

Criminalization of HIV non disclosure, exposure and transmission; is it the solution to the protection of women against violence in Zimbabwe

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## Declaration

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

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

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

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## **Dedication**

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

My Mother. All this is for you. I would not be where I am today if it was not for your love and support.

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## **Abstract**

This research seeks to interrogate whether section 79 of the Criminal Law codification and Reform Act, that is on wilful transmission of HIV protects women against infections and violence. The main focus was on the attitudes towards sexuality by various women as well as the problems of prosecuting such cases. I used methodologies which includes the women's law approach, the human rights approach, actors and structures as well as the sex and gender analysis. Each methodology assisted me to explore the real challenges in using the law to prevent new infections on HIV as well as protecting women against such. The women's law approach was useful in getting to know what the women really wanted and how they thought this law could help them. The actors and structures helped me to interrogate deep into what these key informants thought about the law and how they were dealing with the problems they encountered in dealing with such cases. An example is on prosecutors who bring the cases before the court. They face various challenges in trying to prove beyond a reasonable doubt that an accused person actually infected the complainant with the virus and if he did, it was deliberate. I also interrogated the law on the doctor patient relationship and how the laws should be aligned so that the prosecutors know what to do when the doctor is the one with the evidence and is supposed to testify, yet because of the doctor client privilege the same law does not allow them to testify, disclosing what they would have discussed with their patients. I also discussed the right to know one's status against the right to private, and sought to strike a balance between the two competing rights.

## **Executive summary**

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

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

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

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

The war of wilful transmission of HIV is far from being won because of the shortcomings of the law, especially on the issue of doctor patient privilege. However, commitment from the government through educational campaigns and addressing gender relations, thereby increasing levels of knowledge and awareness, improving negotiation skills as well as enhancing assertion and heightening self esteem can be a measure effective in ensuring protection in intimate relationships, other than just criminalising, as criminalising on its own will not protect women in any way.

The root of the problem need to be addressed, that is the way gendered power relations, especially in intimate relationships restrict the ability of women to protect themselves against being infected.

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# Chapter 1

## 1.1 Introduction

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

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

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

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

When they arrived, the nurses encouraged them to get tested for HIV and they tested positive. She was so devastated and she asked her husband what had happened as she knew she had only slept with him and no one else. That is when he confessed that he had slept with a certain woman during his gold panning days and all along he knew he was HIV positive but kept it from her for the fear that she would dump him since she was the bread winner. He was actually taking herbs to suppress the virus for the past four years. He however said there was no guarantee that she had not has sexual intercourse with someone else when she had gone to Namibia.

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

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

Zimbabwe is one of the sub-Saharan countries whose people have not managed to escape the severe impact of HIV/AIDS, a majority of which are women who contract the disease from partners who know their statuses and chose not to disclose. This dissertation looks at those women who are victims of deliberate transmission of HIV. It seeks to interrogate whether s79 of the Criminal Law Codification and Reform Act Chapter 9: 23 protect women against infections and violence. It provides that “ any person who, or realising that there is a real risk or possibility that he or she is infected with HIV; intentionally does anything or permits the doing of anything which he or she knows will infect, or does anything which he or she realises involves a real risk or possibility of infecting another person with HIV, shall be guilty of deliberate transmission of HIV, whether or not he or she is married to that other person, and shall be liable to imprisonment for a period not exceeding twenty years.”

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

“Criminalisation of HIV” refers to the enactment of criminal statutes that penalise the exposure of or the transmission of another of HIV. (Burris and Weait, 2011). Many countries across the globe, Zimbabwe being one of them, are now criminalising HIV non disclosure, exposure and transmission. The rationales and justifications for this are different, including incapacitating of offenders and protecting the community from the risk of transmission. Many might see it as a powerful and effective way of

articulating social disapproval for conduct. As a feminist and a student of Master in Women's law, I therefore sought to interrogate if there is compelling evidence that it protects women against infections and violence. Weait (2011) notes that there is an increasing amount of evidence that it does harm, especially to those particularly vulnerable, the women.

## **1.2 Background of study**

As a public prosecutor, experience has taught me that the prosecution of deliberate transmission hardly lead to convictions, if ever the matter gets into court. When vetting cases, I discovered that there was hardly any evidence linking the accused to the commission of this offence and I sought to interrogate why this was so, and how the law could be used to protect women against infections, re-infections and violence. Before coming to SEARCWL<sup>1</sup>, I never thought about this, then I thought this was a good opportunity for me to explore the topic, concentrating on women as victims. This, then resulted in my conducting the grounded research on the actual lived realities and experiences of the women whose partners deliberately infects them with the deadly virus, or just exposed them to it, by not disclosing their statuses yet they allegedly knew of the same. I concluded that the law was not protecting the women as such, and there was need to come up with gender sensitive strategies to protect them, rather than criminalising.

## **1.3 Justification of the Study**

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

As a woman working towards realisation of women's rights, I felt it was important to interrogate the law and see how it is protecting women or helping women to avoid

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<sup>1</sup> Southern and Eastern African Regional Centre for Women's Law

infections and violence. It is anticipated that this research, through the gender sensitive recommendations, will contribute to the growing literature on Zimbabwean women and HIV/AIDS, especially on how to have them be able negotiate for safe sex.

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

#### **1.4 Objectives of the study**

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

1. To assess whether attitudes towards sexuality makes it difficult for women to talk about sexuality.
2. To establish whether women find it difficult to negotiate safe sex, therefore easily getting infected.
3. To investigate whether prosecutors find it difficult to prove beyond a reasonable doubt that someone has infected the other with HIV.
4. To interrogate whether magistrates find it difficult to convict because the state would have failed to prove beyond a reasonable doubt that a complainant has been infected by the accused.
5. To establish whether doctors are allowed by the law to disclose their patients’ status.
6. To assess whether there is need to develop gender sensitive strategies to prevent new infections.

## 1.5 Statement of the problem

*“20 years ago HIV/AIDS was western gay men’s disease. Today it is the number one disease for African Women” (Kelly; 1999)*

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

In the Zimbabwean Constitution, there is a right to life (s48) and the right to health (s76) as well as the right to privacy s57. All these rights apply to the issue of HIV non disclosure, exposure and transmission. Everyone has the right to health, meaning one cannot deliberately transmit the virus as this is a breach of one’s right to health as well as the right to privacy, which is the right to have a person’s HIV status protected by the doctors or medical personnel who will be treating the person. However, as much as this is the current situation, whereby everyone has the right to health, it is competing with the right to privacy as the constitution specifically provides in s57 (e) that everyone has the right not to have their health condition disclosed. Such a provision then poses a big challenge when the state prosecutors try to prove section 79 of the code, as the doctors and nurses are the ones who have the information that an accused person actually knew of his status but chose not to disclose to their sexual partners. That is one of the essential elements of the offence, that is the person knew of their status and chose not to disclose, yet if the nurses and doctors cannot testify, it becomes difficult to prove such an essential element. S198 (3) of the Criminal Procedure and evidence act provides that if the state fails to prove one of the essential elements of an offence then the accused is entitled to an acquittal. So most of these cases are discharged at the close of the state case since the state would have failed to prove that essential element that is the accused

actually knew of their status and chose not to disclose, thereby exposing someone or worse still infecting them with the virus.

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

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

In the Zimbabwean Constitution,

## **1.6 Assumptions**

1. Attitudes towards sexuality make it difficult for women to talk about HIV/AIDS.
2. Women find it difficult to negotiate safe sex, therefore they easily get infected
3. Prosecutors find it difficult to prove beyond a reasonable doubt that someone has infected the other with the HIV virus
4. Magistrates find it difficult to convict because the state would have failed to prove beyond a reasonable doubt that a complainant has been infected by the accused.
5. Doctors are not allowed by law to disclose their patients' HIV status because of the patient doctor privilege

6. There is need to develop gender sensitive strategies to prevent new infections

## **1.7 Research Questions**

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

## **1.8 Definition of key concepts**

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

HIV- Human Immunodeficiency Virus

Anti Retroviral Drugs- chemical agents used to alleviate the virus sequelae thereby inhibiting viral replication

Cd4 count- the important indicator of the presence of HIV

Viral Load- the quantity of the HIV detected in the blood also essential to determine prognosis and the management of the disease

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

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

Disclosure-the condition or state of a person voluntarily and publicly divulging their status

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

Confidentiality –keeping private information about someone e.g. a patient/client

## **1.9 Ethical considerations**

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

## **1.10 Chapter disposition**

Chapter 1 Introduction and background of the study

This chapter serves as an introduction to the thesis. I narrated the story o Emma and Muza, which made me develop interest in such a topic. Key concepts were defined, as well as the ethical considerations, that is how I managed to hide the identities of my informants .I also discussed the objectives of my study and included in the same, my research assumptions and questions

Chapter 3 Research Methodologies and methods

This chapter describes the methods and methodologies used when I was doing my research. The methodologies includes among others, the women's law approach being the umbrella term, the human rights approach as well as the grounded theory. I will go on to explain how these methodologies helped me to come up with the recommendations I have as well as discussing the methods of research that I used like perusal of court records, interviewing key informants and observations among others. I finally evaluated these methods, clearly bringing out the advantages and disadvantages f using each of them.

### Chapter 3 Law and Literature Review

The chapter addresses some of the existing laws, both national and international laws on HIV and how the laws address the issue, as far as women are concerned. The CEDAW, and Protocol to the African Charter on Human and People's Rights were discussed, as well as the national Laws like the Constitution and the Criminal law codification and reform Act. These provide for certain rights, that is the right to life, the right to health as well as the right to privacy, and also these competing rights are further discussed, as far as issues of HIV are concerned.

### Chapter 4 Research Findings and Analysis

On this chapter, I went deeper into my research findings, by concentrating on assumptions 4, 5 and 6. I discussed the problems faced by prosecutors in trying to prove wilful transmission beyond a reasonable doubt, the problems faced by magistrates as well as the doctor patient relationship. I went deeper into problems faced by prosecutors as doctors refuse to come and testify basing on the client-doctor privilege. I then analysed the law on deliberate transmission of HIV and how it affects women

### Chapter 5: Piercing the veil of secrecy in HIV/AIDS; Right to know and the right to privacy

This chapter first explains what is meant by the right to know and the right to privacy and explains what the law says on the two concepts. It then concludes by trying to balance these two competing rights, to establish which right holds, when there is a conflict between the two. Assumptions 1 and 2 are also discussed, that is the problems faced by women in negotiating safe sex because of the way they are socialised, that is to believe that one becomes of loose morals if they are free to talk about sex.

### Chapter 6 Recommendations and Conclusions

In this chapter I made several conclusions that I came up with some conclusions, linking them with my assumptions and made some recommendations on what I thought could be

done to make the law protect women against HIV. This is the chapter where I answered all my research questions and made some recommendations.

## **Chapter 2 Methodological Framework**

### **2.0 Introduction**

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

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

### **2.1 In search of right methodologies**

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

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

Its major component is to critique the interplay between the law and life, because it is predicated on the need to capture women's lived realities with the aim of addressing any existing gender specific injustices. I interviewed some women who had reported cases against their partners, to get to understand why they reported, why they withdrew charges if they did, and the impact of the trial to their marriages, after the man had been acquitted. One woman said she had to withdraw the charges as she felt nothing was going to change on her HIV status, whether he was convicted or not and it was better to stay together and take care of the family.

She said *“zvichabatsirei kumusungisa ini ndatozorwa kare, ndinosara ndichichengetwa nani nevana, ndagara ndichangofa saka ndakafunga kumuregerera. Ndakanga ndamhan'ara because ndanga ndarwadziwa kuziva kuti ainwa zvake mapiritsi achichengetedza hwake utano ini ndiri murima”*

Translated “what is the point of getting him arrested and prosecuted when I have been infected already? Who will take care of me and my children? After all I am going to die so I decided to forgive him. I had reported because I was bitter due to the fact that he was taking his tablets without disclosing his status to me, taking care of his health whilst I did not know”<sup>2</sup>

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

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

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<sup>2</sup> Mbare Musika, 20/11/2015

To them, it was all about the man, and for women to talk about it would mean they were of loose morals. I also noted that it was difficult to prosecute such matters even if one decided to institute proceedings, and I explored their actual experiences by interviewing those women who had caused the arrests of their partners for non-disclosure. I noticed that there was a need to “question the underpinnings of our society and find ways to escape the patriarchal constructs that were the partners of androcentric paradigms” (Stewart and Ncube; 1997) as many withdrew the charges because they were not expected by the patriarchal society to cause a partner’s arrest. A patriarchal society is a society which is dominated by males therefore they would not expect a woman to cause the arrest of a man over wilful transmission of HIV.

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

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

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

## 2.2 Data collection methods

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

### 2.2.1 Interviews with key informants

I interviewed some key informants, a method which involves the collection of data from those who ‘know’ or have experience on the topic as well as or including those with influence in the community.(Chirawu et al, 2007).My key respondents were as follows

**Table 1: Table of respondents**

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

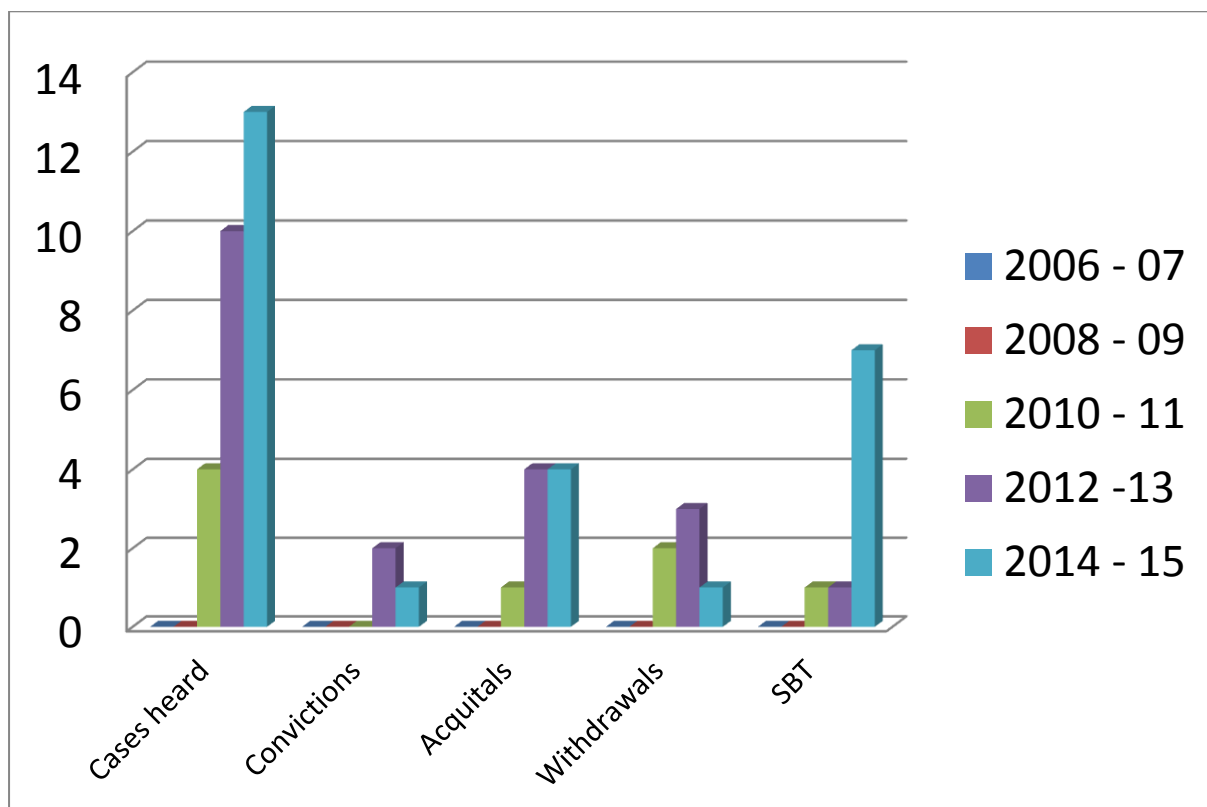
These were chosen based on their expertise and its skills, since I perceived them to have either experience in trials and providing medical care for those living with HIV.I found the method to be a reliable tool of collecting desired data from strategic sources as I got the official positions from the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

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

### 2.2.1 Perusal of Records

I chose this method in-order to get the statistic on how many cases were brought to court for each year and the outcome of each. Some were withdrawn before/after plea, most were acquitted, a few convicted and others sent back to the police station with instructions that the police had to follow but were never brought back to court whilst others were not updated. Below is a graph showing such, from the year 2006. For 2004 and 5 the books could not be found therefore no data was available.

**Table 2 : Cases in court**



\*(S b t- sent back to station)

I also noted, when checking court records, that they “are rarely compiled with the needs of the researchers in mind and could not be seen as a key source of data” (Stewart, 1997) as they are rarely self explanatory, hardly updated and the books were torn such that some pages were missing and the information I found was not 100% accurate. Some cases were not updated such that I could not ascertain their correct positions and the clerks did not have a reasonable explanation. I noted that, as Stewart (1997) puts it, it was necessary to do a pilot study to assess the availability and comprehensibility of court records before using them as a key source in data collection. It was also time consuming to check these records, since I had to do it manually, and there was no guarantee that the information reflected was relevant with sufficient clarity, as some people were initially charged with different sexual offences but it was later discovered that they had transmitted the virus to the victim or had exposed them to the same and were convicted of such but the record would still only be written about the initial charge.

### **2.2.2 Individual Interviews**

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

### **2.2.3 Observations**

There are times when I would go to Harare Magistrate court regional vetting office and listen to prosecutors as they interviewed parties. I did not take part but would just listen and observe. Of important significance, is the openness with which the parties would have in the set-down office as they articulated the issues on the dockets as they gave their personal experiences and arguments. Litigants were free to express their views in the presence of public prosecutors and it proved to be quite revealing and very effective as I noticed all problems women faced as well as the loopholes in the state case. Most of these matters were however returned back to the station for lack of evidence as there will not be any proof that the transmission was deliberate or that she had been tested negative prior to engaging in sexual intercourse with the accused person. Mostly, the men would admit that they might have infected their partners but it was not intentional, with the wives arguing that they were taking antiretroviral drugs, but there was no proof that they were doing so. This helped me to gather divergent views within a short space of time as well as capture the weaknesses of the state case. This is what can be referred to as passive observation, whereby the observer takes no part in the activities that are being observed and is distant in the emotional sense from the events. (Stewart et al, 1997) It was a useful tool in that it helped me to embellish the research record.

#### **2.2.3.1 Testimonies**

On one occasion, I was able to use testimonies given on formal occasions as a way of extracting my data. This was by means of listening to someone as they testified in a court of law. It involved her public recounting of a life experience which she witnessed and was affected by. That meant the individual would be afforded an opportunity to express her concerns and at the same time contribute to the ways of addressing the problem in the future as I listened seated in the gallery. This had a disadvantage however in that since evidence will be led from a public prosecutor, r cross examination by a defence counsel, she was often cut short as they wanted her to concentrate on the evidence that was only necessary for the proving of the essential elements of the offence.

### **2.2.4 Life Histories**

There were times when I would let my respondents relate their lives in an uninterrupted manner, and I managed, from this pool of data, to extract information that was directly related

to the research problems, as well as analyze it from its broadest perspective. I would think that the interview had gone away off tangent, only to discover later that the interviewee would have had a range of perspectives on the topic and wanted to give a broad life based backdrop to the issue that was being researched. Of course, this method was time consuming as the respondents would talk and talk about other things and thereby spending less time on the area that was of interest to me.

### **2.2.5 Evaluation of Methodologies and methods**

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

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

I however managed to collect sufficient data which I will discuss in my findings and I was able to find the women's lived realities covering the theme of my research, such that I managed to triangulate the data I gathered with the experiential data.

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

I also noted that, as I went through the interviews, the topic on deliberate transmission of HIV was a sensitive topic especially to the victims of such and as a researcher I needed to be

sensitive to interviewees' reactions and on occasions, grief. I should have sought counselling myself as "prior to the field work, advice from personal grief counsellors on how to deal with these situations is very useful." (WLSA, 1997) It was important therefore for me to seek expert advice on how to deal with reliving of trauma needs.

### **2.2.6 Conclusion**

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

## Chapter 3 Law and Literature Review

### 3.0 Introduction

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

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

There are a lot of human rights instruments that are in place, to try and protect those living with HIV, as well as protecting those who are vulnerable, in this case women, from being exposed to the virus. One scholar notes that “more broadly, the evolving HIV pandemic has shown a consistent pattern through which discrimination, marginalisation, stigmatisation and, more generally, a lack of respect for the human rights and dignity of individuals and groups heighten their vulnerability to **being exposed** to hiv” (my emphasis) (Mann et al; 1999) These human rights instruments will be discussed in detail below.

The objective of this chapter is to discuss what work has already been done locally and in other parts of the world in-order to identify gaps and take advantage of lessons learnt at a local level as a basis for guiding my research and note if at all wilful transmission really protects women against infections.

There has been a lot written on deliberate transmission in Zimbabwe, but very little written on whether or not it protects women, therefore it is important that I interrogate the law with a woman's perspective, since it is always being dealt with as a matter of general human rights, not as a woman's approach as I took it. Mostly, (my emphasis) women are being infected by their partners who are aware of their status and choose not to disclose, yet it seems the topic of women and wilful transmission is not thoroughly interrogated. The experience of men dominated HIV/AIDS discourses and defined a lot of issues on HIV and course of the illness.(Lindsey,1997)The invisibility of women in AIDS literature led to a delay in understanding how it affected women(Baylies,2003).It is therefore important to include other underclass approaches to wilful transmission of HIV, that insists on the "importance of studying women and 'studying up' instead of studying 'down'".(Harding,1987)

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

### **3.1 International Framework**

#### **3.1.1 The Convention on the Elimination of all forms of Discrimination against Women (CEDAW)**

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

On the issue of confidentiality (which will be discussed in detail below) the G.R 24 noted that "all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice. It is interesting to note that the lack of confidentiality may deter women from seeking advice and treatment and thereby adversely affecting their health and well being. This is an argument which has been advanced by many writers when it comes to confidentiality on HIV issues.

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

### **3.1.2 Recommendation on Ethical Issues in Health Care and Social Settings**

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

This recommendation goes on to draw the attention of medical personnel to the importance of assisting patients in understanding their responsibility towards their partners when it comes to HIV. I noted as I was doing my research that medical personnel do not talk about disclosure, it seems they do not have clear guidelines on that, but only clear guidelines on the principle that it must be voluntary and they must not be the ones doing it without the consent of the patient, not at all considering the right of the third party to know.

### **3.1.3 Protocol On the African Charter on Human and People’s Rights**

Article 14 (e) of this protocol gives everyone the right to be informed of one’s status as well as that of their partner’s, especially when it comes to hiv as well as any other sti. This however creates a problem on the issue of confidentiality v partner notification and this research sought to interrogate the women on what they really wanted. Article 14 (1)

recognises the vulnerability of women to infection by their husbands, boyfriends and partners, some of whom may be aware of such risks but chooses not to disclose.

## **3.2 National Laws**

### **3.2.1 The Constitution of Zimbabwe Amendment (No 20) 2013**

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

The Constitution gives in s57 to everyone, the right to privacy, including the right not to have one's health condition disclosed. This has posed a big challenge in my research as people are no-longer forced to get tested for HIV even when they have committed offences. There is a case whereby an uncle raped one minor girl child, and supposedly infected her with the virus. He argued in court that he was not hiv positive as the minor was found to be positive, and the state intended to charge him with deliberate transmission of hiv but could not do so because they could not ascertain the results of the accused person and to force him to get tested meant a breach to his constitutional right to privacy. This is the same even when the interest of justice is at stake and the magistrates are no longer granting court orders to compel them to. One can only be compelled after being convicted, not anytime before that. It has to be out of one's own free will.

### **3.2.2 Criminal Law Codification and Reform Act Chapter 9; 23**

Section 79 of the code criminalises HIV non disclosure, exposure and transmission, and gives a mandatory sentence of ten years to anyone who, knowing that they are HIV positive, does anything or permits the doing of anything which they realise will infect another with the virus, not considering whether or not the two are married. The enactment of this provision in the code means that an uninfected person has a right to life which should be protected by the law, and unlike the other scenarios whereby it is the state versus the individual, this is a right to life between individuals. The one who knows their status has a duty to disclose to the other party, or else they face criminalisation. This is important for the reinterpretation of rights, as they are relevant to the risks faced by women.

### **3.3.3 National Aids Policy Framework**

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

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

Section 7 of the same then talks of unequal power relations between men and women which leads to masculinity taking precedence over femininity, leading to oppressions of women and in my own assessment, that is what is leading to more women being infected by the HIV virus and not reporting, as alluded for in the first and second assumption, that they fail to talk about sex because of the way they are raised. expectations and norms that regulate their behaviour makes the women fail to negotiate safe sex and the unequal power relations make them not report even when they are sure the husband and partners deliberately infected them with HIV.

### **3.3.4 Case Law**

Zimbabwe's jurisprudence on HIV has not fully developed as many cases are not appealed such that they get to the constitutional court or high court for them to be reported. However, at the Constitutional Court a matter was brought whereby the applicant was challenging the constitutionality of the law on wilful transmission of HIV, and the judgement has been reserved. However, the applicant did not specifically make that application in respect of women in particular but on a human rights issue. There is need to create a judicial precedent that can be used to advance women's human rights, not human rights in general.

### **3.4 Conclusion**

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

## **Chapter 4 Research findings and analysis**

### **4.1 Introduction (Women as victims)**

I realised, from my research that many women did not want the protection of the law or were forced to withdraw charges against their partners because the court sessions were not held in camera and the publishing of those stories by local newspapers meant that their identities could be known, as much as journalists do not disclose the names of the victims. However, if her partners name is revealed, it definitely means that those who know them will know even the name of the victim and they felt they had been exposed as well. Mostly, these women would not have disclosed their status to their families and it was traumatising especially on their children because of the stigma surrounding HIV. One notable example is of a lady who had sued her husband for deliberate transmission of the virus and he was acquitted. The woman was a doctor by profession and she felt betrayed by the press when her matter was publicised.

I showed her a clip whereby her story had been published in a local newspaper; she was shaken for some minutes and started crying. She was surprised, she had not seen the article and she was so touched. She said this ex husband of hers had even gone to the extent of posting on social platforms like face-book and whatsapp that she had lied that he had infected her with the deadly virus since he had now been acquitted and it was so difficult for her, especially considering her work as a doctor as all her staff would look at her with a suspecting eye and she was stigmatised. She even lost some of her valuable patients, as they did not want to be treated by an HIV positive doctor. She blamed to media for publishing such stories without getting accurate information and wondered how her story got into the hands of the press as she believed court documents were supposed to be privileged.

She went on to say as a woman and a victim, the laws had not done justice in protecting her as her matter was published in a local newspaper and it tarnished her image as a medical doctor as well as a mother which affected her so much. She went on to suggest that the press

should not take pride in publicising such issues as they have a very negative impact, especially on women.

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

## **4.2 Prosecution issues**

### **4.2.1 Introduction**

Assumption number says that prosecutors find it difficult to prove beyond a reasonable doubt that an accused has infected the complainant with the virus, whereas assumption number 4 postulate that magistrate find it difficult to convict on such cases because the state would not have managed to prove beyond a reasonable doubt that the offence had been committed. Criminalisation of HIV exposure and non disclosure is a public health intervention, that the law makers thought would reduce the risk of transmission from those who knew that they were infected. "Over the course of the HIV pandemic new statutes have to be written, and general criminal statutes re-interpreted, to allow for such prosecutions."(Bray; 2003) They hoped it would serve as a deterring measure to exposing and transmitting between those who know and their unsuspecting partners, and in Zimbabwe up to date there have been several cases of non disclosure brought before the courts. However, the results that I found upon doing my research were not 100% accurate as many cases were never taken into the court room for trial because of want of evidence, and the books were not updated. It is assured that the results do not constitute an exhaustive review of all prosecuted matters.

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

transmitted. The first known successful prosecution in Zimbabwe took place in 2008, although it is believed that more than 20 prosecutions had been attempted. (Makoni, 2004)

There are a number of hurdles in prosecuting cases of wilful transmission of HIV, which relates to the need for sexual history evidence and causation. Also, mostly because there is a lot of distress on the part of the complainants who are usually women after the accused has been found not guilty. As I interviewed one woman whose husband had been found not guilty, and acquitted after a full trial, she said she felt more traumatised after the trial than before, mostly because she, during cross examination, had to disclose some things about their bedroom life with so much difficulty, hoping to secure a conviction. It is so difficult for women to talk about sex, but after enduring such a difficult time, the court found him not guilty.

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

#### **4.2.2 Proof of (non) disclosure**

I noted as I was doing my research, that some women claimed their partners had not disclosed their statuses to them prior to engaging into sexual activity, yet they knew that they were HIV positive. One Public prosecutor said, usually the women reported after being dumped and one can never be able to ascertain in actual terms whether the accused had disclosed or not, as this would have happened behind closed doors. Also, because some women are not free to talk about sex, for fear of being labelled that they are of loose morals, thereby failing to negotiate safe sex even after being told, they might want to sue their partners upon divorce.

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

*“kusiri kufa ndekupi, ndogona kana kungotsikwa nemota panze apo ndikafa, plus mazuvano vanhu vaakurarama makore akawanda nechirwere hazvina basa izvo, plus handisi pfambi ini inopfekerwa condom”*

*(meaning I can die anytime, I can even be hit by a car outside and still die, so since people are now living longer with hiv we can go ahead and have unprotected sex it does not matter, after all I am not a prostitute, with whom you should opt for condoms).*

<sup>3</sup>

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

From this scenario, one can never be able to know who is telling the truth; therefore it is difficult to prove non disclosure when prosecuting such cases. Women should therefore insist on going for HIV testing before engaging into sexual intercourse with anyone.

One day I had a chance to peruse some dockets which were still in the hands of the prosecutors awaiting consideration. I found one docket, whereby in the facts of the case, the parties got married in July 2010 and agreed to use protection until they got tested. The woman went to the New Start Centre alone in November 2010 and she tested negative to HIV, but the accused always gave excuses saying he was negative. However, they had unprotected sex in May 2012 and the woman developed some rash and went to the clinic where she tested positive to HIV. In April 2015 she discovered empty HIV tablets containers in the accused’s room which he used at his parents’ place. She then went on to look for medical cards which she found and they were in the name of the accused person, indicating that he started taking ARVS in 2005.

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<sup>3</sup> Queensdale, 4/12/15

The problem with this case was; the accused in his warned and cautioned statement said he disclosed his status to the complainant and she agreed to have sex with him saying she was not a prostitute, just like in the above scenario. Also, considering the time that has lapsed, one cannot certainly say that the complainant only had sexual intercourse with the accused. She might have had it with someone else and got infected. Also, if she consented to the act, knowing the accused's status, the court cannot find him guilty of deliberately transmitting the same.

Almost all cases of exposure and transmission come to court because complainants will be claiming that they were not explicitly informed by the accused of his status. (Benard, 2010). It is very common for both parties to disagree on whether there was a disclosure, although this does not necessarily indicate that one of them is misleading the court, since "communication regarding sexual encounter is often complex, with both verbal and non verbal elements, with many assumptions made and many things left unsaid" (UNAIDS, 2012)I am of the view that the courts should find the complainant to be a more credible witness, as mostly (but not at all times) men do not disclose because of fear of stigma.

#### **4.2.3 Proof of exposure**

In Zimbabwe, it is an offence to have sexual intercourse with someone without disclosing, even when the virus has not been transmitted (s79 of the code). This is what is called exposure to the virus. As I did my research, I noted that so many women were being exposed to the virus by their husbands but did not know that it was an offence.

One day I was given a docket by the prosecutor in charge for consideration. The facts of the case were that the complainant Sylvia reported a case of deliberate transmission against her husband Jonathan. The 2, upon getting married, had not been tested, as the complainant kept on asking the accused to go for testing but he refused, saying he was negative. They stayed staying together as husband and wife and sometime in April 2015 the complainant discovered some tablets in the accused person's jacket, and recognised them to be Lamivudine, which is an ARV. She confronted him and he said they belonged to his nephew. She then went for HIV testing and she tested positive. She reported the matter to the police and when she went

to test again she came out negative. She tested for the third time and the result still came out negative.

After being given the docket, I tried calling the complainant on her mobile, which she had supplied to the police but she kept answering and said it was a wrong number. What I drew from this scenario was that women fail to negotiate safe sex even when they have not been tested; they tend to believe when a man tells them he is negative. This is evidenced by the fact that this above mentioned complainant was told by her husband that he was hiv negative and she believed him at face value, instead of insisting that they get tested, thereby being exposed to the virus. When I tried calling her again so that she goes and gets tested for the fourth time, to establish accurate results, she was evasive, maybe did not want to get tested, neither did she want to talk about it, thereby fulfilling the assumption that women find it difficult to talk about sexuality because of the way they are raised.

I am also of the view that although she was exposed to HIV, she does not want the world to know, therefore cannot go ahead with testifying against the accused. People are not free to talk about HIV as they are afraid of being stigmatised or to let the 'world' know that they have been tested positive to HIV.

Also, I noted that people do not know that exposure in itself is a criminal offence, so even if one tests negative, she can still sue the accused for exposing her to HIV. Basing on this case, criminalising cannot be the solution. People need to be taught first, of the essential elements of the offence, especially the fact that exposure in itself is an offence and women must use the law to protect themselves against infections and violence. It is not important that there has not been any transmission.

#### **4.4.4 Proof of transmission**

The most difficult thing to prove on prosecuting such cases is transmission. (Benard, 2010) One might be found to be HIV positive, but the million dollar question remains, who transmitted it to her. It could have been the accused person and there is also a possibility that it can be someone else beside the accused person.

Constable Masamvu, one of my respondents from Glenview VFU unit had this to say: she had dealt with a few cases on deliberate transmission but the women later came to them requesting that the charges be withdrawn as they would not want to have their husbands arrested over the issue. They only cause their arrest because they will be bitter when they first find out that they are HIV positive but with time they forgive their husbands. She said

*“vakadzi vazhinji vanoongoona kuti ndatozorwa kudhara rega tichingogarisana, hapana need yekusungisana”*

*Meaning: many women just think since they are already infected there is no need to press charges but continue to stay together as husband and wife.<sup>4</sup>*

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

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

Mrs Chigwedere, who is a public prosecutor at Harare magistrate court supported this point when said that the state had several problems in trying to prove the guiltiness of the accused beyond a reasonable doubt. Firstly, there won't be any evidence of the complainant's results, who are usually women before the 2 engages in sex so it is difficult to prove who infected who and at what point. "In Zimbabwe, there is no culture of testing before engaging, people just do it willy nilly". Therefore we hardly prove beyond a reasonable doubt that a woman was deliberately infected by the man.

One male doctor whom I interviewed, Doctor Masamha said proof of transmission was hard to find. When I asked her if there was a way of doctors being able to tell who infected who, she said, "there is a speculation that if we take a viral load test one can establish who infected

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<sup>4</sup> Mbare Court, 16/11/15

who, but it is worthy to note that even if its flue, a virus like hiv can multiply rapidly in one person as compared to the other, therefore the results are never 100% accurate”

#### **4.4.5 Proof of intention**

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

*“Most of these cases are acquitted only on the pretext that the accused did not know that he was HIV positive and it becomes difficult to prove that the infecting was deliberate.”<sup>5</sup>*

Tinashe Kanyemba, another Regional Prosecutor also gave an example of a case she was dealing with, whereby a minor child was raped by 2 of her uncles and tested positive to HIV. The minor’s parents and siblings were tested and they were all negative and the uncles were arrested for raping her and deliberately infecting her with HIV. However, it was difficult for the state to prove deliberate transmission as they both alleged that they were negative and the court refused to compel them to get tested, basing on the pretext that it was an infringement on their constitutional rights, therefore they were only convicted of rape and not deliberate transmission of HIV. Also, it was difficult to prove whether or not the minor was positive before the time of being abused, therefore it is very difficult to prove such an offence.

She went on to say the state does not have the HIV results for both men, and the court could only compel them to get tested only after a conviction, but we cannot prove deliberate transmission without those results. Therefore, under the said circumstances, deliberate transmission could not be proved, yet the child is HIV positive indeed, but who infected her, remains the question.

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<sup>5</sup> Rotten Row Magistrate Court, 20/11/2015

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

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

### **4.3 The Doctor Patient Relationship**

#### **4.3.1 Introduction**

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

#### **4.3.2 The duty of confidentiality**

Before commencing my research, one of my assumptions was that doctors are restricted by law from disclose their patients’ HIV status to a third party because of the patient doctor privilege. The national Aids Policy of Zimbabwe defines confidentiality as “not disclosing private or personal information without consent”. There is a great debate on whether doctors should just keep quiet when it comes to HIV, even if they know that the person infected is spreading the virus knowingly, and although it is not part of this thesis, I will discuss it in brief.

*“The emergence of the HIV pandemic has added to the tension between patients’ private interests and public health interests regarding medical confidentiality. Many*

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<sup>6</sup> 21/11.2016 Rotten row Magistrate court

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

Upon doing my research, I discovered that doctors could not come to court to testify against their clients, which made it difficult for the state to prove that the accused persons actually knew of their status. In one case, the doctor came but was not so clear when giving his evidence, as he did not want to breach the doctor patient confidentiality. Below are the facts of the case, as I read it in the judgement by the learned magistrate Mr Mujaya.

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

In his defence, the accused said he did not have any knowledge of the complainant being tested of hiv and found to be negative, he only discovered that he was positive when they tested together. He went on to say he had filed for divorce and the complainant was opposed

to the application, hence the proceedings were characterised with acrimony so she wanted to fix him to compel him to withdraw the divorce action.

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

From the above circumstances, the doctor indeed came to court to testify, but could not disclose what he had discussed with the accused as it was privileged information and upon being asked by the defence whether or not he had told the accused that he was HIV positive, he boldly said he could not remember, thereby weakening the state case. This supports the idea mentioned above that the discretion has been left with the individual doctors, to choose whether to breach the right of confidentiality or the right to information. The complainant, who was a woman in this case, was not protected by the law because of the issue of the doctor patient confidentiality.

#### **4.3.3The duty to disclose to the police/court**

Another pressing issue on criminalisation of deliberate transmission of HIV will be: do doctors have a duty to disclose to the police or to the court, someone's HIV status? The National Aids Policy Guiding Principle 3 notes that "*confidentiality regarding a person's HIV status should be respected. Legal provisions should be made to enable health professionals to disclose to those who have critical reasons to know.*" Under the same principle on 5, the Policy noted that legislation should be developed to enable professionals to disclose to a third party who has critical reasons to know under specific conditions even if consent is denied. However, these are just guiding principle and not law therefore the medical personnel feel they are not legally bound to disclose be it to the police or to the court.

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

#### **4.4 Documentary Exhibits**

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

##### **4.4.1 Authenticity of documents**

There is a very complicated issue on tendering of documentary exhibits when it comes to wilful transmission of HIV, thereby making it difficult to criminalise and protect women. There are instances when women would find cards bearing their partner's names inside their home, as proof that the man was actually taking ARVs and that alone could be proof enough that he knew of his status and chose not to disclose. However, the Zimbabwean Criminal Procedure and evidence Act provides that a document is supposed to be tendered through someone who authenticated it, unless if it is a public document, which can be produced in court through the bar. There has been a challenge on how to tender such documents in court as the nurses and doctors cannot come to court to testify because of the doctor patient relationship. Also, there is the issue of how the document would have been obtained. If it has been unconstitutionally obtained from the accused, then, that made such a document an illegal document which would be difficult to tender as an exhibit in court, thereby destroying the state case and making it difficult for the prosecution to prove beyond a reasonable doubt that the accused actually knew of his status.

As I was doing my research, I came across a docket that was in the vetting office that could not be taken to court because of the issue of documentary exhibits. The facts of the case were such that the complainant was staying in Botswana and that is where she was tested and her result came out negative. She was tested as she was looking for a job and was given a

pathology report to show that she was negative. She was the deported and came back to Zimbabwe, where she met the accused and she showed him her results, but he kept on saying he would bring his own. They started staying together as husband and wife, until she discovered some tablets which she knew were anti retroviral tablets in his possession. She asked him and he confessed, but there was no witness, it was just the two of them. She decided to get him arrested for wilful transmission of HIV since she then went to the clinic and tested positive.

The challenge with this case was that, the woman had proof, that she was HIV negative before she met the accused, in the form of a pathology report, but she had obtained it from Botswana and it meant that the doctor who had tested her was supposed to come and testify that she actually tested negative and that was the proof on the report(considering that a document should be tendered through its author), but then the state was short of resources and could not subpoena the doctor who tested her to come to testify in Zimbabwe. Also, the pathology report was just written “results-negative” and was not explaining what she was tested for that came out negative. The state held such a pathology result with such scepticism and considering that the results were from Botswana, the state did not know how to tender them, and worse still, were they fake or not. The matter could not proceed to trial, and the woman was not protected by the law. There were also other cases where after being caught, the men would destroy their cards from the clinics, and would allege that they did not know that they were HIV positive; thereby the issue of intentionally infecting her would fall away.

#### **4.4.2 Availability of Documentary exhibits**

The other problem with this issue of documentary exhibits came when a warrant of search and seizure was issued in terms of section 303 A as read with 49 (b) and 50 (1) (a) of the Criminal Procedure and evidence act. The courts are now hesitant to issue such warrants which would provide the medical history of the accused and the searches are not conducted, but the medical history will be there in the hospitals. The arguments of the magistrates will be that it will be a breach of the accused person’s constitutional right to privacy; therefore documentary exhibits are posing a very big problem to the issue under discussion.

I also noted that the courts were sceptical in compelling an accused person to go and get tested for HIV prior to the commencement of the trial. An accused could only be compelled to get tested after he has been convicted, but without such results, it is difficult for the state to even place the accused on remand considering that a reasonable suspicion that the accused

deliberately infected the complainant would only be there after the accused has been tested, yet no one can force the same to get tested. Therefore criminalising could not protect women as there would be no proof that the accused person was even HIV positive in the first place, until he volunteers himself to do so. In one case that I dealt with, the accused opted to get tested but just went and brought what he called “his HIV test results.” Although they were in his name, no one could ascertain for sure that it was him who was tested and the result he brought were his as he went on his own to get tested. That matter also, could not be placed on remand. Also, some people do get tested but do not use their real names, which will be discussed below such that it becomes difficult to tell whose results are they.

#### **4.4.3 The use of pseudo names**

The other problem I saw during the prosecution of such matters is that of the use of pseudo names. Often, for the sake of confidentiality, people choose not to use their real names when getting tested for hiv, such that it is difficult to tell if the results they have are theirs or not. There are two cases that were not worthy on the use of such. In the first case, the woman was so positive that her husband, who was a doctor was not using his real name when collecting the ARVs at the clinic and even if she could bring his cards, there was no way they could be accepted since they were not in the accused person’s name. In the second issue the matter went to trial and in trying to prove that she was HIV Negative before having sexual intercourse with the accused, the complainant brought such results, which were in the pseudo name of Debra, yet her real name was Diana. There was absolutely no nexus between these two names and it was difficult for the magistrate to convict, as was my assumption number 4. Therefore the use of pseudo names posed a big problem in instances where people had been tested using names other than their real names, such that their identity was questionable and could not, with no uncertain terms be attributed to them.

### **4.5 Wilful transmission and violence**

#### **4.5.1 Introduction**

Gender based violence is violence that is directed against a woman because she is a woman or that affects women disproportionately” (CEDAW General Recommendation 19) Many women in Zimbabwe face so many kinds of violence, including physical and sexual violence. This is mainly facilitated by patriarchal hierarchies and serves to perpetuate male power and control over women. We have the Domestic Violence Act, which tries to combat any form of violence against women, as well as the constitution, which seeks to provide legal protection

of women from all forms of violence, as well as several efforts being made to set up administrative, social and educational processes that combats violence against women.

#### **4.5.2 Sexual violence**

Women and girls are at a risk of sexual violence, be it from their partners or from strangers. Sometimes the man who sexually abuses the woman might be HIV positive, thereby exposing her to the virus, or even transmitting it. In Zimbabwe, we have the criminal law codification and Reform act which guides all forms of sexual abuse, in s65, be it in marriage or by strangers.

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

#### **4.5.3 Physical violence**

I noted, as I was in the field, that many victims of wilful transmission of HIV were also experiencing physical abuse, from their sexual partners. In the case of S v KM (unreported), the complainant was so clear that she would not have reported wilful transmission had he not physically and emotionally abused her when he was now trying to dump her. As I read the record of proceedings, I found such statements, during cross examination by the defence.

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

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

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

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

From the above, it became so clear that this complainant was both physically and emotionally abused by the accused, after wilful transmission of HIV. This is just one example of the many

women who reported after they had been physically abused by their husbands and sexual partners.

#### **4.5.4 Links between violence and HIV infection**

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

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

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

#### **4.6 Conclusion**

In summing up, there are a lot of problems associated with prosecuting deliberate transmission of HIV. There is no way one can tell who infected who with the virus and it is really difficult to prove non disclosure as these issues are usually said in people's bedrooms, such that one cannot tell whether or not the words were uttered expressly or impliedly, or were even uttered at all. Generally, it will be a one on one issue and proving beyond a reasonable doubt as to what actually transpired. Also the issue of documentary exhibits makes prosecution difficult, as obtaining these documents would mean a breach of someone's constitutional right to privacy. The laws need to be aligned, and further research conducted,

so that prosecutors find a way around the issue of obtaining and tendering of documentary exhibits.

## **Chapter 5 Piercing the veil of secrecy in HIV/AIDS; Right to know and Right to Privacy**

### **5.0 Introduction**

This chapter presents the research findings on criminalising wilful transmission of HIV, mainly concerning one partner's right to know the other's status versus the accused's right to privacy. By criminalising wilful transmission, significant implications for public health privacy are imposed. (Lazarrini, 2002) As a prosecutor, one has a duty to prove that the accused knew of his HIV status, and such information can only be found from health records that are proof of such. Previously, in Zimbabwe it was allowed for the prosecutor to use an accused's public health record to prove that he was infected, but nowadays it is problematic to obtain such records as the hospitals will not release them, arguing that the same has a right to privacy and such a record is privileged information. Warrants of searches and seizures are being issued in terms of section 302 A (3) as read with 49 (b) and 50 (1) (a) of the Criminal Procedure and Evidence Act to provide medical history of accused persons but the searches are no-longer permissible to conduct because the matter is before the constitutional court, since the documents are considered confidential and releasing them would amount to a breach of one's constitutional right to privacy (s57).

### **5.1 The Right to Privacy**

According to the Black's Law Dictionary (6<sup>th</sup> ed, 1990), the right to privacy "is the right to be let alone; the right of a person to be free from unwarranted publicity...and such right prevents governmental interference in intimate personal relationships or activities..." In The Zimbabwean Constitution, s57 (e) every person has the right to privacy, which includes the right not to have their health condition disclosed. The National HIV/AIDS Policy of Zimbabwe defines confidentiality as "not disclosing private or personal information without consent"

The right to self preservation is a bona fide human right which is of fundamental importance. Article 12 of Universal Declaration of Human Rights provides that "no one shall be subjected to arbitrary interference with his privacy, family....." This means the right to privacy must be followed and one's HIV status ought not to be disclosed without their consent, as it will amount to a breach of that important right. No one therefore should disclose the other's

status, and the one infected must disclose if it is out of free will, not to be forced by anyone or anything. In the case of *Bestin v Bester SA (1)1996* the constitutional court ruled out that the right to privacy is recognised as an independent personality right, which the courts has included as the concept of *dignitas*” meaning this right is also together with one’s right to dignity.

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

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

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

However, this issue of confidentiality poses a very big problem. If, a doctor is faced with a scenario whereby a patient, a married man or someone who is sexually active tests positive to HIV, and insists that he will not disclose to his partner(s), he will keep on having unprotected sex with her and the patient declares that despite knowing he would not disclose, what will the doctor do? Would he contact the sexual partner(s) and tell her of the same? This would be ethically and legally wrong, yet the wife has the right to know of her husband's status, a right which will be discussed in below. This means there is need to strike a balance between the infected individual's right to privacy and the right to have the other party know.

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

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

## **5.2 Right to know**

Guiding Principle 39 of National HIV Policy Guidelines of Zimbabwe provides that all persons have the absolute right to clear and accurate information on HIV/AIDS. This section

thereby examines the right to know the HIV status of others. For the HIV epidemic to be halted, people will have to protect their sexual partners who are not infected from infection” (Maman and Medly, 2004). The best way to protect and the first step towards protecting will be to let someone know of one’s status.

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

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

Article 14 (e) of the Protocol to the African Charter on Human and People’s Rights gives everyone the right to be informed of one’s status, as well as their partner’s, especially when it comes to STI’S and HIV. This then poses a very big problem as the infected partner has the right to privacy, and the next chapter will try and balance these two competing rights.

### **5.3 Striking the balance/balancing the competing rights**

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

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

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

*“iye akazorora, ini ndasara ndiri mupenyu ndichirwadziwa. Iyezvino zvanaka, manures anobva ati uyai mese motestwa pamwechete, mobva maziva. Confidentiality haishande inouraya nyika”*

*Meaning: “now he has passed on, and I am still alive, I am not feeling well. Nowadays its better the nurses call both of you so that you get tested together and you both know. Confidentiality is destructive to the nation”<sup>7</sup>*

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

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

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

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<sup>7</sup> Waterfalls, Harare 06/01/16

But personally he felt he had the duty to disclose as the other partner had the right to know. There was never going to be a balance between the two rights, and he concluded by saying that the right to know held more power.

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

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

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

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

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

*“if you do not inform the families that a patient has hiv, you are taking away the family’s authority and making it impossible for them to be fully involved. It puts all the responsibilities on the patient, which is not how this disease is handled.”*<sup>8</sup>

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<sup>8</sup> Makoni, 2004 (unpublished)

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

### **5.3 Right to know and attitudes towards sexuality**

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

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

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

Religion also is a factor to blame when it comes to women failing to negotiate safe sex. As I went through the interviews, most of the women were Christians and they said the bible did not allow them to deny their husbands sex. One even quoted Hebrews 13 v 4 which says "marriage should be held in honour among all..." and to her if it was to be held in honour no one was to deprive the other, and went on to say, 1 Corinthians 7 verse 5 was clear that they were not supposed to refuse each other sex, except by agreement for a time, so that they would devote themselves to prayer, but beside that, the bible was clear that no one should deny the other.

One man even had this to say, basing on the bible “As a loving hind and a graceful doe, Let her breasts satisfy you at all times; Be exhilarated always with her love.” Proverbs 5 verse 19. He said the bible was clear that her breast was to satisfy him “*at all times, saka mukadzi anondinyima bonde anondinyimirei? After all pandakamuroora ndakamuroorera bonde, ndiro raakabvira kumusha kwavo, hapana chekutura apa. Musi wandinoroora ndinokumbira sadza and kubvuma kwake kunoreva kuti abvua kundipa bonde pandadire.*

*No two ways about it” he laughed. Meaning at all times she must give me sex since that is the reason why I married her. After all when I prayed her bride price I married her for the sex, that is the reason why she left her parents’ home, there is nothing to negotiate. When I married her, her acceptance meant she was accepting to give me sex each time I wanted, no two ways about it.*<sup>9</sup>

### **5.3.1 Conclusion**

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

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<sup>9</sup> Mbare Magistrate Court 13/01/16

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

### **6.1 Conclusion**

1. Attitudes towards sexuality make it difficult for women to talk about HIV/AIDS
2. Women often find it difficult to negotiate safe sex thereby getting infected.
3. Also, prosecutors find it difficult to prove beyond a reasonable doubt that the complainant has been wilfully infected with the virus by the accused
4. Prosecutors find it difficult to prove that the complainant has been wilfully infected with the virus by the accused as doctors are not allowed to disclose a patient's HIV status since it is considered to be privileged information, such that magistrates find it difficult to convict people of wilful transmission as the state would have failed to prove its case beyond a reasonable doubt.
5. There is need to develop gender sensitive strategies to prevent new infections, and these will be discussed in detail below.
6. Instead of criminalising wilful transmission of HIV, Zimbabwe has to follow other jurisdictions like that of Kenya which has different methods of dealing with the same. These include choosing to focus on more effective methods of deterring the spread of the virus by knowing partners, like creating education programs that are culturally sensitive and timely. "It is likely that the focus on educating the constituents will be a more effective means of spreading HIV" (Bellany, 2004). It is very difficult for the state to prove that the accused intentionally infected the complainant with the virus, as well as the fact that it was the accused person and no one else whose virus is in the complainant's body. As was noted from the evidence of one of my interviewees, he explained that the virus has a different stance; they have more than 100 types so they take different shapes and forms, such that one cannot prove which virus is it and whether or not it can be the same as the one in the next person. It can change its shape depending on the person's immune system therefore there is no way of knowing if it is the same as the one that entered x from y.
7. Also, one scholar notes that "criminalising transmission will not open floodgates for greater disclosure. What is needed to stanch the spread of the epidemic is more understanding of, and action towards social justice and the protection of the rights of

individuals affected, with women at the forefront. ”(O’Grady,2011).I therefore conclude by saying that criminalisation on its own will not make much difference, but together with the recommendations below, women will be better protected from infections in Zimbabwe.

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

## **6.2 Recommendations**

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

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

1. Besides criminalising, people should be educated about sex and HIV. Sex education should be introduced at school level and at work places because just after school they go to work and they are prone to being infected with the virus. We see many beautiful but vulnerable ladies who have sex with men so that they are given different favours in life like getting a job or even being promised very little material things like money and cars by men who know their status yet choose not to disclose.

2. In the rural areas, people should be taught against such cultural beliefs that having sexual intercourse with a virgin will cure one of HIV. Women also, should be taught that there is nothing wrong in talking about sex and in negotiating safe sex. One does not become someone of loose morals because they are free to talk about sex and HIV. The National Aids Policy notes that unprotected sex within marriage is the most risk factor for any woman. This is because most (but not all) men do not feel it is right to use condoms in the marital home, they might prefer using them outside. The women and men should be taught that there is nothing wrong with using condoms inside marriage.
3. Also, prosecution is done publicly, and the parties will be exposed and no one wants their statuses to be known because of the stigma surrounding HIV in Zimbabwe. The trials should be held under camera, so that the women who testify against their partners are not traumatised. Prosecution should not be prohibited, but used on its own; it will never protect women against infections. Basically, the justice system should put in place support systems for these trials to be held under camera to safeguard the confidentiality of those involved. The press should not be allowed to publicise such stories, as it is doing more harm than good to the victims, who are mostly women.
4. I am also of the view that, as a strong recommendation, laying the burden of responsibility solely on those who know they have HIV may deter some people from getting tested to avoid prosecutions, therefore both partners should be responsible for their own health and as mentioned above, women be taught that there is nothing wrong in negotiating for safe sex. They also should not only wait for men to put on condoms, they themselves should be in a position to wear condoms, as most men, as seen in the above discussion, do not disclose their status, thereby exposing their partners, or in worse situations, transmitting the virus to them.
5. Still on condom use, I noted that they are mostly controlled by men, who are reluctant to use them. I also noted that female condoms offer protection to some women but still there will be need to negotiate with the partner before using it, therefore I recommend that the government need to come up with fully woman controlled protective methods.
6. I would also recommend that the laws be aligned to make prosecutions easier, especially regarding confidentiality and the right to know. Doctors should be allowed to testify upon being called to do so by a court of law so that the state can prove

beyond reasonable doubt that the accused person actually knew of his status and did not disclose. Doctors should not disclose for the sake of disclosing, but only to those who have the right to know, like the court and the partner of those who might be recalcitrant patients, who insist that they will not disclose to their partners. However, this might be a bit difficult, as all the partners might not be known.

7. Empowerment of women is one strong recommendation. Women need to be educated and be given information about their bodies and sex, providing them with skills training in communication about sex, especially in marriages and how to use a condom, as well as foster inter-partner communication. Their decision Making in the household should also be improved, as well as in the community and at national level, thereby supporting their leadership and participation. They need to be given a voice, opportunities to create group identity as well as separate from that of the family since for many of them it is the family that often enforces strict adherence to traditional gender norms. They need to be taught that there is nothing wrong in getting their partners arrested for wilful transmission of HIV, whatever the outcome and to be self sustaining, so that they do not withdraw the charges simply because they feel that no one will be able to take care of them once he is arrested.
8. As some women are driven by poverty and a desire for a better life, “they find themselves having sex in exchange for goods, services, money, transportation, accommodation or other basic necessities” which is what most Zimbabwean women call ‘food for work’ (UNICEF,2003)Research shows that in such situations, they are even less likely to be able to negotiate for safe sex and protect themselves against HIV infections.(Preston-Whyte, et al, 2000).The need immediate need to pay school fees that are due, or to put food on the table often outweighs the risk of illness and death at some indeterminable future time. I therefore strongly recommend that women and girl be taught that whatever the situation they are faced with, they should be in control and insist on protection, or even make use of the female condoms themselves, because the men will seem to be so understanding and give them what they want, but fact still remains, they might not have disclosed their HIV status they the women and girls are exposed to the virus, or worse still, have it transmitted to them. Such women should therefore be economically empowered, for example by providing them with access to credit and business, entrepreneurship and marketing skills, to help increase their self confidence and self esteem.

9. I also recommend that the government collapse the bridge of infection between younger women and girls with older men. I noted during the course of my research that so many women have sex with men who are more than six years older than they are; who are more likely to be infected with the virus than younger men of their age. Such relationships with older men lead to unequal power relations within the couples, thereby leaving the women vulnerable to abuse and exploitation by the older men, and the risk of transmission becomes high. This bridge has to be collapsed if we are to see a change in cases of wilful transmission of HIV.
10. The culture of silence also needs to be killed in our societies. The word “taboo” is more often than not associated with sex and sex talk in women. Usually parents, elders and teachers are too embarrassed to talk about sex to children as they strongly believe that it will thereby encourage them to become sexually active. This lead to very limited knowledge in young women and girls when it comes to HIV, who are the most vulnerable group. Many women are in the dark when it comes to sex, sexuality and their bodies, such that when they eventually start to engage, they do not have enough knowledge on HIV. Young girls should be taught early about HIV and break this culture of silence. I strongly recommend that even health workers impart knowledge on HIV to young women and girls, in non-judgemental ways since they are trained to handle such questions.

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