IS MARRIAGE A HAVEN OR A RISK FOR WOMEN IN ZIMBABWE IN THE ERA OF HIV/AIDS: INTERROGATING WOMEN'S REPRODUCTIVE RIGHTS IN MARRIAGE

By

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Abstract

The study sought to establish the extent to which civil and registered customary marriages in Zimbabwe protect married women from or expose them to the risk of HIV/AIDS infection. It interrogates the susceptibility of married women to socio-cultural practices and factors that violate their sexual and reproductive rights and thereby rob them of their sexual autonomy. A sample of 160 male and female respondents aged between 20 and 60 years of age were selected to participate in this study and they were drawn from the Central Business District of Harare, Zimbabwe's capital, and from Dzivarasekwa, one of its high density suburbs. Individual interviews and focus discussion groups were conducted to measure the extent and depth of the problem of the predisposition of married women to infection. Key informant interviews were also carried out to assess the nature of the problem confronting married women and to try to find solutions to remedy such violations. This study uses a combination of mainly qualitative and some quantitative methods of data collection. Using a number of gender-focused methodologies, especially the Women's Law Approach, the writer collected and scrutinized an extensive range of data which disclosed that while marriage was to some extent an important factor in curbing the spread of HIV/AIDS, it was also a risk factor. It revealed that power dynamics, gender roles and cultural practices have taken away married women's capacity to realise and enjoy their sexual and reproductive rights. It was established that whereas married women did not enjoy sexual autonomy, their unmarried counterparts were in a far better position to negotiate safe sex which made them comparatively safer in terms of exposure to HIV/AIDS. In other words, the operation of socio-cultural factors meant that whereas married women find contracting HIV/AIDS from their matrimonial bed almost unavoidable, diligent unmarried women enjoy more freedom to safely exercise their sexual and reproductive rights. The study recommends that since the implementation of the law has been found to be problematic, part of the solution lies in educating married women about their reproductive and sexual rights in an attempt to empower them with the capacity to bargain for safe sex (which they currently lack), thereby enabling them to make choices that reduce their exposure to the risk of HIV/AIDS infection.

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Declaration

I, Bridget Musandirire, certify that this dissertation is my original work; it is an honest and true reflection of my personal effort in carrying out this research. I certify that the work above has not been presented anywhere else before for any thesis.

Signed.....

Date.....

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

Signed.....

Date.....

Supervisor: Professor J. Stewart

Director of the Southern and Eastern African Regional Centre for Women's Law, University of Zimbabwe

Date.....Signed.....

Dedication

I dedicate this work to my loving family, my mother, Ms J. Musandirire, who contributed to what I am today, my daughter, Motrish Ruvarashe, and my sister, Lettie Moira, for supporting me throughout this programme.

I Salute You.

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To the class of 2015/2016 for walking this journey with me till the end. May you be fruitful as you put to work the lessons you learnt in the Women's Law Class.
God Bless You All.

List of abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBD	Central Business District
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
Criminal Code	Criminal Codification and Reform Act, Chapter 9:23
HIV	Human Immunodeficiency Virus
MOHCC	Ministry of Health and Child Care
MOHCW	Ministry of Health and Child Welfare
NAC	National Aids Council
NGO	Non-governmental organisation
SafAIDS	Southern Africa HIV/AIDS Information Dissemination Service
STI	Sexually transmitted disease
WASN	Women and Aids Support Network
ZDHS	Zimbabwe Demographic Health Survey
ZLHR	Zimbabwe Lawyers for Human Rights
ZNNP+	Zimbabwe National Network for People Living with HIV/AIDS

List of human rights instruments

Beijing Declaration and Platform of Action: Women and health

Cedaw Committee General Recommendation Number 19

Cedaw Committee General Recommendation Number 24

Cedaw Committee General Recommendation Number 21

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Protocol to the African Charter on Human And Peoples' Rights on the Rights of Women in Africa

SADC Protocol on Gender and Development

United Nations Human Rights Committee General Comment No 28

United Nations HIV and Human Rights International Guidelines

List of legislation and policies

Zimbabwe

Constitution of Zimbabwe Amendment 20 of 2013

Criminal Codification and Reform Act, Chapter 9:23 (Criminal Code)

Customary Marriages Act, Chapter 5:07

Domestic Violence Act, Chapter 5:16

Marriages Act, Chapter 5:11

National Aids Policy 1999

List of cases

Mudzuru & Another v Ministry of Justice, Legal & Parliamentary Affairs (N.O.) Case No Const Application No 79/14; Media Neutral Citation: [2015] ZWCC 12

State v Pitty Mpofu SC-96-12

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Executive summary

This study sought to tackle the challenges posed by HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) infections in marriage where the violation of reproductive and sexual rights of married women takes place through discrimination and power imbalances. It aimed at establishing the extent to which marriage could protect women against HIV/AIDS infection and the extent to which it could harm them through infection and violation of their sexual autonomy. According to UNAIDS (2006) at least sixty percent of infected people in the Sub-Sahara are women and heterosexual sex is the main method of spreading the infection. The cause of such a rapid rise in HIV prevalence among women is attributed to blatant violations of rights and gender inequality.

Gender inequality is a by-product of the socialisation process that creates gender which assigns the roles and status of men and women culturally. Out of gender, power imbalances are created between men and women and these establish women's unequal access to key resources such as information, education and employment. Yet when decision makers implement HIV programmes the gender determinants are either completely omitted or played down and hardly ever incorporated into the programmes. Therefore, simply put, if issues of inequality and violations of rights are not addressed in marriage then by and large the attempts to halt the epidemic will remain unsuccessful.

Despite the fact that Zimbabwe is one of the countries in Southern Africa with the highest rates of HIV infection and notwithstanding all the available information on the AIDS pandemic, people still seem bent on maintaining the way they conduct themselves in the face of the pandemic. Socio-cultural practices such as *roora*, polygny, promiscuity and dry sex practices are rampant and unsafe sex practices appear to be the order of the day in Harare. Within this context locating a married woman's position is difficult. She finds herself in the vulnerable position of her sexual autonomy being largely overlooked in the face of these socio-cultural practices which reinforce and deepen married women's subordination and inequality, which in turn increases their risk to HIV infection. In other words, the position of a married woman within the reality of the world of HIV/AIDS (embracing its infection, prevention and discrimination against its numerous sufferers) is far from enviable.

So Zimbabwe remains one of the countries that have not found a specific remedy on how to deal with women in relation to the mounting prevalence and brutal force of HIV/AIDS. Despite the acknowledged decrease in HIV/AIDS statistics over the past few years in Zimbabwe, the HIV prevalence rate among women remains unacceptably high in general. The deadly virus makes married women more susceptible due to their social, cultural and economic positioning in society and as a result they bear the brunt of the HIV/AIDS and its effects. As a result of the summarised position above the discussion revolves around these supposed threats to specific fundamental human rights which flow from some of these deep-seated cultural practices that persist in reinforcing married women's subordinate position in society.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Pondering marriage, cultural practices and HIV

'Women's reproductive health and rights cannot be fully appraised without examining women's status in the society they live in. Not only do laws relating to women's legal status reveal societal attitudes that will impinge on reproductive rights, but such laws frequently have a direct impact on women's capability to implement reproductive rights'
(Centre for Reproductive Rights, 2003).

The more I ponder the issue of married women and the exercise of their reproductive rights in the society in which I live, the more the truth of this quotation makes sense. My personal experiences and perceptions are that marriage is the norm in our society and to a very large degree determinative of a woman's status in society. According to the standards of Zimbabwean society, marriage is considered a major achievement for every woman because it is believed that by entering into marriage she accomplishes lifetime sanctuary (Nyoni, 2008). Therefore, it is not surprising that single women often find it difficult to withstand family and social pressure to marry. I hold nothing against marriage as an institution and as a foundation for establishing the family unit because the idea is dignified and women also derive many benefits from it. One of its advantages is that given the right circumstances and conditions in which to exercise sexual and reproductive health, the institution of marriage is capable of offering a haven for women which protects them from deadly diseases such as HIV/AIDS.

However, reflecting further on the abovementioned quotation, I am also of the view that while society is so busy painting a rosy picture of marriage it is often guilty of forgetting to sound important warnings against the possible risks of HIV/AIDS infection that may attach to the institution. Therefore, while commending marriage, we must not turn a blind eye to and fail to sound the alarm about the dangers which befall married women when that institution is abused or violated, thereby robbing them of the promised sanctuary it is believed to offer. As I started this research journey I inspected the HIV/AIDS statistics for women and men in Harare and as will be shown in my research background, women have always suffered and continue to suffer from the disease more than their male counterparts.

Taking a look at the group of women who are 18 years and over, infected yet married, made me realise that being married and faithful does not necessarily protect them from being infected with HIV/AIDS. The question that continued to play on my mind was, 'If marriage is meant to be a haven for women (as presumed by society), why is it that married women are dying from HIV/AIDS related diseases at all?' Taking a step back and reflecting on past events in my life reminded me that I had witnessed numerous deaths of married friends and relatives who were mostly women and the causes of their deaths were usually linked to HIV/AIDS diseases although this was only known to close relatives. So after tossing the question about in my mind I decided to take it upon myself to investigate and find out the truth about whether, in this era of HIV/AIDS in Zimbabwe, marriage is a heaven or a hell for married women and what factors make it one or the other. At the end of my research journey the answer laid itself right in front of me as I realised that apart from infidelity which may occur within in a marriage, there are also certain cultural practices attached to the institution of marriage, such as *roora* (the paying of bride price), polygny and dry sex practices that compromise women's reproductive and sexual rights and expose them to the risk of HIV/AIDS infection.

1.2 Background to the research

Zimbabwe identified its first case of HIV in 1985 and since then we have been plagued by the virus at an alarming rate as it has wreaked pain, havoc and death on the nation's entire population (MOHCW, 1999). According to the literature, it is clear that the disease has a gendered aspect resulting in women suffering the most (Nyoni, 2008). The Situational Analysis of December 2014 drafted by National Aids Council (NAC) shows that about 1.3 million Zimbabweans are living with HIV (ZNHAES, 2014). The NAC statistics show that the total HIV population for the Harare region is currently sitting at 40% for men and 60% for women, while the total number of new infections is 43.7% for men and 56.3% for women (ZNHAES, 2014). These statistics reveal the heightened vulnerability of women in Harare and to make matters worse, according to the 2010-11 Zimbabwe Demographic Health Survey, the prevalence of HIV in Harare is 17% among women as compared with 9% among men (ZDHS, 2010-2011).

It is against this background and the alarming statistics for women that as a student studying for my Masters in Women's Law, I decided to investigate their deeper implications for

married women whose position makes them even more vulnerable (than women in general) by virtue of the inferior status society imposes upon them both within their private married and family lives and their lives within the public arena.

1.3 Problem statement

Marriage in Zimbabwe is highly regarded and every woman is expected to marry. Marriage, however, may also be the source of serious health problems as it may expose women to cultural practices such as *roora*, polygny, promiscuity and dry sex practices which weaken their protection against HIV/AIDS infection. The impact of the HIV/AIDS epidemic is felt most keenly by individuals who are especially vulnerable to HIV infection and married women are no exception as they constitute one of the groups at risk of infection. This is largely due to the fact that by its very character, *Shona* and African society do not permit women to control their sexuality or their reproductive rights. Basically, women's incapacity to defend their sexual autonomy flows from their lack of power to negotiate for safe sex thereby violating their reproductive and sexual rights. Culturally, women's bodies are believed to be owned, controlled and inhabited by men, hence it is the power imbalance or inequality manifesting itself in the behavioural dynamics between the sexes that lies at the very heart of women's vulnerability to HIV infection. So, for example, cultural expectations of female timidity and male dominance merge to prevent women from confidently making choices and decisions about their lives which are calculated to minimise risks to their own health and well being as well as to that of their own partners and family.

1.4 Study objectives

- To scrutinize the relationship between laws, policies and cultural practices relating to marriage that predisposes women to HIV/AIDS infection (Chirawu, 2006).

- To show that marriage and its related cultural practices are playing a considerable part in exposing women to the risk of HIV/AIDS and in the process violating a number of their human rights.

- To show that women in reality do not have sexual autonomy despite their having been granted it by national and international laws.

- To show that unless the power imbalances created by our male-dominated society and certain of its cultural issues are addressed we will not achieve the desired outcome of reducing HIV/AIDS infection.

- To show that HIV/AIDS prevention or reduction will not be achieved unless harmful cultural practices are tackled to encourage individual and social behaviour/attitudes to turn away from them and unless appropriate relevant coping strategies against HIV/AIDS prevention or reduction are adopted.

- To also show that the criminalisation of the wilful transmission of HIV/AIDS has not been the best response in the circumstances because its outcomes usually tend to harm rather than protect women.

1.5 Research assumptions

1. No matter what type of marriage women find themselves in they are unable to negotiate safe sex with their husbands despite international human rights instruments and national laws that give them the authority and power to do so.

2. When men pay *roora* they acquire procreative powers that disempower most married women from being able to demand safe sex from their husbands.

3. Women's vulnerability to HIV/AIDS is increased when they fail to negotiate for safe sex with their husbands.

4. Economic need, lack of education, lack of formal employment merged with cultural expectations of female timidity and male authority and dominance jointly prevent women from confidently and actively making choices and decisions about their lives, mainly with a view to reducing risks to sexual health and protecting their health.

5. The incidences predisposing married women to HIV infection are increased by laws, cultural practices and beliefs that govern and surround marriage (Chirawu, 2006).

6. Safe forms of sex are sometimes limited because no open discussion takes place between the sexes and male desires usually dominate and take precedence over female needs.

7. The way in which cultural practices (such as *roora*, polygamy, promiscuity and dry sex practices in marriage) dominates women's lives has the effect of exposing women to HIV/AIDS because women lack the capacity to negotiate safe sex.

8. The subordination of women in marriage is sometimes a result of the payment of *roora*.

9. Where the socialisation process promotes male dominance in sexual matters, married women's ability is restricted when it comes to negotiating safe sex whether *roora* (bride price) has been paid or not.

10. The harmful cultural practices such as *roora*, polygamy, promiscuity and dry sex practices are inconsistent with the Zimbabwe's Constitution and human rights instruments as they violate the reproductive, sexual and marriage rights to which women are entitled.

11. The State's failure to protect against practices such as *roora*, polygamy, promiscuity and dry sex practices that increase the risk of HIV/AIDS violates the right to reproductive and sexual health, in addition to other rights.

12. The criminalisation of HIV/AIDS as a response does not work as it serves to endanger women further.

13. The criminalisation of marital rape exists solely on paper as it is rendered useless in practice as a result of the impact of semi autonomous social fields such as family and religion.

1.6 Research questions

1. Is it the case that no matter what type of marriage women find themselves in they are unable to negotiate safe sex with their husbands despite international human rights instruments and national laws that give them the authority and power to do so?

2. Do perceived notions about the role of *roora* in marriages and in particular the procreative power vested in men disempower most married women from demanding safe sex practices from their husbands?

3. Is it the case that women's vulnerability to HIV/AIDS is increased when they fail to negotiate for safe sex with their husbands?

4. Do economic need, lack of education, lack of formal employment merged with cultural expectations of female timidity and male authority jointly prevent women from confidently and actively making choices and decisions about their lives, predominantly with view to restricting sexual risks and protecting their health?

5. Are the incidences that predispose married women to HIV infection increased by laws, cultural practices and beliefs that govern and surround marriage (Chirawu, 2006)?

6. Do the supremacy of male desires and the refutation of female needs and desires hinder open dialogue between the sexes and reduce people's chances of attaining mutually, respectful and safe forms of sexual behaviour?

7. Does the way in which cultural practices (such as *roora*, polygamy, promiscuity and dry sex practices in marriage) dominate women's lives have the effect of exposing women to HIV/AIDS because women lack the capacity to negotiate safe sex?

8. Is the subordination of women in marriage sometimes a result of the payment of *roora*?

9. Is it the case that where the socialisation process promotes male dominance in sexual matters, married women's ability is restricted when it comes to negotiating safe sex whether *roora* (bride price) has been paid or not?

10. Is it the case that the harmful cultural practices such as *roora*, polygamy, promiscuity and dry sex practices are inconsistent with the Zimbabwe's Constitution and human rights instruments as they violate the reproductive, sexual and marriage rights to which women are entitled?

11. Is it the case that the State's failure to protect against practices such as *roora*, polygamy, promiscuity and dry sex practices that increase the risk of HIV/AIDS violates the right to reproductive and sexual health, in addition to other rights?

12. Is it the case that the criminalisation of HIV/AIDS as a response does not work as it serves to endanger women further?

13. Is it the case that the criminalisation of marital rape exists solely on paper as it is rendered useless in practice as a result of the impact of semi autonomous social fields such as family and religion?

1.7 Demarcation of the study

This research was conducted in Harare Central Business District (CBD) and Dzivarasekwa 2, a high density suburb on the outskirts of Harare. The reasons for my choice of these two sites are that I live in the former and work in the latter, so accessibility was my main consideration and being familiar with both places was an added advantage. In Dzivarasekwa 2, I was in daily touch with the people that I live with and relate to so it was quite easy to approach them and discuss with them all the pertinent and sensitive issues like HIV status as they confided in me and appeared not to withhold any information. However in the CBD I had to be more diplomatic when I approached men and women in the street whom I did not know and had selected randomly because some were hesitant to talk about sensitive issues spontaneously since they also initially suspected that I was a journalist. The non-governmental organisations (NGOs), government departments and ministries were also fairly easy to access. Most of them accommodated me the first time I consulted them and requested an appointment to

obtain the information that I needed. The only exception was the NAC where I had difficulties accessing information but eventually I did manage to receive after some persistence. So not only was I able to plan my research logistics with minimal cost but it was also relatively easy to interact with women and men either while they were relaxing in their homes or while they were working in their businesses either in the informal or formal sector where I encountered a very few minor challenges which were easily overcome.

CHAPTER TWO

2.0 LAW AND LITERATURE REVIEW

2.1 Introduction

This chapter explores the human rights framework that informed this study and makes a comparison between the provisions of the local Zimbabwean and international laws and policies to see whether the former conform to the latter. The aim is to explore how marriage rights and sexual and reproductive rights are accorded to married women but why, despite this, they fail to exercise them.

2.2 Human rights framework

2.2.1 Marriage rights

The international law and national law specifies the fact that marriage has to be entered into with the free and full consent of both parties who are to be equal within the marriage. The equality of parties implies that all decisions are to be made with due consultation of each other since the rights and responsibilities are the same for both parties. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa specify some of these rights (below) and encompassed in these are the rights to make decisions on their sexual and reproductive rights.

These rights will linger in the abstract and remain unrealised for women if not appropriated at domestic level. The State has an obligation to make sure that married women are regarded as equal partners in marriages and enjoy the same rights as men. To achieve this equality, the State has to eliminate cultural practices that discriminate against women and those that promote the superiority of one sex over another. As the discussion in this paper progresses a number of practices such as bride price payment (*roora*), dry sex practices, promiscuity and polygny will show that they have granted men the view that they are entitled to dominate women.

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

Article 5 of CEDAW provides that the States Parties should take measures to modify the social and cultural patterns of conduct of men and women with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women. While the article provides this, the reality on the ground in Zimbabwe is that women fail to attain this right because of their socio-cultural and economic vulnerability. Socio-cultural practices continue to play a major role in the life of married women by subjecting them to culture and customs. These socio-cultural practices militate against women in that they allow men to discriminate against women and in the process women are forced to yield power and authority over to men in marriage.

Article 16 of CEDAW provides that the State Parties shall eliminate discrimination against women in all matters relating to marriage and family relations and shall ensure on the basis of equality of men and women the same right to enter into marriage and the same rights and responsibilities during marriage and at its dissolution. The international human rights instruments define marriage rights which eliminate discrimination and gives equality to both spouses. However, this paper will reflect that such rights exist only on paper because as one investigates the marriage institution in *Shona* society they are bound to realise that ironically the reality is that far from being a small part of the problem the discrimination of women and their inequality are major characteristics of most marriages in Zimbabwe.

2.2.1.2 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

The very same provisions stated above are repeated in articles 2, 5 and 6 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, although in article 6(c) it goes on to specifically state that while monogamy is encouraged as the preferred form of marriage, the rights of women in marriage and family, including those in polygamous marital relationships, are promoted and protected. It is this specific failure of these human rights instruments to prohibit polygny that has resulted in its manifestation and perpetuation in most African and European countries. However, when the realisation later hit home that polygny has undesirable and harmful effects, especially for women, a turnaround was made in soft laws, like recommendations and guidelines, which expressly prohibit

polygny and uphold monogamy as will be seen in the progression of this paper. However, some Zimbabwean men have taken the opportunity to practise polygny which the law allows and the results have proved devastating mostly for women.

Zimbabwe has clear obligations under both human rights instruments to achieve the desired outcomes having signed and ratified both documents. In pursuance of Zimbabwe's obligations to CEDAW, the Committee on the Elimination of All Forms of Discrimination reviewed the country's progress in February 2012 and in its concluding observations, raised issues pertaining to marriages in Zimbabwe. The Committee's observation was that the persistent discrimination against women by customary laws and practices (such as *roora* and polygamy) was caused by the continued existence of a variety of marriage laws which granted different rights to men and women (Cedaw Committee, 2012).

The CEDAW Committee recommended the immediate amendment by the state of all laws and regulations discriminating against women in matters relating to the family, marriage and divorce (Cedaw Committee, 2012). The Committee's General Recommendation 21 was also used to encourage the state to prohibit polygamy as the document noted its negative impact on women and children. In agreement with the Cedaw Committee's stance to abolish practices associated with customary and religious marriages like polygyny, the UN Human Rights Committee stated that:

> 'Equality of treatment with regard to the right to marry implies that polygamy is incompatible with this principle. Polygamy violates the dignity of women. It is an inadmissible discrimination against women. Consequently it should be abolished wherever it continues to exist' (United Nations Human Rights Committee General Comment No 28).

In its concluding observations, the Cedaw Committee also expressed its concern at the high prevalence of violence against women in the country and in particular domestic and sexual violence which in many cases went unreported despite the existence of the Domestic Violence Act, 2006 (Cedaw Committee, 2012). As a result they recommended that Zimbabwe take adequate and full practical steps to prevent and address violence against women and girls, including prosecution, considering that such violence is a form of discrimination against women and a violation of their human rights under Cedaw (Committee's General Recommendation No 19).

However five years have passed since then and we as a nation still find ourselves tormented by the very same issues that the Cedaw Committee raised as pertinent and in need of quick amending. The Cedaw Committee rightly pointed out that polygny and *roora* are being upheld and perpetuated by the State's preservation of a combination of civil and customary marital regimes and by the adoption of legislation such as the Customary Marriages Act 5:07. The continued existence of these practices has continued to pose problems for married women, as will be further discussed in this research.

2.2.2 Reproductive and sexual rights

2.2.2.1 CEDAW

In 1998 and in response to the country's report, the Cedaw Committee recognised the fact of the HIV/AIDS pandemic and that a very high rate of infection was found among young women who comprised 84% of those infected in the age group of 15-19 years and 55% of the 20-29 year age group (Cedaw Committee, 1998). The Committee was also not pleased with the situation given the risks of transmission to infants through childbirth and breastfeeding (Cedaw Committee, 1998). The Committee therefore urged the government to increase its efforts to combat the HIV/AIDS pandemic and to ensure that appropriate sexual and reproductive health information, education and services be provided to all women and, in particular, to adolescents (Cedaw Committee, 1998). Despite this recommendation having been made over ten years ago, the problem still persists today and one begins to wonder whether it is only the State that has failed to increase its efforts to combat the HIV/AIDS pandemic or the fact that something else has hindered their efforts and that perhaps people's behaviour and attitudes are also partly to blame.

Since the 1998 problem was far from being solved, the Cedaw Committee once again referred to it in its 2012 report when they expressed their concern over the fact that HIV/AIDS continued to be a health challenge in Zimbabwe despite reports of a major reduction in infection rates (Cedaw Committee, 2012). The Committee recommended that all measures necessary be taken to improve women's access to health care and health–related services within the framework of the Committee's general Recommendation No 24 and to promote widely education on sexual and reproductive health and the control of sexually transmitted diseases (STIs), including HIV/AIDS (Cedaw Committee, 2012).

2.2.2.2 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (AU, 2003)

Article 14(1) of the above Protocol states that State Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes (a) the right to control their fertility, (b) the right to decide whether to have children, the number of children and the spacing of children, (c) the right to choose any method of contraception, (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS, (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices.

This article realises the particular vulnerability of women to infection by their sexual partners and rightly so because in Zimbabwe married women lack the capacity to negotiate for condom usage in attainment of safe sex. As a result their right to dignity and self protection is violated, their right to use the contraceptive of their choice such as condoms is violated and so are the rest of their rights in this article pertaining to fertility and deciding whether to have children or not. In Zimbabwe one does know their partner's status unless they decide to divulge it voluntarily because the source of their knowledge is contained in a private and confidential medical report to which the law does not compel third party access. This probably means that most of the time partners have sexual relations with each other ignorant of each other's health status.

2.2.2.3 SADC Protocol on Gender and Development

Article 27 of the SADC Protocol on Gender and Development states that State Parties shall ensure that the policies and programmes referred to in sub-article 1 take account of the unequal status of women as well as harmful cultural practices and those biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS and by 2015 to have developed gender sensitive strategies to prevent new infections. This article acknowledges the unequal status of women which is the reality on the ground for married women in Zimbabwe and goes on to show the same harmful cultural practices that fuel the spread of HIV/AIDS infection which are widespread in *Shona* society.

2.2.2.4 Beijing Declaration and Platform of Action: Women and Health

Section 96 of the Beijing Declaration and Platform of Action: Women and Health provides that the rights of women include their right to have control and decide freely and responsibly on matters relating to their sexuality including sexual and reproductive health. Section 98 states how HIV/AIDS transmission through sex has a devastating effect on women's health as they normally have no power to insist on safe and responsible practices as a result of the social vulnerability caused by the unequal power relationship between men and women in society. The Beijing document brings to the fore and addresses the reality in Zimbabwe and manages to show a true reflection of the disastrous effects of HIV on women, especially married women, who have little or no negotiating power to protect themselves from harmful cultural practices.

2.2.2.5 United Nations HIV and Human Rights International Guidelines

Guideline 8 of the United Nations HIV and Human Rights International Guidelines provides that States should in collaboration with and through the community promote a supportive and enabling environment for women and children by addressing underlying prejudices and inequalities through community dialogue. States should support the establishment of national and local forums to examine the impact of the HIV/AIDS epidemic on women and examine issues such as (a) the sexual and reproductive rights of women and men including the inability to negotiate for safe sex, (b) strategies for increasing educational and economic opportunities for women, (c) the impact of religious and cultural traditions on women. Religion is not exempted as a factor that puts women at the risk of HIV/AIDS infection as almost all church doctrines preach the submission of women to men and other so-called churches like the Johanne Marange sect which has chosen polygny as a lifestyle for themselves (Machingura, 2011).

2.3 National framework

The elimination of discrimination is not accomplished by the enactment of laws alone. This is witnessed by the fact that Zimbabwe has a dual legal system which means that both general law and customary law are recognised as valid systems of law. Yet the existence of both laws existing side by side causes a lot of tension and conflict because the choice of law sometimes acts to the detriment of women, especially when customary law is chosen which is already biased towards men. Generally, a customary marriage is subject to customs and cultural

practices which discriminate more against women; in a civil marriage women tend to enjoy a more privileged position.

2.3.1 Constitution of Zimbabwe, Amendment No 20 of 2013

Section 26 of the Zimbabwe Constitution on the issue of marriage provides that the State must take all appropriate measures to ensure that (a) that no marriage shall take place without the free and full consent of the intending spouses, (c) there is equality of rights and obligations of spouses during marriage and at its dissolution. Section 78 also goes hand in hand with section 26 as it establishes the founding of a family for anyone who is 18 years and above. While the equality of the sexes undoubtedly exists on paper, the implementation of these provisions reveals the gaps between the written law and its reality on the ground when the glaring inequalities between men and women in marriage becomes too glaring to simply brush aside.

In section 52 the right to personal security is granted where every person has the right to bodily and psychological integrity, which includes the right to (a) freedom from all forms of violence from public and private sources and (b) subject to any other provisions of this Constitution, to make decisions concerning reproduction. Once again the law is captured on paper but no policing takes place in the bedroom of the home which a husband presumes to be his castle and where he takes from his wife the authority and power given to her by the Constitution to make informed decisions about her reproductive and sexual rights and well being.

In section 56 all persons are regarded as equal before the law and have the right to equal protection and benefit of the law without being unfairly discriminated against on the grounds of custom, culture, sex, gender and marital status. But the question must still be asked, 'In reality are all persons truly treated equally, especially men vis-à-vis women?'

In section 63 every person has the right to participate in the cultural life of their choice but no person exercising these rights may do so in a way that is inconsistent with the other provisions contained in the same chapter. So the legislation continues to uphold *roora* and polygny cultural practices in marriage but these practices are largely a downright violation of women's rights.

In section 76 every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services. However the state must take reasonable legislative and other measures, within the limits of its resources available to it, to achieve the progressive realisation of this right.

In section 80 on the rights of women it is stated that all laws, customs, traditions and cultural practices that infringe rights of women conferred by this Constitution are void to the extent of that infringement. Yes, the provisions of the Constitution conform with international standards but the practices of polygny, *roora* and dry sex must be put under close scrutiny so that the State may entertain no doubt as to its urgent need to eliminate all three of these harmful and unacceptable practices.

2.3.2 Marriage legislation

Two types of marriages are recognised by the law as will be discussed below and the rights and duties granted by each relationship differ with each type of marriage. Customary marriages are governed by customary law and civil marriages are governed by general law. Due to the gender neutrality of our marriage laws there is no spousal power over each other. Nevertheless, the prerogative to choose the type of marriage one wants to enter into mainly lies with the husband. As a result the reward of being in one type of marriage as compared to another is enjoyed by the husband, whereas the negative consequences mainly affect the wife (Dube, 2013). Furthermore, it should be pointed out that ironically the unregistered customary union which is not recognised as a marriage by law but by society is the most common form of 'marriage' in Zimbabwe and ZWLA estimates it as high as 70% (ZWLA, 2000). As soon as payment of *roora* is made the 'marriage' is 'validated' and recognised by the concerned families and a family is founded.

2.3.2.1 Marriages Act, Chapter 5:11

Although *roora* is recognised as a legal requirement for this marriage in terms of section 12 of the Customary Marriages Act 5:07, this section has largely fallen into disuse. The monogamous nature of a marriage under the Marriages Act, Chapter 5:11 means that a person is only entitled to be married to one spouse as long as the marriage subsists. The crime of bigamy is captured as follows in the Criminal Codification and Reform Act, Chapter 9:23 (Criminal Code) in section 104:

'(1) Any person who, being a party to

(a) a monogamous marriage and, knowing that the marriage still subsists, intentionally purports to enter into another marriage, whether monogamous or polygamous, with a person other than his or her spouse by the first-mentioned marriage; shall be guilty of bigamy and liable, if convicted in terms of…

(i) paragraph (a), to a fine not exceeding level six or imprisonment for a period not exceeding one year or both;

(ii) paragraph (b) or (c), to a fine not exceeding level five.'

2.3.2.2 Customary Marriages Act, Chapter 5:07

Under the Customary Marriages Act, Chapter 5:07 only the registered customary marriage (as opposed to the unregistered customary law union, above) is recognised legally and it is potentially polygamous. The registered customary marriage known as *muchato wekwamudzviti* means, in the *Shona* vernacular, that the man is authorized to marry more than one wife with no requirement to notify his wife or request her consent to marry (Dube, 2013). Section 12 requires proof of the *roora* payment for registering the marriage. The polygnous nature of this marriage stands in contrast to the human rights principles of equality and non-discrimination. The *roora* issue also poses the same challenges as polygny.

2.3.3 HIV and AIDS legislation and policies

2.3.3.1 The Criminal Code

Zimbabwe enacted section 79 of the Criminal Law (Codification and Reform) Act, Chapter 9:23 (Criminal Code) which states that:

'(1) Any person who

(a) knowing that he or she is infected with HIV; or

(b) 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.

(2) It shall be a defence to a charge under subsection (1) for the accused to prove that the other person concerned—

(a) knew that the accused was infected with HIV; and

(b) consented to the act in question, appreciating the nature of HIV and the possibility of becoming infected with it.'

Before section 79 (above) was incorporated into the Criminal Code it was section 15 of the now repealed Sexual Offences Act, Chapter 9:21 which had been enacted to deal with HIV/AIDS. The section came into being as a result of the realisation that women were vulnerable to HIV/AIDS and the prohibition of the wilful transmission of HIV/AIDS and marital rape were made law in order to try and protect women. However, the law makers did not see foresee that in trying to protect women by section 79 of the Criminal Code they would in fact be endangering them further. This is because women only usually discover their HIV/AIDS status after they have sought medical attention. So feeling ill and not being aware of their positive status, women seek medical attention. Then those who discover that they are HIV positive cruelly end up likely to being prosecuted as being transmitters of the disease simply by virtue of having been infected themselves and having discovered their positive status. In the same manner section 68 of the Criminal Code (below) is also meant to protect women yet they rarely use this section because of the effect of the situational factors which impact upon their lives.

Section 68 of the Criminal Code provides for marital rape and it states that:

'It shall not be a defence to a charge of rape, aggravated indecent assault or indecent assault

(a) that the female person was the spouse of the accused person at the time of any sexual intercourse or other acts that forms the subject of the charge:

Provided that no prosecution shall be instituted against any husband for raping or indecently assaulting his wife in contravention of section sixty-six or sixty-seven unless the Attorney-General has authorised such a prosecution.'

2.3.3.2 National AIDS Policy 1999

This policy was brought into place as a response and guide to the past, present and future after the hard hitting HIV/AIDS epidemic had ravaged Zimbabwe. In its attempt to provide guidelines on how to deal with HIV/AIDS, the policy, as will be shown below, fails to adequately provide practical solutions to married women which they can put into effect in trying to protect themselves against HIV/AIDS.

In the preamble to Guiding Principle 4, the policy acknowledges that gender inequality and certain negative cultural norms and practices are among the factors that appear to fuel the spread of HIV/AIDS and disturb the marital regime and it suggests a strategy be set up to advocate for the promotion and sustainability of marital integrity. Yet the policy does not offer concrete solutions on how to maintain that marital integrity.

Guiding Principle 9 recognises the need for all sexually active persons to have access to condoms but the cultural constraints on women's access to the use of condoms are not acknowledged. The proposed strategies do not include the strategic need for women to be liberated from cultural constraints or the need to educate communities so that they adopt new social norms like the use of female condoms and women's initiation of safe sex.

While Guiding Principle 23 encourages the partners to share information about their HIV status, it has no legal effect because the legislative provisions in the form of the Health Act do not provide for the issue of partner notification. In other words, this guiding principle can only be effective if the necessary legislative framework for mandatory disclosure is enacted.

Guiding Principle 38 has correctly recognised and condemned the increase in widespread gender based violence in marriage in Zimbabwe and encouraged its prohibition through the use of laws such as the Domestic Violence Act or the Criminal Code. Despite this, however, this and other research observes that gender based violence in marriage continues to rise. The Guideline's proposed strategies include providing married women with temporary shelters to protect them from their husbands. But married women who are dependent on their husbands are in need of more permanent solutions including capital to start income generating activities so they can become independent and self-sufficient.

Guiding Principle 36 provides that men and women need to understand and respect their own and each others' sexuality as this gives them both an opportunity to discuss openly and share their sexual experiences and knowledge and the advantages of adopting and negotiating risk-reducing options. It also advocates for the education of women and men about the risks relating to certain practices that may facilitate the transmission of HIV, e.g., the adverse physical effects of using herbs and chemicals which some women insert into their genital area. While the section is quite progressive, the reality on the ground is that the sexual rights of women are not being realised because women use dry sex methods to protect their marriages and in the absence of better options, they will continue to use such methods even when their health is threatened. Further, society regards women's ignorance of sexual matters and reproduction as a sign of their purity; yet the regarding of ignorance as innocence may prevent women from seeking information that is vital to their well-being.

2.4 Literature review

The literature review helped me to reach a deeper understanding on the topic of marriage and HIV/AIDS from various angles and different countries. It enabled me to understand how women in general worldwide are facing challenges in exercising their reproductive rights in marriage because States generally attach less significance to them than other rights.

I strongly subscribe to the opinions of Johns in her article which acknowledge the lack of attention given to the realisation of women's reproductive rights by virtue of the societal view of their roles as wives and mothers (Johns, 1998). The author noted that even though acquiring full and free exercise of reproductive rights ranks low politically, its social importance cannot be ignored as the current status of reproductive health among women and the results of its failure are having very serious consequences all over the world (Johns, 1998). She points out that there is a stark contrast between the construction and the realisation of the rights of women when she compares the reproductive rights of women in United States law and those in relevant international instruments (Johns, 1998).

She notes that while international law requires that reproductive rights be shared equally between men and women, the reality of the impact of the power imbalance between the sexes means that women are unable to exercise their rights (Johns, 1998). She also draws attention to the fact that while reproductive rights are constructed and articulated quite differently

under international and United States law, the outcome is the same under either law - women are still unable to enjoy or exercise their reproductive rights (Johns, 1998). John's sentiments also accurately describe the dilemma faced by married women in Zimbabwe trying to exercise their sexual autonomy.

Chireshe's article, 'Monogamous marriage in Zimbabwe: An insurance against HIV/AIDS' increased my understanding of the deeper context of the challenges faced by married women in Zimbabwe in their fight against HIV/AIDS (Chireshe, 2011). The author's choice to focus monogamous marriage was due to the already existing assumption that those in polygnous unions were already at a greater risk of contracting HIV/AIDS than their counterparts in monogamous marriages (Kelly, 2006). Chireshe researched the relationship of marriage since heterosexual sex is the most common way of HIV transmission accounting for 88-98% of all infections (Moyo, 2005). In his paper Chireshe concluded that monogamous marriages were perceived as having the possibility to protect the couples against HIV and AIDS (Chireshe, 2011). He however qualified that conclusion by revealing that whereas it was men who regarded the monogamous marriage as a protective institution in relation to HIV and AIDS because they physically and socially prevail in such marriages, women entertained serious doubts about that protection because of their husbands' domination over them and their lack of capacity to negotiate for safe sexual conditions (Chireshe, 2011; Chitando, 2004).

The author's view that monogamy had the possibility of being a haven emanated from his arguments that monogamy made sure that couples were sexually gratified which deters them from having extramarital affairs and that the fear of HIV/AIDS infection deters couples from infidelity (Chireshe, 2011). The author however quickly pointed to that kind of security being given by marriage only if both partners are HIV negative upon marriage and if both continue to be faithful to each other till death (Chireshe, 2011). The author also cautioned that a monogamous marriage could be a risk factor and pose a danger to its partners where they were unfaithful or where one partner had entered the marriage already infected and then infected their spouse (Chireshe, 2011).

The author acknowledged women's vulnerability to the virus as emanating partly from the unequal power relationship between men and women and the domination of men which is sometimes expressed through violence (De Lange, 2006; Kelly, 2006). He therefore observed that an infected man can use his social and physical powers to force sex on his wife; yet a

wife whose husband is promiscuous and fears infection is not able to negotiate for condom usage and if she tried to do so, she would have to suffer his reprimands and accusations (Chireshe, 2011). He also discovered that most women consider marriage a risky business and that single women have a better chance of successfully negotiating safe sex practices with their sexual partners to protect themselves against infections (Chireshe, 2011). Chireshe acknowledged that this finding was similar to that of Muzvidziwa's (2001:151) who had conducted a study in Masvingo into informal marital unions (*kuchaya mapoto*) which indicated that because of the greater sexual autonomy they enjoyed, women in these unions were in a better situation than women in formal marriages who lacked such autonomy and were 'sitting ducks in the face of HIV/AIDS' (Muzvidziwa, 2001).

Chirawu's article, 'Till Death Do Us Part: Marriage, HIV/AIDS and the Law in Zimbabwe' reinforced Chireshe's main finding that married women in Zimbabwe face a double-edged sword in that their rights and obligations as married women make it difficult for them to insist on safe sex practices and in that regard formal marriages potentially expose wives to HIV/AIDS infection (Chirawu, 2006). The author pointed out that this disempowerment of women originates from the payment of *roora* coupled with marriage vows which recognise that sex is the essence of marriage (Chirawu, 2006). Chirawu's conclusion that cultural practices increase the incidence of and predispose married women to infection (Chirawu, 2006) endorses Chitando's (2004) finding that women in society are expected to condone men's infidelity as part of culture and bear with it because men always do it.

Whilst Chireshe and Chirawu's articles concluded that marriage was largely a risky business, Gumbo's article mainly concluded that marriage was indeed the haven that offered sanctuary to married women because his findings had shown that they had the lowest prevalence rates thereby implying that marriage strongly protects Zimbabwean women against HIV/AIDS infection (Gumbo, 2011). Whereas Chireshe and Chirawu's articles were qualitative, Gumbo's research was based mainly on empirical evidence. He had based his premises on Hattori's proposal that married people should have a lower risk of HIV/AIDS due to the long term sexual exclusivity offered by marriage and so he investigated the viability of marriage in reducing HIV/AIDS infection (Hattori *et al.*, 2006). The author's research interests had been further advanced by Shishana and Reither's articles that suggested a link between HIV/AIDS and marital status but had failed to establish which marital status is associated with the highest prevalence rate of HIV/AIDS (Shisana *et al.*, 2004; Reither, 2009).

The correctness of Gumbo's findings is in serious doubt due to the following factors. First, in the case of formerly married women (like separated/divorced/widowed) who are HIV positive, his study could not establish whether they were infected before, during or after their marriage (Gumbo, 2011). Further, in the case of the marital status being categorised as never married, currently married and formerly married his findings that the lowest prevalence was among currently married could be challenged on the ground that it is most likely that formerly married women, especially widows, could have been infected during their marriage as they were married and only became categorised as formerly after their husbands had passed away (Gumbo, 2011). And the author himself suggests that it is only sensible to connect their risk of HIV/AIDS infection with marriage. The low HIV/AIDS prevalence among currently married women is because women who have the highest risk of HIV/AIDS infection were excluded from the category, yet in fact that is the time when they are most likely to have been infected (Gumbo, 2011).

Based on his findings, the researcher concluded with the recommendation that marriage could be prescribed as a possible behavioural practice to reduce infections among women in Zimbabwe (Gumbo, 2011). He also added that marriage alone is ineffective in the fight against HIV/AIDS infection and that other complementary behavioural practices also need to be encouraged and practised such as being faithful to one sexual partner, consistent condom use and regular HIV testing (Gumbo, 2011). The main finding of this research is the same as that concluded by the Zimbabwe Demographic and Health Survey 2010-2011 (that married women have the lowest risk of association) and therefore, the rider which Gumbo applies to his main finding applies with equal force to the identical main finding of this Survey.

Spurred on by the hope offered by Gumbo's article, I sought to explore further empirical studies on the link between HIV/AIDS and marital status. Kposowa's article was helpful in that it sought to make sense of the possible relationship between HIV/AIDS deaths and marital status. Kposowa's data analysis revealed that there a connection does indeed exist between the two. The author found out that those who were single/never married, divorced and separated recorded the highest number of deaths suggesting that marriage be promoted as institutional buffers against HIV/AIDS because marriage can be counted on to provide a stable sexual network and acceptable form of social control (Kposowa, 2013). The author's further finding was startling. He found that marital status is a significant factor for male mortality from HIV/AIDS only and it has no significant association with death for women

(Kposowa, 2013). My opinion was that since this article is Western based it only indicated that HIV/AIDS patterns and their effect on women may differ depending on whether one is situated in Africa or countries in the West; while married women die here in large numbers because of HIV/AIDS related diseases, the trend in western countries is totally different.

I then returned home to Africa in the next stage of my research journey to explore how Ugandan society had fared in the face of HIV/AIDS. In their article, Mukiza-Gapere and Ntozi showed that AIDS had negatively affected the institution of marriage (Mukiza-Gapere and Ntozi, 1995). The marriage business has become fearsome and people suspect one another one of being moving corpses, victims or carriers of HIV/AIDS (Mukiza-Gapere and Ntozi, 1995). Although some spouses were found to be faithful, most marriages had been wrecked by divorce and separation because of the virus (Mukiza-Gapere and Ntozi, 1995). Married women have become sacrificial lambs because they cannot divorce their husbands on grounds of infidelity and if they have been infected by their husbands with HIV then it was simply considered their fate (Mukiza-Gapere and Ntozi, 1995).

Ironically polygny has become a protective institution within the community in that co-wives co-operate with each other to make sure their shared husband does not leave the existing sexual network to look for other women (Mukiza-Gapere and Ntozi, 1995). The authors said that while AIDS has dampened some people's interest in the institution of marriage, there are others who ignore it and continue to live reckless lifestyles (Mukiza-Gapere and Ntozi, 1995). This also accurately describes the situation pertaining in Zimbabwe today.

In rounding off my literature review I chose to inspect Madrama's article which focuses on the Baganda people's vulnerability to HIV/AIDS through the practice of their customary marriage and norms. It explores how through high risk behaviour the social and cultural factors predispose married people to HIV infection (Madrama, 2003). The author stated that since the discovery of HIV in Uganda in 1982 evidence has shown the vulnerability of women is greater than that of men where the virus is transmitted heterosexually (Oleke, 1996). This high degree of vulnerability suffered by women is attributed to their status which is subordinate to men and their lack of capacity to control their sexual and reproductive rights. This leads to the unavoidable conclusion that they are powerless as a result of socio-cultural and economic factors to avoid infection in marriage (Reid and Hamblin, 1993). Basically since women have no power to control their husband's activities in or out of their

matrimonial homes, they have no choice but to accept exposure to infection through their husbands. Madrama insists that the use of condoms as a mitigation strategy is unrealistic in addressing the married women's situation in the face of men who function under norms, rules and values generated by socialisation and dynamic social fields which control their lives and behaviour and sometimes even encourage risky behaviour (Madrama, 2003).

The author observes that customary marriage indeed creates situations where couples run the risk of HIV/AIDS infection but advises that it is not helpful to blame husbands for infecting their wives because after all they only infect their wives after having been infected by another woman (Madrama, 2003). Sayagues concurred with Madrama by stating that treating the problem as male-driven isolates men in policy and responses to the problem (Sayagues, 2003). This is a valid argument and we as Zimbabweans should learn from it. Isolating and targeting men as the main perpetrators of the problem may not be the best response considering that it takes two to make a marriage work. Therefore if the problem is considered to be a shared one between men and women, husbands and wives, it is more likely that we can ask them both to co-operate and come up with joint and mutually beneficial strategies for the prevention and reduction of the HIV virus.

CHAPTER THREE

3.0 RESEARCH METHODOLOGIES AND METHODS

3.1 Introduction

I used a variety of methods and methodologies during my research and they all worked differently in shaping the research and in data collection and as a result I was able to obtain cogent findings.

3.2 My research journey: Methodological approaches

The **women's law approach** takes women's real lived experiences and life based situations such as sexuality as the starting point for the investigation of the position of women in law and in society. In my quest to find answers I investigated the reality of married women to see whether they considered marriage as a haven or a risk in the face of HIV/AIDS and harmful cultural practices such as polygny, dry sex practices, promiscuity and *roora*. Due to the sensitivity of the topic I chose as my starting point Dzivarasekwa 2, Ward 1 where I live and since I am quite familiar with the residents they were be able to open up to me and in the process say exactly what was on their minds without feeling like they were being judged. In the same manner, I decided to concentrate in Harare's Central Business District where I have the advantage of working and this made it easy for me to access the relevant key informants and the women as they went about their everyday activities.

As I sought the views of ordinary women in their homes and on the street I approached them wearing whichever of my multiple faces at my disposal in order to gain their confidence and persuade them to talk to me. So, depending on the person I approached I presented myself to them as a fellow woman, a lawyer, a friend and a confidante. These multiple faces enabled me to witness the lived reality of women as I witnessed their daily lives and routines through interacting with them differently depending on what suited the situation most. As a fellow women, friend and confidante the women were able to tell me whether they were enjoying their marriages or not. They elaborated their roles in marriage as wives and mothers. The women were able to confide in me about their fears concerning HIV/AIDS and their marriage. For example, most married women stated that they feared the risk of infection because they indulged in unprotected sex with their husbands who flatly refused any suggestions of condom use. Some of the women were also concerned about their increased

vulnerability to infection as a result of their husband's infidelity. The women who were infected during their marriage and became HIV positive managed to narrate their story in their own way and as a result capturing their voices was an easy task. I discovered that although these women had come from different classes and enjoyed different social statuses, their marriage experiences were almost identical. I also realised that most of these women were unaware of the full nature, extent and implications of their reproductive and sexual rights and asked myself the question, even if they were aware of them, to what extent could they practically enforce them, in view of the various impediments that they face. These women consulted me as a lawyer on very intimate issues as they tried to explore different possible legal solutions to the legal problems connected with their marriages.

I embarked on my research with a **human rights approach** in mind because my research involved many human rights issues but of greatest importance to me were the reproductive, sexual rights and marriage rights. As attested by their articulation and formulation in international law these rights are asserted and protected because everyone is entitled to enjoy them irrespective of their sex, nationality, religion, culture or status. Throughout my research I consistently questioned the evidence I was gathering from a human rights perspective in order to examine whether the reality I was discovering on the ground met the standards encapsulated in the specific rights that had been reduced to writing and contained in relevant human rights instruments. So as I interviewed and related with each married woman I would also indirectly look at whether she was enjoying her marriage and reproductive health and sexual rights. And I would also ask myself whether the state was playing its role by fulfilling its obligations of protecting, respecting and fulfilling these rights and upholding them.

The human rights approach is an excellent way of helping the government to take action against problems that HIV/AIDS creates by providing a framework within which laws and policies may be formulated in line with the human rights standards. The State has invoked the principle of the progressive realisation of human rights as far as health rights are concerned in acknowledgement of the fact that it suffers from financial constraints due to the limited availability of resources.

Zimbabwe as a pluralistic country recognises the co-existence of customary as well as general law. This customary law system recognises the established customs and practices of the community. Legal Pluralism helped me to identify the fact that different women were

married under different marital regimes and their rights and obligations under these diverse marital regimes favour some women under one type of regime while discriminate against other women under another. For example, while couples in a civil marriage could get away with not paying *roora*, those in a registered customary law marriage would not find it so easy to do so.

Employing **gender analysis** I learnt that gender entails on the one hand, men's and women's active roles in society and on the other, ingrained social ideas about femininity and masculinity (Bentzon *et al.*, 1998). What men and women should do and how they ought to behave and interact spliced together with culture, social and legal interpretations of perceived gender differences constitute a gender system (Bentzon *et al.*, 1998).

The gender issue was explored to see whether and how women and men are socialised into roles by society and the impact of that socialisation process on women in marriage and how it negates their rights coupled with the cultural practices that put them at the risk of infection. This analysis helped me to understand the implications of the reproductive roles of a mother and a wife for the marriage and reproductive rights of a woman. I was also able to investigate what it means to be a father and husband and the head of the house through the voices of both women and men. I was also able to discover that the ranking by society of men and women was not the same and that this same ranking is carried over into marriage. By heeding male voices I also came to understand that women are equally capable of being unfaithful, contracting the virus outside the matrimonial home and infecting their faithful husbands.

During my research I also used **the actors and structures approach** as I sought to interact with key players whose role is crucial in HIV/AIDS combating programmes and these included government ministries and departments, NGOs dealing specifically with HIV/AIDS issues and women and churches. The actors in these structures included government and NGO officials whose task is mainly the implementation of the various programmes on HIV/AIDS and their beneficiaries including men and women of different categories. I also targeted private doctors in surgeries and pharmacists who are in constant touch with women and men seeking and receiving treatment for HIV/AIDS related diseases and who dispense drugs for all kinds of illnesses. The key informants were able to discuss the position of women and men in society, in marriage in relation to HIV/AIDS.

The identified structures included the Ministry of Health and National AIDS Council whose responsibility is at the core of co-ordinating and facilitating the national multi-sectoral response to HIV and AIDS. Also included are the National Prosecuting Authority responsible for implementing the law by prosecuting cases such as marital rape and the wilful transmission of HIV/AIDS. The NGOs I interviewed included the Zimbabwe Human Rights Lawyers an organisation that fights for the rights of indigent women in court including cases of the wilful transmission of HIV/AIDS. I also approached Women and AIDS Support Network (WASN) and Zimbabwe National Network for People Living with HIV (ZNNP+) and both organisations advocate for the rights of women; the ZNNP+ also advocates for men who are already infected and laws and policies that protect women from infection. Initially I was not aware of the existence of WASN and was only referred to it after I had called ZWRCN an NGO which I had found on the internet and thought that they could help me with my research. I also interviewed SafAIDS (Southern Africa HIV/AIDS Information Dissemination Service) whose interests are similar to those of other NGOs and whose mandate is to protect the rights of HIV positive people, to interact with people at large in the fieldwork and promotion of policies and laws that seek to curb HIV infection.

I included the apostolic churches or so-called churches of the Johanne Marange and Johanne Masowe sects as structures to investigate as well, yet I chose not to approach the leaders of the sects but only its ordinary members whom I knew at my workplace. By doing so I was able to obtain evidence of the lived realities of women and men in the Johanne Marange sect as their members shared with me first hand uncensored information of what transpired behind closed doors in their church on issues of marriage, polygny, child marriage, *roora* and dry sex practices.

Catherine Mackinnon puts forward **the dominance theory** in which she links gender to the power between the sexes and finds that males dominate over females and they are required to submit to male supremacy (Tong, 1994). In essence this theory attests to the view of every woman and man I interviewed who recognised that men and women in our society occupy unequal positions of power which explains why women continually find themselves unable to make important decisions concerning themselves even though they have the ability to do so. The dominance theory is reinforced by factors such as culture, economy and religion. If a husband is the breadwinner of the family and his wife is at his mercy, she depends entirely on him for survival. This almost always means that if he cheats on her, she usually considers that

she has no option but to condone his behaviour and stay in the relationship simply because she has no other source of income to empower her to leave him. Church teaching only serves to reinforce this dominance of men over women. It preaches a wife's deference to her husband even in the face of his promiscuity and it encourages women to keep their family together by forgiving their husbands, staying in the matrimonial home and praying to solve any marriage problems using Biblical scriptures.

Simone De Beauvoir explained how society defines woman as 'the other' with no autonomy as humanity is measured by the qualities of 'maleness' and 'man' and therefore, a woman is only defined relative to man and not in her own person (Tong, 1994). As I looked at this theory in the context of the reality revealed by my research, it explained to me the phenomenon behind men's interests continually dominating those of women. For example, it was the man who chose the type marriage with which he felt most comfortable and was most advantageous to him. Most of the time married women have no choice about whether or not they want to have children, nor do they have any control over any sexual issues pertaining to their bodies as to how, when and where to have sex with their husbands. Basically their sexual pleasure is subordinate to that of their husbands.

3.3 Data collection methods

I employed a number of data collection methods in collecting evidence from various sources.

3.3.1 Focus group discussions (FGDs)

I used the focus group discussion (FGD) method four times in my research whenever I came across large groups of women and men who were eager to participate by listening and sharing their own views on the research. Table 1 (below) shows details of the FGDs that I conducted. It was very easy to have these focus groups because the topic itself drew women and men together in places like salons and flea markets and clinics where people are already clustered in groups and when anything of interest is discussed they automatically join in with or without invitation. By its very nature this subject is very topical and went to the core of their everyday lives and so they were more than willing to express their views without holding back. This made the discussion more interesting as the members of the group tried to outdo each other. The biggest problem I faced was the fact that sometimes it was difficult to control the activity of the group with others leaving and others joining at any point. Again, there was

a bit of competition between men and women who were trying to blame each other or justify their actions. But this kind of method is time saving as you gather the opinions of so many people in a short space of time instead of going around trying to interview each one of them separately. So at the end of the day you do a lot of work in a relatively short time.

Table 1: Showing details of Focus Group Discussions (FGDs)

Location	No of Focus Group Discussions	Males	Females	Total
Salons	1	5	15	**20**
Flea Market in city centre	1	6	6	**12**
Flea Market, 4th St	1	5	10	**15**
Premier Clinic, 4th St	1	5	10	**15**
Total	**4**	**21**	**41**	**67**

3.3.2 Collective/Individual interviews

I conducted collective/individual interviews with ordinary men and women whom I chose randomly in their homes, workplaces and on the street. Sometimes I would collectively engage two or three people at the same time. These interviews were very valuable to the research as they became the source of more intimate and pertinent information as the person felt more comfortable speaking about their marriage difficulties in the comfort of their own homes and without the fear of being overheard. These interviews however tended to be time-consuming as the person normally ended up wanting to tell me their whole life story including unnecessary details which were not relevant to the research and I had to learn to practise patience over and over again. A few individuals actually walked away during an interview, especially in town and I was left wondering whether their reaction was out of mere unwillingness to talk or whether I had touched a raw nerve by raising marriage and AIDS in the same breath. Below is Table 2 showing details of the individual interviews that I conducted.

Table 2: Showing details of individual interviews

Interviewees	Male	Female	Total
Street	6	10	**16**
Markets	0	6	**6**
Offices	5	5	**10**
Homes	10	30	**40**
Church	2	2	**4**
Total	**35**	**53**	**76**

3.3.3 Interviews with key informants

This method involves collection of data from the perceived 'knowers' or those with experience on the issue or some people of influence in the community. I made appointments with government officials and NGOs and they were granted without difficulty. I was also able to talk to private doctors who happen to be my family doctors and pharmacists as well. The key informants gave me a deeper insight of my topic from both a theoretical and practical point of view. The NGOs gave me crucial information about women and men, their sexual and reproductive rights and HIV/AIDS issues; Zimbabwe Lawyers for Human Rights and the National Prosecuting Authority told me about the legal implications relating to these issues and finally the NAC and Ministry of Health and Child Care shed light on health implications relating to the topic. Putting all this evidence together made it extremely cogent and valuable to the research. Below is Table 3 showing details of the interviews that I conducted with the key informants.

Table 3: Showing details of interviews with key informants

Interviewees	Male	Female	Total
Doctors	1	1	**2**
Pharmacists	3	0	**3**
MOHCC	0	1	**1**
NAC	2	0	**2**
SafAIDS	1	0	**1**
WASN	0	1	**1**
Prosecutors	2	1	**3**
ZNNP+	1	1	**2**
ZHLR	1	1	**2**
Total	**11**	**6**	**17**

3.3.4 Observations

I made various important observations throughout my research. I took special note of women who fiercely discussed the research topic during focus group discussions and I would move from being an active participant to a passive observer so that I could observe their body language, facial expressions and change of emotions as discussions progressed. I behaved the same way towards those women who confided in me about their HIV positive status and normally gave them the freedom to narrate their story without interruption as I watched their emotions and body language closely. I also observed the conduct of women and men when I conducted interviews in their homes. I watched and took note of women and men selling herbs/chemicals for dry sex practices and their customers who bought them. Observing women at various stages throughout the research helped me to able to determine whether they were being sincere or trying to impress their fellow counterparts with the knowledge they claimed to possess they had about the research topic.

3.3.5 Telephone interview

I conducted one telephone interview with an official who was always busy and out of the office claiming to conduct fieldwork outside Harare. After several attempts to make an appointment to see them had failed, I resorted to a telephone interview to gather the data I wanted because the official was the only person who could give it to me. So we agreed to do our interview telephonically and I had the privilege of doing it from a workplace that offered me this phone service without charge for which I was very grateful as it was quite a long call.

3.3.6 Policy and documents review/internet research

This was a combination of internet and library research where I was trying to gather information from articles, books, international instruments, national policies and laws and literature review on women's sexual rights in marriage and the implications of HIV.

3.4 Limitations of the study

The study has been limited in that I was only able to focus my attention on two locations in Harare, namely, Dzivarasekwa and the Harare CBD. The study was also focused on *Shona* society to the exclusion of other ethnic groups such as the *Ndebele*, the second largest ethnic group in Zimbabwe. This is because of certain constraints I encountered, such as the lack of financial resources, time and human resources to increase the reach of the research and the human resources necessary to manage the increased research load. Given more such

resources I could have included in the study more ethnic groups (including the *Ndebele*) and greater coverage of rural as well urban areas nationwide which together would have given a more complete understanding of a greater cross-section of Zimbabwean women's sexuality and the problems they face relating to HIV/AIDS in marriages. Despite these limitations the methods and methodologies used gave sufficient information to draw conclusions about women's sexuality and socio-cultural practices that prevent the behavioural change of women living in the face of the danger of HIV/AIDS.

CHAPTER FOUR

4.0 INVESTIGATING THE SOCIO-CULTURAL PRACTICES ARENA

4.1 Introduction

This chapter focuses on the study's findings and it scrutinises specific marriage-related socio-cultural practices that increase the risk of HIV/AIDS infection for married women, thus seriously compromising their reproductive rights.

4.2 Socio-cultural practices

Cultural norms and beliefs are recognised as promoting dangerous sexual behaviour among individuals especially women and they are regarded as a key factor in the spread, transmission and treatment of infectious diseases globally (Doherty *et al.*, 2005, Akwara 2003, Parker 2001). These include *roora* (the payment of bride price), polygny and promiscuity and dry sex practices.

4.3 *Roora*

Various terms are used to define *lobola* which consists of a number of stages before a couple is said to be married. Among the *Shona*–speaking people in Zimbabwe, the practice is referred to as *roora* (WLSA, 2002). The term *roora* is where in a marriage process bride price is paid by the husband's family to the wife's family. *Roora* consists of essentially two stages: the introductory stage, where small payments are made to indicate the beginning of marriage and the main stage, where larger payments are made in the form of *danga* (father's cattle) (WLSA, 2002).

As I went into the field I started to recognise the significance *Shona* society in general attach to *roora* and I also began to realise that this was one cultural practice they would not be prepared to give up easily, no matter how negative its direct or indirect effects proved to be against its women. On the importance of *roora*, one respondent, Tsitsi, started by remarking:

> *'Hapana mukadzi asingade kubvisirwa* roora *chero ari kuchaya mapoto chaiwo nekuti zvinopa unhu.'*
> (The respondent meant that every woman wanted her bride price to be paid including those in informal unions because it gives woman dignity.)

In acknowledging the important role of *roora* in any *Shona* woman's marriage, the respondent pointed out that even those who co-habitat expect payment of *roora* at some future point in time, no matter how long they have stayed together. The view of female respondents was that *roora* was a part of culture that it should continue to be observed and upheld because it validates the status of women in society. It is so highly regarded that out of desperation some women even ended up paying their own *roora*. The female respondents were socialised to accept that the portion known as *rusambo* in *roora* means that their husbands have unlimited sexual access to their wives for whom they have paid *roora*.

The male respondents subscribed to the view that *roora* is the pillar of a family, a sentiment shared by the female respondents. The male respondents did not view the practice itself as being the problem but the way it was being commercialised and abused in modern times. One respondent argued that *roora* is being abused by some men to make their wives victims by relying on it to validate their superiority and dominance in their marriage and creating inequality between themselves and their wives.

The NAC official stated that, by virtue of our *Shona* society and cultural expectations where *roora* has been paid for them, most married women are precluded from making decisions about sexual and reproductive issues within their marriage which as a result increases their vulnerability to HIV/AIDS infection. The women's sentiments were that *roora* permanently transfers (from their own fathers/male ownership) ownership of themselves to their husbands and discernibly disempowers them and restrains them from exercising or achieving safe and healthy sexual well being. In confirming this position one of the respondents, Tendai, said:

> *'Kuramba kuita bonde nemurume akakubvisira roora chinhu chakaoma uyezve varume vacho havazvitambiri.'*
> (The respondent meant that if a husband paid bride price for his wife she found it very difficult to refuse him sex and even where she attempts to do so the husband does not take kindly to such behaviour.)

So *roora* makes women the subject matter of the marriage contract rather than a party to it and as far as these intimate marital relations are concerned, the subordination of women to

men begins and their dependency on men is institutionalised. May's proposition succinctly captures this state of affairs when she says that men will never regard women as free and equal members of society as long as the *lobola* system continues to exist (May, 1987: 41).

4.4 Polygny and promiscuity

According to ZDHS (2010-11), polygny is the practice of a husband having more than one wife. Eleven percent of women in Zimbabwe are reported to be in polygnous unions. And in Harare out of the 972 women that ZDHS interviewed 85, 1% said that there were in monogamous unions, 5, 1% said that they had 1 co-wife, 0, 9% said they had 2 co-wives and 8, 9% did not know whether they had co-wives or not bringing the total to 100% (ZDHS 2010-11). Promiscuity is a practice where a person has more than one sexual partner with whom they engage in sexual relations and the parties may or may not be married. I looked in the ZDHS for the percentages of men and women in Harare who had 2 partners and it indicated that women had 1.75% whereas men had 12 % (ZDHS 2010-11).

The Customary Marriages Act, Chapter 5:07 allows men to be polygynous, thereby increasing the risk of infection for women. Even many men married under the Marriages Act, Chapter 5:11 were indulging in a great deal of bigamy these days by purporting to marry women under customary law without either divorcing their first wife or by purporting to marry with the knowledge of their first wife. Polygny increases the risk of infection for women and men in such marriages because if their co-wives are not sexually or financially satisfied they are likely to go out and have extramarital affairs and in the process contract STIs and AIDS, thereby putting the whole network of sexual partners at risk. Polygny mostly involves women who are not economically independent and are looking for security in marriage. There are however a few women who are educated and capable of providing for themselves but are still part of these polygnous unions probably because they desire the status of a wife. The women respondents stated that polygny these days was identified as either disclosed or undisclosed and most of it took place without the knowledge of the first wife or the co-wives, so that by the time they have realised that they are in fact in a polygnous union, a lot of compromise has already taken place including the compromise of their sexual and reproductive rights. The Johanne Marange sect, however, publicly embraces polygny.

The women respondents complained that the practice was biased and favoured men whilst it disempowers women as it allows men to prevail over women. In subscribing to this view that shows society endorses the inequality between women and men, one woman said:

> *'Barika harirambidze murume kutora vakadzi vakawanda zvaanoda asi haribvumidze vakadzi kuita zvimwe chetezvo uye haripe vakadzi simba rekuriramba kana murume zvirizvo zvaada.'*
> (The respondent meant that while polygny allows men to take as many wives as they wish, it did not allow women to exercise the same privilege.)

All the women agreed that the main disadvantage of polygny was that:

> *'Yakashatira circulation yezvirwere mazuva ano zvepabonde kunyanya HIV/AIDS.'*
> (The women meant that polygny's main disadvantage was the increased risk of infections such as STIs or HIV/AIDS.)

Although a few women indicated that it might be a good solution in the case of a wife's infertility, most of them generally disliked polygny and only entertained it as a possible choice for specific reasons and mostly where they believed that their circumstances gave them little or no choice. This observation was also made by Rodriquez (2007) who states that sometimes Zimbabwean women give in to polygny as a result of cultural pressure or fear of social discrimination.

The women said that they stay in polygnous unions for various reasons such as for the sake of their children and/or because of their financial or economic dependence on their husbands. For example one respondent woman expressed the view:

> 'As long as *murume ari kundichengeta ndinogara akatora mumwe mukadzi* why should I leave?'
> (The respondent meant that as long as the husband looks after her financially, she had no reason to leave if he takes another woman.)

All women agreed that promiscuity was a growing fashionable trend followed mainly by men. They acknowledged that although religion deterred some men from turning polygamous, the trend had actually increased so such an extent that the 'the small house' phenomenon had become so prevalent that now even a considerable number of married women were indulging in the practice of pursuing extramarital affairs. Beauty said:

> ‘*Anenge ahurirwa* solution *ndeyekuhurawo* it’s a 50/50 situation *arwadziwa ngaabude*.’
> (The respondent meant that when one of the couples discovers the other is committing adultery, they themselves resolve to do the same so that they are at par and whoever is hurt most will get out of that marriage.)

One of the male respondents explained that in his view society’s growing lack of respect for marriage as an institution is the simple cause of promiscuity and to illustrate his point he drew my attention to the following headline of that day’s H-Metro, one of Harare’s newspapers:

> *‘Married woman dated 27 men and aborted 5 pregnancies within 5 years.’*

He also stated that this behaviour by men was a form of compensation that men believe they owe themselves when they feel that their wives are unable to satisfy them (usually because they are so busy with their many marital and family duties) but find that girlfriends can because they are willing to do almost anything to please married men and they go out of their way to treat them especially well. In support of his colleague another male respondent stated:

> *‘Dzimba idzi midhuri chete.’*
> (This respondent’s meant that other couples just lived in matrimonial homes as a formality but they are otherwise as good as divorced and it is only the marriage certificates that holds them together for failure of getting divorce.)

The male respondents defended their extramarital affairs and bluntly stated that if women fail to perform their wifely and motherly duties they were prepared to flee and seek solace elsewhere.

WASN director stated that men normally start cheating during courtship and despite that women continue to pursue their relationship with and get married to such men because society says:

> *‘Hapana murume asingaite misikanzwa.’*
> (She meant that there wasn’t a man who didn’t cheat.)

She also said that in most marriages it is usually the man who does the cheating and the woman who does the forgiving all the time; eventually HIV/AIDS becomes part of this cycle because married women find it difficult to refuse having unsafe sex with their husbands even

after they realise that their husbands are coming home to them straight after being with their girlfriends. She stated that culturally it is allowed and acceptable for a man to have more than one sexual partner apart from his married wife, but the same rule does not apply to women and society actually punishes those who attempt to copy their husbands' behaviour. Women gave various reasons for staying married despite their husbands' promiscuity and one of their reasons was that:

> *'Vakadzi vanofira kusada kusekwa kuti ndakarambwa.'*
> (This means women risk death in marriage for fear of being ridiculed as a divorcee so they persisted in failed marriages all their lifetime.)

4.5 Dry sex practices

Dry sex practice is when a woman dries and tightens her vagina for sexual intercourse (Brown, Ayowa, Brown, 1993). Traditional herbs and medicinal drugs and substances are used to dry the vagina before and during sexual acts. This is achieved by inserting various drying and absorbent materials and agents into the vagina before and during the sexual act itself (Soul City *et al*., 2009). The reason for dry sex practices is simply to get rid of excessive fluids in the vagina and increase friction during sex. The main reason for using such preparations is to ensure a tight, warm vagina without 'excessive' vaginal secretions during sexual intercourse (Runganga and Kasule, 2010). Women engage in this practice to increase sexual pleasure for men (Runganga, Pitts, McMaster, 1996)

This is a prevalent practice in Harare performed by women who seek to sexually please their male partners in the belief that by so satisfying and maximising their sexual pleasure these men will not reject them and seek out other women to satisfy them. One woman Chido said:

> *'Varume kana muri pabonde havadi mazimvura mvura anobuda pamukadzi vanoda* friction instead.*'*
> (She meant that during sex men preferred dry to wet sex.)

So in their quest to please their husbands women seek these products from different sources such as pharmacies, traditional markets and even *sangoma*s and prophets and these products are either processed products or comprise traditional unprocessed herbs. The women stated that they normally do not enjoy this sexual experience as the suffer tearing and bruising of their intimate parts of their genitalia as a result of the excessive friction inflicted on them by

their male partners during intercourse; essentially women use dry sex products to create over and over again the lie that men want: that they are virgins who need to be continually dominated and broken by dry, or more truthfully, rough sex. Having been seduced by this lie, women are prepared to keep their sexual partners no matter at what personal cost, even their own health.

The pharmacists and street vendors of these dry sex products acknowledged that business was booming as usual. One male pharmacist said the use of such products cause women discomfort and gave as an example that if women put alum salts on to cotton (instead of first dissolving them in water and then letting the cotton absorb the solution) and then place the cotton directly into their the vagina, they will experience a painful burning sensation. The sellers on the streets on the other hand praised the efficiency and effectiveness of their traditional herbs and one of them promised:

> *'Ukashandisa mushonga uyu ukarara nemurume hapana kwaachabuda achienda kunotsvaga bonde zvekare.'*
> (The vendor's statement was to the effect that once you used the herb on your partner they will never be promiscuous again.)

Both the doctors and pharmacists warned that the practice carried severe health implications for women as it increases their chances of contracting cancer of the cervix. Further they also stated that the excessive friction that men desire during sexual intercourse and which tears the delicate internal organs of women's bodies exposes both of them to the easy contraction of HIV/AIDS. In 2000 the Ministry of Health and Child Welfare noted that women practise acts such as dry sex because:

> 'Sexual pleasure is perceived to be under the control of the male counterpart and women are not supposed to express enjoyment. It is believed that sex is centred on the pleasure and satisfaction of men putting women at the risk of carcinoma of the cervix and other infections.'

Figure 1: Photograph of Ivan woman's herbal soap used in dry sex practices

The photograph shown in Figure 1 was taken through the glass counter of a herbal pharmacy in Nkwame Nkrumah Avenue in Harare and it is displayed with winnowing baskets, one of which contains other unidentified products used in dry sex practices.

4.6 Discussion of emerging issues

During my research many emerging issues arose and one of them was the hard hitting fact that promiscuity was no longer a male domain only because some women were now also busy practising it for various reasons. This means that husbands, like wives, are also at risk of contracting HIV/AIDS from their marriage. This issue brought to my attention one important point which is that maybe it is high time we move away from blaming men for being the sole transmitters of the virus into marriage; in some cases, it is the women who are solely to blame for bringing it into the marriage. This was confirmed by one male interviewee who is also a close friend and who told of how his wife brought the virus into the marriage though he was lucky enough not to be infected by it and how she continued to have extramarital affairs when their financial situation suffered as a result of his having lost his job.

Another issue raised concerned *roora* and that instead of the positive cultural connotations it originally had, it is now part of a get rich quick scheme (it is being abused and has become commercialised). It no longer serves its original purpose of being a token of appreciation that unites two families. As a result of this twist, women were also bearing the negative brunt that comes with such commercialisation. This was described as an undesirable situation and both sexes were against the way *roora* was being handled in modern days. In addition, men also

argued that the practice of paying *roora* discriminated against them because according to the custom, only women are paid for in marriage, never men.

Another of the emerging issues was the practice of child marriages within polygnous unions which are characteristic of so-called churches such as the Johanne Marange Apostolic Sect. This issue was crucial because from an interview with one of the respondents who attended this sect, the girl's lives were at in a continual crisis as they experienced untold suffering in these so-called marriages. As a result of the prohibition of child marriage following the recent constitutional case of *Mudzuru* (2015), it remains to be seen whether sects like the Johanne Marange sect will accept and implement this change in the law and overhaul their doctrine or whether they will continue following such practices in secret until they are forced to stop by the long arm of the law. As if the situation is not bad enough already, a dire health hazard for women in that so-called church is that they also give birth at *chitsidzo* without receiving medical attention, even when they develop and suffer from birth complications, such as fistula. It is clear that doctrinal teaching of the sect that the more wives and children men acquire, the more respect and power the sect will give them, makes their children and wives vulnerable to the harmful practices from which their children and women were found to suffer.

4.7 Further analysis

4.7.1 Marriage and the state

The law is contradictory in that while the Constitution invalidates some of these harmful cultural practices other pieces of legislation still uphold them, such as the Customary Marriages Act, Chapter 5:07, which still allows polygny and *roora* payment. By allowing polygyny, the Customary Marriages Act, Chapter 5:07 effectively gives men permission to have multiple sex partners in that they will use that law as an excuse for their behaviour; in the meanwhile a formal recognition of polygnous unions actually strengthens the patriarchal idea that women should passively agree to their husbands exercising control over sexual decision-making. Section 12 of the Customary Marriages Act, Chapter 5:07 which retains the requirement of proof of payment of *roora* when an African couple seek to register their marriage keeps women in a position of subservience to men. The man's payment of *roora* to the woman's family marks the start of a relationship of inequality between the parties which

puts the man in the position of a purchaser who exercises power and control over the woman, who is merely the object of a sale.

In light of all the circumstances described above why is it that reproductive and sexual rights in marriage are continuously and consistently violated despite clearly worded protective legal provisions? The answer lies in the fact that the law has its limitations, meaning that the influence of the law starts but it also ends somewhere and another realm, the social realm, begins to operate. Therefore we need to look beyond the law and its formulation in order to protect the reproductive and sexual rights of the vulnerable.

4.7.2 Women, roora and the right to sexual and reproductive health

Since *roora* is closely connected with the issues of children and family lineage it also has a large bearing upon family planning and safe sex practices (Ansell, 2001). *Roora*'s link to reproduction is of such a nature in the minds of some men that they think they should have power over reproductive decisions after paying *roora*, resulting in their refusing to use any contraceptives or to practice safe sex (Bawah, Akweongo, Simmons & Phillips, 1999). This is subscribed to by WLSA (2002) which stated that *roora* is paid for the woman's reproductive capacity and it is usually considered her fault if no children are born to the marriage. The payment of *roora* also has the effect of shifting the procreative function of the wife from her family to that of her husband, meaning that the children born to the couple belong to the husband (WLSA, 2002). Since *roora* is still considered an essential requirement according to custom, if a woman's family realises that she entered into a marriage without their involvement, they will leave her to deal with her marital problems alone and without their help; and her husband's family will not recognise her as his wife according to their culture (WLSA, 2002). As a result, African women will not normally have the courage to marry or to register their marriage without involving their family completely.

Taking all the above into account, how can any woman, so thoroughly overwhelmed by the areas of disempowerment which surround her, be in any kind of a position to negotiate about protecting herself or any of her rights, including: her right to enjoy safe sex and good sexual health (especially in view of the current real threat of contracting sexually transmitted diseases (including HIV/AIDS)); her right to decide whether to have any children or not, the number of spacing of such children and her general reproductive health requirements unless and until she is empowered to do so. The fact is that the exercise of reproductive rights by

women is still a far-off reality notwithstanding the existence of international law because of the patriarchal model which governs our society on the one hand, and its traditions and negative cultural and social practices, on the other (WLSA, 2002). An obvious violation of a woman's bodily integrity is clearly illustrated when she has to seek her husband's permission before conducting family planning or when she continues to bear children against her doctor's advice because her husband forces her to do so (WLSA, 2002). If a woman does not have control of her own fertility, her health and even her life may be at risk; so long as her husband has the final say over her fertility, he may even end up deciding whether she lives or dies in cases where his consent must be sought for surgery with reproductive connotations that she may be required to undergo (WLSA, 2002). Hence, one cannot deny that it is crucial to take a better and closer look at the factors that impact sexual and reproductive decision-making, including *roora*, as they will help in our efforts to protect Zimbabwean women from HIV infection (WLSA, 2002).

4.8 Conclusion

The above findings show that while the entire human rights framework concerning the granting and exercise of reproductive and sexual rights is based upon equality between the spouses, it is clear that married women do not enjoy such rights and are especially incapable of demanding safe sex from their husbands. The main reason for this is that legal rights and obligations are overtaken by socio-cultural factors which come into play within Zimbabwean society.

CHAPTER FIVE

5.0 MARRIAGE AND REPRODUCTION: IS IT MARITAL BLISS OR MYTH?

5.1 Introduction

This chapter presents the findings of my research pertaining to marriage and a discussion of the key issues that flow from them.

5.2 Marriage

Our Zimbabwe society promotes or sells marriage as a glamorous event and Figure 2, below, is the typical image of a perfect couple at their wedding ceremony wearing elaborate matching embroidered outfits.

Figure 2: Photograph of a couple participating in their wedding ceremony

Source: Internet: www.mas.leon.com

Advertisements openly commercialising weddings, such as the one shown in Figure 3 (below), are very common in Zimbabwe and they make one seriously consider that our society sees marriage as a money-making scheme in which the couples' preoccupation with

the glamour of the public event and their outfits (especially in the case of women) take precedence over the meaning of the ceremony itself.

Figure 3: A typical commercial advertisement promoting marriage

Source:Internet:https://www.facebook.com/events/166881410349318/?ref=3&ref_newsfeed_story_type=regular&action_history=null

Both key and individual informants subscribed to the fact that marriage is regarded as a socio-cultural practice that is generally held in high esteem in that every woman should participate in it if she is to be regarded as a 'real, good and complete woman'. This social duty requires that every women of every class and social status should partake of it. The significance attached to marriage and family in Zimbabwe was revealed by Rutendo (30), who said:

> *'Muchivanhu chedu chechi*Shona *munhu wese anonzi mukadzi anotarisirwa kuroorwa nekuvaka imba yake akatadza kudaro haana chiremera mumhuri kana nzvimbo yaanogara.'*
> (She meant that in our *Shona* culture every woman is expected to settle down through marriage and establish a family of her own otherwise failure to do so means that society will fail to respect her as much as they respect a married woman.)

This sentiment was echoed by Chitauro-Mawema's (2003: 14) observation that when it comes to marriage, Zimbabwean women considered it their eventual destination.

I also found that the society validates marriage by the payment of *roora*, no matter what kind of marriage the parties enter into and when such payment is not made, the families of the

couple frown upon the relationship and may never even accept it as being a marriage, even if it is certified by a marriage certificate. A significant number of the women in focus discussion groups who were either never married or divorced/separated indicated that they frequently resisted the on-going social pressure to marry because of the challenges posed by the marriage institution.

Marriage is one of the risk factors that increase women's vulnerability to HIV/AIDS infection. The Director of WASN captured this when she said that in her view, the urge to get married may very well be a more important concern than the marriage itself and should be properly addressed first because of the toll marriage takes on women's sexual health. For example, once *roora* has been paid for a woman she is socialised to believe that she cannot refuse her husband sex whenever he asks for it. Furthermore as soon as it has been paid, the woman, according to *Shona* culture, binds herself to her husband as her only sexual partner, but the same rule does not apply to men who have the liberty to pay bride price for more than one wife. So *roora*, being such an important element of the marriage contract, is used by men to justify their imposition of control over their wives' sexuality and reproductive rights on the basis that they have bought her.

While married women dare not ask their husbands to a condom even if they know that unprotected sex increases their chances of contracting HIV/AIDS, the lovers of those same men suffer no such impediment and when they ask them to use condoms, they oblige. One of the married women respondents related that when she once attempted to ask her husband to use a condom, he scolded her and said:

> *'Ndingadyire sweet yangu mupepa here ndiwe wave hure rangu here wakazviwanepi zvauri kutaura unofurirwa neshamwari dzako.'*
> (The respondent meant that her husband was refusing use of condom by alleging that he will not eat the sweet he purchased in its plastic wrapping and neither was she his prostitute that she could make such a request to him and he was blaming her behaviour by putting the blame on her friends.)

In affirmation of that position Dr Bopoto stated that:

> 'The incapability of married women to use condoms exposes them to HIV/AIDS as they lack the bargaining power to ask for safe sex and to protect their reproductive rights.'

Married women are expected to fulfil and honour the expectations imposed on them relating to their socially designated role of childbearing even though their husbands, bent on their own personal sexual gratification, deliberately expose them to the deadly risk of contracting HIV/AIDS. The respondents stated that marriage and reproduction in *Shona* society were inseparable because unless and until children are born to a marriage it is considered incomplete. As a result, a woman who is unable to have children will inevitably find herself with a husband who either turns polygamous (by marrying another wife) or promiscuous (with 'a small house' lurking somewhere in the shadows) or both, or she will end up divorced and sent back to her parents. The male respondents stated that the use of condoms in marriage was unacceptable because it contravened the African culture which glorifies fertility at any cost.

To show the importance of fertility one respondent stated that:

> *'Kubara ndiko kunokudza rudzi nedzinza saka mukadzi asingabare ane nhamo panyika.'*
> (She meant that the sole existence of a woman is based on her ability to have children otherwise failure to do so means she has problems for a lifetime.)

Simply put, *Shona* society requires women to reproduce and to do so under conditions of unsafe sex which exposes them to HIV/AIDS infection. Officials at both the NAC and the Ministry of Health agree that this is indeed the case and that the lack of the use of condoms predispose women to HIV/AIDS infection. From the discussions and interviews that I conducted, it was the stereotypical teachings about *Shona* marriage that make women more susceptible to HIV/AIDS infection as they are socially indoctrinated to believe that they are duty bound to go to any lengths to please their husbands sexually. By merely looking at these findings, marriage and its institutional demands and rewards can be described as one of the socio-cultural practices that increase Zimbabwe women's vulnerability to HIV/AIDS.

The pregnant woman captured in the photograph in Figure 4 (below) is the typical image of a wife fulfilling the procreative role society expects of her.

Figure 4: Photograph of a pregnant woman

Source: Internet: thegrio.com

5.3 The link between marriage and violence

Throughout my research I found that fear was a common characteristic of the married women I interviewed as they did every possible thing not to upset the so-called harmony in their marriages. It was this same fear that prevented them from actively asserting themselves in sexual matters or any other matter of importance that directly concerned them and their welfare. This fear was either induced through the threat of violence or actual violence inflicted on them by their husbands who abused them physically, verbally, emotionally and financially. The ultimate fear which gripped these women was the possible dissolution of their marriages. Violence therefore presented a much bigger problem for these same women who cannot leave their marital home for one reason or another because they want to hold on to their married status to avoid shaming their parents and relatives by coming back home having been divorced by their violent husbands. One respondent clearly stated that:

> *'Zvinonyadzisa kunzwa kuti munhu akarwambwa nemurume pamusoro penhau dzebonde.'*
> (She meant that it was a shaming act that one would be divorced by her husband for sexual issues.)

Therefore, held to ransom by their husbands' violence and/or threats of violence based on all kinds fears they use to threaten to destroy the marriage, married women choose to ignore and sacrifice their reproductive health in order to stay married.

The Zimbabwe SADC Gender Protocol Barometer (2014) observed that regardless of the country's fairly strong Gender Based Violence (GBV) legal framework, the incidence of all forms of violence against women, especially physical and sexual violence, was still increasing (Barometer, 2014). They also realised that the most common form of GBV which was suffered by women and committed by men happened in intimate relationships (Barometer, 2014). About 90% of the women interviewed suffered intimate partner violence (IPV), while 73% of the men admitted to causing this form of violence (Barometer, 2014). The same information is substantiated by the Information Bulletin Series, Study Number 1 that revealed that it was a result of the high rates of HIV infection in women that has brought the problem of violence against women into sharp focus.

The Ministry of Health and Child Welfare (2004.45) did not fail to notice that:

> 'The exposure of women/girls to HIV infection was result of the manifestation of power imbalances in the form of sexual violence.'

This observation confirmed my findings that no open discussion about issues of sex occurs between husbands and wives as a result of the dominating positions of husbands. The female respondents attested to the fact that wife-battering is normal and common in their own households and/or they have witnessed it happen to fellow women. The female respondents acknowledged their worries over the gruesome murders by men of women in the so-called name of love that were published almost daily on national television (the Zimbabwe Broadcasting Corporation) and in local newspapers. Consequently, murders as a result of domestic violence are flooding the judiciary as the State seeks justice on behalf of the murdered women and their relatives. Figure 5 (below) is a typical story of one of these cases published in the local Newsday newspaper and which confirms that there is a link between gender based violence and marriage as the deceased woman referred to in this story was intentionally killed by her husband on suspicion of infidelity; yet it is almost always the case that it is actually husbands who are unfaithful and promiscuous but get away with their misconduct scot free because of the power imbalance in marriage.

Figure 5: Newsday newspaper article entitled 'Gweru killer husband caged' dated 3 March 2016

Gweru killer husband caged

BY STEPHEN CHADENGA

A top educationist, who allegedly fatally struck his wife with a hoe following a love triangle row, was yesterday remanded in custody to March 16.

Freddie Nyamanga Shavi (63) was not asked to plead to the murder charge when he briefly appeared before Gweru magistrate Judith Taruvinga. Shavi, an inspector in the Ministry of Primary and Secondary Education, allegedly butchered his wife Netsai Ncube (48) with a hoe on February 27 this year, accusing her of infidelity.

Ncube was a lecturer at the Midlands State University. After committing the heinous crime, Shavi allegedly fled to his rural home in Sanyati, leaving Ncube lying in a pool of blood. She later succumbed to the injuries at Gweru Provincial Hospital.

State allegations are that on the fateful day, the couple had a heated exchange, with Shavi accusing his wife of cheating on him. In a fit of rage, Shavi allegedly dashed outside the house, picked up a hoe and struck Ncube three times on the head and fled the scene.

He allegedly later called his Kwekwe-based relative, Xmas Mutero, and briefed him about the incident. Mutero rushed to the family home in Southdowns and ferried Ncube to hospital, where she later died that same day.

Shavi was arrested in Sanyati the following day.

Figure 6 (below) is a photograph from the internet website of the Sunday Mail newspaper published on 28 February 2016, showing a married Zimbabwean woman being violently attacked by her husband out in the open. It confirms the research findings that women subjected to or threatened by violence fail to stand up for themselves on issues that directly affect them such as sexual matters.

Figure 6: Photograph showing a husband violently attacking his wife out in the open

This kind of violence has resulted in women adopting a silent culture of fear in which they choose not to talk about sex with their husbands or even dare to ask them to use condoms for their sexual and reproductive health. One of the respondents Fadzai stated:

> *'Kana uchida kunetsana nemurume kana kurohwa naye taura nyaya yemacondom mumba.'*
> (The respondent simply meant that the requests of condom use could result in one either being verbally abused or more so being beaten by the husband.)

As a result I came to realise that husbands' forcing their wives to have sex with them is a risk factor in itself. This kind of violence and the threat of its use exacerbate discrimination between men and women and compromise women's autonomy, health, security and dignity. This is worsened by the fact that other people in society continue to accept wife beating for their supposed bad behaviour thereby normalising domestic violence in the process and making it a private matter rather than bringing it into the public spotlight for legal scrutiny. Koffi Anan, the Secretary General of the United Nations (2005), observed that a woman who experiences violence on a daily basis cannot be and is not a free woman because this fear and violence against her results in her submissiveness which prevents her from being able to negotiate for safe sex to protect herself and in the process risks infecting herself simply in order to please men.

The story of one of my respondent's Nyasha verified this. She explained that after about four months into the marriage her husband coerced her into having unprotected sex with him. She initially refused and her husband reported her to his family whose 'aunties' called a meeting and the family gave her an ultimatum that she either indulges him or she immediately leaves the matrimonial home. She gave in and contracted the virus within a short space of time. In her heart-rending words she said:

> *'Kuda imba ndiko kwandisvitsa pandiri nhasi kwandiita nditarisane neguva ndiri mwana mudiki pamusoro pechirwere chandasangana nacho nhasi nekuda kuwanikwa.'*
> (She meant that her desire to be married had led her to her death as a young woman because of the HIV/AIDS infection she had contracted on the matrimonial bed.)

While most married women fear contracting HIV/AIDS during their marriage, Nyasha actually did contract the virus very quickly after the wedding ceremony. And she is

representative of many other women in this situation who either feel too embarrassed to speak of their HIV status or who have now just resigned themselves to their fate that they will contract the virus sooner or later. Nyasha will never know whether her husband contracted the virus from his previous marriage or from his exposure to multiple sex partners while he lived as a divorcee. What is clear, however, is the fact that he was probably aware of his HIV positive status. Hence, his refusal to submit to an HIV test together with his forcing Nyasha to have unprotected sex with him means that he knowingly infected her with the virus under the guise of his right to demand that she satisfy his conjugal rights. So it is safe to conclude that fear and violence in marriage is a factor that impedes attaining of safe sexual methods for women in the face of HIV/AIDS.

5.4 Substantive or formal equality in marriage vs Sexual relations

The husband is considered the head of the family and holds the decision–making power in all family matters. There is major power imbalance between males and females in all family relationships and this makes it impossible for a woman to attain her own sexual autonomy. The *Mudzuru* case provides a ray of hope to women who suffer from inequality right from the inception of their marriage and by prohibiting child marriage, the stage has been set for leaving behind formal equality and moving towards achieving substantive equality (*Mudzuru*, 2015).

The *Mudzuru* case identified that gender inequality in marriage originates from the differential treatment of girls and boys which is then formalised by impugned legislation, in this case, section 22(1) of the Marriages Act, Chapter 5:11 and the Customary Marriages Act, Chapter 5:07 in so far they allow a girl child who is under 18 years to be married (*Mudzuru*, 2015). The judge pointed to this as being an old stereotypical perception which destined women for home and child rearing whereas only males were qualified to work in the public sphere (*Mudzuru,* 2015). The women respondents confirmed that this perception exists when they said men can never accept their wives as being equal counterparts in marriage because they basically think that equality cannot exist between the two sexes since they regard themselves as being superior to women.

However upon taking a closer view of the pluralistic nature of marital regimes in Zimbabwe, it becomes obvious that the gap of sexual inequality is found to exist not just at the inception

of marriage, but before its formation and after its dissolution as well. Since the enforcement of the law is personal in that it only regulates the behaviour of people but not their attitudes, there are limitations to what the law can achieve in changing their attitudes. For example, it is not the type of marriage that determines whether women will have any bargaining power concerning sexual and reproductive issues because the issue of power falls within the domain of gender relations between male and females in society. However, men will tend to choose the type of marriage with which they feel most comfortable being the one in which they can exercise more as opposed to less power over their partners. Therefore it is not surprising that statistics show that most marriages are in fact unregistered customary marriages (Dube, 2013). Most of my female respondents desired to have a civil marriage (i.e., registered in terms of the Marriages Act, Chapter 5:11) but most of them found themselves 'stuck' with unregistered customary unions as their husbands were reluctant to register their marriage for various reasons, one of them being women begin to disrespect their husbands once they have a marriage certificate. Being subject to the socio-cultural pressure to be married, a woman will rather indulge the man's whim to choose the type of marriage that suits him and she will tolerate living in any type of marriage rather than not be married and stay or become single. This situation outlined here shows that the reality of the condition of women's human rights to sexual and reproductive health does not marry up with the provisions of the human right instruments which create, promote and protect them. In other words, the equality which is supposed to exist between men and women in marriage is largely documented in law but does not exist in reality. Zimbabwean society has been largely identified as one where community priorities take precedence over those of its individual members (Rodriguez, 2007; Dunkle *et al.*, 2008; Mhaka, 2010). For this reason traditional norms and values which are revered by the community and which generally favour men are likely to act as vehicles for HIV/AIDS transmission among women through their partners.

5.5 Semi-autonomous social fields (religion, family and society) vs Marriage and marital rape

> *'Vakadzi vanorepwa mudzimba asi vangani vanoenda kucourt nesociety yedu ino akasazvinyarira anenge achitsiudzwa nevamwe kuti ndochii chawave kuita ichocho.' (SafAIDS Official, 2015).*
> (This means marital rape occurs often in marriage but not many women go to court because of the society because if not ashamed yourself to report, others will be busy reprimanding you for attempting such prosecution against your husband.)

Zimbabwe is a patriarchal society that is flooded with other factors besides law that control what happens in marriage and these include family, society and religion and the operation of these factors is so strong that married women find it very difficult to escape their grip. Families and society in general will try at all costs to keep a woman in a marriage no matter how bad it turns out to be because divorce and the status of being single remains a problem they prefer not to have to deal with in their families. Before they go into marriage women are already socialised to respect their husbands. Mary Sandasi of WASN captured this extremely well in our interview when she pointed out that it was the 'aunties' of the woman who started the process of disempowering her by teaching her that she should succumb without question to sexual relations with her husband whenever he so desires. The aunties referred to here are the sisters of the father's bride who when their niece gets married sit with her and explain the expected roles and duties she is required to perform when she goes to her husband's matrimonial home and one of the duties she is taught is that she should never refuse her husband sex no matter the circumstances to protect him from pursuing extra-marital affairs. The ladies at kitchen parties also do the same thing.

So when she gets married submission is already a priority in her marriage and she does not think of the consequences of such silence for her health as a woman until she is given a rude awakening by maybe contracting STIs or HIV itself. Whilst the family and society are playing their part, religion comes in and reinforces the message of submissiveness. A person's religious background always influences the way they live and behave. Therefore religion and its teaching expose women to the risk of HIV/AIDS, especially through the doctrine of submission according to Biblical scriptures.

From the respondents I interviewed, I discovered that in the Johanne Marange sect condom use is non-negotiable and neither is the taking of medication of any sort for any disease as going to medical institutions is forbidden. The fact that marriage is expected to take place between sect members means that there is high risk of infection and re-infection. Further, the fact women are taught to be subordinate to men means that the former owe their HIV status to the latter. This is bolstered by the fact that a woman is expected to forgive her husband for infidelity and pray while continuing to perform all her duties as wife and mother. Affirming this view the Ministry of Health in 2000 stated:

> ‘The submissive role of women disempowers and makes her unable to question issues pertaining to their health and sexuality. The inability to question pertinent issues regarding their sexuality makes women susceptible to HIV/AIDS and STIs.’

Society does not know or acknowledge marital rape as it presumes that a woman must submit sexually to her husband whether she wants sex or not. As a result many married women from different classes and social backgrounds are made prisoners in their own homes because marital rape occurs often enough in their matrimonial homes yet women feel powerless to do anything about it because the society they live in does not acknowledge marital rape. The respondents in the field acknowledged that marital rape is common but women have learnt to turn a blind eye to it to avoid societal castigation. Rudo said:

> *‘Kakawanda muupenyu paunonzwa kusada kurara nemurume asi anongokumanikidza chete nekuti varume vakasikwa vachingoda zvebonde zvakanyanya.’*
> (The respondent simply meant that marital rape occurs often enough and a woman is powerless to do anything about it.)

Be that as it may, the failure of women to protect themselves from sexually transmitted diseases within their marriage is a dangerous factor in light of the high prevalence of HIV/AIDS infections in Zimbabwe.

To understand the position of women in terms of legal implications, I then interviewed prosecutors in their offices who stated that marital rape is a thorny issue. While the law criminalises marital rape and gives women the right to sue their perpetrators, most women never report their husbands although some cases of marital rape are prosecuted every now and then. The prosecutors stated that typically, marital rape cases are dogged by suspicion as one can never be sure whether a wife is genuine in her complaint against her husband or abusing the law by trying to punish him for a perceived unrelated wrong. Therefore, the legislation provides a safeguard in that no prosecution may be instituted for marital rape unless the prior authorisation of the Attorney-General has been obtained (in terms of section 68 of the Criminal Code). The prosecutors agreed that the criminalisation of marital rape has been largely undermined by society and the church which both advocate against it by their teachings. While sections 79 and 68 of the Criminal Code and Reform Act were intended to deter marital rape and wilful transmission of HIV, in reality the law is failing to act as a

deterrent as many women are being silently infected in the so-called sanctuaries of their homes.

5.6 The criminalisation of the wilful transmission of HIV/AIDS and its effect on married women

As has been indicated above, married women are exposed to HIV/AIDS infection through their marriage and its cultural practices. This was supported by the SafAIDS official who said that a woman can be exposed to the risk of infection in the course of the usual performance of her sexual duty without the slightest knowledge that her husband has become HIV positive. In the case of a husband's wilful transmission of HIV to his wife, the criminalisation of this act has been rendered more or less useless by the fact that infected women do not approach the courts to prosecute their husbands.

This was confirmed by the female respondents who, rather than prosecuting their husbands, chose to keep their marriages intact and accept their fate, especially if they are financially and economically dependent on them. One of the respondents made herself very clear:

> *'Kana ndabatwa chirwere kuburukidza nehunhu hwababa ndinotambira zvinorwadza asi hapana pandichasiya vana vangu kana musha wangu nekuti zvinenge zvichabatsirei nekuti hachirapike.'*
> (She meant that once she is infected through her husband she is prepared to stay in her matrimonial home as there are no measures she can take that will change her HIV positive status.)

So unless there is breakdown of the marriage, criminalisation is never an issue with women, as they simply suffer in silence.

The problem that arises out of the criminalisation of the wilful transmission of HIV/AIDS is that instead of being the intended beneficiaries of the legislation, married women ultimately become its target. It works like this. When married women get pregnant and attend antenatal classes they are tested for HIV/AIDS and hence it is most often women, and not their husbands, who first discover their HIV status. This creates a problem in that when the women then disclose their status to their husbands, they normally react negatively by deserting/divorcing their wives and remarrying which serves only to increase the spread of the infection. The ultimate tragedy is that it is the women who end up being prosecuted under

section 79 of the Criminal Code and Reform Act for being the wilful transmitter of the virus to their husbands. In other words, the law fails to take into account that when it is enforced under circumstances such as those related above, it is the woman who has been infected by her husband who first discovers her HIV status and, although the innocent victim, she is likely to end up being prosecuted for infecting her husband, the really guilty culprit!

State v Samukelisiwe Mlilo SC-340-12 is a typical case of how the enforcement of section 79 violates women's rights and puts them at a cruel disadvantage. Mlilo was in an abusive relationship and was the first to be tested for HIV/AIDS when she got pregnant and chose not disclose her HIV positive status to her husband for fear that he would become violent against her. She was convicted despite there being no conclusive proof that she had infected her husband. ZHLR has queried this case and approached the Supreme Court about it.

Although the prosecutor stated that in most cases the state usually fails to prove beyond a reasonable doubt who infected who (meaning that most prosecutions end in acquittals), women have been successfully prosecuted and have had to challenge their cases in the Constitutional Court as seen by the pending cases of *State v Pitty* SC-96-12 and *State v Samukelisiwe Mlilo* SC-340-12, to mention but just a few. Therefore the dilemma and problematic effect of enforcing section 79 against women must be re-examined when considering the criminalisation of the wilful transmission of HIV/AIDS.

Zimbabwe Lawyers for Human Rights (ZLHR) is of the view that the criminalisation of the wilful transmission of HIV/AIDS is a poor response to the problem and that section 79 needs to be repealed as it infringes on the human rights of women and fuels gender based violence as women are the ones more likely to know their status before men. When women test positive they have to disclose this fact to their spouses and thereby expose themselves to imminent abuse, violence and eviction from the matrimonial home. If they fail to disclose their status they risk prosecution. In addition, section 79 is wide enough to cover mother to child transmission in cases of pregnancy. However, despite having this reality drawn to their attention, the prosecutors remained adamant that this law was specifically passed to protect women from the wilful infection of HIV/AIDS and as far as they were concerned the law is doing a great job doing just that for women were courageous enough to invoke it.

In addition, the WASN director agreed with the ZLHR's stance and stated that WASN was one of the women's civic groups that fought for the criminalisation of wilful transmission but they had not anticipated who would be criminalised as a result of the enforcement of the law. She also said that it is turning out that it is mostly women who are being prosecuted because they discover their HIV positive status earlier than men. She went on to say that in her own opinion, criminalisation actually victimises women and having realised their blunder, the civic groups need to come together again to try and rectify this error by re-visiting this whole area of the law and advocating for its amendment where suitable.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Concluding remarks

This chapter presents a summary of the research and the recommendations which flow from it. Generally the conclusion of the research is that the Zimbabwean legal framework grants women marriage and reproductive rights and autonomy as provided for under various regional and international human rights instruments. The problem within Zimbabwe's *Shona* society which is under examination is that despite the existence of such laws, their implementation is problematic because married women fail to realise and enjoy their rights not only because they do not know them, but even if they do them, the patriarchal nature of the society prevents them from doing so.

I have come to realise that the control of sexual behaviour in a marriage depends solely on an individual's willingness to change their attitudes, beliefs and ideas of power and responsibility. When it comes to the social issue of what goes on in the bedroom, the long arm of the law clearly has its limitations because at some point the law stops being an influence and other social ideologies and philosophies come into play in informing an individual's choice. Therefore a more holistic approach that extends beyond law needs to come into operation. The fact that power of the law to bring about positive behavioural change is limited means that addressing married women's vulnerability to HIV/AIDS remains a challenging issue. The reason for this is that the factors that ultimate converge and result in married women's vulnerability are often the result of deeply entrenched social and cultural roles and stereotypes.

The married women's vulnerable position frequently requires them to acquiesce to unsafe or harmful practices simply because the social, economic and cultural costs of refusing to do so are considered to be too high. Basically a woman's life is at a juncture: on the one hand, she lives within a world of patriarchy and harmful stereotyping which equate a woman's worth to her reproductive capacity and on the other, her subordinate role within her community exposes her as a vulnerable woman to the risk of infection.

Married women are easily susceptible to the virus because of their limited bargaining capacity in sexual encounters notwithstanding the fact that the right of reproductive autonomy is assured by the Constitution. The reality on the research ground gives a clear picture of just how absent the realisation of these rights are from most of the lives of the respondent married women. Ultimately specific positive behavioural changes are required to address the issue of HIV/AIDS vis-à-vis married women and their reproductive autonomy, and the starting point is the need to address behaviour through communication.

6.2 Recommendations from the study

Zimbabwean law is to a large extent compatible with the international human rights frameworks as regards women's reproductive rights and autonomy as well as marriage rights. Thus in my opinion what is required is the realization and enjoyment of those rights. The following are some of the interventions I consider prudent in the circumstances.

6.2.1 Legal recommendations

1. The harmonisation of the pluralistic marriage regimes in Zimbabwe to make them one and by so doing remove the discrimination that is created between the Marriage Act, Chapter 5:11 and the Customary Marriages Act, Chapter 5:07 so that on paper women are given the same marriage protection and equality. Then men will no longer have the excuse that the law sanctions some of their more problematic behaviour.

2. The alignment of marriage laws to the provisions of the Constitution to remove the current legislative gaps that continue to permit discrimination and inequality as recently found by the Constitutional Court in the *Mudzuru* case which impugned certain areas of the laws of the marriage.

3. The education of women by informing them of the different types of marriage regimes and the implications of each.

4. The empowerment of women within their marriages and how they can protect their reproductive rights.

5. The establishment and management of well functioning legal and social structures and systems to remedy violations of women's reproductive rights as the existence of human rights instruments and national legislation on their own does not suffice.

6. The adoption of effective means or measures to promote and protect the reproductive rights of women and men.

7. The abolition of polygyny or its discriminatory effects against women.

8. The abolition of *roora* will remove the view attached to the practice that men purchase their wives and give them oppressive power over women which propagates and intensifies gender violence against women and children who are the 'products' of their marriage.

9. Sensitisation of the entire country, that is all men and women in our society, law and policy makers on the practices of *roora* and polygny and their implications for women and their rights and why advocating for their abolition should succeed.

10. A test case that brings the issues of *roora* and polygny before the Constitutional Court case challenging their constitutionality.

11 The repealing of section 79 of the Criminal Code and Reform Act to the extent that it violates the human rights of people living with HIV and other vulnerable groups (including married women) and to the extent to which it is counterproductive to HIV prevention, treatment, care and support efforts and replacing it with general criminal laws that are not HIV specific.

12. The State's implementation of policies and legislation against harmful traditional practices that increase vulnerability to HIV.

13 Society's lobbying of the State to implement its existing national and international legal commitments which promote the reproductive and sexual rights of married women.

14. Society's lobbying against State policies that perpetuate gender and sexual inequality.

6.2.2 Social recommendations

1. The implementation of relevant programmes which address the causes of gender-based vulnerability to HIV.

2. A nationwide education campaign promoting the use of condoms in marriages in which men are encouraged to play an active role and religious and opinion leaders are involved to design effective behavioural change strategies.

3. The involvement of couples who are HIV positive in outreach programmes. They can act as role models to educate their fellow colleagues on the importance of behavioural change.

4. The general encouragement of open responsible dialogue about sex and sexual issues between men and women as couples or groups.

6.2.3 Economic recommendations

1. The allocation of more resources towards encouraging women to start and maintain income generating activities to empower them.

2. Prioritisation of vocational and educational training programmes for women.

3. Lobbying of the State to take progressive steps to ensure the economic empowerment of women.

6.3 Areas of future research

In my opinion there is a need for more quantitative empirical studies in Zimbabwe proving the link between the risk of HIV/AIDS infection and marriage and its associated cultural norms such as *roora*, polygny and promiscuity and dry sex practices and when they are then combined with qualitative studies (like this one) they will add weight to the findings of the present research. There is also a need to extend this kind of research to the rest of Zimbabwe with an additional focus of creating ways and means of encouraging men and women to work

together to combat the spread of the HIV/AIDS virus. The reason for this is that the findings and implications of this research have proven to have a powerful and potentially life-and-death impact on their sexual behaviour and relationships and ultimately their marriages. Both sexes need to be well educated and empowered so that they can both enjoy exercising their mutually beneficial sexual and reproductive rights within healthy marriage relationships.

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