before coming to SEARCWL[1] I had never thought deeply about this, but I thought more about it after entering the programme and its focus on women gave me the idea to investigate the topic more thoroughly, concentrating on women as victims. And so I conducted grounded research into the actual lived realities and experiences of women whose partners had deliberately infected them with the deadly virus, or just exposed them to it, by failing to disclose their positive status when they knew they had the virus. I concluded that the law was not protecting the women, and there was a

[1] Southern and Eastern African Regional Centre for Women's Law.

need to come up with gender sensitive strategies to protect them, rather than simply criminalising the act.

1.3 Justification of the study

This study is significant as it seeks to analyse whether or not the law on the criminalisation of deliberate transmission really protects women against infections. HIV/AIDS is a women's issue because the risks and consequences are different for women (Campbell, 1999) and should therefore be studied using a different feminist perspective.

As a woman working towards the realisation of women's rights, I felt it was important to interrogate the law and see how it protects women or helps them avoid being infected and becoming victims of violence. It is anticipated that this research, through its gender sensitive recommendations, will contribute to the growing literature on Zimbabwean women and HIV/AIDS, especially on how to equip them to negotiate for safe sex.

'Most HIV prevention literature portrays women as especially vulnerable to infection because of biological susceptibility and men's sexual power and privilege' (Huggins). This encouraged me to seek deeper into the reasons why that was so, especially considering that the men choose not to disclose their positive status. I also noted that gender power imbalances can render women unable or unwilling to persuade their partners to use protection, and those gendered power dynamics prevent them from successfully avoiding HIV.

1.4 Objectives of the study

On embarking on this research, I was mainly guided by the following research objectives:

1. To assess whether attitudes towards sexuality make it difficult for women to talk about sexuality.
2. To establish whether women find it difficult to negotiate safe sex, therefore easily getting infected.
3. To investigate whether prosecutors find it difficult to prove beyond a reasonable doubt that someone has infected a person with HIV.

4. To interrogate whether magistrates find it difficult to convict because the state has failed to prove beyond a reasonable doubt that a complainant has been infected by the accused.
5. To establish whether doctors are allowed by the law do disclose their patients' status.
6. To assess whether there is a need to develop gender sensitive strategies to prevent new infections.

1.5 Statement of the problem

'20 years ago HIV/AIDS was a western gay men's disease. Today it is the number one disease for African Women' (Kelly, 1999).

According to UNAIDS (2008) women constitute 60% of those infected with HIV/AIDS in Sub-Saharan Africa. They get infected faster than men because of their social, economic, cultural and biological vulnerabilities. Zimbabwe is one of those countries highly affected by the pandemic and most of the infections are from partners who are aware of their status but choose not to disclose it. Guiding Principle 30 of the Zimbabwe's National HIV/AIDS Policy (1999) provides that this wilful transmission should be considered a crime in the same sense as inflicting other life threatening injuries to another.

In the Zimbabwean Constitution, the rights to life (section 48), health (section 76) and privacy (section 57) are recognised and protected. All these rights apply to the issue of HIV non-disclosure, exposure and transmission. Everyone has the right to health, meaning one cannot deliberately transmit the virus as this is a breach of one's right to health as well as the right to privacy, which is the right to have a person's HIV status protected by the doctors or medical personnel who treat the person. However, as much as this is the current situation, whereby everyone has the right to health, it competes with the right to privacy as the Constitution specifically provides in section 57(e) that everyone has the right not to have their health condition disclosed. Such a provision then poses a big challenge when state prosecutors try to prove section 79 of the Code, as the doctors and nurses are the ones who have the information that an accused person actually knew of their status but chose not to disclose it to their sexual partners. That is one of the essential elements of the offence: that the person knew of their status but deliberately chose not to disclose it. If the nurses and doctors cannot testify to this fact, it becomes difficult to prove this essential element of the

crime. Section 198(3) of the Criminal Procedure and Evidence Act provides that if the state fails to prove one of the essential elements of an offence then the accused is entitled to an acquittal. So most of these cases are discharged at the close of the state case since the state often fails to prove that essential element, that is, that the accused actually knew of their HIV positive status and chose not to disclose it, thereby exposing someone or, worse still, infecting them with the virus.

Currently, many studies reveal that unprotected sex within marriage may be the most significant risk factor for any woman as condom use is lowest in marriage. The Criminal Law Codification and Reform Act, Chapter 9:23, under section 79 makes it a criminal offence for people who know they have HIV to transmit it to anyone, or to do anything that is likely to lead to transmission (even if there is no actual transmission). Those living with HIV are criminalised, unless they can prove beyond a reasonable doubt that they informed their partners, who consented to having sex with them, with the full knowledge of the risk.

The problem is about using the law to protect women against infections and violence. There is a large gap in the conflict between confidentiality and disclosure as well as attitudes towards sexuality which make it difficult for women to negotiate safe sex, and this thesis will look deeper into this issue. As a Masters in Women's Law student, I felt it was important to explore further ways in which the government can increase its effectiveness in ensuring that the law on wilful transmission of HIV protects women against infections, re-infections and violence.

1.6 Assumptions

1. Attitudes towards sexuality make it difficult for women to talk about HIV/AIDS.
2. Women find it difficult to negotiate safe sex, therefore they get easily infected.
3. Prosecutors find it difficult to prove beyond a reasonable doubt that someone has infected another person with the HIV virus.
4. Magistrates find it difficult to convict because the state often fails to prove beyond a reasonable doubt that a complainant has been infected by an accused.
5. Doctors are not allowed by law to disclose their patients' HIV status because of the doctor/patient privilege.
6. There is a need to develop gender sensitive strategies to prevent new infections.

1.7 Research questions

1. Do attitudes towards sexuality make it difficult for women to talk about HIV/AIDS?
2. Do women find it difficult to negotiate safe sex thereby causing them to become easily infected?
3. Is it the case that prosecutors find it difficult to prove that a complainant has been wilfully infected with the virus by an accused?
4. is it the case that magistrates find it difficult to convict people of wilful transmission because the state would have failed to prove its case beyond a reasonable doubt?
5. Are doctors allowed to disclose a patient's HIV status since it is privileged information?
6. Is there a need to develop gender sensitive strategies to prevent new infections?

1.8 Definition of key concepts

Deliberate transmission:

The wilful attempt by people who know that they are HIV positive to infect other people, normally through deliberate failure to take adequate precautions to prevent the risk of transmission or unprotected sexual intercourse

HIV:

Human Immunodeficiency Virus

Anti-Retroviral Drugs:

Chemical agents used to alleviate the virus *sequelae* thereby inhibiting viral replication.

Cd4 count:

The important indicator of the presence of HIV.

Viral Load:

The quantity of the HIV detected in the blood also essential to determine prognosis and the management of the disease.

Transmission:

The process of transferring the HIV virus from one person through blood, semen, vaginal secretions, menstrual blood, breast milk, and/semen precum.

Infection:

The invasion of the body by organisms such as bacteria, viruses, fungus or parasites.

Disclosure:

The condition or state of a person voluntarily and publicly divulging their status.

Sero-conversion:

A process through which blood that is HIV negative changes within 6 weeks to six months to the presence of HIV anti-bodies (from negative to positive).

Confidentiality:

Keeping private information about someone, e.g., a patient/client.

1.9 Ethical considerations

Working on HIV presents unique challenges given the stigma, discrimination and dangers that are often experienced by those living with HIV/AIDS. Ethical research is supposed to be consistent with the general principles of autonomy, beneficence, non-malevolence and justice (Thomas, 1992). Autonomy occurs when the people participating become free to partake in the project having given their full informed consent; beneficence refers to the fact that the researcher aims at promoting the well-being of the participants at the individual as well as the public health level. I therefore tried protecting my participants by fully explaining to them that the research would be purely for academic purposes and in some instances I used pseudo-names to hide their true identity. This is the process of non-malevolence, which ensures that the researcher takes all possible means to protect the participants.

1.10 Chapter disposition

Chapter 1 serves as an introduction to the thesis. I narrate the story of Emma and Muza, which sparked my interest in the research topic. Key concepts are defined, as well as the ethical considerations concerning how I manage to hide the identities of my informants. I also discuss the objectives of my study and state my research assumptions and questions. Chapter 2 describes the methods and methodologies used when I was doing my research. The methodologies include, among others, the overarching women's law approach which was used in conjunction with the human rights and grounded theory approaches. I explain how these methodologies helped me to come up with final recommendations and I also discuss the methods of research that I used like the perusal of court records, interviewing key informants and observations, among others. I finally evaluate these methods, stating the advantages and disadvantages of using each of them. In chapter 3, containing the law and literature review, I explain some of the existing national and international laws on HIV and how the laws address the issue, as far as women are concerned. CEDAW and the Protocol to the African Charter on Human and People's Rights are discussed, as well as national laws including the Constitution

and the Criminal Law Codification and Reform Act. These provide for certain rights, such as the rights to life, health and privacy, and a discussion is presented on how they compete with each other as far as issues of HIV are concerned. The research's findings are presented and analysed in chapter 4 concentrating in particular on assumptions 4, 5 and 6. I discuss the problems faced by prosecutors in trying to prove wilful transmission beyond a reasonable doubt and the problems faced by magistrates and those arising from the operation of the doctor/patient privilege. I also explore the problems faced by prosecutors when doctors refuse to come to court to testify based on the client-doctor privilege. I then analyse the law on deliberate transmission of HIV and how it affects women. In chapter 5 entitled, Piercing the veil of secrecy in HIV/AIDS; The right to know and the right to privacy, I first explain what is meant by and what the law is concerning the right to know and the right to privacy. I then conclude by trying to balance these two competing rights, to establish which right holds, when there is a conflict between the two. Assumptions 1 and 2 are also discussed, that is the problems faced by women in negotiating safe sex because of the way they are socialised. Finally in chapter 6 in which I answer all my research questions, I make several conclusions which are linked to my assumptions and suggest some recommendations as to what I think can be done to make the law protect women against HIV.

CHAPTER 2

2.0 METHODOLOGICAL FRAMEWORK

2.1 Introduction

Researching and writing on HIV/AIDS is not an easy task (Chirawu, 2006). It is therefore important that the researcher comes up with an appropriate methodology and theoretical framework. As stated by WLSA (1997), 'The theoretical perspectives and attendant methodologies that are adopted for...research...determine not only the issues that are to be pursued but what will be revealed through research.' I am a feminist, although there are variances in the feminist movement.

> 'There is a general consensus that the feminist methodological stance is focused on uncovering the social relations which deny the lived realities of oppressed groups, particularly women. Additionally research is intended to be emancipator, to enable women and others to be active agents of their own rights. There is also an acknowledgement that research for (rather than on) women ought to be attentive to power relations between "subjects" and "researchers"'(Penelope, 2008).

2.2 In search of the right methodologies

In this chapter, I describe the methodologies and data collection methods used. A qualitative approach was used, much effort being made to capture the voices of women who are victims of wilful transmission of HIV. Although I focused on women being victims, men were not excluded, so as to have a balanced view. I noted that, as Bentzon (1998) puts it, empirical research is not undertaken in a vacuum but is informed by a variety of factors. Grounded theory and the human rights approaches were used, under the umbrella of the women's law approach, as well as the actors and structures perspective.

Dahl (1987) noted that a woman-centred approach, which takes women's actual lived realities and experiences, is the starting point for analysing the position of women in law and society. Women who are victims of wilful transmission were a central focus of my investigation and enquiry, as it helped me to understand and examine their lived realities.

Its major component is to critique the interplay between the law and life, because it is predicated on the need to capture women's lived realities with the aim of addressing any

existing gender specific injustices. I interviewed some women who had reported cases against their partners, to get to understand why they reported them, why they later withdrew the charges, if they did, and the impact of the trial on their marriages, after the man had been acquitted. One woman said she had to withdraw the charges as she felt nothing was going to change about her HIV status, whether he was convicted or not, and that it was better to stay together and take care of the family. She said:

> *'Zvichabatsirei kumusungisa ini ndatozorwa kare, ndinosara ndichichengetwa nani nevana, ndagara ndichangofa saka ndakafunga kumuregerera.Ndakanga ndamhan'ara because ndanga ndarwadziwa kuziva kuti ainwa zvake mapiritsi achichengetedza hwake utano ini ndiri murima.'*
> (Translation: 'What is the point of getting him arrested and prosecuted when I have been infected already? Who will take care of me and my children? After all I am going to die so I decided to forgive him. I had reported because I was bitter due to the fact that he was taking his tablets without disclosing his status to me, taking care of his health whilst I did not know.')[2]

One of the main objectives of conducting such research was to get women's views and experiences on the issue of non-disclosure, transmission and exposure. Drawing from my experience as a public prosecutor, I felt I had a fairly good grasp of reality on the ground, but this needed to be worked on, as I sought to interrogate the gap between law and practice, and put them together with the women's real needs. I also sought to interrogate deep into the issue of non-disclosure, not only from a woman as a victim's point of view, but the man's as well, as I tried to look deeper into his fears and needs as far as disclosure is concerned.

The women's law approach was the method that I mainly used. Employing this approach, I used what Stewart *et al.* (1997) call a grounded activist approach, whereby I 'had to be grounded in identifying specific problems that women experienced...by exploring the actual experiences of women with the problem.' I identified the problem that many women were being infected with the virus by men who knew their status and chose not to disclose it, and they, in accordance with the first assumption, failed to negotiate safe sex or even talk about it. Negotiating was so difficult, because they are raised in such a way that they are made to believe that it is improper to discuss sex or to say no when their husband or boyfriend demands it. To them, it was all about the man, and for women to talk about it would mean they were women of loose morals. I also noted that it was difficult to prosecute such matters

[2] Mbare Musika, 20/11/2015.

even if one decided to institute proceedings, and I explored their actual experiences by interviewing those women who had caused the arrests of their partners for non-disclosure. I noticed that there was a need to 'question the underpinnings of our society and find ways to escape the patriarchal constructs that were the partners of androcentric paradigms' (Stewart and Ncube, 1997), as many withdrew the charges because they were not expected by the patriarchal society to cause a partner's arrest. A patriarchal society is a society which is dominated by males therefore they would not expect a woman to cause the arrest of a man over wilful transmission of HIV.

I also used the women's law approach which sought to be more inclusive of women, to leave space for their lives and their stories (Stewart,1997) as I interviewed them to see what they really knew of the law, what they wanted and how they wanted the law on non-disclosure to help them protect themselves against getting infected.

I also sought to interrogate what the women's experiences of the right to information and confidentiality were. Having ascertained this, I went on to investigate the attitudes of those dealing with such matters in trials, the actors and structures, as well as organisations dealing with HIV/AIDS, in order to compare and contrast their views on what they were doing 'for women' and what the women actually wanted. My research was mainly informed by the National Aids Policy, so I sought to investigate if the policy was being translated into reality, so that, if possible, I could map the gap between policy and practice.

The women's law approach is a basket methodology, and in the field it helped me a lot as I was questioning what the women wanted and how they were living. What I noted was that they wanted to negotiate safe sex but it was not easy for them as they were socialised in such a way that they believed that talking about sex would mean they would be perceived as women of loose morals and so they chose not to discuss anything about it. They feared what the society would say about them, or how their negotiation would impact their marriage so they would rather stay in their marriage than risk saying things which would lead to its break-up. Even getting the man arrested would more often than not create more problems, so as much as they wanted to report him, their hands were tied.

2.3 Data collection methods

These are methods employed in gathering of the desired data (Bentzon *et al.*, 1997) and the following methods were used. This involved selecting the appropriate methods to elicit the necessary data to answer the research questions (Stewart *et al.*, 1997). The importance of these methods was mainly to 'problematise the researcher's own knowledge and encourage them to explore the extent of their experiential data (life experience) as a source of data or at least as a way of triangulating with data from other sources' (WILSA, 1997).

2.3.1 Interviews with key informants

I interviewed some key informants, a method which involves the collection of data from those who 'know' or have experience of the topic as well as or including those with influence in the community (Chirawu *et al.*, 2007). Details of my key informants are captured in Table 1.

Table 1: Showing details of key informants

Respondents	Males	Females	Total
Regional Magistrates	4	2	6
Regional Prosecutors	8	6	14
Social workers	3	2	5
Doctors	4	3	7
Care givers	3	3	6
Journalists	4	4	8
Police officers	6	5	11
Nurses	3	5	8

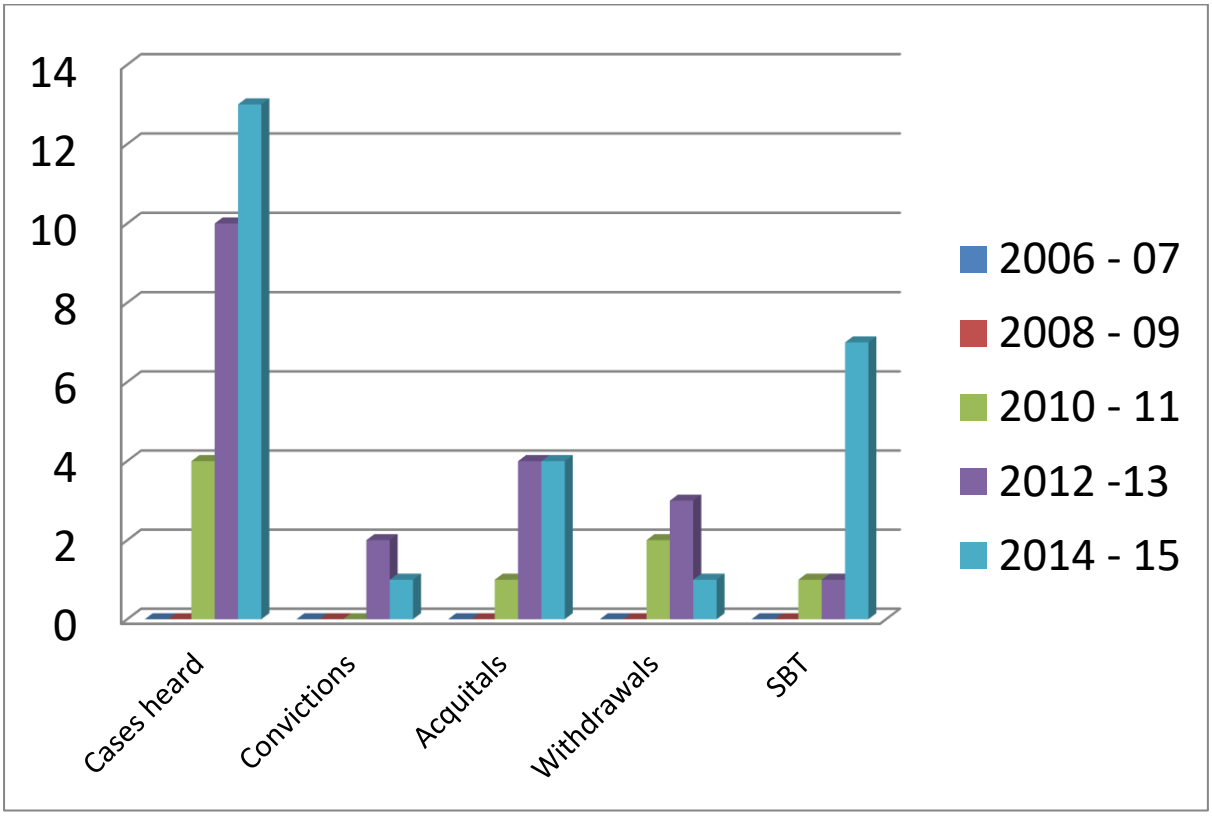
The key informants were chosen based on their expertise and skills, since I perceived them to have either experience in trials and providing medical care for those living with HIV. I found the method to be a reliable tool for collecting desired data from strategic sources as I got the official positions from the key informants. My research would have been incomplete without their voices in order to verify the information, as I directly obtained information from individuals who directly deal with cases of wilful transmission of HIV.

My key informants had expert knowledge about handling trials and for medical practitioners, the medical view on doctor/client privilege. They were very important as they used their own personal experiences and observations.

2.3.2 Perusal of records

I perused court records in order to get the statistics on how many cases were brought to court for each year and the outcome of each. Some were withdrawn before/after plea, most were acquitted, a few convicted and others sent back to the police with instructions that they had to follow but were never brought back to court whilst others were not updated. Figure 1 is a bar chart showing these details from the year 2006 to 2015. For the years 2004 and 2005 no records could be found, therefore no data was available.

Figure 1: Bar chart showing the outcome of wilful transmission of HIV cases at the Harare Magistrates Courts for the years 2006-2015 (excluding 2004 and 2005)



Key:

SBT=Sent back to police station

I also noted, when checking court records, that they 'are rarely compiled with the needs of the researchers in mind and could not be seen as a key source of data' (Stewart, 1997) as they are rarely self-explanatory, hardly updated and the books were torn, some pages were missing and the information I found was not 100% accurate. Some cases were not updated which meant that I could not ascertain their correct positions and the clerks did not have a

reasonable explanation. I noted that, as Stewart (1997) puts it, it was necessary to do a pilot study to assess the availability and comprehensibility of court records before using them as a key source in data collection. It was also time consuming to check these records, since I had to do it manually, and there was no guarantee that the information reflected was relevant with sufficient clarity. For example, some people were initially charged with different sexual offences and when it was later discovered that they had transmitted the virus to the victim or had exposed them to it and were accordingly convicted, the record did not reflect this change and only reflected details about the initial charge.

2.3.3 Individual interviews

I interviewed a combination of women who had reported cases of wilful transmission of HIV as well as men who had been accused of such. These interviewees were selected from the dockets I got from the Harare Magistrates Courts and from 242 Forms (Request For Remand forms) after they had come to court to attend their cases. Some whose cases had already been completed, I got their names through the record books from the registry offices, and for one woman I was referred to by her lawyer. I used this method as I could deeply question the life situation and individual circumstances of the particular person which I could not do in a group discussion. The advantage of using this method was that I managed to establish a relationship of trust with the respondents and could understand the feelings and opinions each of them carried, on the reason why they chose to have their partners arrested and why they chose to withdraw charges (if they did) or how they felt after their acquittals. Most women were willing to talk and I was surprised at the content and quality of information they would share with me, although some were not as free in talking about sex as I had anticipated when I drafted my assumptions. I managed however to gather more information that was pertinent to my research and the data was more focused. I also got a chance to relate the data to particular individuals, thereby allowing me to do a more intensive study of perceptions and attitudes, as the responses were spontaneous, specific and self-relying.

2.3.4 Observations

There are times when I would go to the Harare Magistrates Courts Regional Vetting Office and listen to prosecutors as they interviewed parties. I did not take part but would just listen and observe. Of important significance was the openness of the parties in the set-down office as they articulated the issues in the dockets as they gave their personal experiences and arguments. Litigants were free to express their views in the presence of public prosecutors

and it proved to be quite revealing and very effective as I heard all the problems women faced as well as the loopholes in the state case. Most of these matters were however returned back to the police for lack of evidence as there was no proof that the transmission was deliberate or that she (the complainant) had been tested negative prior to engaging in sexual intercourse with the accused person. In most cases, the men would admit that they might have infected their partners but it was not intentional, with the wives arguing that they were taking anti-retroviral drugs, but there was no proof that they were doing so. This helped me to gather divergent views within a short space of time as well as capture the weaknesses of the state case. This is what can be referred to as passive observation, whereby the observer takes no part in the activities that are being observed and is distant in the emotional sense from the events (Stewart *et al.*, 1997). It was a useful tool in that it helped me to embellish the research record.

2.3.4.1 Court testimony

On one occasion, I was able to use a testimony given on a formal occasion as a way of extracting my data. This was done when I sat in a court gallery and listened to a witness (a complainant) as she testified before a magistrate. It involved her publicly recounting a life experience which she witnessed and was affected by. She was afforded an opportunity to express her concerns and at the same time contribute to the ways of addressing the problem in the future. This had the following disadvantage. Although she gave evidence in chief led by the public prosecutor and evidence when she was cross-examined by the defence counsel, she was often cut short by them as they only wanted her to concentrate on the evidence that was necessary for the proving/rebuttal of the essential elements of the offence.

2.3.5 Life histories

Life histories of respondents were acquired when I would let my respondents relate details and information about their lives in an uninterrupted manner, and I managed, from this pool of data, to extract information that was directly related to the research problems, as well as analyze them from their broadest perspective. I would sometimes think that an interview had gone away off tangent, only to discover later that the interviewee actually had a range of perspectives on a topic and wanted to give a broad life based backdrop to the issue that was being researched. Of course, this method was time consuming as the respondents would talk on and on about other things and spend little time on aspects that were of direct interest to me.

2.4 Evaluation of methodologies and methods

These methods proved to be very effective, although each had its own challenges. The first problem was time. Many doctors and magistrates were always busy and would give me a scheduled appointment but then fail to make it in time or at all. Some nurses, especially those from council clinics could not be interviewed as they needed authority from their Director, yet obtaining the authority was not an easy task. I wanted to use the authority from the Ministry of Health but they refused, saying they did not operate under the same authority as the Municipality. Several follow-ups were made with the City Municipal offices at the Rowan Martin building but my request was never approved. As a researcher, one does not need to get the feeling that they are disrupting something too much (Chirawu *et al.*, 2007) so that was quite a big challenge to me.

The disadvantage of one-on-one interviews was that often respondents would go on and on about some issues, not related to my research. Although I could not rush them, it cost me a lot in terms of time as I would spend a lot of time with one respondent. Their concerns were irrelevant to my research, as they wanted to know how I could help them to appeal the cases as they felt cheated by the courts and in this respect I found the women's law approach limiting.

Despite these challenges, I managed to collect sufficient data which I will discuss in my findings and I was able to uncover the women's lived realities covering the theme of my research and I also managed to triangulate the data I gathered with the experiential data.

When I went to the Harare Magistrates Court, I managed to interview 6 regional magistrates (that is, 4 men and 2 women) who were my key informants. Prosecutors, doctors and police officers were mostly male and this posed a dilemma for a feminist research project which seeks to challenge andocentric knowledge (Stewart *et al.*, 1997).

I also noted that, as I went through the interviews, the topic on deliberate transmission of HIV was a sensitive topic, especially to the victims of such and as a researcher I needed to be sensitive to interviewees' reactions and on occasions, grief. I should have sought counselling myself as 'prior to the field work, advice from personal grief counsellors on how to deal with

these situations is very useful' (WLSA, 1997). It was important therefore for me to seek expert advice on how to deal with the needs of those reliving traumatic events in their lives.

2.5 Conclusion

In conclusion, these methods and methodologies helped me greatly in coming up with my conclusions. In the research design phase, I made decisions on what type of data to collect, where to collect it and from whom, as well as how the data was collected in the field. In this chapter, I discussed the various methods which were used to collect observational and oral data. I will conclude by saying the type of data to be collected is very important to the way in which it is to be collected and I had to spend much time planning the data collection methods and deciding on the questions to be asked and how I was to ask them.

CHAPTER THREE

3.0 LAW AND LITERATURE REVIEW

3.1 Introduction

Women remain at the lowest end of the HIV pandemic due to several underlying social and economic factors contributing to their vulnerability. These included their lack of social power to make responsible sexual decisions, their powerlessness in policy making decisions as well as cultural values and practices. Poverty also leads to women's vulnerability in that they fail to negotiate safe sex and if ever they are deliberately infected, they cannot and do not air their views as they are mostly dependent upon their husbands and boyfriends for support and in most cases they either withdraw the charges against those who infect them or they do not report them at all.

HIV has placed women in double jeopardy. They are viewed as vessels of transmission and they are also consigned to an inferior place in society, thereby prejudicing their position in a world in which they are already marginalised. Due to their lack of economic agency, many women fail to make decisions about their sexual behaviour, thereby getting more infected and prone to violence. The UNAIDS simply notes that there is a need for a rights based approach to HIV, which requires 'the realisation and protection of rights of people and the need to avoid exposure to HIV' (UNAIDS; 2012).

There are a lot of human rights instruments that are in place to try and protect those living with HIV, as well as protecting those who are vulnerable, in this case women, from being exposed to the virus. One scholar notes that:

> 'more broadly, the evolving HIV pandemic has shown a consistent pattern though which discrimination, marginalisation, stigmatisation and, more generally, a lack of respect for the human rights and dignity of individuals and groups heighten their vulnerability to *being exposed* to HIV' (Mann *et al.*,1999) (my emphasis).

These human rights instruments will be discussed in detail below.

The objective of this chapter is to discuss what work has already been done locally and in other parts of the world in order to identify gaps and take advantage of lessons learnt at a

local level as a basis for guiding my research to determine whether the criminalisation of the wilful transmission of HIV really protects women against infections.

There has been a lot written on criminalising deliberate transmission in Zimbabwe, but very little written on whether or not it protects women. Therefore it is important that I interrogate the law using a woman's perspective, since the subject is always being debated within a general human rights context and not specifically as a women's problem. While it is mostly *women* who are being infected by partners who are aware of their HIV positive status but choose not to disclose it, the topic of women and wilful transmission is not thoroughly interrogated. The experience of men dominates most of the HIV/AIDS discourse and it also defines a lot of issues on HIV and the course of the illness (Lindsey, 1997). The invisibility of women in AIDS literature has led to a delay in understanding how it affects them (Baylies, 2003). It is therefore important to include other underclass approaches to wilful transmission of HIV that insist on the importance of studying women and 'studying up' instead of studying 'down' (Harding, 1987).

I therefore wrote this thesis with the notion in mind, that for women's pain to be felt, they need to be able to describe their gender specific pain to communicate its magnitude, and I chose to concentrate on women as victims of wilful transmission of HIV.

3.2 International framework

3.2.1 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Article 12 of CEDAW deals with women and health but does not cover HIV. However, in its General Recommendation (GR) 24, the drafters recommend programs to combat HIV/AIDS giving special attention to factors relating to women's reproductive role and subordinate social position which makes them vulnerable to HIV. It goes on to emphasise the need for state parties to implement a comprehensive national strategy to promote women's health throughout their lifespan.

On the issue of confidentiality (which will be discussed in detail below) the GR 24 notes that 'all health services [should be] consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice. It is interesting to

note that the lack of confidentiality may deter women from seeking advice and treatment and thereby adversely affecting their health and well being. This is an argument which has been advanced by many writers when it comes to confidentiality on HIV issues.'

CEDAW Committee General Recommendation 15/1990 talks about the avoidance of discrimination against women in national strategies for the prevention and control of HIV. It recommends that 'state parties shall intensify efforts in disseminating information to increase public awareness of the risk of HIV infection, especially in women and children, its effects on them.' This issue of information dissemination is based upon on the right to know which will also be discussed in the chapters to follow.

3.2.2 Recommendation on ethical issues in health care and social settings

This recommendation has application in Europe, but is also very relevant to this dissertation considering that it goes deeper into the issue of the balancing of the competing rights of the right to privacy and the right to know. The appendix to Recommendation R(89) 14 talks about confidentiality in relation to partner notification by saying that there should be, as a general rule, no partner notification without the consent of the patient. It starts by recommending that full respect of confidentiality is necessary, but does not, however, go on to stress it at any cost. It does go on to say however that where a patient refuses to co-operate in the notification of an unsuspecting third party, procedures of consultation in accordance with national codes of medical ethics should be followed.

This recommendation goes on to draw the attention of medical personnel to the importance of assisting patients in understanding their responsibility towards their partners when it comes to HIV. I noted as I was doing my research that medical personnel do not talk about disclosure. It seems that they do not have clear guidelines about that. They do however have clear guidelines on the principle that disclosure must be voluntary and that they cannot disclose without the consent of the patient, and no consideration is given to the right of the third party to know.

3.2.3 Protocol on the African Charter on Human and People's Rights

Article 14(e) of this Protocol gives everyone the right to be informed of one's status as well as that of their partner's, especially when it comes to HIV as well as any other sexually transmitted infection (STI). This however creates a problem on the issue of confidentiality

versus partner notification and this research sought to interrogate the women about what they really wanted. Article 14(1) recognises the vulnerability of women to infection by their husbands, boyfriends and partners, some of whom may be aware of such risks but choose not to disclose their status.

3.3 National Laws

3.3.1 The Constitution of Zimbabwe Amendment (No 20) 2013

The Constitution of Zimbabwe is the supreme law of the land and any law that is not consistent with it is void. The right to health is not justiciable in Zimbabwe and many women and girls fall victim to its violation.

In section 57, the Constitution gives everyone the right to privacy, including the right not to have one's health condition disclosed. This has posed a big challenge in my research as people are no longer forced to get tested for HIV even when they have committed offences. In one case an uncle raped a minor girl child and supposedly infected her with the virus. The minor was found to be positive but he argued in court that he was not HIV positive. The state intended to charge him with deliberate transmission of HIV but could not do so because they could not ascertain the HIV status of the accused person and to force him to get tested meant breaching his Constitutional right to privacy. This is the same even when the interests of justice are at stake and magistrates are no longer granting court orders compelling accused persons to be tested. One can only be compelled to be tested after being convicted but not any time before that. Generally, a person can only be tested if they agree to be tested; they cannot be compelled to be tested.

3.3.2 Criminal Law Codification and Reform Act, Chapter 9: 23

Section 79 of the Criminal Law Codification and Reform Act, Chapter 9: 23 (the Code) criminalises HIV non-disclosure, exposure and transmission, and imposes a mandatory sentence of ten years on anyone who, knowing that they are HIV positive, does anything or permits the doing of anything which they realise will infect another with the virus, not considering whether or not the two are married. The enactment of this provision in the Code means that an uninfected person has a right to life which should be protected by the law, and unlike the other scenarios in which it is the state versus the individual, this is a right to life between individuals. The one who knows their status has a duty to disclose to the other party,

or else they face criminal prosecution. This is important for the reinterpretation of rights, as they are relevant to the risks faced by women.

3.3.3 National Aids Policy Framework

In Zimbabwe we have a National Aids Policy framework which includes the Health Charter, the National HIV/AIDS Policy (1999) as well as the National HIV/AIDS Strategic Plan (ZNASP). In our National HIV/Aids Policy there is a provision that the government should change the underlying social and cultural structures that perpetuate the vulnerability of women to infections and transmission. The National Aids Policy and ZNASP 11 go on to emphasise the importance of respecting, protecting and fulfilling human rights and gender equality in the context of the HIV epidemic and all this shows that the legislators had women in mind but what is lacking is the implementation of the laws so that they offer the protection that women need.

Guiding Principle 3 of the National HIV/AIDS Policy talks of confidentiality regarding a person's HIV status which should be respected, thereby encouraging the country to make laws enabling health professionals to disclose to those who have critical reasons to know, like the shared confidentiality between doctors. This is the basis of this research, especially in the next chapter, as I seek to strike a balance between such a right and the right to know, which is also found in Guiding Principle 23. This talks about partner notification, considering it to be an important issue between both women and men which should be supported at all costs. It goes on to talk about wilful transmission of HIV in Guiding Principle 30, providing that it should be considered a crime and this is the main issue under discussion in this thesis. Section 3 of the National Aids Policy also goes on to lay down its human rights framework, by stating that 'discrimination should be avoided as far as is consistent with the rights of society and *those who are uninfected*' (my emphasis). This is a very important point, as it clearly spells out that a person's rights are guaranteed only in so far as their exercise does not lead, together with its enjoyment, to the abuse of the next person's right. One scholar says 'your right to swing your fist ends where my nose begins' (Makoni, 2004).

Section 7 of the same then talks of unequal power relations between men and women which leads to masculinity taking precedence over feminity, leading to the oppression of women and in my own assessment, that is what is leading to more women being infected by the HIV virus and their failure to report (as implied in the first and second assumption) in that they fail

to talk about sex because of the way they are raised. Expectations and norms that regulate their behaviour prevent women from negotiating safe sex and the unequal power relations discourage them from reporting their husbands and partners who they are sure have deliberately infected them with HIV.

3.3.4 Case law

Zimbabwe's jurisprudence on HIV has not fully developed as most of the cases which are prosecuted in the Magistrates Courts are not taken on appeal which means that they do not reach the Constitutional Court or High Court where they would be more widely and publicly reported. One case has however reached the Constitutional Court in which the applicant challenged the constitutionality of the law on wilful transmission of HIV. The matter has been heard and the judgement has been reserved. However, the applicant did not specifically make that application in respect of women in particular but on a human rights issue. There is need to create a judicial precedent that can be used to advance women's human rights, not human rights in general.

3.4 Conclusion

Although the country has, at national and international level, committed itself to the protection of women against HIV infection and violence, the laws and policy framework have not been fully implemented. There is a need to align the laws with the Constitution as well as with international human rights instruments so that implementation is achievable.

CHAPTER 4

4.0 RESEARCH FINDINGS AND ANALYSIS

4.1 Introduction (Women as victims)

I realised from my research that many women do not want the protection of the law or were forced to withdraw charges against their partners because the court cases were not held *in camera* and the publishing of court cases by local newspapers meant that their identities could be discovered. Even though journalists do not disclose the names of the victims, their naming of their partners is enough information for the public to discover the identity of their victims. In most cases, these women victims have not disclosed their status to their families and they find publicity about their cases traumatising not only for them but for their children as well because of the stigma surrounding HIV. One notable example is of a lady who had sued her husband for the deliberate transmission of the virus and he was acquitted. The woman was a doctor by profession and she felt betrayed by the press when her matter was publicised.

I showed her a clip showing that her story had been published in a local newspaper. She was shaken for some minutes and started crying. She was surprised as she had not seen the article and she was so emotional about it. She said her ex-husband had even gone to the extent of publishing on social platforms like Facebook and Whatsapp that she had lied that he had infected her with the deadly virus since he had now been acquitted and it was so difficult for her, especially in her work as a doctor as all her staff now looked at her with suspicion and distrust and she felt stigmatised. She even lost some of her valuable patients, as they did not want to be treated by an HIV positive doctor. She also blamed the media for publishing such stories without first verifying their information and wondered how her story got into the hands of the press as she believed court documents were privileged.

She went on to say as a woman and a victim, the laws had not done justice in protecting her as her matter was published in a local newspaper and it tarnished her image as a medical doctor as well as a mother which affected her so much. She went on to suggest that the press should not take pride in publicising such issues as they have a very negative impact, especially on women.

I therefore wrote this thesis with the intention in mind that for women's pain to be felt, they need to be able to describe their gender specific pain in their own words in order to communicate and make known the nature and extent of its magnitude, and I chose to concentrate on women as victims of wilful transmission of HIV.

4.2 Prosecution issues

4.2.1 Introduction

Assumption number 3 says that prosecutors find it difficult to prove beyond a reasonable doubt that an accused has infected a complainant with the virus, whereas assumption number 4 postulates that magistrates find it difficult to convict in such cases because the state would not have managed to prove beyond a reasonable doubt that the offence has been committed. Criminalisation of HIV exposure and non-disclosure is a public health intervention that the law makers thought would reduce the risk of transmission by those who know that they are infected. 'Over the course of the HIV pandemic new statutes have to be written, and general criminal statutes re-interpreted, to allow for such prosecutions' (Bray; 2003). They hoped it would serve as a deterrent against transmission from those who know their HIV positive status to their unsuspecting partners. To date there have been several cases of non-disclosure which have been brought before the courts. However, the results that I found upon doing my research were not 100% accurate as many cases never reached trial for lack of evidence, and the books were not updated. It is certain that the results do not constitute an exhaustive review of all prosecuted matters.

Under the current Zimbabwean criminal law, people living with HIV can be charged if they do not tell their partner(s) about their HIV positive status before engaging in sexual intercourse. This is what is referred to as the criminalisation of HIV non-disclosure, which is the main discussion of this paper. The legal obligation to disclose was established by the Sexual Offences Act Chapter 9:21 (section 15), and was adopted into the Code, under section 79. Since there is no legal distinction between a lie and silence, those living with the virus are criminalised for not disclosing their status, even if their partner does not enquire before engaging in sexual intercourse, and the charges can be laid, leading to someone being prosecuted even when the virus has not been transmitted. The first known successful prosecution in Zimbabwe took place in 2008, although it is believed that more than 20 prosecutions had been attempted (Makoni, 2004).

There are a number of hurdles in prosecuting cases of wilful transmission of HIV which relate to the need for sexual history evidence and causation. This often leads to a great deal of distress on the part of the complainants who are usually women, especially after an accused has been acquitted. For example, I interviewed one woman whose husband had been acquitted after a full trial. She said she felt more traumatised after the trial than before, largely because during cross-examination, she suffered the discomfort of having had to disclose some deeply personal and sensitive things about their private bedroom life in the hope of securing a conviction. Having overcome the difficulty most women experience in talking about sex, she was very distressed and disappointed that the court found him not guilty.

In order to prove deliberate transmission of HIV, the state must prove beyond a reasonable doubt that the accused was aware of his positive HIV status before engaging in sexual intercourse, realised a real risk or possibility that he is infected, intentionally does anything or permits the doing of anything he knows will infect the other, or realises the real risk or possibility of infecting another with HIV.

4.2.2 Proof of (non)disclosure

I noted as I was doing my research, that some women claimed their partners had not disclosed their statuses to them prior to engaging into sexual activity, yet they knew that they were HIV positive. One public prosecutor said that the women usually reported their partners after they had been dumped by them and that whether the accused had disclosed or not can never be ascertained because such disclosure happens in private between the parties behind closed doors. Also, because some women are not free to talk about sex, for fear of being labelled that they are of loose morals, thereby failing to negotiate safe sex even after being told, they might want to sue their partners upon divorce.

During my interviews, I met a man who said he had opened up to his girlfriend before they started staying together that he was HIV positive and she said she still loved him and it did not matter. However, she insisted that they do not use condoms, saying:

> *'Kusiri kufa ndekupi, ndogona kana kungotsikwa nemota panze apo ndikafa, plus mazuvano vanhu vaakurarama makore akawanda nechirwere hazvina basa izvo, plus handisi pfambi ini inopfekerwa condom.'*

> (Translation: 'I can die any time, I can even be hit by a car outside and still die, so since people are now living longer with HIV we can go ahead and have unprotected sex it does not matter, after all I am not a prostitute, with whom you should opt for condoms.')[3]

He went on to say:

> 'However I suggested that she goes and gets tested, and when she came back she told me that she had tested negative but did not show me the results. After we started having problems as any other married couple does, she started threatening me, which is when she raised the allegation that I had infected her with the virus. There was nothing that could show that when we met she was not positive already since we were never tested together or the virus she had came from me. During the course of our marriage, she was so promiscuous and she might have been infected then. There is no way to tell that the virus she has, is from me or from any other person. But personally I disclosed and she consented, only to change goal posts at a later stage. Maybe she thought I was lying to her as very few people can disclose their statuses just like that.'

In scenarios like this one can never know who is telling the truth; therefore it is difficult to prove non-disclosure when prosecuting such cases. Women should therefore insist on going for HIV testing before engaging in sexual intercourse with anyone.

One day I had a chance to peruse some dockets which were still in the hands of the prosecutors awaiting consideration. I found one docket in which the facts were that the parties got married in July 2010 and they agreed to use protection until they got tested. The woman went on her own to the New Start Centre in November 2010 and she tested HIV negative, but the accused kept giving excuses not to go and be tested, insisting that he was HIV negative. However, they had unprotected sex in May 2012 and the woman developed some rash and went to the clinic where she tested HIV positive. In April 2015 she discovered empty HIV tablets containers in the accused's room which he used at his parents' home. She then looked for medical cards which she found and they were in the name of the accused person, indicating that he had started taking ARVS in 2005.

The problem with this case was that in his warned and cautioned statement the accused said he disclosed his status to the complainant and she agreed to have sex with him saying she was not a prostitute (just like the situation in the previous scenario). Also, considering the time

[3] Queensdale, 4/12/15.

that had lapsed, one cannot say for certain that the complainant only had sexual intercourse with the accused. She might have become infected having had sexual intercourse with someone else. Also, if she consented to the act, knowing the accused's status, the court would not be able to find him guilty of deliberate transmission of the virus.

Almost all cases of exposure and transmission come to court because complainants claim that they were not explicitly informed by the accused of his positive HIV status (Benard, 2010). It is very common for both parties to disagree on whether there was disclosure, although this does not necessarily indicate that one of them is misleading the court, since 'communication regarding sexual encounters is often complex, with both verbal and non verbal elements, with many assumptions made and many things left unsaid' (UNAIDS, 2012). I am of the view that the courts should incline toward finding women complainants to be more credible witnesses than their partners as men often (although not always) fail to disclose their HIV positive status because of their fear of being stigmatised.

4.2.3 Proof of exposure

In Zimbabwe, it is an offence to have sexual intercourse with someone without disclosing one's HIV positive status, even when the virus has not been transmitted (section 79 of the Code). This is what is called exposure to the virus. As I did my research, I noted that so many women were being exposed to the virus by their husbands but did not know that it was an offence.

One day I was given a docket by the prosecutor in charge of deciding whether cases should be prosecuted. The facts of the case were that the complainant Sylvia reported a case of deliberate transmission against her husband Jonathan. The two, upon getting married, had not been tested, as the complainant kept on asking the accused to go for testing but he refused, saying he was HIV negative. They continued to stay together as husband and wife and some time in April 2015 the complainant discovered some tablets in the accused person's jacket, and recognised them to be Lamivudine, which is an ARV. She confronted him and he said they belonged to his nephew. She then went for HIV testing and she tested positive. She reported the matter to the police and when she went to test again she came out negative. She tested for the third time and the result still came out negative.

After being given the docket, I tried calling the complainant on her mobile, which she had supplied to the police but she kept answering and said it was a wrong number. What I drew from this scenario was that women fail to negotiate safe sex even when they have not been tested; they tend to believe their partner when he tells them he is negative. This is evidenced by the fact that this abovementioned complainant was told by her husband that he was HIV negative and she believed him at face value, instead of insisting that they get tested, and as a result she exposed herself to the virus. When I tried calling her again to encourage her get tested for the fourth time, to make absolutely sure of her status, she was evasive. Maybe she did not want to get tested and she did not want to talk about the matter, thereby fulfilling assumptions 1 and 2 that women find it difficult to talk about sexuality because of the way they are raised.

I am also of the view that although she was exposed to HIV, she did not want the world to know, and therefore she could not go ahead and testify against the accused. People do not free to talk about HIV as they are afraid of being stigmatised or they do not want to let the 'world' know that they have been tested and found to be HIV positive.

Also, I noted that people do not know that exposure in itself is a criminal offence. So, in this case, where the woman has tested negative, she could still lodge a complaint against the accused for exposing her to the virus. Based on this case, criminalisation of exposure is not a viable solution. People first need to be taught the essential elements of the offence, especially the fact that exposure in itself is an offence and then women must use the law to protect themselves against infections and violence. It is immaterial that no transmission has taken place,

4.2.4 Proof of transmission

The most difficult thing to prove in prosecuting such cases is transmission (Benard, 2010). A complainant might find themselves to be HIV positive, but the million dollar question remains as to the identity of the person who transmitted the virus to the complainant. It could have been the accused person and there is also a possibility that it could have been someone else.

Constable Masamvu, one of my respondents from the Glenview Victim Friendly Unit (VFU), said that she had dealt with a few cases of deliberate transmission but the women later

returned withdrawing the charges as they did not want to have their husbands arrested over the issue. She said that they only originally want to have their husbands arrested because they feel bitter having first found out that they were infected by their husbands, but over time they forgive them. She added:

> *'Vakadzi vazhinji vanozongoona kuti ndatozorwa kudhara rega tichingogarisana,hapana need yekusungisana.'*
> (Translation: 'Many women just think since they are already infected there is no need to press charges but continue to stay together as husband and wife.')[4]

She gave an example of a case which she dealt with of deliberate transmission of HIV which was never taken to court because although the lady was a virgin when she got married and slept with her husband, she had not been tested before their marriage and it was difficult to prove who infected whom. It is a prerequisite for the complainant to have been tested prior to having sex with the accused person for her to report and have the matter successfully prosecuted.

Had she not withdrawn the charges, there was no proof that it was the accused who had transmitted the virus to her, as nowadays children can be born and live up to 25 years being HIV positive. The fact that she was a virgin does not mean that she had no virus in her body. Her mother could have transmitted it to her before the introduction of the prevention of mother to child programs in which children born to HIV positive mothers are born negative.

Mrs Chigwedere, who is a public prosecutor at the Harare Magistrates Courts, supported this point when said that the state had several problems in trying to prove the guilt of an accused beyond a reasonable doubt. Firstly, there is no evidence of the complainant's HIV status (who are usually women) before the two engage in sex so it is difficult to prove who infected whom and at what point. She commented:

> 'In Zimbabwe, there is no culture of testing before engaging (in sexual intercourse), people just do it willy nilly. Therefore we hardly prove beyond a reasonable doubt that a woman was deliberately infected by the man.'

[4] Mbare Magistrates Court, 16/11/15.

One male doctor whom I interviewed, Doctor Masamha, said proof of transmission was hard to proove. When I asked her if there was a way for doctors to tell who infected whom, she said:

> 'There is a speculation that if we take a viral load test one can establish who infected who, but it is worthy to note that even if its flu, a virus like HIV can multiply rapidly in one person as compared to the other, therefore the results are never 100% accurate.'

4.2.5 Proof of intention

Another thing that the state has to prove beyond a reasonable doubt is the fact that the accused actually had the intention to transmit the virus to the victim. This is the most difficult element to prove for prosecutors. As I continued to interview Mrs Chigwedere, she said that this is one of the cases that requires proof of specific intent and that it is so difficult, if not impossible, to prove which confirmed assumption three that these cases are difficult to prove. Ressy Nyamombe, another prosecutor at the same court, also had this to say:

> 'Most of these cases are acquitted only on the pretext that the accused did not know that he was HIV positive and it becomes difficult to prove that the infecting was deliberate.'[5]

Tinashe Kanyemba, a regional prosecutor, also gave an example of a case she was dealing with in which a minor child was raped by two of her uncles and tested HIV positive. The minor's parents and siblings were tested and they were all negative and the uncles were arrested for raping her and deliberately infecting the minor with HIV. However, it was difficult for the state to prove deliberate transmission as both uncles alleged that they were negative and the court refused to compel them to get tested, based on the pretext that it was an infringement of their Constitutional rights. As a result they were only convicted of rape but not deliberate transmission of HIV. It was also difficult to prove whether or not the minor was HIV positive before the abuse. This case is a typical example of how very difficult it is to prove this element of the offence.

Tinashe Kanyemba also added that the state did not have proof of the HIV status of either man and the court could compel them to get tested only after their conviction; yet the difficulty lies in the fact that deliberate transmission cannot be proved without those same

[5] Rotten Row Magistrates Court, 20/11/2015.

results. Therefore, under these circumstances, deliberate transmission could not be proved. So here is the case of an HIV positive child, but the person who infected her remains unknown.

Mr Tsikwa, a regional magistrate at the same court had this to say:

> 'From its wording, section 79 is clear that this is not a strict liability offence as evidenced by the use of the words intentionally and deliberately. It is therefore abundantly clear that the state will have to prove beyond a reasonable doubt that the accused had full knowledge that he was HIV positive, he deliberately exposed a sexual partner to the risk of contracting it. Therefore a child cannot sue its mother as they are not sexual partners.'[6]

4.3 The doctor/patient relationship

4.3.1 Introduction

Protecting a patient's confidentiality is one of the inherent obligations of a doctor (Odunsi, 2002). The Zimbabwean medical profession imposes a moral or ethical duty on its members to respect the confidences of its patients. One doctor I interviewed even said he would respect the secrets confided to him by a patient, even after the patient's death, as the violation of the doctor/patient relationship exposes him to different sanctions by the medical society, including cancellation of his medical practising certificate. The courts have acknowledged and upheld this principle in many cases according to my research, and doctors cannot be forced to come and testify against their clients as far as deliberate transmission is concerned. This poses a very big problem for the prosecution, as they really need the doctor's evidence to prove beyond a reasonable doubt that the accused person knew of his HIV status and did not disclose it to the complainant. According to the AMA Journal of Ethics, there is a need to strike a balance between legal mandates and medical ethics.

4.3.2 The duty of confidentiality

Before commencing my research, one of my assumptions was that doctors are restricted by law from disclosing their patients' HIV status to a third party because of the patient/doctor privilege. The National Aids Policy of Zimbabwe defines confidentiality as 'not disclosing private or personal information without consent.' There is a great debate on whether doctors should just keep quiet when it comes to HIV, even if they know that the person infected is

[6] 21/11/2016, Rotten Row Magistrates Court.

spreading the virus knowingly, and although it is not part of this thesis, I will discuss it in brief.

> 'The emergence of the HIV pandemic has added to the tension between patients' private interests and public health interests regarding medical confidentiality. Many people become infected with HIV because they are unaware of the positive sero-status of their sexual partner. Informing or warning the sexual partners of the HIV positive person, of the patients' sero-status could assist in curtailing the spread of HIV because sexual partners could thereby choose to avoid having unprotected sex with infected persons. By law, however, doctors have a duty to their patients to protect their medical confidentiality. Doctors, therefore, face a dilemma concerning which should prevail: patient's right to privacy and confidentiality or the importance of the society of controlling the spread of the pandemic. Most medical regulatory bodies do not take clear-cut positions on the issue, leaving the decision to the discretion of individual doctors' (Studies in Family Planning, 2007).

While doing my research, I discovered that doctors do not come to court to testify against their clients, which makes it difficult for the state to prove that accused persons actually knew of their status before engaging in sexual intercourse with complainants. In one case, the doctor came to court but was not very clear when giving his evidence, as he did not want to breach the doctor/patient confidentiality with the accused. Below are the facts of the case, as I read it in the judgement by Magistrate, Mr Mujaya.

The accused and complainant were husband and wife and in March 2012 the complainant was tested at a pre-natal clinic and was HIV negative. The accused later left the complainant and had extra-marital affairs and then came back to her in April 2012, upon which they went together for HIV testing but the accused did not go into the doctor's office with the complainant. He went in alone and told the complainant that the problem he had had been caused by not having sex for a long time, which was a lie. After some time they discussed the issue as a family with family members involved and finally agreed to have sex, as the complainant had been refusing to give the accused his conjugal rights. They then went to the New Start Centre and were both tested positive. After a week, a lady phoned the complainant and told her that she (the caller) was HIV positive and she also knew the accused was HIV positive. She even bragged that the accused had come back to the complainant to infect her with the virus and then return to the caller. In fact, the accused did then leave the complainant and went back and stayed with one of his girlfriends.

In his defence, the accused said he did not have any knowledge of the complainant having been tested for HIV and found negative. He said he only discovered that he was positive when they were tested together. He went on to say he had filed for divorce and the complainant had opposed the action. He said that the proceedings were acrimonious and that the complainant wanted to report him for infecting her with the virus in order to 'fix' him and compel him to withdraw the divorce action.

The witness, Dr M, had tested the accused on 2 April 2012 but, according to his testimony, he did not disclose the results to him. Therefore a conviction could not be secured against the accused because if he had been aware of his status, he would have had a duty to tell his wife whether he was positive or negative. I however concluded that the state was expected to prove beyond a reasonable doubt that the accused knew of his status but did not, because Dr M kept changing his statements and his evidence was confusing. The court also noted that the doctor talked of a possibility of re-infection which is said to be deadly to someone who is HIV positive already. The accused was then given the benefit of the doubt and was found not guilty and acquitted.

In the above circumstances, the doctor indeed came to court to testify, but did not disclose what he had discussed with the accused as it was privileged information and upon being asked by the defence whether or not he had told the accused that he was HIV positive, he boldly said he could not remember, thereby weakening the state case. This supports the observation mentioned above that the discretion lies the individual doctors, they may choose for themselves whether to breach an accused's right to confidentiality or a complainant's right to information. The complainant, who was a woman in this case, was not protected by the law because of the operation of the doctor/patient privilege.

4.3.3 The duty to disclose to the police/court

Another pressing issue on criminalisation of deliberate transmission of HIV is: Do doctors have a duty to disclose a person's HIV status to the police or to the court? The National Aids Policy Guiding Principle 3 notes that 'confidentiality regarding a person's HIV status should be respected. Legal provisions should be made to enable health professionals to disclose to those who have critical reasons to know.' Under Guiding Principle 5, the Policy notes that legislation should be developed to enable professionals to disclose to a third party who has critical reasons to know under specific conditions even if consent is denied. However, these

are just guiding principles and not law, therefore the medical personnel feel they are not legally bound to disclose either to the police or to the court.

As I went through my interviews, I talked to one lady who was a care giver and she said if called upon by the court with proper documents she could come and testify that the accused person was actually taking ARVs if indeed he was, but many doctors said they could never testify in court against their patients. This doctor who refused to be named said their code of conduct and professional ethics is strict when it comes to issues of confidentiality. She said as medical personnel, they are not allowed at any point to talk about a person's status to a third party.

4.4 Documentary exhibits

There was a problem on the issue of tendering exhibits that I also noted during the period of my research, thereby posing a problem with the criminalisation of the wilful transmission of HIV.

4.4.1 Authenticity of documents

There is a very complicated issue on the tendering of documentary exhibits when it comes to wilful transmission of HIV, thereby making it difficult to criminalise and protect women. There are instances when women find cards bearing their partner's name inside their home, as proof that the man is actually taking ARVs and that alone could be sufficient proof that he knew of his status and chose not to disclose it. However, the Zimbabwean Criminal Procedure and Evidence Act provides that a document is required to be introduced into evidence through someone who can authenticate it, unless it is a public document, in which case it can be produced in court through the bar (one of the parties' lawyers). The challenge has been about how to tender such documents in court as the nurses and doctors do not come to court to testify because of the doctor/patient privilege. Also, there is the issue of how the document was obtained. If it has been unconstitutionally and therefore illegally obtained from the accused, then it becomes difficult to tender as an exhibit in court, thereby making it difficult, if not impossible without other evidence, for the prosecution to prove beyond a reasonable doubt that the accused actually knew of his HIV positive status.

As I was doing my research, I came across a docket that was in the vetting office that could not be taken to court because of the issue of documentary exhibits. The facts of the case were that the complainant was staying in Botswana and that is where she was tested and her result came out negative. She was tested as she was looking for a job and was given a pathology report to show that she was negative. She was then deported and came back to Zimbabwe, where she met the accused and she showed him her results, but he kept on saying he would bring his own. They started staying together as husband and wife, until she discovered some tablets which she knew were anti-retroviral tablets in his possession. She asked him and he confessed, but there was no witness, it was just the two of them. She decided to get him arrested for wilful transmission of HIV since she then went to the clinic and tested positive.

The challenge with this case was that, the woman had proof that she was HIV negative before she met the accused, in the form of a pathology report, but she had obtained it from Botswana and it meant that the doctor, the author of the report, who had tested her had to come and testify that she actually tested negative. The state, however, was short of resources and could not subpoena the doctor. Also, the words in the pathology report simply read 'results-negative' and did not explain the nature of the test for which she had tested negative. As a result, the state was sceptical of the pathology report. In addition, it was a foreign report and the state was unsure how to tender it into evidence and whether it was a genuine or fake document. The matter did not proceed to trial and as a result the woman was not protected by the law. There were also other cases where after being caught, the men destroyed their cards from the clinics, and alleged that they did not know that they were HIV positive; thereby the issue of intentionally infecting their partners fell away.

4.4.2 Availability of documentary exhibits

Another problem with documentary exhibits is the issuing of warrants of search and seizure in terms of section 303A as read with 49(b) and 50(1)(a) of the Criminal Procedure and Evidence Act. The courts are now hesitant to issue such warrants in order to obtain the medical history of an accused. As a result, such searches are not conducted, although the medical history of accused persons remains in the custody of the relevant medical institutions. Magistrates are concerned that such warrants breach an accused person's Constitutional right to privacy. As can be seen, the issue of documentary exhibits poses a very big problem to the topic under discussion.

I also noted that the courts were sceptical about compelling an accused person to be tested for HIV prior to the commencement of a trial. An accused can only be compelled to be tested after he has been convicted, but without such results, it is difficult for the state to even place an accused on remand considering that a reasonable suspicion that the accused deliberately infected the complainant is only available after he has been tested and found to be HIV positive, yet no one can force an accused to be tested. Therefore criminalisation does not protect women as there is no proof that an accused person is even HIV positive in the first place, until he himself volunteers to be tested. In one case that I dealt with, the accused opted to be tested. He went away and returned later with what he called 'his HIV test results.' Although they were in his name, no one could ascertain for sure that it was he who had been tested and that the results he brought were actually his as he went on his own to get tested. That matter also could not be placed on remand. Also, some people do get tested but do not use their real names, and then it becomes difficult to tell to whom the results belong. This will be discussed below.

4.4.3 The use of pseudo names

Another problem I saw during the prosecution of such matters is that of the use of pseudo names. Often, for the sake of confidentiality, people choose not to use their real names when getting tested for HIV, in which case it is difficult to tell if the results they have are theirs or not. There are two cases that failed on this account. In the first case, the woman was very sure that her husband (who was a doctor) was not using his real name when collecting his ARVs from a clinic but even if she could bring his cards, they would not be accepted as evidence since they were not in the accused person's name. In the second case the matter went to trial and in trying to prove that she was HIV negative before having sexual intercourse with the accused, the complainant brought what she alleged were her results, which were in the pseudo name of Debra, yet her real name was Diana. There was absolutely no nexus or connexion between these two names and it was difficult for the magistrate to convict, thus confirming assumption number 4. Therefore the use of pseudo names poses a big problem in instances where people have been tested using names other than their real names.

4.5 Wilful transmission and violence

4.5.1 Introduction

Gender based violence is 'violence that is directed against a woman because she is a woman or that affects women disproportionately' (CEDAW General Recommendation 19). Many women in Zimbabwe face so many kinds of violence, including physical and sexual violence. This is mainly facilitated by patriarchal hierarchies and serves to perpetuate male power and control over women. We have the Domestic Violence Act which tries to combat any form of violence against women, as well as the Constitution, which seeks to provide legal protection for women against all forms of violence, as well as several efforts being made to set up administrative, social and educational processes that combat violence against women.

4.5.2 Sexual violence

Women and girls are at risk of sexual violence, be it from their partners or from strangers. Sometimes the man who sexually abuses the woman might be HIV positive, thereby exposing her to the virus, or even transmitting it. In Zimbabwe, we have the Criminal Law Codification and Reform Act which covers all forms of sexual abuse (section 65), be it in marriage or by strangers.

As I noted from my research, many women are sexually abused by men whose status they do not know. One in four women in Zimbabwe report ever having been sexually abused by an intimate partner. Marital rape is high in Zimbabwe and many women are contracting the virus from such kinds of abuse by their husbands.

4.5.3 Physical violence

I noted, as I was in the field, that many victims of wilful transmission of HIV also experienced physical abuse from their sexual partners. In the case of *S v KM* (unreported), the complainant was quite sure that she would not have reported wilful transmission against the accused had he not physically and emotionally abused her when he was now trying to dump her. When I read the record of proceedings, I found the following statements made during cross-examination by the defence:

Q. 'Why did you make such a report against the accused?'

A. ‘I made a report because he started to physically abuse me and later said he no longer loves me, then if he goes away who is going to look after me in such a condition?’

Q. ‘Do you mean to say that if he was not leaving you were not going to report?’

A. ‘I decided to make a report because he decided to leave, had he not decided to leave then I would not have reported against him. I would have accepted the situation as it is and learn to live with it.’

From the above, it became very clear that this complainant was both physically and emotionally abused by the accused after wilful transmission of HIV. This is just one example of the many women who reported after they had been physically abused by their husbands and sexual partners.

4.5.4 Links between violence and HIV infection

Usually, violence against women results in HIV infections, as it makes them vulnerable to HIV in the sense that they suffer fear of violence within the relationship (if they are sexual partners) or unsafe sexual behaviours by an abused woman at a later stage in life, as well as direct transmission through coerced or forced sexual acts. If a woman is abused, the risk of sexually transmitted infections is high, and also it has proven to be associated with risk taking sexual behaviours later in life (Brown, 1986). There seem to be a direct co-relation between sexual abuse by a partner as an adult as well as early initiation of sexual activity.

There is also direct transmission through sexual violence. In Zimbabwe, especially the rural areas, some people still believe that having sex with a virgin will cure them of HIV, as a result of which women and girls are forced into sex, increasing the risk of contracting the virus. In forced sex, abrasions and cuts normally occur, thus facilitating the entry of the virus and to women who lack the knowledge of Post Exposure Prophylaxis or are abused by those close to them and choose not to report, the risk is high.

It is also worth noting that in relationships characterised by violence and forced sex, women often find themselves unable to negotiate safe sex or insist on the fidelity of their partner, for fear of provoking further violence.

4.6 Conclusion

In summing up, there are many problems associated with prosecuting deliberate transmission of HIV. There is no way one can tell who infected whom with the virus and it is really difficult to prove non-disclosure as these issues are usually said in people's bedrooms, meaning that one cannot tell whether or not the words were uttered expressly or impliedly, or were even uttered at all. Generally, it is a one-on-one issue and it is very difficult to prove beyond a reasonable doubt as to what actually transpired. Also the issue of documentary exhibits makes prosecution difficult, as obtaining these documents means breaching an accused person's Constitutional right to privacy. The laws need to be reformed and further research conducted, so that prosecutors find a way around the issue of obtaining and tendering of documentary exhibits.

CHAPTER FIVE

5.0 PIERCING THE VEIL OF SECRECY IN HIV/AIDS: THE RIGHT TO KNOW AND THE RIGHT TO PRIVACY

5.1 Introduction

This chapter presents the research findings on criminalising wilful transmission of HIV, mainly concerning a complainant's right to know an accused person's HIV status and his right to privacy. By criminalising wilful transmission, significant implications for public health privacy are imposed (Lazarrini, 2002). As a prosecutor, one has a duty to prove that the accused knew of his HIV status, and such information can only be found from health records that are proof of such. Previously, in Zimbabwe a prosecutor was allowed to use an accused person's public health record to prove that he was infected, but nowadays it is problematic obtaining such records as hospitals will not release them, arguing that such persons have the right to privacy and such a record is privileged information. Warrants of searches and seizures are being issued in terms of section 302A(3) as read with sections 49(b) and 50(1)(a) of the Criminal Procedure and Evidence Act to provide medical history of accused persons but these searches are no longer permissible to conduct because the matter is before the Constitutional Court, since the documents are considered confidential and releasing them would amount to a breach of an accused person's Constitutional right to privacy (section 57).

5.2 The right to privacy

According to Black's Law Dictionary (1990), the right to privacy 'is the right to be let alone; the right of a person to be free from unwarranted publicity...and such right prevents governmental interference in intimate personal relationships or activities...' In section 57(e) of the Zimbabwean Constitution, every person has the right to privacy, which includes the right not to have their health condition disclosed. The National HIV/AIDS Policy of Zimbabwe defines confidentiality as 'not disclosing private or personal information without consent'.

The right to self preservation is a *bona fide* human right which is of fundamental importance. Article 12 of Universal Declaration of Human Rights provides that 'no one shall be subjected to arbitrary interference with his privacy, family…' This means the right to privacy must be

followed and one's HIV status ought not to be disclosed without their consent, as it will amount to a breach of that important right. No one therefore should disclose another person's status, and an infected person must only disclose his status based on his own free will and not as the result of being forced to do so by anyone or anything. In the case of *Bestein v Bester* 1996 (1) SA the South African Constitutional Court ruled out that the right to privacy is recognised as an independent personality right, but held that it is part of the concept of *dignitas* meaning that this right is bound up with one's right to dignity.

Many doctors I interviewed, together with nurses and care givers, made reference to the right to privacy and had strongly held belief about the need to maintain confidentiality. According to the Zimbabwean health laws, these professionals have a duty to protect their patients' medical history. 'By Law, doctors have a duty to their patients to protect their medical confidentiality...' (Odunsi, 2007). They are not allowed under whatever circumstance to give a person's medical history to a third party. However, one doctor said there is only one exception, that is when a doctor or medical personnel is disclosing to another medical practitioner which is called 'shared confidentiality', but this can only be done for the benefit of the patient as well as managing the same. Besides that, they are not allowed to disclose, even in a court of law.

I saw a docket in which a woman tested positive to HIV in 2008 at Belvedere Maternity Home and was accused of wilfully transmitting it to her boyfriend whom she later married after she had not disclosed her status. The state intended to use such records, but the gynaecologist totally refused to come to court to testify based on the fact that what had happened between them remained in their office and it was therefore privileged information falling within the confidential doctor/patient relationship.

Also, in another case of *KM* (a record which I read at the Rotten Row Magistrates Court), the doctor agreed to come to court to testify against the accused who was being accused of wilfully transmitting the virus to his wife and during cross-examination, he did not want to come clean as to whether he had told the accused of his status or not and the magistrate was left with no option but to acquit the accused person, because he (the magistrate) held that it was not clear whether the doctor had told the accused of his status when he tested him, so there was a possibility that the accused was not aware of such, and a conviction could not be secured. The doctor did not want to share what he had discussed with the accused because of

the issue of confidentiality and therefore he chose to say he was not sure whether or not he disclosed the same to the accused.

However, this issue of confidentiality poses a very big problem. What does a doctor do when faced with a scenario in which a patient, a married man or someone who is sexually active, tests positive for HIV, insists that he will not disclose his HIV status to his partner(s) and continues to have unprotected sex with her? Should the doctor contact the other sexual partner(s) and tell her this information? This would be ethically and legally wrong, yet she has the right to know of her husband's status, a right which will be discussed in below. This means there is a need to strike a balance between the infected individual's right to privacy and the right to have the other party know.

Notifying the partner poses an ethical concern for medical practitioners, since they are duty bound not to breach the confidence of their patients. The right to privacy connotes the right to control information about oneself (Shattuck, 1977) and is at the epicentre of all human freedoms and rights (Westin, 1967), which is important, although in conflict with the right to know when it comes to HIV/AIDS.

Guiding Principle 23 of the National HIV/AIDS Policy Guidelines talks of partner notification. It defines partner notification as 'sharing information about one's HIV status with his/her sexual partners'. It recommends that men and women should be informed of the risks of engaging in sex with a new partner of unknown HIV status, because information regarding a partner's status may not be shared. It is therefore problematic for health workers to breach the confidentiality of their clients without their consent but it is encouraged that people with HIV inform their partners of their status, not to have someone else (like a doctor) do it for them as it 'may destroy the confidence of the patient in the health advisor and may reduce the effectiveness of care'. Also, it will amount to a breach of one's Constitutional right to privacy. UN Guidelines on HIV-related Human Rights also notes that 'States should enact or strengthen protective laws that protect vulnerable groups…ensure privacy and confidentiality...' This also means that the right to privacy is internationally recognised.

5.3 The right to know

Guiding Principle 39 of National HIV Policy Guidelines of Zimbabwe provides that all persons have the absolute right to clear and accurate information on HIV/AIDS. This section thereby examines the right to know the HIV status of others. For the HIV epidemic to be halted, people will have to protect their sexual partners who are not infected from infection (Maman and Medly, 2004). The best way to protect and the first step towards protecting will be to let someone know of one's status.

In regard to the disclosure of one's HIV status to sex partners if one is living with HIV, the simple basic ethical approach would be that, of course, everyone should disclose their status to their sex partners as soon as they learn that they are infected with the virus (O'Grandy, 2011), failing which, one would endanger their partners' health through transmission, or expose them to the same, thereby increasing the chances of contracting it. Disclosure is important for the other partner's right to know the relevant information about the health status and potential disease infectiousness of a current or potential sexual partner. Getting to know such can then in turn help the uninfected partner to maintain their health and potentially prevent exposure.

Everyone has the right to know information to help them protect their own health. This right to know can also attach to other medical practitioners, for the benefit of the patient, which is called shared confidentiality. Guiding Principle 3 of the National HIV/AIDS Policy says that the health of another person should be disclosed 'to those who have critical reasons to know'. There was a case in which a doctor tested one of his clients for HIV and the patient tested positive. As the doctor was playing golf with his friends who are also doctors, he disclosed the information and it circulated in the small community in which they live. This doctor was sued and the patient won the matter because it was held by the judge that the doctors who were informed did not have any critical reason to know. However, partner notification is important as mentioned by Guiding Principle 23, where it says 'partner notification on HIV status is an important issue for both men and women and should be encouraged and supported.'

Article 14(e) of the Protocol to the African Charter on Human and People's Rights gives everyone the right to be informed of one's status, as well as their partner's, especially when it

comes to STIs and HIV. This then poses a very big problem as the infected partner has the right to privacy, and the next section will try and balance these two competing rights.

5.4 Striking the balance between the competing rights

From the interviews I had, I noted that men generally did not disclose their status to their partners. Most of the men I interviewed said they would never disclose, if they were to be found to be HIV positive, whether or not their partners had the same status. They said they feared rejection from their partners as no one would want to stay with an HIV positive partner. However, most (but not all) women I interviewed said they would disclose and even insist on safer sex methods. One couple that I interviewed told the following story: the husband went and got tested but did not disclose his status to his wife. The wife then discovered that he had gone for testing and enquired from him as to why he had decided to go and get tested but he said he wanted to know where he stood and it was just good to get tested regularly. They then stayed together for years and the husband fell sick. He had a fever. They initially thought it was just a fever and would go away and after sometime he recovered. He then fell sick again with continuous diarrhoea and they thought he was being bewitched by their neighbours. He then went to the hospital and was admitted after he was dehydrated. It was then that he was tested in the presence of his wife and he tested positive for HIV. Fortunately, the wife tested negative, but did not get him arrested for exposing her to the virus, although he admitted that he had known of his status for quite some time.

From this story, I deduced that some men did not want to disclose their status. I had to interview them separately and the man in the above scenario confided in me that he was afraid that his wife would send him away had she discovered his status. She also told me separately that it seemed like he wanted to pass the blame on to her for bringing the disease home as she was a cross-border trader, but she felt she had the right to know of her husband's status. I asked her what she thought about the issue of confidentiality and she did not know what it was all about. After explaining to her, she said it was very important for women to know, so that they would protect themselves from the virus. She said it was better for one partner to die and the other to live and take care of the children, rather than leaving them destitute because of something they could have avoided if one of them had disclosed. She felt the right to know should rank above the right to privacy, as information would enable her to make informed decisions.

Rutendo, another married woman, felt it was important to know as she would avoid re-infection and a series of other sexually transmitted infections that her husband had continually infected her with. Had her husband disclosed his status to her, she would have insisted on using condoms and she was against the issue of confidentiality as she felt non-disclosure had led her to the situation she was now facing. She said:

> *'Iye akazorora, ini ndasara ndiri mupenyu ndichirwadziwa.Iyezvino zvanaka, manures anobva ati uyai mese motestwa pamwechete, mobva maziva.Confidentiality haishande inouraya nyika.'*
> (Translation: 'Now he has passed on, and I am still alive, I am not feeling well. Nowadays it's better the nurses call both of you so that you get tested together and you both know. Confidentiality is destructive to the nation.')[7]

One social worker at Harare Hospital said confidentiality between couples was problematic, as it would lead to infections, re-infections and violence. He had seen many people who came to the hospital without their partners to get their anti-retroviral tablets and would hide them so that they would not find out. Everyone has a right to know and the issue of confidentiality should only apply to health care workers, who were not allowed to disclose to third parties; but between couples, there was supposed to be no privacy issues. Each was supposed to know, so that if they are to sleep with someone else, they would not spread the virus.

The above sentiments were shared by a number of my respondents. They believed that between the two rights, the right to know should override that of confidentiality, as a protection against the possible consequences of non-disclosure, exposure and transmission of the virus.

Many people felt criminalising would really work, as it would deter those who have the virus from spreading it knowingly. They really felt that even nurses and doctors were supposed to disclose to the other partner, so that they take precautions against the deadly disease. One doctor said he personally believed that criminalising would solve everything, but quickly pointed out that his words were his personal views and not that of the Ministry of Health which he was from, but their policy as medical personnel was that confidentiality was supposed to be maintained, and if he breached it could be sued and have his licence cancelled. But personally he felt he had a duty to disclose as the other partner had the right to

[7] Waterfalls, Harare 06/01/16.

know. There was never going to be a balance between the two rights, and he concluded by saying that the right to know held more power.

It was the view of many respondents and scholars that the right to confidentiality could not be absolute.

> 'Legally the doctrine of confidentiality is founded on the law of contract and equity - the duty of confidence is certainly not absolute. In fact that some qualification exists has long been recognised.'

This is a correct proposition and in the case of *Attorney General v Foster* (1963) 2 QB 477, the judge noted that 'while confidence is very important, we must recognise that it must be modified to meet the inevitable changes that occur in the necessities of various generations..' He also said that important principles lie at the heart of the right to know of the person informed and the degree of public risk.

One might want to argue that there is no greater right to know than that of a sexual partner. Getting to know obviously means the difference between life and death. Another scholar notes that 'the benefits and costs of keeping strict confidentiality need weighing against each other, taking into account the needs of individual clients or other sexual partners' (Jackson, 2002). I would conclude by saying that the costs of maintaining confidentiality outweigh the benefit of disclosing to sexual partners.

Sibanda (2002), a Zinatha National Aids Co-ordinator once said:

> 'If you do not inform the families that a patient has HIV, you are taking away the family's authority and making it impossible for them to be fully involved. It puts all the responsibilities on the patient, which is not how this disease is handled.'[8]

This statement, according to my research, was very correct, and many of my respondents were of the same view. Therefore, one really needs to disclose their status to their partners and men should disclose so that they avoid criminal charges as well as infecting their partners.

[8] Makoni, 2004 (unpublished).

5.5 The right to know and attitudes towards sexuality

As I went through my research, I found out that as much as the women feel they have the right to know about their partners' status, they find it difficult to negotiate safe sex because of attitudes towards sexuality. Most women were raised to believe that if one talks about sex freely they are of loose morals.

One woman had this to say:

> 'I cannot ask my husband to wear a condom and I cannot wear a female condom without having to ask him first. If he says no, then his word is the law and I have to do what he wants or else that will be the end to my marital life and I cannot afford to be a single parent simply because of a condom. If he does not want it, who am I to insist?'

From this, I could simply tell that even if she knew her husband was having extra marital affairs, she could not negotiate safe sex. It is all about what the husband wanted. Another lady said she had a white wedding and at her bridal shower she was strongly warned against denying her husband conjugal rights as it would lead to the breakdown of their marriage and would force him to look for sex outside the marriage. I concluded that they could easily get infected because that is what they were told as they were about to get married, that it is her duty to give him sex and his right to have sex whenever he wanted it, on his terms and conditions.

Religion also is a factor to blame when it comes to women failing to negotiate safe sex. As I went through the interviews, most of the women were Christians and they said the Bible did not allow them to deny their husbands sex. One even quoted Hebrews 13 v 4 which says 'marriage should be held in honour among all…' and according to her, if it was to be held in honour, neither spouse was to deprive the other, and went on to say that 1 Corinthians 7 v 5 was clear that they were not supposed to refuse each other sex, except by agreement for a time, so that they would devote themselves to prayer, but besides that, the Bible was clear that no one should deny the other.

One man even had this to say, basing what he said on the Bible:

> 'As a loving hind and a graceful doe, Let her breasts satisfy you at all times. Be exhilarated always with her love.' Proverbs 5 v 19.'

He said the Bible was clear that her breast was to satisfy him…:

> '…at all times, *saka mukadzi anondinyima bonde anondinyimirei?After all pandakamuroora ndakamuroorera bonde, ndiro raakabvira kumusha kwavo, hapana chekutaura apa.Musi wandinoroora ndinokumbira sadza and kubvuma kwake kunoreva kuti abvua kundipa bonde pandadire.* No two ways about it.' (He laughed)
> (Meaning: 'At all times she must give me sex since that is the reason why I married her. After all when I prayed her bride price I married her for the sex, that is the reason why she left her parents' home, there is nothing to negotiate. When I married her, her acceptance meant she was accepting to give me sex each time I wanted, no two ways about it.')[9]

5.6 Conclusion

From the above, I would safely conclude that the women have the right to know, but because of religion and the way they are brought up, they could not negotiate safe sex and even the men themselves could not fathom why their wives denied them sex. Even those who did not go to church or were not Christians would often refer to the Bible when it came to sexual matters.

[9] Mbare Magistrates Court, 13/01/16.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

Having had the above discussion and findings, the author came to the following conclusion and recommendations:

6.1 Conclusion

1. Attitudes towards sexuality make it difficult for women to talk about HIV/AIDS.

2. Women often find it difficult to negotiate safe sex and thereby become infected.

3. Also, prosecutors find it difficult to prove beyond a reasonable doubt that a complainant has been wilfully infected with the virus by an accused.

4. Prosecutors find it difficult to prove that a complainant has been wilfully infected with the virus by an accused as doctors are not allowed to disclose a patient's HIV status since it is considered to be privileged information. Magistrates therefore find it difficult to convict people of wilful transmission as the state would have failed to prove its case beyond a reasonable doubt.

5. There is a need to develop gender sensitive strategies to prevent new infections, and these will be discussed in detail below.

6. Instead of criminalising wilful transmission of HIV, Zimbabwe should follow other jurisdictions like that of Kenya which has different methods of dealing with the same problem. These include choosing to focus on more effective methods of deterring the spread of the virus by knowing partners, like creating education programs that are culturally sensitive and timely. 'It is likely that the focus on educating the constituents will be a more effective means of preventing the spread of HIV' (Bellany, 2004). It is very difficult for the state to prove that an accused has intentionally infected a complainant with the virus, as well as the fact that it was the accused person and no one else whose virus is in the complainant's body. As was noted from evidence of one of my interviewees, the virus takes more than 100 different shapes and forms which

means that one cannot prove which virus from one person actually infected another person. The virus is intelligent and can change its shape depending on the recipient's immune system and therefore there is no way of knowing if the virus that infected Y is the very same virus that they received from X.

7. Also, one scholar notes that 'criminalising transmission will not open the floodgates for greater disclosure. What is needed to stem the spread of the epidemic is more understanding of, and action towards social justice and the protection of the rights of individuals affected, with women at the forefront' (O'Grady, 2011). I therefore conclude by saying that criminalisation on its own will not make much difference, but together with the recommendations below, women will be better protected from infections in Zimbabwe.

8. Based on this research, I conclude in summary that when it comes to the protection of women against wilful transmission of HIV, there is no evidence that on their own criminal laws specific to HIV transmission will make any significant impact on the protection of women against infections. Priority must therefore be given to increasing access to comprehensive and evidence-informed prevention methods in the fight against the disease, and more importantly empowering women (especially married women) so that they are able to negotiate safe sex and freely talk about it. Criminalisation victimises, oppresses and endangers women much more than protecting them as it leads to the breaking-up of marriages. I noted that very few cases led to convictions, and after an acquittal, the man would not want to return to and stay with someone who had caused his arrest!

6.2 Recommendations

'We must make sure that girls – who run a particular risk of infection–, have all the skills, the services and the self confidence to protect themselves. Across all levels of society, we need to see a deep social resolution that transforms relationships between women and men, so that women will be able to take greater control of their lives – financially as well as physically. And we must encourage men to replace risk taking behaviour with taking responsibility'

Kofi Annan, United Nations Secretary General.

Being guided by such wise words, and from the above conclusions I came up with the following recommendations:

1. Besides criminalising their irresponsible conduct, people should be educated about sex and HIV. Sex education should be introduced in schools and work places because just after school young people enter the work place and a life style of greater freedom where they are more prone to being infected with the virus. We see many beautiful but vulnerable young ladies who have sex with men in exchange for favours or the promise of favours such as employment, money and cars. These men know their HIV positive status yet choose not to disclose it.

2. In the rural areas, people should be taught against such cultural beliefs that having sexual intercourse with a virgin will cure a person of HIV. Women also should be taught that there is nothing wrong in talking about sex and in negotiating safe sex. A woman does not become immoral simply because she talks freely about sex and HIV. The National Aids Policy notes that unprotected sex within marriage poses the highest risk factor for any woman. This is because most (but not all) men do not feel it is right to use condoms with their wives although they might prefer using them with other women. Husbands and wives should be taught that there is nothing wrong with their using condoms.

3. Also, prosecutions in Zimbabwe are conducted in public courts which expose parties to the outside world and the press. However, no one wants their status to be known because of the stigma that still continues to surround HIV in Zimbabwe. Therefore, trials should be held *in camera* (in private), so that the women who testify against their partners are not traumatised. While prosecutions should not be prohibited, used on their own they will never protect women against infections. Basically, the justice system should put in place support systems for these trials to be held *in camera* to safeguard the confidentiality of those involved. The press should not be allowed to publicise such stories, as it is doing more harm than good to the victims, who are mostly women.

4. I am also of the view that, as a strong recommendation, laying the burden of responsibility solely on those who know they have HIV may deter some people from

getting tested to avoid prosecution, therefore both partners should be responsible for their own health and, as mentioned above, women should be taught that there is nothing wrong in negotiating for safe sex. They also should not encourage men to wear condoms, they themselves should be prepared to wear condoms, as most men, as seen from the above discussion, do not disclose their status, thereby exposing their partners to the virus or even worse transmitting it to them.

5. Still on condom use, I noted that they are mostly controlled by men, who are reluctant to use them. I also noted that female condoms offer protection to some women but still there will be need to negotiate with the partner before using it, therefore I recommend that the government needs to come up with fully woman-controlled protective methods.

6. I would also recommend that the laws be reformed to make prosecutions easier, especially regarding confidentiality and the right to know. Doctors should be allowed to testify upon being called to do so by a court of law so that the state can prove beyond a reasonable doubt that an accused person actually knew of his positive status but chose not to disclose it. Doctors should not disclose the confidential details of their patients simply for the sake of disclosing it, but only to those who have the right to know, like the court and the partner of recalcitrant patients, who insist that they will not disclose their HIV positive status to their partners. However, this might be a bit difficult, as all their partners might not be known.

7. The empowerment of women is one of my strongest recommendations. Women need to be educated and given information about their bodies and sex, skills training in communication about sex, especially in marriages, and taught how to use a condom, as well as how to foster inter-partner communication. Their decision-making in the household should also be improved, as well as at the community and national level, thereby increasing their leadership and participation potential. They need to be given a voice, opportunities to create group identities outside of their families since, for a great many of them, it is the family that often enforces strict adherence to traditional gender norms which can harm women. They need to be taught that there is nothing wrong in getting their partners arrested for wilful transmission of HIV, whatever the outcome, and to be self-sustaining, so that they do not withdraw the charges simply

because they feel that no one will be able to take care of them once their partner is arrested.

8. As some women are driven by poverty and a desire for a better life, 'they find themselves having sex in exchange for goods, services, money, transportation, accommodation or other basic necessities' which is what most Zimbabwean women call 'food for work' (UNICEF, 2003). Research shows that in such situations, they are even less likely to be able to negotiate for safe sex and protect themselves against HIV infections (Preston-Whyte *et al.*, 2000). The immediate need to pay school fees that are due, or to put food on the table often outweigh the risk of illness and death at some indeterminable future time. I therefore strongly recommend that women and girls be taught that whatever the situation they are faced with, they should be in control and insist on protection, or even make use themselves of female condoms. This is especially important because men may agree to give their partners whatever they want just to get them to agree to have sex with them, but still choose not to reveal their own HIV positive status to them. This situation means that their partners will be exposed to the virus, or worse still, have it transmitted to them. Such women should therefore be economically empowered, for example by providing them with access to credit and business, entrepreneurship and marketing skills, to help increase their self confidence and self esteem.

9. I also recommend that the government collapse the bridge of infection between younger women and girls with older men. I noted during the course of my research that so many women have sex with men who are more than six years older than they are and who are more likely to be infected with the virus than younger men of their age. Such relationships with older men lead to unequal power relations within the couples, thereby leaving the women vulnerable to abuse and exploitation by the older men, and the risk of transmission becomes high. This bridge has to be collapsed if we are to see a change in cases of wilful transmission of HIV.

10.. The culture of silence also needs to be killed in our societies. The word 'taboo' is more often than not associated with sex and sex talk among women. Usually parents, elders and teachers are too embarrassed to talk about sex to children as they strongly believe that it will encourage them to become sexually active. This leads to very

limited knowledge among young women and girls when it comes to HIV, and they are the most vulnerable group. Many women are in the dark when it comes to sex, sexuality and their bodies, such that when they eventually start to engage, they do not have enough knowledge about HIV. Young girls should be taught early about HIV and break this culture of silence. I strongly recommend that even health workers impart knowledge about HIV to young women and girls in non-judgemental ways since they are trained to discuss and give good, helpful advice about such sensitive private and social issues.

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